STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Survey Date: 7/01/22 Census: 99 Sample: 22 + 2 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to accurately code a resident's Minimum Data Set (MDS), an assessment tool used to facilitate the management of care. This deficient practice was identified for 1 of 22 residents (Resident #67) reviewed and was evidenced by the following: On 6/21/22 at 11:00 AM, the surveyor observed Resident #67 walking in hallway NJ Ex Order 26.4(b)(1), with NJ Ex Order 26.4(b)(1). Resident #67 called the surveyor [redacted] while passing by. The resident was wearing a EX Order 26.4B1 on the EX Order 26.4B1. The surveyor observed that the resident wore this alarm device on all survey days. Resident #67 then sat in a chair in the dayroom near the surveyor and began talking to the surveyor NJ Ex Order 26.4(b)(1).	F 641	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; -On 06/29/22, the U.S. FOIA (b)(6) completed a modification to resident #67's MDS Section E dated NJ Ex Order 26.4(b) to include NJ Ex Order 26.4(b)(1) exhibited during the 7-day lookback period. 2. How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken; -All residents have the potential to be affected by this deficient practice.	7/27/22

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

Electronically Signed | 07/28/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 641	Continued From page 1 On 6/23/22 at 11:26 AM, the surveyor observed Resident # 67 EX Order 26.4B1 around the dayroom. The resident spoke to the surveyor in EX Order 26.4B1. When the surveyor stated that she only NJ Ex Order 26.4(b)(1), the resident stated, 'EX Order 26.4B1. Then Resident #67 continued EX Order 26.4B1 to EX Order 26.4B1 in the room and saying something in [redacted]. He/she also NJ Ex Order 26.4(b)(1) to another resident in the room, who NJ Ex Order 26.4 [redacted]. On 6/23/22 at 11:35 AM, the surveyor observed Resident #67 return to the dayroom and continued EX Order 26.4B1, EX Order 26.4B1 EX Order 26.4B1. On 6/23/22 at 11:45 AM, the surveyor interviewed the Licensed Practical Nurse #1 (LPN#1), who stated that the staff try to observe Resident #67 "from a distance." LPN #1 continued, indicating that Resident #67 would get EX Order 26.4B1 if the staff NJ Ex Order 26.4(b) the resident. LPN #1 stated that they had to NJ Ex Order 26.4(b)(1) a few times. He explained that they try to let Resident #67 just NJ Ex Order 26.4(b)(1) and observe to make sure he/she NJ Ex Order 26.4(b)(1) any other residents. LPN #1 also stated that the resident's significant other visits frequently and then Resident #67 [redacted]. The resident's significant other had told the staff that Resident #67 Ex Order 26.4B1 and sometimes just EX Order 26.4 Ex Order 26.4B1." LPN #1 stated that staff don't always understand his/her EX Order 26.4B1. On 6/23/22 at 12:17 PM, the surveyor observed the resident EX Order 26.4B1, despite encouragement from two staff members.	F 641	-By 07/27/2022, the Director of Nursing conducted an audit of active residents' most recent MDS assessment with emphasis on behavioral coding in section E of the MDS assessment during the look back period to identify other residents that may have been affected. - All concerns identified were immediately addressed. 3. What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur. -On 6/30/2022, the facility U.S. FOIA (b)(6) [redacted] was reeducated by the Regional Case Manager on the components of this regulation with an emphasis on section (E) of the MDS. -By 07/26/22, the Regional Case Manager/designee re-educated the facility MDS Coordinators on the components of this regulation with emphasis on accuracy of assessments and coding of behaviors in section (E) of the MDS assessment during the look back period. Newly hired MDS staff will be educated on these components during orientation. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place; -The Director of Nursing/designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 641	Continued From page 2 Resident #67 continued EX Order 26.4B1 in the dayroom and attempted Ex Order 26.4B1. Staff members offered the resident a chair, but he/she refused. Eventually, a Certified Nursing Assistant (CNA) was able to assist Resident #67 to a table. On 6/24/22 at 12:11 PM, the surveyor observed a CNA feeding Resident #67 while she stood next to him/her. The CNA explained that she had to stand... that if she sat, Resident #67 would become EX Order 26.4B1 at her. The resident sat EX Order 26.4B and ate well. The CNA did sit toward the end of the meal. Resident # 67 was not EX Order 26.4B1 at that time. On 6/27/22 at 11:49 AM, the surveyor observed Resident #67 seated at a table in the dayroom, EX Order 26.4B1 and EX Order 26.4B1 with EX Order 26.4B1. A staff member set up the lunch tray for Resident #67 and the resident began eating a sandwich and remained NJ Ex Order. The resident's roommate was seated at the same table and both residents NJ Ex Order 26.4(b)(1) throughout the meal. On 6/27/22 at 12:58 PM, the surveyor observed Resident #67 make Ex Order 26.4B1. One staff member stated that the NJ Ex Order 26.4(b)(1) would make the resident stop trying to NJ Ex Order 26.4(b)(1). After the second try, Resident #67 Ex Order 26.4B1 On 6/28/22 at 10:45 AM, the surveyor observed Resident #67 EX Order 26.4B1 through the hallway. The resident occasionally stepped into another resident's room, then came right out. LPN #1 stated that the resident was more	F 641	conduct a weekly audit x4 weeks and then every 2 week x2 months of at least 10 residents' most recent MDS assessments for accuracy of coding with emphasis on section (E) as it pertains to behaviors in the look back period. -The findings of these audits will be reported to the Quality Assurance/ monthly until committee determines substantial compliance has been met and recommends moving to quarterly monitoring by the Regional Case Manager.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 641	Continued From page 3	F 641		

when sitting. Resident #67 stated to the surveyor, Ex Order 26.4B1" The surveyor reported this to LPN #1 and the U.S. FOIA (b)(6)), who arranged to have a sandwich brought to Resident #67.

On 6/29/22 at 10:47 AM, two surveyors interviewed LPN #2 regarding behaviors displayed by Resident #67. The LPN stated that she was an agency nurse and had worked at the facility for NJ Ex Order 26.4(b)(1) . She stated that she knew Resident #67 well and that the resident EX Order 26.4B1 . EX Order 26.4B1 EX Order 26.4B1 . EX Order 26.4B1 . There have been so many incidents. [He/she] has Ex Order 26.4B1 in the dayroom...so much going on." The LPN concluded that she "sometimes asks people from the kitchen who EX Order 26.4B1 to Ex Order 26.4B1 Ex Order 26.4B1

On 6/29/22 at 10:50 AM, two surveyors observed Resident #67 approach the nurse's station EX Order 26.4B1 and EX Order 26.4B1 LPN #3 redirected the resident. LPN #2 spoke softly to Resident #67, who then Ex Order 26.4B1 . LPN #2 redirected the resident to the dayroom, where he/she EX Order 26.4B1 ate lunch.

On 6/29/22 at 10:55 AM, two surveyors interviewed LPN #3 who stated that she had worked at the facility for almost NJ Ex Order 26.4(b)(1) and knew the resident well. LPN #3 stated that the resident "can get EX Order 26.4B1 . They changed [him/her] from EX Order 26.4B1 , so we can give... the EX Order 26.4B1 ...We needed a way to EX Order 26 [him/her]. If [he/she] was not willing to take the medication Ex Order 26.4B1 . [His/her] meds were Ex Order 26.4B1 and [he/she] shows some

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 641	Continued From page 4 improvement." The surveyor reviewed the hybrid medical record of Resident #67. According to the Admission Record, Resident #67 was admitted a EX Order 26.4B1 prior to the survey with diagnoses that included, but was not limited to EX Order 26.4B1 [redacted] Review of the Significant Change Minimum Data Set (MDS), an assessment tool dated EX Order 26.4B1 indicated that Resident #67 had a Brief Interview for Mental Status score of [redacted] out of 15, which indicated that the resident's EX Order 26.4B1 was EX Order 26.4B1. The MDS further indicated that Resident #67 displayed EX Order 26.4B1 including EX Order 26.4B1 [redacted] Section E of the MDS also reflected that Resident #67 displayed no EX Order 26.4B1 directed toward self or others. Progress notes from nursing, physician, psychiatrist and the social worker (SW) revealed the following information regarding the resident's EX Order 26.4B1 A review of the Behavior Note dated EX Order 26.4B1 revealed the "Resident was observed by the unit secretary in the day room waving over [his/her] EX Order 26.4B1 Nursing staff attempted to intervene, [he/she] EX Order 26.4B1 EX Order 26.4B1 while acting as if [he/she] was	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 641		F 641		

Continued From page 5

Ex Order 26.4B1. When the nurse attempted to retrieve the object [he/she] EX Order 26.4B1 against her. [He/she] EX Order 26.4B1 and then EX Order 26.4B1 [his/her] hand. She was able to retrieve the EX Order 26.4B1 without further incident but...continues to act EX Order 26.4B1 while in the day room, staff attempts to NJ Ex Order 26.4(b) failed. PRN [as needed] EX Order 26.4B1 given by medication nurse. Will monitor for effectiveness."

A review of the EX Order 26.4B1 note dated EX Order 26.4B1 revealed "At times patient get very EX Order 26.4B1. EX Order 26.4B1 EX Order 26.4B1

A review of the EX Order 26.4B1 Note dated EX Order 26.4B1, revealed that Resident #67 got very EX Order 26.4B1 and EX Order 26.4B1 when he/she tried to get out of the exit door and would not listen to the staff who tried to hold him/her away from the door. Then the resident started EX Order 26.4B1 at the staff. Resident #67 started to EX Order 26.4B1 EX Order 26.4B1 at the staff. Resident #67 was EX Order 26.4B1 and EX Order2. The staff was unable EX Order 26.4B1 the resident. Nurse was able to give EX Order 26.4B1 po [by mouth] and then the resident made EX Order 26 EX Order 26.4B1. The MD [doctor] was made aware and ordered to send the resident to the hospital. NJ Ex Order 26.4(b)(1). While Resident #67 was on the EX Order 26.4B1 the resident was attempting to EX Order 26.4B1. "POA...was made aware of the transfer and also the ." The hospital was called for report. The resident was transferred to the EX Order 26.4B1 emergency room. Resident was sent out for a EX Order 26.4B1 Ex Order 26.4B1

A review of the Health Status Note dated NJ Ex Order 26.4(b)(1), revealed "at 7:00 PM. Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 641	Continued From page 6	F 641		

started EX Order 26.4B1. [He/she] stood up from [his/her] Ex Order 26.4B1 ...CNA called and with RN tried to Ex Order 26 resident. Redirected back to bed, but [he/she] Ex Order 26.4B1. [He/she] walk out to hallway, appear Ex Order 26.4B1. EX Order 26.4B1 [He/she] became EX Order 26.4B1 and EX Order 26.4B1 and would not listen to the staff who are trying to hold [him/her] EX Order 26.4B1 EX Order 26.4B1. [He/she] was EX Order 26.4B1 [his/her] EX Order 26.4 EX Order 26.4B1 EX Order 26.4B1. Attempt made to give [him/her] EX Order 26.4B1, but [he/she] EX Order 26.4B1 significant other was called and returned to building. [He/she] calmed down and they were able to administer EX Order 26.4B1, which was effective."

A review of the EX Order 26.4B1 Note dated EX Order 26.4B1, revealed "Resident noted with EX Order 26.4B1 and EX Order 26.4B1 while speaking EX Order 26.4B1. [He/she] had episodes of EX Order 26.4B1. EX Order 26.4B1 administered. continued EX Order 26.4B1 but stopped EX Order 26.4B1. Resident was NJ Ex Order 26.4(b)(1) several times as [he/she] kept NJ Ex Order 26.4(b)(1) other than [his/hers]. [Spouse] visited at 4 pm. No EX Order 26.4B1 noted with [spouse] present."

A review of the EX Order 26.4B1 Progress Note dated EX Order 26.4B1, revealed "Pt. [patient] was sent out due to EX Order 26.4B1..."

A review of the Physicians note Late Entry dated EX Order 26.4B1, revealed "follow up acute visit...Resident was very EX Order 26.4B1, attempting to EX Order 26.4B1 staff, not EX Order 26.4B1 NJ Ex Order and NJ Ex Order 26.4(b)(1) now. tolerating increased EX Order 26.4B1, awaiting EX Order 26.4B1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 641	Continued From page 7 A review of the Health status note dated EX Order 26.4B1, revealed "C/O [complaining of] EX Order 26.4B1 towards staff, seen EX Order 26.4B1 down halls." A review of the Social Services Note dated EX Order 26.4B1, revealed "Reached out to pt's [patient's] Guardian to explore the possibility of alternative, appropriate LTC]long term care] placement. Pt. is primary EX Order 26.4B1, communication board in place and staff/ NJ Ex Order 26.4(b)(1) available; however pt may benefit from more EX Order 26.4B1 community. Pt. also followed by EX Order 26.4B1, recent medication adjustments r/t behaviors in place. Team will continue to NJ Ex Order 26.4(b)(1) as needed and continue to invite to NJ Ex Order 26.4(b)(1) and offer NJ Ex Order 26.4(b)(1), tasks that pt appears to enjoy. Awaiting f/u from Guardian." A review of the resident's Care Plan initiated on NJ Exec Order 26.4 and revised on EX Order 26.4B1 reflected a focus area for EX Order 26.4B1 problems including EX Order 26.4B1, EX Order 26.4B1 EX Order 26.4B1 related to EX Order 26.4B1 with EX Order 26.4B1 disturbances and EX Order 26.4B1 Interventions included: 1. Administer medications as ordered. Monitor for side effects and effectiveness. 2. Assist resident with coping mechanisms, Encourage resident to express feelings appropriately. Provide non-verbal language barrier cue cards for self-expression. 3. Educate resident's family and caregivers regarding coping and interactive strategies. 4. Intervene to protect rights and safety of others. Approach in a calm manner. Remove from situation and take to alternate location, 5. Monitor behavior episodes and determine underlying cause. Consider location, day, time, persons	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 641	Continued From page 8	F 641		

involved and situations. Document behavior and underlying causes. 6. Provide a program of activities that is of interest and accommodates residents status. 7. Reach out to resident's friend to alleviate agitation.

On 6/29/22 at 12:31 PM, the surveyor interviewed the U.S. FOIA (b)(6) regarding the resident's Significant Change MDS, dated NJ Ex Order 26.4(b). She stated that the significant change was due to improvements in all activities of daily living. Therefore, the resident experienced a significant improvement. She stated that the social worker was new and completed sections C (NJ Ex Order 26.4(b)(1) D (NJ Ex Order 26.4 E (NJ Ex Order 26.4(b)(1) and Q (Participation in Assessment and Goal Setting) of the MDS. The U.S. FOIA (b)(6) stated that she "closes the MDS and each person completing their section signs off themselves. I was the one closing it."

On 6/29/22 at 12:45 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated she began working at the facility on EX Order 26.4B1. The U.S. FOIA (b)(6) stated that she was familiar with Resident # 67 and that the resident "EX Order 26.4B1 EX Order 26.4B1." She further stated they have been looking for a EX Order 26.4B1 unit to place Resident #67, where the resident "would be EX Order 26.4B1. She had made referrals to other facilities. The U.S. FOIA (b)(6) stated that she was familiar with the MDS and that she had been working the field of Long Term Care for about [redacted] and had worked with children before working with the elderly. The U.S. FOIA (b)(6) confirmed that she completed sections C, D, E and Q in the MDS. She stated that she uses interaction from residents, feedback from nurses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 641	Continued From page 9 and sees EX Order 26.4B1 notes. She also refers to Progress notes and looks at nurse's notes. She told the surveyor that she was not aware of [redacted] of the resident. She stated, "I know [he/she] EX Order 26.4B1. EX Order 26.4B1 put in notes about EX Order 26.4B1 She claimed she was not aware of the resident NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) [redacted] to staff. The social worker stated that the "[spouse] thinks the behaviors are because the staff doesn't [redacted] the resident." On 6/29/22 at 12:54 PM, the U.S. FOIA (b)(6) [redacted] entered the room while the surveyor was interviewing the US FOIA (b)(6). In the presence of the US FOIA (b)(6), the surveyor mentioned the discrepancies between the coding of behaviors in the MDS, dated Ex Order 26.4B1, and the behaviors described by the staff members. The U.S. FOIA (b)(6) acknowledged that there were errors in the MDS for Resident # 67. She then stated, "We can reevaluate and amend whatever we need to." On 6/30/33 at 9:17 AM, the U.S. FOIA (b)(6) provided a copy of the revision made to the resident's Significant Change MDS of Ex Order 26.4B1. The assessment was revised on Ex Order 26.4B1 at 5:44 PM by the U.S. FOIA (b)(6) and included the following changes in Section E: 1. NJ Ex Order 26.4(b)(1) symptoms directed towards NJ Ex Order 26 (e.g., NJ Ex Order 26.4(b)(1) [redacted]). Response: Behavior of this type occurred 1 to 3 days. 2. NJ Ex Order 26.4(b)(1) symptoms directed towards NJ Ex Order 26 (e.g., NJ Ex Order 26.4(b)(1)	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 641		F 641		

Continued From page 10

NJ Ex Order 26.4(b)(1)). Response: Behavior of this type occurred 1 to 3 days.

3. NJ Ex Order 26.4(b)(1) not directed towards others (e.g., NJ Ex Order 26.4(b)(1) symptoms such as NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), or NJ Ex Order 26.4(b)(1) symptoms like NJ Ex Order 26.4(b)(1)). Response: Behavior of this type occurred 4-6 days.

4. How does the resident's current NJ Ex Order 26.4(b)(1) status, NJ Ex Order 26.4(b)(1), or NJ Ex Order 26.4(b)(1) compare to prior assessment? Response:

According to a review of the Resident Assessment Instrument (RAI) Manual for proper coding of the MDS - Section E - Behaviors the intent of the MDS assessment is to, "identify behavioral symptoms in the last seven days that may cause distress to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment. These behaviors may place the resident at risk for injury, isolation, and inactivity and may also indicate unrecognized needs, preferences or illness. Behaviors include those that are potentially harmful to the resident himself or herself. The emphasis is identifying behaviors, which does not necessarily imply a medical diagnosis. Identification of the frequency and the impact of behavioral symptoms on the resident and on others is critical to distinguish behaviors that constitute problems from those that are not problematic. Once the frequency and impact of behavioral symptoms are accurately determined, follow-up evaluation and care plan interventions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 641	Continued From page 11 can be developed to improve the symptoms or reduce their impact." The RAI Manual further indicated steps for coding - E0200 - Behavioral Symptom- "Presence & Frequency (cont.) Steps for Assessment 1. Review the medical record for the 7-day look-back period. 2. Interview staff, across all shifts and disciplines, as well as others who had close interactions with the resident during the 7-day look-back period, including family or friends who visit frequently or have frequent contact with the resident. 3. Observe the resident in a variety of situations during the 7-day look-back period. Coding Instructions - Code 0, behavior not exhibited: if the behavioral symptoms were not present in the last 7 days. Use this code if the symptom has never been exhibited or if it previously has been exhibited but has been absent in the last 7 days. Code 1, behavior of this type occurred 1-3 days: if the behavior was exhibited 1-3 days of the last 7 days, regardless of the number or severity of episodes that occur on any one of those days. Code 2, behavior of this type occurred 4-6 days, but less than daily: if the behavior was exhibited 4-6 of the last 7 days, regardless of the number or severity of episodes that occur on any of those days. Code 3, behavior of this type occurred daily: if the behavior was exhibited daily, regardless of the number or severity of episodes that occur on any of those days." NJAC 8:39-11.1	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		7/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 658	Continued From page 12 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, and record review, it was determined that the facility failed to ensure that a.) medications were administered according to physician orders for 1 of 4 residents (Resident#16) observed during medication administration pass and b.) staff label the EX Order 26.4B1) medication that was administered to 1 of 1 resident (Resident#57) according to the standard of clinical practice. 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 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	F 658	F658 - Services Provided Meet Professional Standards 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. -On 6/27/22, LPN (#1) received education by the DON on the six (6) rights of medication administration. -Resident #16 received EX Order 26.4B1 on EX Order 26.4B1 with no ill effect. -On 6/27/22, LPN (#2) received education by the DON on the six (6) rights of medication administration with an emphasis on EX Order 26.4B1) bag labeling according to the standard of clinical practice to include the residents name, type of medication, rate, date, time, and initials of the licensed nurse. -Resident #57 was monitored. No ill effect noted. Doctor was notified seen by the attending physician on 6/24/2022, 6/27/2022, and 6/29/2022 with no new orders relating to EX Order 26.4B1. 2. How you will identify other residents having potential to be affected by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 658	Continued From page 13 responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 06/23/22 at 9:05 AM, the surveyor observed a Licensed Practical Nurse (LPN#1) preparing to administer medications for Resident #16. The surveyor observed LPN #1 placed all medications that were plotted for 9 AM in a medication administration cup except for an EX Order 26.4B1 capsule (a EX Order 26.4B1 [redacted] On that same date and time, the surveyor observed LPN #1 double-checked each medication that she placed in the medication cup, but LPN #1 failed to recognize that the EX Order 26.4B1 capsule was omitted. The surveyor then observed LPN #1 administering all the medications inside the medication cup to Resident #16. The surveyor stopped LPN#1 prior to signing off the electronic Medication Administration Record (eMAR) and asked LPN #1 if she could open the bottle of EX Order 26.4B1 capsules. At that time, the surveyor interviewed LPN #1 who stated after identifying the contents of the EX Order 26.4B1 bottle that she failed to administer the medication to Resident #16. The surveyor reviewed the medical records of Resident#16.	F 658	same practice and what corrective actions will be taken; -All residents have the potential to be affected by this deficient practice. -By 7/29/2022, the facility DON/designee will conduct an observational audit for licensed nursing staff on the six (6) rights of medication administration to ensure medications were administered according to physician orders. - By 7/29/2022 the facility DON/designee will conduct an audit of active residents with Intravenous Fluid (IVF) orders to ensure the labeling is in place in accordance with the standard of clinical practice. - Any concerns identified will be immediately addressed. /3. What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur. By 7/29/2022, the ADON/designee re-educated the licensed nursing staff on the components of F658 Services Provided to Meet Professional Standards with an emphasis on: " Six (6) rights of medication administration o Right patient o Right medication o Right dose	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 658	Continued From page 14 The Admission Record for Resident #16 indicated that the resident was admitted to the facility with diagnoses that included, but were not limited to: NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)( ), NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) . The NJ Ex Order 26.4(b)(1) eMAR revealed an order for an NJ Ex Order 26.4(b)(1) dated NJ Ex Order 26 with a direction of 1 capsule by mouth two times daily for a supplement with a slotted time of 10:00 AM and 5:00 PM (10:00, 17:00). On 6/27/22 at 1:00 PM, the surveyor met with the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) , and there was no additional information provided by the facility. A review of the facility's policy for Medication Administration that was dated 5/18/22 provided by the U.S. FOIA (b)(6) indicated the following: "A. Licensed nursing professionals will administer medications according to times of administration determined by the facility's Pharmacy Committee." 2. On 6/20/22 at 10:15 AM, the surveyor observed Resident #57 lying with the head of the bed elevated. The resident was NJ Ex Orde and responded to the surveyor NJ Ex Order 26.4(b)(1) On 6/23/22 at 8:34 AM, the surveyor observed the resident seated in their bed with NJ Ex Order 26.4(b)(	F 658	o Right route o Right time o Documentation in the Medication and Treatment record " Intravenous Fluid (IVF) bag labeling according to the standard of clinical practice to include the resident□s name, type of medication, rate, date, time, and initials of the licensed nurse. Newly hired licensed nurses will receive education during orientation. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place; Each Unit Manager/ designee will audit 1 resident medication pass each week x 3 months this includes focus on oral medications as well as IV medications to ensure proper labeling. The results of these audits will be submitted monthly to the DON for review at the monthly QA meeting and quarterly to the QAPI Committee for review and action, as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 658		F 658		

Continued From page 15

NJ Ex Order 26.4(b)(1) via a EX Order 26.4B1 (where it showed the NJ Ex Order 26.4(b)(1) to be NJ Ex Order 26.4(b) that was between and . The manual dial tube had an increment of . The was NJ Ex Order 26.4(b)(1). There was approximately less than EX Order 26.4B1 left in the EX Order 26.4B1. There was no label attached to the to identify the resident's name and the information about the

At that same time, the resident informed the surveyor that the was by a nurse "yesterday" (and was unable to remember the exact time when the was The resident was not sure how many bags will be The resident further stated that the was ordered by a physician because the resident's laboratory results were

On 6/23/22 at 8:38 AM, two surveyors and LPN#2 entered the resident's room. LPN#2 checked the of the resident. Both the surveyors and the LPN#2 did not see a label on the . No label can be found in the surrounding of the resident's room.

