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 _____	C 10/19/2023

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 Complaints#: NJ00160546, NJ00163908, NJ00156816, and NJ00158985 Survey Date: 10/19/23 Census: 105 + 1 bed hold Sample: 21 (sample) + 3 (Closed Records) + 20= 44 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 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility provided documents it was determined that the facility failed to provide a NJ Ex Order 26.4b1 resident a specialized call bell according to the resident's limitation and preference. This deficient practice was identified for Resident #1, one (1) of two (2) residents reviewed for the NJ Exec Order 26.4b1, and was evidenced by the following:	F 558	EElement One - Corrective Action: Resident #1 care plan updated to reflect with call bell usage for tap (pancake) call bell and staff educated on placement of tap bell. Element Two -Identification of at Risk Residents: All residents that require a tap (pancake)call bell are at risk. Resident who the facility identifies may be at risk for decreased ability to use a call bell will be	11/9/23

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

Electronically Signed | 11/08/2023

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F 558	Continued From page 1 On 10/13/23 at 11:47 AM, during the courtesy meeting with the facility's US FOIA (b)(6) US FOIA (b)(6) informed the survey team that she was the one who recommended to the facility for the resident to have a specialized call bell due to the resident's NJ Ex Order 26.4b1 as per resident's preference. The surveyor reviewed Resident #1's medical records. The Admission Record (or face sheet; an admission summary) showed that the resident was admitted to the facility with diagnoses that included but were not limited to Ex Order 26.4B1 [redacted] According to the most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of Ex Order 26.4B1 Section C Cognitive Patterns had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which reflected that the resident's cognitive status was Ex Order 26.4B1 . The qMDS also reflected in Section [redacted] NJ Exec Order 26.4b1 Status, G0400 NJ Exec Order 26.4b1 in [redacted] of [redacted] that the resident was coded [redacted] for the [redacted] that interfered with NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1 and [redacted] for NJ Exec Order 26.4b1	F 558	screened by therapy for appropriate call bell and care planned for use. Element Three – Systemic Change: The Director of Rehabilitation conducted an audit to determine which residents have a tap call bell ,and care plans were reviewed and updated. Nursing staff were educated on use of and placement of tap call bell for resident #1 by DON or designee. Interdisciplinary team educated for care planning regarding tap call bell by DON or designee. Element Four - Quality Assurance: The measure the facility will take to ensure problem does not re-occur is that Director of Rehabilitation/Designee will conduct random audits of tap (pancake bell) to ensure proper placement 2x per week x4 weeks and monthly x4 months. Needed corrections will be addressed as they are discovered. Findings to be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary.	

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A review of the personalized care plan with a focus that the resident had a Ex Order 26.4B1 [redacted]. The limited ADL care plan's interventions/tasks did not include information about the specialized call bell.

Further review of the care plan showed that the resident had a focus care plan for at risk for Ex Order [redacted] The interventions/tasks included call the light is within reach, encourage the resident to use it for assistance as needed, and needs a prompt response to all requests for assistance that was created on NJ Exec Order 26.4 and revised on NJ Exec Order 26.4B1 The personalized care plan interventions did not specify where to put the call bell according to the resident's limitations and preferences.

In addition, the resident had a care plan focus that the resident has Ex Order 26.4B1 [redacted]

The IDCP (Interdisciplinary Care Planning)- Team Conference for quarterly assessment dated NJ Exec Order 26.4 and was locked (closed) on NJ Exec Order 26.4B1. The information included that the resident was dependent on staff for NJ Ex Order 26.4b1 [redacted] and that the resident requires total care for all aspects of care NJ Exec Order 26.4b1, NJ Exec Order 26.4b

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NJ Exec Order 26.4b1 NJ Exec Order 26.4b and all NJ Exec Order 26.4 require total assist. In addition, it included that the resident could follow NJ Exec Order 26.4b1 and was currently on NJ Exec Order 26.4b1 services.

