STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING _____ B. WING _____	C 06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

(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 Complaint # NJ00159306 This facility is not 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. Complaint investigations were also completed during this survey.	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness	E 004		7/26/23

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

Electronically Signed | 07/06/2023

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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E 004	Continued From page 1 requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's Emergency Preparedness Plan and Program (EPP) revealed that the facility failed to ensure that the EPP was reviewed and updated at least annually, as evidenced by the following: On 6/8/23 at 10:25 AM, the surveyor reviewed the facility's EPP and noted no documented evidence that the facility reviewed and updated the EPP for 2022. The last review and update of the facility's EPP was in 2021, according to documentation provided by the facility. This concern was confirmed in an interview with the facility's Business Office Manager, the acting facility's Maintenance Director at 11:30 AM, who indicated that this problem would be corrected. On 6/12/23 at 11:03 AM, the survey team met with the Licensed Nursing Home Administrator	E 004	E004 1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice: No residents were affected. The Emergency Response Manual was reviewed and updated by facility administration on 7/10/23. An Annual Emergency response planning meeting is scheduled for 7/26/2023. Representatives from Lebanon and Hunterdon OEM have been invited to the planning meeting to review and finalize changes to the plan. 2. The facility identified other residents having the potential to be affected by the same deficient practice:	

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E 004	Continued From page 2 (LNHA), who acknowledged that the EPP manual was incomplete. The LNHA stated that the EPP manual was being worked on. No further information was provided. NJAC 8:39-31.2(e), 31.6(i)(1)	E 004	All Residents have the potential to be affected. The Emergency Response Manual was reviewed and updated by facility administration on 7/10/23. An Annual Emergency response planning meeting is scheduled for 7/26/2023. Representatives from Lebanon and Hunterdon OEM have been invited to the planning meeting to review and finalize changes to the plan. 3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: The administrator will hold an Emergency Management Planning meeting at least annually to review the plan to ensure its accuracy and relevance to potential emergencies. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The quarterly QAPI Meeting is scheduled for 7/26/2023 and a report of approved changes to the Emergency response plan will be submitted to the QAPI committee for review and any further recommendations. At least annually and as required, the administrator and/or designee will submit a report detailing a review of all drills and/or actual disasters/emergency response, performance improvement plans, and all changes made to the Emergency Response Plan to the quarterly QAPI committee for review and	

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E 004	Continued From page 3	E 004	any further recommendations	
E 009 SS=F	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.542(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's Emergency Preparedness Policies and Procedures (EPP), it was determined that the	E 009	E009 1. The corrective action(s) accomplished	7/26/23

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E 009	Continued From page 4 facility failed to ensure that a documented process for cooperating/collaborating with regional, State and Federal emergency preparedness officials was included in their Emergency Preparedness Manual as evidenced by the following: On 6/8/23 at 10:25 AM, the surveyor reviewed the facility's EPP which revealed that their policies and procedures included cooperation/collaboration efforts only with local emergency preparedness officials. This was confirmed in an interview with the facility's Business Office Manager, who indicated that their EPP was being updated to comply with the new Emergency Preparedness regulations. On 6/12/23 at 11:03 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), who acknowledged that the EPP manual was incomplete. The LNHA stated that the EPP manual was being worked on. No further information was provided. NJAC 8-39-31.2(e), 31.6(i)(1)	E 009	for the resident found to be affected by the deficient practice: No residents were affected. The Emergency Response Manual was reviewed and updated by facility administration on 7/10/23. An Annual Emergency response planning meeting is scheduled for 7/26/2023. Representatives from Lebanon and Hunterdon OEM have been invited to the planning meeting to review and finalize changes to the Emergency Response Plan. The Emergency response manual was reviewed and updated as appropriate on 7/10/23 to include contact information of local county, state, and federal emergency preparedness agencies/officials. 2. The facility identified other residents having the potential to be affected by the same deficient practice: All Residents have the potential to be affected. The Emergency Response Manual was reviewed and updated by facility administration on 7/10/23. An Annual Emergency response planning meeting is scheduled for 7/26/2023. Representatives from Lebanon and Hunterdon OEM have been invited to the planning meeting to review and finalize changes to the plan. 3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: The facility administrator will invite	

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E 009	Continued From page 5	E 009	representatives from the local and county offices of emergency management and emergency services to the facility's annual Emergency Management planning meeting. The facility administration will seek to obtain valuable input and ensure an integrated response to the emergency management plan that aligns with local and county emergency management response and recovery protocols and capabilities. Representatives who are unable to attend will receive a copy of the revised plan as well as meeting minutes from the meeting. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The quarterly QAPI Meeting is scheduled for 7/26/2023 and a report of approved changes to the Emergency response plan will be submitted to the QAPI committee for review and any further recommendations. At least annually and as required, the administrator and/or designee will submit a report detailing a review of all drills and/or actual disasters/emergency response, performance improvement plans, and all changes made to the Emergency Response Plan to the quarterly QAPI committee for review and any further recommendations The QAPI Plan will be updated to include ongoing evaluation of the Emergency	

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E 009	Continued From page 6	E 009	Response procedures and training.	
E 025 SS=F	Arrangement with Other Facilities CFR(s): 483.73(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services	E 025		7/26/23

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E 025	Continued From page 7 to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that its Emergency Preparedness Program and Plan (EPP) included transfer agreements with other long-term care facilities. This deficient practice was evidenced by the following: On 6/8/23 at 10:25 AM, the surveyor reviewed the facility's EPP and noted no documented transfer agreements with other long-term care facilities for sending and/or receiving residents during an emergency evacuation. The facility provided a list of long-term care facilities in the same county (Hunterdon) that they may have agreements with. However, the facility could not provide documented transfer agreements with these or other facilities. The facility's Business Office Manager confirmed the above in an interview at 1:49 PM, who further stated that they could not provide any additional information. On 6/14/23 at 9:55 AM, the surveyor was provided by the Director of Social Services (DSS) a Transfer Agreement for a nearby long term care facility dated as signed by that facility on 6/12/23 and signed by the Licensed Nursing Home Administrator (LNHA) on 6/14/23. The DSS	E 025	E025 1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice: No residents were affected. The facility obtained transfer agreements from two local nursing facilities. 2. The facility identified other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. The facility obtained transfer agreements from two local nursing facilities. 3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: During the annual Emergency Management planning meeting the administrative team will review the transfer agreements to determine the continued viability in the event of an evacuation. 4. How the facility will monitor its	

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E 025	Continued From page 8 stated that they were working on getting more Transfer Agreements. On 6/12/23 at 11:03 AM, the survey team met with the LNHA, who acknowledged that the EPP manual was incomplete. The LNHA stated that the EPP manual was being worked on. No further information was provided. NJAC 8:39-31.2(e), 31.6(f)(2)(g)(i)(2)	E 025	corrective actions to ensure that the deficient practice is being corrected and will not recur: The quarterly QAPI Meeting is scheduled for 7/26/2023 and a report of approved changes to the Emergency response plan including a review of the transfer agreements to determine the continued viability in the event of an evacuation will be submitted to the QAPI committee for review and any further recommendations. At least annually and as required, the administrator and/or designee will submit a report detailing a review of all drills and/or actual disasters/emergency response, performance improvement plans, a review of the transfer agreements, and all changes made to the Emergency Response Plan to the quarterly QAPI committee for review and any further recommendations	
E 031 SS=F	Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.542(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:	E 031		7/26/23

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E 031	Continued From page 9 (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's Emergency Preparedness Program and Plan (EPP), it was determined that the facility failed to ensure that its communication plan included the required contact information as evidenced by the following: On 6/8/23 at 10:25 AM, the surveyor reviewed the facility's EPP and noted that Emergency Officials' contact information was not included for Federal Emergency Preparedness Staff. During an interview with the facility's Business office Manager, who was the acting Maintenance Director, acknowledged that no documented Federal Emergency preparedness staff contact	E 031	E031 1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice: No residents were affected. 2. The facility identified other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. The Federal Emergency Management Agency contact information for region 2 was added to the communication plan.	

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E 031	Continued From page 10 information was listed on the form titled, "Emergency Call Lists." On 6/12/23 at 11:03 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), who acknowledged that the EPP manual was incomplete. The LNHA stated that the EPP manual was being worked on. No further information was provided. NJAC 8:39-31.2(e), 31.6(f)(6)(7)	E 031	3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: The administrator and/or designee will review the emergency communication list of contacts and update it as appropriate. During the annual Emergency Management planning meeting the administrative team will review the emergency communication plan for accuracy. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The quarterly QAPI Meeting is scheduled for 7/26/2023 and a report of approved changes to the Emergency response plan including a review of the emergency communication plan to ensure all Local, County, State and Federal contact information is included and up to date will be submitted to the QAPI committee for review and any further recommendations. At least annually and as required, the administrator and/or designee will submit a report detailing a review of all drills and/or actual disasters/emergency response, performance improvement plans, a review of the transfer agreements, and all changes made to the Emergency Response Plan to the quarterly QAPI committee for review and any further recommendations.	
E 039 SS=F	EP Testing Requirements	E 039		7/26/23

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E 039	Continued From page 11 CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or	E 039		

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(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]
(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:
(i) Participate in a full-scale exercise that is community based every 2 years; or
(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by

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a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.

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E 039	Continued From page 14 *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.	E 039		

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E 039	Continued From page 15 *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):]	E 039		

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E 039	Continued From page 16 (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:	E 039		

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E 039	Continued From page 17 (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years;	E 039		

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or.

(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.

*[For OPOs at §486.360]

(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:

(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem

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E 039	Continued From page 19 statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's Emergency Preparedness Policies and Procedures (EPP), it was determined that the facility failed to conduct two (2) exercises (facility and community-based) within the last 12 months to test their emergency plan. This deficient practice was evidenced by the following: On 6/8/23 at 10:25 AM, the surveyor reviewed the facility's disaster drill reports from June 2022	E 039	E039 1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice: No residents were affected. 2. The facility identified other residents having the potential to be affected by the same deficient practice:	

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E 039	Continued From page 20 through June 2023 and noted that only two (2) tabletop disaster drills/exercise were conducted as indicated by a report dated 2/2023 and 5/2023. The facility's Business Office Manager (BOM), the acting Maintenance Director, was informed of this requirement on 6/8/2023 at 1:10 PM and confirmed that only two (2) tabletop disaster drills/exercises were conducted during the period reviewed. The BOM further stated that no other emergency preparedness exercises, or occurrence of an actual emergency event, had been done during this period. On 6/12/23 at 11:03 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), who acknowledged that the EPP manual was incomplete. The LNHA stated that the EP manual was being worked on. No further information was provided. NJAC 8-31.2(e), 31.6(b)(o)	E 039	All residents have the potential to be affected. • On May 28, 2023, the facility Conducted a Tabletop disaster exercise on a simulated active shooter scenario. • On June 17, 2023, the facility encountered a fire alarm activation caused by a faulty smoke detector, resulting in the activation of the emergency response plan and the involvement of fire and police departments. The incident was reported to the New Jersey State Department of Health and has been documented in an after-action report to assess the response and identify areas for improvement. 3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: During the annual Emergency Management planning meeting the administrative team will select and plan two simulated emergency/disaster scenarios and schedule them within the year. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: A report will be submitted to the QAPI committee in the quarter in which the simulated emergency/disaster scenarios was held detailing a review of the drill and/or actual disaster/emergency response, including performance improvement plans and status, and all	

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E 039	Continued From page 21	E 039	changes made to the plan as a result of the drill and/or actual disaster/emergency response. The quarterly QAPI Meeting is scheduled for 7/26/2023 and a report of approved changes to the Emergency response plan as well as a schedule of all planned disaster and/or tabletop drills will be submitted to the QAPI committee for review and any further recommendations. At least annually and as required, the administrator and/or designee will submit a report detailing a review of all drills and planned drills and/or tabletop exercises and/or actual disasters/emergency response, performance improvement plans, a review of the transfer agreements, and all other changes made to the Emergency Response Plan to the quarterly QAPI committee for review and any further recommendations.	
F 000	INITIAL COMMENTS Complaint #s NJ00155172, NJ00161276, NJ00160806, NJ00159306, NJ00155489 STANDARD SURVEY: 6/15/23 CENSUS: 29 SAMPLE SIZE: 17 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this	F 000		

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survey.

During a Standard Survey conducted on 6/15/23, it was determined that effective 6/1/23, the Facility was found to have been in Immediate Jeopardy for F756K and F760K, and effective 6/5/23, the Facility was found to have been in Immediate Jeopardy for F689L, F835L, and F836L.

The Department of Health sent a Notice of Determination of Immediate Jeopardy to the Facility Administrator on 6/1/23 and 6/5/23, including the Immediate Jeopardy Templates.

The Facility failed to:

- ensure that the Consultant Pharmacist recommendations dated 3/7/23 were acted upon in a timely manner regarding the documentation and administration of critical medications, including NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26 medications, to prevent serious adverse outcomes for Resident #13, #19, and #20 who required NJ Exec. Orde and were dependent on NJ Exec. Order 26:4 and Resident #17 and #230 who had physician orders for an NJ Exec. Order 26:4.b.1 to prevent NJ Exec. Orde

- ensure that residents are free of significant medication errors regarding the documentation and administration of critical medications, including NJ Exec. Order 26:4.b.1 and NJ Exec. Order 2 medications, to prevent serious adverse outcomes for Residents #13, #19, and #20, who required NJ Exec. Orde and were dependent on NJ Exec. Order 2, Resident #17, #25 and #230 who had physician orders for an NJ Exec. Order 26:4.b.1 to prevent NJ Exec. Orde and Resident #19 who had a physicians

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order for an NJ Exec. Order 26:4.b.1 agent (medications to NJ Exec. Order 26:4.b.1). The Facility failed to ensure that Resident #18 was given medication validated by the physician, and the pharmacy, reviewed for allergies, and entered into the electronic Medication Administration Record (eMAR) to prevent serious adverse outcomes, including significant allergic reactions.

- ensure 29 residents were adequately supervised when Licensed Practical Nurse (LPN) #1 worked 24 hours straight, six times in May 2023, with one Certified Nursing Assistant (CNA) #1 on the assignment during designated shifts.

- ensure a.) staffing levels set forth in the Facility Assessment Tool were consistently met to address the population census and needs of their residents; b.) minimum State staffing requirements were met for 17 weeks of 17 weeks reviewed, during which time the Facility continued to admit residents; c.) safe medication administration to residents resulting in significant medication errors; d.) Consultant Pharmacist (CP) monthly medication review reports were acted upon by the Director of Nursing (DON) and the Physician in a timely manner; e.) adequate supervision and competent staff when LPN#1 would sleep during excessive continuous hours at work, leaving no nurse to supervise the CNA and no nurse to supervise the 29 residents while LPN #1 slept. Additionally, the LNHA failed to actively engage the Medical Director regarding ongoing concerns expressed during the survey.

-maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for 118 of 119-day shifts, 54 of 119 evening shifts, and 10 of 119 overnight shifts.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 24 On 6/8/23, the Department of Health received an acceptable allegation for Removal of the Immediate Jeopardy. The following Immediate Jeopardy (IJ) situations were identified for F756K, F760K, F689L, F835L, and F836L. During a Standard Survey, the surveyors were on site during the dates of 5/24/23, 5/25/23, 5/26/23, 5/30/23, 5/31/23, 6/1/23, 6/2/23, 6/5/23, 6/6/23, 6/7/23, 6/8/23, 6/9/23, 6/10/23, 6/11/23, 6/12/23, 6/13/23, 6/14/23, and completed the survey on 6/15/23, and the survey team identified the following: 1. F756 scope and severity (s/s) of K and F760 s/s of K: The IJ began on 6/1/23. The Facility was notified of the IJ on 6/1/23, and an acceptable Removal Plan was received on 6/8/23. The survey team verified the implementation of the Removal Plan on 6/9/23. 2. F689 s/s L, F835 s/s L, and F836 s/s L: The IJ began on 6/5/23. The Facility was notified of the IJ on 6/5/23, and an acceptable Removal Plan was received on 6/8/23. The survey team verified the implementation of the Removal Plan on 6/9/23.	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,	F 550		7/25/23

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self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and 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:

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F 550	Continued From page 26 Based on observation, interview, and record review, it was determined that the facility failed to treat each resident with respect and dignity in a manner that promotes his/her quality of life during lunch. This deficient practice was identified for one (1) of three (3) residents (Resident #11) who required NJ Exec. Order 26:4.b.1 and were not being NJ Exec. Order 26:4.1 while the other residents at the same table were either eating or being NJ Exec. Order 26:4.b This deficient practice was evidenced by the following: On 5/24/23 at 12:20 PM, during lunch in the dining area, the surveyor observed Resident #11 seated in a NJ Exec. Order 26:4.b.1 [redacted] at a table with two (2) unsampled residents. All three residents had their lunch trays in front of them, and Resident #11's lunch tray remained covered. One of the unsampled residents could eat independently, and a Certified Nursing Assistant (CNA) assisted the other unsampled resident at a hospice company (HCNA). The HCNA was seated between the unsampled resident she was feeding and Resident #11. On 5/24/23 at 12:44 PM, the surveyor observed the HCNA finish feeding the unsampled resident and go to perform hand hygiene. At that time, the surveyor interviewed the HCNA, who stated that she had just finished feeding the unsampled resident who was receiving hospice services and was going to feed Resident #11, who was also receiving hospice services. The HCNA added that she was not allowed to feed both residents simultaneously.	F 550	F550 1. How the corrective action will be accomplished for those residents found to have been affected by the practice. • The Hospice aide was educated on 6/5/23 by the administrator on Dining procedures and feeding assistance and an additional staff member was assigned to feed resident #11. 2. How the facility will identify other residents who have the potential to be affected by the same deficient practice? • All residents requiring feeding assistance have the potential to be affected by this deficient practice. • Staff will identify all residents that require assistance with meals and they will be seated accordingly. • All residents, including those requiring assistance, will be provided with meal trays at the same time as their table mates. • Feeding assistance will be provided to the identified residents, ensuring that they receive the support they need in a consistent manner. 3. What measures will be put into place to ensure that the deficient practice will not Recur? • The Administrator will review and	

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F 550	Continued From page 27 On 5/25/23 at 12:10 PM, the surveyor interviewed the HCNA, who stated that she was at the facility Monday through Friday during lunch to feed the two (2) residents receiving hospice services and required assistance with feeding. The HCNA stated that her usual was to feed the unsampled resident first because they were more challenging to feed, and then she would feed Resident #11. At that time, the surveyor observed the HCNA assisting the unsampled resident with lunch, and another unsampled resident was eating independently at the same table. At the same time, Resident #11 had their covered lunch tray in front of them. On 5/25/23 at 12:35 PM, the surveyor interviewed the Director of Nursing (DON), who stated that there was an HCNA specifically here to feed two (2) residents receiving hospice services that required assistance. The DON pointed out to the surveyor in the dining area the HCNA and stated that she was currently feeding an unsampled resident, and then she would feed Resident #11, who was seated next to the HCNA in their [redacted] with their covered lunch tray in front of them. On 5/25/23 at 12:48 PM, the surveyor observed the HCNA had finished feeding the unsampled resident and began to assist Resident #11 with their lunch. The unsampled resident, who was eating independently, was completed and had left the table. The surveyor also observed a majority of finished lunch trays returned to the dietary truck and returned to the kitchen. On 6/2/23 at 12:20 PM, the surveyor again	F 550	revise its existing policies and procedures regarding feeding assistance to incorporate clear guidelines for mealtime protocols, (ie distributing meal trays to each table simultaneously and providing feeding assistance to each resident as needed). • The Director of Nursing and/or designee will conduct comprehensive training for all current nursing staff involved in providing feeding assistance on best practices, proper techniques, and protocols for assisting residents with meals as per the revised policy. • The Director of Nursing and administrator will review the current seating plan and changes will be implemented as needed. • The administrator will implement an audit tool to ensure that staff members are adhering to the established protocols and providing appropriate and dignified care to all residents requiring feeding assistance. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. • Audits based on revised dining procedures will be conducted and documented by the Director of Nursing and or/designee on a weekly basis for 1 month and then monthly for three months. • Results of the dining audits will be compiled into a quarterly report to be reported at the quarterly QAPI Meeting.	

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observed the HCNA seated between the unsampled resident she was feeding and Resident #11. Resident #11 again had their covered lunch tray in front of them.

On 6/2/23 at 12:41 PM, the surveyor interviewed the HCNA, who stated that she was unsure if a facility CNA was available to help feed Resident #11. The HCNA stated that she thought CNA #4 was responsible for the care of Resident #11 during the day.

At that time, the surveyor observed CNA #4 assisting another resident with lunch.

On 6/5/23 at 11:51 AM, the surveyor interviewed the DON, who stated that every staff member must pitch in where they could help during dining. The DON added that CNAs and nurses could help feed the residents that required assistance, and other staff members could facilitate the trays, assist with needed items and help with clean up. The DON acknowledged that the HCNA had two (2) residents receiving hospice services and required assistance with feeding and that Resident #11 had to wait to be fed until the unsampled resident was fed first. The DON stated that there was not enough staff to help feed the residents and that she depended on the HCNA to feed the two (2) residents receiving hospice services. The DON added that when the HCNA was not at the facility, it was up to the facility CNAs to feed Resident #11. The DON added that she had suggested a feeding assistant program be instituted, but that had not started. The DON stated that the Licensed Nursing Home Administrator (LNHA) knew additional CNAs were needed to feed.

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On 6/5/23 at 12:20 PM, the surveyor again observed the HCNA seated between the unsampled resident she was feeding and Resident #11. Resident #11 again had their covered lunch in front of them.

The surveyor reviewed the medical record for Resident #11.

A review of the resident's Admission Record revealed that the resident had diagnoses that included but were not limited to EX Order 26 § 4b1 [redacted]

A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care with an assessment reference date of 4/21/23, reflected the resident NJ Exec. Order 26:4.b.1 a Brief Interview for Mental Status (BIMS) obtained, so staff performed a NJ Exec. Order 26:4.b. [redacted] which reflected the resident had a EX Order 26 § 4b1 [redacted] with a EX Order 26 § 4b1 [redacted]. The MDS reflected in the Special Treatment, Procedures, and Program section that the resident received EX Order 26 § 4b [redacted] care.

A review of the resident's interdisciplinary care plan with an initiated date of 12/20/2019 and revised date of 1/24/23 had a Focus area that indicated "Resident #11 is on EX Order 26 § 4b1 [redacted]" The Goal indicated,

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F 550	Continued From page 30 "Resident #11 will have all NJ Exec. Order 26:4.b.1 needs met." On 6/12/23 at 11:03 AM, the survey team met with the LNHA. The LNHA acknowledged that an HCNA was at the facility to assist with lunch for the two (2) residents receiving hospice services. The LNHA acknowledged that Resident #11 should not sit in the dining room at the table with their meal in front of them, waiting until another resident was fed. The LNHA acknowledged that all residents should eat at the table at the same time. The LNHA could not speak to why this was occurring. A review of the facility policy dated 2023 for "Dining Room-Meals" provided by the LNHA reflected that the Unit Nurse will "Supervise nursing assistants during the meal to ensure: Residents are served food in accordance with prescribed diets and assisted with feeding appropriately." In addition, the policy reflected that the Nursing Assistants were to "Serve and assist residents at the same table concurrently."	F 550		
F 607 SS=D	NJAC 8:39-4.1(a)(12)(28), 17.3(c), 17.4(d) Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 607		7/25/23

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F 607	Continued From page 31 §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on the interview and review of pertinent facility documents, it was determined that the facility failed to obtain current and past-employer reference checks prior to hiring in accordance with the facility's abuse policy and procedure for screening newly hired employees. This deficient practice was identified for 3 of 5 newly hired employees and was evidenced by the following: On 6/5/23, the surveyor reviewed pre-screening for five (5) newly hired employees. Three of the 5 employees listed below had no reference checks performed before starting work at the facility. a) A Dietary Aide (DA) who began working at the	F 607	F607 1. How the corrective action will be accomplished for those residents found to have been affected by the practice. • No residents have been affected by this deficient practice. • Dietary Aide, Hire date: 5/12/22-Resigned • Certified Nursing Assistant (CNA), Hire Date: 3/13/23 o Reference Check was conducted 7/13/23 • Registered Nurse (RN), Hire Date:	

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F 607	Continued From page 32 facility on 5/12/22. b) A Certified Nursing Assistant (CNA) who began working on 3/13/23. c) A Registered Nurse (RN) who began working on 3/10/23. On 6/5/23 at 9:20 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated the DA, CNA, and RN did not have pre-employment reference checks done. The LNHA stated the facility's policy is to perform them before hiring. The LNHA did not give a reason for the omissions. The LNHA provided the surveyor with the Resident Abuse Prohibition Policy, reviewed in 2023. The policy indicated, "Prospective employees are interviewed, references are checked, and State/Federal criminal background checks are performed prior to hiring and annually." NJAC 8:39-13.4(c)12	F 607	3/10/23 o Reference Check was conducted 7/13/23 2. How the facility will identify other residents have the potential to be affected by the same deficient practice. • All residents have the potential to be affected by the failure to obtain current and past employer reference checks prior to hire. • An audit of all current employees' employment records was completed on 7/12/23 to ensure compliance with the abuse policy of two reference checks. The office manager will obtain two references checks on all current employees by 7/25/23. 3. What measures will be put into place to ensure that the deficient practice will not Recur. • The administrator reviewed and revised the Abuse policy and developed new guidelines as of 6/16/23 requiring two reference checks prior to hire. • The Administrator educated the business office manager on 6/16/23 on completing two reference checks on employee candidates prior to hire. • Two reference checks will be completed by the business office manager or designee on all potential employees prior to hire. 4. How the facility will monitor its corrective actions to ensure that the	

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F 607	Continued From page 33	F 607	deficient practice will not recur. • On a monthly basis the Business Office Manager will review with the Administrator all new hire records to ensure compliance with the abuse policy of completing two reference checks prior to hire. • Business office manager will report the number of new hires for the quarter and report compliance of reference check completion rate at the Quarterly QAPI meeting.	
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party	F 622		7/25/23

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payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)

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F 622	Continued From page 35 (2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to document the circumstances of the resident change of condition leading to emergency transfer and the resident's readmission to the facility NJ Exec. Order 26:4.b.1 The deficient practice was identified for 2 of 5 residents (Residents #26, #4) reviewed for NJ Exec. Order 26:4.b.1. The evidence is as follows: 1. The surveyor observed Resident #26 sitting in bed on 5/24/23 at 10:45 AM. The NJ Exec. Or and NJ Exec. Order 26:4. resident discussed her various medical conditions with the surveyor.	F 622	F622 1. How the corrective action will be accomplished for those residents found to have been affected by the practice. • Resident #26 – Late entry admission and discharge documentation was completed. • Resident #4 – Upon investigation, a discharge note by nurse # 1 , was entered as an “orders” progress note rather than a “transfer” progress note. • On 6/3/23 and 6/5/23 nurses were	

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F 622	Continued From page 36 A review of the resident's Electronic Medical Record (EMR) revealed the following information: The Admission Record (AR) listed diagnoses of [redacted] The 3/19/23 Admission Minimum Data Set (MDS) assessment tool indicated the resident scored [redacted] out of 15 on the Brief Interview for Mental Status (BIMS), indicating [redacted] A Social Service (SS) Progress Note written on 4/14/2023 at 14:08 (2:08 PM) indicated that the SS Director (SSD) spoke with the resident regarding an imminent emergency transfer to the [redacted] The SSD confirmed the resident's family would be notified. An Activity Participation Progress Note written on 4/14/2023 at 18:29 (6:29 PM) by the Activity Director (AD) described welcoming the resident back to the facility. There were no Nursing Progress Notes documenting the reason for the emergency transfer, the resident's condition upon discharge, or the resident's return from the [redacted] 2. The surveyor observed Resident #4 awake in bed on 5/24/23 at 11:18 AM. The resident was [redacted] and [redacted] and engaged in conversation with the surveyor. A review of the EMR revealed the following	F 622	educated regarding appropriate documentation for admissions, discharges, and transfers. 2. How the facility will identify other residents have the potential to be affected by the same deficient practice. • All residents who are admitted, transferred, and/or discharged have the potential to be affected. • On 7/11/2023 the Director of Nursing audited all previous resident admissions, discharges, and, transfers from 6/15/23 to the present for the omission of resident admission, discharge, and transfer documentation. No additional missing documentation of admissions/discharges/transfers was found. 3. What measures will be put into place to ensure that the deficient practice will not Recur. • All nurses will be re-educated by the Director of Nursing on the policy regarding admission, discharge, and transfer documentation. • The Director of Nursing or designee will monitor nurse's notes when there is a discharge, admission or transfer for compliance. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur.	

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	315467	A. BUILDING _____ B. WING _____	C 06/15/2023

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F 622	Continued From page 37 information: The AR included diagnoses of EX Order 26 § 4b1 [redacted]. The 2/4/23 Quarterly MDS assessment tool indicated the resident scored a [redacted] of 15 on the BIMS interview, meaning the resident had no EX Order 26 § 4b1. The "Census" tab in the EMR listed a NJ Exec. Order 26:4 [redacted] NJ Exec. Order 26:4 leave and noted the resident was back to active on NJ Exec. Order 26:4 [redacted]. The Progress Notes had no documentation after 5/18/23 at 15:10 (3:10 PM) until 5/29/23 at 9:55 AM. On 5/31/23 at 11:25 AM, Licensed Practical Nurse #1 (LPN #1) stated to the surveyor that nurses should document when a resident goes out to the NJ Exec. Order 26:4 [redacted] and is readmitted. On 5/31/23 at 12:50 PM, the Director of Nursing (DON) confirmed that nurses are required to document a Progress Note when the resident is transferred, discharged, and readmitted. The undated facility policy titled Subject: Transfer and Discharge was provided to the surveyor by the DON on 5/26/23. The procedure was as follows: "Documentation in the resident's medical record must include the following: the reason for transfer/discharge, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s)." The	F 622	• Audit findings regarding documentation of admission, discharges and/or transfers will be submitted to the Administrator monthly and reported at the Quarterly QAPI meetings.	