Afterward, both surveyors and LPN#2 left the resident's room. During an interview with the surveyor, LPN#2 informed the surveyors that the physician ordered an because of elevated EX Order 26.4B1 level and for EX Order 26.4B1. LPN#2 stated that there should have been an label attached to the that included the resident's name, medication name, NJ Ex Order 26.4(b)(1), the date the was and the signature of the nurse who the to notify another nurse of the when being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 658	Continued From page 16 checked during nursing rounds to make sure it was the right medication according to the physician's order. LPN#2 confirmed to both surveyors that there was no [EX Order 3] label at that time. On that same date and time, the surveyor asked LPN#2 what the ordered [NJ Ex Order 26] for the resident's [EX Order] was. LPN#2 stated, "I have to check the order first." Then, LPN#2 checked the eMAR and stated that the order was [EX Order 26.4B1]. LPN#2 further stated that the 3-11 nurse on [redacted] who started the [EX Order] should have put the [redacted] label. He indicated that the facility had one kind of [EX Order] [EX Order 26.4B] [NJ Ex Order 26] that had NJ Ex Order 26.4(b)(1) for and at the time both the surveyors and LPN#2 observed the [EX Order 26.4B1] it was on a higher level between [EX Order] and [EX Order] which reflected [NJ Ex Order 26.4(b)(1)]. The surveyor reviewed the resident's medical records: The admission summary reflected that the resident was admitted to the facility with diagnoses that included NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1)) of NJ Ex Order 26.4(b)(1) . According to the [EX Order 26.4B1] Admission Minimum Data Set (AMDS), an assessment tool used to facilitate the management of care indicated that the resident's Brief Interview for Mental Status score of [NJ Ex] out of 15 which indicated that the resident's EX Order 26.4B1.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 658	Continued From page 17 There was a physician order dated EX Order 26.4B1 to start NJ Ex Order 26.4(b)(1) at NJ Ex Order 26.4(b)(1) for c NJ Ex Order 26.4(b)(1) every shift for NJ Ex Order 26.4(b)(1) d/c (discontinue) when completed. The above corresponding physician order was transcribed onto the EX Order 26.4B1 eMAR. On 6/28/22 at 11:37 AM, the surveyor interviewed via phone conference the U.S. FOIA (b) (6)) in the presence of the survey team. The U.S. FO informed the surveyor that she was an agency nurse assigned to Resident #57 on NJ Ex Order 26.4(b) of the 3-11 shift. The U.S. FO stated that she was the one who administered and initiated the EX Order to the resident that was taken from the EX Ord medication backup supplies. She further stated that as per facility practice, when administering an EX Order, there should be a label attached to the NJ Ex Order 26.4 to identify the medication, NJ Ex Order 26, when it was NJ Ex Order 2 and the resident's name. She stated that it is important to have a label in the NJ Ex Order 26.4 because it "helps to double-check the order of the resident." At the same time, the surveyor asked the U.S. FO why there was no label on the resident's EX Order bag on EX Order 26.4B1. The U.S. FO stated, "I don't know what actually happened." The U.S. FO acknowledged that there should have a label. On 6/28/22 at 11:48 AM, the surveyor followed up with the U.S. FOIA (b)(6) on the facility policy concerning EX O medication and accountability for EX O backup meds. The U.S. FOIA (b)(6) informed the surveyor that there was no facility policy and accountability for EX Ord backup meds. On 6/28/22 at 2:03 PM, the survey team met with	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 658	Continued From page 18 the U.S. FOIA (b)(6) and were made aware of the above concerns. On 7/1/22 at 10:43 AM, the survey team met with the U.S. FOIA (b)(6). The U.S. FOIA (b)(6) informed the surveyors that there will be no additional information.	F 658		
F 688 SS=D	NJ 8:39-11.2 (b) Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow physician orders for an NJ Ex Order 26.4(b)(1) for 2 of 3 residents (Resident #2 and R #87)	F 688	F688 - Increase/Prevent Decrease in ROM/Mobility 1. What corrective action(s) will be	7/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 688	Continued From page 19 reviewed. This deficient practice was evidenced by the following: 1. On 6/21/22 at 11:16 AM, the surveyor observed Resident # 2 in bed sleeping. The head of the bed was NJ Ex Order 26.4(b)(1). The television was in use. A [redacted] recreation aide entered the room to play music for the resident. There was no Ex Order 26.4B1 in use. On 6/23/22 at 11:01 AM, the surveyor observed Resident # 2 in bed awake and fully dressed. The resident's bedside table was observed with a half pint (240 ml's) of regular milk, 4 ounces (oz) of orange juice, and 12 oz (ounces) of water in a white Styrofoam cup with a lid and a straw. There was no Ex Order 26.4B1 in use. On 6/23/22 at 11:45 AM, the surveyor interviewed the resident's assigned U.S. FOIA (b)(6) [redacted] who stated that the [redacted] aide takes care of the resident usually every morning but if the [redacted] aide wasn't there then she would care for the resident. The [redacted] stated "in the beginning [redacted] had [redacted], but I don't know what happened to it. I don't know if it was discontinued. I don't know. I haven't seen it." On 6/23/22 at 12:15 PM, the surveyor interviewed the U.S. FOIA (b)(6) who could not speak to the [redacted] for resident #2 and stated he would look into it. He further stated that the resident was on [redacted] care, and he doesn't get involved with residents who are on [redacted] On 6/23/22 at 12:13 PM, the surveyor reviewed	F 688	accomplished for those residents found to have been affected by the deficient practice; -By 6/26/2022 Resident (#2) was assessed by a licensed practitioner. Order for the Ex Order 26.4B1 was discontinued by primary care physician due to [redacted]. -By 6/29/2022 Resident (#87) was evaluated by therapy and nursing services related to [redacted]. [redacted] were initiated as appropriate. -6/30/2022 LPN (#1) and LPN (#2) were educated by the DON on the components of this regulation with an emphasis on the use of adaptive/splinting devices ordered by the physician to include documentation standards that reflect resident refusals. 2. How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken; -All resident have the potential to be affected by this deficient practice. -On 7/19/2022, the Rehab/Therapy department in conjunction with nursing leadership conducted a facility wide audit of active residents with orders for adaptive/splinting devices to ensure devices are in use and are being carried out per physicians' orders.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 688	Continued From page 20 the "plan of care book" on the unit which revealed an NJ Ex Order 26.4(b)(1) wing" list (a list with the names of the residents who utilize NJ Ex Order 26.4(b)(1)). The surveyor, in the presence of the U.S. FOIA (b) reviewed the adaptive devices list which was dated 10/11/20. The U.S. FOIA (b) acknowledged that the list was outdated. On that same date and time, the surveyor interviewed the U.S. FOIA (b)(6) who stated, "we don't have a restorative aide right now." He confirmed that the physician's order for the Ex Order 26.4B1 was active but not transcribed onto the medication or treatment administration record for accountability of the Ex Order 26.4B1. The U.S. FOIA further stated "I don't know what happened. I don't know why it wasn't transcribed or why the resident isn't NJ Ex Order 26.4(b)(1) ." On 6/24/22 at 10:54 AM, the surveyor observed Resident # 2 awake in bed fully dressed watching TV. The resident answered "hello" when the surveyor greeted him/her. There was no Ex Order 26.4B Ex Order 26.4 in use. The surveyor reviewed the medical record for Resident #2. A review of the resident's Admission Record reflected that the resident was admitted to the facility on Ex Order 26.4B1, with diagnoses which included but were not limited to unspecified Ex Order 26.4B1	F 688	-Issues or concerns were addressed as they were identified. 3. What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur. -By 07/29/22, the DON/Designee will re-educate the nursing and therapy staff on the components of this regulation with emphasis on: • Maintaining range of motion, development of restorative nursing programs or provision of therapy services to meet the needs of the residents. • Use of adaptive/splinting devices ordered by the physician to include documentation standards that reflect resident refusals. Newly hired nursing and therapy staff will receive education during orientation. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place; The Director of Nursing/designee will conduct a weekly observational audit x4 weeks and then every 2 weeks x4 months of residents with orders for adaptive/splinting devices to ensure devices are in use and are being carried out per physicians' orders. -The results of these audits will be presented and reviewed at the monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 688	Continued From page 21 EX Order 26.4B1 [redacted] A review of the resident's Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated EX Order 26.4B1 reflected that the resident's Brief Interview for Mental Status (BIMS) score was EX out of 15 which indicated that the resident's EX Order 26.4B1 skills for daily decision making was EX Order 26.4B1. Review of the Medication Review Report (MRR) revealed a physician's order (PO) dated U.S. FOIA (b)(6), for Ex Order 26.4B1 on at all times, dx [diagnoses] EX Order 26.4B1 at all times for EX Order 26.4B1. Review of the EX Order 26.4B1 [redacted], electronic Medication, and Treatment Administration Records (eMAR/eTAR) did not indicate that the above corresponding PO was transcribed onto the eMAR/eTAR's. On 6/28/22 at 2:03 PM, the surveyor met with the administrative team and discussed the above observations and concern. On 6/29/22 at 9:55 AM, the survey team met with the U.S. FOIA (b)(6) [redacted] who stated that the resident was on [redacted] and was no longer using the EX Order 26.4B1. The U.S. FOIA (b)(6) could not speak to a physician's order for discontinuing the EX Order 26.4B Ex Order 26.4. The U.S. FOIA (b)(6) further stated that the resident was refusing and removing the EX Order 26.4B1Ex Order 26.4B but it wasn't documented since the resident's	F 688	QA meeting and quarterly to the QAPI Committee for review and action, as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 688	Continued From page 22	F 688		

admission. She further acknowledged that the adaptive device wasn't care planned.

On 6/30/22 at 1:55 PM, in the presence of the survey team, the [redacted] stated that the resident was refusing to wear the [redacted], but staff did not document the refusals of the [redacted]. There was no additional information provided.

2. On 6/21/22 at 11:29 AM, the surveyor observed that Resident #87 was seated in a [redacted] wheelchair with a [redacted] pad beneath the chair and with a [redacted] limitation. The resident was not wearing an [redacted] or a [redacted] splint.

On 6/21/22 at 11:30 AM, the surveyor interviewed the [redacted]. The [redacted] informed the surveyor that she has been working in the facility for [redacted] as a regular aide on the 3-11 shift. The [redacted] stated that she also worked the 7-3 shift and takes care of Resident #87. She further stated that she was the regular aide for Resident #87 on the 3-11 shift.

Furthermore, the [redacted] informed the surveyor that Resident #87 was [redacted], had no [redacted], and [redacted]. The [redacted] stated that the resident required total assistance with activities of daily living (ADL), a [redacted], with limitation to the [redacted] which was not something new to the resident. She further stated that the resident does not use an [redacted] for their [redacted].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 688	Continued From page 23 On 6/21/22 at 11:55 AM, two surveyors observed the resident in their room. The resident was not wearing a EX Order 26.4B1. The surveyor interviewed the resident who stated that he/she does not use a [redacted]. The resident can not remember the last time he/she had worn a [redacted] and denied refusing a [redacted] before. The resident further stated that the EX Order 26.4B1 limitation was not something new and Ex Order 26.4B1 of [redacted] A short time later, th U.S. FOIA (b)(6) [redacted] came inside the resident's room and delivered the resident's lunch tray. The surveyor reviewed the medical record for Resident #87. A review of the Face sheet (admission record) indicated the resident was admitted to the facility with diagnoses that included but were not limited to EX Order 26.4B1 [redacted] A review of the [redacted], Annual Minimum Data Set (AMDS), an assessment tool used to facilitate care management, indicated a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which reflected that the resident's EX Order 26.4B1 [redacted]. The MDS indicated that the resident had limited [redacted] The AMDS did not indicate that the resident was in the Restorative Nursing Program (RNP).	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 688	Continued From page 24 A review of the EX Order 26.4B1, Order Summary Report included a physician order dated EX Order 26.4B1 for EX Order 26.4B1 on at all times, except for NJ Ex Order 26.4(b)(1 and NJ Ex Order 26.4(b and remove every shift and check EX Order 26.4B1 every shift for The order for the EX Order 26.4B1 was transcribed to the electronic Treatment Administration Record (eTAR) for EX Order 26.4B1 signed by nurses as administered or applied. The personalized care plan focus for EX Order 26.4B1 : EX Order 26.4B1 was revised on EX Order 26.4B1. The care plan interventions created and revised on EX Order 26.4B1 included applying EX Order 26.4B1 on all times except for EX Order 26.4B1 per MD (medical doctor) order, monitor signs and symptoms of NJ Ex Order 26.4(b)(1) every shift, and refer to EX Order 26.4B1 as necessary. Further review of the EX Order 26.4B1 hybrid medical records showed that there was no further documentation that indicate that the resident declined the use of the EX Order 26.4B1, EX Order 26.4B1 and that EX Order 26.4B1 was notified of any concern with regard to the use of EX Order 26.4B1. The 3/11/22 U.S. FOIA (b)(6) signed by the U.S. FOIA (b)(6)) included "Pt (patient) referred for NJ Ex Ord intervention for EX Order 26.4B1 EX Order 26.4B1. Pt presents with EX Order 26.4B1 presentation of gently NJ Ex Order 26.4(b)(1) (EX Order 26.4B1. No sign of NJ Ex Order 26.4(b)(1). Pt reported EX Order 26.4B1 . EX Order 26.4B1	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 688	Continued From page 25 EX Order 26.4B1, to which Pt reported EX Order 26.4B1 and reported comfort with EX Order 26.4B1. Pt expressed interest and agreed to recommendation to wear at all times, except for care. Communicated with unit manager and assigned U.S. FOIA (b). Orders placed. Checked in-with EX Order 26.4B1 or EX Order 26.4B1 noted." The 6/6/22 U.S. FOIA (b) signed by U.S. FOIA (b)(6) included "Pt presents at usual level of function upon re-admission from hospital. Pt NJ Ex Order 26.4(b)(1) fits well with EX Ord s/s (EX Order 26.4B1. Pt requires assist with EX Order 26.4B1 and EX Order 26.4B1 for bed mobility and adls. Pt is a EX Order 26.4B1 r. Pt is at usual level of function and EX Order 26.4B1 EX Order 26.4B1) recc (recommended) at this time. On 6/23/22 at 11:20 AM, the surveyor interviewed Licensed Practical Nurse#1 (LPN#1) in the presence of the U.S. FOIA (b)(6) LPN#1 informed the surveyor that she was not sure if the resident should have a EX Order 26.4B1 and stated "the U.S. FOIA (b) can answer for that." Both the surveyor, U.S. FOIA (b), and LPN#1 went inside the resident's room and observed Resident #87 seated on a wheelchair with no EX Order 26.4B1 in use. After leaving the resident's room, LPN#1 checked the eTAR and stated that the resident should have the EX Order 26.4B1 as ordered at all times except during care. On that same date and time, the U.S. FOIA (b) stated that since she worked 3-11 shifts and "few" of 7-3 shifts, she did not see the EX Order 26.4B The U.S. FOIA (b) confirmed that on 6/21/22 when the surveyor interviewed the U.S. FOIA (b) that day, there was no EX Order 26.	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 688	Continued From page 26	F 688		

in use and that she did not see it even on 3-11 shifts. Then, the [U.S. FOIA (b)] went to the resident's room to look for the [redacted]. Afterward, the [U.S. FOIA (b)] informed both the surveyor and LPN#1 that there was [EX Order 26.4B1] in the resident's room that she can find.

On 6/23/22 at 11:38 AM, the surveyor in the presence of the survey team interviewed the [U.S. FOIA (b)(6)]. The [U.S. FOIA (b)(6)] informed the surveyor that once the resident was discharged from [Ex Order 26.4B1], [Ex Order 26.4B1], the responsible [EX Order 26.4B1] will do a trial, if tolerated, the [U.S. FOIA (b)(6)] will train the assigned [U.S. FOIA (b)] and the [U.S. FOIA (b)] then provide an order for the [redacted]. He further stated that the care plan for the [redacted] was initiated by him and was updated quarterly during MDS review by "me" and/or nursing.

On that same date and time, the [U.S. FOIA (b)(6)] stated "I don't know where nursing document accountability for [EX Order 26.4B] use and application." According to the [U.S. FOIA (b)(6)] "I do the quarterly screen, I interview the nurse and staff about the [EX Order 26.4B1] and [EX Order 26.4B1]." He further stated that Resident#87 has a [EX Order 26.4B1] for [NJ Ex Order 26] and [NJ Ex Order 26.4(b)] and that the resident was [NJ Ex Order 26.4(b)(1)].

At that time, the surveyor informed the [U.S. FOIA (b)(6)] of the above observations and concerns that the [EX Order 26.4B1] was not in use during the surveyor's observations. The surveyor asked the [U.S. FOIA (b)(6)] to check what happened and where was the [EX Order 26.4B1]. The [U.S. FOIA (b)(6)] stated that he will get back to the surveyor.

On 6/23/22 at 12:07 PM, the surveyor met with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 688	Continued From page 27 the [U.S. FOIA (b)(6)] in the presence of the survey team. The [U.S. FOIA (b)(6)] informed the surveyor that upon checking with nursing, the [EX Order 26.4B] was found. The surveyor asked the [U.S. FOIA (b)(6)] where did they see the [EX Order 26.4B] and the [U.S. FOIA (b)(6)] stated "I don't know, they just told me that it was found." Furthermore, the [U.S. FOIA (b)(6)] stated that as per nursing, and the [U.S. FOIA (b)] the resident was refusing the [EX Order 2] at times due to [EX Order 2]. Then the surveyor asked the [U.S. FOIA (b)(6)] when the resident refused the [EX Order 26.4] should the staff document the refusal, where should the documentation be written, and if he received a report of [EX Order 2] due to the use of the [EX Order 2]? The [U.S. FOIA (b)(6)] stated that it should be documented in the electronic medical records, "I did not receive a report" about [EX Order 2] with the use of a [NJ Ex Order 2] and the [EX Order 2B4] was appropriate from the last [NJ Ex Order 2] screen. During an interview of two surveyors on 6/23/22 at 1:22 PM, LPN#1 informed the surveyors that the EX Order 26.4B1 was found under the resident's bed by the [U.S. FOIA (b)] On 6/23/22 at 1:23 PM, the surveyors interviewed the [U.S. FOIA (b)] The [U.S. FOIA (b)] informed the surveyors that the EX Order 26.4B1 was found inside the resident's bottom drawer covered by the resident's personal belongings. The [U.S. FOIA (b)] stated that it was the first time that she saw the [EX Order 2B4]. During an interview of the surveyors on 6/27/22 at 10:48 AM, LPN#2 informed the surveyors that she worked on [redacted] on the day that the surveyor did not observe the resident wearing a EX Order 26.4B1 on multiple occasions on	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 688	Continued From page 28	F 688		

that date. She further stated, "I don't know what happened or why it was not with the resident at that time." The surveyor asked LPN#2 why the CNA did not know about the EX Order 26.4B1, LPN#2 had no answer.

On that same date and time, the surveyor asked LPN#2 when the resident refused the [redacted] where should it be documented, and if the resident had refused the use of the [redacted] LPN#2 stated that refusal should be documented in the eTAR. She further stated "yes" that it was being refused at times. Then the surveyor asked LPN#2 did she document the refusal and LPN#2 did not answer.

On 6/28/22 at 01:01 PM, the surveyor interviewed the U.S. FOIA (b)(6) in the presence of the survey team. The [redacted] informed the surveyor that the facility used to have a U.S. FOIA (b)(6) and since the [redacted] was on medical leave, there was no replacement. The [redacted] stated that the responsibility of the [redacted] was now transferred to the assigned [redacted] The surveyor asked the [redacted] if the assigned [redacted] was educated and trained in the restorative program which included EX Order 26.4B1 The [redacted] stated that the [redacted] were trained but there was no documentation that the [redacted] signed the education and training.

On 6/28/22 at 2:03 PM, the survey team met with the U.S. FOIA (b)(6), and the three regional directors and were all made aware of the above concerns.