A review of the electronic Progress Notes (PN) dated NJ Exec Order 26.4b1 by the US FOIA (b)(6) showed that the resident was issued a last cover date of NJ Exec Order 26.4b1 because the resident met the goals for NJ Exec Order 26.4b1 and NJ Exec and that the resident could not sign the NJ Exec Order 26.4b1 is a notice that indicates when your care is set to end from a skilled nursing facility (SNF) example skilled NJ Exec and NJ Exec O due to NJ Ex Ord

On 10/17/23 at 8:49 AM, the surveyor interviewed Licensed Practical Nurse #1 (LPN#1) in the NJ Exec D-wing nursing station. LPN#1 informed the surveyor that LPN#2 was the assigned nurse of Resident # 1.

On 10/17/23 at 8:51 AM, the surveyor interviewed LPN#2. LPN#2 informed the surveyor that she was a per diem nurse and assigned nurse of Resident # 1. The surveyor asked the LPN to go with the surveyor inside the resident's room. In the resident's room, the surveyor and the LPN both observed the flat call bell attached/pinned to the left part of the head bed approximately (two) 2 inches away from the pillow where the head of the resident was. The specialized call bell was placed where the resident was unable to use the call bell. The surveyor observed the resident with NJ Ex Order 26.4b1 .

On that same date and time, the surveyor asked LPN#2 if that was where the call bell should be

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and the LPN stated that "definitely not," and the LPN took it and placed it just above the Ex Order 26.4B1 process (Ex Order 26.4B1) and grabbed the residents hands to be able to touch the call bell. The surveyor then asked the LPN should the call bell was there, and the LPN stated "yes" and that the resident could use it with the resident's hand. At this time the resident said it should be under the NJ Ex Order 26.4b1.

Then, the surveyor observed the US FOIA (b) went outside the room and took a towel before entering the resident's room again.

On 10/17/23 at 8:53 AM, the surveyor interviewed the assigned US FOIA (b)(6)) of the resident. The US FOIA (b) informed the surveyor that he was the regular US FOIA (b) in the Ex Order 26 wing, worked 7-3 and 3-11 shifts, and had been working in the facility for NJ Ex Order 26.4b1. He further stated that he was assigned to the resident and he was familiar with the resident.

At that same time, the US FOIA (b) stated that the resident's specialized call bell should be placed in the resident's chest so the resident could reach it with their hand. He further stated that, lately the resident was not able to use the call bell and the US FOIA (b) was unable to state how long and why. The surveyor asked the US FOIA (b) how he knew that it should be placed in the resident's chest and who educated him about the proper placement of the resident's call bell, and the US FOIA (b) stated that he just knew. The US FOIA (b) was unable to state who informed him that it should be in the resident's chest.

On 10/17/23 at 9:48 AM, the surveyor notified the

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F 558	Continued From page 5 US FOIA (b)(6)) of the above findings. On 10/17/23 at 11:00 AM, the surveyor interviewed the US FOIA (b)(6) in the presence of the survey team. The US FOIA (b)(6) acknowledged that he knew Resident #1 and that he recently treated and discharged (d/c) the resident from US FOIA (b)(6). The US FOIA (b)(6) informed the surveyor that the resident was d/c with no significant changes, and remained in NJ Ex Order 26.4b1 with ADLs except for the Ex Order 26.4B1 "have some movement." On that same date and time, the surveyor asked about the resident's specialized call bell. The US FOIA (b)(6) claimed he called it a "pancake call bell" the way it looked, flat and circular. He stated that the pancake call bell should be placed on the left breast area of the resident. The surveyor asked the US FOIA (b)(6) if education was provided to the staff regarding the proper use of the pancake call bell and who provided the call bell. The US FOIA (b)(6) stated that he discussed with the US FOIA (b)(6) verbally how to use it. The surveyor then asked how other nurses and CNAs were educated, and he stated that he did not talk to nurses and CNAs. The US FOIA (b)(6) further stated that generally, it should be nurses who document for care plan for the use of the call bell. On 10/17/23 at 11:55 AM, the surveyor interviewed the US FOIA (b)(6) in the presence of the survey team. The US FOIA (b)(6) informed the surveyor that when she was promoted as a US FOIA beginning of NJ Exec Order 26.4b1, that was the same time she observed that the resident had the specialized call bell. The US FOIA (b)(6) stated that she was not sure	F 558		