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F 622	Continued From page 38 procedure indicated the documentation is to be made by a nurse. NJAC 8:39-4.1(a)31	F 622		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined that the facility failed to: a.) assess a weight change for 1 of 1 resident reviewed for [redacted], which did not contribute to [redacted], Resident #229, and b.) follow the physician's order (PO) for medication used to raise [redacted] for 1 of 1 resident, Resident #26. 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 states, "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist."	F 658	F658 1. How corrective action will be accomplished for those residents found to have been affected by the practice. • Resident #229 was [redacted] immediately, and [redacted] was found to be the same as the March [redacted] indicating there was [redacted]. • Resident #26 was assessed for signs of [redacted], resident was found to be [redacted] as per the attending physician's monthly progress note. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. • All residents have the potential for [redacted]. • All residents with [redacted] have the potential to be	7/25/23

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F 658	Continued From page 39 On 5/30/23 at 12:20 PM, the surveyor observed Resident #229 eating lunch in the main dining room. The resident ate about 75% of the meal provided. Resident #229 stated [redacted] and has not NJ Exec. Order 26:4.b.1 and that he/she is happy with their current [redacted] and [redacted] According to the admission record, Resident #229 was admitted to the facility with diagnoses that included but were not limited to [redacted] The surveyor reviewed the Quarterly Minimum Data Set (QMDS), an assessment tool, with an Assessment Reference Date (ARD) of 5/31/23. The included Brief Interview for Mental Status (BIMS) referenced a score of [redacted], which identified that the resident's cognition was a [redacted]. A review of the resident's Weights and Vitals summary revealed that the resident weighed [redacted] (pounds) on 5/30/23; the same weight was recorded for 5/01/23. The resident's weight was recorded as [redacted] on 4/22/23, [redacted] on 4/08/23, and the resident's weight was [redacted] lbs on 3/31/23. A review of the nurse progress notes in the electronic health record on 4/20/23, 4/21/23, and 4/22/23 revealed that the resident was [redacted] and [redacted] with appetite were documented. A review of the Quarterly Nutrition Assessment written by the Registered Dietitian (RD), dated	F 658	affected. • The dietitian will review resident [redacted] for the past three months for all residents and report any discrepancies to the Director of Nursing for [redacted] • Pharmacy consultant reviewed the eMAR for all residents on [redacted]. All nurses were provided one-to-one education on recording [redacted] and following medication parameters. 3. What measures will be put into place to ensure that the deficient practice will not recur? • Reviewed and revised the [redacted] and Intervention Policy to include: Any [redacted] of 5% or more since the last NJ Exec. Order 26:4.b.1 will be retaken within 24 hours for confirmation. If the [redacted] verified, nursing will notify the Dietitian. All nurses and CNAs will be trained on the policy revisions. • All nurses will be re-educated to follow vital sign parameters associated with medications and to document accordingly. • The Administrator, Director of Nursing, and Dietitian will participate in a monthly Nutrition and Weight meeting During this meeting the dietitian will review all NJ Exec. Order 26:4.b.1 in each month including % of [redacted], etiology, and interventions provided. • The Director of Nursing, Pharmacy Consultant, and Administrator will participate in a monthly Pharmacy and Therapeutics meeting. During this	

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F 658	Continued From page 40 5/30/23, revealed "EX Order 26 § 4b1 [redacted]" The RD wrote no other note or assessment prior to 5/30/23 and after the NJ Exec. Order 26:4.b.1 occurred in April 2023. On 5/31/23 at 11:10 AM, the surveyor interviewed the Director of Nursing (DON), who stated that she was unaware of these NJ Exec. Order 26:4.b.1 and that the resident should have been reweighed when the NJ Exec. Order 26:4.b.1 occurred. The DON revealed that the RD should have also addressed these NJ Exec. Order 26:4.b.1. The DON stated that those two weights from April must have been errors because Resident #229 EX Order 26 § 4b1 [redacted] On 5/31/23 at 11:18 AM, the surveyor interviewed the RD, who stated that she monitors all the	F 658	meeting, they will examine the outcomes of the Pharmacy Consultant's monthly regimen review, as well as review reports such as Med Pass observations, medication error incidents, and the effectiveness of Medication Management and Administration training conducted throughout the month. The members will also discuss any identified areas for improvement and collaborate to develop performance improvement plans. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. • Dietitian will compile a quarterly nutrition report detailing residents with NJ Exec. Order 26:4.b.1 in each month including % of NJ Exec. Order 26:4.b.1, etiology and interventions provided. The report will be presented at the Quarterly QAPI meeting. • The Director of Nursing will compile a quarterly report on the findings and activities of the monthly Pharmacy and Therapeutics meeting and present it at the Quarterly QAPI meeting.	

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Continued From page 41

resident's weights monthly and saw a [NJ Exec. Order 26] in the resident's weight in April 2023. The RD noted that she asked the staff for a reweigh but cannot recall who she asked for this reweigh. The RD revealed that she did not record her reweigh request or that she addressed the weight in April 2023, and she stated that she should have documented it. The RD revealed that this resident [NJ Exec. Order 26:4.b.1] and has [NJ Exec. Order 26:4.b.1]. The RD stated that she feels this [NJ Exec. Order 26:4.b.1] was inaccurate because [NJ Exec.] is returning to [NJ Exec. Order 26:4.b.1] trends.

A review of the weight assessment and intervention policy and procedure revealed that "EX Order 26 § 4b1

2. The surveyor observed Resident #26 sitting in bed on 5/24/23 at 10:45 AM. The [NJ Exec. Ord] and [NJ Exec. Order 26:4.] resident discussed [NJ Exec.] various medical conditions with the surveyor.

A review of the resident's Electronic Medical Record revealed the following information:

The Admission Record listed a diagnosis of EX Order 26 § 4b1).

The 3/19/23 MDS assessment tool indicated the resident scored [EX Or] out of 15 on the BIMs test, indicating EX Order 26 § 4b1 .

The May 2023 electronic Medication Administration Record (eMAR) listed the following

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F 658	Continued From page 42 physician order for [EX Order 26 § 4b1], a medication used to treat [EX Order 26 § 4b1] [EX Order 26 § 4b1] Between 5/1/23 and 5/9/23 - [NJ Exec. Order 26:4.b.] were given without documenting the [NJ Exec]. Between 5/11/23 and 5/22/23 - [NJ Exec. Order 26:4] were given when the [NJ Exec. Or] was greater than [NJ Exec.]. The 5/4/23 Consultant Pharmacist's Monthly Report identified irregularities with [EX Order 26 § 4b1] parameters and administration. The irregularities was addressed by the facililty, indicating education was provided to nursing staff. The facility response was undated. On 5/26/23 the DON provided the survey team with the undated policy and procedure for Medication Administration/eMAR. Procedure #1 indicated the facility will provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all medications to meet the needs of each resident. Procedure #10 indicated the nurse should check what vital signs should be monitored before the medicine is given and the information should be documented on the eMAR. On 5/31/23 at 11:26 AM Licensed Practical Nurse (LPN) #1 stated she understood the hold parameters for [EX Order 26 § 4b1]. LPN #1 stated she did	F 658		

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F 658	Continued From page 43 not remember giving the medication incorrectly. On 6/5/23 at 12:10 PM the surveyor discussed concerns regarding [redacted] administration with the DON. No further information was provided by the facility. NJAC 8:39-27.1(a) NJAC 8:39-29.2(d	F 658		
F 689 SS=L	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: Complaint #s NJ00155172, NJ00161276, NJ00160806, NJ00159306 Refer to F760K; F835L; F836L Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure 29 residents were adequately supervised when Licensed Practical Nurse (LPN) #1 worked 24 hours straight, six times in May 2023 with one Certified Nursing Assistant (CNA) #1 on the assignment during designated shifts. The failure to have adequate staff led to a lack of supervision for residents, which increased the	F 689	F689 1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice • All residents had the potential to be affected by the deficiencies identified. • The Nurse was counseled and retrained to emphasize the importance of staying alert and responsive on the 11:00 pm and 7:00 am shift. • Nurses have been educated that nurse supervision of residents is required in the building at all times. • No nurse or CNA will be scheduled to	7/25/23

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risk of improper care, resident neglect, accidents such as falls, entrapments or elopements, and/or medication administration errors or omissions. Serious injury or death may have occurred due to staff inability to respond to an emergent situation in a timely manner.

This resulted in an Immediate Jeopardy (IJ) situation. The facility was notified of the IJ on 6/5/23, and it continued until 6/8/23, when the facility implemented their written removal plan. The facility's Licensed Nursing Home Administrator (LNHA) was notified of the IJ on 6/5/23 at 2:26 PM. An acceptable written Removal Plan (RP) was received on 6/8/23. The RP was verified by the survey team onsite on 6/8/23, lifting the immediacy, and the survey team continued verification of the RP onsite throughout the remainder of the survey through observation, interview, and review of records.

The evidence is as follows:

On 5/24/23 at 9:30 AM, the surveyor observed one LPN and one CNA working in the nursing unit. The surveyor interviewed the Social Services Director (SSD), who stated the census was 29, and there was one LPN (LPN #1) and one CNA (CNA #1) working the day shift. The SSD stated LPN #1 and CNA #1 also worked the previous 11 PM to 7 AM shift. The SSD stated the facility was actively recruiting candidates; however, they are hired and "just don't show up for work."

The surveyor reviewed the written nursing schedule for the week beginning 4/23/23. LPN #1 was scheduled as the only nurse on 5/23 from 11:15 PM to 7 AM; on 5/24 from 7 AM to 3:45 PM and 11 PM to 7 AM; on 5/25 from 7 AM to 3:30

work a consecutive 24 hours.
- The Director of Nursing conducted regular checks of staff members during off hours to ensure nurse presence and attentiveness.
- The Facility Assessment was reviewed and updated to establish new nurse staffing plan based on current census and care/acuity levels.
- Provided education and training to all staff on the importance of vigilant supervision and adherence to professional responsibilities while on shift, and emphasizing the impact on resident safety and quality of care.
- Conducted performance appraisals and competencies assessments for all staff members who did not have a documented annual performance appraisal.

2. The facility identified other residents having the potential to be affected by the same deficient practice
- All residents have the potential to be affected.
- A root cause analysis was conducted to identify factors contributing to inadequate staffing and appropriate measures were taken to address those factors including: engaging multiple staffing agencies as well as online temporary nurse staffing platforms to secure temporary RNs, LPNs, and CNAs for unfilled shifts.

3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur:

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F 689	Continued From page 45 PM and 10:45 PM to 8:15 AM. CNA #1 was scheduled as the only CNA on 5/23 from 11 PM to 7 AM, on 5/24 from 11 PM to 9:30 AM, and 5/25 from 8 PM to 8 AM. On 6/2/23, staffing was obtained from the LNHA for a total of 17 weeks in three segments: 8/28/22 - 11/5/22 and 1/01/23 - 2/04/23 (periods when complaints were lodged for the shortage of staffing) and 5/07/23 - 5/20/23 (two weeks prior to the standard recertification survey). A review of the documentation revealed the following. For the 10 weeks of staffing from 8/28/22 to 11/05/22, the facility was deficient in CNA staffing for residents on 70 of 70 day shifts, deficient in total staff for residents on 35 of 70 evening shifts, deficient in CNAs to total staff on two of 70 evening shifts, and deficient in total staff for residents on 18 of 70 overnight shifts. For the five weeks of staffing from 1/01/23 to 2/04/23, the facility was deficient in CNA staffing for residents on 34 of 35 day shifts, deficient in total staff for residents on eight of 35 evening shifts, deficient in CNAs to total staff on six of 35 evening shifts, and deficient in total staff for residents on six of 35 overnight shifts. For the two weeks of staffing prior to the survey from 5/07/23 to 5/20/23, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 11 of 14 evening shifts, deficient in CNAs to total staff on one of 14 evening shifts, and deficient in total staff for residents on two of 14 overnight shifts. A further review of staffing for the period of 5/1/23	F 689	• Policies related to staffing will be reviewed and revised to include prohibiting all staff from being scheduled to work consecutive 24-hour shifts as well as being present and attentive during work hours. • The administrator will review staffing schedules daily to ensure that no nurse or CNA is scheduled for a consecutive 24 hours. • Director of Nursing or designee implemented a system of regular checks and rounds to ensure staff presence and attentiveness during the 3 PM-11 PM and 11 PM-7 AM shifts. Any staff found to be non-compliant will be disciplined up to and including termination. • The Administrator and Director of Nursing will establish a system to track and monitor the completion of performance appraisals and competencies, providing reminders and support to managers and supervisors to ensure timely and thorough evaluations in the future. • The Administrator and medical director will review all completed staff competency assessments with the department head each month and address any skill gaps with appropriate training. • The Administrator will hire and rehire staff to meet minimum staffing ratios. • The Administrator will establish contracts with temporary staffing agencies to address staffing gaps when necessary. • Wage rates and benefit packages will be reviewed by the administrator, who will make adjustments as needed to remain	

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F 689	Continued From page 46 -5/31/23 revealed LPN #1 worked daily with no days off for 31 days. LPN #1 worked five times for 24 consecutive hours, one time for 26.5 consecutive hours, and thirteen times for 16 consecutive hours. There were no CNAs on duty at the facility for the following times: - 5/2/23: 11 PM to 7 AM - 5/3/23: 7:00 AM to 10:30 AM; 11 PM to 7 AM - 5/9/23: 7 AM - 10:00 AM - 5/10/23: 7 AM - 10:00 AM - 5/13/23: 11 PM - 7 AM - 5/16/23: 8:30 AM - 10:00 AM - 5/17/23: 7 AM - 2 PM - 5/18/23: 7 AM - 2 PM; 11 PM- 7 AM - 5/22/23: 7 AM - 10 AM There were no nurses in the building on 5/4/23 from 3 PM to 6 PM. On 5/23/23, there was no Registered Nurse (RN) on duty during any of the three shifts. On 5/26/23, the LNHA provided the surveyor with the Facility Assessment Tool, updated 5/1/23. Part 2, Example 2 described the general staffing plan to ensure enough staff is on hand to meet the needs of residents at any given time. The breakdown was as follows: Director of Nursing (DON) - one full time day. An RN or LPN Charge Nurse for each shift (for 1-18 residents, the DON may be a Charge Nurse). One licensed nurse for each 36 residents on day and evening shifts. One licensed nurse for each 18 residents on the night shift.	F 689	competitive and attract skilled staff. • The Administrative team will develop employee recognition and perks programs to acknowledge and appreciate the efforts of the staff. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes: • The Administrator and Director of Nursing will compile a report on all performance appraisals, competency assessments, and employee training completed to be presented quarterly to QAPI Committee for review and provide further recommendations. • A comprehensive report will be created, compiling nurse staffing metrics, new hire and resignation/termination data, and information on employee retention programs and events. This report will be presented quarterly to QAPI Committee for review and provide further recommendations.	

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LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

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Direct Care Staff required was listed as 1 direct care staff person for 36 residents on day, evening, and night shifts.

The surveyor interviewed CNA #1 on 6/1/23 at 10:06 AM. CNA #1 stated she had worked at the facility for one year and 4 months and is the only CNA who works the 11 PM - 7 AM shift. She stated she has only worked with LPN #1 on the night shift. CNA #1 stated LPN #1 may have been off for one or two days during the time CNA #1 has worked. There was no coverage of nurses at that time. She did not remember the dates. CNA #1 stated it was very difficult to take care of all the residents by herself.

She stated LPN #1 appeared tired all the time and has observed her sleeping while on duty. CNA #1 stated she would wake LPN #1 if the nurse was needed. CNA #1 stated she has spoken to the LNHA about the shortage of staff on the night shift. CNA #1 has told the LNHA that LPN #1 is exhausted.

The surveyor interviewed CNA #2 on 6/1/23 at 9:55 AM. She stated she has worked at the facility since 11/2022 and works only on the day shift. CNA #2 stated there are days when she is the only CNA working. She said the facility does not utilize temporary agency staff. She stated it is very difficult to provide care to all the residents, especially when there are call outs.

The surveyor interviewed CNA #8 on 6/1/23 at 10:26 AM. The CNA stated he has worked at the facility on Friday, Saturday, and Sunday for the past 2 ½ months. He stated it is very difficult to care for all the residents by himself. He stated he

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takes no breaks and is unable to get assistance from the nurse working with him because the nurse is also very busy.

The surveyor interviewed the Activity Director (AD) on 6/1/23 at 10:30 AM. The AD was employed at the facility for thirteen years. She stated staffing has never been as short as it is at present, especially since the COVID-19 pandemic. The AD stated, "sometimes medications are given a little late. Sometimes resident care is a little late. There are times when only 1 CNA works on a shift, especially if there is a call out. The nurse helps with resident care. There is a lot of sacrifice here by the staff."

The surveyor interviewed LPN #1 on 6/1/23 at 10:59 AM. She stated her regular shift was 11 PM - 7 AM. LPN #1 stated the 7 AM - 3 PM nurse resigned last month. The 3 PM - 11 PM nurse (LPN #2) works 2 to 3 times a week.

LPN #1 stated she frequently works multiple shifts in a day, including all 3 shifts if no other nurse is scheduled.

LPN #1 stated that when she works 24 hours consecutively, she will get a 1 - 2 hour break to sleep. There is one CNA working with her and no covering nurse when she takes a break.

On 6/01/23 at 10:30 AM, the surveyor interviewed the DON and Assistant Director of Nursing (ADON). The ADON stated the LNHA did not want 2 nurses to be working together on the day shift because there is not enough work for them. She further stated "good CNAs" have left because of the number of residents each CNA is responsible for. "They cannot handle the work."

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They explained that LPN #1 "is an in house nurse and lives here at the facility." She was offered a room but prefers to sleep in a reclining chair in the dayroom. She showers at the facility. There are multiple times when LPN #1 will do medication pass, rest for an hour, and then go back on the floor to resume nursing duties. The DON stated LPN #1 frequently works 7 AM- 3 PM, 3 PM - 11 PM, and 11 PM - 7 AM shifts. The DON stated that LPN #1 is the on duty nurse almost all the time and that this was not safe for the residents because the nurse is not resting enough.

On 6/05/23 at 11:17 AM, the surveyor interviewed the LNHA regarding the failure to meet staffing requirements outlined in the Facility Assessment Tool and the State minimum staffing requirements. The LNHA stated overtime has been the answer for the ability to meet staffing for CNAs and LPNs. The LNHA stated she does not allow staff to work 3 shifts in a row. The LNHA stated she does not use temporary staff because "that goes against you financially." She stated she has utilized on-line employment agencies. She stated she has daily contact with job applicants. The new employees will come on board and work for a while and resign. "New employees don't want to work here because we are small, so there is no place to hide out in the open. [they must] work all day long, so they don't want to work here. If staffing is too high, it goes against you. [I] know the requirement, [there] would have to be 2 CNAs on 11-7, but this facility doesn't need it." She further stated "perfect staffing for 29 census" would be 2 nurses and 3 CNAs on day shift, 1 nurse and 2 CNAs each on evening and night shifts.

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On 6/05/23 at 11:30 AM, the LNHA provided the surveyor with a document titled In-House Universal Staff Nurse which was signed by LPN #1 on 10/14/22. The section titled In-House Residency indicated the nurse "will typically work two 8-hour shifts and are [sic] permitted to leave or sleep on the premises." The LNHA explained LPN #1 is like a Resident in a hospital. LPN #1 can sleep in the facility and be on call when she is needed by the CNA.

On 6/05/23 at 12:12 PM, the surveyor requested from the LNHA annual performance appraisals and competencies for all current nurses and CNAs on the payroll. The LNHA referred the surveyor to the DON. The DON stated she could not locate them and would contact the previous DON to see if they are filed at the facility.

On 6/05/23 at 3:30 PM, the surveyor was provided with all of LPN #1's competencies. They were as follows: Enteral Nutrition Feeding, 10/29/22; Personal Protective Equipment (PPE) Competency Validation, 11/13/22; Hand Washing, 11/13/22; Binax Now Competency Record (nasal swab for COVID-19 testing), 9/10/22.

No further competencies or performance appraisals used for the evaluation of knowledge and skill set for nurses and CNAs were provided to the surveyor.

On 6/05/23 at 2:20 PM, the surveyor requested the LNHA policies related to staffing. None was provided to the surveyor.

As evidenced by observation, interview, and review of pertinent records, it was clear that

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facility administration was aware of the dangerously low nursing and CNA staffing on all shifts.

Facility administration was aware of the frequency of multiple consecutive shifts worked by LPN #1 with 1 CNA.

Facility administration was aware of CNAs working on a unit without nursing supervision and without performance appraisals and competencies. Facility administration failed to complete performance appraisals and competencies on licensed nurses. These actions placed all 29 residents in the facility at risk for serious harm, impairment, or death from lack of adequate supervision. The administration was aware of this practice and did not implement procedures to correct it.

On 6/5/23 at 2:26 PM, the facility LNHA was notified of the IJ.

On 6/6/23 at 12:45 PM, the surveyors were provided the RP. After review, it was rejected based on insufficient evidence, which was needed to remove the immediacy. The surveyor discussed this with the LNHA.

On 6/7/23 at 10:00 AM, the surveyor requested the RP, which was not provided. The LNHA explained that she is still working on the RP.

On 6/07/23 at 12:40 PM, the surveyor requested the RP, which was not provided again. The LNHA explained that she is unsure if the RP will be ready today.

On 6/08/23 at 10:45 AM, the surveyors reviewed

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F 689	Continued From page 52 the RP sent by the facility, and after review, it was rejected based on insufficient evidence, which was needed to remove the immediacy. The surveyor discussed this with the LNHA. After the facility revised the RP, it was accepted. The RP was verified by the survey team onsite on 6/8/23, lifting the immediacy, and the survey team continued verification of the RP onsite throughout the remainder of the survey through observation, interview, and review of records.	F 689		
F 695 SS=D	NJAC 8:39-27.1(a) 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 observation, interview, and record review, it was determined that the facility failed to maintain the necessary [redacted] and services for 1 of 1 residents (Resident #4) reviewed for [redacted]. The deficient practice was evidenced by the following: On 5/24/23 at 10:11 AM, the surveyor observed the resident in bed receiving [redacted] at [redacted]	F 695	F695 1. How the corrective action will be accomplished for those residents found to have been affected by the practice • New order was received for resident #4 and order was placed in MAR to [redacted] weekly. 2. How the facility will identify other	7/25/23

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F 695	Continued From page 53 The [NJ Exec. Order 26:4.b.1] was not labeled to indicate when the [EX Order 26 § 4b] had been changed. On 5/25/23 at 10:10 AM, the surveyor observed the resident in bed with eyes closed, receiving [NJ Exec. Order 26:4] The [EX Order 26 § 4b] was not dated. On 5/25/23 at 10:17 AM, the Certified Nursing Assistant (CNA) told the surveyor the resident always used [EX Order 26 § 4b], "She needs it." The CNA stated nurses and CNAs encourage the resident to use [EX Order 26 § 4b]. The CNA revealed the nurse changes the [EX Order 26 § 4b1] once a week. On 5/25/23 at 11:10 AM, the Licensed Practical Nurse (LPN) told the surveyor that the resident used [NJ Exec. Order 26] continuously. She stated the nurse routinely changed the [EX Order 26 § 4b] weekly on the night shift. This LPN was the regularly scheduled night shift nurse. When the surveyor noted the [EX Order 26 § 4b] was not dated, the LPN stated she forgot to date it when she changed the [EX Order 26 § 4b]. On 5/31/23 at 11:29 AM, the surveyor observed the [EX Order 26 § 4b1] was still undated. A review of the Electronic Medical Record (EMR) and recent hospital records revealed the following information: The Admission Record (AR) listed multiple diagnoses; however, none related to the resident's [EX Order 26 § 4b1]. The 5/20/23 Hospital Medical/Surgical Admission Assessment listed exacerbation of [EX Order 26 § 4b1]. The 5/23/23 readmission Physician's Order sheet	F 695	residents having the potential to be affected by the same deficient practice. • All residents with assessed need for [NJ Exec. Order 26] have the potential to be affected by this deficient practice. • Acuity audit was completed to identify other residents on [NJ Exec. Order 26] and orders implemented as needed. 3. What measures will be put into place to ensure that the deficient practice will not recur. • The Director of Nursing reviewed policy to ensure guidelines that [NJ Exec. Order 26:4.b.1] orders are entered into the eMAR system. • All staff were re-educated by the Director of Nursing on facility policy regarding [NJ Exec. Order 26] orders and [NJ Exec. Order 26:4.b.1] on a weekly basis. • Acuity audit will be completed weekly by the DON to identify new residents with orders for [NJ Exec. Order 26]. 4. How the facility will monitor its corrective action to ensure that the deficient practice will not recure. • DON or designee will audit [NJ Exec. Order 26] on weekly basis to ensure [NJ Exec. Order 26] has been labeled and changed weekly X4 then monthly X4. • Audit findings will be submitted by the DON or designee to the Quarterly QAPI meeting. • The QAPI committee will determine need for further audits and/or action plans	

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F 695	Continued From page 54 listed an order for EX Order 26 § 4b1 [redacted] weekly on Sundays. The resident's current care plan addressed the resident's use of continuous EX Order 26 § 4b. It did not address changing or dating EX Order 26 § 4b1 On 5/31/23 at 1:02 PM, the Director of Nursing (DON) stated the EX Order 26 § 4b1 should be dated when changed weekly. The DON provided the " EX Order 26 § 4b " facility policy, reviewed in 2023. The policy did not address EX Order 26 § 4b1 [redacted]. NJAC 8:39-25.2(b)	F 695	for compliance.	
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident	F 726		7/25/23

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F 726	Continued From page 55 assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that three (3) Licensed Practical Nurses (LPN #1, #2, #3) had competencies to assess nursing care for residents' needs. The deficient practice was evidenced by the following: On 6/01/23 at 3:25 PM, the surveyor reviewed the requested nurse competencies for LPN #1 provided by the Director of Nursing (DON). The competencies were for handwashing, covid antigen nasal swab testing, enteral nutrition feedings, and personal protective equipment donning and doffing. The competencies were done between 9/2022 and 11/2022. On 6/1/23 at 3:30 PM, the surveyor asked the DON if LPN #1 had completed other competencies. The surveyor also requested competencies for the other two (2) LPNs (LPN #2 and #3) who worked at the facility. The DON stated that no other nurse competencies were found. She stated she would	F 726	F726 1. How the corrective action will be accomplished for those residents found to have been affected by the practice. • Nurse #1 completed appropriate competencies • Nurse #2 completed appropriate competencies • Nurse #3 completed appropriate competencies • All nurses will complete competencies based upon the needs of the residents found in the Facility Assessment. • CNA mandatory education and competencies have been initiated 2. How the facility will identify other residents have the potential to be affected by the same deficient practice. • All residents have the potential to be	

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F 726	Continued From page 56 call the former DON to see where they were filed. No additional nurse competencies were provided to the surveyor. Additionally, the facility did not have a policy for nurse competencies. NJAC 8:39-9.3	F 726	affected by this deficient practice. 3. What measures will be put into place to ensure that the deficient practice will not recur. • Facility will initiate appropriate competencies upon hire for Nurses and CNA's • New competencies will be initiated and completed on a monthly basis based on resident needs. • CNAs will complete 12 hours of yearly mandatory education. One to two mandatory in-services will be completed monthly. • The facility will develop a competency policy for all nursing staff based upon facility assessment, acuity, care plans and resident needs. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. • Competencies will be reviewed weeklyX4, monthlyX4 and quarterly at the QAPI meeting.	
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced	F 730		7/25/23

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F 730	Continued From page 57 by: Based on record review and interview with the Licensed Nursing Home Administrator (LNHA), it was determined that the facility failed to complete the annual Nurse Aide performance appraisals for 4 of 4 Certified Nursing Assistants (CNA) reviewed and was evidenced by the following: On 6/5/23 at 9:36 AM, the surveyor requested the annual Nurse Aide performance appraisals for CNA #1, 2, 3, and 4. The LNHA referred the surveyor to the Director of Nursing (DON). On 6/5/23 at 12:12 PM, the DON told the surveyor that the performance appraisals were not done. The DON stated, "I will begin them now." On 6/5/23 at 1 PM, the surveyor requested the facility policy regarding employee annual performance appraisals. The policy was not provided to the surveyor. NJAC 8:39-43.17(b)	F 730	F730 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. • No residents have been affected by this deficient practice. • CNA #1- Performance appraisals were completed on 7/3/23 • CNA #2- Performance appraisals were completed on 6/8/23 • CNA #3- Performance appraisals were completed on 7/3/23 • CNA #4- Performance appraisals were completed on 7/3/23 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. • All residents have the potential to be affected by this deficient practice. • All current employee records were audited by the Business Office Manager for current performance appraisals. Any employee that did not have a performance appraisal completed within the year, a new performance appraisal was completed by the appropriate department head. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 730	Continued From page 58	F 730	recur. • Performance Appraisal Policy was reviewed and revised by the administrator. • The Office Manager was in-serviced on 6/8/23 on the performance appraisal policy by the Administrator. • The Business Office Manager will review employee records monthly to ensure all performance reviews are completed accurately and timely. The results of the audit will be submitted to the administrator monthly. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. • A comprehensive quarterly report will be generated by the Business Office Manager, consolidating monthly audits of employee performance evaluation compliance. This report will be presented to the QAPI Committee on a quarterly basis for thorough review and to provide further recommendations.	
F 755 SS=F	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.	F 755		7/25/23

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F 755	Continued From page 59 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure that medications were administered and accurately signed in the electronic medication administration record (eMAR). This deficient practice was identified for 13 of 13 residents (Residents #4, #11, #13, #17, #18, #19, #20, #22, #26, #79, #179, #229, and #230) reviewed for medication management. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states:	F 755	F755 1. How the corrective action will be accomplished for those residents found to have been affected by the practice. • Resident #13 was assessed by the Medical Director on 7/11/23 and found to be NJ Exec. Order 26:4.b.1. • Resident #17 was assessed by the Medical Director on 7/11/23 and found to be NJ Exec. Order 26:4.b.1. • Resident #18 was assessed by the Medical Director on 7/11/23 and found to be NJ Exec. Order 26:4.b.1.	