A review of the facility Restorative Nursing Program Policy revised 7/21, provided by the [redacted] included " Restoration and maintenance of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 688	Continued From page 29 optimal independence shall be integral to the care provided to all residents. Restorative programs shall be individualized and designed to restore and/or maintain functions which have been lost or reduced by illness, injury or inactivity. Procedure: ....5. All residents shall be assessed for restorative nursing care within twenty-four (24) hours of admission and upon discharge from any rehabilitation therapy program. 6. Resident shall be placed in a restorative program appropriate to his or her needs. A description of the restorative care to be provided will be inputted as a task into the POC system. 7. All restorative services shall be appropriately documented as having been provided in the Point of Care system." On 6/29/22 at 2:26 PM, the survey team met with the U.S. FOIA (b)(6) [redacted] The surveyor asked the facility if they have additional information about the surveyor's concerns, the [redacted] stated that there was no additional information. NJAC 8:39-27.2(m)	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690		7/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 690	Continued From page 30 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide appropriate care and services of Ex Order 26.4B1 Ex Order 26.4B1 for 1 of 2 residents (Resident#57) reviewed for Ex Order 26.4B1. This deficient practice was evidenced by the following: On 6/20/22 at 10:15 AM, the surveyor observed Resident #57 lying with the head of the bed	F 690	F690 - Bowel/Bladder Incontinence, Catheter, UTI 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; On 6/28/22, Ex Order 26.4B1 was carried out for resident (#57); Ex Order 26.4B1 plan of care initiated to include Ex Order 26.4B1.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 690	Continued From page 31 elevated. There was a EX Order 26.4B1 NJ Ex Order on the left side below the level of the EX Order 26.4..., and off the NJ Ex Ord... with a EX Order 26.4B1 NJ Ex Ord... The resident was NJ Ex Ord... and responded to the surveyor NJ Ex Order 26.4(b)(1) The surveyor reviewed the resident's medical records: The admission summary reflected that the resident was admitted to the facility with diagnoses that included essential EX Order 26.4B1 [redacted] According to the NJ Ex Order 26.4(b..., Admission Minimum Data Set (AMDS), an assessment tool used to facilitate the management of care indicated that the resident's Brief Interview for Mental Status score of EX Ord... out of 15 which indicated that the resident's EX Order 26.4B1. The AMDS indicated that the resident had an EX Order 26.4B1 [redacted] There was an a physician order dated EX Order 26.4B1, that EX Order 26.4B1." Other physician orders included an order dated EX Order 26.4B1, to record EX Order 26.4B1 for NJ Ex Order 26.4(b)(1) NJ Ex Order 2... NJ Ex Order 26.... and NJ Ex Order 26.4(b)(1) q (every) shift. The above corresponding physician order was transcribed onto the EX Order 26.4B1 electronic Treatment Administration Record (eTAR). Further review of the Ex Order 26.4B1 eTAR showed	F 690	NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) NJ Ex Order 2... NJ Ex Order 26.... and NJ Ex Order 26.4(b)(1) was documented in the medical record. 2. How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken; - All residents have the potential to be affected by this deficient practice. -By 6/28/22, the Regional Director of Nursing conducted an audit of residents with indwelling catheters to ensure care and services are documented per physicians' orders with an emphasis on: • Documentation related to urinary output for amount, color, clarity, and presence of sediment is present within the medical record if applicable • Indwelling catheter plan of care initiated and updated as appropriate -Any concerns identified were immediately addressed. 3. What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur. -By 07/29/22, the DON re-educated licensed nurses on the components of this regulation with emphasis on ensuring: • Documentation related to urinary output for amount, color, clarity, and presence of sediment is present within the medical record if applicable	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 690	Continued From page 32 the following dates with missing EX Order 26.4B1, NJ Ex Order 2 NJ Ex Order 26.4 and NJ Ex Order 26.4(b)(1) documented and did not follow the above physician's order: Day (7-3 shift): NJ Ex Or NJ Ex O , NJ Ex O , NJ Ex Orde , and NJ Ex Order 26.4(b Evening (3-11 shift): NJ Ex Orde and NJ Ex Order 26.4(b Night (11-7 shift): NJ Ex O , NJ Ex Or NJ Ex Orde , NJ Ex Orde , NJ Ex Orde , and NJ Ex Order 26.4(b Review of the personalized care plan did not include information about the care of Ex Order 26.4B1 Ex Order 26.4B1 On 6/28/22 at 12:43 PM, the surveyor interviewed the U.S. FOIA (b)(6) about the Ex Order 26.4B1 concerns. The U.S. FOIA U.S. FOIA (b)(6) stated that it was better to speak with the concerning the care plan and missing logs in the eTAR according to the physician's order. The U.S. FOIA (b) further stated, "just ask the U.S. FOIA (b)(6) On 6/28/22 at 1:01 PM, the surveyor in the presence of the survey team, interviewed the U.S. FOIA (b) who stated that the U.S. FOIA (b)(6) used to do the care plans, but now it was the U.S. FOIA (b)(6) who does care plans and care plan was being updated with the help of the U.S. FOIA (b)(6) The U.S. FOIA (b) further stated that a Ex Order 26.4B1 care plan should be initiated "immediately" upon admission in the baseline care plan, quarterly, and updated when there is a change. The surveyor asked the U.S. FOIA (b) if the EX Order 26.4B1 should have been included in Resident#57's care plan and the U.S. FOIA (b) stated "absolutely."	F 690	• Indwelling catheter plan of care initiated and updated as appropriate -Newly hired licensed nurses will receive education during orientation. -Newly admitted residents will be reviewed in the daily clinical meeting to ensure orders related to catheters are completed as ordered. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place; -The Director of Nursing/designee will conduct a weekly audit x4 weeks and then every 2 weeks x 4 months of residents with indwelling catheters to ensure documentation standards surrounding indwelling catheter care is being carried and plan of care is initiated and updated as appropriate. -The results of these audits will be submitted monthly to the QA meeting and quarterly to the QAPI Committee for review and action, as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 690	Continued From page 33 On that same date and time, the surveyor asked the [U.S. FOIA (b)] should there be an order and accountability for EX Order 26.4B1? The [U.S. FOIA (b)] stated it should be in the eMAR (electronic Medication Administration Record) or eTAR. The surveyor informed the [U.S. FOIA (b)(6)] of the above concerns regarding the EX Order 26.4B1 plan and physician orders not being followed concerning EX Order 26.4B1. On 6/28/22 at 2:03 PM, the survey team met with the U.S. FOIA (b)(6) and were made aware of the above concerns. On 6/29/22 at 9:50 AM, the surveyor met with the U.S. FOIA (b)(6)). The [U.S. FOIA (b)(6)] provided a copy of the [EX Order 26.4B1] for the EX Order 26.4B1 [EX Order 26.4B1]) care plan date initiated on [EX Order 26.4B1]. The surveyor asked the [U.S. FOIA (b)(6)] why the [EX Order 26.4B1] EX Order 26.4B1 plan was initiated after the surveyor's inquiry, and the [U.S. FOIA (b)(6)] stated that she will get back to the surveyor. On 6/29/22 at 2:26 PM, the survey team met with the U.S. FOIA (b)(6) The [U.S. FOIA (b)(6)] stated, "I reviewed the case" and there was inconsistencies with the [EX Order 26.4B1] [EX Order 26.4B1] documentation and omission. The [U.S. FOIA (b)(6)] further stated that it was because on [EX Order 26.4B1], the [U.S. FOI] quit and the care plan was not done in a timely fashion.	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 690	Continued From page 34 A review of the undated facility's Foley Care Policy that was provided by the [redacted] included "Policy Statement: It is the policy of [name redacted] that an indwelling Foley catheter will be maintained thru Catheter Care as per medical staff order, every shift or as directed by the medical staff....Catheter Care Protocol: ....9. Measure drainage at end of each 8 hour tour of duty, unless more frequent measurements have been ordered, or large volumes of urine are collected. Empty into clean container and discard. 10. Assess urine output every shift for amount, color, odor, sediment or resident complaints...11. Maintain output record unless otherwise indicated....15. Change catheter as ordered by the physician, based on assessment of the resident. Bedside drainage bags are to be replaced at least every 30 days when the Foley catheter is changed, or more often as warranted. Leg bags are to be changed each night with a new bedside drainage bag." On 7/1/22 at 10:43 AM, the survey team met with the [redacted]. The [redacted] informed the surveyors that there will be no additional information. NJ 8:39-27.1(a)	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 692		7/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 692	Continued From page 35 §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to a.) identify and address clinically significant [NJ Ex Order 26.4(b)(1)] until surveyor inquiry, b.) obtain and assess [NJ Ex Order 26.4(b)(1)] in a timely manner (readmission [NJ Ex Order 26.4(b)(1)], and weekly [NJ Ex Order 26.4(b)(1)] c.) ensure care planned nutrition interventions were implemented, d.) perform consistent meal consumption monitoring, e.) use industry standard parameters to calculate [NJ Ex Order 26.4(b)(1)]. This was identified for 2 of 6 residents (Resident #77 and Resident #80) reviewed for nutrition. This deficient practice was evidenced as follows: Resource referenced: Review of the Nutrition Care Manual from the Academy of Nutrition and Dietetics: Anthropometric Measurements reflected the following:	F 692	F692 - Nutrition/Hydration Status Maintenance 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: -On 06/28/2002, Resident (#77) was [NJ Ex Order 26.4(b)(1)], and results were recorded in the medical record. The Registered Dietician reassessed the [redacted] and made recommendations for interventions to assist with [redacted]. Interventions were implemented per physician's order. Preferences were obtained and communicated to the kitchen, recorded on meal ticket to ensure specific preferences as it pertains to interventions to [redacted]. -Resident returned from the hospital on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 692	Continued From page 36 "To effectively use weight in the assessment of a client/patient's nutritional status, it is important to obtain accurate measurements." "The significance of the percentage of weight change depends on the length of time in which the weight change occurred, as well as whether the weight loss was intentional or unintentional." "Assessing Percentage of Weight Change: Interpretation, Percentage of Weight Change" as follows: "Time Frame Significant Weight Loss Severe Weight Loss 1 week 1-2% >2% 1 month 5% >5% 3 months 7.5% >7.5% 6 months 10% >10%." 1. On 6/20/22 at 9:49 AM, the surveyor observed the Resident #77 in his/her room. The resident was seated in a wheelchair. The surveyor reviewed the medical record for Resident #77. Review of the residents Admission Record (an admission summary) reflected that the resident had diagnoses that included but were not limited to: EX Order 26.4B1 . Review of the residents Quarterly Minimum Data Set (MDS) dated EX Order 26.4B , a tool used to facilitate the management of care, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of EX Ord out of 15, which reflected an EX Order 26.4B1 .	F 692	(#80) and was weighed upon admission, results were recorded in the medical record. The Registered Dietician reassessed the and made recommendations for interventions to assist with . Interventions were implemented per physician's order. -On 6/30/2022 the facility interim U.S. FOIA (b) was reeducated by the Licensed Nursing Home Administrator (LNHA) on the components of this regulation with an emphasis on meal ticket accuracy to include prescribed diet including resident preference, likes/dislikes, and alternative meals as appropriate. -On 6/30/2022 The facility U.S. FOIA (b)(6) was reeducated by the Administrator on the components of this regulation with an emphasis on: • Identification of clinically significant weight • Obtainment, assessment, and reporting of weights • Ensuring care planned nutrition interventions are implemented • Performing consistent meal consumption monitoring • Utilizing industry standard parameters to calculate caloric needs 2. How you will identify other residents having potential to be affected by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 692	Continued From page 37 Review of the resident's nutrition care plan dated [redacted] reflected that the resident had a history of [redacted], frequently changed his/her [redacted] preferences and had a desire for [redacted] maintenance. It also reflected a goal to "maintain [redacted]" (a numerical [redacted] value was not included in the care plan goal) "plus or minus [redacted] pounds" which was revised on [redacted] the resident's [redacted].). In addition, it reflected that the resident's [redacted] should be monitored and recorded for each [redacted] It also reflected to provide an ice cream at lunch per the resident's request. Review of the resident's physician Order Summary Report for [redacted] reflected a physician's order dated [redacted] to obtain a [redacted] every Monday, once a week for monitoring. The surveyor reviewed the residents' weights in the electronic medical record (EMR). Weights documented were as follows: - [redacted]	F 692	same practice and what corrective action will be taken: -By 7/26/2022, facility RD ran an audit report to review all recent weights for [redacted] and [redacted] Current weights of active residents, compared to historical weight documentation, notified the physician and/or resident representative of significant weight loss if identified. -By 7/28/2022, facility Food Service Director conducted a facility audit of active residents to review preferences, likes and dislikes with an emphasis on updating the meal ticket if appropriate. -Any concerns identified were immediately addressed. 3. What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur: By 07/29/22, the Director of Nursing/designee re-educated nursing staff on the components of this regulation with an emphasis on: • Identification and reporting of weight loss or gain trending • Obtainment, assessment, and reporting of weights • Ensuring care planned nutrition interventions are implemented • Performing consistent meal consumption monitoring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 692	Continued From page 38 Ex Order 26.4B1 . -Ex Order 26.4B1 bs. [no evidence of a NJ Ex Order 26.4(b)(1) The Ex Order 26.4B1 , NJ Ex Order 26.4 reflected a NJ Ex Order 26.4(b)(1) of Ex Order 26.4B1 . - Ex Order 26.4B1 - NJ Ex Order 26.4(b) . NJ Ex Order 26.4(. [no evidence of a reweight] The , NJ Ex Order 26.4 reflected a NJ Ex Order 26.4(b)(1) Ex Order 26.4B1 , a NJ Ex Order 26.4(b)(1) of Ex Order 26.4B1 and a NJ Ex Order 26.4(b)(1) of Ex Order 26.4B1 . -There was no evidence for a weekly NJ Ex Order 26.4 on Ex Order 26.4B1 - Ex Order 26.4B1 (lbs.) Review of the Registered Dietitian's U.S. FOIA (b progress notes (PN) did not reflect documented evidence that she identified or addressed the above noted NJ Ex Order 26.4(b)(1) . Review of an U.S. FOIA PN dated NJ Exec Order 28 , indicated that "changes to NJ Ex Order 26.4 are not significant NJ Ex Order 26.4 days, however the resident is clearly on a ." In addition, her PN reflected "Willing to have half egg salad sandwich added to lunch tray as the resident claims to NJ Ex Order 26.4(b The resident remains at risk for NJ Ex Order 26.4(b)(1) ..." On 6/27/22 at 12:32 PM, the surveyor observed the resident in his/her room during lunch. The resident stated that he/she did not eat too much for lunch. Upon surveyor inquiry the resident stated that he/she did not receive a half or whole	F 692	Newly hired licensed nurses will receive education during orientation. (D) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing Services/designee will conduct a weekly audit of 10 active residents x4 weeks and then every 2 weeks x2 months of to ensure: • Weights are obtained per physician orders and/or the plan of care and documented in the clinical record. • Residents demonstrating significant weight loss are referred to the dietitian for assessment and intervention. • Care planned nutrition interventions are implemented • Facility staff notify the physician, resident and/or resident representative related to significant weight loss. • Consistent meal consumption is recorded in the medical record. • Preferences, likes and dislikes are updated on the resident's meal ticket if appropriate The findings of these audits will be reported to the Quality Assurance Committee monthly and quarterly at the QAPI meeting until committee determines substantial compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 692	Continued From page 39	F 692		

egg salad sandwich nor an ice cream on the lunch tray but would have liked to. The meal ticket did not indicate to provide these items at lunch.

Review of a copy of the resident's lunch meal ticket for [NJ Exec Order 26.4] provided to the surveyor by the [NJ Exec] at 1:11 PM that day, did not reflect provision of half an egg salad sandwich nor ice cream to be provided with the lunch meal.

On 6/28/22 at 11:17 AM, the surveyor interviewed the U.S. FOIA (b)(6)) and the [U.S. FOIA] in the presence of a second surveyor. The [U.S. FO] stated that the kitchen had "no production sheets." She stated that the Cook prepared meals and menu items according to the likes and dislikes noted on the resident's meal tickets. The [U.S. FO] stated that the food/beverage items a resident should receive daily should appear on the right side of the meal ticket.

On 6/28/22 at 11:25 AM, the surveyor interviewed Resident #77's Licensed Practical Nurse #1 (LPN#1) in the presence of a second surveyor. LPN #1 stated that monthly [NJ Ex Order 26.4(b)] were obtained by the 8th of the month. She stated that a [NJ Ex Order 26.] should be obtained on admission and readmission but could speak to more frequent [NJ Ex Order 26.4(b)] after that unless there was a physician's order such as when a resident is on a [redacted] prescription. She stated that Resident #77 had a physician's order to be [NJ Ex Order 26.4(b)(] on Monday's. LPN #1 stated that [NJ Ex Or] were recorded in the eMAR. She also stated that if a resident had a [NJ Ex Order 26.4(b)(1)] they would be placed on weekly [NJ Ex Order 26.4(b)] for four weeks. LPN #1 also stated that the [redacted] would indicate on the [NJ Ex Order 26.] worksheets

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 692	Continued From page 40	F 692		

if a resident required a [NJ Ex Order 26.4(b)(] or weekly [NJ Ex Order 26.4(b)(] She showed the worksheets to the surveyors and provided a copy.

Review of the [NJ Ex Order 26.] worksheet titled Resident [NJ Ex Order 26.4(b)] for [Ex Order 26.4B1] revealed Resident #77 had a [NJ Ex Order 26.] of [Ex Order 26.4B1]. for the month of [Ex Order 26.4] There was an indication to obtain a [NJ Ex Order 26.4(b)(1] however it was blank.

LPN #1 also stated that there were meal monitoring accountability books that the Certified Nurse Aides (CNAs) recorded each resident's meal consumption as a percentage. She further stated that the CNAs also verbally communicate if a resident was eating poorly or not eating. She could not speak to what staff member was responsible to review the meal accountability books to ensure that they were completed and to identify any trends/changes in resident intake, however her expectation was that the [U.S. FC] did so. She provided the books for the surveyors to review.

Review of the [NJ Ex Order 26.4(b)(1)] worksheets revealed Resident #77 had varied [NJ Ex Order] for breakfast at lunch ranging from [NJ Ex Order 26.4(b)] from [Ex Order 26.4B1]. There was no documented evidence of the resident's consumption for the dinner meal from [Ex Order 26.4B] through [Ex Order 26.4B1]

On 6/28/22 at 12:24 PM, the surveyor observed the resident in his/her room at lunch. The resident stated they [NJ Ex Order 26.4(b)(1)] and showed the surveyor a copy of the menu which indicated the meal should have consisted of Southern fried chicken, mashed potatoes with gravy, Harvard

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 692	Continued From page 41	F 692		

beets, watermelon cubes, whole milk and coffee. The resident removed the lid from her lunch tray and showed the surveyor that he/she received a plate of cheese tortellini with broccoli, which was untouched. The resident also showed the surveyor that this was the alternate meal on the menu. The resident did not have milk on the tray nor the watermelon cubes, half an egg salad sandwich or ice cream. There was a fresh sliced orange which was indicated on the meal ticket. She stated that she was supposed to get milk at every meal. The resident stated that a previous U.S. FOIA (b)(6)) used to visit regularly and go over the menus with him/her and further stated that no one from the kitchen had done this since the U.S. FOIA left.

U.S. FOIA (b)(6) provided the surveyor with a timeline of U.S. FOIA (b)(employment status from March till present. This reflected that the U.S. FOIA the resident was referencing was no longer employed by the facility as of U.S. FOIA (b)(6).

The surveyor continued interviewing the resident who stated that he/she was NJ Ex Order 26.4(b)(1) and did not NJ Ex Order 26.4(. The resident further stated that he/she was now NJ Ex Order 26.4 . At that time a U.S. FOIA (b)(6) brought the resident a plate of chicken with mashed potatoes and broccoli. The U.S. FOIA stated that the chicken was a boneless thigh, and the resident did not like dark meat chicken (this was indicated on the resident's meal ticket). She stated that she did not cook the meal, however, there was no white meat chicken available. The resident requested Harvard beets, however the U.S. FOIA stated there were no more beets available. The U.S. FOIA stated there was no selective

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 692	Continued From page 42	F 692		

menu for the resident, whereby the resident could select meals in advance. The resident stated that [redacted] had asked the [redacted] for a selective menu, but it was never done.

On 6/28/22 at 12:43 PM, the surveyor interviewed the [redacted] in the presence of the [redacted] regarding the recipe for Southern fried chicken. The [redacted] provided the surveyor a recipe for oven fried chicken which he stated he used to prepare todays lunch for Southern fried chicken.

Review of the recipe indicated Chicken breast as the main ingredient. At the bottom there was indication that chicken parts such as legs or thighs maybe used in place of breasts.

The [redacted] stated that if he knew in advance that a resident would only eat white meat chicken, he could have prepared chicken tenders which were white meat chicken.

On 6/29/22 at 12:02 PM, the surveyor interviewed the U.S. FOIA (b)(6) in the presence of the survey team. She stated that resident meal monitoring was assessed by the CNA's and recorded in accountability books. She stated that the CNA was responsible to record consumption for each meal daily. She stated that the [redacted] reviewed the meal monitoring to monitor intake trends related to weight loss or gain. She stated that the [redacted] utilized this information. She stated that weights were obtained for new and readmissions. She also stated that resident's weights were monitored monthly unless a resident had Ex Order 26.4B1 [redacted] and then they would be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 692	Continued From page 43	F 692		

weighed on Monday, Wednesday and Friday. She stated that only residents that were newly or readmitted to the [EX Order 26.4B1] unit would be weighed weekly for four weeks. The [U.S. FOIA (b)] stated that monthly weights were obtained by the 7th till the 10th of the month and recorded on the worksheet. She stated that then the Unit Managers (UM's) would review the weights and notify the [U.S. FO] if she needed to add interventions. She stated that if there was no UM then the charge nurse would be responsible. She stated that after weights were obtained, they were recorded in the EMR, and the hard copies were discarded. She stated that a reweight would be obtained if there was a five-pound discrepancy. She stated that the [U.S. FO] added to the worksheet if a resident required weekly weights (i.e., for a resident who was not eating well). She further stated that there would be a physician's order for weekly weights or more frequent weights for CHF monitoring. The [U.S. FOIA (b)] also stated that nursing used the Dietary Alert Sheet to notify the [U.S. FO] of weight changes.

On 6/29/22 at 1:09 PM, the surveyor interviewed the [U.S. FO] in the presence of the survey team. She stated that resident meal monitoring was done by the CNA's and daily consumption was recorded in an accountability logs. She stated that the [U.S. FOIA (b)] delegated which staff member would be responsible to review the meal monitoring accountability logs to ensure completion and monitor for trends. The [U.S. FO] stated that she also reviewed these logs when she conducted nutritional documentation on residents. She stated that she used the information when a resident had a weight loss, a significant change or to monitor how newly admitted residents were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 692	Continued From page 44	F 692		

eating. She further stated that she notified the [redacted] if she observed omissions on the meal monitoring sheets.

The [redacted] stated that weights were taken on admission and readmission. She stated that monthly weight monitoring was completed by the 7th of the month and that any deviation of five lbs. from prior month required a reweight. She stated that a nurse would automatically reweigh the resident. The [redacted] stated that she reviewed weights after they were entered into the EMR. She stated that nursing determined which residents required reweights and calculated weight changes and notified her via a communication tool titled, Dietary Alert Sheet. The [redacted] stated that newly admitted residents should be weighed for four weeks after admission, and that the same process applied to readmissions on the subacute unit. She stated that on the long-term care unit, weekly weights for four weeks were not required for readmissions. The [redacted] stated that there were physician's orders to obtain weights. She stated that weights were recorded under the Weights/Vitals tab of the EMR and sometimes in the eMAR. She stated that the [redacted] designated who entered the weights into the EMR. She stated that if she finds weights were not recorded in the EMR she would enter them herself from the weight book. She stated that she would inquire if weights were not recorded and that it was part of her "assessment." The [redacted] stated that she documents for significant weight changes, quarterly reviews, and follow-ups. She stated that she followed-up on weekly weights. She stated that the purpose of weekly weight's was that if a resident was having continued weight loss there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 692	Continued From page 45	F 692		

would be a need for added interventions. She further stated that she looked at weekly weight's and if she saw a decline she would intervene. She also stated that she typically reviewed the weekly weights after the four-week period, not necessarily week to week. She stated that she did not conduct weight meetings, but that weight losses were discussed in the facility's daily morning meetings, however no minutes were taken. She stated that she considered significant weight change 5% over one month and 10% over six months. She stated that a five lbs. weight change required a reweight to verify the change, and that nursing would notify her. She could not speak to any other parameters she would use when considering weight loss, she stated "I don't have a set number."

The [redacted] stated that Resident #77 had a physician's order for weekly [redacted] every Monday. She acknowledged there was no documented evidence to address the residents [redacted] on [redacted] She stated that she was unaware if she needed to address a [redacted] that occurred over a one-week period of time. The [redacted] stated, "I did not put a note." She acknowledged that she did not enter a progress note until 11 days later. The [redacted] stated that she felt the [redacted] was unavoidable since the resident was [redacted] and [redacted] interventions." She stated that the resident had wanted to [redacted] and at some point, wanted to maintain [redacted]. The [redacted] could not speak to why there was no weekly [redacted] entry for [redacted] and further stated, "I wouldn't know because I did not look at it." She stated that if a resident was on weekly [redacted] she was not looking at the [redacted] and that nursing would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 692	Continued From page 46	F 692		

alert her if there was a change. She acknowledged that she documented the intervention to provide the resident with half an egg salad sandwich at lunch. The U.S. FO stated that she informed the kitchen in writing to add the sandwich to the resident's meal ticket but could not speak to why it was not done. She stated that the egg salad sandwich "was an intervention for NJ Ex Order 26.4 maintenance, even NJ Ex Order 26.4(b)(1)." The U.S. FO stated that she was notified yesterday that the resident was not receiving the sandwich. She stated that the goal she had for the resident on the nutrition care plan should have had a 90-day time frame and that she reviewed the goal quarterly. She stated that goals should be measurable to assess whether or not interventions were working or needed to be adjusted. The U.S. FO stated that nursing gave her a Dietary Alert Sheet for Resident #77 yesterday which indicated the resident had a NJ Ex Order 26.4(b)(1) change within one month, was NJ Ex O and had a Ex Order 26.4B1. She provided a copy to the surveyor which was dated Ex Order 26.4B1.

On 6/29/22 at 3:02 PM, the survey team met with the U.S. FOIA (b)(6) he U.S. FOIA (b)(6) stated that nursing obtained NJ Ex Order 26.4(b)(recorded the NJ Ex Order 26.4(b in the EMR and when there were significant NJ Ex Order 26. changes nursing notified the U.S. FO. She stated that the U.S. FO did not review NJ Ex Order 26.4(b)(for significant NJ Ex Order 26 changes.

On 6/30/22 at 10:17 AM, the surveyor interviewed the resident after breakfast. Resident #77 stated that he/she had not eaten much.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 692	Continued From page 47	F 692		

On 6/30/22 at 10:50 AM, the surveyor interviewed LPN #1 in the presence of a second surveyor. She stated that the [U.S. FOIA] left about four weeks ago. She stated that the [U.S. FOIA] typically reviewed the [NJ Ex Order 26.4(b)] but now "I guess it's us" who were responsible. LPN #1 stated responsibilities for [NJ Ex Order 26.4] monitoring were not discussed with her from management after the [U.S. FOIA] left. She stated that she did not know how to calculate significant [NJ Ex Order 26.4] changes and was unaware of what parameters were used to identify significant [NJ Ex Order 26.4] changes. She provided the surveyors with a copy of a communication tool used titled [NJ Ex Order 26.4] Alert Sheet which indicated that if a resident [NJ Ex O] or [NJ Ex Order 26.4(b)(1)]. within a one month or two-month period of time, they should alert the [U.S. FO]. She stated that [U.S. FO] notified nursing when a resident required a [NJ Ex Order 26.4(b)(1)] or needed to be placed on weekly [NJ Ex Order 26.4(b)(1)] LPN #1 stated that she gave the [U.S. FO] a Dietary Alert sheet for Resident #77 yesterday since the residents [NJ Ex Order 26.4(b)] have been declining and he/she was now [redacted]. She stated that "I see the weekly [NJ Ex Order 26.4(b)(1)] because I enter them into the EMR, and I saw the resident was down to [EX Order 26.4B1]., so I had to notify the [U.S. FOIA]" She stated that the resident had a poor appetite and was prescribed very few medications. She stated that the resident was on a EX Order 26.4B1 and had no issues with [EX Order 26.4B1], and that could not have contributed to [NJ Ex Order 26.4(b)(1)]. LPN #1 stated that the resident had Ex Order 26.4B1" and that "we probably missed it." She further stated that "we started a three-day [NJ Ex Order 26.4(b)(1)] today and the resident barely [NJ Ex Order 26.4(b)(1)]."

On 6/30/22 at 12:16 PM in the presence of the survey team and the [U.S. FOIA (b)(6)] the [U.S. FO] stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 692	Continued From page 48 she had no further responses related to the concerns addressed for Resident #77. She stated only that she entered a progress note on [redacted] and started a calorie count [redacted] after surveyor inquiry. 2. On 6/20/22 at 10:49 AM, the surveyor interviewed Resident #80 in the presence of his/her significant other. They both reported to the surveyor that the resident had [redacted]. The surveyor reviewed the medical record for Resident #80. Review of the residents Admission Record reflected that the resident had diagnoses that included but were not limited to [redacted] Review of the residents Quarterly MDS dated [redacted] a tool to facilitate the management of care, reflected that the resident had a BIMS score of [redacted] out of 15, which reflected an [redacted]. Review of the resident's nutrition care plan dated [redacted], reflected that the resident had a significant [redacted] prior to admission in the community and again within the first month of admission. It also reflected that the resident desired [redacted] maintenance. In addition, on [redacted] it reflected that the resident's readmission was pending and was being seen by the [redacted] due to [redacted]. Interventions on the care plan included [redacted] Monitor/report/record ... significant [redacted] in 1	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 692		F 692		

Continued From page 49

month, > [redacted], > [redacted]," and "Provide, serve diet as ordered. Monitor [redacted] and record [redacted]."