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who provided the call bell. She further stated that it was the [NJ Exe] who recommended the specialized call bell since the resident had NJ Ex Order 26.4b1 [redacted] The [US FOIA (b)(6)] stated that the call bell should be placed NJ Exec Order 26.4b1. She further stated that it was her and the [US FOIA (b)(6)] who assessed the resident that the resident can use their left hand in using the specialized call bell.

On that same date and time, the surveyor asked the [US FOIA (b)(6)] if education was provided to the staff including the aides on the proper placement of the specialized call bell, the [US FOIA] stated that just verbal instructions to the aides in the morning shift. The surveyor then asked how about other shifts, 3-11 and 11-7, the [US FOIA] stated that she told the nurses in the morning, and that they do shift reports, and "probably" the nurses notified other staff. The [US FOIA (b)(6)] acknowledged that in-service or education should have been provided to all staff and all shifts on the proper placement of the call bell.

In addition, the surveyor also asked if should it be in the care plan. The [US FOIA] stated that it should be documented in the care plan the proper placement of the call bell. She further stated that the preference of the resident should be consider on where to put the specialized call bell and it should be in the care plan interventions. The [US FOIA (b)(6)] informed the surveyor that the resident was NJ Exec Order 26.4b1, not [NJ Exec Order 26.4b1] and had no NJ Exec Order 26.4b1.

On 10/17/23 at 12:51 PM, the survey team met with the [US FOIA (b)(6)] US FOIA (b)(6) in US FOIA (b)(6) [redacted], and notified of the above findings.

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F 558	Continued From page 7 On 10/18/23 at 12:00 PM, the surveyor reviewed the typewritten explanation that was provided by the [US FOIA (b)(6)] included that the staff education and care plan was updated about the pancake call bell after the surveyor's inquiry. Included in the typewritten explanation also was that the maintenance provided a call bell at the request of the Ombudsman on [NJ Ex Order 26.4b1]. The pancake bell was on the premises and supplied on [NJ Ex Order 26.4b1] A review of the updated care plan showed an intervention/task dated [NJ Ex Order 26.4b1] for a [Ex Order 2] call within reach "Patient prefers [NJ Ex Order 26.4b1]." On 10/19/23 at 12:55 PM, the survey team met with the [US FOIA (b)(6)] and the facility management stated that there was no additional information and the team could proceed with decision making.	F 558		
F 559 SS=D	NJAC 8:39- 4.1 (a), 12 Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is	F 559		11/9/23

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F 559	Continued From page 8 changed. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and other pertinent facility documentation, it was determined that the facility failed to a) notify in advance and in writing of a resident's new roommate change for a NJ Ex Order 26.4b1 [redacted] in accordance with federal and state regulations. This deficient practice was identified for one (1) of three (3) residents reviewed for room change (Resident #81) and was evidenced by the following: On 10/17/23 at 10:07 AM, the surveyor interviewed the US FOIA (b)(6) [redacted] who stated the process for a resident's room change were discussed during the morning clinical meeting with the Interdisciplinary team. The team was comprised of the US FOIA (b)(6) [redacted] to the resident, US FOIA (b)(6), the US FOIA (b)(6) [redacted]) or the US FOIA (b)(6) [redacted]) assigned to the resident, the US FOIA (b)(6) [redacted]), the US FOIA (b)(6) [redacted], and the US FOIA (b)(6) [redacted] The conversation involved discussing the resident's NJ Exec Order 26.4b1, NJ Exec Order 26.4b [redacted] We also wanted the resident in the room to be comfortable along with the new resident who was going to be moved into the room. At that time, the US FOIA (b) [redacted] stated that the conversation was not documented anywhere. The team meetings were documented but not our conversations. "We did document the notification to the family and guardian" [as applicable]. At that time, the US FOIA (b) [redacted] informed the surveyor that she recalled the Resident who was being moved	F 559	Element One - Corrective Action: Resident #81 guardian was made aware of the transfer. Element Two -Identification of at Risk Residents: All residents that have an incoming roommate have the potential to be affected. ELEMENT THREE: SYSTEMIC CHANGES: The Interdisciplinary team was educated on providing written and verbal documentation to resident /guardian of an incoming roommate. QUALITY ASSURANCE To maintain and monitor ongoing compliance, the Administrator or Designee will audit all room changes to confirm written and verbal notification of incoming roommate was completed, weekly x4 weeks and monthly x4months Needed corrections will be addressed as they are discovered. Findings to be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary.	