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F 755	Continued From page 60 "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "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." This deficient practice was evidenced by the following: 1. The surveyor reviewed the medical records for Resident #13 that revealed the following: According to the Order Summary Report (OSR), Resident #13 had a Physician's Order (PO) for medications to be administered to the resident at different times of the day. The May 2023 Electronic Medication Administration Record (eMAR) revealed that the following medications that were due had no	F 755	• Resident #11 was assessed by the Medical Director on 7/11/23 and found to be EX Order 26 § 4b1. • Resident #79 was assessed by the Medical Director on 7/11/23 and found to be EX Order 26 § 4b1. • Resident #22 was assessed by the Medical Director on 7/11/23 and found to be EX Order 26 § 4b1. • Resident #26 was assessed by the Medical Director on 7/11/23 and found to be EX Order 26 § 4b1. • Resident #4 was assessed by the Medical Director on 7/12/23 and found to be EX Order 26 § 4b1. • Resident #179 was assessed by the Medical Director on 7/12/23 and found to be EX Order 26 § 4b1. • Resident #20 was assessed by the Medical Director on 7/12/23 and found to be EX Order 26 § 4b1. • Resident #229 was assessed by the Medical Director on 7/12/23 and found to be EX Order 26 § 4b1. • Resident #230 was transferred to the NJ Exec. Order 26-4 on NJ Exec. Order 26-4 with a diagnosis of EX Order 26 § 4b1; patient returned to the facility on EX Order 26 § 4b with a recommendation for EX Order 26 § 4b1. The resident expired on EX Order 26 §. • Nurse #1 was re-educated on the use of the eMAR system and the importance of signing for medication immediately following medication administration. 2. How the facility will identify other residents have the potential to be affected by the same deficient practice.	

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F 755	Continued From page 61 documentation of being administered: - EX Order 26 § 4b1 [redacted] 2. The surveyor reviewed the medical records for Resident #17 that revealed the following: According to the OSR, Resident #17 had a PO for medications to be administered to the resident at different times of the day. The May 2023 eMAR revealed that the following medications that were due had no documentation of being administered: - EX Order 26 § 4b1 [redacted]	F 755	• All residents receiving medications may be affected by this deficient practice. • The Director of Nursing conducted an audit of the electronic Medication Administration Record (eMAR) to identify any missing signatures. In the event of incomplete eMAR documentation by nurses, medication error reports and/or disciplinary action was completed by the DON for the staff members involved. Additionally, all nursing staff received in-service training to emphasize the significance of signing for all administered medications when required. 3. What measures will be put into place to ensure that the deficient practice will not recur. • The Director of Nursing will re-educate all nursing staff on the importance of signing for medication immediately after administration. • The Director of Nursing will review and revise the licensed nursing staff orientation process regarding entering physician orders and signing for medications in the eMAR system. • Review and revised the Shift-to-Shift Report Policy to include the following: “The incoming nurse and the outgoing nurse are required to review the Electronic Medication Administration Record (eMAR) of each resident. Any missing signatures or inconsistencies in the records should be addressed immediately as appropriate.”	

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F 755	Continued From page 62 - EX Order 26 § 4b1 [redacted] 3. The surveyor reviewed the medical records for Resident #18 that revealed the following: According to the OSR, Resident #18 had a PO for medications to be administered to the resident at different times of the day. The May 2023 eMAR revealed that the following medications that were due had no documentation of being administered: - EX Order 26 § 4b1 [redacted]	F 755	• All nursing staff will be educated on the revised Shift-to-Shift Policy 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. • The DON and/or designee will review the eMAR daily for missing signatures for 1 month, then weekly for 1 month and then monthly thereafter. In the event of incomplete eMAR documentation by nurses (i.e., missing signatures), the Director of Nursing will complete medication error reports and/or disciplinary action as well as retraining. • Audit findings on missing eMAR signature rates, and other medication errors will be submitted to the monthly Pharmacy and Therapeutics committee. • The Director of Nursing will compile a quarterly report detailing the findings of the monthly eMAR audits and present it at the Quarterly QAPI meeting.	

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F 755	Continued From page 63	F 755		

4. The surveyor reviewed the medical records for Resident #11 that revealed the following:

According to the OSR, Resident #11 had a PO for medications to be administered to the resident at different times of the day.

The May 2023 eMAR revealed that the following medications that were due had no documentation of being administered:

- EX Order 26 § 4b1 [redacted]

5. The surveyor reviewed the medical records for Resident #79 that revealed the following:

According to the OSR, Resident #79 had a PO for medications to be administered to the resident at different times of the day.

The May 2023 eMAR revealed that the following medications that were due had no documentation

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F 755	Continued From page 64 of being administered: - EX Order 26 § 4b1 [redacted] 6. The surveyor reviewed the medical records for Resident #22 that revealed the following: According to the OSR, Resident #22 had a PO for medications to be administered to the resident at different times of the day. The May 2023 eMAR revealed that the following medications that were due had no documentation of being administered: - EX Order 26 § 4b1 [redacted]	F 755		

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EX Order 26 § 4b1 [redacted]

7. The surveyor reviewed the medical records for Resident #179 that revealed the following:

According to the OSR, Resident #179 had a PO for medications to be administered to the resident at different times of the day.

The May 2023 eMAR revealed that the following medications that were due had no documentation of being administered:

- EX Order 26 § 4b1 [redacted]

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F 755	Continued From page 66	F 755		

8. The surveyor reviewed the medical records for Resident #4 that revealed the following:

According to the OSR, Resident #4 had POs for medications to be administered to the resident at different times of the day.

The May 2023 eMAR revealed that the following medications that were due had no documentation of being administered:

- EX Order 26 § 4b1 [redacted]

9. The surveyor reviewed the medical records for Resident #26 that revealed the following:

According to the OSR, Resident #26 had POs for medications to be administered to the resident at different times of the day.

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F 755	Continued From page 67 The May 2023 eMAR revealed that the following medications that were due had no documentation of being administered: - EX Order 26 § 4b1 [redacted] The surveyor reviewed the medical records for Resident #19 that revealed the following: According to the OSR, Resident #19 had physician orders for medications to be administered to the resident at different times of the day. The May 2023 eMAR revealed that the following medications that were due had no documentation of being administered: - EX Order 26 § 4b1 [redacted]	F 755		

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F 755	Continued From page 68	F 755		

EX Order 26 § 4b1 [redacted]

11. The surveyor reviewed the medical records for Resident #20 that revealed the following:

According to the OSR, Resident #20 had physician orders for medications to be administered to the resident at different times of the day.

The May 2023 eMAR revealed that the following medications that were due had no documentation of being administered:

- EX Order 26 § 4b1
- EX Order 26 § 4b1

[redacted]

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F 755	Continued From page 69	F 755		

12. The surveyor reviewed the medical records for Resident #229 that revealed the following:

According to the OSR, Resident #229 had physician orders for medications to be administered to the resident at different times of the day.

The May 2023 eMAR revealed that the following medications that were due had no documentation of being administered:

- EX Order 26 § 4b1 [redacted]

13. The surveyor reviewed the medical records for Resident #230 that revealed the following:

According to the OSR, Resident #230 had physician orders for medications to be administered to the resident at different times of the day.

The May 2023 eMAR revealed that the following medications that were due had no documentation of being administered:

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F 755	Continued From page 70 - EX Order 26 § 4b1 [redacted] On 6/1/23 at 11:00 AM, the surveyor interviewed LPN #1 regarding the omitted medication administration in the eMARs, and LPN #1 stated that she was signing the medication she administers but could not speak for other nurses if they were signing for them or not. LPN #1 added that she did not have time to check those signatures. On 6/1/23 at 04:13 PM, the survey team met with the Licensed Nursing Home Director (LNHA) and Director of Nursing (DON). The LNHA stated that she sees LPN #1 administering medications. The DON said that LPN #1 was not fast enough to complete all her work because she was also pulled to do other functions. On 6/5/23 at 9:50 AM, the surveyor conducted an additional interview with LPN #1, who stated that she was not trained at the facility on the electronic records but knew some of the electronic entries for documentation of medication administration from working at a previous facility. LPN #1 added that she was not that fast at the eMAR and had no knowledge of entering a PO electronically because the DON or ADON had been doing that. LPN #1 added that she thought the other nurses were more familiar with the electronic system from working at other facilities. On 6/6/23 at 12:45 PM, the surveyor interviewed the LNHA, who stated that LPN # 1 had a stack of	F 755		

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F 755	Continued From page 71 papers that she wrote on when she administered medications, and the LNHA noted that these papers were not given to the surveyors because they were not facility documents nor official resident charting. The surveyors were not provided any further documents to show that medications were administered. A review of the facility policy dated as new 5/2021 provided by the DON for "Documentation in Electronic Medical Records (EMR)" reflected that the facility would provide a complete clinical record on every resident, including but not limited to monthly care plans." The procedure included that "Training on the EMR is done by the department in which the employee works." A review of the undated revised policy for "Medication Administration/eMAR-[name redacted]" provided by the DON reflected that the procedure was "The facility will provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all medications, to meet the needs of each resident. Accordingly, no medication/s must be administered except those reviewed and confirmed with the physician, validated with the pharmacy, and entered into electronic Medication Administration Record (eMAR), that is [name redacted]." In addition, the policy reflected that "After the resident has taken the medication, immediately initial its square in the eMAR. Never delay this action." NJAC 8:39-11.2(b), 29.2(d), 29.3(a)(5)	F 755		
F 756 SS=K	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		7/25/23

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§483.45(c) Drug Regimen Review.
§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.

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F 756	Continued From page 73 This REQUIREMENT is not met as evidenced by: Refer to 760K Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that the Consultant Pharmacist (CP) recommendations dated 3/7/23 were acted upon in a timely manner regarding the documentation and administration of critical medications, including EX Order 26 § 4b1 [redacted] for Resident #13, #19 and #20 who required EX Order 26 § 4b [redacted] and Resident #17 and #230 who had physician orders for an EX Order 26 § 4b1 [redacted] The failure to act upon the CP recommendations in a timely manner to ensure all residents were accurately receiving the necessary medications in the appropriate timeframe in accordance with their physician's orders to prevent an adverse outcome placed all residents who received critical medications at risk for a serious outcome. The failure to monitor and document EX Order 26 [redacted] when indicated per the physician's order is likely to result in EX Order 26 § 4b1 [redacted] The failure to administer and document an EX Order 26 § 4b1 in accordance with a physician's order to prevent EX Order 26 § 4b1 is likely to lead to a EX Order 26 § 4b1 [redacted]	F 756	F756 1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice: Resident # 19 – The nurse assessed the resident for any signs and symptoms of NJ Exec. Order 26:4.b.1. An internal medication error report was completed and the nurse was in-serviced on the importance of NJ Exec. Order 26:4.b.1 monitoring and proper administration of NJ Exec. Order 2 as per physician's orders. On 6/8/23 Submitted a medication error report to the state. Resident # 20- The nurse assessed the resident for signs and symptoms of NJ Exec. Order 26 and administered NJ Exec. Order 26 to the resident as ordered. The nurse administered a NJ Exec. Order 26:4.b.1 for NJ Exec. Order 26:4.b.1 level and assessed the resident for any other signs and symptoms of NJ Exec. Order 26:4.b.1 The nurse administered NJ Exec. Order 2 as per the physician's orders. An internal medication error report was completed, and the nurse was in-serviced on the importance and procedure of signing for all administered medications and completing regular NJ Exec. Order 2 as ordered. Submitted a medication error report to the state. Resident # 230– The nurse assessed the resident for signs and symptoms of NJ Exec. Order 26 and administered NJ Exec. Order 26 to the resident as per the physician's order. An internal medication error report was completed and the nurse was in-serviced	

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F 756	Continued From page 74 EX Order 26 § 4b1 . This resulted in an Immediate Jeopardy (IJ) situation that began on 3/7/23 when the CP made their recommendations. The facility's Licensed Nursing Home Administrator (LNHA) was notified of the IJ on 6/1/23 at 4:28 PM. The IJ continued until 6/8/23, when the facility implemented its written removal plan. An acceptable written Removal Plan (RP) was received on 6/8/23. The RP was verified by the survey team onsite on 6/8/23, lifting the immediacy, and the survey team continued verification of the RP onsite throughout the remainder of the survey through observation, interview, and review of records. This deficient practice was identified for 5 of 17 residents reviewed for medication management (Resident #13, #17, #19, #20, and #230). The evidence was as follows: 1. On 5/24/23 at 10:40 AM, the surveyor observed Resident #19 in a EX Order 26 § 4b1 in the dining area with their eyes closed. The surveyor attempted to interview the resident, but the resident could not answer the surveyor's inquiry. According to the Admission Record (AR), an admission summary, Resident #19 was admitted to the facility with diagnoses that included but were not limited to EX Order 26 § 4b1 A review of the physician Order Summary Report	F 756	on the importance and procedure for signing all administered medications as ordered. Submitted a medication error report to the state. Resident #13 - The nurse assessed the resident for signs and symptoms of NJ Exec. Order 26:4 and administered NJ Exec. Order 26 to the resident as ordered. Additionally, the nurse administered a NJ Exec. Order 26:4.b.1 for NJ Exec. Order 26:4.b.1 level and assessed the resident for any other signs and symptoms of EX Order 26 § 4b1 . The nurse administered EX Order 26 § as per the physician's order. The physician was notified. An internal medication error report was completed, and the nurse was in-serviced on signing for all administered medications and completing regular NJ Exec. Orde as ordered. Submitted a medication error report to the state. Resident #17 - The nurse assessed the resident for signs and symptoms of NJ Exec. Order 26:4 and administered EX Order 26 § 4 to the resident as ordered. An internal medication error report was completed, and the nurse was in-serviced on discontinuing medications in the eMAR. Submitted a medication error report to the state. 2. The facility identified other residents having the potential to be affected by the same deficient practice: • This practice has the potential to affect all residents in the facility. • The Director of Nursing reviewed the eMAR to find any other residents that may have had missing medications and the medical director performed assessment	

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F 756	Continued From page 75 (OSR) for May 2023 revealed the following Physician's Order (PO) for EX Order 26 § 4b1 [redacted] The orders specified EX Order 26 § 4b1 [redacted] before meals and at bedtime using the sliding scale for EX Order 26 § [redacted] coverage: EX Order 26 § 4b1 [redacted] A review of the March 2023 Electronic Medication Administration Reports (eMAR) did not show documentation of the administration of critical medication EX Order 26 § 4b1 for 45 of 120 doses due. A review of April 2023 eMAR did not show documentation of the administration of critical medication EX Order 26 § 4b1 for 31 of 120 doses due. A review of May 2023 eMAR did not show documentation of the administration of critical medication EX Order 26 § 4b1 for 65 of 120 doses due.	F 756	and evaluation of these residents for any adverse effects of missing medications. • The DON completed medication error reports and in-serviced nursing staff on the importance of signing for all administered medications and treatments when necessary. 3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: • The DON will review the monthly pharmacy consultant report with the Medical Director every month and implement all recommendations as appropriate within 7 days. • The Director of Nursing will conduct additional in-service training as per the pharmacy consultant's recommendations. • The Administrator will form a monthly Pharmacy and Therapeutics committee. The Administrator, DON, and pharmacy consultant will review the completion of the pharmacy consultant's monthly reports/recommendations, medication errors, observations, and in-services from the previous month, and collaborate on improvement plans. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes: • The Administrator will establish a Pharmacy and Therapeutics committee to meet monthly. The Administrator, DON, and pharmacy consultant will review	

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F 756	Continued From page 76 A review of the March eMAR EX Order 26 § 4b1 results indicated that the EX Order 26 § 4b1 were to be taken before meals (6:30 AM, 11:30 AM, and 4:30 PM) and at bedtime (9:00 PM). The documented EX Order 26 § 4b1 results ranged from EX O, which required no Ex.Order 26.4(b)(1), requiring 4 units of Ex.Order 26.4(b)(1) to be administered. A review of the April eMAR EX Order 26 § 4b1 results indicated that the EX Order 26 § 4b1 were to be taken before meals (6:30 AM, 11:30 AM, and 4:30 PM) and at bedtime (9:00 PM). The documented Ex.Order 26.4(b)(1) results ranged from Ex.Order which required no EX Order 26 § 4b1, to Ex.Order 26 requiring 6 units of EX Order 26 § 4b1 to be administered. A review of the May eMAR EX Order 26 § 4b1 results indicated that the EX Order 26 § 4b1 were to be taken before meals (6:30 AM, 11:30 AM, and 4:30 PM) and at bedtime (9:00 PM). The documented EX Order 26 § 4b1 results ranged from Ex.Order, which required no EX Order 26 § 4b1, to Ex.Order 2, requiring 4 units of EX Order 26 § 4b1 to be administered. There was no documentation that EX Order 26 § 4b1 was taken on each of the omitted EX Order 26 § doses and no documentation of EX Order 26 § 4b1 [redacted] A review of the Progress Notes revealed no follow-up with the physician regarding any medication omissions in the eMARs. A review of the March, April, and May 2023 CP recommendations revealed no specific CP recommendations addressing the omissions in the resident's eMAR. The CP Consultant Evaluation form dated 5/4/23 noted an Ex.Order 26.4(b) of Ex.Orde results from 4/4/23.	F 756	completion of Pharmacy consultant recommendations, all medication error reports, Medication administration observations, and in-services conducted in the month. • All Pharmacy consultant recommendation audits, medication error report data and in-services will be compiled into a quarterly report and submitted to the Quarterly QAPI Committee.	

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2. On 5/31/23 at 11:40 AM, the surveyor observed Resident #20 in the resident's room in a chair. The resident's eyes were closed. The surveyor attempted to interview the resident, but the resident was unable to answer the surveyor's inquiry.

According to the AR, Resident #20 was admitted to the facility with diagnoses that included but were not limited to EX Order 26 § 4b1 [redacted]

A review of the OSR for May 2023 revealed the following POs for EX Order 26 § 4b1 [redacted] The order specified to EX Order 26 § 4b1 as per the sliding scale:

EX Order 26 § 4b1 [redacted]

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EX Order 26 § 4b1 [redacted]

In addition, there was a physician's order for EX Order 26 § 4b1 [redacted].

A review of March 2023 eMAR did not show documentation of the administration of the critical medications of EX Order 26 § 4b1 [redacted]

A review of April 2023 eMAR did not show documentation of the administration of the critical medications of EX Order 26 § 4b1 [redacted]

A review of May 2023 eMAR did not show documentation of the administration of the critical medications of EX Order 26 § 4b1 [redacted]

A review of the March eMAR Ex.Order 26.4(b)(1) results indicated that the EX Order 26 § 4b1 were to be taken before meals (6:30 AM, 11:30 AM, and 4:30 PM) and at bedtime (9:00 PM). The documented EX Order 26 § 4b1 results ranged from Ex.Orde which required no EX Order 26 § 4b1, to Ex.Order, requiring 10 units of EX Order 26 § 4b1 to be administered.

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A review of the April eMAR blood sugar results indicated that the EX Order 26 § 4b1 were to be taken before meals (6:30 AM, 11:30 AM, and 4:30 PM) and at bedtime (9:00 PM). The documented EX Order 26 § 4b1 results ranged from Ex.Order which required no EX Order 26 § 4b1, to Ex.Order, requiring EX Order to be administered.

A review of the May eMAR blood sugar results indicated that the EX Order 26 § 4b1 were to be taken before meals (6:30 AM, 11:30 AM, and 4:30 PM) and at bedtime (9:00 PM). The documented EX Order 26 § 4b1 results ranged from Ex.Order which required no EX Order 26 § 4b1 to Ex.Order, requiring 10 units of EX Order 26 § 4b1 to be administered.

There was no documentation revealing a EX Order 26 taken on each of the EX Order 26 § 4b1 doses and no documentation of EX Order 26 § 4b1

There was no documented evidence that the resident had a Ex.Order 26.4(b)(1)

A review of the Progress Notes revealed no follow-up with the physician regarding any medication omissions in the eMARs.

A review of the March, April, and May 2023 CP recommendations revealed no specific CP recommendations addressing the omissions in the resident's eMAR. The CP Consultant Evaluation form dated 5/4/23 noted an Ex.Order 26.4(b)(1) of Ex.Order results from 4/4/23.

3. On 6/1/23 at 10:45 AM, the surveyor observed Resident #230 in a chair in the resident's room.

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F 756	Continued From page 80 The surveyor attempted to interview the resident, but the resident was unable to answer. According to the AR, Resident #230 was admitted to the facility with diagnoses that included but were not limited to EX Order 26 § 4b1 . A review of the OSR for May 2023 revealed the following POs for EX Order 26 § 4b1 [redacted] A review of May 2023 eMAR did not show documentation of the administration of the critical medications of EX Order 26 § [redacted] for 13 of 36 doses due. There was no documented evidence of Ex.Order 26.4(b)(1) [redacted] A review of the Progress Notes revealed no follow-up with the physician regarding any medication omissions in the eMARs. A review of the March, April, and May 2023 CP recommendations revealed no specific CP recommendations addressing the omissions in the resident's eMAR. 4. On 6/7/23 at 11:23 AM, the surveyor observed Resident #13 in bed. The resident was unable to answer any questions. The surveyor reviewed the electronic medical record for Resident #13. A review of the AR	F 756		

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F 756	Continued From page 81 revealed that the resident had diagnoses that included but were not limited to Ex.Order 26.4(b)(1) [redacted] A review of the May 2023 OSR revealed the following POs: - EX Order 26 § 4b1 [redacted] A review of the March 2023 eMAR revealed that there was no documentation for the administration of critical medications as follows: - EX Order 26 § 4b1 [redacted] A review of the April 2023 eMAR revealed that there was no documentation for the administration of critical medications as follows: - EX Order 26 § 4b1 [redacted]	F 756		

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A review of the May 2023 eMAR revealed that there was no documentation for the administration of critical medications as follows:

- EX Order 26 § 4b1 [redacted]

There was no documentation revealing a Ex.Order 26.4 [redacted] taken on each of the omitted Ex.Order 26.4(b) doses and no documentation of Ex.Order 26.4(b)(1) [redacted]

There was no documentation revealing any Ex.Order 26.4 [redacted] concerns identified nor any documentation of Ex.Order 26.4(b)(1) for this resident.

A review of the Progress Notes revealed no follow-up with the physician regarding any medication omissions in the eMARs.

A review of the March eMAR Ex.Order 26.4(b)(1) results indicated that the Ex.Order 26.4(b)(1) were to be taken before meals (6:30 AM, 11:30 AM, and 4:30 PM) and at bedtime (9:00 PM). The documented EX Order 26 § 4b1 [redacted] that were administered.

A review of the April eMAR Ex.Order 26.4(b)(1) results indicated that the EX Order 26 § 4b1 were to be taken before meals (6:30 AM, 11:30 AM, and 4:30 PM) and at bedtime (9:00 PM). The documented EX Order 26 § 4b1 results ranged from [redacted], which required no EX Order 26 § 4b1, to [redacted], requiring [redacted] that were administered.

A review of the May eMAR EX Order 26 § 4b1 results

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indicated that the EX Order 26 § 4b1 were to be taken before meals (6:30 AM, 11:30 AM, and 4:30 PM) and at bedtime (9:00 PM). The documented EX Order 26 § 4b1 results ranged from EX Orde, which required no EX Order 26 § 4b1, to EX Orde, requiring 5 units of EX Order 26 § 4b1 that were administered.

A review of the March, April, and May 2023 CP recommendations revealed no specific CP recommendations addressing the omissions in the resident's eMAR. The CP Consultant Evaluation form dated 5/4/23 noted an Ex.Order 26.4(b) of Ex.Orde results from 4/4/23 was noted. There was no specific recommendation made for the facility or the physician.

5. On 6/7/23 at 11:39 AM, the surveyor observed Resident #17 in a EX Order 26 § 4b1 at the back of the dining/day room. The resident ended a phone call using the facility telephone. The resident stated that they had called their physician because they wanted to check on something. The resident also said that they received their medications because they see LPN#1 all the time and knew that they were supposed to take their EX Order 26 § 4b1, Ex.Order 26.4(b)(1) with food. The resident was unable to speak to all medications that were administered or what times they were administered.

The surveyor reviewed the electronic medical record for Resident #17.
A review of the AR revealed that the resident had diagnoses that included but were not limited to Ex.Order 26.4(b)(1).

A review of the May 2023 OSR revealed a PO with a start date of 3/1/23 for EX Order 26 § 4b1

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EX Order 26 § 4b1 [redacted]

A review of the March 2023 eMAR revealed no documentation for administering a critical medication, Ex.Order 26.4(b [redacted] which had 17 out of 62 omitted doses.

A review of the April 2023 eMAR revealed no documentation for administering a critical medication, Ex Order 26 [redacted], which had 10 out of 60 omitted doses.

A review of the May 2023 eMAR revealed no documentation for administering a critical medication, Ex Order 26 [redacted], which had 29 out of 62 omitted doses.

There was no documentation revealing any Ex Order 26 [redacted] concerns identified nor any documentation of Ex.Order 26.4(b)(1) for this resident.

A review of the Progress Notes revealed no follow-up with the physician regarding medication omissions in the eMARs.

A review of the CP recommendations and monthly evaluations for March, April, and May 2023 revealed no specific CP recommendation addressing omissions from the resident's eMAR.

A review of the CP monthly report, dated 3/7/23, revealed that the pharmacist indicated a general note that blanks were noted in the eMAR and issues discussed with the administrator. No specific resident was pointed out on the monthly

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report to show which resident's charts had omissions. There was no indication that the facility reviewed this recommendation, and no signature or follow-up note was written.

A review of the CP monthly report, dated 4/5/23, revealed that the pharmacist indicated frequent charting omissions noted in March, with some improvement in April, and that pharmacy recommendations still need to be addressed from March. No specific resident was pointed out on the monthly report to indicate which resident's charts had omissions and the seriousness of omitting the medications prescribed. There was no indication that the facility reviewed this recommendation, and no signature or follow-up note was written.

A review of the CP monthly report, dated 5/5/23, revealed that the pharmacist indicated that there were frequent charting omissions from the resident's charts and the report specified "e.g., 0600 4/3, 4/4, 4/6, 4/7, 4/17, 4/18, 4/19, 4/21, 4/25, 5/1, 5/3; 0900 4/1, 4/6, 4/16, 4/19, 4/24, 5/1, 5/3; 1400 4/1, 4/6, 4/10, 4/16, 4/19, 4/24; 2100 4/5, 4/7, 4/16, 4/21, 4/27, 5/2".

There was no specific resident note on the monthly report to indicate which resident this note referred to and which charts had medication omissions. There was no indication that the facility reviewed this recommendation, and no signature or follow-up note was written.

On 6/1/23 at 11:00 AM, the surveyor interviewed LPN #1 regarding the omitted medication administration in the eMARs, and LPN #1 stated that she was signing the medication she administers but could not speak for other nurses

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if they were signing for them or not. LPN #1 added that she did not have time to check those signatures.

On 6/1/23 at 3:08 PM, the surveyor attempted to contact the CP via telephone.

On 6/1/23 at 4:13 PM, the surveyors interviewed the Director of Nursing (DON) and the LNHA, who stated that LPN #1 was not fast enough to complete her work and was being pulled to do other tasks.

On 6/1/23 at 4:28 PM, the facility LNHA was notified of the IJ.

On 6/2/23 at 10:09 AM, the surveyor interviewed the CP supervisor, who stated that the pharmacy recommendation reports get sent to the DON, and it is up to the facility's nursing staff to respond to the report. The CP supervisor stated that days and times for frequent charting omissions might not specify the resident or drugs omitted. The CP's responsibility is to identify any irregularities and report them to the facility.

On 6/5/23 at 10:24 AM, the surveyor interviewed the CP via telephone, who stated that he was covering for the regular CP during April and May and was familiar with the reports. The CP stated that he had reviewed with the LNHA the charting omissions he had noticed. The CP also said that he emailed the CP reports to the facility, and it was the facility's responsibility to respond to the recommendations.