Review of the resident's physician Order Summary Report for [redacted] reflected a physician's order to obtain a weekly [redacted] every [redacted]

Review of the residents eMAR for [redacted] did not reflect documented evidence that a weekly [redacted] was obtained for [redacted] and [redacted]

The surveyor reviewed the [redacted] record in the EMR. [redacted] documented were as follows:

[redacted]

There was no documented evidence for obtaining weights and weight monitoring after [redacted].

Review of the [redacted] did not reflect documented evidence that she identified or addressed the above noted [redacted].

Review of the [redacted] initial assessment for Resident #80 dated [redacted], reflected the resident weighed [redacted] and experienced [redacted] prior to admission to the facility. It reflected that the resident had a [redacted] with [redacted]). It reflected that the resident's [redacted] was [redacted] or less and was at risk for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 692		F 692		

Continued From page 50

Ex Order 26.4B1. The [redacted] calculated the resident's NJ Ex Order 26.4 needs at NJ Ex Order 26.4(b) per NJ Ex Order 26.4(b)(of NJ Ex Order at that time.

Review of the U.S. FO PN dated U.S. FOIA (b)(6), , reflected that the resident was readmitted to the facility on EX Order 26.4B after a hospitalization and that a readmission Ex Order 26.4B1 was "pending." It reflected that "prior to being hospitalized the resident weighed EX Order which showed that was significant from prior month, [redacted] It reflected that the resident returned "on a EX Order 26.4B consistency, apparently had Ex Order 26.4B1 EX Order 26.4B1 prior to being Ex Order 26.4B1." It also reflected that the resident was at risk for EX Order 26.4B1 and would be Ex Order 26.4B1 weekly. The U.S. FOIA calculated the resident's NJ Ex Order 26.4(b)(1) at Ex Orc calories per NJ Ex Order 26.4(b)(of NJ Ex Order 26.4(b)(1)

On 6/28/22 at 11:00 AM, the surveyor interviewed LPN #2 who cared for Resident #80 in the presence of a second surveyor. He stated that NJ Ex Order 26.4(b)(1) was done by the CNAs and NJ Ex Order 26.4(b)(1) was recorded in accountability books. LPN #2 also stated that CNAs would verbally report if a resident was NJ Ex Order 26.4(b)(1) or was NJ Ex Order 26.4(b)(1). He could not speak to what staff member was assigned to review the accountability books, however he stated that he would expect that the U.S. FOIA would review and use the information. He showed the surveyor the NJ Ex Order 26.4(b)(1) accountability books and copies were made for Resident #80.

Review of the NJ Ex Order 26.4(b)(1) worksheets revealed Resident #80 had varied NJ Ex Order for all three NJ Ex Order 26 on dates NJ Ex Order 26 through NJ Ex Order 26.4(most of which reflected NJ Ex Order 2 or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 692	Continued From page 51 less of the NJ Ex Order 26.4(b)(1). There were omissions for the following: NJ Ex Order 26.4(b)(1) NJ Ex Order 26. NJ Ex Order 26. , and NJ Ex Order 26.4(b)(1). NJ Ex Order 26. NJ Ex Order 26. NJ Ex Order 26. , and NJ Ex Order 26.4(b)(1). NJ Ex Order 26. NJ Ex Order 26. , and NJ Ex Order 26.4(b)(1). There was documentation of NJ Ex Order 26.4(b)(1) for NJ Ex Order and NJ Ex Order 26. on NJ Ex Order 26.4(b during which time the resident was hospitalized. LPN #2 also stated that residents were weighed on admission and readmission and were then placed on weekly weights for four weeks. He stated that if a resident had CHF, they would be weighed three times a week on Monday, Wednesday and Friday. He also stated that if a resident was brittle, they may weigh them daily. LPN #2 stated there were physician's orders for weights, and further stated that served as a reminder to record the weights in the eMAR and then it auto populated to the Weights/Vital section of the EMR. He stated that the CNAs know who to weigh as it was indicated in the weight book. He could not speak to when a reweight was required but stated that the U.S. FO monitored resident weights and would let the staff know when a reweight needed to be done by indicating that on the weekly weight worksheets. Review of the weekly NJ Ex Order 26. worksheets did not reflect documented evidence of a weekly NJ Ex Order 26. obtained after NJ Ex Order 26.4 On 6/30/22 at 11:16 AM, the surveyor interviewed LPN #2 in the presence of a second surveyor. He stated that the U.S. FO reviewed the weights and that he did not calculate significant weight losses. He	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 692	Continued From page 52	F 692		

stated that if a resident lost three pounds in a week, he would notify the [redacted] and the physician. LPN #2 stated that he notified the [redacted] if a resident was refusing to be weighed or was eating poorly. He also stated that the subacute residents, which were the residents on his unit, were weighed weekly.

Review of a typed document from the [redacted] dated [redacted] and provided to the surveyor on 7/1/22 at 8:51 AM from the [redacted] reflected the following:

"On Ex Order 26.4B1 the resident had a [redacted] of [redacted] or [redacted] the resident [redacted] that is a total [redacted] of [redacted]. on [redacted] the resident's [redacted]. which is [redacted] from the [redacted] of 4 [redacted]. On [redacted] the resident's [redacted] was [redacted] which was a loss of [redacted] from [redacted]. The resident was not flagged for a significant [redacted] as he/she did not have a [redacted] in a 30-day span. On the resident's readmission I wrote a note that mentioned a [redacted] of [redacted] (technically was only [redacted] but that [redacted] was not experienced over a 30-day period. When I wrote the note it was not my intention to say that he/she experienced a Ex Order 26.4B1, rather I was giving a brief summary of Ex Order 26.4B1

Review of an additional typed document from the [redacted] dated [redacted] and provided to the surveyor on 7/1/22 at 8:51 AM from the [redacted] reflected the following:

"Calculated [redacted] requirement: the resident is [redacted], and [his/her] [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 692	Continued From page 53 NJ Ex Order 26.4(b); The National Institutes of Health (NIH) now defines NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b) according to NJ Ex Ord rather than the traditional NJ Ex Order 26.4(b)(1) in calculation [his/her] daily NJ Ex Order 26.4(b)(1) needs NJ Ex Order 26.4(b)(1) / NJ Ex Order 26.4(b)(1) was utilized on [his/her] readmission NJ Ex Order 26.4(b) assessment." Review of the facility policy Diet Identification and Preference Ticket with a revised date of 12/6/21, included that tray tickets were used to properly identify each individuals prescribed diet, food preferences, dislikes ...etc. It further reflected that FSD, or designee was responsible for keeping the tray ticket information up to date. Review of an undated policy provided by the facility titled Significant Weight Loss, included that the goal of medical nutrition therapy for significant unintended weight loss was to identify underlying causes and factors and intervene as appropriate to resolve the problem and stabilize the weight. It identified significant weight loss as 5% in 1 month, 7.5% in 3 months and 10% in 6 months. If further identified severe weight loss as >5% in 1 month, >7.5% in 3 months and >10% in 6 months. It reflected to reweigh the resident to assure an accurate weight. It reflected to review the resident's food intake records to estimate the average percentage of food/fluid intake in the past two to four weeks. It reflected to document the resident's estimated nutritional needs (calories, protein and fluid) versus estimated food/fluid intake (utilizing food intake records). The policy also reflected to interview the resident to identify possible causes and to determine appropriate nutrition interventions as well as to	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 692	Continued From page 54	F 692		

implement nutrition interventions based on the resident's food and beverage preferences. It reflected to place the resident on weekly weights for one month and to monitor the weights weekly. The policy further reflected to monitor and evaluate to assess the effectiveness of the intervention, alter interventions as needed and complete follow-up documentation as needed.

Review of the facility policy Weights Policy dated 5/25/22, included that residents would be weighed within 24 hours upon admission, readmission and on a monthly basis. It reflected that weight deviations of five pounds from the previous month will be confirmed with a reweigh with nursing supervision. If confirmed a Dietary Alert Sheet will be initiated and forwarded to the RD. Weights will be recorded by nursing staff in the weight book and transcribed to the EMR.

Review of an undated facility policy Recording Percent of Meal Consumption included that staff would document the percentage of each meal consumed for an individual on a daily basis and data would be recorded in the CNA accountability log.

Review of an undated facility policy Interdisciplinary Care Planning Policy and Procedures included that individualized interdisciplinary interventions will be planned by each discipline to correct problems identified. It reflected that a minimum of quarterly each resident's progress will be evaluated and documented. It reflected that problems not resolved will be reevaluated and new interventions established as necessary. In the interim between quarterly assessments, any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 692	Continued From page 55 significant changes in a resident's condition will be reviewed by the interdisciplinary team. Since the care plan is a dynamic document, in the interim between quarterly reviews, the team must revise problems, goals, and interventions in response to changes in the needs of residents. The [redacted] provided a typed document with a list of resources she used for clinical guidance which included the following: Nutrition Care of the Older Adult: A handbook for nutrition throughout the continuum of care, 3rd Edition. Academy of Nutrition and Dietetics. Becky Dorner - Diet and Nutrition Care Manual. Dietitian in Health Care Facilities - Zoll. Essential Pocket Guide for Clinical Nutrition. The Diet Manual - A nutritional handbook training guide. Additional resources referenced: Review of the Nutrition Care Manual from the Academy of Nutrition and Dietetics: "Body Mass Index (BMI) is a ratio of weight to height and is used as an estimate of body fat in the healthy population." "As with any other diagnostic tool, BMI should be evaluated in conjunction with other information related to the patient's health status." Review of the Becky Dorner & Associates Diet and Nutrition Care Manual: A Comprehensive Nutrition Care Guide with a copyright date of 2021 reflected the following: Malnutrition is a broad term often used to describe patients who appear to have	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 692	Continued From page 56 compromised nutritional status, poor intake and unintended weight loss. Malnutrition is associated with many adverse outcomes, including loss of function, decreased quality of life, and increased mortality. Loss of lean body mass may also be an additional consequence. Nutrition screening, assessment, and early nutrition intervention can reduce these complications. "Unintended weight loss (UWL) is a decrease in body weight that is not planned or desired. It is one criterion used to diagnose malnutrition and can have profound consequences for older adults. Studies indicate that UWL can lead to a decreased ability to fight infection, poor wound healing, risk of pressure injuries, weakness, and decline in ability to function independently. It can be significant or severe ... or slow and insidious (gradual unintended weight loss over time). Both types of UWL should be addressed. To prevent negative clinical outcomes, it is essential that individuals at risk for or with UWL are identified. Nutrition assessment, intervention, monitoring and evaluation can help prevent and/or treat UWL." Review of The Essential Pocket Guide for Clinical Nutrition, Third Edition with a copyright date of 2021, reflected that energy (calorie) requirements based on kilocalories per kilogram of body weight (kcal/kg) under "Normal" conditions should be 25-30, under "Mild Stress" conditions 30-35 and under "Moderate to Severe Stress" conditions 35-45. NJAC 8:39-17.2(c), 17.4(a)(1), 27.1(a), 27.2(a)(e)	F 692		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		8/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 695	Continued From page 57 § 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 a.) maintain the necessary [NJ Ex Order 26.4(b)(1)] and services for a resident who was receiving [NJ Ex Order 26.4(b)(1)] for 2 of 3 residents (Resident#22 and #338) and b.) ensure that [NJ Exec Order 26.4b1] care and services were provided according to the standard of practice for 1 of 1 resident (Resident#76) reviewed for [NJ Exec Order 26.4b1] care. This deficient practice was evidenced by the following: According to the U.S. CDC (Centers for Disease Control and Prevention) Guidelines for Preventing Health-Care-Associated Pneumonia, Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee, dated 3/26/2004, included, "III. Prevention of Transmission of Microorganisms ...B. Prevention of Person-to-Person Transmission of Bacteria..1. Standard Precautions a. Hand hygiene: Decontaminate hands by washing them with either antimicrobial soap and water or with nonantimicrobial soap and water (if hands are	F 695	F695 - Respiratory/Tracheostomy Care and Suctioning 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: -On [NJ Ex Order 26.4(b)] [NJ Exec Order 26.4b1] for Resident (#22) was immediately changed and labeled/dated. Physician orders and the plan of care were reviewed. -On [NJ Ex Order 26.4(b)], Resident (#338) was assessed with no concerns noted. Physician orders and the plan of care were reviewed. On [NJ Ex Order 26.4(b)(1)], order to [ ] weekly and as needed was scheduled/transcribed to populate on the electronic treatment administration record. -On [NJ Ex Order 26.4(b)], a registered nurse assessed Resident (#76) [NJ Ex Order 26.4(b)(1)] status and performed an overall assessment. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 695	Continued From page 58 visibly dirty or contaminated with proteinaceous material or are soiled with blood or body fluids) or by using an alcohol-based waterless antiseptic agent (e.g., hand rub) if hands are not visibly soiled after contact with mucous membranes, respiratory secretions, or objects contaminated with respiratory secretions, whether or not gloves are worn. Decontaminate hands as described previously before and after contact with a patient who has an endotracheal or tracheostomy tube in place, and before and after contact with any respiratory device that is used on the patient, whether or not gloves are worn. b. Gloving 1) Wear gloves for handling respiratory secretions or objects contaminated with respiratory secretions of any patient. 2) Change gloves and decontaminate hands as described previously between contacts with different patients; after handling respiratory secretions or objects contaminated with secretions from one patient and before contact with another patient, object, or environmental surface; and between contacts with a contaminated body site and the respiratory tract of, or respiratory device on, the same patient." According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers for Hand Hygiene and COVID-19, page last reviewed 1/8/2021 included, "Hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom. Immediately after glove removal." 1. On 6/20/22 at 10:38 AM, the surveyor observed Resident # 22 lying in bed with [redacted]	F 695	resident was noted to be in [redacted] condition. Physician orders and the plan of care were reviewed. On [redacted] a physician's order was received to perform [redacted] care and [redacted] The resident's plan of care was updated as appropriate. -On 6/29/22, LPN (#3) was re-educated by the DON on the components of this regulation with an emphasis on labeling and dating respiratory tubing/equipment. -On 6/29/22, LPN (#1) and LPN (#2) was re-educated by the DON on the components of this regulation with an emphasis on following physician's orders related to the administration of oxygen. -On 6/29/22, LPN (#4) was reeducated by the DON on the components of this regulation with an emphasis on validating the physicians order prior to carrying out a treatment, maintaining infection control practices related to tracheostomy care, and signing off on the electronic treatment administration record once completed. Tracheostomy care competency was reviewed with LPN (#4) by the Director of Nursing/designee and carried out with a return demonstration conducted. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 695	Continued From page 59 Ex Order 26.4B1 not labeled or dated attached to the Ex Order 26.4B1 (type of Ex Order 26.4B1 s) with Ex Order 26.4B1 bottle (Ex Order 26.4B1 commonly used, because the Ex Order 26.4B1 used is a NJ Ex O and NJ Ex Order 26.4(b)(1) that, if Ex Order 26.4B1, causes of the Ex Order 26.4B1). On 6/27/22 at 11:14 AM, the surveyor interviewed the staff Licensed Practical Nurse#3 (LPN#3) who stated, "if Ex Order 26.4B1 is not dated we are supposed to change it, but we prioritize med's and direct care is more important. The night shift signs the Ex Order 26.4B1 bottle changes on Wednesdays which is a generated task on the Medication Review Record (MAR). There is no NJ Exec Order 26.4b1 currently in the facility." On 6/28/22 11:39 AM, the surveyor interviewed, the U.S. FOIA (b) (6) who stated, NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 is changed on the 11 pm-7 am shift, there is no specific day the task is assigned. The NJ Ex Order 26 and NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) should be labeled and dated. The NJ Ex Order 26.4(b)(1) treatment NJ Ex Order 26 gets changed daily, NJ Ex Order 2 gets rinsed, dried, and put in a bag and that is dated and labeled." On 6/28/22 at 1:00 PM, the surveyor interviewed, the NJ Exec Order 26.4b1) in the presence of another surveyor. The U.S. FOIA (b)(stated, "the nurse on the 11 pm-7 am, Tuesday night going into Wednesday will change the NJ Ex Order 26 and NJ Ex Order 26.4(b)(1) and label and date it." The further described infection control practices for NJ Ex Order 26.4(b)(1) care, and further stated, "the nurse changes the NJ Ex Order 26 weekly and label and date it,	F 695	-All residents have the potential to be affected by this practice. -By 08/05/2022, the Director of Nursing/ designee will conduct an audit of active residents who have a tracheostomy to ensure tracheostomy care/suctioning orders were in place. Plan of care updated as appropriate. -By 08/05/2022 the Director of Nursing/ designee will conduct an observational audit of active residents receiving oxygen therapy to ensure oxygen tubing and humidification has been appropriately and timely changed and dated with orders in place and populated onto the electronic treatment administration record. By 08/05/22, the Director of Nursing/ designee will carry out tracheostomy care competencies with licensed nurses to ensure infection control practices were being carried out. Any concerns identified were immediately addressed. 3. What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur: By 08/05/2022, the DON/ designee will re-educate licensed nursing staff on the components of this regulation with emphasis on:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 695	Continued From page 60 all equipment should have a tag stating the date, time, and nursing initials that changed it, nurses on every shift are responsible to make rounds on their residents checking the tubing for a label and date." The surveyor reviewed the medical records for resident #22. Review of the Admission Record revealed a diagnosis of EX Order 26.4B1 following EX Order 26.4B1, (EX Order 26.4B1 (EX Order 26.4B1EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1) A review of the Annual Minimum Data Set (MDS) dated EX Order 26.4B1 reflected that the resident's EX Order 26.4B1 Skills for Daily Decision Making was EX Order 26.4B1. A review of the Care Plan dated EX Order 26.4B1, and revised on EX Order 26.4B1, indicated a focus area was that the resident was on EX Order 26.4B1 and EX Order 26.4B1 related to EX Order 26.4B1 illness.	F 695	• Ensuring oxygen tubing and humidification is changed and dated appropriately and timely for residents requiring oxygen therapy with physician's order in place • Following physician orders related to liter flow of oxygen • Electronic treatment administration record signed after treatment • Infection control practices during tracheostomy care is being carried out per the standard of practice with orders to reflect tracheostomy care/suctioning • Plan of care related to respiratory therapy Newly hired licensed nurses will receive education during orientation. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: -The Director of Nursing /designee will conduct a weekly audit x4 weeks and then every 2 weeks x2 months to ensure: • Residents receiving oxygen therapy have had their oxygen tubing and humidification changed appropriately and timely, physician orders are in place, observation review reflects the resident's current oxygen flow rate per physician's orders and the plan of care updated as appropriate • Residents who have a tracheostomy have orders to reflect tracheostomy	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 695	Continued From page 61 A review of the [redacted] Order Summary Report (OSR) reflected a physician order (PO) dated [redacted] to "[redacted] bottle weekly, label with date and time every night shift Wednesday for infection control." A further review of the [redacted] Order Summary Report reflected a PO dated [redacted] "change [redacted] or [redacted] every Wednesday for infection purposes." The PO did not specify to label and date the [redacted] A review of the [redacted] electronic Medication Administration Record (eMAR) revealed "change [redacted] weekly, label with date and time every night shift Wednesday for protocol/ infection control dated [redacted]" The eMAR did not specify to label and date the [redacted] 2. On 6/21/22 at 12:01 PM, the surveyor observed Resident# 338 laying in bed with [redacted] with use [redacted] attached to the [redacted] with [redacted]. The surveyor asked the resident how he/she was and the resident stated [redacted] On 6/23/22 at 8:34 AM, the surveyor observed the resident on [redacted] via [redacted]. The surveyor reviewed the medical record of Resident#338.	F 695	care/suctioning, staff are maintaining infection control practices during tracheostomy care/suctioning and the plan of care is updated as appropriate -The findings of these audits will be reported to the Quality Assurance/meeting monthly and present at QAPI quarterly until committee feels substantial compliance has been met and recommends moving to quarterly monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 695	Continued From page 62 According to the Admission Summary, the resident was admitted to the facility with diagnoses that included EX Order 26.4B1 [redacted]. Review of the NJ Ex Order 26.4(b) Comprehensive Minimum Data Set (CMDS), revealed a BIMS score was Ex Ord out of 15, which indicated that the resident's EX Order 26.4B1. The CMDS noted that the resident was on EX Order 26.4B1. Review of the Ex Order 26.4B1 OSR revealed an order dated NJ Ex Order 26.4(b), for EX Order 26.4B1) via EX Order 26.4B1 every shift for NJ Ex Orde EX Order 26.4B1 [redacted]. The above order for [redacted] was not transcribed to the Ex Order 26.4B1 eMAR or electronic Treatment Administration Record (eTAR). Further review of the NJ Ex Order 26.4(b)(1) OSR showed that there was no order for Ex Order 26.4B1 change and care. Review of the personalized care plan revealed a focus area for Ex Order 26.4B1 therapy r/t [related to] Ex Order 26.4B1 [redacted] plan did not include interventions on how often the NJ Ex Order 26.4(Ex Order 26.4B1 [redacted]. [redacted] the surveyor interviewed the U.S. FOIA (b)(6) [redacted] who stated that the Ex Order 26.4B1 order should be followed. On 6/29/22 at 10:32 AM, the surveyor in the	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 695	Continued From page 63	F 695		

presence of another surveyor interviewed the Licensed Practical Nurse #1 (LPN#1) who stated that Resident#338 was Ex Order 26.4B1 required NJ Ex Order 26.4(b)(1) assistance with activities of daily living (ADL), and was on Ex Order 26.4B1 Ex Order 26.4B1 The LPN#1 further stated that there should be an order for Ex Order 26.4B1 and accountability for Ex Order 26.4B1 change in the eMAR or eTAR signed by nurses. She also stated that the 11-7 shift nurse was responsible for changing the Ex Order 26.4B1 once a week.

A short time later, the surveyor asked the LPN#1 to go to the resident's room to show the surveyor how much Ex Order 26.4B1 the resident was receiving. In the resident's room, the LPN#1 checked the Ex Order 26.4B1 and showed it to the surveyor. The LPN#1 stated that the Ex Order 26.4B and that the "resident was on Ex Order 26.4B1 right now." The resident was NJ Ex Order 26 and did not NJ Ex Order 26.4(b)(1 to the nurse.

On that same date and time, the surveyor and the LPN#1 went back to the nursing station and reviewed the Ex Order 26.4B1 order for Resident#338. The LPN#1 then checked the eMAR and eTAR, and stated 'Ex Order 26.4B1 She further stated that "the order was not flagged," which was why the Ex Order 26.4B1 order was not transcribed to either the eMAR or eTAR. The LPN#1 indicated that there was no order for Ex Order 26.4B1 change once a week and "I'm fixing the order now." The LPN#1 stated that there was no negative effect on the resident and she showed the surveyor that nurses have been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 695	Continued From page 64 documenting the Ex Order 26.4B1 [redacted] in the medical record which indicated that the Ex Order 26.4B1 [redacted]. On 6/29/22 at 2:05 PM, the surveyor interviewed LPN#2 who stated that Ex Order 26.4B1 [redacted] and when I came in today at 7 AM, as ordered." The surveyor informed LPN#2 of the Ex Order 26.4B1 order. LPN#2 then stated, "I thought the order was for Ex Order 26.4B1 On 6/29/22 at 02:26 PM, the survey team met with the U.S. FOIA (b)(6) [redacted] and were made aware of the above concerns. On 7/01/22 at 10:43 AM, the survey team met with the U.S. FOIA (b)(6) [redacted]. The U.S. FOIA (b)(6) [redacted] informed the survey team that there was no additional information. 3. On 6/23/22 at 1:31 PM, the surveyor observed Resident #76 in a Ex Order 2 [redacted] chair recliner awake, however, did [redacted] to the surveyor's inquiries. The resident had a Ex Order 26.4B1 and a Ex Order 26.4B1 Ex Order 26.4B [redacted]) mask attached to a Ex Order 26.4B1 [redacted] that was set at Ex Order 26 [redacted]. The resident had no signs and Ex Order 26.4B1 [redacted]. On 6/27/22 at 9:16 AM, the surveyor reviewed	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 695	Continued From page 65 the NJ Ex Order 26.4(b)(1) eTAR which reflected a physician's order to change the Ex Order 26.4B1 Ex Order 26.4B1 weekly one time a day, every Monday. A further review of the eTAR did not reflect a physician's order for NJ Exec Order care and NJ Exec Order 26.4B1 On 6/27/22 at 11:35 AM, the surveyor observed LPN#4 performed a treatment to change Ex Order 26.4B1 in the presence of another surveyor. The resident was lying on a Ex Order 26 chair Ex Order 26.4B1 awake but , and with no signs and symptoms of . The surveyor observed a bedside table covered with a white linen cloth that was already set up with Ex Order 26.4B1 supply kits, two unopened bottles of Ex Order 26.4B1, several individual packs of sterile dressings (gauzes), a black marker, and tape. LPN#4 started by closing the resident's door for privacy which he then proceeded to perform appropriate hand hygiene and explained the procedure to the resident. The surveyor did not observe LPN#4 review the physician's orders prior to starting the procedure. Next, he donned (put on) a pair of sterile gloves using the sterile glove technique, but he tore his right glove in the process. He doffed (removed) the gloves and proceeded to apply new sterile gloves grasping the inside surface of the cuff of the glove. The surveyor did not observe LPN#4 performed hand hygiene after doffing the ripped gloves and before donning a new pair of sterile gloves. At that same time, the surveyor observed a nightstand drawer in the resident's room that was currently being utilized for the storage of the Ex Order 26.4B1 and Ex Order 26.4B1 supplies,	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 695		F 695		

Continued From page 66

including Ex Order 26.4B1 .