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into Resident #81's room was documented as the [NJ Ex Order 26.4b1] but did not see the report before it was sent to the State Agency. "As the [US FOIA (b)(6)] I thought it was ok" to move the resident into Resident 81's room. "When I placed the resident in the room, I did not think the [NJ Exec Order 26.4b1] to be was the [NJ Exec Order 26.4b1] I effectuated the room changes [NJ Exec Order 26.4b1] after a team conversation to determine the room change".

At that time, the DSS stated that she had notified the guardian of the Resident who was being moved into Resident #81's room.

At that time, the [US FOIA (b)] stated that she had not provided a written notification to Resident #81's family.

The surveyor reviewed Resident #81's medical record.

A review of the resident's Admission Record (an admission summary) reflected that Resident #81 was admitted to the facility with diagnoses that included [Ex Order 26.4B1] [redacted].

According to the quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate management of care dated, [Ex Order 26.4B1] Resident #81 was documented as having a Brief Interview for Mental Status score of [Ex Order 2] out of [Ex Order 2]

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F 559	Continued From page 10 indicating that the resident had a Ex Order 26.4B1 Ex Order 26.4B1 . A review if the Census (total number of residents) list reflected Resident #81 had been in the room since Ex Order 26.4B1 . There was no documentation that Resident #81 was notified of a new roommate, or their representative was notified in writing. On 10/18/23 at 12:32 PM, during a meeting with the surveyors, the US FOIA (b)(6) and the US FOIA (b)(6) the surveyor discussed the concern regarding the missing written notification of a new roommate for Resident #81. On 10/19/23 at 11:52 AM, during a meeting with the surveyors, the US FOIA (b)(6) the US FOIA (b)(6) and the US FOIA (b)(6) stated the US FOIA (b) was educated on the process of roommate notifications. At that time, the US FOIA (b)(6) stated that they did not have a facility policy on room changes.	F 559		
F 584 SS=D	N.J.A.C. 8:39-4.1(a)(13) Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		11/9/23

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F 584	Continued From page 11 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation it was identified that the facility failed to provide residents with a clean, safe, comfortable, and home like	F 584	Element One - Corrective Action: Construction material was removed from dining area immediately.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 12 environment. This deficient practice was identified in one (1) of two (2) dining areas where morning activities for the English-speaking residents were also held. A review of the Material Safe Data Sheet for [brand name redacted] under Section 7: Handling and Storage included the following: Provide good ventilation. Do not use in confined spaces without adequate ventilation and/or respirator. Avoid contact with skin and eyes. Do not eat, drink, or smoke when using the product. Methods of Clean-up: Small spillages: Absorb with sand or other inert absorbent. Large spillages: Dam and absorb. Collect spillage in containers, seal securely and deliver for disposal according to local regulations. Wear necessary protective equipment. Storage: Keep separate from food, feedstuffs, fertilizers and other sensitive material. Store in closed original container at temperatures between 5°Cand 30°C/ 40°F and 86°F. Protect from freezing and direct sunlight. On 10/06/23 at 01:20 PM, the surveyors observed Resident #95 walking the hallway adjacent to the dining area without assistance. The resident was NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 At that time, the surveyor walked with Resident #95 towards the US FOIA (b)(6) office. The US FOIA (b)(6) stepped outside her room and assisted the resident towards their wing. On 10/11/23 at 10:28 AM, the surveyor met with the US FOIA in the main dining room to commence the meeting with the resident council president and	F 584	Element Two -Identification of at Risk Residents: All residents that utilize the dining room have the potential to be affected. ELEMENT THREE: SYSTEMIC CHANGES: US FOIA (b)(6) were educated on ensuring construction materials are not in common resident areas. QUALITY ASSURANCE To maintain and monitor ongoing compliance, LNHA or designee to monitor all common resident areas to ensure there are no construction materials in area weekly x4 and monthly x4. Needed corrections will be addressed as they are discovered. Findings of audits will be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary.	