The surveyor continued to meet with the LNHA to review the components of the Removal Plan (RP) necessary to remove the immediacy on 6/6/23 at

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F 756	Continued From page 87 12:45 PM, 6/7/23 at 10:00 AM, and 12:40 PM when the RP was not provided. On 6/08/23 at 10:45 AM, the surveyors reviewed the RP sent by the facility, and after review, it was rejected based on insufficient evidence, which was needed to remove the immediacy. The surveyor discussed this with the LNHA. After the facility revised the RP, they were accepted. On 6/8/23 at 10:30 AM, the surveyor interviewed the Medical Director (MD), who stated that he was unaware of concerns about the quality issues of EX Order 26 § 4b1 [redacted]. MD added, "If I had known that, I would have addressed that at our quality meetings." The MD stated that he had not gotten medication error reports from the facility. He also said he did not know why the facility did not notify him of the pharmacy consultant's recommendations. On 6/8/23 at 12:00 PM, DON stated that the pharmacy consultant's recommendations go to the LNHA, and then they are given to the DON, and sometimes there is a delay. DON did not indicate if she was aware of this recommendation made by the pharmacist. The RP was verified by the survey team onsite on 6/8/23, lifting the immediacy, and the survey team continued verification of the RP onsite throughout the remainder of the survey through observation, interview, and review of records.	F 756		
F 759 SS=D	NJAC 8:39-27.1(a) Free of Medication Error Rts 5 Prcnt or More	F 759		7/25/23

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F 759	Continued From page 88 CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication observations on 5/25/23 and 5/26/23, the surveyors observed one (1) nurse administer medications to five (5) residents. There were twenty-seven (27) opportunities, and two (2) errors were observed, calculated to a medication administration error rate of 13.5%. This deficient practice was identified for one (1) of five (5) residents observed (Resident #18) that were administered medications by one (1) nurse. The deficient practice was evidenced by the following: 1. On 5/25/23 at 8:46 AM, during the morning medication pass, the surveyor observed the Licensed Practical Nurse (LPN #1) preparing eight (8) medications which included one (1) EX Order 26 § 4b1 EX Order 26 § 4b1 tablet for Resident #18. On 5/25/23 at 9:01 AM, the surveyor observed LPN #1 preparing thickened water and stated that she would administer the eight (8) medications to Resident #18. At that time, the surveyor stopped LPN #1 from	F 759	F759 1. How the corrective action will be accomplished for those residents found to have been affected by the practice. • Resident #18 – EX Order 26 § 4b1 [redacted] was administered from house stock. The nurse contacted the physician for a new EX Order 26 § 4b1 order. The resident received a new medication order for EX Order 26 § 4b1 EX Order [redacted] days on 5/25/23. EX Order 26 § [redacted] was immediately discontinued. • LPN# 1 was educated by the Director of Nursing on reading the order on the eMAR and comparing it with the label on the bingo card prior to administration. • LPN#1 was immediately educated to review new orders for medication with the attending physician prior to administration. • LPN#1 Received disciplinary action for failure to follow proper medication administration procedures. • All nurses were re-educated on the process of reviewing mediation labels against medication orders prior to putting them in the medication cart.	

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F 759	Continued From page 89 administering the (8) medications, including the EX Order 26 § 4b1. The surveyor asked LPN #1 to review the Electronic Medication Administration Record (eMAR) for Resident #18 regarding the Physician's Order (PO) for EX Order 26 § 4. The surveyor, with LPN #1, reviewed the eMAR, which revealed a PO dated 3/01/22 for EX Order 26 § 4b1 [redacted]. LPN #1 stated that she was not administering the chewable form of the EX Order 26 § 4 because the provider pharmacy had sent the EC formulation. (ERROR #1) There was no documentation indicating that the EC formulation could be substituted for the chewable formulation of EX Order 26 § 4. On 5/25/23 at 9:09 AM, the surveyor interviewed LPN #1 in the presence of the Director of Nursing (DON) and Assistant Director of Nursing/Registered Nurse (ADON/RN), who stated that she was not going to crush the EX Order 26 § 4. LPN #1 added that if she were going to crush the Ex.Order 26.4(b), she would have been concerned since the EC cannot be crushed. The DON stated that the PO must be followed for the Ex.Order 26.4(b)(1) [redacted] tablet. The DON added that the provider pharmacy must be notified that the wrong formulation was sent. The DON added that the pharmacy provider should have been informed when the EX Order 26 § 4b1 was sent because the PO was for the chewable EX Order 26 § [redacted] formulation. The surveyor reviewed the medical record for Resident #18. A review of the resident's Admission Record (AR)	F 759	2. How the facility will identify other residents have the potential to be affected by the same deficient practice. • All residents have the potential to be affected. • All nurses were re-educated by the Director of Nursing on the following: a. Review and reconcile mediation labels against medication orders prior to putting them in the medication cart. b. Reconciling the medication order on the eMAR with the label on the bingo card prior to administration. c. Review new orders for medication with the attending physician prior to administration. • Pharmacy consultant completed med pass observation/competencies with all nurses. • LPN#1 was immediately re-educated to review all orders and allergies with M.D. prior to administration. 3. What measures will be put into place to ensure that the deficient practice will not recur. • Reviewed and revised the policy on “Accepting Delivery of Medications from the Pharmacy” to include the procedure of reconciling mediation labels against medication orders prior to placing them in the medication cart. • All nurses will be educated on the revised policy of “Accepting Delivery of Medication from the Pharmacy. • Nurses will be re-educated to review	

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F 759	Continued From page 90 revealed diagnoses that included but were not limited to EX Order 26 § 4b1 [redacted] A review of the annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of 5/7/2023, reflected the resident had a brief interview for mental status (BIMS) score of three [redacted] out of 15, indicating that the resident had a EX Order 26 § 4b1 [redacted]. A review of the Order Summary Report (OSR) revealed a PO with a start date of 3/01/23 for "EX Order 26 § 4b1 [redacted]" 2. On 5/25/23 at 8:46 AM, during the morning medication pass, the surveyor observed LPN #1 preparing seven (7) medications according to the eMAR for Resident #18. At that time, LPN #1 stated that she was the nurse who worked on the 11:00 PM to 7:00 AM shift and knew that Resident #18 had been sent to the Ex.Order 26.4(b)(1) [redacted] and returned after midnight with a prescription from the Ex.Order 26.4(b)(1) [redacted] physician for EX Order 26 § 4b1 [redacted]. LPN #1 added that she wanted to start the EX Order 26 [redacted] and administer the medication with the other morning medications. LPN #1 then called the ADON/RN, who brought over to LPN #1 to show the surveyor a prescription dated 5/24/23 from a Ex.Order 26.4(b)(1) physician for "EX Order 26 § 4b1 [redacted]	F 759	all orders and allergies with M.D. prior to administration of medication. • DON and/or Pharmacy consultant will perform med pass observation/competency on all new licensed nurses and submit to the Director of Nursing to be reviewed at the Monthly Pharmacy and Therapeutics meeting . • The Pharmacy consultant will conduct med-pass observation on LPN#1 monthly for 3 months. • All nurses that are med passed with a greater than 5% error will be immediately suspended and re-evaluated for medication administration competency. • All new orders on current, admitting, or readmitting residents will be reviewed by the DON or designee. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. • The Pharmacy consultant medication observation/competency results will be compiled into a comprehensive Pharmacy and Therapeutics report to be presented by the Director of Nursing at the Quarterly QAPI meeting.	

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EX Order 26 § 4b1 by mouth 3 times a day for 5 days." The ADON/RN stated that she was working on faxing the prescription to the provider pharmacy and entering the PO in the electronic computer system. LPN #1 stated that she had EX Order 26 § in the facility backup box, which was kept in the medication cart. The surveyor observed LPN #1 remove two (2) of the EX Order 26 § 4b1 from the backup box and place them in the medication cup with the seven (7) other medications she had prepared for Resident #18.

The surveyor had not observed a PO for EX Order 26 § 4 in the eMAR that LPN #1 was documenting for Resident #18.

On 5/25/23 at 9:01 AM, the surveyor observed LPN #1 preparing thickened water and said she would administer the eight (8) medications to Resident #18.

At that time, the surveyor stopped LPN #1 from administering the (8) medications, which included the EX Order 26 § capsules. The surveyor asked LPN #1 to review the eMAR for Resident #18. LPN #1 stated that the EX Order 26 § PO was not entered electronically in the eMAR. The surveyor then asked LPN #1 to review Resident #18's eMAR profile, particularly the allergy indicated on the eMAR. LPN #1 checked the resident's profile and stated that the resident was allergic to EX Order 26 § 4b1 EX Order 26 § 4b1 LPN #1 also said that she could not administer the EX Order 26 § and would have to call the primary physician. (ERROR #2) The surveyor observed LPN #1 remove the EX Order 26 § 4b1 capsules from the medication cup. LPN #1 could not speak to what EX Order 26 § 4b reaction occurred if the resident received PCN or had received a

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EX Order 26 § 4b1 medication in the past without a reaction. LPN #1 could also not speak to whether the primary physician had approved the PO for Ex.Order 26.4 to be administered with a Ex.Order 26.4(b)(1).

On 5/25/23 at 9:09 AM, the surveyor interviewed LPN #1 in the presence of the DON and ADON/RN, who stated that she had assumed the ER physician had reviewed the Ex.Order 26.4(b)(1. The DON revealed that LPN #1 should not have assumed. The DON added that the ADON/RN called the primary physician for the resident, and they were waiting to verify whether the Ex.Order 26.4 could be administered. At that time, LPN #1 stated that her usual procedure was to call the physician and review any medication orders from the hospital and the allergies with the physician. However, this was a different situation.

On 5/25/23 at 9:20 AM, the surveyor interviewed the DON, who stated that the ADON/RN called the primary physician, and the physician changed the PO to Ex.Order 26.4(b)(1)). The DON acknowledged that the administration of the Ex.Order 26.4 with a Ex.Order 26.4(b)(1) was not verified by the physician and had the potential to cause a severe reaction.

On 5/25/23 at 9:36 AM, the surveyor interviewed the ADON/RN, who stated that the physician changed the EX Order 26.4 to EX Order 26 § 4b but that the physician had said that there was a low chance of cross-sensitivity. The ADON/RN added that the Ex.Ord physician had written the prescription and thought that was sufficient. The ADON/RN acknowledged that the facility had processes to follow to receive new medication orders and that the primary physician was called to verify PO. The PO would then be faxed to the provider

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pharmacy, and the pharmacy usually called the physician if there was an issue. The ADON/RN acknowledged that she had called the primary physician and faxed the PO for [redacted] to the provider pharmacy after LPN #1 was going to administer the [redacted] to the resident.

On 5/25/23 at 10:00 AM, the surveyor was provided the AR and OSR for Resident #18 by the DON, who stated that the forms were sent to the hospital. The surveyor reviewed the forms, and an Ex.Order 26.4(b)(1) was noted on both forms.

On 5/25/23 at 11:00 AM, the survey team met with the DON and LPN #1. LPN #1 stated that Resident #18 was readmitted on her shift but that she had not called the primary physician to get approval for the [redacted] to be administered and had yet to fax the [redacted] prescription to the provider pharmacy. The DON acknowledged that the proper procedure for the new medication order needed to be followed.

On 6/1/23 at 3:01 PM, the surveyor interviewed the DON and ADON/RN. The ADON/RN stated that no progress note was completed regarding the issue with the Ex.Order 26.4(b)(1) because she didn't think it was a big issue when she spoke with the physician and the provider pharmacy. The ADON stated that she entered the new order for [redacted] in the eMAR. The DON verified that the PO was not entered in the eMAR, confirmed by the primary physician, or faxed to the provider pharmacy before LPN #1 was going to administer the [redacted] to the resident, and there was no knowledge of the type of Ex.Order 26.4(b)(1) that Resident #18 had to [redacted]

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On 6/1/23 at 3:22 PM, the surveyor interviewed the DON, who stated that she had called the family representative for Resident #18, but they did not know about any [redacted]. The DON added that the unknown [redacted] to [redacted] had the potential to be a severe reaction. The DON stated that the provider pharmacy had said the reaction could be mild to moderate, but the physician had to verify that the [redacted] could be administered with a [redacted]. The DON added that every new PO for medication should have the [redacted] checked before administration.

The surveyor reviewed the medical record for Resident #18.

A review of the electronic record of Resident #18 revealed an [redacted] tab that listed the [redacted]" was [redacted]," with the "Type" listed as "[redacted]" and the "Category" listed as "drug" with no "Reaction/Type/Subtype" listed and "Severity" listed as "Unknown" dated 6/25/2020.

A review of the hospital records revealed an "After Visit Summary," which revealed that the reason for the visit was an altered mental status, and the diagnoses included [redacted]. In addition, there was a prescription written on 5/24/23 by the [redacted] physician for "[redacted]. There was no indication that the [redacted] was noted.

On 6/1/23 at 4:13 PM, the survey team met with

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the Licensed Nursing Home Administration (LNHA) and DON. The DON stated that she had thought the Ex.Order 26.4(b)(1) transfer form had the Ex.Order 26.4(b)(1) noted but could not obtain the universal transfer form. The DON revealed that LPN #1 was not able to verify the PO or fax the PO to the provider pharmacy because she was the only nurse on duty from 11:00 PM to 7:00 AM and then stayed for the 7:00 AM shift and was also pulled to do other job duties while passing medications. The LNHA stated that the Ex.Order 26.4(b)(1) physician should have known the resident had a Ex.Order 26.4(b)(1) because it was on the resident's profile that was sent with the resident to the Ex.Order 26.4(b)(1). The LNHA acknowledged that the Ex.Order 26.4(b)(1) should have been verified with the physician when the resident returned to the facility before the administration of the Ex.Order 26.4(b)(1).

On 6/2/23 at 9:16 AM, the surveyor interviewed the CPS via telephone, stating that the CP assigned to the facility was out on leave. The CPS stated that she would email any completed med passes or in-services.

On 6/5/23 at 9:50 AM, the surveyor interviewed LPN #1, who stated that she needed to be trained at the facility on the electronic records but knew some of the electronic entries for documentation of medication administration from working at a previous facility. LPN #1 added that she was not fast at the eMAR and needed to learn to enter a PO electronically because the DON or ADON/RN had been doing that.

On 6/5/23 at 9:58 AM, the surveyor interviewed the CPS via telephone, who stated that she had emailed medication observations, which included two (2) completed for LPN #1. The CPS added

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that there were no in-services performed recently. The CPS said that there was a covering CP that may have more information.

A review of the "Medication Pass Observation" completed by the CP on leave dated 12/7/22 revealed that LPN #1 had zero (0) errors, resulting in a zero percent error rate.

A review of the "Medication Pass Observation" completed by the covering CP dated 4/4/23 revealed that LPN #1 had one (1) error, resulting in a nine (9) percent error rate.

A review of the employee file of LPN #1 revealed that no performance evaluations or competencies were completed, and no other medication observations were completed.

On 6/5/23 at 10:24 AM, the surveyor interviewed the CP via telephone, who stated that he was covering for the CP, who was on leave during April and May and was familiar with the reports. The CP stated that he had completed a medication observation with LPN #1 in April and that she had failed because a medication was administered outside of the allowed time. The CP stated that he performs an in-service on the spot after a medication administration is completed using the Medication Observation form. The CP added that LPN #1 was aware of the reason for the error and noted on the form, "Reviewed with nurse." The CP added that he was unsure if there was a DON and had given the completed forms to the LNHA. The CP also stated that all PO should be verified with the primary physician, then entered electronically and faxed to the pharmacy before administration. The CP added that allergies should be checked and thought there

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was a 15 % chance of cross-sensitivity between EX Order 26 § 4b1. The CP stated that the nurses should check and document what Ex.Order 26.4(b) occurred. When the EX Order 26.5 was ordered, the physician should be contacted to verify whether the EX Order 26.5 could be administered.

On 6/5/23 at 11:51 AM, the surveyor interviewed the DON, who stated that there should be training if a nurse failed a medication observation. A follow-up medication observation would have to be completed. The surveyor, with the DON, reviewed the Medication Pass Observation form dated 4/4/23 for LPN #1, which resulted in an error rate of nine (9) percent. The DON stated that there was no follow-up with LPN #1 because the error noted on the form was because the medication was not administered within one hour of the prescribed time or half-hour when the order was before or after meals. The DON explained that medications not being administered on time was an "umbrella issue" in the facility. The DON further explained that the "umbrella issue" meant an overall issue with timing because of understaffing, and the nurses were stretched thin. The DON added that she trained the nurses to stay on time and not be distracted during the medication pass. Still, if only one nurse were on the floor, they would be interrupted for other responsibilities such as helping the Certified Nursing Aide (CNA), completing admissions paperwork, swabbing anyone at the facility's door, and answering phones. The DON also stated that the one nurse on the shift does the best that they can. The DON added that the ADON/RN was fairly new and that she was an interim DON.

On 6/8/23 at 10:26 AM, the survey team met with the Medical Director (MD), who stated that he

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was the primary physician for Resident #18. The MD also noted that [EX Order 26 §] had approximately a 30 % chance of a cross-sensitivity to [EX Order 2] and could cause an [EX Order 26 § 4b1] reaction, but there was a minimal chance. The MD added that the PO for [EX Order 26 §] with a [EX Order 26 § 4b1] should be verified with the physician before administering the [EX Order 26 §] as part of the checks and balances. The MD added that the pharmacy usually called him and first confirmed the PO with the [Ex Order 26.4(b)(1)] The MD acknowledged that LPN #1 had not followed the proper procedure and should have verified the PO for [EX Order 26 §] before administering.

A review of the undated facility policy for "Medication Ordering and Receiving from Pharmacy" provided by the LNHA included that the procedure was "When an emergency or "stat" order is received the nurse follows the procedure for order documentation in accordance with the policy on Prescriber Medication Orders (see IB1: Non-Controlled Medication Order Documentation)."

The surveyor was not provided the policy on "Prescriber Medication Orders (see IB1: Non-Controlled Medication Order Documentation)" that was referred to in the policy "Medication Ordering and Receiving from Pharmacy" above.

A review of the facility policy dated as new 5/2021 provided by the DON for "Documentation in Electronic Medical Records (EMR)" reflected that "The facility would provide a complete clinical record on every resident, including but not limited to monthly care plans." The procedure included "Training on the EMR is done by the department in which the employee works."

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F 759	Continued From page 99 A review of the undated revised policy for "Medication Administration/eMAR-[Name redacted]" provided by the DON reflected that the procedure was "The facility will provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all medications, to meet the needs of each resident. Accordingly, no medication/s must be administered except those reviewed and confirmed with the physician, validated with the pharmacy, and entered into electronic Medication Administration Record (eMAR), that is [Name redacted]." The policy also reflected "Check the resident's allergies listed on the eMAR to make sure the resident is not allergic to the medication." NJAC 8:39-11.2(b), 29.2(d)	F 759		
F 760 SS=K	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Refer to F756K, F689L, F835L and F836L Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that residents are free of significant medication errors regarding the documentation and administration of critical medications, including EX Order 26 § 4b1 [redacted] medications to prevent serious	F 760	F760 1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice: Resident #13 - The nurse assessed the resident for signs and symptoms of [redacted] and administered [redacted] to the resident as ordered. Additionally, the	7/25/23

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F 760	Continued From page 100 adverse outcomes for Resident #13, #19 and #20 who required EX Order 26 § 4b1 monitoring and were dependent on EX Order 26 § 4, Resident #17, #25 and #230 who had physician orders for an EX Order 26 § 4b1 to prevent EX Order 26 § 4b1, and Resident #19 who had a physicians order for an oral EX Order 26 § 4b1 . The facility failed to ensure that Resident #18 was given medication validated by the physician, and the pharmacy, reviewed for allergies, and entered into the Electronic Medication Administration Record (eMAR) to prevent serious adverse outcomes, including significant allergic reactions. The failure to monitor and document Ex.Order 26 nd administer EX Order 26 § 4b1 agents when indicated per the physician's order is likely to result in EX Order 26 § 4b1 The failure to administer and document an EX Order 26 § 4b1 in accordance with a physician's order to prevent EX Order 26 § 4b1 is likely to lead to a EX Order 26 § 4b1 . Resident #25 received double dosing of an EX Order 26 § 4b1 medication for five days, likely leading to increased EX Order 26 § 4b1 . The failure to give a medication validated by the physician, the pharmacy, reviewed for allergies, and entered into the eMAR is likely to lead to significant allergic reactions, which would require immediate emergency intervention.	F 760	nurse assessed the resident for any other signs and symptoms of EX Order 26 § 4b1 . The nurse administered EX Order 26 § as per the physician's order. The physician was notified. An internal medication error report was completed, and the nurse was in-serviced on signing for all administered medications and completing regular EX Order 26 as ordered. Submitted a medication error report to the state. Resident #17 - The nurse assessed the resident for signs and symptoms of EX Order 26 § 4 and administered EX Order 26 § 4 to the resident as ordered. An internal medication error report was completed, and the nurse was in-serviced on discontinuing medications in the eMAR. Submitted a medication error report to the state. Resident #25 -On 6/7/2023 Assessed the resident for signs of symptoms of EX Order 26 § 4b1 . Notified physician of medication administration and transcription error. A medication error report was completed and the nurse was in-serviced on the correct procedure for transcription and setting up administration in the eMAR. On 6/8/23 Submitted a medication error report to the state. Resident Care Plan was updated. Resident #19 – The nurse contacted the physician and notified him of the med error and received an order to discontinue EX Order 26 § 4b1 order on 6/6/23. The DON assessed and the staff nurses monitored the resident for signs and symptoms of EX Order 26 § 4b1 . An internal medication error report was	

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This resulted in an Immediate Jeopardy (IJ) situation. The facility was notified of the IJ on 6/1/23, which began on 3/7/23 (the start date on which the Consultant Pharmacist (CP) alerted the facility of concerns on documentation of medications on the eMAR) and continued until 6/8/23 when the facility implemented their written removal plan. The facility's Licensed Nursing Home Administrator (LNHA) was notified of the IJ on 6/1/23 at 4:28 PM. An acceptable written Removal Plan (RP) was received on 6/8/23. The RP was verified by the survey team onsite on 6/8/23, lifting the immediacy, and the survey team continued verification of the RP onsite throughout the remainder of the survey through observation, interview, and review of records.

This deficient practice was identified for 7 of 17 residents reviewed for medication management (Resident #13, #17, #18, #19, #20, #25, and #230).

The evidence was as follows:

1. On 5/24/23 at 10:40 AM, the surveyor observed Resident #19 out of bed to the [redacted] in the dining area, eyes closed, unable to answer the surveyor's inquiry.

According to the Admission Record (AR), Resident #19 was admitted to the facility with diagnoses that included but were not limited to [redacted]

The surveyor reviewed the Quarterly Minimum

completed, and the nurse was in-serviced on discontinuing medications in the eMAR. On 6/8/23 Submitted a medication error report to the state.
Resident #18 – The nurse contacted the physician for a new [redacted] order. The resident received a new medication order for [redacted] days on 5/25/23. [redacted] was immediately discontinued. The nurses were in-serviced on eMAR alerts to allergies and other medication irregularities.
Resident #20 – The nurse assessed the resident for signs and symptoms of [redacted] and administered [redacted] to the resident as ordered.
The nurse assessed the resident for any signs and symptoms of [redacted]. The nurse administered [redacted] as per the physician's order. The physician was notified. An internal medication error report was completed, and the nurse was in-serviced on signing for all administered medications and completing regular [redacted] as ordered. Submitted a medication error report to the state.
Resident #230 – The nurse assessed the resident for signs and symptoms of [redacted] and administered [redacted] to the resident as ordered. An internal medication error report was completed, and the nurse was in-serviced on signing for all administered medications as ordered. Submitted a medication error report to the state.

- All nurses were in-serviced on signing for all administered medications as ordered.

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F 760	Continued From page 102 Data Set (MDS), an assessment tool, with an Assessment Reference Date (ARD) dated 3/03/23. The included Brief Interview for Mental Status (BIMS) referenced a score of [redacted], which identified that the resident's [redacted] was a [redacted]. A review of the Pharmacy Therapeutic Suggestions Sheets (consult sheet) Final Report revealed under "Subject: Therapeutic suggestions" dated "04/04/23, The eGFR was found to be [redacted]" "Accepted:" handwritten signature by the doctor on 4/26/23. Handwritten order: "[redacted]" A review of the Progress Notes dated 4/26/23 at 13:00 revealed under "Note Text: Visited by Dr. Segaram (for routine). Rcvd. NO. Decrease med dose of [redacted]. NO noted and carried out." A review of the Order Summary Report (OSR) for April 2023 revealed on 4/26/23 an order for "[redacted] A review of the Order Summary Report (OSR) for April 2023 revealed on 3/01/23 an order for "[redacted]	F 760	2. The facility identified other residents having the potential to be affected by the same deficient practice: • This practice has the potential to affect all residents in the facility. • On 7/7/2023 Pharmacy consultant reviewed all residents' medication orders to ensure the accurate transcription of medication orders, medication-related problems/interactions, medication errors, medication administration/omissions of critical medications or other irregularities. • A root cause analysis was completed using the Failure Mode and Effects Analysis (FMEA) to determine the cause of transcription/medication administration errors. • The Pharmacy consultant conducted a Medication Pass Observation on all facility nurses and documented the results. • Nurses were in-serviced on: o Inputting Quick Admission/Discharge/Transfers (Quick ADT) o Managing Allergies in the EHR o Properly documenting physician orders in the eMAR/eTAR 3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: • During admission and readmissions, all physician orders will be entered into the eMAR/eTAR system and verified by the DON or designee for accuracy. The DON will be notified of any other orders for	

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F 760	Continued From page 103 A review of the April 2023 and May 2023 electronic Medication Administration Reports (eMARs) revealed that EX Order 26 § 4b1 [redacted] are reflected as both ordered until 05/31/23. A review of the April 2023 eMAR order for Ex.Order 26.4(b) [redacted] reflected the following signatures showing the administration of the medication on 4/26 and 4/27. The April 2023 eMAR also showed orders for EX Order 26 § 4b1 [redacted] reflected the following signatures showing the administration of both medications on 4/28, 4/29, and 4/30/23. A review of the May 2023 eMAR orders for EX Order 26 § 4b1 [redacted] reflected the following signatures showing administration of both of the medications on 5/1, 5/3, 5/4, 5/5, 5/6, 5/7, 5/8, 5/9, 5/10, 5/11, 5/13, 5/14, 5/16, 5/17, 5/18, 5/19, 5/25, 5/26, and 5/30/23. On 05/30/23 at 11:11 AM, the surveyor interviewed a Licensed Practical Nurse (LPN #1), who stated that she worked in the facility for two years. LPN # 1 said that when the medication changed, the person who did the changes would be the one to write the order, she added that she does not have the time to follow the doctor's order, and usually, the Director of Nursing (DON) or Assistant Director of Nursing (ADON) would be the one carrying out that recommendation from the doctor and whoever takes the order from the doctor should be the one to enter it in the electronic health record. LPN #1 added that she accidentally signed the EX Order 26 § 4b1, but the order should be deleted. On 5/30/23 at 11:45 AM, the DON stated that she	F 760	residents and will review the orders for accuracy on an ongoing basis. • During shift handoff the incoming/outgoing nurse will review the previous shifts eMAR for accuracy of documentation. • Inservice education will be provided to all nurses on: o Review Pharmacy Provider warning of dosage/frequency with the physician. o Verifying orders/allergies with the physician • Facility will utilize allergy stickers on the residents' physical medical records. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes: • The DON and/or designee will review the eMAR daily for missing signatures daily for 1 week, then weekly for 1 month and then monthly thereafter. In the event of incomplete eMAR documentation by nurses (i.e., missing signatures), the Director of Nursing will complete medication error reports and/or disciplinary action as well as retraining. • Audit findings on Missing eMAR signature rates, and other medication errors will be submitted to the monthly Pharmacy and Therapeutics committee. • Inservice Training will be conducted quarterly to all licensed nurses on the following topics: o Transcription of physician orders	

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F 760	Continued From page 104 picked up the order based on the recommendation of the pharmacy and carried out that specific order but forgot to check them one by one. A review of the facility policy revised 2023 revealed under "Policy: 3. The Charge Nurse/ADON will make sure: a. All of the recommendations are acted upon." A review of the OSR for Resident # 19 dated 4/23 revealed on 3/01/23 an order for "EX Order 26 § 4b1 [redacted] " A review of the March 2023 eMAR did not show documentation of the critical medication EX Order 26 § 4b1 [redacted] A review of April 2023 eMAR did not show documentation of the administration of the critical medication EX Order 26 § 4b1 for 31 of 120 doses due. A review of May 2023 eMAR did not show documentation of the administration of the critical medication EX Order 26 § 4b1 for 65 of 120 doses due. A review of the March eMAR blood sugar results indicated that the EX Order 26 EX Order 26 § 4 were to be taken before meals (6:30 AM, 11:30 AM, and 4:30 PM) and at bedtime (9:00 PM). The documented Ex.Order 26.4(b)(1) results ranged from Ex.Orde which required no EX Order 26 § 4b1 [redacted]	F 760	o Medication Administration and the eMAR med pass. • The Administrator will establish a Pharmacy and Therapeutics committee to meet monthly. The Administrator, DON, and Pharmacy consultant will review Pharmacy consultant findings and recommendations, all medication error reports, Medication administration observations and in-services conducted in the previous month. • All monthly pharmacy and therapeutics committee meeting results will be compiled into a comprehensive quarterly report and submitted to the Quarterly QAPI Committee by the DON.	

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EX Order 26 § 4b1 .

A review of the April eMAR Ex.Order 26.4(b)(1) results indicated that the EX Order 26 § 4b1 were to be taken before meals (6:30 AM, 11:30 AM, and 4:30 PM) and at bedtime (9:00 PM). The documented EX Order 26 § 4b1 results ranged from Ex.Orde, which required no EX Order 26 § 4b1 to Ex.Order, requiring Ex

A review of the May eMAR EX Order 26 § 4b1 results indicated that the EX Order 26 § 4b1 were to be taken before meals (6:30 AM, 11:30 AM, and 4:30 PM) and at bedtime (9:00 PM). The documented EX Order 26 § 4b1

There was no documentation revealing a EX Order 26 taken on each of the EX Order 26 § 4b1 doses or documentation of EX Order 26 § 4b1

A review of the Progress Notes revealed no follow-up with the physician regarding any medication omissions in the eMARs.

On 6/1/23 at 11:00 AM, the surveyor asked LPN #1 regarding the missing signatures, and LPN #1 stated that she was signing the medication she had been giving but could not speak for other nurses if they were signing or not, and the nurse added that she does not have time to check those signatures.