After the completion of the Ex Order 26.4B1 change treatment, LPN#4 utilized paper towels to pick up the unopened sterile NJ Ex Order 26.4(b)(1) bottle, several unopened sterile dressings, black marker, and tape from the bedside table and transferred them to the top of the resident's nightstand drawer, where the NJ Ex Order supplies were stored. The surveyor did not observe LPN#4 performed hand hygiene.

At approximately 12:17 PM, LPN#4 stated that he finished the procedure and informed the surveyor that he was done with the treatment. The surveyor asked LPN#4 if there was anything else he needed to do and he responded "no, I'm done." The surveyors did not observe LPN#4 sign the eTAR for the Ex Order 26.4B1 change.

On that same date at 12:43 PM, the surveyors interviewed LPN#4 in the presence of the survey team. He stated that before performing the treatment, the physician's orders should have been reviewed. He acknowledged that he did not review the physician's order before performing the Ex Order 26.4B1 change procedure. Furthermore, he stated that he should have read and reviewed the physician's order before performing the treatment to the resident.

During the interview, he informed the surveyors that he realized that there was no physician's order for Ex Order 26.4B care and stated, "I thought there was an order" for Ex Order 26.4B1 care. He stated that there should have been a physician's order for [redacted] and stated, "it was overlooked." He informed the surveyors that the physician's order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 695	Continued From page 67	F 695		

for [redacted] was "only obtained today."

In that same interview, LPN#4 stated that he was supposed to sign the eTAR "right after" he performed the [redacted] change procedure. He acknowledged that he did not sign the eTAR after performing the procedure in the presence of the surveyors.

At that same time, LPN#4 informed the surveyors that hand washing was required "every time" before donning and after doffing gloves. He stated that the resident's personal [redacted] care supplies that were stored on top of the nightstand drawer were "clean." He also referred to the bedside table as the "dirty area" after he used it to perform the treatment. He acknowledged that he took the unopened and unused supplies that were on the bedside table and transferred them to the resident's top nightstand drawer. He also acknowledged that the unused supplies were transferred using paper towels, without using gloves, and without performing hand washing afterwards.

On 6/29/22 at 10:27 AM, the surveyor interviewed the [redacted] in the presence of another surveyor. She stated that residents with [redacted] needed [redacted] care and [redacted] to ensure that they were receiving appropriate treatment and care. Furthermore, she acknowledged that [redacted] care and [redacted] orders required physician orders. However, the [redacted] could not speak to why there was no physician orders for [redacted] and [redacted] for Resident #76 and stated, "I don't know what happened."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 695	Continued From page 68 On that same date at 10:44 AM, the surveyor interviewed the Licensed Practical Nurse #1 (LPN#1). She acknowledged that Resident #76 had multiple readmissions to the facility following hospitalizations on Ex Order 26.4B1. She also acknowledged that the Ex Order 26 care and Ex Order 26.4B1 required physician's orders. She confirmed that there was no physician's orders or documented evidence for Ex Order 26.4B care and Ex Order 26.4B1 in the eTAR since the resident's readmission to the facility since . The LPN#1 could not speak to why the care and Ex Order 26.4B1 were not ordered after each readmission. She informed the surveyors that the physician's orders for Ex Order 26 care and Ex Order 26.4B1 was obtained on NJ Exec Order 26.4b On that same date at 12:20 PM, the U.S. FOIA (b) stated in the presence of the survey team that a resident with a U.S. FOIA (b)(6) should have physician's orders for NJ Ex Order care and NJ Ex Order 26.4(b)(1) PRN [as needed] upon admission to the facility. The U.S. FOIA (b) could not speak to why there was no physician's orders for U.S. FOIA (b)(6) care and NJ Ex Order 26.4(b)(1) upon the resident's readmissions to the facility. On 7/1/22 at 10:43 AM, the survey team met with the administrative team. No further information was provided. The surveyor reviewed the hybrid medical record for Resident #76. Review of the electronic Progress Notes dated reflected Physicians notes that documented medical diagnoses which included but were not limited to EX Order 26.4B1	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 695	Continued From page 69	F 695		

EX Order 26.4B1 [redacted]

Review of the Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] indicated that the EX Order 26.4B1 for daily decision making for the resident was EX Order 26.4B1. The assessment reflected that the resident was [redacted] on staff seven days a week for all care and required [redacted] of one to two person assistance with care.

Review of the electronic Progress Notes dated EX Order 26.4B1, reflected that the resident was readmitted to the facility.

Review of the Universal Transfer Form (a form that communicates pertinent clinical patient care information at the time of a transfer between health care facilities) indicated that the resident was also readmitted to the facility following a hospitalization on [redacted].

Review of the [redacted] eTARs, indicated no documented evidence of physician's orders and accountability for EX Order 26.4B1 EX Order 26.4B1.

Review of the NJ Ex Order 26.4(b)(1) [redacted] electronic Skilled Charting reflected that the resident was provided with EX Order 26.4B1. Furthermore, there was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 695	Continued From page 70 no documented evidence that an assessment was performed on how the resident tolerated the procedure after providing the EX Order 26.4B1 care. Review of the electronic Progress Notes for U.S. FOIA (b) reflected no documented evidence that an assessment of how the resident tolerated the procedure after performing EX Order 26.4B1 care on the above corresponding dates. Further review of the electronic Progress Notes reflected the following Health Status Notes: - NJ Ex Order 26.4(b) at 04:46 AM, indicated that the resident was ' NJ Ex Order 26.4(b)(1) - NJ Ex Order 26.4(b) at 00:03 reflected U.S. FOIA (b)(6) U.S. FOIA (b)(6) from EX Order 26.4B1 , NJ Ex Order 26.4(b)(1) applied." - NJ Ex Order 26.4(b) at 01:40 indicated that ' EX Order 26.4 was NJ Ex Order 26.4(b)(1) There was no evidence of a physician order for the NJ Ex Order 26.4(b)(1) of the EX Order 26.4B1 Review of the facility's EX Order 26.4B1 NJ Ex Order 26.4(b)(1) form that was utilized and completed for staff competency reflected steps that included "Verifies physician's order." The facility's EX Order 26.4B1 Care procedure guidelines reflected that the purpose of EX Order 26.4B1 care was to maintain clean and patent NJ Ex Order 26.4(b)(1) It also indicated that it should be done according to the physician's orders. The facility policy for Handwashing reflected to wash hands after removing gloves, "after handling soiled ....tissues", and upon completion of duty.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 695	Continued From page 71 The facility policy and procedure for EX Order 26.4B1 Care, reviewed on EX Order 26.4B1 reflected that when concluding EX Order 26.4B1 care, it was indicated to properly clean or dispose of all equipment, supplies, solutions, and trash. It was also specified to repeat the EX Order 26 care procedure at least once every 8 hours and to document the resident's tolerance of the treatment. NJAC 8:39-25.2 (b), (c) 4	F 695		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 758		7/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 758	Continued From page 72 contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to provide a documented clinical rationale for the reason that "as needed" (PRN) NJ Ex Order 26.4(b)(1) medications, including EX Order 26.4B1 were prescribed for greater than EX Orde days. This deficient practice was identified for 1 of 5 residents (Resident #67), reviewed for unnecessary medications and was evidenced by the following: On 6/21/22 at 11:00 AM, the surveyor observed	F 758	F758 - Free from Unnecessary Psychotropic Meds/PRN Use 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: -On 06/29/22, the physician for Resident (#67) was contacted to review the EX Order 26.4B1 medication use. Recommendations received to continue EX Order 26.4B1 every EX Orde hours PRN for EX Orde more days and then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 758	Continued From page 73 Resident #67 walking in hallway NJ Ex Order 26.4(b)(1) with no need for an NJ Ex Order 26.4(b)(1). Resident #67 called the surveyor [redacted]" while passing by. The resident was wearing a EX Order 26.4B1 on the EX Order 26.4B1. The surveyor observed that the resident wore this NJ Ex Order 26.4(b)(1) on all survey days. Resident #67 then sat in a chair in the dayroom near the surveyor and began talking to the surveyor in EX Order 26.4B1. On 6/23/22 at 11:26 AM, the surveyor observed Resident # 67 EX Order 26.4B1 around the dayroom. The resident spoke to the surveyor in EX Order 26.4B1. When the surveyor stated that she only NJ Ex Order 26.4(b)(1), the resident stated, EX Order 26.4B1 " Then Resident #67 EX Order 26.4B1 to EX Order 26.4B1 in the room and saying something in EX Order 26.4B1. He/she also pointed and spoke to another resident in the room, who did not respond. On 6/23/22 at 11:35 AM, the surveyor observed Resident #67 return to the dayroom and continued EX Order 26.4B1, EX Order 26.4B1 EX Order 26.4B1 On 6/23/22 at 11:45 AM, the surveyor interviewed Licensed Practical Nurse #1 (LPN#1), who stated that the staff try to observe Resident #67 "from a distance." LPN #1 further stated that Resident #67 would get EX Order 26.4B1 if the staff NJ Ex Order 26.4(b) the resident. LPN #1 also stated that they had to send the resident EX Order 26.4B1. He explained that they try to let Resident #67 just walk through the hallways and observe to make sure he/she doesn't bother any other residents. LPN #1 also stated that the resident's significant other visits frequently and then Resident #67	F 758	re-evaluate. Further recommendations included the discontinuation of the order for EX Order 26.4B1 to be discontinued. -On 6/29/2022, the facility U.S. FOIA (b)(6) [redacted] was reeducated on the components of this regulation with an emphasis on documentation to reflect the necessity/rationale of the PRN psychotropic med use beyond the initial 14-day prescription. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: -By 07/28/22, the U.S. FOIA (b)(6) [redacted] audited active residents to ensure 14-day stop dates were present for PRN EX Order 26.4B1 medications initially ordered. If a new order to extend beyond the 14 days is carried out, the physician's necessity/rationale was present in the medical record. Any concerns identified were immediately addressed. 3. What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur: -By 07/28/22, the U.S. FOIA (b)(6) [redacted] re-educated the licensed nursing staff on the components of F758 Free of unnecessary	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 758	Continued From page 74 calms down. LPN #1 stated that staff don't always understand his/her [redacted] On 6/27/22 at 11:49 AM, the surveyor observed Resident #67 seated at a table in the dayroom, speaking loudly in [redacted] with [redacted]. A staff member set up the lunch tray for Resident #67 and the resident began eating a sandwich independently and remained quiet while eating. The resident's roommate was seated at the same table and both residents remained [redacted] throughout the meal. On 6/27/22 at 12:58 PM, the surveyor observed Resident #67 make two attempts to [redacted]. One staff member stated that the [redacted] would make the resident stop trying to [redacted]. After the second try, Resident #67 stopped attempting to [redacted] On 6/28/22 at 10:45 AM, the surveyor observed Resident #67 [redacted] through the hallway. The resident occasionally stepped into another resident's room, then came right out. Resident #67 stated to the surveyor, [redacted]" The surveyor reported this to LPN #1 and the [redacted], who arranged to have a sandwich brought to Resident #67. On 6/29/22 at 10:50 AM, two surveyors observed Resident #67 approach the nurse's station [redacted] in [redacted] LPN #3 redirected the resident. LPN #2 spoke softly to Resident #67, who then [redacted] the resident down. LPN #2 redirected the resident to the dayroom, where he/she [redacted] ate lunch.	F 758	psychotropic meds with emphasis on ensuring residents on PRN psychotropic medications have a 14-day stop date for the initial order until evaluated by the practitioner and ordered to continue beyond the initial 14-day stop date with necessity/rationale included in the medical record. -Newly hired licensed nurses will receive education during orientation. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: -The Director of Nursing /designee will conduct a weekly audit x4 weeks and then every 2 weeks x2 months to ensure residents on PRN psychotropic medications have a 14 day stop date for the initial order until evaluated by the practitioner and ordered to continue beyond the initial 14-day stop date with necessity/rationale included in the medical record. -The findings of these audits will be reported to the QA meeting monthly until committee determines substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 758	Continued From page 75 The surveyor reviewed the hybrid medical record for Resident # 67. According to the Admission Record, Resident #67 was admitted a few months prior to the survey with diagnoses that included, but was not limited to unspecified EX Order 26.4B1 not due to a substance or known EX Order 26.4B1 [redacted]. Review of the Significant Change Minimum Data Set (MDS), an assessment tool dated [redacted] indicated that Resident #67 had a Brief Interview for Mental Status score of [redacted] out of 15, which indicated the resident's EX Order 26.4B1 EX Order 26.4B1. The MDS further indicated that Resident #67 displayed no EX Order 26.4B1 including EX Order 26.4B1, EX Order 26.4B1, EX Order 26.4B1 or EX Order 26.4B1. Section E of the MDS also reflected that Resident #67 displayed no NJ Ex Order 26.4(b) or NJ Ex Order 26 symptoms directed towards NJ Ex Order 26.4(b)(1). A review of the resident's [redacted] Order Summary Report (OSR) included the following physician's orders for EX Order 26.4B1 Tablets and EX Order 26.4B1 dated EX Order 26.4B1 1. EX Order 26.4B1 Give [redacted] tablet by mouth (PO) every [redacted] hours as needed for increased EX Order 26.4B1, if initial dose is ineffective give this dose one hour after initial PRN dose if EX Order 26.4B1 persists. Further review of the order revealed the order did not contain a EX Order 26.4B1 duration.	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 758		F 758		

Continued From page 76

2. EX Order 26.4B1 l Apply EX Order 26.4B1 EX Order 26.4B1 every EX Order hours as needed if resident EX Order 26.4B1. Maximum dose of all formulations is EX Order 26.4B1 hours every EX Order hours as needed for EX Order 26.4B1 EX Order 26.4B1 of PO dosing. Only use if resident refuses PO dosing, maximum dose/24 hours is NJ Ex Order 2 Further review of the order revealed the order did not contain a EX Orde day duration.

A review of the U.S. FOIA (b) (6)) EX Order 26.4B1 Suggestions, dated , included that following statement:

"A duration must be specified for PRN EX Order 26.4B1 medications. First order is limited to only EX Orde days, but if rationale documented by prescriber to continue order, then next duration may be for longer, i.e. EX Order 26.4B1 days. Please update order for EX Order 26.4B1 per CMS regulations."

The resident's physician who had ordered the EX Order 26.4B1 for Resident #67 signed the U.S. FO suggestion form as "Accepted" on EX Order 26.4B1 with a hand-written notation next to the suggestion, "As per EX Order 26.4B1 Notes."

A review of the EX Order 26.4B1 Progress Note, written on EX Order 26.4B1 included the following plan for resident #67:
"Discontinue EX Order 26.4B1 ..Start EX Order 26.4B1 PO every 12 hours PRN x 14 Days..EX Order 26.4B1 apply EX Order 26.4B1 every 12 hours PRN, only if refused PO EX Order 26.4B1

The EX Order 26.4B1 indicated to stop the PRN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 758	Continued From page 77	F 758		

medications in 14 days, the OSR did not indicate a stop date. Fourteen days past the original physician's order of EX Order 26.4B1 would reflect a stop date of EX Order 26.4B1. The resident received NJ Ex doses of either EX Order 26.4B1 after the stop date suggested by the pharmacist and the EX Order 26.4B1 as evidenced by the following:

Review of the NJ Ex Order 26.4(b)(1) Medication Administration Reports (eMAR) reflected that Resident #67 received EX Order 26.4B1 by mouth on the following dates and times:

- EX Order 26.4B1

The eMAR for EX Order 26.4B1 indicated that Resident #67 received EX Order 26.4B1 EX Order 26.4B1 on the following dates and times:

- EX Order 26.4B1

On 6/29/22 at 10:47 AM, two surveyors interviewed LPN #2 who stated that she had worked at the facility for NJ Ex Order 26.4(b)(1). When asked about the process for giving EX Order 26.4B1 medication, LPN #2 stated, "See that they (residents) display EX Order 26.4B1 such as EX Order 26.4B1, EX Order 26.4B1, etc. Follow the doctor's order. Check the last time they had the medication. Check the day the order began and if it is discontinued."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 758	Continued From page 78 On 6/29/22 at 10:55 AM, two surveyors interviewed LPN #3, who stated that she had been employed at the facility for [redacted]. The LPN knew Resident #67 well and stated that the resident "can get EX Order 26.4B1. They changed...from Ex Order 26.4B1 so we can give...the EX Order 26.4B1." LPN #3 explained that they needed a way to [redacted] the resident if he/she was not willing to take medication [redacted]. She stated that the resident's medications "were tweaked a little bit" and Resident #67 "shows some improvement." She stated that the original dose of [redacted] was decreased and the EX Order 26.4B1 was following the resident. LPN #3 and the two surveyors observed the electronic Physicians Orders, which indicated that PRN [redacted] EX Order 26.4B1 were started on 5/26/22, and an end date indicating '[redacted]." The surveyors referred to the CP recommendation to reevaluate the PRN [redacted] orders after 14 days, but could be continued for longer if the prescriber documents a reason to continue the medication. The surveyors also pointed out that the EX Order 26.4B1 note indicated '[redacted] x 14 days." LPN #3 stated that Resident #67 "has [redacted]...can be different each day..we do the best we can to keep...all residents and the staff safe." When asked about what happens to the CP recommendations, LPN #3 stated that they were shared with the [redacted]. "It would have been sent to her and she shares them." On 6/29/22 at 11:06 AM, two surveyors interviewed the U.S. FOIA (b)(6)) regarding the [redacted] recommendation to have a stop date on the PRN [redacted] orders.	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 758	Continued From page 79	F 758		

The [U.S. FO] stated that the medication should be re-evaluated in 14 days but, "We write [EX Order 26.4B1], because of resident's continued [NJ Ex Order 26.4(b)(1)] and because of recommendations from [redacted] to continue the medications. The nurses notes reflect the continued [NJ Ex Order 26.4(b)(1)] of the resident and the need to continue the [redacted]." The [U.S. FO] stated that the [U.S. FO] wrote about several [NJ Ex Order 26.4(b)(1)] incidents in [NJ Ex Order 2] The surveyors brought to the [U.S. FOIA (] attention the [EX Order 26.4B1] note indicating [EX Order 2...] x [NJ Ex] days. In response, the [U.S. FO] stated, "Yes...should re-evaluate in 14 days and document resident's [NJ Ex Order 26.4(b)(] and reason for continuing the medication past 14 days. Should have an end date and if need to continue should write a new start date. Understood."

On 6/29/22 at 11:47 PM, the two surveyors interviewed the U.S. FOIA (b) (6) who ordered the PRN [redacted] for Resident #67. When asked about her reply to the CP recommendations to "refer to the [EX Order 26.4B1] note." The [U.S. FO] stated, "the note means that we co-manage the resident." She stated that Resident #67 "has on-going problems and gets sent out. I go by the [EX Order 26.4B] assessment. We can re-evaluate, but I mostly follow the [EX Order 26.4B] recommendation." The surveyor pointed out that on the [EX Order 26.4B1] order, the stop date was "Indefinite." The surveyor showed the physician the [EX Order 26.4B1] evaluation, dated [EX Order 26.4B1], with a recommendation for PRN [EX Order 26.4B] x [NJ Ex O] days. The physician stated that they should re-evaluate the need to continue the [EX Order 26.4B] in 14 days and put a stop date and if need to continue the medication, put a new start date. She stated that "moving forward" she would document the reason for continuing the PRN [EX Order 26.4B] past the 14 days. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 758	Continued From page 80	F 758		

also stated that the [U.S. FC] gives her monthly notes. "I go through them and address them." The [U.S. FOIA] concluded that the goal was to keep the resident safe.

On 6/30/22 at 1:04 PM, the surveyor interviewed the [U.S. FOIA (b)] who stated that she did not get the [U.S. FC] recommendations. "Not the [NJ Ex Order 26.4(b)(1)] suggestions. They go to the [redacted] who reviews suggestions, accepts or not. If she accepts then the nurse is supposed to follow up with the orders. In this case it refers to the [EX Order 26.4B1] note. I think the nurse is supposed to say whatever is in the [EX Order 26.4B1] note. Which referred to 14 days." The surveyor stated that the medications mentioned in the [U.S. FC] [NJ Ex Order 26.4(b)(1)] Suggestions for Resident #67 were given to the resident beyond 14 days of the original order. The [U.S. FOIA (b)] replied, "Right."