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representatives.

At that time, the [US FOIA] stated that the resident council meeting was always held in the main dining room. The main dining room had two entrance and exit doors from the hallway and across the entrance/exit doors was the entrance to the kitchen.

At that time, the surveyor observed a heavy-duty flatbed dolly cart with handles and wheels, a hand truck, a fan, a mop, a palette of wood flooring, and multiple gallons of vinyl flooring adhesive (construction materials) next to one of the entrances/exit doors in which one of the resident council representatives (Resident #50) entered from. Resident#50 parked their [NJ Exec Order 26.4b1] [redacted] next to the palette of construction materials.

At that time, the resident council member(s) who did not want to be identified stated that the floor construction where we had our resident council meeting was new. They were unsure exactly when.

On 10/11/23 at 12:16 PM, the surveyor observed residents in the dining area waiting for lunch to be served. The construction materials were still in the corner of the dining area next to the entrance/exit and adjacent to a dining table where residents were seated.

On 10/11/23 at 01:09 PM, the surveyor met with the [US FOIA (b)(6)] [redacted]) and walked into the dining area together. The [US FOIA (b)] confirmed observing the construction material

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with visible seepage from the vinyl glue adhesive gallon container. The [redacted] informed the surveyors that he did not put the construction materials into the dining area. "I just noticed it was there." The [redacted] stated that the facility had a contractor who did not report to him.

At that time, the [redacted] stated that the facility did not have space to put the construction materials. The [redacted] had hired the contractor and reported to the [redacted] directly. The [redacted] stated he was in -charge of water, the hood in the kitchen, painting, temperature, and water testing. The materials purchased by the [redacted] were not in bulk and could be kept downstairs.

On 10/11/23 at 01:25 PM, the surveyors met with the [redacted] and discussed the concern regarding the construction materials and the visible seepage from the vinyl glue adhesive gallon container stored inside the dining area where residents ate and had activities.

At that time, the [redacted] stated it did not occur to him that it was a problem. The [redacted] stated yes, the area is a resident area, yes, he did see the residents in the area, and yes, food was served there. The [redacted] confirmed he had knowledge that he had wandering residents living in the facility and yes, it can be a hazard.

At that time, the [redacted] stated that it did not occur to him that it was a problem. The [redacted] informed the surveyors that he would move the construction materials from the dining area.

On 10/13/23 at 10:19 AM, the surveyor observed the dining area was cleared of the construction

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F 584	Continued From page 15 materials. At that time, during the meeting with the survey team, the [redacted] stated he was ultimately responsible for the construction. He did not see that it was a contradiction to a homelike or safety environment. On 10/13/23 at 11:28 AM, during a meeting with the surveyors, the [redacted], the surveyor discussed the concern regarding safety, homelike environment (similar to those found in a private residence or apartment) and storing construction materials in an area where confused wandering residents, residents that required assistance with daily living, and all the residents who had access to dining area. On 10/16/23 at 12:06 PM, during a meeting with the surveyors, the [redacted] stated the supplies were not a danger, a resident would have to use a crowbar to open the vinyl adhesive glue gallon containers. The [redacted] did not discuss the palette of wood, the heavy-duty flatbed dolly cart with handles and wheels, the hand truck, the fan stored next to the entrance/exit of the dining area and the decrease in dignity for the residents who used the dining/activities area. At that time, the [redacted] stated we moved it immediately. Based on the regulations it was not against homelike environment. It was appropriate to keep it there for a few days. It was a big process to remove the palette. It took 45 minutes to remove from the dining area. It was there for a	F 584		