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F 760	Continued From page 106 2. The surveyor observed Resident #25 on 5/24/23 at 10:54 AM, receiving personal care from the Certified Nursing Assistant (CNA). The surveyor again observed the resident on 5/26/23 at 11:45 AM, awake in bed watching television. The resident was [redacted] and [redacted] and able to Ex.Order 26.4(b)(1). A review of the hybrid medical record revealed the following: According to AR, Resident #25 was admitted to the facility with diagnoses that included but were not limited to [redacted] EX Order 26 § 4b1 [redacted] The resident was care planned (5/29/23) for using Ex.Order 26.4(b)(1) [redacted] Interventions included: "Administer EX Order 26 § 4b1 medications as ordered by the physician. Monitor for side effects and effectiveness q [every] shift." "Monitor/document/report PRN [as needed] adverse reactions of EX Order 26 § 4b1 [redacted] Review the medication list for adverse interactions. Avoid the use of EX Order 26 § 4b1." A 4/27/23 at 21:58 physician's phone order for [redacted] an EX Order 26 § 4b1	F 760		

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and used to treat [redacted], was entered into the electronic record by the nurse.

The physician's order was written as follows:
EX Order 26 § 4b1 [redacted]

A 4/27/23 at 22:23 electronic provider pharmacy order note was written as follows: "This order is outside of the recommended dose or frequency. . . . The daily dose of 6 tablets exceeds the usual dose of 1 to 2 tablets. The frequency of 4 times per day exceeds the usual frequency of 2 times a day. The single dose of 2 tablets exceeds the maximum single dose of 1 tablet. The usual daily dose is 1 to 2 tablets."

A second provider pharmacy order note dated and timed the same as the previous pharmacy order note alerted the facility the 4/27/23 new [redacted] order created a drug-to-drug interaction with two (2) other medications [redacted] with the potential of increased risk of [redacted]

There was no evidence that the order notes were addressed by nursing staff.

The April 2023 eMAR revealed the following Eliquis administration:
On 4/28, 4/29, and 4/30 at 0900, [redacted] On 4/28, 4/29, and 4/30 at 2100, EX Order 26 § 4b1 [redacted]

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The May 2023 eMAR included the exact incorrect double twice daily dosing on 5/1/23 and 5/3/23. On 5/2/23 eMAR documentation indicated the incorrect 0900 doses were administered, and double dosing was administered for the 2100 time slot. On 5/4/23 eMAR documentation indicated no 0900 doses were given, and double dosing was administered for the 2100 time slot.

There were no nursing progress notes between 4/27/23 through 5/2/23 addressing the EX Order 26 § order or an assessment of the resident regarding EX Order 26 § 4b1

The physician documented in a 5/3/23 at 12:54 Physician Progress Note, ". . . Patient is to continue EX Order 26 § 4b1 ."

The 5/4/23 CP monthly report included the following statement: "Please clarify the order for EX Order 26 §: the loading doses and maintenance doses were both charted starting 4/28/23, i.e., EX Order 26 § 4b1 Were 3 tablets given cumulatively? Please review." The undated Action Taken response by the facility was "updated all medication orders & directions."

On 5/31/23 at 11:26 AM, the surveyor interviewed LPN #1, who stated she remembered when the resident started on EX Order 26 § but did not recall if the resident received incorrect dosing from 4/28/23 to 5/4/23. She said she couldn't remember that far back.

On 5/31/23 at 12:57 PM, the surveyor interviewed

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the DON, who stated she was unaware of the EX Order 26 § dosing errors. DON said she would initiate an investigation of the errors.

On 6/1/23 at 11:34 AM, the DON stated she had not completed the investigation. DON said the physician had not been notified of the EX Order 26 § errors.

On 6/1/23 at 4:13 PM, the surveyor interviewed LNHA regarding the EX Order 26 § administration errors between 4/28/23 and 5/4/23. The LNHA stated she was unaware of the errors and would immediately begin a medication error report.

On 6/2/23 at 10:10 AM, the surveyor interviewed the CP supervisor, who stated medication errors were brought to the nurse's attention. "It is up to the nurse to follow up and do an investigation."

The CP supervisor further stated that the CP identified the EX Order 26 § error after it had occurred. The CP informed the facility and would review it on the next visit, which did not yet happen.

On 6/5/23 at 1:44 PM, the DON stated she did not have a completed investigation, and the physician had not been notified.

On 6/7/23 at 2:16 PM, the surveyor interviewed the Medical Director (MD) on the phone. The MD was also the primary physician for Resident #25. He was the prescriber for the 4/27/23 EX Order 26 §; however, he stated he was unaware of the EX Order 26 § medication errors.

On 6/8/23 at 12:55 PM, the surveyor interviewed the MD on the phone.
He stated he had not received medication error

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F 760	Continued From page 110 reports or CP monthly reports. There was no documentation revealing any Ex.Order 26.4 [redacted] identified nor any documentation of Ex.Order 26.4(b)(1) for this resident. The facility policy and procedure for Medication Administration/eMAR was provided to the surveyor by the DON on 5/26/23. The policy was reviewed and signed by the LNHA in 2023 (no month was noted). Procedure #1 included the following verbiage ". . . no medication/s must be administered except those reviewed and confirmed with the physician, validated with the pharmacy, and entered into electronic eMAR. . ." Procedure #2 noted, ". . . check to make sure [medication] is the. . . right dose. . ." Procedure #4 noted, "Check the label of the medication against the order on the resident's eMAR, making sure that everything matches including the . . . dose. . ." Procedure #5 noted, "Double check the resident's other medication orders to make sure there are no contraindications between the medications." 3. On 5/31/23 at 11:40 AM, the surveyor observed Resident #20 in the resident's room in a chair. The resident's eyes were closed. The surveyor attempted to interview the resident, but the resident was unable to answer the surveyor's	F 760		

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F 760	Continued From page 111 inquiry. According to the AR, Resident #20 was admitted to the facility with diagnoses that included but were not limited t EX Order 26 § 4b1 [redacted] The surveyor reviewed the Quarterly MDS, with an ARD dated 5/7/23. The included BIMS referenced a score of [redacted], which identified that the resident's EX Order 26 § 4b1 [redacted]. The resident was care planned (11/14/2020) for the diagnosis of EX Order 26 § 4b1. Interventions included: EX Order 26 § 4b1 [redacted] The resident was care planned (5/29/2) for using EX Order 26 § 4b1 therapy. Interventions included: "EX Order 26 § 4b1 [redacted] A review of the OSR for May 2023 revealed the following POs for EX Order 26 § 4b1 [redacted] The order specified to inject the	F 760		

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F 760	Continued From page 112 EX Order 26 § 4b1 : EX Order 26 § 4b1 An additional PO dated 3/1/23 administered EX Order 26 § 4b1 The order specified administering EX Order 26 § 4b1 A review of March 2023 eMAR did not show documentation of the administration of the critical medications of EX Order 26 § 4b1 A review of April 2023 eMAR did not show documentation of the administration of the critical medications of EX Order 26 § 4b1	F 760		

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A review of May 2023 eMAR did not show documentation of the administration of the critical medications of EX Order 26 § 4b1 doses due.

A review of the March eMAR EX Order 26 § 4b1 results indicated that the EX Order 26 § 4b1 were to be taken before meals (6:30 AM, 11:30 AM, and 4:30 PM) and at bedtime (9:00 PM). The documented EX Order 26 § 4b1 results ranged from EX O, which required no EX Order 26 § 4b1, to Ex.Order, requiring 10 units of EX Order 26 § 4b1 to be administered.

A review of the April eMAR EX Order 26 § 4b1 esults indicated that the EX Order 26 § 4b1 were to be taken before meals (6:30 AM, 11:30 AM, and 4:30 PM) and at bedtime (9:00 PM). The documented blood sugar results ranged from Ex.Or, which required no EX Order 26 § 4b1, to Ex.Order, requiring 10 units of EX Order 26 § 4b1 to be administered.

A review of the May eMAR Ex.Order 26.4(b)(1) results indicated that the EX Order 26 § 4b1 were to be taken before meals (6:30 AM, 11:30 AM, and 4:30 PM) and at bedtime (9:00 PM). The documented EX Order 26 § 4b1 results ranged from Ex.Or, which required no EX Order 26 § 4b1, to Ex.Order requiring 10 units of EX Order 26 § 4b1 to be administered.

There was no documentation revealing a EX Order 26 taken on each of the EX Order 26 § 4b1 doses or documentation of EX Order 26 § 4b1

There was no documented evidence that the resident had a EX Order 26 § 4b1.

A review of the Progress Notes revealed no

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follow-up with the physician regarding any medication omissions in the eMARs.

4. On 6/1/23 at 10:45 AM, the surveyor observed Resident #230 in a chair in the resident's room. The surveyor attempted to interview the resident, but the resident was unable to answer.

According to the AR, Resident #230 was admitted to the facility with diagnoses that included but were not limited to EX Order 26 § 4b1 .

The resident was care planned (5/27/23) for using EX Order 26 § 4b1 related to EX Order 2.
Interventions included:

'EX Order 26 § 4b1

'EX Order 26 § 4b1

A review of the OSR for May 2023 revealed the following POs for EX Order 26 § 4b1 start date of 5/13/23.

A review of May 2023 eMAR did not show

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documentation of the administration of the critical medications of [redacted] for 13 of 36 doses due.

There was no documented evidence of hospitalization.

A review of the Progress Notes revealed no follow-up with the physician regarding any medication omissions in the eMARs.

5. On 6/7/23 at 11:23 AM, the surveyor observed Resident #13 in bed. The resident was unable to answer any questions.

According to the AR, Resident #13 was admitted to the facility with diagnoses that included but were not limited to EX Order 26 § 4b1 [redacted]

A review of the resident's Significant Change MDS with an ARD of 2/24/23, reflected the resident had a BIMS score of [redacted] out of 15, indicating that the resident had a [redacted].

A review of the resident's individualized interdisciplinary care plan (IDCP) reflected as a Focus area with a date initiated and revised of 4/1/22, "The resident is on EX Order 26 § 4b1 [redacted] "Administer Ex.Order 26.4(b)(1) medications as ordered by the physician. Monitor side effects and effectiveness every shift." There was an additional Focus area with a date initiated and revised 3/28/22,

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F 760	Continued From page 116 "Resident #18 has EX Order 26 § 4b1 " with interventions " EX Order 26 § 4b1 medication as ordered by the doctor. Monitor/document for side effects and effectiveness. EX Order 26 § 4b1 as ordered by the doctor. Monitor/document the resident/family's ability to manage the treatment program, i.e., medications, dietary, EX Order 26 § 4b , exercise, and knowledge of complications. Monitor/document/report PRN any signs and symptoms of EX Order 26 § 4b1 A review of the May 2023 OSR revealed the following Physician's Orders (PO): - EX Order 26 § 4b1 A review of the March 2023 eMAR revealed that there was no documentation for the administration of critical medications as follows: - EX Order 26 § 4b1	F 760		

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F 760	Continued From page 117 - EX Order 26 § 4b1 [redacted] A review of the April 2023 EMAR revealed that there was no documentation for the administration of critical medications as follows: - EX Order 26 § 4b1 [redacted] There was no documentation of EX Order 26 § 4b1 on each of the EX Order 26 § 4b1 or documentation o EX Order 26 § 4b1 [redacted] There was no documentation revealing any EX Order 26 [redacted] concerns identified nor any documentation of EX Order 26 § 4b1 for this resident. A review of the Progress Notes revealed no follow-up with the physician regarding any medication omissions in the eMARs. A review of the March eMAR EX Order 26 § 4b1 results indicated that the EX Order 26 § 4b1 were to be taken before meals (6:30 AM, 11:30 AM, and 4:30 PM) and at bedtime (9:00 PM). The documented EX Order 26 § 4b1 results ranged from [redacted], which required no EX Order 26 § 4b1, to [redacted] requiring 4	F 760		

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units of [EX Order 26 § 4b1] that were administered.

A review of the April eMAR [EX Order 26 § 4b1] results indicated that the [EX Order 26 § 4b1] were to be taken before meals (6:30 AM, 11:30 AM, and 4:30 PM) and at bedtime (9:00 PM). The documented [EX Order 26 § 4b1], which required no [EX Order 26 § 4b1], requiring [EX] that were administered.

A review of the May eMAR [Ex.Order 26.4(b)(1)] results indicated that the [EX Order 26 § 4b1] were to be taken before meals (6:30 AM, 11:30 AM, and 4:30 PM) and at bedtime (9:00 PM). The documented [EX Order 26 § 4b1] results ranged from [Ex.Orde], which required no [EX Order 26 § 4b1], to [Ex.Order], requiring 5 units of [EX Order 26 § 4b1] that were administered.

6. On 6/7/23 at 11:39 AM, the surveyor observed Resident #17 in a [EX Order 26 § 4b1] at the back of the dining/day room. The resident ended a phone call using the facility telephone. The resident stated that they had called their physician because they wanted to check on something. The resident also said that they received their medications because they see LPN#1 all the time and knew that they were supposed to take their [EX Order 26 § 4b1], with food. The resident was unable to speak to all medications that were administered or what times they were administered.

The surveyor reviewed the electronic medical record for Resident #17. A review of the AR revealed that the resident had diagnoses which included but were not limited to [EX Order 26 § 4b1]

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A review of the resident's quarterly MDS with an ARD of 3/10/23, reflected the resident had a BIMS of [redacted] out of 15, indicating that the resident had [redacted].

A review of the resident's IDCP reflected as a Focus area with a date initiated and revised of 4/1/22, "[redacted]."

A review of the May 2023 OSR revealed a PO with a start date of 3/1/23 for [redacted]

A review of the March 2023 eMAR revealed no documentation for administering a critical medication, [redacted], which had 17 out of 62 omitted doses.

A review of the April 2023 eMAR revealed no documentation for administering a critical medication, [redacted], which had 10 out of 60 omitted doses.

A review of the May 2023 eMAR revealed no documentation for administering a critical medication, [redacted], which had 29 out of 62 omitted doses.

There was no documentation revealing any [redacted] concerns identified nor any documentation of [redacted] for this resident.

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A review of the Progress Notes revealed no follow-up with the physician regarding medication omissions in the eMARs.

A review of the CP recommendations and monthly evaluations for March, April, and May 2023 revealed no specific CP recommendation addressing omissions from the resident's eMAR.

7. On 5/25/23 at 8:46 AM, during the morning medication pass, the surveyor observed LPN #1 preparing seven (7) medications according to the eMAR for Resident #18.

At that time, LPN #1 stated that she was the nurse who worked on the 11 PM to 7 AM shift and knew that Resident #18 had been sent to the [redacted] and returned after midnight with a prescription from the [redacted] for [redacted]. LPN #1 added that she wanted to start the [redacted] and administer the medication with the other morning medications. LPN #1 then called the Assistant Director of Nursing/Registered Nurse (ADON/RN), who brought over to LPN #1 to show the surveyor a prescription dated 5/24/23 from a hospita[redacted] physician for [redacted] The ADON/RN stated that she was working on faxing the prescription to the provider pharmacy and entering the PO in the electronic computer system. LPN #1 said she had [redacted] in the facility backup box, which was kept in the medication cart. The surveyor observed LPN #1 remove two (2) of the [redacted] from the backup box and place them in the

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medication cup with the seven (7) other medications she had prepared for Resident #18.

The surveyor had not observed a PO for [redacted] in the eMAR that LPN #1 was documenting for Resident #18.

On 5/25/23 at 9:01 AM, the surveyor observed LPN #1 preparing thickened water and said she would administer the eight (8) medications to Resident #18. At that time, the surveyor stopped LPN #1 from administering the (8) medications, which included the [redacted] capsules. The surveyor asked LPN #1 to review the eMAR for Resident #18. LPN #1 stated that the [redacted] PO was not entered electronically and was not on the eMAR. The surveyor then asked LPN #1 to review Resident #18's eMAR profile, particularly the [redacted] indicated on the eMAR. LPN #1 checked the resident's profile and stated that the resident was [redacted] to [redacted] LPN #1 also stated that she could not administer the [redacted] and would have to call the primary physician. The surveyor observed LPN #1 remove the two (2) 250 MG [redacted] capsules from the medication cup.

LPN #1 could not speak to what allergic reaction occurred if the resident received [redacted] or had received a [redacted] medication in the past without a reaction. LPN #1 could also not speak to whether the primary physician had approved the PO for [redacted] to be administered with a [redacted].

On 5/25/23 at 9:09 AM, the surveyor interviewed LPN #1 in the presence of the DON and

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ADON/RN, who stated that she had assumed the emergency room physician had reviewed the allergies. The DON said that LPN #1 should not have assumed. The DON added that the ADON/RN called the primary physician for the resident, and they were waiting to verify whether the [EX Order 26 §] could be administered.

At that time, LPN #1 stated that her usual procedure was to call the physician, review any medication orders from the hospital, and review the allergies with the physician. However, this was a different situation.

On 5/25/23 at 9:20 AM, the surveyor interviewed the DON, who stated that the ADON/RN called the primary physician, and the physician changed the PO to EX Order 26 § 4b1. The DON acknowledged that the administration of the [EX Order 26 §] with a [EX Order 26 § 4b1] was not verified by the physician and had the potential to cause a severe reaction.

On 5/25/23 at 9:36 AM, the surveyor interviewed the ADON/RN, who stated that the physician changed the [EX Order 26 §] to [EX Order 26 § 4b] but that the physician had said that there was a low chance of cross-sensitivity. The ADON/RN added that the ER physician had written the prescription and thought that was sufficient. The ADON/RN acknowledged that the facility had processes to follow for the receipt of new medication orders and that the primary physician was called to verify PO, and the PO would be faxed to the provider pharmacy. The pharmacy usually calls the physician to confirm dispensing the [EX Order 26 §] with a [NJ Exec. Order 26:4.b.1]. The ADON/RN acknowledged that she had called the primary physician and faxed the PO for [EX Order 26 §] to the provider pharmacy after

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F 760	Continued From page 123 LPN #1 was going to administer the [NJ Exec. Order] to the resident. On 5/25/23 at 10 AM, the surveyor was provided the AR and OSR for Resident #18 by the DON, who stated that the forms were sent to the hospital. The surveyor reviewed the documents, and an [NJ Exec. Order 26:4.b.1] was noted on both forms. No documentation was provided that the ER physician was aware of the [NJ Exec. Order 26:4.b.1]. On 5/25/23 at 11:00 AM, the survey team met with the DON and LPN #1. LPN #1 stated that Resident #18 was readmitted on her shift but that she had not called the primary physician to get approval for the [EX Order 26 5] to be administered and had not faxed the [EX Order 26 5] prescription to the provider pharmacy. The DON acknowledged that the proper procedure for the new medication order was not followed. On 6/1/23 at 3:01 PM, the surveyor interviewed the DON and ADON. The ADON stated that no progress note was completed regarding the issue with the [NJ Exec. Order 26:4.b.1] because she didn't think it was a big issue when she spoke with the physician and the provider Pharmacy. The ADON stated that she entered the new order for [EX Order 26 5 40] in the eMAR. The DON verified that the PO was not entered in the eMAR, confirmed by the primary physician, or faxed to the provider pharmacy before LPN #1 was going to administer the [NJ Exec. Order] to the resident, and there was no knowledge of the type of [NJ Exec. Order 26:4.b.1] that Resident #18 had to [NJ Exec. Order] On 6/1/23 at 3:22 PM, the surveyor interviewed the DON, who stated that she had called the	F 760		

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family representative for Resident #18, but they did not know about any allergies. The DON added that the unknown NJ Exec. Order 26:4.b.1 had the potential to be a severe reaction. The DON stated that the provider pharmacy had said the reaction could be mild to moderate, but the physician had to verify that the [redacted] could be administered with a [redacted]. The DON added that every new PO for medication should have the allergies checked before administration.

The surveyor reviewed the medical record for Resident #18.

A review of the Admission Record revealed that the resident had diagnoses that included but were not limited to [redacted].

A review of the annual MDS with an ARD of 5/7/2023 reflected the resident had a BIMS score of three [redacted] out of 15, indicating that the resident had EX Order 26 § 4b1 .

A review of the electronic record of Resident #18 revealed an [redacted] tab that listed the "[redacted]" was [redacted]" with the "Type" listed as "allergy" and the "Category" listed as "drug" with no "Reaction/Type/Subtype" listed and "Severity" listed as "Unknown" dated 6/25/2020.

A review of the hospital records provided by the DON revealed an "After Visit Summary," which indicated that the reason for the visit was an EX Order 26 § 4b1 , and the diagnoses included EX Order 26 § 4b1 [redacted] In addition, there was a prescription written on 5/24/23 by the [redacted] physician for "EX Order 26 § 4b1

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EX Order 26 § 4b1 ", with a quantity noted for 15 capsules with a start date of 5/24/23 and an end date of 5/29/23. There was no documentation that the physician stated the NJ Exec. Order 26:4.b.1.

On 6/1/23 at 4:13 PM, the survey team met with the LNHA and DON. The DON stated that she had thought the EX Order 26 § 4b transfer form had the NJ Exec. Order 26:4.b.1 noted but could not obtain the universal transfer form. The DON then said that LPN #1 was not able to verify the PO or fax the PO to the provider pharmacy because she was the only nurse on duty from 11 PM to 7 AM and then stayed for the 7 AM shift and was also pulled to do other job duties while passing medications. The LNHA stated that the NJ Exec. O physician should have known the resident had a NJ Exec. Order 26:4.b.1 because it was on the resident's profile that was sent with the resident to the EX Order 26 § 4b. The LNHA acknowledged that the NJ Exec. Order 26:4.b.1 should have been verified with the physician when the resident returned to the facility before the administration of the EX Order 26 §.

On 6/2/23 at 9:16 AM, the surveyor interviewed the CPS via telephone, stating that the CP assigned to the facility was out on leave. The CPS stated that she would email any completed med passes or in-services.

On 6/5/23 at 9:50 AM, the surveyor interviewed LPN #1, who stated that she was not trained at the facility on the electronic records but knew some of the electronic entries for documentation of medication administration from a previous facility. LPN #1 added that she was not that fast

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at the eMAR and had no knowledge of entering a PO electronically because the DON or ADON had been doing that.

On 6/5/23 at 9:58 AM, the surveyor interviewed the CPS via telephone, who stated that she had emailed medication observations that included two (2) completed for LPN #1. The CPS added that there were no in-services performed recently. The CPS said that there was a covering consultant Pharmacist (CP) that may have more information.

A review of the "Medication Pass Observation" completed by the CP, that was on leave dated 12/7/22, revealed that LPN #1 had zero (0) errors which resulted in a zero (0) percent error rate. A review of the "Medication Pass Observation" completed by the covering CP dated 4/4/23 revealed that LPN #1 had one (1) error, resulting in a nine (9) percent error rate.

A review of the employee file of LPN #1 revealed that no performance evaluations or competencies were completed, and no other medication observations were completed.

On 6/5/23 at 10:24 AM, the surveyor interviewed the CP via telephone, who stated that he was covering for the regular CP during April and May and was familiar with the reports. The CP stated that he had completed a medication observation with LPN #1 in April and that she had failed because a medication was administered outside of the allowed time. The CP stated that he performs an in-service medication administration on the spot after a medication administration is completed using the Medication Pass Observation form. The CP added that, as

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indicated on the form, the results were reviewed with the nurse, and LPN #1 was aware of the reason for the error. The CP also stated that he was unsure if there was a DON and had given the completed medication observation forms to the LNHA. The CP also said that all PO should be verified with the primary physician, then entered electronically and faxed to the pharmacy before administration. The CP added that allergies should be checked and thought there was a 15% chance of cross-sensitivity between [NJ Exec. Ord] and [NJ Exec. Order]. The CP stated that the nurses should check and document what allergy occurred. When the [NJ Exec. Order] was ordered, the physician should be contacted to verify whether the [NJ Exec. Order 2] could be administered.

A review of the CP Medication Pass Observation form included that "Medication checked against medication administration record (MAR) before administering" was part of the proper procedure for medication administration.

On 6/5/23 at 11:51 AM, the surveyor interviewed the DON, who stated that there should be training if a nurse failed a medication observation. A follow-up medication observation would have to be completed. The surveyor, with the DON, reviewed the Medication Pass Observation form dated 4/4/23 for LPN #1, which resulted in an error rate of nine (9) percent. The DON stated that there was no follow-up with LPN #1 because the error noted on the form was because the medication was not administered within one hour of the prescribed time or ½ hour when the order was before or after meals. The DON explained that medications not being administered on time was an "umbrella issue" in the facility. The DON further explained that the "umbrella issue" meant

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a widespread issue with timing because of understaffing, and the nurses were stretched thin. The DON added that she trains the nurses to stay on time and not to be distracted during the medication pass. Still, if only one nurse were on the floor, they would be interrupted for other responsibilities such as helping the Certified Nursing Aide, completing admissions paperwork, swabbing anyone at the facility's door, and answering phones. The DON also stated that the one nurse on the shift does the best that they can. The DON added that the ADON was fairly new and that she was an Interim DON.

On 6/8/23 at 10:26 AM, the survey team met with the Medical Director (MD), who stated that he was the primary physician for Resident #18. The MD also stated that [redacted] had approximately a 30% chance of a cross-sensitivity to [redacted] and could cause an EX Order 26 § 4b1, but there was a minimal chance. The MD added that the PO for [redacted] with a [redacted] should be verified with the physician before administering the [redacted] as part of the checks and balances. The MD added that the pharmacy usually called him and first confirmed the PO with the [redacted]. The MD acknowledged that LPN #1 had not followed the proper procedure and should have verified the PO for [redacted] before administering.

A review of the updated facility policy for "Medication Ordering and Receiving from Pharmacy" provided by the LNHA included that the procedure was "When an emergency or "stat" order has received the nurse follows the procedure for order documentation in accordance with the policy on Prescriber Medication Orders (see IB1: Non-Controlled Medication Order

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Documentation)."
The surveyor was not provided the policy on "Prescriber Medication Orders (see IB1: Non-Controlled Medication Order Documentation)" that was referred to in the policy "Medication Ordering and Receiving from Pharmacy" above.

A review of the facility policy dated as new 5/2021 provided by the DON for "Documentation in Electronic Medical Records (EMR)" reflected that the facility would provide a complete clinical record on every resident, including but not limited to monthly care plans." The procedure included that "Training on the EMR is done by the department in which the employee works."

A review of the undated revised policy for "Medication Administration/eMAR-[name redacted]" provided by the DON reflected that the procedure was "The facility will provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all medications, to meet the needs of each resident. Accordingly, no medication/s must be administered except those reviewed and confirmed with the physician, validated with the pharmacy, and entered into electronic Medication Administration Record (eMAR), that is [Name redacted]." The policy also reflected "Check the resident's allergies listed on the eMAR to make sure the resident is not allergic to the medication."

On 6/1/23 at 4:28 PM, the facility LNHA was notified of the IJ.

On 6/6/23 at 12:45 PM, the surveyors were

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F 760	Continued From page 130 provided the RP, and after review, it was rejected based on insufficient evidence, which was needed to remove the immediacy. The surveyor discussed this with the LNHA. On 6/7/23 at 10:00 AM, the surveyor requested the RP, which was not provided. The LNHA explained that she is still working on the RP. On 6/07/23 at 12:40 PM, the surveyor requested the RP, which was not provided again. The LNHA explained that she is unsure if the RP will be ready today. On 6/08/23 at 10:45 AM, the surveyors reviewed the RP sent by the facility, and after review, it was rejected based on insufficient evidence, which was needed to remove the immediacy. The surveyor discussed this with the LNHA. After the facility revised the RP, they were accepted. The RP was verified by the survey team onsite on 6/8/23, lifting the immediacy, and the survey team continued verification of the RP onsite throughout the remainder of the survey through observation, interview, and review of records. NJAC 8:39-27.1(a); 29.2(d); 29.3(a)1; 29.3(a)3; 29.3(a)6	F 760		
F 835 SS=L	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 835		7/25/23

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F 835	Continued From page 131 This REQUIREMENT is not met as evidenced by: Complaint #s NJ00155172, NJ00161276, NJ00160806, NJ00159306 Refer to F689, F756, F760, F836 Based on observations, interviews, review of medical records, and review of facility documents, it was determined that the facility Licensed Nursing Home Administrator (LNHA) failed to ensure a.) staffing levels outlined in the Facility Assessment Tool were consistently met to address the population census and needs of their residents; b.) minimum State staffing requirements were met for 17 weeks of 17 weeks reviewed during which time the facility continued to admit residents; c.) safe medication administration to residents resulting in significant medication errors; d.) Consultant Pharmacist (CP) monthly medication review reports were acted upon by the Director of Nursing (DON) and the Physician in a timely manner; e.) adequate supervision and competent staff when Licensed Practical Nurse #1 (LPN #1) would sleep during excessive continuous hours at work, leaving no nurse to supervise the Certified Nursing Assistant (CNA) and no nurse to supervise the 29 residents while LPN #1 slept. The failure of the LNHA to ensure the facility operated safely by following staffing benchmarks outlined in the Facility Assessment Tool and following State minimum staffing requirements while continuing to admit new residents placed all residents at risk for serious harm, impairment, or death, which resulted in a citation for F836L. Staff interviews revealed short staffing was typical, often consisting of 1 nurse and 1 CNA. This	F 835	F835 1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice: A. No residents were affected. B. Staffing levels/patterns based on Facility Assessment- • The Facility Assessment was reviewed and updated to establish new nurse staffing minimums based upon the NJ annotated 30:13-18 revised minimum staffing for long-term care facilities. • Contracts have been executed with multiple nursing agencies and online temporary staffing platforms to secure temporary RNs, LPNs, and CNAs. C. Meeting State Minimum Staffing Levels • Scheduling Improvement: The Director of Nursing has developed a comprehensive master schedule for the nursing department. This schedule includes the existing employees and their established shifts, as well as identifies the current open shifts that need to be filled with permanent and/or temporary employees. • Incentives for New Hires: The administration has implemented referral and sign-on bonuses to attract new hires. • Temporary Overtime: Current staff members from other shifts have been requested to temporarily work overtime to help fill the open shifts. • Rehiring Former Staff: The facility has	

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resulted in citations for F689L and F836L. Multiple significant medication administration errors were identified, which resulted in a citation for F760K. Failure to respond to the CP's monthly medication review reports resulted in a citation for F756K. Additionally, the LNHA failed to actively engage the Medical Director regarding ongoing concerns expressed during the survey.