On 6/30/22 at 9:17 AM, the [NJ Exec Order] provided an undated document entitled "[U.S. FOIA (b) (6)] [NJ Ex Order 26.4(b)(1)] Suggestions Process" which included the following statements:

"1- After [U.S. FOIA (b) (6)] monthly report is received the [U.S. FOIA (b)(6)] will review the Unit Inspection Report, Nursing Suggestions and [NJ Ex Order 26.4(b)(1)] Suggestions.
2- Verbal report will be given to [U.S. FOIA] [redacted] with instructions to pay attention to certain suggestions.
3- The [NJ Ex Order 26.4(b)(1)] Suggestions are placed in the [U.S. FOI] Binder on unit. The [U.S. FOIA (b) (6)] will review and either accept or not accept the recommendations and will sign off. 4- The [U.S. FOIA (b) (6)] will leave the completed form for the nurses who will then review and if the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 758	Continued From page 81 recommendations are accepted the nurse should carry through with recommended orders. 5- The U.S. FOIA (b) (6) completes the Report and provides actions taken. This report is then returned to the U.S. FOIA (b)(6). If there are any issues a discussion will take place and further action will be taken otherwise it is noted that suggestions are completed." The U.S. FOIA (b)(6) also presented a progress note for Resident #67 dated EX Order 26.4B1, which indicated that the U.S. FOIA (b) (6), U.S. FO and U.S. FOI agreed that Resident #67 should continue EX Order 26.4B1 every 12 hours PRN for 14 more days and then re-evaluate. The note also indicated the EX Order 26.4B1 should be discontinued. The U.S. FOIA (b)(6) provided copies of the physician's orders which reflected these changes.	F 758		
F 761 SS=D	NJAC 8:39-27.1(a), 29.3 (a)(4) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		7/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 761	Continued From page 82 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to properly label, store and dispose of medications in 1 of 4 medication carts and 1 of 2 medication refrigerators inspected. This deficient practice was evidenced by the following: On 06/27/22 at 10:10 AM, the surveyor inspected the 200-nursing wing medication cart #1 in the presence of a Licensed Practical Nurse (LPN#1). The surveyor observed an opened Novolog insulin (Diabetes) vial that had an opened date of 5/29/22 and an expiration date of 6/24/22. At that time, the surveyor interviewed LPN #1 who acknowledge that the Novolog Insulin was expired and should have been removed from the medication cart on 6/24/22. On 06/27/22 at 10:25 AM, the surveyor inspected the 100-unit medication room refrigerator in the presence of LPN #2. The surveyor observed an	F 761	F761 - Label/Store Drugs and Biologicals 1. How the corrective action will be accomplished for those residents found to have been affected by the practice: -Residents receiving insulin, blood glucose levels were reviewed from 6/24-6/27/22 to ensure the efficacy of insulin administration from medication cart #1 - 200 wing and monitored for ill affects of use of insulin after use by date. No ill effects noted. On, 6/27/22, the insulin was immediately removed from the 200-hall nursing wing medication cart, discarded, and reordered from the pharmacy. -On 6/27/22 the Lorazepam oral solution in the 100-unit medication room refrigerator was removed and destroyed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 761	Continued From page 83 opened bottle of Lorazepam 2 mg/ml solution (anxiety medication) that was not dated but had a pharmacy label date of 5/16/22. The surveyor also observed an opened Lorazepam 2 mg/ml single use IM vial that was dated 6/15/22 and was still in the medication refrigerator. The surveyor interviewed LPN #2 who stated that Lorazepam 2 mg/ml oral solution should have been dated when opened. LPN #2 also acknowledge that a single use Lorazepam vial should have been disposed once opened. A review of the Manufacturer's Specifications for the following medications revealed the following: 1. Novolog insulin vial once opened have an expiration date of 28-days 2. Lorazepam 2 mg/ml oral solution once opened have an expiration date of 90-days. On 6/27/22 at 1:30 PM, the surveyor met with the U.S. FOIA (b)(6) [redacted], and no further information was provided by the facility. A review of the facility's policy for Labeling of Medication Containers that was dated 5/22/22 and was provided by the [redacted] indicated the following: "3. Labels for individual resident medications include all necessary information, such as:" "h. The expiration date when applicable; and." A review of the facility's policy for Controlled that was undated and was provided by [redacted] indicated the following:	F 761	per facility protocol. -On 6/27/22, the single-dose Lorazepam vial in the 100-unit medication room refrigerator was removed and destroyed per facility protocol. -On 6/28/22, LPN (#1) was reeducated on the components of this regulation with an emphasis on checking for expired medications and discarding those which extend beyond the required date. -On 6/28/22, LPN (#2) was reeducated on the components of this regulation with an emphasis on dating medication after opening and the destruction of a single-dose vial once opened per facility protocol. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: -All residents have the potential to be affected by this deficient practice no concerns noted. -By 6/29/2022, the Director of Nursing conducted an observational audit of medication cart and medication room refrigerator contents to ensure: " Insulin that has been opened have the appropriate open date labeled on the insulin container or pen " Single-dose vials are not being stored	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 761	Continued From page 84 "8. Unless otherwise instructed by the [U.S. FOIA (b) (6) redacted], when a resident refuses a non-unit dose medication or it is not given, or receives partial tablet or single dose ampules, or it is not given, the medication shall be destroyed, and may not be returned to the container." NJAC: 8:39-29.4 (a) (h) (d)	F 761	once opened Any concerns identified were immediately addressed. 3. What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur: -By 07/28/22, the Director of Nursing educated licensed nurses on the components of this regulation with an emphasis on: " Insulin that has been opened have the appropriate open date labeled on the insulin container or pen " Single-dose vials are not being stored once opened " Checking for expired medications and discarding those which extend beyond the required date per facility protocol Newly hired licensed nurses will receive education during orientation. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: -The Director of Nursing /designee will conduct a weekly audit x4 weeks and then every 2 weeks x2 months to ensure: " Insulin that has been opened have the appropriate open date labeled on the insulin container or pen " Single-dose vials are not being stored once opened	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 761	Continued From page 85	F 761	" Expired medications are discarded which extend beyond the required date per facility protocol -The findings of these audits will be reported to the QA meeting monthly and QAPI quarterly if any deficient practices noted in audits.	
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to ensure foods were provided and prepared in a manner consistent with physician prescribed NJ Ex Order 26.4(b)(1) for 2 of 20 residents (Resident's #72 and #58) observed during a lunch meal. This deficient practice was evidenced by the following: On 6/21/22 at 12:11 PM, the surveyor observed the lunch tray for Resident #72 in the presence of a second surveyor. The meal ticket on the tray indicated the resident was on a EX Order 26.4B1 diet.	F 808	F808 - Therapeutic Diet Prescribed by Physician 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: -On 6/28/2022 the US FOIA (b)(6) was reeducated by the Registered Dietician on the components of this regulation with an emphasis on preparing and serving therapeutic diets, to include mechanically altered diets, to residents in a manner consistent with physician prescribed mechanically altered diets.	7/26/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 808	Continued From page 86 There were two chocolate chip cookies wrapped in a bag on the tray. At approximately the same time, the surveyors observed the lunch tray for Resident #58. The meal ticket indicated the resident was on a EX Order 26.4B diet. The EX Order 26.4B1 vegetables did not appear NJ Ex Order 26.4(b) and had EX Order 26.4B1 particles. A review of Resident #72's Order Summary Report for EX Order 26.4B1, reflected that the resident had a diet order for a EX Order 26.4B1 texture dated EX Order 26.4B1. A review of Resident #58's Order Summary Report for EX Order 26.4B1, reflected that the resident had a diet order for a EX Order 26.4B1 texture dated EX Order 26.4B1 At 12:15 PM, the surveyor requested a sample tray for a EX Order 26.4B1 and EX Order 26.4B1 consistency diet from the U.S. FOIA (b)(6)) in the presence of a second surveyor. Both surveyors joined the U.S. FO into the kitchen as the U.S. FOIA (b prepared plates of the EX Order 26.4B1 and EX Order 26.4B1 lunch meal and the surveyor also asked for a sample of the EX Order 26.4B1 and EX Order 26.4B1 lunch desserts. At that time the U.S. FOIA (b)(6) entered the kitchen. The surveyors immediately brought the samples to the conference room in the presence of the entire survey team. The survey team observed that there were two NJ Ex Order 26.4(b)(1) chocolate chip cookies identified as the dessert for the EX Order 26.4B1 diet. The survey team also observed that the NJ Ex Order 26.4 mixed vegetables which was not NJ Ex Order 26.4(b) and had NJ Ex Order 26.4(b)(of green bean, carrot and other fibrous pieces.	F 808	2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: -By 7/26/22, the Speech Pathologist conducted an audit of residents receiving mechanically altered diets to ensure foods were provided and prepared in a manner consistent with physician prescribed mechanically altered diets. -By 07/26/22, kitchen staff responsible for meal preparation were evaluated through competency including return demonstration related to mechanically altered diets by the Food Services Director to ensure foods are provided and prepared in a manner consistent with physician prescribed mechanically altered diets. -Any concerns identified were immediately addressed. 3. What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur: -On 07/18/22, kitchen staff were reeducated by the Registered Dietician on the importance of preparing and serving therapeutic diets, to include mechanically altered diets, to residents in a manner consistent with physician prescribed mechanically altered diets.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 808	Continued From page 87 At 12:45 PM, the surveyor interviewed the U.S. FOIA (b)(6)) in the presence of the survey team. After reviewing the samples, the U.S. FOIA stated that NJ Ex Order 26.4(b)(1) are typically EX Order 26.4B1 to bite size pieces, EX Order 26.4B1. She stated that EX Order 26.4B1 diet were NJ Ex Or foods and that EX Order 26.4B1 diets should indicate EX Order 26.4B1 as NJ Ex Or or NJ Ex Order 26.4(b) Then she assessed the sampled meals with the surveyor. She stated that a EX Order 26.4B1 or EX Order 26.4B1 diet should not receive NJ Ex Order 26.4(b)(1) cookies "like these" as she pointed to the cookies on the tray and stated that "these are NJ Ex Order 26.4(b)(1) In addition, as she assessed the vegetables, she stated that she would "not be ok with the vegetables that were in the EX Order 26.4B1 food." The U.S. FOIA (b) stated that she would have expected the EX Order 26.4B1 vegetables to be smooth. She stated that she would expect the kitchen staff to have knowledge about the diet consistencies and what would and would not be allowed. In addition, she stated that she would expect the kitchen staff to ensure the trays were accurate before they were delivered to the residents. At 1:35 PM, the U.S. FOIA (b)(6) requested to meet with the survey team. The U.S. FO stated that "the NJ Ex Order 26.4(b) diet and the EX Order 26.4B1 diet are the same" for the lunch meal that day. The U.S. FO stated that she reviewed and signed the facility menus for adequacy, accuracy and appropriateness and she bases this on the guidelines from the Diet Manual. The U.S. FO stated that the EX Order 26.4B1 diet were NJ Ex Or foods and EX Order 26.4B1 was specific to meats as NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b) She stated that	F 808	-Newly hired kitchen staff will receive education during orientation. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: -Registered Dietician/designee will conduct a weekly audit x4 weeks and then every 2 weeks x2 months of residents receiving mechanically altered diets to ensure foods were provided and prepared in a manner consistent with physician prescribed mechanically altered diets. -The findings of these audits will be reported to the QA Meeting monthly x 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 808	Continued From page 88 the EX Order 26.4B1 diet and the EX Order 26.4B1 diets were interchangeable. The U.S. FO stated that on the EX Order 26.4B1 diet "the cookies should be NJ Ex Order As she felt the cookies in the presence of the survey team, she stated that the cookies were "not as NJ Ex Or as they could have been, they could have been better." She stated that the cookies were fresh baked and that they were "cooked more than they should have been." The U.S. FOIA (b) acknowledged the same and stated that they were " NJ Ex Order 2 The U.S. FO stated that the EX Order 26.4B1 diet should be NJ Ex Order 26.4(b) As the surveyor pointed out the particles in the EX Order 26.4B1 vegetables on the plate the U.S. FO responded, "could have been EX Order 26.4B1 a little bit more." The U.S. FOIA acknowledged the same. She stated that the Cooks prepare the meals, and it was the responsibility of the U.S. FOIA (b)(3) to oversee the process for accuracy. The further stated that the U.S. FOIA performed competencies on the Cooks for EX Order 26.4B1 food preparation. At 1:45 PM, the U.S. FO provided the surveyor with a copy of the Mechanical Soft Consistency policy used by the facility dated 2018. Under the title "i.e., EX Order 26.4B1 " was handwritten. The U.S. FOIA acknowledged that she wrote that. She also provided the surveyor with a copy of the Puree Consistency policy from the same manual. On 6/23/22 at 12:22 PM, the U.S. FOIA (b)(3) informed the surveyor that she could not find the Cooks competencies for EX Order 26.4B preparation. On 6/28/22 at 11:17 AM, the surveyor interviewed the interim U.S. FOIA in the presence of a second surveyor. He stated that a pureed consistency should be smooth and pudding-like. He further	F 808		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 808	Continued From page 89 stated that the pureed consistency should not have any particles or pieces in it. A review of the facility's NJ Ex Order 26.4(b)(1) Menu for Week [redacted] - Tuesday dated [redacted] and signed by the [redacted] reflected the lunch meal served on [redacted]. It indicated that the [redacted] diet should have received 2 chocolate chip cookies for dessert which was the dessert the [redacted] diet received. A review of the Mechanical Soft Consistency i.e., Chopped policy dated 2018, reflected that the purpose was "To safely provide adequate nutrition and to facilitate eating for individuals with impaired chewing and/or swallowing ability." It also reflected that "Mechanical Soft foods are easy to chew and soft in texture." It further reflected that foods with "dry hard crusts" should be limited/avoided. A review of the Puree Consistency i.e., Chopped policy dated 2018, reflected that the purpose was "To safely provide adequate nutrition and to facilitate eating for individuals with impaired chewing and/or swallowing ability." It further reflected that "Foods are pureed, homogeneous, and smooth; and have pudding-like consistency." It further reflected that when pureeing vegetables "Avoid any foods that cannot be pureed to the appropriate texture i.e., smooth non-fibrous consistency."	F 808		
F 812 SS=F	NJAC 8:39-17.2(a), 17.4(a)1,2 Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		7/18/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 90 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices and properly store potentially hazardous foods in a safe and sanitary environment to prevent the development of food borne illness. This deficient practice was observed during kitchen tours and was evidenced by the following: On 6/20/22 at 9:27 AM, the surveyor toured the kitchen with the U.S. FOIA (b)(6)). She stated that the Food Service Director (FSD) #1 was off for the day.	F 812	F812 Kitchen Sanitation/Procurement of Food (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: -On 6/21/22, the handwashing sink near the kitchen entrance area to the wall was secured. The handwashing sink was cleaned thoroughly of discoloration, debris and particles present. The plastic, foil and paper on the floor under the sink were immediately discarded on 6/20/22 and the handwashing sink areas was thoroughly mopped for any free-standing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 91 The following was observed: 1. The handwashing sink near the kitchen entrance area was loose from the wall. The sink had a reddish/orange like substance and there was an accumulation of a white and black fuzzy substance. The area under the sink had an accumulation of black and white particles and there was an accumulation of still standing water. In addition, there were pieces of plastic, foil and paper on the floor. The [redacted] stated that the floor looked like there was a lime substance and should have been cleaned. She further stated, "obviously could do a little cleaning." In addition, the [redacted] stated that "I'm not sure how long it was not cleaned but need a cleaning." 2. The clear plastic ice scoop was inside a clear plastic ice scoop holder which was not covered and exposed to the environment. There was an accumulation of a black and white substance in the tube/water line of the ice machine. 3. The reach in freezer digital thermometer located on the outside of the unit read 11 degrees Fahrenheit (F). There were two internal thermometers, one read 18 degrees F and the other 29 degrees F. The [redacted] stated, "I don't know why the temperature was off." In addition, she stated that the temperatures were checked that morning and were fine. The [redacted] further stated that the freezer temperature should be below 0 degrees F and that there were temperature logs that she would show the surveyor. 4. The reach in refrigerator digital thermometer located on the outside of the unit read 42 degrees F. There were two internal	F 812	water. -On 6/27/22, the plastic ice scoop holder on the ice machine was replaced and the tube/water line was cleaned/disinfected of any noted discoloration or substances. -On 6/27/22, the internal thermometers for the reach in freezer were discarded and replaced with a new and calibrated thermometer providing accurate temperature readings. -On 6/27/22, the internal thermometers for the reach in refrigerator were discarded and replaced with a new and calibrated thermometer providing accurate temperature readings. -On 6/21/22, the hood above the cooking area with the brownish substance along one side was cleaned to remove the brownish substance noted. -On 6/21/22, the glass inserts of the double stacked convection oven doors were cleaned of any debris or discoloration noted. -On 6/21/22, the sink the storage room was repaired of the leaking faucet and the brownish/greenish residue in the sink was cleaned. -On 6/20/22, when items were moved in the walk-in freezer, the internal thermometer was located. At that time, the thermometer was checked for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 92 thermometers, one read 20 degrees F and the other 32 degrees F. 5. The hood above the cooking area had a brownish substance along one side. The [redacted] stated that the kitchen staff cleans the area/hood once a week. At that time the surveyor requested documented evidence of a cleaning accountability system. 6. The glass inserts of the double stacked convection oven doors were covered with a brown substance which obscured visibility into the ovens. Cook #1 stated that the ovens were cleaned three months ago. The [redacted] stated that the brownish substance on both glass doors were accumulation of debris and grease. The [redacted] further stated that it should have been cleaned. 7. There was a storage room that the [redacted] stated held kitchen cleaning materials and supplies. There was a sink with a leaking faucet and there was a brownish/greenish residue in the sink. The bottom of the sink had a heavy buildup of a fuzzy black and white substance. There were plastic containers and mop heads inside the floor sink that also had a buildup of a brownish substance. The [redacted] stated that the faucet sink was probably not closed properly, and the [redacted] tried to tighten the faucet. She stated that, "I think I've gotten it worse, it won't turn off." The [redacted] stated that the room should have been cleaned. 8. The walk-in freezer external thermometer read 30 degrees F. The [redacted] stated that, "I don't know why it's reading like that," and she stated that it should have been below 0 degrees F. The [redacted] was unable to locate an internal thermometer.	F 812	accuracy of temperature which demonstrated a temperature below 0 degrees Fahrenheit. -On 6/20/22, the kimchi was immediately discarded, and the ceiling fan was cleaned of any debris. -On 6/20/22, the cans of mixed vegetables in the box stored on the floor in storage room were removed from the case, dated, placed appropriately on the shelves off the floor. -On 6/28/22, the emergency water supply area was thoroughly cleaned, supplies reviewed for cleanliness and placed on an elevated surface. -On 6/27/22, the internal thermometers for the walk-in refrigerator were discarded and replaced with a new and calibrated thermometer providing accurate temperature readings. -On 6/27/22, the unpasteurized eggs and produce stored below were immediately discarded. -On 6/27/22, the dented cans were removed from the other stored cans and placed in a specific and labeled area for return to ensure they were not in use. (b) How you will identify other residents having potential to be affected by the same practice and what corrective action	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 93 The [redacted] joined the tour at 10:23 AM and confirmed that there was no internal thermometer in the walk-in freezer. In addition, Cook #1 confirmed that she too could not locate an internal thermometer in the walk-in freezer. Cook #1 stated that it was the cook's responsibility to check and record the temperatures of the refrigerators and freezers in the morning. She further stated that she had not gotten the chance to do so that morning because the kitchen was short staffed. In addition, Cook #1 stated that there was a binder that had all the refrigerator and freezer temperature monitoring logs. At that time, the [redacted] joined the tour. 9. There was a ceiling fan directly over a food prep table that had a heavy buildup of a fuzzy gray substance. There was an open container of kimchi (a Korean dish of spicy pickled cabbage) directly under the fan. The [redacted] stated that the container should have been closed or covered. 10. There was a case of canned mixed vegetables stored directly on the floor in the storage room. 11. At 10:35 AM, the [redacted] checked the temperatures of the reach-in freezer again in the presence of the surveyor. The external digital thermometer read 15 degrees F. The two internal thermometer's read 19 degrees F and 32 degrees F. In the presence of the [redacted], Cook #1 stated that she had not checked the temperatures that morning for any/all the freezers and refrigerators since the kitchen was short staffed.	F 812	will be taken: -By 7/18/22, the Administrator/designee conducted an audit of the kitchen to identify others that have the potential to be affected to include: 1. Walk-in refrigerators, walk-in freezers, reach-in refrigerators and reach-in freezers have internal thermometers in place that demonstrate accurate temperatures. 2. Handwashing sink and storage room sink are in good repair and free of debris and discoloration indicative of lack of cleaning. 3. The ice scoop holder is cleanly and properly covered and the water tubing is free of discoloration indicative of lack of cleaning/disinfection. 4. The hood above the cooking area along the side is free of debris and discoloration indicative of lack of cleaning. 5. The glass inverts in the convection oven are free of debris and discoloration indicative of lack of cleaning. 6. Ceiling fans are free of debris or build up. 7. Food products, emergency water supply or boxes are not stored directly on the floor. 8. Eggs are appropriately stored in the refrigeration areas to ensure items below them cannot be contaminated. 9. Dented cans are not in circulation with other canned products, but rather placed in a specified area for return or are discarded.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 94 The [redacted] provided the surveyor with copies of the kitchens "Daily Freezer/Refrigerator Temperature Log's" for the month of June 2022. It revealed that there were no temperatures recorded the mornings of June 9th, 16th and 20th for the following units: "cook fridge," "cook freezer," "ice cream," "beverage fridge," "walk-in fridge," and "walk-in freezer." 12. At 10:51 AM, the surveyor toured with the [redacted] to view the emergency water supply. There were crates of water that were stored directly on the floor with a heavy build up of a fuzzy grayish/brownish substance. On 6/21/22 at 11:08 AM, in the presence of two surveyors, the [redacted] stated that when she started working at the facility in [redacted], she found that the kitchen was not clean and the previous FSD #2 was not competent. She stated that a new FSD #1 started [redacted]. She stated that he had worked on the weekend and then resigned on [redacted] without notice. The [redacted] acknowledged that there was no accountability system in place for kitchen sanitation. In addition, she stated that the [redacted] would be overseeing the kitchen until the facility was able to replace the [redacted] position. On 6/27/22 at 9:34 AM, two surveyors conducted a second kitchen tour with the [redacted] and an interim [redacted]. The following was observed: 13. The clear plastic ice scoop was inside a clear plastic ice scoop holder which was not covered and exposed to the environment. The interim	F 812	Any areas of concern identified were immediately addressed. (c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: -By 7/18/22, the Administrator/designee re-educated the food services staff on the components of this regulation with emphasis on kitchen sanitation and storage of food products to include: 1. Walk-in refrigerators, walk-in freezers, reach-in refrigerators and reach-in freezers have internal thermometers in place that demonstrate accurate temperatures. 2. Handwashing sink and storage room sink are in good repair and free of debris and discoloration indicative of lack of cleaning. 3. The ice scoop holder is cleanly and properly covered and the water tubing is free of discoloration indicative of lack of cleaning/disinfection. 4. The hood above the cooking area along the side is free of debris and discoloration indicative of lack of cleaning. 5. The glass inverts in the convection oven are free of debris and discoloration indicative of lack of cleaning. 6. Ceiling fans are free of debris or build up. 7. Food products, emergency water supply or boxes are not stored directly on the floor. 8. Eggs are appropriately stored in the refrigeration areas to ensure items below	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 95 [redacted] acknowledged that the scoop was exposed and showed the surveyors there was an attached cover to the scoop holder but was not properly placed. He stated that the ice scoop should have been covered. 14. The reach-in freezer external digital thermometer read 19 degrees F and the internal thermometer read 18 degrees F. Both the interim [redacted] and the [redacted] stated that the temperature should have been below 0 degrees F. They also both stated that the unit had been opened. The surveyors requested that the unit remain closed for a bit to recheck. The [redacted] announced to the kitchen employees not to open the unit. 15. The reach-in refrigerator external digital thermometer read 47 degrees F and the internal thermometer read 41 degrees F. The surveyors requested that the unit remain closed for a bit to recheck. The [redacted] announced to the kitchen employees not to open the unit. 16. The walk-in refrigerator external thermometer read 41 degrees F and there were three internal thermometers. One read 30 degrees F, the second 32 degrees F, and the third read 40 degrees F. Both the [redacted] and the interim [redacted] stated that staff should use the internal thermometers to monitor and record temperatures but could not speak to how the staff would know which internal thermometer to use. 17. In the walk-in refrigerator, there were two plastic containers of store bought raw (unpasteurized) eggs stored on the third shelf directly above fresh produce. There was one full container with 30 raw eggs and the second had	F 812	them cannot be contaminated. 9. Dented cans are not in circulation with other canned products, but rather placed in a specified area for return or are discarded. -Newly hired food services staff will be educated on these components during orientation. -During daily temperature checks, the food services staff will not utilize the external temperature of the walk-in or reach-in refrigerators or freezers but will only utilize the singular internal thermometer for accuracy of temperature documentation. (d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: -The Administrator/designee will conduct an audit three times weekly X 4 weeks and then weekly X 2 months of kitchen sanitation and food storage to include: 1. Walk-in refrigerators, walk-in freezers, reach-in refrigerators and reach-in freezers have internal thermometers in place that demonstrate accurate temperatures. 2. Handwashing sink and storage room sink are in good repair and free of debris and discoloration indicative of lack of cleaning. 3. The ice scoop holder is cleanly and properly covered and the water tubing is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 96 10 raw eggs. The [redacted] and the interim [redacted] confirmed the raw eggs were not pasteurized. They both also acknowledged that raw eggs should be stored on a bottom shelf. The [redacted] stated that the raw eggs should have been stored on the bottom shelf to "prevent contamination." 18. The [redacted] acknowledged that after "10 minutes" the temperature of the reach-in freezer had not gone down and that the reach-in refrigerator temperatures went up. The reach-in freezers external digital temperature of the reach-in freezer read 19 degrees F and the internal thermometer read 20 degrees. The reach-in refrigerators external digital thermometer read 48 degrees F and then went up to 50 without opening the unit, and the internal thermometers read 39 degrees. The U.S. FOIA (b)(6) [redacted] joined the tour. He stated that the staff never use the external temperatures for monitoring and that the unit had been opened for use. At that time, the [redacted] and interim [redacted] acknowledged and confirmed that it had not been opened and could not speak to why the temperatures of the freezer thermometers were reading above 0 degrees F. The [redacted] the interim U.S. FOIA (b)(6) stated that when a piece of equipment was not working that their facility process was to notify maintenance and log the concern in a maintenance log. They could not provide documented evidence that this was logged or that maintenance had been notified. In addition, they could not speak to why the process of monitoring and recording refrigerator and freezer temperatures using an internal thermometer was not indicated on the facility policy they provided.	F 812	free of discoloration indicative of lack of cleaning/disinfection. 4. The hood above the cooking area along the side is free of debris and discoloration indicative of lack of cleaning. 5. The glass inverts in the convection oven are free of debris and discoloration indicative of lack of cleaning. 6. Ceiling fans are free of debris or build up. 7. Food products, emergency water supply or boxes are not stored directly on the floor. 8. Eggs are appropriately stored in the refrigeration areas to ensure items below them cannot be contaminated. 9. Dented cans are not in circulation with other canned products, but rather placed in a specified area for return or are discarded. -Findings of these audits will be reviewed in the monthly QA meeting x 90 days	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 97 19. Upon observation of the emergency food area, there were dented cans stored on the bottom shelf in the middle of the emergency food. There was a paper sign loosely placed on top that indicated dented cans. The interim [U.S. FOIA (b)(6)] stated that the dented cans should have been stored in a separate area and stated that "we will get it to a different place." 20. At 10:21 AM, two surveyors in the presence of the [U.S. FOIA (b)(6)] and the [U.S. FOIA (b)(6)] observed nine cases of water (four gallons in each) stored directly on the floor. When asked if the water could be stored directly on the floor? [U.S. FOIA (b)(6)] stated " I don't know." The cased water supply had a heavy buildup of a fuzzy brownish substance. On 6/29/22 at 1:09 PM, in the presence of the survey team, the [U.S. FOIA (b)(6)] stated that she conducted kitchen sanitation audits on a monthly basis, and she then sent the reports via email to the [U.S. FOIA (b)(6)] The surveyor requested copies of the reports from [NJ Exec Order 26.4b1] till present, however the [U.S. FOIA (b)(6)] was unable to provide the audits. On 6/29/22 at 2:26 PM, the survey team met with the [U.S. FOIA (b)(6)] to review the above concerns. At that time the [U.S. FOIA (b)(6)] stated that there were Performance Improvement (PI) reports for FSD #2 which she could provide to the surveyor. At that time, the administrative team was notified that the surveyor requested copies of the [U.S. FOIA (b)(6)] monthly kitchen sanitation audits. On 6/30/22 at 9:52 AM, in the presence of the survey team, the [U.S. FOIA (b)(6)] was unable to provide	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 98	F 812		

Performance Improvement (PI) reports for the FSD #2, nor the RDs monthly kitchen sanitation audits.