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F 584	Continued From page 16 short period of time. At that time, the [redacted] informed the surveyors that the facility did not have a Policy and Procedure for homelike environment. A review of the undated/unsigned facility provided job description for the facility Maintenance Director under position summary included. The Maintenance Director follows established safety rules and policies and procedures of the maintenance department, keeps required records and submits them to the administrator and director of property management when required and cooperates with other employees and department heads. Under responsibilities/accountabilities included performs overall supervision of the maintenance department including "hands on" performance of maintenance and repair work. Concerns his/ herself with safety of all facility residents in order to minimize the potential for fire and accidents. Also ensures that facility adheres to the legal, safety, health, fire, and sanitation codes by being familiar with his/ her role in carrying out the facilities fire, safety, disaster plans and by being familiar with current MSDS. A review of the undated/unsigned facility provided job description for the Administrator (LNHA) included the following: Position Summary The administrator is responsible for planning and is accountable for all activities and department of the facility subject to rules and regulations promulgated by government agencies to ensure proper health care services to residents. The administrator administers directs and coordinates all activities of the facility to assure that the	F 584		

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F 584	Continued From page 17 highest degree of quality of care is consistently provided to the residents. Responsibilities 2. Interprets personal practices within policy guidelines and recommends changes as necessary; 5. Super intense physical operations of the facility; 9. Concerns his/herself with the safety of all nursing facility residents in order to minimize the potential for fire and accidents. Also, ensures that the facility adheres to the legal safety health fire and sanitation codes by being familiar with his/her role in carrying out the facilities fire safety disaster plans and by being familiar with the current MSDS. NJAC 8:39-31.4(a)(f)	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes	F 607		11/9/23

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F 607	Continued From page 18 occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent documentation provided by the facility it was determined that the facility failed to implement the facility's [NJ Exec Order] policy to ensure licensed staff credentials were verified upon hire. This deficient practice was identified for three (3) of nine (9) newly hired staff reviewed, (Staff #1, #4, and #6) and was evidenced by the following: On 10/18/23 at 9:16 AM, the surveyor reviewed nine randomly selected new employee files for license verification which revealed the following: Staff #1, a Certified Nursing Assistant (CNA), hired [NJ Exec Order 26.], had a New Jersey Department of Health (NJDOH) online Public Registry license verification printout (used to verify the status of a CNA's license and to check the nurse aide registry) which did not include the date that the verification was done. Staff #4, a [US FOIA (b)(6)], hired [NJ Exec Order 26.4b], did not have a New Jersey Division Consumer Affairs license verification printout for license verification. There was no documented evidence that Staff	F 607	Element One - Corrective Action: Employee # 4 license was immediately verified. Element Two -Identification of at Risk Residents: All residents that are cared for by licensed personnel have the potential to be affected. An audit was completed on all new hires in the last 12 months to ensure all licensed personnel have licensure verification. ELEMENT THREE: SYSTEMIC CHANGES: The [US FOIA (b)(6)] was re-educated on the onboarding process and the facility's policy titled Prohibition of Resident Abuse & Neglect which includes ensuring newly hired personnel that have a license have a dated licensure verification completed prior to start date. In addition, [US FOIA (b)] was educated on how to print licensure verification with the date on it. QUALITY ASSURANCE Audits of new employee files will be	