The LNHA was notified of the initial Immediate Jeopardy (IJ) on 6/1/23 at 4:28 PM for F756K and F760K.

The LNHA was notified of subsequent IJs on 6/5/23 at 2:26 PM for F836L, F689L, and F835L. An acceptable written Removal Plan (RP) was received on 6/8/23. The RP was verified by the survey team onsite on 6/8/23, lifting the immediacy, and the survey team continued verification of the RP onsite throughout the remainder of the survey through observation, interview, and review of records.

The evidence was as follows:

1. On 5/24/23 at 9:30 AM, the surveyor observed one LPN and one CNA working on the nursing unit. The surveyor interviewed the Social Services Director (SSD), who stated the census was 29, and there was one LPN (LPN #1) and one CNA (CNA #1) working the day shift.
The SSD stated LPN #1 and CNA #1 also worked the previous 11 PM to 7 AM shift. The SSD stated the facility was actively recruiting candidates; however, they are hired and "just don't show up for work."

The surveyor reviewed the written nursing schedule for the week beginning 5/23/23. LPN #1

reached out to former nursing staff members who have previously worked at the facility to fill open positions capitalizing on their previous experience and familiarity with the organization.
• Online Applicant Review: The facility is actively reviewing applications for registered nurses (RNs), licensed practical nurses (LPNs), and certified nursing assistants (CNAs) on various online employment sites.
• Temporary Staffing Agencies: Contracts have been executed with multiple nursing agencies as well as online temporary nurse staffing platforms to secure temporary RNs, LPNs, and CNAs for unfilled shifts.

D. Safe administration of medications
• All medication errors were addressed as stated in F760
E. Pharmacy Consultant Report
• The DON reviewed the pharmacy report with the Medical Director and implemented all recommendations as appropriate.

F. Adequate Supervision
• The agreement with the nurse to sleep while on duty was terminated.
• All staff were informed that sleeping while on duty is an unacceptable practice and grounds for termination.
• The Director of Nursing will conduct spot visits on the 11-7 shift to provide support and guidance to the staff.

2. The facility identified other residents having the potential to be affected by the

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F 835	Continued From page 133 was scheduled as the only nurse on 5/23 from 11:15 PM to 7 AM; on 5/24 from 7 AM to 3:45 PM and 11 PM to 7 AM; on 5/25 from 7 AM to 3:30 PM and 10:45 PM to 8:15 AM. CNA #1 was scheduled as the only CNA on 5/23 from 11 PM to 7 AM, on 5/24 from 11 PM to 9:30 AM, and on 5/25 from 8 PM to 8 AM. A further review of staffing for the period of 5/1/23 -5/31/23 revealed LPN #1 worked daily with no days off for 31 days. LPN #1 worked five times for 24 consecutive hours, one time for 26.5 consecutive hours, and thirteen times for 16 consecutive hours. There were no CNAs on duty at the facility for the following times: - 5/2/23: 11 PM to 7 AM - 5/3/23: 7:00 AM to 10:30 AM; 11 PM to 7 AM - 5/9/23: 7 AM - 10:00 AM - 5/10/23: 7 AM - 10:00 AM - 5/13/23: 11 PM - 7 AM - 5/16/23: 8:30 AM - 10:00 AM - 5/17/23: 7 AM - 2 PM - 5/18/23: 7 AM - 2 PM; 11 PM- 7 AM - 5/22/23: 7 AM - 10 AM There were no nurses in the building on 5/4/23 from 3 PM to 6 PM. On 5/23/23, there was no Registered Nurse (RN) on duty during any of the three shifts. On 5/26/23, the LNHA provided the surveyor with the Facility Assessment Tool, updated on 5/1/23. Part 2, Example 2 described the general staffing plan to ensure enough staff is on hand to meet the needs of residents at any given time. The	F 835	same deficient practice: • All Residents have the potential to be affected by the deficient practice. • A root cause analysis was completed using the Failure Mode and Effects Analysis (FMEA) to determine to identify nurse staffing, recruitment, and retention challenges. • Scheduling Improvement: The Director of Nursing has developed a master schedule for the nursing department. This schedule includes the existing employees and their established shifts, as well as identifies the current open shifts that need to be filled with permanent employees. • The Administrator has executed contracts with multiple nursing agencies as well as online temporary nurse staffing platforms to secure temporary RNs, LPNs, and CNAs for unfilled shifts. 3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: • A new nurse staffing methodology will be implemented for the facility assessment report to ensure appropriate staffing levels based on the specific needs of the residents. • The Administrator will evaluate and implement comprehensive recruitment strategies, which will include targeted advertising, forging partnerships with educational institutions, and offering incentives such as sign-on bonuses and referral rewards for qualified candidates. • The Administrator will establish contracts with temporary staffing agencies to address staffing gaps when necessary.	

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F 835	Continued From page 134 breakdown was as follows: Director of Nursing (DON) - one full-time day. An RN or LPN Charge Nurse for each shift (for 1-18 residents, the DON may be a Charge Nurse). One licensed nurse for every 36 residents on day and evening shifts. One licensed nurse for every 18 residents on the night shift. Direct Care Staff required was listed as 1 direct care staff person for 36 residents on day, evening, and night shifts. 2. On 6/2/23, staffing was obtained from the LNHA for a total of 17 weeks in three segments: 8/28/22 - 11/5/22 and 1/01/23 - 2/04/23 (periods when complaints were lodged for the shortage of staffing) and 5/07/23 - 5/20/23 (two weeks prior to the standard recertification survey). A review of the documentation revealed the following. For the 10 weeks of staffing from 8/28/22 to 11/05/22, the facility was deficient in CNA staffing for residents on 70 of 70 day shifts, deficient in total staff for residents on 35 of 70 evening shifts, deficient in CNAs to total staff on two of 70 evening shifts, and deficient in total staff for residents on 18 of 70 overnight shifts. For the five weeks of staffing from 1/01/23 to 2/04/23, the facility was deficient in CNA staffing for residents on 34 of 35 day shifts, deficient in total staff for residents on eight of 35 evening shifts, deficient in CNAs to total staff on six of 35 evening shifts, and deficient in total staff for residents on six of 35 overnight shifts. For the two weeks of staffing prior to the survey	F 835	• Wage rates and benefit packages will be reviewed by the Administrator, who will make adjustments as needed to remain competitive and attract skilled staff. • The administrative team will develop employee recognition and perks programs to acknowledge and appreciate the efforts of the staff. • The Administrator will organize quarterly employee engagement meetings to foster open communication, feedback, and solutions from current employees. • The Administrator, in collaboration with department heads, will conduct a thorough review of the four-week working schedules for each department before finalizing and posting them. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes: • The Director of Nursing will submit nurse staffing schedules and staffing metrics to the Administrator on a daily basis for a period of three months and then weekly for one month and then monthly thereafter. • A comprehensive report will be created, compiling nurse staffing metrics, new hire and resignation/termination data, and information on employee retention programs and events. The report will be presented at the Quarterly QAPI meeting, for review and further recommendations.	

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from 5/07/23 to 5/20/23, the facility was deficient in CNA staffing for residents on 14 of 14-day shifts, deficient in total staff for residents on 11 of 14 evening shifts, deficient in CNAs to total staff on one of 14 evening shifts, and deficient in total staff for residents on two of 14 overnight shifts.

3. Significant medication errors occurred regarding the documentation and administration of critical medications, including EX Order 26 § 4b1 [redacted] medications to prevent serious adverse outcomes were identified for Resident #13, #19, and #20, who required EX Order 26 § 4b1 [redacted] and were dependent on EX Order 26 § [redacted]; Resident #13, 17, 20, 25 and 230 who had physician orders for EX Order 26 § 4b1 [redacted] medication to EX Order 26 § 4b1 [redacted]; and Resident #19 who had a physicians order for an EX Order 26 § 4b1 [redacted].

The facility nurse failed to ensure that Resident #18 received medication that was first validated by the physician and the pharmacy, reviewed for allergies, and entered into the electronic Medication Administration Record (eMAR) to prevent serious adverse outcomes, including significant allergic reactions.

The facility nurse's failure to monitor and document EX Order 26 § 4b1 [redacted] and administer EX Order 26 § [redacted] and EX Order 26 § 4b1 [redacted] agents when it was indicated in accordance with a physician's order was likely to result in EX Order 26 § 4b1 [redacted] which would require immediate emergency intervention if the resident became symptomatic.

The facility nurse's failure to administer and document an EX Order 26 § 4b1 [redacted] in accordance with a

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physician's order to prevent EX Order 26 § 4b1 increased the risk of EX Order 26 § 4b1, EX Order 26 § 4b1 [redacted] Residents #13, 17, 25, 20, 230 were identified as having EX Order 26 § 4b1 under and EX Order 26 § 4b1.

Resident #25 received double dosing of an EX Order 26 § 4b1 medication for 5 days, EX Order 26 § 4b1 [redacted].

This resulted in an Immediate Jeopardy (IJ) situation. The facility was notified of the IJ on 6/1/23 which began on 3/7/23 (the start date on which the Consultant Pharmacist alerted the facility of concerns on documentation of medications on the eMAR) and continued until 6/8/23 when the facility implemented their written removal plan. The facility's Licensed Nursing Home Administrator (LNHA) was notified of the IJ on 6/1/23 at 4:28 PM. An acceptable written Removal Plan (RP) was received on 6/8/23. The RP was verified by the survey team onsite on 6/8/23, lifting the immediacy, and the survey team continued verification of the RP onsite throughout the remainder of the survey through observation, interview, and review of records.

This deficient practice was identified for 7 of 17 residents reviewed for medication management (Resident #13, #17, # 18, #19, #20, # 25, and #230).

4. Consultant Pharmacist (CP) recommendations dated on 3/7/23 were not acted upon in a timely manner. The recommendations regarded the documentation and administration of critical medications, including EX Order 26 § 4b1

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medications, to prevent serious adverse outcomes. Residents #13, #19, and #20 required EX Order 26 § 4b1 monitoring and were dependent on EX Order 26 §. Residents #17 and #230 required NJ Exec. Order 26:4.b.1 to prevent EX Order 26 .

The failure to act upon the CP recommendations in a timely manner to ensure all residents were accurately receiving the necessary medications in the appropriate timeframe in accordance with their physician's order to prevent an adverse outcome placed all residents who receive critical medications at risk for a serious outcome.

The failure to monitor and document NJ Exec. Orde and administer NJ Exec. Order 2 when it was indicated in accordance with physician orders is likely to result in EX Order 26 § 4b1 both of which require immediate emergency intervention. The failure to administer and document NJ Exec. Order 26:4.b.1 medication in accordance with a physician's order to prevent EX Order 26 § 4b1 is likely to lead to EX Order 26 § 4b1 throughout the body.

5. The surveyor interviewed LPN #1 on 6/1/23 at 10:59 AM. She stated her regular shift was 11 PM - 7 AM. LPN #1 stated the 7 AM - 3 PM nurse resigned last month. The 3 PM - 11 PM nurse (LPN #2) works 2 to 3 times a week.

LPN #1 stated she frequently works multiple shifts in a day, including all 3 shifts if no other nurse is scheduled.

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LPN #1 stated that when she works 24 hours consecutively, she will get a 1 - 2 hour break to sleep. There is one CNA working with her and no covering nurse when she takes a break.

On 6/01/23 at 10:30 AM, the surveyor interviewed the DON and Assistant Director of Nursing (ADON). The ADON stated the LNHA did not want 2 nurses to be working together on the day shift because there is not enough work for them.

She further stated "good CNAs" have left because of the number of residents each CNA is responsible for. "They cannot handle the work."

They explained that LPN #1 "is an in-house nurse and lives here at the facility." She was offered a room but prefers to sleep in a reclining chair in the dayroom. She showers at the facility. There are multiple times when LPN #1 will do a medication pass, rest for an hour, and then return to the floor to resume nursing duties. The DON stated LPN #1 frequently works 7 AM- 3 PM, 3 PM - 11 PM, and 11 PM - 7 AM shifts. The DON stated that LPN #1 is the on duty nurse almost all the time and that this was not safe for the residents because the nurse is not resting enough.

On 6/05/23 at 11:30 AM, the LNHA provided the surveyor with a document titled In-House Universal Staff Nurse which was signed by LPN #1 on 10/14/22. The section titled In-House Residency indicated the nurse "will typically work two 8-hour shifts and are [sic] permitted to leave or sleep on the premises." The LNHA explained LPN #1 is like a Resident in a hospital. LPN #1 can sleep in the facility and be on call for when she is needed by the CNA.

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F 835	Continued From page 139 On 6/6/23 at 12:45 PM, the surveyors were provided the RP. After review, it was rejected based on insufficient evidence, which was needed to remove the immediacy. The surveyor discussed this with the LNHA. On 6/7/23 at 10:00 AM, the surveyor requested the RP, which was not provided. The LNHA explained that she is still working on the RP. On 6/07/23 at 12:40 PM, the surveyor requested the RP, which was not provided again. The LNHA explained that she is unsure if the RP will be ready today. On 6/08/23 at 10:45 AM, the surveyors reviewed the RP sent by the facility, and after review, it was rejected based on insufficient evidence, which was needed to remove the immediacy. The surveyor discussed this with the LNHA. After the facility revised the RP, it was accepted. The RP was verified by the survey team onsite on 6/8/23, lifting the immediacy, and the survey team continued verification of the RP onsite throughout the remainder of the survey through observation, interview and review of records. NJAC 8:39-4.1(a)11; NJAC 8:39-25.2(a)(b); NJAC 8:39-27.1(a); NJAC 8:39-29.2(d); NJAC 8:39-29.3(a)1. 3. 6.	F 835		
F 836 SS=L	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure.	F 836		7/3/23

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F 836	Continued From page 140 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 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: Complaint #s NJ00155172, NJ00161276, NJ00160806, NJ00159306 Refer to F689, F756, F760, F835 Based on observation, interview, record review,	F 836	1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice: A. All residents have the potential to be affected. B. Staffing levels/patterns based on	

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F 836	Continued From page 141 and review of facility provided documentation, it was determined that the facility failed maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for 118 of 119 day shifts, 54 of 119 evening shifts, and 10 of 119 overnight shifts. The failure of the facility to operate safely by following State minimum staffing requirements while continuing to admit new residents placed all residents at risk for serious harm, impairment or death. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties, and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.	F 836	Facility Assessment- The facility Assessment was reviewed and updated to establish new nurse staffing minimums based on current census and care/acuity levels and care needs. • Contracts have been executed with multiple nursing agencies and online temporary staffing platforms to secure temporary RNs, LPNs, and CNAs. C. Meeting State Minimum Staffing Levels • Scheduling Improvement: The Director of Nursing has developed a comprehensive master schedule for the nursing department. This schedule includes the existing employees and their established shifts, as well as identifies the current open shifts that need to be filled with permanent and/or temporary employees. • Incentives for New Hires: The administration has implemented referral and sign-on bonuses to attract new hires. • Temporary Overtime: Current staff members from other shifts have been requested to temporarily work overtime to help fill the open shifts. • Rehiring Former Staff: The facility has reached out to former nursing staff members who have previously worked at the facility to fill open positions capitalizing on their previous experience and familiarity with the organization. • Online Applicant Review: The facility is actively reviewing applications for registered nurses (RNs), licensed practical nurses (LPNs), and certified nursing assistants (CNAs) on various online employment sites.	

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F 836	Continued From page 142 Nurse Staffing Reports were completed by the facility for 3 distinct periods of time equaling 17 weeks in total. The weeks of 8/28/2022-11/05/22 and 01/01/2023-02/04/2023 were reviewed due to complaints filed for low staffing during these 2 periods. A third period was reviewed for the 2 weeks of staffing prior to the standard recertification survey from 05/07/2023 to 05/20/2023, 1. For the 10 weeks of staffing from 08/28/2022 to 11/05/2022, the facility was deficient in CNA staffing for residents on 70 of 70 day shifts, deficient in total staff for residents on 35 of 70 evening shifts, deficient in CNAs to total staff on 2 of 70 evening shifts, and deficient in total staff for residents on 18 of 70 overnight shifts as follows: -08/28/22 had 1 CNA for 31 residents on the day shift, required 4 CNAs. -08/28/22 had 2.5 total staff for 31 residents on the evening shift, required 3 total staff. -08/29/22 had 0.0 CNAs for 31 residents on the day shift, required 4 CNAs. -08/30/22 had 1 CNA for 31 residents on the day shift, required 4 CNAs. -08/30/22 had 2.8 total staff for 31 residents on the evening shift, required 3 total staff. -08/31/22 had 1 CNA for 31 residents on the day shift, required 4 CNAs. -08/31/22 had 2 total staff for 31 residents on the evening shift, required 3 total staff. -08/31/22 had 1.8 total staff for 31 residents on the overnight shift, required 2 total staff. -09/01/22 had 1 CNA for 31 residents on the day shift, required 4 CNAs. -09/01/22 had 2.8 total staff for 31 residents on the evening shift, required 3 total staff.	F 836	• Temporary Staffing Agencies: Contracts have been executed with multiple nursing agencies and online temporary staffing platforms to secure temporary RNs, LPNs, and CNAs. 2. The facility identified other residents having the potential to be affected by the same deficient practice: All Residents have the potential to be affected by the deficient practice. A root cause analysis was completed using the Failure Mode and Effects Analysis (FMEA) to determine the cause of poor nurse staffing, recruitment, and retention. A. Staffing levels/patterns based on resident care needs The facility Assessment was reviewed and updated to establish new nurse staffing minimums based on the current census and care/acuity levels and care needs. B. Meeting State Minimum Staffing Levels • Scheduling Improvement: The Director of Nursing has developed a comprehensive master schedule for the nursing department. This schedule includes the existing employees and their established shifts, as well as identifies the current open shifts that need to be filled with permanent employees. • Incentives for New Hires: The administration has implemented referral and sign-on bonuses to attract new hires.	

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F 836	Continued From page 143 -09/01/22 had 1.3 total staff for 31 residents on the overnight shift, required 2 total staff. -09/02/22 had 1 CNA for 31 residents on the day shift, required 4 CNAs. -09/02/22 had 2 total staff for 31 residents on the evening shift, required 3 total staff. -09/03/22 had 0.0 CNAs for 31 residents on the day shift, required 4 CNAs. -09/03/22 had 2.6 total staff for 31 residents on the evening shift, required 3 total staff. -09/04/22 had 1 CNA for 30 residents on the day shift, required 4 CNAs. -09/04/22 had 1.9 total staff for 30 residents on the evening shift, required 3 total staff. -09/04/22 had 0.9 CNAs to 1.9 total staff, required 1 CNA. -09/05/22 had 0.0 CNAs for 30 residents on the day shift, required 4 CNAs. -09/05/22 had 2.6 total staff for 30 residents on the evening shift, required 3 total staff. -09/07/22 had 0.0 CNAs for 30 residents on the day shift, required 4 CNAs. -09/07/22 had 2 total staff for 30 residents on the evening shift, required 3 total staff. -09/08/22 had 0.0 CNAs for 30 residents on the day shift, required 4 CNAs. -09/08/22 had 2.6 total staff for 30 residents on the evening shift, required 3 total staff. -09/09/22 had 0.0 CNAs for 30 residents on the day shift, required 4 CNAs. -09/09/22 had 2 total staff for 30 residents on the evening shift, required 3 total staff. -09/10/22 had 2 CNAs for 30 residents on the day shift, required 4 CNAs. -09/10/22 had 2 total staff for 30 residents on the evening shift, required 3 total staff. -09/11/22 had 1 CNA for 30 residents on the day shift, required 4 CNAs.	F 836	• Temporary Overtime: Current staff members from other shifts have been requested to temporarily work overtime to help fill the open shifts. • Rehiring Former Staff: The facility has reached out to former nursing staff members who have previously worked at the facility to fill open positions capitalizing on their previous experience and familiarity with the organization. • Online Applicant Review: The facility is actively reviewing applications for registered nurses (RNs), licensed practical nurses (LPNs), and certified nursing assistants (CNAs) on various online employment sites. • Temporary Staffing Agencies: Contracts have been executed with multiple nursing agencies as well as online temporary nurse staffing platforms to secure temporary RNs, LPNs, and CNAs for unfilled shifts. 3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: • The Director of Nursing will create a comprehensive master schedule for the nursing department, encompassing the current employees and their assigned shifts. It will also identify open shifts that require permanent staffing. • A new nurse staffing methodology will be implemented for the facility assessment report to ensure appropriate staffing levels based on the specific needs of the residents. • The administrator will evaluate and implement comprehensive recruitment	

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F 836	Continued From page 144 -09/11/22 had 2 total staff for 30 residents on the evening shift, required 3 total staff. -09/11/22 had 1.5 total staff for 30 residents on the overnight shift, required 2 total staff. -09/12/22 had 0.0 CNAs for 30 residents on the day shift, required 4 CNAs. -09/13/22 had 1 CNA for 30 residents on the day shift, required 4 CNAs. -09/13/22 had 2.3 total staff for 30 residents on the evening shift, required 3 total staff. -09/14/22 had 0.5 CNAs for 30 residents on the day shift, required 4 CNAs. -09/15/22 had 0.8 CNAs for 31 residents on the day shift, required 4 CNAs. -09/15/22 had 2 total staff for 31 residents on the evening shift, required 3 total staff. -09/16/22 had 1 CNA for 31 residents on the day shift, required 4 CNAs. -09/16/22 had 2.5 total staff for 31 residents on the evening shift, required 3 total staff. -09/17/22 had 1 CNA for 31 residents on the day shift, required 4 CNAs. -09/17/22 had 0.0 CNAs to3 total staff on the evening shift, required 1 CNA. -09/18/22 had 1 CNA for 31 residents on the day shift, required 4 CNAs. -09/18/22 had 2 total staff for 31 residents on the evening shift, required 3 total staff. -09/19/22 had 2 CNAs for 32 residents on the day shift, required 4 CNAs. -09/19/22 had 2 total staff for 32 residents on the evening shift, required 3 total staff. -09/19/22 had 1 total staff for 32 residents on the overnight shift, required 2 total staff. -09/20/22 had 2 CNAs for 32 residents on the day shift, required 4 CNAs. -09/21/22 had 2 CNAs for 32 residents on the day shift, required 4 CNAs. -09/22/22 had 1 CNA for 32 residents on the day	F 836	strategies, which will include targeted advertising, forging partnerships with educational institutions, and offering incentives such as sign-on bonuses and referral rewards for qualified candidates. • The administrator will establish contracts with temporary staffing agencies to address staffing gaps when necessary. • Wage rates and benefit packages will be reviewed by the administrator, who will make adjustments as needed to remain competitive and attract skilled staff. • The administrative team will develop employee recognition and perks programs to acknowledge and appreciate the efforts of the staff. • The administrator will organize quarterly employee engagement meetings to foster open communication, feedback, and solutions from current employees. • The administrator, in collaboration with department heads, will conduct a thorough review of the four-week working schedules for each department before finalizing and posting them. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes: • The administrator and the Director of Nursing will review nurse staffing schedules and staffing metrics on a daily basis for a period of three months. Afterward, they will transition to weekly meetings for one month and then shift to monthly meetings thereafter. • A comprehensive report will be	

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F 836	Continued From page 145 shift, required 4 CNAs. -09/22/22 had 2 total staff for 32 residents on the evening shift, required 3 total staff. -09/23/22 had 1 CNA for 32 residents on the day shift, required 4 total staff. -09/24/22 had 2 CNAs for 32 residents on the day shift, required 4 total staff. -09/25/22 had 0.0 CNAs for 32 residents on the day shift, required 4 CNAs. -09/25/22 had 2 total staff for 32 residents on the evening shift, required 3 total staff. -09/26/22 had 1 CNA for 32 residents on the day shift, required 4 CNAs. -09/27/22 had 1 CNA for 32 residents on the day shift, required 4 CNAs. -09/28/22 had 1 CNA for 31 residents on the day shift, required 4 CNAs. -09/29/22 had 1 CNA for 31 residents on the day shift, required 4 CNAs. -09/29/22 had 2 total staff for 31 residents on the evening shift, required 3 total staff. -09/30/22 had 2 CNAs for 31 residents on the day shift, required 4 CNAs. -10/01/22 had 1 CNA for 31 residents on the day shift, required 4 CNAs. -10/01/22 had 2 total staff for 31 residents on the evening shift, required 3 total staff. -10/02/22 had 1 CNA for 31 residents on the day shift, required 4 CNAs. -10/02/22 had 2.6 total staff for 31 residents on the evening shift, required 3 total staff. -10/03/22 had 0.0 CNAs for 31 residents on the day shift, required 4 CNAs. -10/04/22 had 1.6 CNAs for 31 residents on the day shift, required 4 CNAs. -10/04/22 had 2 total staff for 31 residents on the evening shift, required 3 total staff. -10/05/22 had 2 CNAs for 33 residents on the day shift, required 4 CNAs.	F 836	created, compiling nurse staffing metrics, new hire and resignation/termination data, and information on employee retention programs and events. • The report will be presented at the Quarterly QAPI (Quality Assurance and Performance Improvement) meeting, providing a holistic overview of nurse staffing and related initiatives.	

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-10/06/22 had 2 CNAs for 32 residents on the day shift, required 4 CNAs.
-10/07/22 had 1 CNA for 31 residents on the day shift, required 4 CNAs.
-10/07/22 had 2 total staff for 31 residents on the evening shift, required 3 total staff.
-10/08/22 had 1 CNA for 31 residents on the day shift, required 4 CNAs.
-10/09/22 had 0.0 CNAs for 31 residents on the day shift, required 4 CNAs.
-10/09/22 had 1 total staff for 31 residents on the overnight shift, required 2 total staff.
-10/10/22 had 2 CNAs for 30 residents on the day shift, required 4 CNAs.
-10/11/22 had 2 CNAs for 30 residents on the day shift, required 4 CNAs.
-10/12/22 had 2.9 CNAs for 30 residents on the day shift, required 4 CNAs.
-10/13/22 had 1 CNA for 30 residents on the day shift, required 4 CNAs.
-10/13/22 had 1 total staff for 30 residents on the overnight shift, required 2 total staff.
-10/14/22 had 1.9 CNAs for 30 residents on the day shift, required 4 CNAs.
-10/15/22 had 2 CNAs for 30 residents on the day shift, required 4 CNAs.
-10/15/22 had 2 total staff for 30 residents on the evening shift, required 3 total staff.
-10/15/22 had 1 total staff for 30 residents on the overnight shift, required 2 total staff.
-10/16/22 had 1 CNA for 29 residents on the day shift, required 4 CNAs.
-10/16/22 had 2 total staff for 29 residents on the evening shift, required 3 total staff.
-10/16/22 had 1 total staff for 29 residents on the overnight shift, required 2 total staff.
-10/17/22 had 1.9 CNAs for 29 residents on the day shift, required 4 CNAs.
-10/17/22 had 2.6 total staff for 29 residents on

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the evening shift, required 3 total staff.
-10/18/22 had 1.9 CNAs for 29 residents on the day shift, required 4 CNAs.
-10/19/22 had 1.9 CNAs for 29 residents on the day shift, required 4 CNAs.
-10/20/22 had 2 CNAs for 29 residents on the day shift, required 4 CNAs.
-10/20/22 had 2.6 total staff for 29 residents on the evening shift, required 3 total staff.
-10/21/22 had 2 CNAs for 29 residents on the day shift, required 4 CNAs.
-10/22/22 had 1 CNA for 29 residents on the day shift, required 4 CNAs.
-10/22/22 had 1.3 total staff for 29 residents on the overnight shift, required 2 total staff.
-10/23/22 had 1 CNA for 28 residents on the day shift, required 3 CNAs.
-10/23/22 had 2 total staff for 28 residents on the evening shift, required 3 total staff.
-10/23/22 had 1 total staff for 28 residents on the overnight shift, required 2 total staff.
-10/24/22 had 1 CNA for 28 residents on the day shift, required 3 CNAs.
-10/25/22 had 2.9 CNAs for 28 residents on the day shift, required 3 CNAs.
-10/26/22 had 2 CNAs for 28 residents on the day shift, required 3 CNAs.
-10/27/22 had 1.9 CNAs for 28 residents on the day shift, required 3 CNAs.
-10/28/22 had 1.9 CNAs for 28 residents on the day shift, required 3 CNAs.
-10/28/22 had 2.5 total staff for 28 residents on the evening shift, required 3 total staff.
-10/29/22 had 0.9 CNAs for 28 residents on the day shift, required 3 CNAs.
-10/29/22 had 2 total staff for 28 residents on the evening shift, required 3 total staff.
-10/29/22 had 1.3 total staff for 28 residents on the overnight shift, required 2 total staff.