On 7/1/22 at 10:21 AM, the surveyor interviewed the U.S. FOIA (b)(6) in the presence of the survey team about the facility's Quality Assurance and Performance Improvement (QAPI) processes. The U.S. FOIA (b)(6) reported the list of topics that were reviewed by QAPI team at their quarterly meeting in April 2022. The U.S. FOIA (b)(6) did not report any topic related to the Food Service Department.

At 10:37 AM, in the presence of the survey team, the U.S. FOIA (b) joined the U.S. FOIA (b)(6) for an interview regarding QAPI topics for the April 2022 quarterly team meeting. There were no Food Service Department topics identified.

A review of a timeline for U.S. FOIA (b)(6) provided by the U.S. FOIA (b)(6) revealed that the U.S. FOIA (b)(6), who was the previous U.S. FOIA (b)(6) toured the kitchen on 3/24/22, and found "the state of the kitchen to be unacceptable." The findings were reviewed with FSD #2. On 4/4/22, the U.S. FOIA (b)(6) toured the kitchen again and "found little to no progress in areas that were discussed." The U.S. FOIA (b)(6) gave FSD #2 a written warning "to properly maintain the kitchen." On 4/15/22, the "Kitchen was rounded again and found to be in the same state." On 6/6/22, the FSD #2 was terminated and on NJ Exec Order 2, FSD #1 began at the facility.

Review of an additional document provided to the surveyor revealed the following: "On 3/24/22 U.S. FOIA (b)(6) did extensive kitchen rounds. We sent a list of items that needed to be rectified. The U.S. FOIA was told to reply daily and let

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 99	F 812		

us know what items were still outstanding. He was told that we will be rounding weekly and expect that everything is completed by the next kitchen round. As of 4/4/22, U.S. FOIA (b) did not respond with any updates. On 4/4/22, U.S. FOIA (b)(6) and U.S. FOIA (b)(6) rounded the kitchen. Of the roughly 40 items on the list at least 33 were not addressed. Amongst these items were things that could have been rectified in 2 minutes or less."

A review of the facility policy "Equipment Temperature Monitoring" with a revised date of 5/2018, reflected that the "AM & PM" cooks were responsible to record temperatures daily in the temperature logbook. It also reflected that refrigerator temperatures should be below 41 degrees F and freezers below 0 degrees F. In addition, it reflected that if a temperature was not within an acceptable range both the MDir and the FSD would be informed and would take the appropriate course of action. It did not indicate which thermometers should be used to monitor temperatures.

A review of the facility policy "Dry Food Storage" with a revision date of 5/18/22, reflected that dry food should be stored in a clean, dry area free of contaminants and at a minimum of six inches above the floor.

A review of an undated policy titled "HACCP and Food Safety" provided by the RD, reflected that "Food and nutrition services staff will be well trained on food safety policies and procedures. Supervisors will monitor staff and correct any problems or concerns at the time they occur." It also reflected that staff would be aware of cross contamination, improper sanitation, and improper

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 100 handling or cross contamination of ice. A review of the facility policy "Cleaning Ice Scoops and Storage" dated 5/18/22, reflected that the ice scoop would be stored beside or on top of the ice machine and would have a lid. A review of the facility policy "Dented Cans" dated 5/18/22, reflected that dented cans should be stored in a designated area for dented cans in the storeroom.	F 812		
F 880 SS=D	NJAC 8:39-17.2(g) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to	F 880		7/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 880	Continued From page 101 §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 880	Continued From page 102 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, and review of pertinent facility documents, it was determined that the facility failed to ensure personal protective equipment (PPE) was removed in accordance with nationally accepted guidelines for infection prevention and control. This deficient practice was identified for 1 of 5 staff members observed donning and doffing. The evidence was as follows: According to the U.S. Centers for Disease Control and Prevention (CDC) guidelines, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the During the Coronavirus Disease 2019 (COVID-19) Pandemic updated 2/2/2022 included, "HCP [Healthcare Personnel] must receive training on and demonstrate an understanding of when to use PPE, what PPE is necessary, how to properly don (put on), use and doff (remove) PPE in a manner to prevent self-contamination, how to properly dispose of or disinfect and maintain PPE, limitations of PPE." It further included that HCP should perform hand hygiene before putting on and removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to	F 880	F880 Infection Prevention and Control 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: -On 6/28/22, the NJ Exec Order 26.4b1 was re-educated on infection control practices with emphasis on transmission-based precaution and proper use of PPE by the Assistant Director of Nursing. -By 7/28/2022, the Infection Preventionist and Director of Nursing completed an observational audit of facility staff members when entering and exiting resident rooms requiring isolation precautions to ensure appropriate donning and doffing of PPE and hand hygiene techniques to identify other residents having the potential to be affected. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: -By 7/27/2022, a Root Cause Analysis	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 880	Continued From page 103 bare hands during the removal process ... Remove and discard gloves before leaving the patient room or care area, and discard gown in a dedicated container for waste or linen before leaving the patient room or care area." On 6/28/22 at 11:08 AM, the surveyor observed room [redacted] with signs for "contact and droplet precautions" and a stop sign which indicated "please see the nurse before entering this room." At that same time, the surveyor observed the U.S. FOIA (b)(6) [redacted]) walk out of room [redacted] into the hallway wearing a blue disposable gown and remove the gown. The [redacted] then rolled the gown up and disposed the gown into a small open trash bin which was located in the hallway next in the to room [redacted] On that same date and time, the surveyor interviewed the [redacted] who stated "yeah, I should have doffed before coming out, but I forgot something. Yes, I was trained to remove PPE prior to coming out of the room." On 6/28/22 at 11:12 AM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted]) who stated that room [redacted] was a PUI [person under investigation] room and spoke to the process of donning and doffing. On 6/28/22 at 1:36 PM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted] who spoke to the process of donning and doffing and stated that the [redacted] should have removed the gown prior to coming out of the room. "I will have to re-educate her."	F 880	(RCA) was completed and reviewed with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. -Root Cause Analysis concluded that despite being educated and in-serviced, the lack of knowledge on the DSW's part on effective and proficient infection control practices on removing and discarding PPE prior to exiting the room has led to this deficient practice. 3. What measures will be put into place or what systemic changes will make to ensure that the practice does not recur: -From 7/22/2022-7/28/2022, Infection Preventionist, Director of Nursing re-educated the staff on the components of this regulation with emphasis maintaining infection control techniques as it pertains to transmission-based precautions, donning and doffing PPE when entering and exiting resident rooms requiring isolation precautions and hand hygiene techniques. -Trainings included: Nursing Home Infection Preventionist Training Course Module 1 - Infection Prevention & Control Program https : //www. train.org/main/course/1081350/ Provided the training to: Topline staff and infection preventionist	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 880	Continued From page 104 On 6/28/22 at 2:03 PM, the survey team met with the administrative staff and discussed the above observation and concern. On 6/29/22 at 9:50 AM, the[redacted] stated that the[redacted] was re-educated on proper donning and doffing of PPE. Review of the facility's policy for contact precautions dated 5/18/22, included "before exiting room, remove and discard gown and gloves and wash hands upon exiting room." Review of the facility's policy for droplet precautions dated 5/18/22, included "before exiting room, remove and discard PPE and wash hands." NJAC: 8:39-19.4	F 880	CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out! https://youtu.be/7srwrF9MGdw Provided the training to: Frontline staff CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Use PPE Correctly for COVID-19 https://youtu.be/YYTATw9yav4 Provided the training to: Frontline staff Nursing Home Infection Preventionist Training Course Module 5 - Outbreaks https://www.train.org/cdctrain/course/l081803/ Provided the training to: Topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 6A - Principles of Standard Precautions https://www.train.org/main/course/1081804/ Provided the training to: All staff including topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 6B - Principles of Transmission Based Precautions https://www.train.org/main/course/1081805/ Provided the training to: All staff including topline staff and infection preventionist	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD PITTSTOWN, NJ 08867**

(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 880	Continued From page 105	F 880	4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, i.e., what quality assurance program will be put into place. -The Infection Preventionist or Director of Nursing/ designee and other nursing leadership will conduct an observational audit 3x a week X 4 weeks then weekly X 4 months of facility staff to ensure infection control techniques are maintained with emphasis on appropriate hand hygiene and donning and doffing of PPE when entering and exiting resident rooms requiring isolation precautions. -Findings of these audits will be reviewed in the QA meetings monthly x 90 days.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061006	A. BUILDING: _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shifts and the overnight shifts as mandated by the state of New Jersey. This was evidenced for 9 of 14 day shifts and 7 of 14 overnight shifts reviewed. Findings include: Reference: New Jersey Department of Health (DOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey	S 560	S560 Mandatory Access to Care 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: -There was no negative outcome to residents the shifts identified as not meeting the NJ staffing requirements during the 06/09/22 on the day shift, 06/10/22 on the day shift, 06/11/22 on the day shift, 06/12/22 on the day shift, 06/12/22 on the overnight shift,06/13/22 on the day shift, 06/13/22 on the overnight shift,06/14/22 on the day shift 06/14/22 on the overnight shift, 06/15/22 on the day	8/2/22

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

Electronically Signed | 07/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061006	A. BUILDING: _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of the "Nursing Staffing Report" completed by the facility for the weeks of 6/5/22 through 6/11/22 and 6/12/22 through 6/18/22, revealed the staffing to residents' ratios did not meet the minimum requirement of one CNA to eight residents for the day shift and one CNA to 14 residents for the overnight shift as documented below: -06/09/22 had 11 CNAs for 95 residents on the day shift, required 12 CNAs. -06/10/22 had 11 CNAs for 94 residents on the day shift, required 12 CNAs. -06/11/22 had 10 CNAs for 94 residents on the day shift, required 12 CNAs. -06/12/22 had 11 CNAs for 94 residents on the day shift, required 12 CNAs. -06/12/22 had 6 total staff for 94 residents on the	S 560	shift, 06/15/22 on the overnight shift, 06/16/22, on the day shift, 06/16/22, on the overnight shift, 06/17/22, on the day shift,06/17/22 on the overnight shift, and 06/18/22 on the overnight shift. -7/19/2022, the facility Staffing Coordinator was reeducated by the Licensed Nursing Home Administrator (LNHA) on the components of this regulation with an emphasis on CNA to resident ratios. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: -All residents have potential to be affected by this deficient practice. 3. What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur: To increase CNA staffing: " Jobs posted on internet job boards and purchase the add to be elevated. " Professional recruiters actively recruiting. " Provided incentive bonuses for staff who refer CNA's " Contacted local schools to recruit new graduates " Scheduled Job Fair " Pay for staff housing " Utilize agency staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061006	A. BUILDING: _____ B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 overnight shift, required 7 total staff. -06/13/22 had 10 CNAs for 94 residents on the day shift, required 12 CNAs. -06/13/22 had 6 total staff for 94 residents on the overnight shift, required 7 total staff. -06/14/22 had 11 CNAs for 94 residents on the day shift, required 12 CNAs. -06/14/22 had 6 total staff for 94 residents on the overnight shift, required 7 total staff. -06/15/22 had 11 CNAs for 94 residents on the day shift, required 12 CNAs. -06/15/22 had 6 total staff for 94 residents on the overnight shift, required 7 total staff. -06/16/22 had 10 CNAs for 94 residents on the day shift, required 12 CNAs. -06/16/22 had 6 total staff for 94 residents on the overnight shift, required 7 total staff. -06/17/22 had 11 CNAs for 98 residents on the day shift, required 12 CNAs. -06/17/22 had 6 total staff for 98 residents on the overnight shift, required 7 total staff. -06/18/22 had 6 total staff for 98 residents on the overnight shift, required 7 total staff. On 6/29/22 at 10:06 AM, the surveyor interviewed the staffing coordinator who acknowledged the new minimum staffing requirements for nursing homes. She further stated, "I try to put seven to eight CNAs on the 200 unit for 7-3 and 3-11 shifts. The 100 unit is census driven. I try to put four to five CNAs. We are trying to hire CNAs. I go on indeed. The sign is out there. We have our recruiter who sends us resumes. I hire on the spot. We try everything to get people in. Yes, I am aware that we are short staffed."	S 560	" Pay for transportation " Contracted bus company to assist with transportation " Contacted Hunterdon County Transportation Authority to add a public bus stop 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: -The Licensed Nursing Home Administrator/designee will conduct an audit 3 times a week for 4 weeks and then weekly x2 months of the staffing schedule. -The findings of these audits will be reported to the monthly QA meeting x 3 months.	

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
315433 Y1	A. Building B. Wing Y2	9/29/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

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 F0641	Correction	ID Prefix F0658	Correction	ID Prefix F0688	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(c)(1)-(3)	Completed
LSC	07/27/2022	LSC	07/30/2022	LSC	07/30/2022
ID Prefix F0690	Correction	ID Prefix F0692	Correction	ID Prefix F0695	Correction
Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.25(g)(1)-(3)	Completed	Reg. # 483.25(i)	Completed
LSC	07/29/2022	LSC	07/29/2022	LSC	08/05/2022
ID Prefix F0758	Correction	ID Prefix F0761	Correction	ID Prefix F0808	Correction
Reg. # 483.45(c)(3)(e)(1)-(5)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(e)(1)(2)	Completed
LSC	07/28/2022	LSC	07/28/2022	LSC	07/26/2022
ID Prefix F0812	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	07/18/2022	LSC	07/28/2022	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
7/1/2022	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061006 Y1	A. Building B. Wing Y2	9/29/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

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 08/02/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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 7/1/2022	☐ 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
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 6/22/22 and 6/23/22, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy The facility is a 1-story building that was built in the 80's and it is composed of Type II protected. The facility is divided into 7- smoke zones. The generator does approximately 70% of the building. This facility has wells that feed the water and fire sprinkler system, from electric pumps located in the ground, this facility also has a septic system. The facility was certified on 12/1/1997. The building is designed to have a center operations wing and 100's wing (left) and 200's wing (right). The building has a partial basement. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing,	K 000		