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-10/30/22 had 0.8 CNAs for 28 residents on the day shift, required 3 CNAs.
-1030/22 had 2.9 total staff for 28 residents on the evening shift, required 3 total staff.
-10/30/22 had 1.1 total staff for 28 residents on the overnight shift, required 2 total staff.
-10/31/22 had 0.4 CNAs for 27 residents on the day shift, required 3 CNAs.
-10/31/22 had 1.3 total staff for 27 residents on the overnight shift, required 2 total staff.
-11/01/22 had 0.9 CNAs for 27 residents on the day shift, required 3 CNAs.
-11/01/22 had 1.5 total staff for 27 residents on the overnight shift, required 2 total staff.
-11/02/22 had 1.7 CNAs for 27 residents on the day shift, required 3 CNAs.
-11/02/22 had 1.1 total staff for 27 residents on the overnight shift, required 2 total staff.
-11/03/22 had 0.8 CNAs for 27 residents on the day shift, required 3 CNAs.
-11/03/22 had 2.3 total staff for 27 residents on the evening shift, required 3 total staff.
-11/03/22 had 1.6 total staff for 27 residents on the overnight shift, required 2 total staff.
-11/04/22 had 1.7 CNAs for 27 residents on the day shift, required 3 CNAs.
-11/04/22 had 1.8 total staff for 27 residents on the overnight shift, required 2 total staff.
-11/05/22 had 0.9 CNAs for 27 residents on the day shift, required 3 CNAs.
-11/05/22 had 1.8 total staff for 27 residents on the overnight shift, required 2 total staff.

2. For the 5 weeks of staffing from 01/01/2023 to 02/04/2023, the facility was deficient in CNA staffing for residents on 34 of 35 day shifts, deficient in total staff for residents on 8 of 35 evening shifts, deficient in CNAs to total staff on 6

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F 836	Continued From page 149 of 35 evening shifts, and deficient in total staff for residents on 6 of 35 overnight shifts as follows: -01/01/23 had 1 CNA for 29 residents on the day shift, required 4 CNAs. -01/01/23 had 1.4 CNAs to 3.4 total staff on the evening shift, required 2 CNAs. -01/01/23 had 1 total staff for 29 residents on the overnight shift, required 2 total staff. -01/02/23 had 1 CNA for 28 residents on the day shift, required 3 CNAs. -01/03/23 had 2.6 CNAs for 28 residents on the day shift, required 3 CNAs. -01/04/23 had 2.7 CNAs for 28 residents on the day shift, required 3 CNAs. -01/05/23 had 1.9 CNAs for 28 residents on the day shift, required 3 CNAs. -01/05/23 had 2.9 total staff for 28 residents on the evening shift, required 3 total staff. -01/06/23 had 2.2 CNAs for 28 residents on the day shift, required 3 CNAs. -01/07/23 had 1 CNA for 28 residents on the day shift, required 3 CNAs. -01/07/23 had 1 total staff for 28 residents on the overnight shift, required 2 total staff. -01/08/23 had 1 CNA for 28 residents on the day shift, required 3 CNAs. -01/08/23 had 2.7 total staff for 28 residents on the evening shift, required 3 total staff. -01/09/23 had 2 CNAs for 28 residents on the day shift, required 3 CNAs. -01/09/23 had 2.7 total staff for 28 residents on the evening shift, required 3 total staff. -01/10/23 had 0.6 CNAs for 28 residents on the day shift, required 3 CNAs. -01/11/23 had 1 CNA for 26 residents on the day shift, required 3 CNAs. -01/12/23 had 1 CNA for 26 residents on the day shift, required 3 CNAs.	F 836		

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F 836	Continued From page 150 -01/12/23 had 1.7 CNAs to 3.5 total staff on the evening shift, required 2 CNAs. -01/13/23 had 1.6 CNAs for 26 residents on the day shift, required 3 CNAs. -01/14/23 had 1 CNA for 26 residents on the day shift, required 3 CNAs. -01/14/23 had 2.7 total staff for 26 residents on the evening shift, required 3 total staff. -01/14/23 had 1 total staff for 26 residents on the overnight shift, required 2 total staff. -01/15/23 had 1 CNA for 28 residents on the day shift, required 3 CNAs. -01/15/23 had 1.4 CNAs to 3.4 total staff on the evening shift, required 2 CNAs. -01/15/23 had 1 total staff for 28 residents on the overnight shift, required 2 total staff. -01/16/23 had 1 CNA for 28 residents on the day shift, required 3 CNAs. -01/17/23 had 1.2 CNAs for 28 residents on the day shift, required 3 CNAs. -01/18/23 had 1.9 CNAs for 28 residents on the day shift, required 3 CNAs. -01/19/23 had 1.2 CNAs for 29 residents on the day shift, required 4 CNAs. -01/19/23 had 1.9 CNAs to 3.2 total staff on the evening shift, required 2 CNAs. -01/19/23 had 1.1 total staff for 29 residents on the overnight shift, required 2 total staff. -01/20/23 had 2 CNAs for 28 residents on the day shift, required 3 CNAs. -01/20/23 had 2.6 total staff for 28 residents on the evening shift, required 3 total staff. -01/21/23 had 1 CNA for 28 residents on the day shift, required 3 CNAs. -01/21/23 had 2.4 total staff for 28 residents on the evening shift, required 3 total staff. -01/22/23 had 2.3 total staff for 28 residents on the evening shift, required 3 total staff. -01/23/23 had 2.8 CNAs for 28 residents on the	F 836		

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F 836	Continued From page 151	F 836		

day shift, required 3 CNAs.
-01/23/23 had 1 total staff for 28 residents on the overnight shift, required 2 total staff.
-01/24/23 had 2.9 CNAs for 27 residents on the day shift, required 3 CNAs.
-01/25/23 had 1.5 CNAs for 27 residents on the day shift, required 3 CNAs.
-01/26/23 had 2 CNAs for 27 residents on the day shift, required 3 CNAs.
-01/26/23 had 2.2 total staff for 27 residents on the evening shift, required 3 total staff.
-01/27/23 had 2.1 CNAs for 27 residents on the day shift, required 3 CNAs.
-01/28/23 had 1.2 CNAs for 29 residents on the day shift, required 4 CNAs.
-01/28/23 had 1.4 CNAs to 3.7 total staff on the evening shift, required 2 CNAs.
-01/29/23 had 2 CNAs for 29 residents on the day shift, required 4 CNAs.
-01/29/23 had 1.4 CNAs to 3.5 total staff on the evening shift, required 2 CNAs.
-01/30/23 had 2.2 CNAs for 29 residents on the day shift, required 4 CNAs.
-01/31/23 had 1.8 CNAs for 29 residents on the day shift, required 4 CNAs.
-02/01/23 had 0.7 CNAs for 29 residents on the day shift, required 4 CNAs.
-02/02/23 had 0.8 CNAs for 29 residents on the day shift, required 4 CNAs.
-02/03/23 had 1 CNA for 29 residents on the day shift, required 4 CNAs.
-02/04/23 had 1 CNA for 29 residents on the day shift, required 4 CNAs.

3. For the 2 weeks of staffing prior to survey from 05/07/2023 to 05/20/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 11 of 14 evening shifts, deficient in CNAs to total

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staff on 1 of 14 evening shifts, and deficient in total staff for residents on 2 of 14 overnight shifts as follows:

-05/07/23 had 1 CNA for 28 residents on the day shift, required 3 CNAs.
-05/07/23 had 2.5 total staff for 28 residents on the evening shift, required 3 total staff.
-05/08/23 had 1 CNA for 27 residents on the day shift, required 3 CNAs.
-05/09/23 had 0.7 CNAs for 27 residents on the day shift, required 3 CNAs.
-05/09/23 had 2.4 total staff for 27 residents on the evening shift, required 3 total staff.
-05/10/23 had 0.7 CNAs for 27 residents on the day shift, required 3 CNAs.
-05/10/23 had 2.1 total staff for 27 residents on the evening shift, required 3 total staff.
-05/10/23 had 0.9 CNAs to 2.1 total staff on the evening shift, required 1 CNA.
-05/11/23 had 0.5 CNAs for 27 residents on the day shift, required 3 CNAs.
-05/11/23 had 2.6 total staff for 27 residents on the evening shift, required 3 total staff.
-05/12/23 had 1.6 CNAs for 27 residents on the day shift, required 3 CNAs.
-05/12/23 had 2.2 total staff for 27 residents on the evening shift, required 3 total staff.
-05/13/23 had 1.7 CNAs for 27 residents on the day shift, required 3 CNAs.
-05/13/23 had 2 total staff for 27 residents on the evening shift, required 3 total staff.
-05/13/23 had 1 total staff for 27 residents on the overnight shift, required 2 total staff.
-05/14/23 had 0.5 CNAs for 27 residents on the day shift, required 3 CNAs.
-05/14/23 had 2.1 total staff for 27 residents on the day shift, required 3 total staff.
-05/15/23 had 0.8 CNAs for 28 residents on the

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day shift, required 3 CNAs.
-05/15/23 had 2 total staff for 28 residents on the evening shift, required 3 total staff.
-05/16/23 had 0.5 CNAs for 28 residents on the day shift, required 3 CNAs.
-05/16/23 had 2.1 total staff for 28 residents on the evening shift, required 3 total staff.
-05/17/23 had 0.8 CNAs for 28 residents on the day shift, required 3 CNAs.
-05/17/23 had 2 total staff for 28 residents on the evening shift, required 3 total staff.
-05/18/23 had 0.4 CNAs for 28 residents on the day shift, required 3 CNAs.
-05/18/23 had 2.1 total staff for 28 residents on the evening shift, required 3 total staff.
-05/18/23 had 1.2 total staff for 28 residents on the overnight shift, required 2 total staff.
-05/19/23 had 2.1 CNAs for 28 residents on the day shift, required 3 CNAs.
-05/20/23 had 2.2 CNAs for 28 residents on the day shift, required 3 CNAs.
-05/20/23 had 2.8 total staff for 28 residents on the evening shift, required 3 total staff.

On 6/01/23 at 10:30 AM the surveyor interviewed the DON and Assistant Director of Nursing (ADON). The ADON stated the LNHA did not want 2 nurses to be working together on the day shift because there is not enough work for them. They explained that LPN #1 "is an in house nurse and lives here at the facility." She was offered a room but prefers to sleep in a reclining chair in the dayroom. She showers at the facility. There are multiple times when LPN #1 will do medication pass, rest for an hour, and then go back on the floor to resume nursing duties. The DON stated LPN #1 is frequently working 7 AM- 3 PM, 3 PM - 11 PM and 11 PM - 7 AM shifts. The DON stated that LPN #1 is the on duty nurse

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 836	Continued From page 154	F 836		

almost all the time and that this was not safe for the residents because the nurse is not resting enough. She further stated "good CNAs" have left because of the number of residents each CNA is responsible for. "They cannot handle the work."

On 6/05/23 at 11:17 AM the surveyor interviewed the LNHA regarding the failure to meet the State minimum staffing requirements. The LNHA stated she has used overtime to meet staffing for CNAs and LPNs. The LNHA stated she does not use temporary staff because "that goes against you financially." She stated she has utilized on-line employment agencies. She stated she has daily contact with job applicants. The new employees will come on board and work for a while and resign. "New employees don't want to work here because we are small so there is no place to hide out in the open. [they must] work all day long so they don't want to work here. If staffing is too high, it goes against you. [I] know the requirement, [there] would have to be 2 CNAs on 11-7 but this facility doesn't need it." She further stated "perfect staffing for 29 census" would be 2 nurses and 3 CNAs on day shift, 1 nurse and 2 CNAs each on evening and night shifts.

On 6/05/23 at 2:20 PM the surveyor requested from the LNHA policies related to staffing. None was provided to the surveyor.

As evidenced by observation, interview, and review of pertinent records, it was clear that facility administration was aware of the dangerously low nursing and CNA staffing on all shifts. Facility administration was aware of the frequency of multiple consecutive shifts worked by LPN #1 with 1 CNA. Facility administration

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	315467	A. BUILDING _____ B. WING _____	C 06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

(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 836	Continued From page 155	F 836		

was aware of CNAs working on a unit without nursing supervision and without performance appraisals and competencies. Facility administration failed to complete performance appraisals and competencies on licensed nurses. These actions placed all 29 residents in the facility at risk for serious harm, impairment, or death from lack of adequate supervision. The administration was aware of this practice and did not implement procedures to correct it.
On 6/5/23 at 2:26 PM, the facility LNHA was notified of the IJ.

On 6/6/23 at 12:45 PM, the surveyors were provided the RP. After review it was rejected based on insufficient evidence which was needed to remove the immediacy. The surveyor discussed this with the LNHA.

On 6/7/23 at 10:00 AM, the surveyor requested the RP, which was not provided. The LNHA explained that she is still working on the RP.

On 6/07/23 at 12:40 PM, the surveyor requested the RP, which was not provided again. The LNHA explained that she is not sure if the RP will be ready today.

On 6/08/23 at 10:45 AM, the surveyors reviewed the RP sent by the facility and after review it was rejected based on insufficient evidence which was needed to remove the immediacy. The surveyor discussed this with the LNHA. After the facility revised the RP, it was accepted.

The RP was verified by the survey team onsite on 6/8/23, lifting the immediacy, and the survey team continued verification of the RP onsite throughout the remainder of the survey through observation,

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F 836	Continued From page 156 interview and review of records. NJAC 8:39-5.1(a) NJAC 8:39-27.1(a)	F 836		
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	F 868		7/25/23

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F 868	Continued From page 157 one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on the interview and record review, it was determined that the facility failed to ensure that the Infection Preventionist (IP), Director of Nursing (DON), Medical Director (MD), or designee attended the quarterly Quality Assurance (QA) meetings. This was identified for 2 of the 3 quarterly QA meetings reviewed. This deficient practice was evidenced by the following: The surveyor reviewed the QA meeting sign-in sheets for the last three (3) quarters dated April 26, 2023, January 25, 2023, and September 30, 2022. Reviewing the sign-in sheets for those 3 quarters revealed no DON signatures to show that the DON was in attendance for September 30, 2022 and January 25, 2023 QA meetings. There were no IP signatures to show that the IP was in attendance for January 25, 2023, and September 30, 2022, QA meetings, and there were no MD signatures to show that the MD attended the QA meeting on September 30, 2022. On 5/25/23 at 10:30 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who confirmed the abovementioned concerns. The LNHA stated that she knows the regulations require those individuals to attend. No further information was provided. At 11:00 AM, the surveyor interviewed the DON, who stated that she had not been present for the	F 868	F868 1. How the corrective action will be accomplished for those residents found to have been affected by the practice. • No residents were affected by this deficient practice • The Director of Social Services scheduled a Quarterly QAPI meeting for July 26, 2023, at 8:00 AM. Invitations were sent to the Administrator, Medical Director, Director of Nursing the Infection Preventionist, Consulting Dietitian, Pharmacy Consultant, Pharmacy Representative, Radiology Company Representative and Department Heads. The Director of Social Services has confirmed that the Administrator, Medical Director, Director of Nursing and the Infection Preventionist will be in attendance. 2. How the facility will identify other residents have the potential to be affected by the same deficient practice. • All residents have potential to be affected by the deficient practice. 3. What measures will be put into place to ensure that the deficient practice will not Recur.	

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F 868	Continued From page 158 QA meetings because she had not been able to attend the meetings during the time frame that the meetings were held. The QAPI plan provided to the survey team revealed that the MD should be an active member of the organization's quality committee, and the Department Directors (DON, Rehab, Dietary, etc.) should participate in the QAPI activities. N.J.A.C. 8:39-33.1 (b)	F 868	• The Quarterly QAPI Meeting Policy will be revised to state that the Quarterly QAPI meeting will be scheduled when the Medical Director, Administrator, Director of Nursing and Infection Preventionist (I.e., Leadership) confirm availability. If any of the QAPI leadership members are unable to attend the QAPI meeting the meeting will be rescheduled. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. • Attendance sheets will be kept for QAPI meeting and will be reviewed by the administrator for compliance. • The Administrator will compile and submit a quarterly report on all QAPI activities including attendance of all QAPI leadership team members to the owner for review and to provide further recommendations.	

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S 000	Initial Comments STANDARD SURVEY: 6/15/23 CENSUS: 29 SAMPLE SIZE: 17 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		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees.	S1405		7/21/23

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

Electronically Signed | 07/06/23

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S1405	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on a review of employee files and an interview with the Licensed Nursing Home Administrator (LNHA), it was determined that the facility failed to provide evidence of timely physical examinations for 5 of 5 employees who had not had physical exams before their hire dates. None of these employees had a nursing assessment performed at the time of hire, and none had physical exams performed within two (2) weeks of hire, as evidenced by the following: 1. Dietary Aide (DA) #1 (DA#1) was hired on 6/20/22 and had a physical exam on 8/22/22. 2. DA #2 was hired on 5/12/22 and did not have a physical exam to date. 3. Certified Nursing Assistant #1 was hired on 3/13/23 and had a physical exam on 5/23/23. 4. Registered Nurse #1 was hired on 3/10/23 and did not have a physical exam to date. 5. Licensed Practical Nurse #1 was hired on 4/24/23 and did not have a physical exam to date. On 6/5/23 at 9:20 AM, the surveyor interviewed the LNHA regarding pre-employment physicals. She stated that it is the policy to perform exams prior to the date of hire. She did not explain why the five (5) employees did not have them completed. The LNHA provided the facility policy for Physicals for New Hires, reviewed in 2023. The first line of the policy indicated it was the policy of the facility "that each employee has a physical completed within 30 days of their hire date."	S1405	S1405 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. • No residents have been affected by this deficient practice. • DA #2 -Physical Exam. DA#2 resigned on 6/2023. • RN #1 Physical Exam completed on 6/2/23 by the Medical Director • LPN #1 Physical Exam. LPN #1 resigned 5/7/23. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. • All residents have the potential to be affected by this deficient practice. • An audit of all active employee records was completed on 7/13/23 for compliance with employee physicals. All active employees will have completed physicals by 7/21/23 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur. • The Office Manager was educated on	

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S1405	Continued From page 2 On 6/8/23, the Director of Nursing (DON) provided the surveyor with a revised, undated policy for Physicals for New Hires. Steps 1 and 2 indicated, "All new employees will receive a nursing assessment by a registered nurse within 2 weeks prior to the first day of hire. From the date of hire the employee has 30 days to provide their physician exam to the facility."	S1405	6/8/23 by the administrator that all new hires will receive a health physical performed by a physician or advanced practice nurse within two weeks prior to the first day of employment or upon employment an RN will conduct a nurse assessment followed by a physical exam by a physician or advance practice nurse within 30 days of their hire date. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. • Business office manager will review compliance of physicals of all employees hired within the quarter and report rate of compliance findings at the quarterly QAPI meeting.	
S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows:	S1410		8/1/23

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S1410	Continued From page 3 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This REQUIREMENT is not met as evidenced by: Based on the review of employee files and interview with the Licensed Nursing Home Administrator (LNHA), it was determined that the facility failed to provide evidence of timely tuberculosis (TB) screening for 4 of 5 employees who had not had screenings before their hire dates. The deficient practice is evidenced by the following: 1. Dietary Aide #1 (DA#1) was hired on 6/20/22 and did not have a TB screening. 2. DA #2 was hired on 5/12/22 and did not have a TB screening. 3. Certified Nursing Assistant #1 was hired on 3/13/23 and had TB screening on 6/2/23. 4. Registered Nurse #1 was hired on 3/10/23 and did not have TB screening. On 6/5/23 at 9:20 AM, the surveyor interviewed the LNHA regarding pre-employment TB screening. She stated the facility policy is to perform a 2-step Mantoux TB skin test before employment. She did not explain why the four (4) employees did not have TB screenings. The LNHA provided the undated facility policy for Mantoux Tuberculin Skin Test. The policy indicated that all new employees would be	S1410	S1410 How the corrective action will be accomplished for residents found to have been affected by this deficient practice. No residents were affected by this deficient practice. DA#1 provided chest x-ray 7/21/23 DA#2 resigned on 5/23/22 RN#1 received 2 step TB testing as of 6/14/23 All residents have the potential to be affected by this deficient practice. All residents have the potential to be affected by this deficient practice, An audit of all active employee records will be in compliance with a 2 step Mantoux TB skin test or chest x-ray by 8/1/23. What measures will be put into place to ensure that the deficient practice will not recur. The administrator will review and revise the policy for TB testing. The Business Office Manager was in-serviced by the administrator on 6/8/23	

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S1410	Continued From page 4 screened for TB prior to employment.	S1410	on the policy for 2 step Mantoux TB skin test. How the facility will monitor its corrective action to ensure that the deficient practice will not recur. Business Office Manager will monitor compliance with 2 step Mantoux TB skin test of new employees and report findings at the quarterly QAPI meeting. DON or designee will audit tubing on weekly basis to ensure tubing was changed and labeled. Audit findings are to be submitted to QAPI meeting. QAPI meeting will determine need for further audits and action plans for compliance.	

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{E 000}	Initial Comments An onsite revisit was conducted on 8/7/2023 to verify the POC for the 6/15/2023 recertification survey. The facility was found to be in compliance.	{E 000}		
{F 000}	INITIAL COMMENTS An onsite revisit was conducted on 8/7/2023 to verify the POC for the 6/15/2023 recertification survey. The facility was found to be in compliance.	{F 000}		

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

Electronically Signed | 08/16/2023

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.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061003		8/7/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

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 S1405 Reg. # 8:39-19.5(a) LSC	Correction Completed 07/21/2023	ID Prefix S1410 Reg. # 8:39-19.5(b)(1) LSC	Correction Completed 08/01/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON
6/15/2023

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

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{S 000}	Initial Comments An onsite revisit was conducted on 8/7/2023 to verify the POC regarding the 6/15/2023 re-licensed survey. The facility was not in compliance.	{S 000}		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff	S 560	S560- minimum staffing CNA to resident ratios. 1. No residents were affected by this deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. The director of nursing was educated on CNA staffing minimum ratios as required by New Jersey Department of Health. In addition, she has been educated to notify the Administrator if CNA staffing ratios have not been met. The facility administrator will review staffing daily for each day, evening, and night shift to ensure the minimum CNA staffing ratios are met. The facility administrator will continue to focus on recruitment and retention including but not limited to, use of web-based recruitment advertising, contract utilization, sign on bonuses and referral bonuses, shift differentials and	8/16/23

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

Electronically Signed | 08/16/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061003	A. BUILDING: _____ B. WING _____	R-C 08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOM	78 SLIKER ROAD CALIFON, NJ 07830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties, and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift	S 560	employee moral incentives. The facility will continue to assess and evaluate the staffing outcomes based on offered rates, job fairs, recruitment packages and staff retention weekly, making necessary adjustments based on analysis and findings. 4. The Administrator and/or designee will create an audit tool to utilize for Recruitment to track and trend recruitment efforts weekly x4, then monthly for 3 months or until compliance is met. All audit results will be reviewed monthly by the quality assurance and performance improvement committee. Audits will be reviewed for 3 months or until compliance is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061003	A. BUILDING: _____ B. WING _____	R-C 08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOM	78 SLIKER ROAD CALIFON, NJ 07830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 7/4/23 and 8/6/23 for the 8/7/23 revisit survey which revealed the following: For the 34 days of alleged compliance, the facility was deficient in CNA staffing for residents on 14 of 34 day shifts as follows: -07/04/23 had 2.7 CNAs for 27 residents on the day shift, required at least 3 CNAs. -07/09/23 had 2 CNAs for 27 residents on the day shift, required at least 3 CNAs. -07/11/23 had 2.4 CNAs for 27 residents on the day shift, required at least 3 CNAs. -07/15/23 had 2.9 CNAs for 27 residents on the day shift, required at least 3 CNAs. -07/17/23 had 1.8 CNAs for 27 residents on the day shift, required at least 3 CNAs. -07/18/23 had 2.8 CNAs for 27 residents on the day shift, required at least 3 CNAs. -07/19/23 had 2.9 CNAs for 26 residents on the day shift, required at least 3 CNAs. -07/20/23 had 2 CNAs for 26 residents on the day shift, required at least 3 CNAs. -07/21/23 had 2.1 CNAs for 26 residents on the day shift, required at least 3 CNAs. -07/22/23 had 2.1 CNAs for 26 residents on	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061003	A. BUILDING: _____ B. WING _____	R-C 08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOM	78 SLIKER ROAD CALIFON, NJ 07830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 the day shift, required at least 3 CNAs. -07/25/23 had 2.8 CNAs for 25 residents on the day shift, required at least 3 CNAs. -07/26/23 had 2.1 CNAs for 25 residents on the day shift, required at least 3 CNAs. -08/01/23 had 2.8 CNAs for 25 residents on the day shift, required at least 3 CNAs. -08/06/23 had 2.1 CNAs for 26 residents on the day shift, required at least 3 CNAs. On 8/7/23 at 2:00 p.m. the surveyor informed the Director of Nursing and the Licensed Nursing Home Administrator of the shifts that the minimum direct care staff to resident ratio was not met.	S 560		

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
315467 Y1	A. Building B. Wing Y2	8/7/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

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 F0550	Correction	ID Prefix F0607	Correction	ID Prefix F0622	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.12(b)(1)-(5)(ii)(iii)	Completed	Reg. # 483.15(c)(1)(i)(ii)(2)(i)-(iii)	Completed
LSC	07/25/2023	LSC	07/25/2023	LSC	07/25/2023
ID Prefix F0658	Correction	ID Prefix F0689	Correction	ID Prefix F0695	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(i)	Completed
LSC	07/25/2023	LSC	07/25/2023	LSC	07/25/2023
ID Prefix F0726	Correction	ID Prefix F0730	Correction	ID Prefix F0755	Correction
Reg. # 483.35(a)(3)(4)(c)	Completed	Reg. # 483.35(d)(7)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	07/25/2023	LSC	07/25/2023	LSC	07/25/2023
ID Prefix F0756	Correction	ID Prefix F0759	Correction	ID Prefix F0760	Correction
Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.45(f)(1)	Completed	Reg. # 483.45(f)(2)	Completed
LSC	07/25/2023	LSC	07/25/2023	LSC	07/25/2023
ID Prefix F0835	Correction	ID Prefix F0836	Correction	ID Prefix F0868	Correction
Reg. # 483.70	Completed	Reg. # 483.70(a)-(c)	Completed	Reg. # 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	Completed
LSC	07/25/2023	LSC	07/03/2023	LSC	07/25/2023

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
6/15/2023	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315467		8/7/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 07/25/2023	ID Prefix F0835 Reg. # 483.70 LSC	Correction Completed 07/25/2023	ID Prefix F0836 Reg. # 483.70(a)-(c) LSC	Correction Completed 07/03/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
6/15/2023	☐ 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
315467 Y1	A. Building B. Wing Y2	8/7/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix E0004	Correction	ID Prefix E0009	Correction	ID Prefix E0025	Correction
Reg. # 483.73(a)	Completed	Reg. # 483.73(a)(4)	Completed	Reg. # 483.73(b)(7)	Completed
LSC	07/26/2023	LSC	07/26/2023	LSC	07/26/2023
ID Prefix E0031	Correction	ID Prefix E0039	Correction	ID Prefix	Correction
Reg. # 483.73(c)(2)	Completed	Reg. # 483.73(d)(2)	Completed	Reg. #	Completed
LSC	07/26/2023	LSC	07/26/2023	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	
6/15/2023	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061003 (Y1)	A. Building B. Wing (Y2)	8/17/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 08/16/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
6/15/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING **01** B. WING _____	C **06/15/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	**78 SLIKER ROAD** **CALIFON, NJ 07830**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Complaint # NJ00159306 The nursing home building construction was stated to be in the 50s with no current major renovations or noted additions. It is a one-story, Type V (000) construction with a partial basement with one exit/egress only, has a staff-operated laundry room, and is fully sprinkled. The exterior LP generator does 100% of the building. The building utilizes an electric fire pump that draws water from a black plastic-lined pond. The facility has 6-smoke zones. The resident rooms have 10-year battery-operated smoke detectors that were installed in 1/2023. Supervised smoke detection is located in the corridors, spaces open to the corridors, and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, fire pump, cross corridor door hold open devices, exterior door releases, emergency facility lighting, and life safety components utilized to preserve life. The facility has 36 certified beds. At the time of the survey, the census was 29. Complaint investigations were also completed during this survey. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 252 SS=F	Number of Exits - Corridors CFR(s): NFPA 101 Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with	K 252		8/3/23

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

Electronically Signed | 07/06/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING **01** B. WING _____	C **06/15/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	**78 SLIKER ROAD** **CALIFON, NJ 07830**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 252	Continued From page 1 Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 05/24/23, it was determined that the facility failed to provide two (2) acceptable exits, remote from each other, for each floor or fire section of the building, as evidenced by the following: At 12:30 PM, in the presence of the new Maintenance Director (MD), it was determined that the facility's basement was provided with only one (1) exit. This exit was a stairway leading to the 1st floor. This condition was confirmed by the MD in an interview during the observation, who stated that the basement exit has always existed. The MD noted that the basement was used for laundry (2 staff members), storage, and mechanical equipment; residents were restricted from accessing this area. The facility's Administrator was informed of this finding during the Life Safety Code survey exit conference on 5/24/23. * It was noted that a time-limited waiver request for K252 has expired. The facility must apply for an extension to the original waiver. NFPA 101:2012 - 19.2.5.4 NJAC 8:39-31.1(b)	K 252	K252 Basement 2nd Egress Construction 1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice: No residents were affected. 2. The facility identified other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. 3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: The facility applied for a second time-limited waiver on 08/03/2023. The facility will have a second egress installed from the laundry basement. The Basement would require structural modification including excavation, structural reinforcement and moving plumbing, for example. Estimation completion date POC will be 08/03/2023. Please see attached time-limited waiver form for details. The facility removed all non-essential supplies from the basement. Only	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING **01** B. WING _____	C **06/15/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	**78 SLIKER ROAD** **CALIFON, NJ 07830**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 252	Continued From page 2	K 252	maintenance equipment for HVAC and boiler/furnace, hot water tanks, well water systems, electrical/generator, sump pump/waste and other equipment and maintenance systems will remain in the basement. The facility Administrator/Maintenance Manager and essential staff only will have access to the basement. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Maintenance Manager will conduct monthly scheduled inspections of all fire prevention and notification systems which will be reported at the Quarterly QAPI Committee Meeting.	
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 5/24/2023, in the presence of the Maintenance Director (MD), it was determined that the facility failed to provide a battery backup emergency light above the two (2) transfer switches (generator and fire pump) independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 19.2.9.1.- 7.9.1 (general) This deficient practice was identified for 2 of 2 transfer switches and was evidenced by	K 291	K291 1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice: • No residents were affected. • Emergency backup lighting with 90-minute battery power will be installed on or before 7/25/23 above both transfer switches (1) Inside the main electrical	7/25/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING **01** B. WING _____	C **06/15/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	**78 SLIKER ROAD** **CALIFON, NJ 07830**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 291	Continued From page 3 the following: 1.) At 11:05 AM, the surveyor, in the presence of the MD, observed one (1) generator transfer switch, ATS-1, inside the main electrical room in the basement. The room was not provided with any emergency lighting. 2.) At 12:14 PM, the surveyor, in the presence of the MD, observed one (1) fire pump transfer switch in the exterior fire pump shed. The area inside the external shed was not provided with any emergency lighting. The MD confirmed the findings at the time of the observations. The Administrator was informed of the findings at the Life Safety Code exit on 5/24/23. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	room and (2) Inside the fire pump shed. 2. The facility identified other residents having the potential to be affected by the same deficient practice: • All residents have the potential to be affected. • Administrator and Maintenance Director will review with the local fire marshal any other areas that require emergency battery backup lighting. 3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: • The Administrator will educate the Maintenance Director on or before 7/25/23 to check all emergency backup lighting monthly and certify they are operational. Any inoperable emergency lighting will be replaced and reported to the administrator. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: • A monthly Emergency lighting audit will be conducted by the Maintenance Director and submitted to the administrator monthly. • The monthly Emergency lighting audits will be compiled into a comprehensive quarterly preventive maintenance report and presented at the quarterly QAPI committee Meeting.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101	K 321		7/25/23

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	315467	A. BUILDING **01** B. WING _____	C **06/15/2023**

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K 321	Continued From page 4 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 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, interview, and document review on 5/24/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to provide a fire barrier with a one-hour fire resistance rating in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1 and 8.7.1. The deficient practice was evidenced for 1 of 5 hazardous areas observed.	K 321	K321 1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice: • No residents were affected. • Wallboard was replaced 5/27/23.	