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

Electronically Signed | 07/28/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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	Continued From page 1 fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 130 certified beds. At the time of the survey the census was 99.	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observations, interview and documentation review on 6/22/22, in the presence of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6), it was determined that the facility failed to a.) inspect fire doors annually in accordance with S&C 17-38-LSC for nine (9) of nine (9) fire doors and b.) maintain exits accessible at all times without obstruction. This was noted for 1 of 6 exit corridors observed. This deficient practice was evidenced by the following: 1. At 10:00 AM, the surveyor reviewed all provided documentation from the [redacted]	K 211	K 211 Life Safety Code Standard Corridor Obstructions 1. What corrective action(s) will be accomplished for those residents/Staff found to have been affected by the practice: -On 06/24/2022 the boxes, beds and mattresses were removed from the corridor by the Maintenance Director and the Housekeeping Director. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:	7/18/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING 01 B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 211	Continued From page 2 [redacted] The annual fire door inspection documentation was not provided for the facility's fire door assemblies. An interview was conducted with the U.S. FOIA (b)(6), during the document review. He stated that currently no further documentation could be provided on fire door inspections (Annual) for the last 12-months as identified in the S&C 17-38-LSC documentation. 2. At 11:18 AM, the surveyor, in the presence of another surveyor and th U.S. FOIA (b)(6) [redacted] observed in the basement exit/egress corridor that excessive combustible boxes, beds and mattresses were stored in the corridor. The means of egress was not continuously maintained free of all obstructions to full use in case of emergency. The U.S. FOIA (b)(6) confirmed the finding during the observation's. The U.S. FOIA (b)(6) was informed of the finding at the Life Safety Code exit conference on 6/27/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 NFPA 101 2012 edition Life Safety Code 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* to 7.2.1.15.8 S&C 17-38-LSC NFPA 101- 2012 edition Life Safety Code 19.7.3 Maintenance of Means of Egress 19.7.3.1	K 211	-All residents have the potential to be affected by the deficient practices On 06/24/2022 Administrator and Maintenance Director conducted an audit to ensure that Corridors/Exits remained clear of obstructions. 3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: On 06/23/2022 US FOIA (b)(6) was in-serviced as to the required components of this regulation by the Administrator. -06/23/2022, the platform was removed that was used to store boxes and beds in the way of egress. -Food Services, Maintenance, Housekeeping, and Central Supply were in-serviced on K-211 with emphasis on ensuring egress exit doorways remain free of obstructions. -Newly hired staff will be in-serviced on the components of this regulation by the Administrator / Designee. -The Facility Maintenance Rounds Checklist will be modified to include the verification and compliance to this standard. Any adjustments identified will be addressed immediately. Environmental rounds completed by managerial staff will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 211	Continued From page 3	K 211	include the verification and compliance to this standard. Fire Door Assemblies will be inspected annually using a fire door inspection audit tool. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: -Administrator/designee to monitor at random times, means of egress daily x 7 days, weekly x4 and monthly x4 with findings reported monthly to QA team for review for 90 days. If needed will report to quarterly QAPI based on findings.	
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the	K 222		7/2/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING 01 B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 222	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and interviews on 6/22/22, in the presence of another surveyor, [redacted], and U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that the 30-second delayed egress feature on three (3) of eight (8) exit discharge doors (with this feature) observed would activate properly when tested. This deficient practice was evidenced by the following: 1. On 6/22/22 at 12:31 PM, the surveyor observed that exit/egress door by resident room EX Order [redacted], when activated with the delayed 30-second egress feature, which was labeled with a sign that read, "Push Until Alarm Sounds, Door Can Be Opened in 30-Seconds." The door's egress feature activated in approximately 9-seconds. The door had a keypad that opened the door, and according to the U.S. FOIA (b)(6), the fire alarm would release the device if it is activated. 2. On 6/22/22 at 1:10 PM, the surveyor observed that exit/egress door by resident room EX Order 46 [redacted] when activated with the delayed 30-second egress feature, which was labeled with a sign that read, "Push Until Alarm Sounds, Door Can Be Opened in 30-Seconds." The door's egress feature activated in approximately 15-seconds. The door had a keypad that opened the door, and according to the U.S. FOIA (b)(6), the fire alarm would release the device if it is activated. 3. On 6/22/22 at 1:10 PM, the surveyor observed	K 222	K 222 NFPA Life Safety Code Standard Egress Doors 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: -On 6/23/2022 all exit/egress doors were checked and reset to have a 15-second delayed egress. -On 6/23/2022 all exit/egress doors were provided with a sign that reads push until alarm sounds, door can be opened in 15-seconds. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: -All residents have the potential to be affected by the deficient practices. -On 6/23/2022 a facility wide audit was completed to ensure that exit/egress doors are set at a 15-second delayed egress. Corrections were made at the time of the audit. -On 6/23/2022 the U.S. FOIA (b) (6) [redacted] was re-educated on the requirement and importance of maintaining a corresponding time with the sign posted on the exit/egress doors. 3. What measures will be put into place	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 222	Continued From page 6 that exit/egress door by the rehabilitation room, when activated with the delayed 30-second egress feature, which was labeled with a sign that read, "Push Until Alarm Sounds, Door Can Be Opened in 30-Seconds." The door's egress feature activated in approximately 15-seconds. The door had a keypad that opened the door, and according to the U.S. FOIA (b)(6) , the fire alarm would release the device if it is activated. During the above observation's, the [redacted] confirmed the findings in an interview. The U.S. FOIA (b)(6) was notified of the findings at the Life Safety Code exit conference on 6/27/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.2.1.6.1.1(3)C	K 222	or what systematic changes you will make to ensure that the practice does not recur: - On 6/23/2022 U.S. FOIA (b)(6) was re-educated as to the required components of this tag by the Administrator. - On 6/23/2022 The Facility Maintenance Rounds Checklist was modified to include the verification and compliance to this standard for all egress doors. Any adjustments identified will be addressed immediately during the monthly rounds going forward. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: -The Maintenance Director/designee will audit all exit doors each month x 90 days to ensure the exit/egress doors are releasing at the corresponding posted time. The findings will be reported to the QA committee on a monthly basis x 3 months.	
K 225 SS=E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2	K 225		7/2/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING 01 B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 225	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 6/22/22, the facility failed to provide stair tread marking stripe (applied as a material that is integral with the nosing of each step, each floor's landing, and handrails) with solid and continuous marking stripe in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.3, 7.2.2, 7.2.2.5.5, 7.2.2.5.5.2, and 7.2.2.5.5.3. This deficient practice was observed in one (1) of one (1) stairwells identified by the U.S. FOIA (b)(6) [redacted]. On 6/22/22 at 11:40 AM, the surveyor, in the presence of another surveyor, U.S. FOIA (b)(6) [redacted] observed that the basement stairwell, revealed that marking stripes were not present on each step, floor landing, and handrails. The U.S. FOIA (b)(6) was informed of this finding during the Life Safety Code survey exit conference on 6/27/22. NJAC 8:31.2(e) NFPA 101:2012 - 19.2.2.3, 7.2.2	K 225	K 225 NFPA Life Safety Code Standard Stairways and Smokeproof Enclosures 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: -On 6/23/2022 the Maintenance Director added marking stripes on each step, floor landing and handrails in the basement stairwell. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: -All residents have the potential to be affected by the deficient practices -On 6/23/2022 an audit was completed to ensure that the basement stairwell had marking stripes on each step, floor landing and handrails. -On 6/23/2022 the U.S. FOIA (b) (6) [redacted] was re-educated on the requirement and importance of maintaining basement stairwell and ensuring that the marking stripes on each step, floor landing and handrails are in place. 3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 225	Continued From page 8	K 225	-On 6/23/2022 U.S. FOIA (b) (6) was re-educated as to the required components of this tag by the Administrator. -On 6/23/2022 The Facility Maintenance Rounds Monthly Checklist was modified to include the verification and compliance to this standard. Any adjustments identified will be addressed immediately. Any issues will be brought to the attention of the Licensed Nursing Home Administrator for review and purchase of new materials as needed. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: -The Maintenance Director/designee will audit the basement stairwell monthly x 90 days to ensure the marking stripes on each step, floor landing and handrails are in place. The findings will be reported to the QA committee on a monthly basis x 3 months.	
K 227 SS=F	Ramps and Other Exits CFR(s): NFPA 101 Ramps and Other Exits Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10	K 227		9/1/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING 01 B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 227	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 6/22/22, it was determined that the facility failed to comply with the requirements of NFPA 101:2012 sect. 7.2.5 pertaining to exit ramps. This deficient practice was identified for two (2) of two (2) exit/egress ramps and as evidenced by the following: 1. At 1:18 PM, the surveyor, in the presence of another surveyor, U.S. FOIA (b)(6) observed, that the exterior ramp leading to the public way, outside the two air conditioner units, had an unprotected edge that was missing approximately 30' of guard railing. 2. At 1:28 PM, the surveyor, in the presence of another surveyor, U.S. FOIA (b)(6) observed, that the exterior ramp leading to the public way, outside resident rooms 235 and 236 was observed to have an unprotected edge. The unprotected edge was approximately 25' in length and the approximately 5 step stairs to the public way was not provided with a handrail on both sides. The U.S. FOIA (b)(6) confirmed the unprotected edge during the observations. 19.2.2.6 RAMPS: 7.2.5.3.2 -landings #(3) every landing shall have a width not less than the width	K 227	K 227 NFPA Life Safety Code Standard Ramps and Other Exits 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: -On 6/23/2022 exterior exit/egress ramps leading to the public way were audited for additional guard rail systems. -On 6/23/2022 a contractor was contacted and contract signed to install additional guard railings on the exterior ramps and provided an estimate on 7/20/2022 to install guard rails at 2 exit/egress ramps leading to the public way. Installation will be completed by 9/1/2022. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: -All residents have the potential to be affected by the deficient practices -On 6/23/2022 the U.S. FOIA (b)(6) was re-educated on the requirement and importance of maintaining guard rail systems at the exterior ramps leading to the public way.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 227	Continued From page 10 of the ramp 19.2.3 Capacity of Means of Egress 19.2.3.4* 7.2.5.3 Ramp Details: 7.2.5.3.2 Landings (1) through (7) 7.2.5.3.3 Drop-Offs The facility's [redacted] was informed of the above finding during the Life Safety Code survey exit conference on 6/27/22. NJAC 8:39-31.1(c)	K 227	-An outside vendor will install additional guard rail systems in the month of August. 3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: -On 6/23/2022 [redacted] was re-educated as to the required components of this tag by the Administrator. -On 6/23/2022 The Facility Maintenance Rounds Checklist was modified to include the verification and compliance to this standard. Any adjustments identified will be addressed immediately. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: -The Maintenance Director/designee will audit guard rail systems once installed monthly x 90 days to ensure the guard railing are intact and functional. The findings will be reported to the QA committee on a monthly basis x 3 months.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire	K 321		7/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 321	Continued From page 11 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 and interview on 6/22/22, in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to provide and maintain self-closing devices and hardware on doors to hazardous area in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice was identified in two (2) of 10 hazardous storage areas in the facility and was evidenced	K 321	K321 Hazardous Areas 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: -On 6/25/2022 the boxes in the basement resident personals room were removed. -On 07/02/2022 a self-closing latch was installed by the Maintenance Director on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 321	Continued From page 12 by the following: 1. At 10:52 AM, the surveyor, in the presence of another surveyor, U.S. FOIA (b)(6) observed in the basement, that the Resident Personals room contained 50 plus combustible cardboard boxes, the door was not self-closing, the door was not rated and a wall was constructed and it was open at the top approximately 6" from the ceiling, restricting the full operation of the fire sprinkler head due to the installation of the wall. 2. At 11:08 AM, the surveyor, in the presence of another surveyor, U.S. FOIA (b)(6) observed that the basement fire sprinkler/shutoff valve room door, was not provided with a latch, that would keep the door closed in the event of a smoke/fire condition. An interview was conducted with the U.S. FOIA (b)(6) at the time of the observation's, who confirmed that hazardous storage areas must have a door with a self-closing device and have hardware that operates correctly. The U.S. FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 6/27/22. NJAC 8:39-31.2(e)	K 321	the basement fire sprinkler / shutoff valve room door. -On 7/05/2022 wall and door were removed by Maintenance Director. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: -All residents have the potential to be affected by the deficient practices -The U.S. FOIA (b)(6) and the U.S. FOIA (b) (6) were in-serviced that no items should be stored in the resident personals room. -By 07/05/2022, the Administrator/designee conducted an observational audit of facility and confirmed that the boxes in the basement resident personals room were removed and the wall was removed. -By 07/05/2022, the Administrator/designee conducted an observational audit of the facility and confirmed that the self-closing latch was installed on the basement fire sprinkler / shutoff valve room door 3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: - Monthly rounds will include inspection of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 321	Continued From page 13	K 321	the personals room to ensure compliance. -By 6/25/2022, the Administrator, and Maintenance Director reviewed the components of this regulation with emphasis on ensuring that no items should be stored in the resident personals room. -By 07/05/2022, the Administrator, and Maintenance Director reviewed the components of this regulation with emphasis on ensuring the required doors automatically latch and that automatic door closers remain in good repair and function. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Maintenance Director / designee will inspect the resident personals room to ensure it is free of boxes each month x 90 days. The findings will be reported to the QA committee on a monthly basis and QAPI committee quarterly to ensure compliance. The Maintenance Director / designee will inspect the self-closing latch on the basement fire sprinkler / shutoff valve room door to ensure it is in good working order, each month x 90 days. The findings will be reported to the QA committee on a monthly basis and QAPI committee quarterly to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 321	Continued From page 14	K 321	compliance.	
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 6/22/22, it was determined that the facility failed to ensure that there was a testing, maintenance, and battery replacement program to ensure proper operation of the battery operated smoke detectors. This deficient practice was evidenced for 20 of 20 observed smoke detectors and evidenced by the following: A tour of the facility, at 11:15 a.m., revealed that the facility resident rooms were provided with battery operated smoke detectors. A review of the facility's preventative maintenance logs did not indicate that there was a preventative maintenance program for the testing of the detectors or for battery replacement. In an interview, at 11:55 a.m., the facility's U.S. FOIA (b)(6) stated that there was no preventative maintenance program for testing the battery operated smoke detectors in resident rooms and could not provide any documentation on the year of installation. He stated that he	K 347	K347 Smoke Detection 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: On 6/23/2022 the Maintenance Director immediately changed all battery-operated smoke detectors with a 10-year life battery and tested all smoke detectors and 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: -All residents have the potential to be affected by the deficient practices -On 6/23/2022 the Maintenance Director audited and tested all battery-operated smoke detectors to ensure that they were operational. 3. What measures will be put into place or what systematic changes you will make	7/2/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 347	Continued From page 15 tested the alarms by pushing the test button periodically and replaced the batteries when the alarms indicated low battery, but he did not record any information on a log. This deficient practice would not ensure the proper operation of these devices and would not ensure that staff was signaled of a smoke condition prior to the smoke entering the exit corridor where permanently wired smoke detectors were located. The U.S. FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 6/27/22. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.3.6.1, 19.3.4.5.2	K 347	to ensure that the practice does not recur: -6/23/2022, the facility U.S. FOIA (b)(6) was re-educated by the Administrator on the components of this regulation with emphasis on ensuring smoke detectors are tested per regulation, if found to be in need repair, that they are repaired/replaced, and documentation is maintained to demonstrate completion of testing and corrective actions taken. -The facility implemented a monthly preventative maintenance log system for the Fire Alarm System/smoke detector testing and subsequent corrective actions. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: -Maintenance Director will present the logs to the Licensed Nursing Home Administrator for review monthly and the findings will be presented at the monthly QA meeting x 90 days.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the	K 351		9/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 351	Continued From page 16 Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 6/22/22, it was determined that the facility failed to provide automatic fire sprinkler system protection, to all areas in accordance with NFPA 13. This deficient practice was identified for one (1) of four (4) areas, observed and was evidenced by the following: At 12:31 PM, the surveyor, in the presence of another surveyor, U.S. FOIA (b)(6) [redacted], observed that there was no fire sprinkler protection provided to the outside combustible overhang, that measured approximately 5' x 5' and was located outside resident room 108. An interview was conducted with the U.S. FOIA (b)(6) [redacted] at the time of the observation, they confirmed that the outside combustible overhang did not have any fire sprinkler coverage.	K 351	K351 Sprinkler System - Installation 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: -On 6/23/2022 the Maintenance Director reviewed the need for the automatic sprinkler system on outside of combustible overhangs. -On 6/23/2022 a contractor was contacted, and contract signed to install automatic sprinkler system on outside of combustible overhangs. -On 9/12/2022 a contractor installed automatic sprinkler system outside combustible overhangs. 2. How the facility will identify other residents having the potential to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 351	Continued From page 17 The U.S. FOIA (b)(6) was informed of the observation at the life Safety Code exit conference on 6/27/22. NJAC 8:39-31.2(e) NFPA 13, 25	K 351	affected by the same deficient practice. -All residents have the potential to be affected by this deficient practice. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur. -On 6/22/2022, the administrator re-educated the U.S. FOIA (b)(6) on the components of this regulation with an emphasis on automatic sprinkler systems on outside combustible overhangs. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, i.e., what quality assurance program will be put into place -Sprinkler service provider to monitor exterior sprinklers every 6 months x2 to assure it is in working order, with findings reported to the administrator/designee. Administrator/designee will report it to monthly to QA meeting for review and action as needed.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for	K 363		7/2/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 363	Continued From page 18 at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 6/27/22, it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the	K 363	K363 Corridor Doors 1. What corrective action(s) will be accomplished for those residents found to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 363	Continued From page 19 requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring that room doors will close and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was identified in six (6) of 50 resident room doors observed and was evidenced by the following: The following resident room doors, when closed left a gap at the top of the room door approximately 1/4 to 1/2 inch, due to a malfunction in the door hardware installation: 124, 123, 206, 226, 231. Resident room door 226 would stick in the door frame. An interview was conducted with the U.S. FOIA (b)(6) at the time of the observations who confirmed the above findings. The U.S. FOIA (b)(6) was informed of the finding at the Life Safety Code exit conference on 6/27/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	have been affected by the practice: -On 6/28/2022 all resident room doors were checked to ensure that they automatically latched to the door frame. 6 resident room doors were repaired to ensure they automatically latched to the door frame. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: -All residents have the potential to be affected by the deficient practices. -By 6/28/2022, the Maintenance Director and conducted an audit of facility resident doors to ensure that resident doors close into the frame and are automatically latched to their door frame. 3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: -By 06/28/2022, the Administrator educated the facility leadership staff on the components of this regulation with emphasis on ensuring that corridor doors close into the frame and are automatically latched to their door frame without obstruction. -The facility implemented a monthly preventative maintenance system for the resident door testing and subsequent	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 363	Continued From page 20	K 363	corrective actions. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: -Administrator/Designee will review preventative maintenance logs monthly and monitor for compliance. The findings will be reported by Maintenance Director at the monthly QAPI Committee meeting x 90 days.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations on 6/22/22 and 6/27/22, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified	K 374	K374 Subdivision of Building Space -Smoke Barrier 1. What corrective action(s) will be accomplished for those residents found to	9/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 374	Continued From page 21 for five (5) of seven (7) sets of smoke barrier doors observed and was evidenced by the following: 1. At 12:20 PM, the surveyor, in the presence of another surveyor, [redacted] and U.S. FOIA (b)(6) observed the set of double smoke doors, by resident room 101, had an added-on black rubber draft-seal gasket installed on the doors, when released from the electro-magnetic hold open device, the door closed and left a gap between the rubber and the door approximately 1/4." This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. 2. At 1:08 PM, the surveyor, in the presence of another surveyor, U.S. FOIA (b)(6) and U.S. FOIA (b)(6) observed the set of double smoke doors, by resident room 122, had an added-on black rubber draft-seal gasket installed on the doors, when released from the electro-magnetic hold open device, the door closed and left a gap between the rubber and the door approximately 1/4." This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. 3. On 6/27/22 at 11:28 AM, the surveyor, in the presence of another surveyor, U.S. FOIA (b)(6) [redacted] observed the set of double smoke doors, by resident room's 201-202, had an added-on black rubber draft-seal gasket installed on the doors, when released from the electro-magnetic hold open device, the door closed and left a gap	K 374	have been affected by the practice: -As per fire door company recommendations, astragal and meeting metal brush gasketing were installed on 5 deficient doors to maintain smoke barrier and to resist the transfer of smoke when completely closed for fire protection. As per product specification, this gasketing material is rated up to 3 hours hold up time. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: -All residents have the potential to be affected by the deficient practices. -The Maintenance Director conducted an audit of facility smoke barrier doors to ensure that doors create a smoke barrier and when released from the electro-magnet hold, the doors close with no air gap. 3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: -6/23/2022, the Administrator educated the U.S. FOIA (b)(6) on the components of this regulation with emphasis on ensuring that double smoke doors when released from the electro-magnet hold the door are closed with no air gap.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 374	Continued From page 22 between the rubber and the door approximately 1/4." This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. 4. On 6/27/22 at 11:51 AM, the surveyor, in the presence of another surveyor, U.S. FOIA (b)(6) [redacted] observed the set of double smoke doors, by resident room's 215-216, had an added-on black rubber draft-seal gasket installed on the doors, when released from the electro-magnetic hold open device, the door closed and left a gap between the rubber and the door approximately 1/4." This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. 5. On 6/27/22 at 11:58 AM, the surveyor, in the presence of another surveyor, U.S. FOIA (b)(6) [redacted] observed the set of double smoke doors, by resident room's 221-222, had an added-on black rubber draft-seal gasket installed on the doors, when released from the electro-magnetic hold open device, the door closed and left a gap between the rubber and the door approximately 1/4." This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The findings were verified and confirmed by the U.S. FOIA (b)(6) [redacted] during the above observations. The U.S. FOIA (b)(6) did not provide any further documentation on the black rubber gasket smoke and fire ratings.	K 374	-The monthly routine documentation system for the smoke barrier door testing and subsequent corrective actions will be maintained by the Maintenance Director and reviewed by the Administrator. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: -The Maintenance Director/designee will inspect all smoke doors each month x 90 days. The findings will be reported to the QAPI committee on a monthly basis x 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 374	Continued From page 23 The surveyor informed the U.S. FOIA (b)(6) of the findings at the Life Safety Code survey exit on 6/27/22. NFPA 101- 2012 edition Life Safety Code 19.3.7.6, 19.3.7.8, 19.3.7.9 NJAC 8:39-31.1(c), 31.2(e)	K 374		
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 6/22/22, it was determined that the facility failed to ensure resident bathroom ventilation systems for eight (8) of 40 units were adequately maintained, in accordance with the National Fire Protection Association (NFPA) 90 A, B. This deficient practice was evidenced by the following: The surveyor, in the presence of another surveyor, U.S. FOIA (b)(6) observed that the ventilation in the following resident room bathrooms did not function: 101, 102, 103, 104, 105, 106, 107, 113, and 114.	K 521	K521 - HVAC 1. How the corrective action will be accomplished for those residents found to have been affected by the practice: -On 6/23/2022 the Maintenance Director reconnected the vent in room 107, 113, and 114. -On 06/30/2022 the Maintenance Director replaced the ventilation unit that provides ventilation for rooms 101,102,103,104,105, and 106. 2. How the facility will identify other	7/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 521	Continued From page 24 The surveyor requested that the U.S. FOIA (b)(6) [redacted] confirm if the units were functioning by placing a piece of single-ply toilet tissue paper across the ceiling grills to confirm ventilation. When tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. At that time, the surveyor interviewed the maintenance staff member and U.S. FOIA (b)(6) [redacted], who confirmed that the exhaust vents in the above resident room bathrooms were not functioning when tested. The U.S. FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 6/27/22. NFPA 90 A NFPA 101-2012 -19.5.2.1 section 9.2.2 NFPA 101-2012- 19.5.2.1 Chapter 9.1 Utilities 9.2.1 NJAC 8:39-31.2(e)	K 521	residents having the potential to be affected by the same deficient practice. -On 6/23/22 Administrator and Maintenance Director checked all rooms requiring ventilation and identified two vents that needed repair. Repairs were completed immediately. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur. -On 6/22/2022 The Administrator re-educated the U.S. FOIA (b)(6) [redacted] on the components of this regulation with emphasis on ensuring exhaust ventilation is in working order. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, i.e., what quality assurance program will be put into place. -Maintenance Director/designee to monitor at random times, ventilation vents daily x 7 days, weekly x4 and monthly x4 with findings reported monthly to QA team for review and action as needed.	
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that	K 911		7/2/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING 01 B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 911	Continued From page 25 are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not maintain the required clearance around electrical panels, guarding of live parts of electrical equipment and controls with unlocked panels in resident accessible areas in accordance with NFPA 101, 2012 Edition, Section 19.5.1,19.5.1.1, 9.1, 9.1.2, NFPA 99 2012 Edition, Section 6.3.2.1, 15.5.1.2 and NFPA 70 2011 Edition, Section 110.26, 110.27 and 110.16. This deficient practice of electrical panels not guarded against accidental contact by approved enclosures and unlocked panels in resident accessible areas. 1. At 11:29 AM, the surveyor, in the presence of another surveyor, U.S. FOIA (b)(6) observed in the basement, that the 480 volt electrical panel was blocked by metal chairs, plastic, resident sitting cushion and metal debris that would prevent staff and emergency personnel from disconnecting the electrical power quickly. 2. At 11:38 AM, the surveyor, in the presence of another surveyor, U.S. FOIA (b)(6) observed outside the Physical Therapy room in the exit/egress corridor that three (3) of three (3) electrical wall panels were not locked.	K 911	K911 SS-E 1. How the corrective action will be accomplished for those residents found to have been affected by the practice: - On 6/23/22 access to electrical panel was cleared of debris. - On 6/23/22 Maintenance director locked electrical wall panels. 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. - On 6/23/22 electrical panels were checked to ensure they were not blocked and were properly locked. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur. - On 6/23/2022, the administrator re-educated the U.S. FOIA (b) (6) on the components of this regulation with an	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 911	Continued From page 26 The observations were confirmed by the U.S. FOIA (b)(6) during the tour of the facility. The U.S. FOIA (b)(6) was informed of the above observations at the Life Safety Code exit conference on 6/27/22. NJAC 8:39-31.2(e) NFPA 70, 99	K 911	emphasis on keeping electrical panels clear and locked. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, i.e., what quality assurance program will be put into place. - Maintenance Director/designee to monitor at random times, electrical panels daily x 7 days, weekly x4 and monthly x4 with findings reported monthly to QA team for review and action as needed.	
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview conducted on 6/22/22, it was determined that the facility failed to ensure that the facility's emergency generator annunciator panel was properly installed as per NFPA 99 and 72. This deficient practice was evidenced by the	K 916	K 916 NFPA Life Safety Code Standard Electrical Systems / Essential Electrical Systems 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice:	7/2/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING 01 B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 916	Continued From page 27 following: At 11:50 AM, the surveyor, in the presence of another surveyor, U.S. FOIA (b)(6) observed that the generator annunciator panel was installed on the wall, at the 100-wing nurse station. The annunciator panel was installed with exposed wire and not enclosed in conduit. The wire was zip-tied to the fire annunciator panel metal enclosed wire conduit up into the drop ceiling. The U.S. FOIA (b)(6) confirmed the finding during the observation. The U.S. FOIA (b)(6) was informed of the above observation at the Life Safety Code exit conference on 6/27/22. NJAC 8:39-31.2(e) NFPA 99 Health Care Facilities Code NFPA 72 National Fire Alarm and Signaling Code	K 916	On 6/23/2022 The wiring for the emergency generator annunciator panel was enclosed with an electrical conduit. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: On 6/23/2022 the Maintenance Director inspected the generator annunciator panel for additional exposed wires. 3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: On 6/23/2022 U.S. FOIA (b) (6) was re-educated as to the required components of this tag by the Administrator. On 6/23/2022 The Facility Maintenance Rounds Checklist was modified to include the verification and compliance to this standard. Any adjustments identified will be addressed immediately. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Maintenance Director/designee will inspect the annunciator panel monthly x 90 days to ensure it is intact and functional. The findings will be reported to the QA committee on a monthly basis x 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 916	Continued From page 28	K 916	months.	
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 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)	K 918		8/8/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING 01 B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 918	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of facility documents on 6/27/22, 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, in accordance with NFPA 99 for emergency electrical generator systems and b.) ensure that a remote manual stop station for the generator was provided in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice was evidenced for one (1) of one (1) generator logs provided by the U.S. FOIA (b) (6) by the following: 1. A review of the generator records for the previous twelve months, did not reveal documented certification that the generator would start and transfer power to the building within ten seconds. Currently the U.S. FOIA (b)(6) was performing a monthly load test, but he was not recording the required transfer times on the testing log. An interview was conducted with the U.S. FOIA (b)(6) at the time of record review, who confirmed there was no transfer time data documented on the facilities report's for the generator's required monthly load tests. 2. On 6/14/22, the surveyor, in the presence of another surveyor, U.S. FOIA (b)(6) it was observed that the facility interior generator (located in the basement) was observed to not	K 918	K918 Electrical Systems- Essential Electrical Systems 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: -06/28/2022, the Maintenance Director coordinated the required transfer load test to ensure the generator was functioning as designed and transferred power to the building and was within the required 10-second time frame and documented as such. -Company contracted on 7/26/2022 to install a manual stop station outside the building and was installed on 8/8/2022. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: 06/28/2022, the Maintenance Director coordinated the required transfer load test to ensure the generator was functioning as designed and transferred power to the building and was within the required 10-second time frame and documented as such. 3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING 01 B. WING _____	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

(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 918	Continued From page 30 have a remote manual stop station inside or outside, to prevent inadvertent or unintentional operation. An interview was conducted during the observation with the U.S. FOIA (b)(6) . He stated that he was unaware that he needed a manual stop station. The U.S. FOIA (b)(6) were informed of the finding's at the Life Safety Code exit conference on 6/27/22. 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	06/28/2022, the Administrator re-educated the facility U.S. FOIA (b) (6) on the components of this regulation with emphasis on ensuring required maintenance testing of the facility generator is conducted per guidelines and documented as such. By 06/28/2022, the Administrator re-educated the facility U.S. FOIA (b)(6) on the need for a manual stop station. -Maintenance Director will present monthly load testing tracking tool to Administrator with transfer times at monthly QA meeting for 90 days. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Administrator/designee will audit the generator test log form monthly x 90 days. The findings will be reported at the QA meeting on a monthly basis x 3 months and QAPI quarterly if there are an deficient findings. The generator company will inspect the manual stop station during semi annual maintenance and report any discrepancies to the Maintenance Director and Administrator. Maintenance Director will bring findings to the QA meetings.	
K 921	Electrical Equipment - Testing and Maintenanc	K 921		9/6/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 921 SS=D	Continued From page 31 CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 6/22/22, it was determined that the facility failed to ensure electrical equipment wiring was safe and in accordance with NFPA 70.	K 921	K921 □ Electrical Equipment - Testing and Maintenance 1. How the corrective action will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 921	Continued From page 32 This deficient practice was evidenced for one (1) of 50 resident beds by the following: At 1:12 p.m., the surveyor observed the electrical power cord to resident room 132, that the doorside resident bed was observed to have exposed wires, where a yellow universal replacement plug was installed. This improvised electrical plug & cord was plugged into the wall receptacle and was in-use. During an interview, at the time of observation, the U.S. FOIA (b)(6) confirmed that the replacement plug was not permitted and should not be like that in the facility. The U.S. FOIA (b)(6) was informed of the finding at the Life Safety Code exit conference on 6/27/22. NJAC 8:39-31.2(e) NFPA 70, 99	K 921	accomplished for those residents found to have been affected by the practice: -On 09/06/2022 the Maintenance Director removed bed from room and replaced with an additional bed. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. -On 6/22/22 U.S. FOIA (b) (6) was re-educated on the components of this regulation with emphasis on maintaining equipment free of exposed wires. -On 6/22/22 Maintenance Director inspected facilities beds to ensure that there were no additional beds with this deficient practice. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur. -On 6/22/22 U.S. FOIA (b) (6) was re-educated on the components of this regulation with emphasis on maintaining equipment free of exposed wires. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, i.e., what quality assurance program will be put into place.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 921	Continued From page 33	K 921	-Maintenance Director/designee to monitor at random times, resident bed wiring daily x 7 days, weekly x4 and monthly x2 with findings reported monthly to QA team for review and action as needed.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier.	K 923		7/2/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 923	Continued From page 34 Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 6/27/22, it was determined that the facility failed to store cylinders of compressed oxygen in a manner that would protect the cylinders against tipping, rupture and damage in accordance with NFPA 99. This deficient practice was identified for one (1) of four (4), H-type oxygen cylinders and was evidenced by the following: At 11:38 AM, the surveyor observed in the 200-wing oxygen storage room by the nurse station, that one (1) of four (4) H-type cylinders were not properly secured. The chain used to secure the cylinder was on the floor in front of the cylinder, offering no protection from tipping, rupture and damage in accordance with NFPA 99. An interview was conducted with the U.S. FOIA (b)(6) who both stated that the cylinders must be secured from tipping, rupture and damage at all times. The U.S. FOIA (b)(6) was informed of the finding at the Life Safety Code exit conference on 6/27/22.	K 923	K923- Gas Equipment 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: -On 06/27/2022 the Facility Maintenance Director immediately secured the H-type cylinders of compressed oxygen in a manner that would protect the cylinders against damage. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: -By 6/27/2022, the Facility Director of Maintenance conducted a facility wide audit to ensure all cylinders of compressed oxygen and helium in the facility were secure and protected from damage. 3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**07/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	**114 PITTSTOWN ROAD** **PITTSTOWN, NJ 08867**

(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 923	Continued From page 35 NJAC 8:39-31.2(e) NFPA 99	K 923	-By 06/27/2022, the Administrator re-educated the U.S. FOIA (b)(6) on the components of this regulation with emphasis on ensuring oxygen and helium cylinders are secure and protected from damage. -By 06/27/2022, the Facility Maintenance Director educated the facility nursing staff on the components of this regulation with emphasis on ensuring oxygen and helium cylinders are secure and protected from damage. 4.How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: -Administrator/designee will monitor at random times, oxygen and helium cylinders daily x 7 days, weekly x4 and monthly x4 with findings reported at the monthly QA meetings for review x 90 days	

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
315433 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/29/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

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 K0211	07/18/2022	LSC K0222	07/02/2022	LSC K0225	07/02/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0227	09/01/2022	LSC K0321	07/05/2022	LSC K0347	07/02/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	09/12/2022	LSC K0363	07/02/2022	LSC K0374	09/20/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0521	07/09/2022	LSC K0911	07/02/2022	LSC K0916	07/02/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0918	08/08/2022	LSC K0921	09/06/2022	LSC K0923	07/02/2022

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?
7/1/2022	☐ YES ☐ NO