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K 321	Continued From page 5 At 11:55 AM, the surveyor observed in the laundry room that an approximately 8' section of the wallboard was not correctly attached to the ceiling (falling down), exposing combustible unprotected wooden beams and flooring. The area was not fully protected in fire-rated material. The MD verified the findings at the time of the observations. The Administrator was informed of the findings at the Life Safety Code exit conference on 5/24/23. NJAC 8:39-31.2(e)	K 321	2. The facility identified other residents having the potential to be affected by the same deficient practice: • All residents have the potential to be affected. • The Maintenance Director and/or designee will inspect all hazardous area enclosures in the facility to ensure that all areas are protected by a fire barrier. 3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: • The Maintenance Director and/or designee will identify and inspect and document all hazardous area enclosures monthly to ensure that all areas are protected by a fire barrier. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: • Results of the Hazardous Area inspection will be included in the quarterly maintenance report to be submitted by the maintenance director at the quarterly QAPI committee Meeting.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily	K 345		7/25/23

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K 345	Continued From page 6 available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review on 5/24/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to a.) Ensure a smoke detection sensitivity testing was completed of the facility's smoke detectors in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2., and b.) Provide an updated fire alarm system & testing inspection report as per NFPA 70 & 72. The deficient practice was identified for 2 of 2 inspection reports and was evidenced by the following: a.) At 11:10 AM, the surveyor reviewed all related fire alarm documentation provided by the MD from the fire alarm vendor to determine if the sensitivity test was performed. During the document review, an interview was conducted with the MD, who indicated he was unsure if the required sensitivity test for the facility smoke detectors was performed. The MD noted he would contact the facility fire alarm vendor to see if sensitivity testing was performed, and no further documentation was provided. b.) At 11:40 AM, the surveyor reviewed all fire alarm documentation from the vendor document review. The last inspection report almost eight months ago was dated 9/26/22. The fire alarm system utilizes sealed lead acid batteries as a backup and requires a semi-annual inspection per NFPA 70 & 72.	K 345	K345 1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice: • No residents were affected. • The fire alarm service provider will conduct an inspection of the fire alarm system including a smoke sensitivity test of all smoke detectors and batteries backing up the fire alarm system on or before 7/25/23 2. The facility identified other residents having the potential to be affected by the same deficient practice: • All residents have the potential to be affected. • The fire alarm service provider will conduct an inspection of the fire alarm system including a smoke sensitivity test of all smoke detectors and batteries backing up the fire alarm system 7/25/23. 3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: • A fire alarm inspection audit tool will be created to ensure all necessary fire alarm inspections are scheduled and completed by a qualified fire alarm service provider within the appropriate regulatory time frames. 4. How the facility will monitor its	

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K 345	Continued From page 7 During an interview with the MD during document review, he stated that he was unsure why the facility fire alarm vendor did not perform the required semi-annual fire alarm inspection. He indicated he would call the fire alarm vendor to see why the inspection was not fulfilled. The MD provided no further information. The Administrator was informed of the findings at the Life Safety Code Exit conference on 5/24/23. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 70, 72	K 345	corrective actions to ensure that the deficient practice is being corrected and will not recur: • The administrator and/or designee will review the maintenance binder with the maintenance director on a monthly basis to ensure all required fire alarm inspections are completed and/or scheduled in the appropriate time frames. • The maintenance director will compile a comprehensive maintenance report to include all completed fire alarm inspections as well as upcoming scheduled inspections. This report will be presented during the quarterly QAPI Committee Meeting.	
K 347 SS=F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review on 5/24/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to a.) Ensure a testing, maintenance, and battery replacement program was conducted to operate the battery-operated smoke detectors properly, and b.) Ensure all facility areas are provided with smoke detectors as per NFPA 72. This deficient practice was evidenced for 15 of 15 observed battery-operated smoke detectors in	K 347	K347 Smoke Detectors 1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice: No residents were affected. 2. The facility identified other residents having the potential to be affected by the same deficient practices: All residents have the potential to be affected.	8/2/23

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K 347	Continued From page 8 resident rooms and evidenced by the following: a.) A facility tour from 11:30 AM to approximately 2:30 PM revealed that the resident rooms had battery-operated smoke detectors. A review of the facility's preventative maintenance logs did not indicate that there was preventative maintenance and testing documentation for testing the detectors for battery replacement (including the make, model, installation date, and type of battery). The MD provided a "smoke detector monthly checklist" for resident rooms, but the provided log was not filled out. The MD stated that new battery-operated smoke detectors were installed on 1/2023 in resident rooms but indicated no information above was provided on the form. b.) At 11:35 AM, the surveyor and MD toured the facility's exterior. It was observed that the attached open storage shed was filled with combustible cardboard boxes to the ceiling and stored gas-operated equipment next to the wooden structure. The area was provided with one (1) fire sprinkler head, but no smoke detector was tied into the fire alarm system to indicate a smoke condition to warn interior staff. The attached structure was unattended at all times. The MD confirmed the findings during the observations. The Administrator was informed of the findings at the Life Safety Code exit conference on 5/24/23. NJAC 8:39-31.2(e)	K 347	3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: All resident rooms are furnished with hardwired smoke detectors. The entire building is sprinkler and hard-wired smoke detector equipped. A sensitivity inspection was completed on 7/20/2023. The maintenance personnel conducted an inspection on all battery-operated carbon monoxide detectors on 7/27/2023 to ensure they are within the expiration dates and functioning properly. Maintenance personnel were in-serviced on the use of the Carbon Monoxide audit tool on 7/27/2023. A hardwired smoke detector was installed in the lean-to open storage shed on 08/02/23. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Administrator/designee will monitor a monthly review of the battery-operated carbon monoxide detector audit sheet to ensure its completeness. The Maintenance Manager will compile a comprehensive maintenance report to include monthly carbon monoxide inspections and all storage areas are clean and organized maintaining proper segregation of combustible materials from sources of ignition. Findings from the audit sheet will be presented during the quarterly QAPI Committee Meeting. Storage of combustibles have been moved and relocated over 10 feet from	

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K 347	Continued From page 9 NFPA 101 Life Safety Code 2012 edition 19.3.6.1, 19.3.4.5.2	K 347	the building.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on the interview and record review on 5/24/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to a.) Ensure that their automatic sprinkler system fire pump pond was clean and free of debris from the pond water and maintained in optimal condition in accordance with the National Fire Protection Association (NFPA) 20 & 25, b.) Ensure the electric fire pump was tested monthly and documented as per NFPA 25, and c.) Ensure fire sprinkler heads are maintained in optimal condition as per NFPA 13.	K 353	K353 1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice: • No residents were affected. • The pond supplying water to the emergency sprinkler system is scheduled to be cleaned on or before 7/25/23. • It was confirmed that a filter screen is in place on the intake pipe to prevent debris from affecting the operation of the	7/25/23

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K 353	Continued From page 10 This deficient practice was evidenced by the following: a.) At 11:30 AM, the surveyor and MD observed the exterior pond that provided water to the fire pump. The pond was dirty and contained debris from the surrounding trees. The pipe feeding the fire pump could not be located to determine if there was a screen to protect the pumping system due to the water being so dirty. The MD provided the most recent quarterly inspection document dated: 2/20/23, which indicated the black plastic-lined pond is "Maintained by Staff." b.) At 11:55 AM, the surveyor and the MD observed the weekly task-maintenance document provided by the Administrator. The record indicated under Fire Pump "test pump that it's working" only and initialed by the MD. The NFPA 25 requires that any electric motor-driven fire pump be operated every month. The test should be executed as follows: Run the fire pump for at least 10 minutes Note the system's suction pressure and discharge pressure Note any strange noises or vibrations Check pump casing or bearings for signs of overheating Check the pump for any possible discharge Check volt and amp readings record all results The MD confirmed the finding's during the observations and document review and indicated he did not know the procedure for testing and documenting the fire pump information properly.	K 353	pump 7/25/23. • Electric pump will be tested by 7/20/23. • The kitchen sprinkler head assemblies will be inspected and cleaned or replaced as necessary on or before 7/25/23. 2. The facility identified other residents having the potential to be affected by the same deficient practice: • All Residents have the potential to be affected. • The pond supplying water to the emergency sprinkler system is scheduled to be cleaned on or before 7/25/23. • The electric pump will be inspected and tested and found to be operational. • It was confirmed that a filter screen is in place on the intake pipe to prevent debris from affecting the operation of the pump. • All sprinkler head assemblies will be inspected and cleaned or replaced as necessary. 3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: • The monthly operation of the Electric Motor-Driven Fire Pump and Pond maintenance policies will be reviewed and revised as appropriate. • A qualified service provider will train the maintenance director and/or designee on maintaining the pond, and sprinkler heads and to conduct a monthly inspection and operational test of the electric motor-driven fire pump on or	

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K 353	Continued From page 11 c.) At 12:20 PM, the surveyor observed that two (2) of five (5) fire sprinkler heads in the kitchen were dirty with a coating of grease surrounding the activation and spray deflector of the head assembly. The MD confirmed the finding during the observations. The Administrator was notified of the findings at the Life Safety Code exit conference on 5/24/23. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 20: Standard for the Installation of Stationary Pumps for Fire Proctetion NFPA 13 Standard for the installation of Sprinkler systems NFPA 25: Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems	K 353	before 7/25/23. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: • On a monthly basis, the administrator will conduct a comprehensive review with the maintenance director to ensure the completeness of the Electric Motor-Driven Fire Pump inspection forms. • The maintenance director will compile a comprehensive maintenance report to include all completed inspections operations and maintenance of the pond, sprinkler heads and the electric motor-driven fire pump . This report will be presented during the quarterly QAPI Committee Meeting.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and an interview on 5/24/23, in the presence of the Maintenance Director (MD), it was determined that the facility	K 355	K355 1. The corrective action(s) accomplished	7/25/23

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K 355	Continued From page 12 failed to perform and document on the tag attached to the fire extinguisher a monthly visual examination for 10 of 10 fire extinguishers, including one (1) K-extinguisher located in the facility kitchen observed by the following: While touring the facility with the MD from 11:05 AM to 2:30 PM, the surveyor observed that the fire extinguisher vendor inspected the extinguishers in July 2022 and replaced the inspection tags. The monthly inspection tags were not filled out and are current. The MD stated that he was unaware of this procedure and confirmed he did not inspect and document any fire extinguishers in the facility. The Administrator was informed of the findings at the Life Safety Code exit conference on 5/24/2023. NJAC 8:39-31.2(e) NFPA 10, Standard for Portable Fire Extinguishers.19.3.5.12, NFPA 10	K 355	for the resident found to be affected by the deficient practice: • No residents were affected. • All fire extinguishers were inspected by the fire extinguisher vendor and found to be in good condition and charged. The vendor tagged the fire extinguishers dated 6/2023. 2. The facility identified other residents having the potential to be affected by the same deficient practice: • All residents have the potential to be affected. • All fire extinguishers were inspected by the fire extinguisher vendor and found to be in good condition and charged. The vendor tagged the fire extinguishers dated 6/2023. 3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: • The Maintenance Director and/or designee was in-serviced on 7/17/23 on inspecting and dating and initialing all fire extinguisher tags monthly. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: • On a monthly basis the Maintenance Director and/or designee will Audit and document on a fire extinguisher checklist that all fire extinguishers are being inspected, dated, and signed monthly. • The Monthly fire extinguisher checklist will be submitted and reviewed by the	

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K 355	Continued From page 13	K 355	administrator monthly. • The maintenance director will compile a comprehensive maintenance report to include all completed inspections of the fire extinguishers. This report will be presented during the quarterly QAPI Committee Meeting.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Complaint # NJ00159306 Based on document review and interview on 5/24/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure fire drills were held at expected and unexpected times under varying conditions, at least quarterly on each shift in accordance with NFPA 101, 2012 Edition, Section 19.7.1.4 through 19.7.1.7. This deficient practice was evidenced for 3 of 12 drills by the following: At 09:00 AM, the surveyor reviewed all fire drill documentation provided by the MD. The fire drills	K 712	K712 1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice: • No residents were affected. • On June 17, 2023, the facility encountered a fire alarm activation caused by a faulty smoke detector, resulting in the activation of the emergency response plan and the involvement of fire and police departments. The incident was reported to the New Jersey State Department of	7/27/23

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K 712	Continued From page 14 were conducted in-house and dated: 2/12/23 9:10 AM 1st shift 3/03/23 5:15? not marked AM or PM 4/03/23 6:40 AM 3rd shift In an interview, the MD stated only three (3) of the required twelve (12) drills were conducted in the last twelve (12) months. The MD said he was unsure of the frequency of the drills and indicated he did not know the routines would be conducted on each shift. The Administrator was informed of the finding at the Life Safety Code exit conference on 5/24/23. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.7.1.4 through 19.7.1.7	K 712	Health and has been documented in an after-action report to assess the response and identify areas for improvement. 2. The facility identified other residents having the potential to be affected by the same deficient practice: • All residents have the potential to be affected. • A fire drill and in-service training will be conducted on or before 7/25/23. 3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: • The administration will engage a fire and disaster drill company on or before 7/25/23 to conduct monthly drills and provide in-service training to staff, ensuring coverage for all shifts every quarter. The company will also be responsible for providing comprehensive documentation of these drills and training sessions. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: • On a monthly basis the maintenance director and/or designee, in collaboration with the administrator, will review all drill documentation to verify that drills have been executed on each shift every quarter. Furthermore, they will ensure that the drills encompass the simulation of realistic scenarios. • The maintenance director will compile a comprehensive maintenance report of	

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	315467	A. BUILDING **01** B. WING _____	C **06/15/2023**

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K 712	Continued From page 15	K 712	all drills conducted during the quarter. The report will include pertinent information about Fire/Disaster drills, such as the date, time, shift, type of drill, location, scenario, and the total number of employees in attendance. This report will be presented during the quarterly QAPI Committee Meeting to provide an overview of the drill activities.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and	K 918		7/27/23

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K 918	Continued From page 16 readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review of facility documents on 5/24/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to: a.) Certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, b.) Perform a weekly non-load test, and c.) Ensure the testing log of the generator indicates proper testing information in accordance with NFPA 99 for emergency electrical generator systems. This deficient practice was identified for 1 of 1 generator logs provided by the MD, and the evidence was as follows: a.) At 10:25 AM, a review of the generator records for the previous twelve (12) months did not reveal documented certification that the generator would start and transfer power to the building within ten seconds. Currently, the MD was performing monthly generator load testing but did not indicate the required transfer times on the provided log for the following dates: 5/13/22, 6/17/22, 7/19/22, 8/30/22, 9/24/22, 10/24/22, 11/23/22, 12/16/22, 1/29/23, 2/13/23, 3/15/23, and 4/10/23. b.) The provided inspection document from the MD did not indicate any weekly generator testing.	K 918	K918 1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice: • No residents were affected. • Generator was tested under load and power transfer time was within 10 seconds. • All Information was documented on a revised Monthly Generator Inspection and Test form. 2. The facility identified other residents having the potential to be affected by the same deficient practice: • All residents have the potential to be affected. • Generator was tested under load and the power transfer time was within 10 seconds on 7/18/23. • Esposito Electric came to the facility and in serviced all staff that are responsible for the operations of the generator. He reviewed load times and documentation required. 3. The measures/systemic changes the facility will put into place to ensure that the	

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K 918	Continued From page 17 c.) The inspection log provided by the MD indicated only time-on and time-off and did not provide any information from the generator annunciator panel. During the document review, an interview was conducted with the MD, and he stated that the transfer time was not provided on the current document. MD noted that the recent record needed to be updated and required a separate column for identifying monthly transfer times. MD indicated he was unaware of any weekly non-load inspections and stated he was not providing any information from the generator annunciator panel on his documentation form. The Administrator was informed of the findings at the Life Safety Code exit conference on 5/24/23. NJAC 8:39-31.2(e), 31.2(g) NFPA 99 NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. NFPA 101 Life Safety Code 2012 edition 9.1.3.1 Standard for Emergency and Standby Power Systems	K 918	deficient practice does not recur: • The generator policy was reviewed and revised as appropriate. • Monthly Generator Inspection and Test form was revised. To include time to transfer power, document weekly inspection and non-load testing of the generator, start time and end time of exercise, total min of exercise and run-time information from controller or annunciator panel • The generator was tested under load on 7/18/23. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: • The maintenance director and/or designee will submit the Monthly Generator Inspection and Test form and/or annual generator inspections to the administrator for review and completeness. • The maintenance director will compile a quarterly comprehensive maintenance report to include all completed weekly, monthly, and annual inspections and testing of the emergency generator. This report will be presented during the quarterly QAPI Committee Meeting.	

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{K 000}	INITIAL COMMENTS An onsite revisit was conducted on 8/7/2023 to verify the facility's POC for the Recertification survey on 6/15/2023. The facility was not in compliance with the POC for K252, K347, K353 and K712.	{K 000}		
{K 252} SS=F	Number of Exits - Corridors CFR(s): NFPA 101 Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4 This REQUIREMENT is not met as evidenced by: The facility did not submit an acceptable POC or an acceptable time-limited waiver by the onsite revisit. A new POC will be required for the deficiency cited below. At 12:30 PM, in the presence of the new Maintenance Director (MD), it was determined that the facility's basement was provided with only one (1) exit. This exit was a stairway leading to the 1st floor. This condition was confirmed by the MD in an interview during the observation, who stated that the basement exit has always existed. The MD noted that the basement was used for laundry (2 staff members), storage, and	{K 252}	K252 Basement 2nd Egress Construction 1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice: No residents were affected. 2. The facility identified other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. 3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur:	8/11/23

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

Electronically Signed | 08/16/2023

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

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{K 252}	Continued From page 1 mechanical equipment; residents were restricted from accessing this area. NFPA 101:2012 - 19.2.5.4 NJAC 8:39-31.1(b)	{K 252}	The facility applied for a second time-limited waiver on 08/03/2023. The facility will have a second egress installed from the laundry basement. The Basement would require structural modification including excavation, structural reinforcement and moving plumbing, for example. Please see attached time-limited waiver form for details. The facility removed all non-essential supplies from the basement. Only maintenance equipment for HVAC and boiler/furnace, hot water tanks, well water systems, electrical/generator, sump pump/waste and other equipment and maintenance systems will remain in the basement. The facility Administrator/Maintenance Manager and essential staff only will have access to the basement. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Maintenance Manager will conduct monthly scheduled inspections of all fire prevention and notification systems which will be reported at the Quarterly QAPI Committee Meeting.	
{K 347} SS=F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1.	{K 347}		8/21/23

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{K 347}	Continued From page 2 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review on 8/7/23, in the presence of the Administrator, it was determined that the facility failed to ensure a testing, maintenance, and battery replacement program was conducted to operate the battery-operated smoke detectors in an existing structure. This deficient practice was evidenced for 15 of 15 observed battery-operated smoke detectors observed in resident rooms and evidenced by the following: The Administrator stated that new battery-operated smoke detectors were installed on 1/2023 in resident rooms but indicated no information above was documented or logged on any form. The Administrator provided a preventative maintenance inspection report dated 7/27/23 but the form indicated Carbon Monoxide (CO) detectors only. The Plan of correction (POC) indicated carbon monoxide inspections, but did not address battery operated smoke detectors in resident rooms, that require a monthly test, date of installation and battery type. The above requirements must be provided on a testing log for each room a battery operated smoke detector is being used in the facility. The Administrator was informed of the findings at the Life Safety Code exit conference on 8/7/23. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.3.6.1,	{K 347}	K347 Smoke Detectors Completed 8/21/2023 1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice: No residents were affected. 2. The facility identified other residents having the potential to be affected by the same deficient practices: All residents have the potential to be affected. 3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: The entire building is equipped with smoke and/or CO detectors, sprinklered and hard-wired heat detectors. A system inspection was completed on 8/21/2023. The maintenance personnel conducted an inspection on all battery-operated carbon monoxide detectors on 8/21/2023 to ensure they are within the expiration dates and functioning properly. Maintenance personnel were in-serviced on the use of the Carbon Monoxide audit tool on 8/21/2023. A hardwired smoke detector was installed in the lean-to open storage shed on 08/02/23. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:	

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{K 347}	Continued From page 3 19.3.4.5.2	{K 347}	The Administrator/designee will monitor a monthly review of the battery-operated smoke and/or carbon monoxide detector audit sheet to ensure its completeness. The Maintenance Manager will compile a comprehensive maintenance report to include monthly smoke and/or carbon monoxide inspections and all storage areas are clean and organized maintaining proper segregation of combustible materials from sources of ignition. Findings from the audit sheet will be presented during the quarterly QAPI Committee Meeting. Storage of combustibles have been moved and relocated over 10 feet from the building.	
{K 353} SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.	{K 353}		8/17/23

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{K 353}	Continued From page 4 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on the interview and record review on 8/7/23, in the presence of the Administrator, it was determined that the facility failed to ensure that their automatic sprinkler system fire pump pond was clean and free of debris from the pond water and maintained in optimal condition in accordance with the National Fire Protection Association (NFPA) 20 & 25. At 09:30 AM, the surveyor observed the outside black lined man made pond, that provided water to the fire sprinkler electric pump system was still dirty and cloudy with debris from the surrounding trees and brush. The surrounding area of trees and brush were cut back around the pond perimeter at the time of the observation on 8/7/23, but the pond was still not cleaned. The facility provided a Plan of Correction from the recertification survey on 6/15/23 indicating "the pond supplying water to the emergency fire sprinkler system is scheduled to be cleaned on or before 7/25/23, but as of the current date of 8/7/23 the pond is still dirty. The plan of correction also indicated the intake pipe filter screen was in place on the pipe to prevent debris from affecting the operation of the pump 7/25/23. The documentation provided by the Administrator did not indicate that the pond intake pipe filter was checked. The pipe could not be located on 8/7/23 as the pond was cloudy and dirty. The new fire sprinkler vendor was on-site and indicated the pipe and screen were not visible due to the pond being so dirty.	{K 353}	K353 1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice: • No residents were affected. • The pond supplying water to the emergency sprinkler system is scheduled to be drained, cleaned, and refilled (08/14/23) • It was confirmed that a filter screen is in place on the intake pipe to prevent debris from affecting the operation of the pump. (08/14/23) • Electric pump will be tested. (08/14/23) • The kitchen sprinkler head assemblies will be inspected and cleaned or replaced as necessary. (08/14/23) 2. The facility identified other residents having the potential to be affected by the same deficient practice: • All Residents have the potential to be affected. • The pond supplying water to the emergency sprinkler system is scheduled to be drained, cleaned, and refilled. (08/14/23) • The electric pump was inspected and tested and found to be operational. (08/14/23) • It was confirmed that a filter screen is in place on the intake pipe to prevent debris from affecting the operation of the pump. (08/14/23)	

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{K 353}	Continued From page 5 The Administrator provided a document (Quote) dated 7/19/23 from the township volunteer fire department to drain the retention pond and provide fire protection services in place of the sprinkler system for Little Brook Nursing Home. This was a quote and no further information was provided. The current electric fire pump is in operation. The Administrator was notified of the findings at the Life Safety Code exit conference on 8/7/23. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 20: Standard for the Installation of Stationary Pumps for Fire Proctetion NFPA 13 Standard for the installation of Sprinkler systems NFPA 25: Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems	{K 353}	• All sprinkler head assemblies will be inspected and cleaned or replaced as necessary. (08/14/23) 3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: • The monthly operation of the Electric Motor-Driven Fire Pump policy was reviewed and revised as appropriate. • A qualified service provider trained the maintenance director and/or designee to conduct a monthly inspection and operational test of the electric motor-driven fire pump. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: • On a monthly basis, the administrator will conduct a comprehensive review with the maintenance director to ensure the completeness of the Electric Motor-Driven Fire Pump inspection forms. • The maintenance director will compile a comprehensive maintenance report to in cludeall completed inspections operations and maintenance of the pond, sprinkler heads and the electric motor-driven fire pump . This report will be presented during the quarterly QAPI Committee Meeting.	
{K 712} SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm	{K 712}		8/15/23

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{K 712}	Continued From page 6 signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on interview and document review on 8/7/23, in the presence of the Administrator, it was determined that the facility failed to conduct fire drills with varying activation types and simulation of specific emergency fire conditions in accordance with NFPA 101, 2012 Edition, Section 19.7.1.4 through 19.7.1.7. This deficient practice was identified for 1 of 1 fire drills and was evidenced by the following: A review of the facility fire drill reports revealed method for the simulation of emergency fire conditions for the 7/17/no year identified (Monday) in house drill performed for the 1st shift at 10:45AM, indicated the location of alarm pulled was in the Boiler room. The form provided indicated was "Central Monitoring Notified" yes/no this was left blank on the document. The fire drill should include the simulation of emergency fire condition: What in the boiler room caused the alarm activation? Who from Central Monitoring was notified? ID# An interview was conducted with the Administrator after documentation review, where	{K 712}	K347 Smoke Detectors 1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice: No residents were affected. 2. The facility identified other residents having the potential to be affected by the same deficient practices: All residents have the potential to be affected. 3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: All resident rooms are furnished with hardwired smoke detectors. The entire building is sprinkler and hard-wired smoke detector equipped. A sensitivity inspection was completed on 8/15/2023. The maintenance personnel conducted an inspection on all battery-operated carbon monoxide detectors on 8/15/2023 to ensure they are within the expiration dates and functioning properly. Maintenance personnel were in-serviced on the use of the Carbon	

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{K 712}	Continued From page 7 she stated and confirmed the findings that current fire drill included the simulation of emergency fire conditions were not identified and a specific area in the Boiler room and the fire drill document was not completely filled out as to was Central Monitoring notified and who was notified. The Administrator was informed of the finding's at the Life Safety Code exit conference on 8/7/23. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.7.1.4 *This was cited at the recertification survey on 6/15/23. The POC indicated the drills encompass the simulation of realistic scenarios and will be responsible for providing comprehensive documentation of these drills and training sessions.	{K 712}	Monoxide audit tool on 8/15/2023. A hardwired smoke detector was installed in the lean-to open storage shed on 08/15/23. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Administrator/designee will monitor a monthly review of the battery-operated carbon monoxide detector audit sheet to ensure its completeness. The Maintenance Manager will compile a comprehensive maintenance report to include monthly carbon monoxide inspections and all storage areas are clean and organized maintaining proper segregation of combustible materials from sources of ignition. Findings from the audit sheet will be presented during the quarterly QAPI Committee Meeting. Storage of combustibles have been moved and relocated over 10 feet from the building.	

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
315467 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/7/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

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 K0291	07/25/2023	LSC K0321	07/25/2023	LSC K0345	07/25/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0355	07/25/2023	LSC K0918	07/27/2023	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	
6/15/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING **01** B. WING _____	R-C **08/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	**78 SLIKER ROAD** **CALIFON, NJ 07830**

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{K 000}	INITIAL COMMENTS A desk review was conducted and K347, 353 and 712 were noted to be in compliance. K252 is not in compliance. The facility is requesting a time-limited waiver. SA recommends approval. CMS approved the time-limited waiver for K252 that will expire on 1/31/2025.	{K 000}		

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

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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POST-CERTIFICATION REVISIT REPORT

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Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0252	08/21/2023	LSC K0347	08/21/2023	LSC K0353	08/17/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0712	08/16/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

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