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F 607	Continued From page 19 #4's license was verified. Staff #6, a [US FOIA (b)(6)] hired [NJ Exec Order 25], had a NJDOH online Public Registry license verification printout which did not include the date that the verification was done. On 10/18/23 at 11:59 AM, the surveyor interviewed the [US FOIA (b)(6)] regarding the process for license verification. The [US FOIA (b)] stated that she would go online and verify the employee's license. The [US FOIA (b)] confirmed that Staff #1 and #6 did not have a date on their license verification printout. The [US FOIA (b)] confirmed that Staff #4 did not have a license verification printout in their employee file. On 10/18/23 at 01:02 PM, in the presence of the survey team, the surveyor notified the [US FOIA (b)(6)] the concern that three newly hired employees did not have documented evidence that their licenses were verified prior to their date of hire. On 10/19/23 at 10:59 AM, in the presence of the survey team, [US FOIA (b)(6)] and [US FOIA (b)(6)] the [US FOIA (b)(6)] stated that the [US FOIA (b)] now knows how to print the date on the printout. The surveyor asked if licensed employees should have their licenses verified prior to hire and that if the date should be on it. The [US FOIA (b)(6)] confirmed that they should be. A review of the undated facility provided policy titled, "New Hire And Onboarding Process" included the following: Prior to a start date: Valid ....NJ State License (RN, LPN, C.N.A., etc.)	F 607	performed by the LNHA or designee for licensure verification as all new employees are onboarded and prior to reporting to work. Needed corrections will be addressed as they are discovered. Findings to be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary.	

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F 607	Continued From page 20 A review of the facility provided policy titled, "Prohibition of Resident Abuse & Neglect" dated 5/18/22, included the following: Employee and Volunteer Screening 2. Inquiry of State Nurse Aide Registry for CNA applicants 3. Inquiry of licensing authorities for all licensed/certified positions.. N.J.A.C. 8:39-43.15(a)	F 607		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. 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 thoroughly investigate an incident/accident: a) on [NJ Exec Order 26.4] that resulted in a [NJ Exec Order 26.4b1] for Resident #27	F 610	Element One - Corrective Action: Incidents and accidents for resident 27 and 208 were investigated and interventions added to care plans.	11/9/23

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F 610	Continued From page 21 and b) Resident 208. This deficient practice was identified for two (2) of six (6) residents reviewed for accident and was evidenced by the following: 1. On 10/10/23 at 11:44 AM, the surveyor observed Resident #27 sitting in their room and NJ Exec Order 26.4b1 as the resident [redacted] in [redacted]. At that time, the US FOIA (b)(6) was at the activities area, attending to other [redacted] residents. On 10/10/23 at 12:47 PM, the surveyor observed the resident was not in the room and found the US FOIA (b)(6)) in the room instead. In the presence of the surveyor and US FOIA (b)(6) stated that she was waiting for the resident to call her from the bathroom. At that time, the [redacted] stated that the resident was [redacted] with their [redacted]. The door to the bathroom was closed. The [redacted] stated that the resident had a NJ Exec Order 26.4b1 [redacted] The surveyor reviewed the medical record for Resident #27 The Admission Record (AR; or facesheet; an admission summary) reflected that the resident had been admitted with diagnoses which included Ex Order 26.4B1 [redacted]	F 610	Element Two -Identification of at Risk Residents: To protect those who could be affected/in a similar situation, incident/accidents for the last three months were audited to ensure complete and through investigations were performed. ELEMENT THREE: SYSTEMIC CHANGES: Interdisciplinary Care Planning Team (IDCP), Nursing and rehabilitation were educated on risk management documentation including completing the investigation thoroughly, gathering witness statements, completing a thorough investigation including root cause analysis and updating the care plans/plan of care. QUALITY ASSURANCE To maintain and monitor ongoing compliance, Director of Nursing (DON)/designee will audit all incident/accidents for thorough and complete investigations and care plans/plan of care updated daily x 7 days then weekly x 6 months. Needed corrections will be addressed as they are discovered. Findings to be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary.	

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Ex Order 26.4B1 [redacted]

The quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care dated Ex Order 26.4B1 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of Ex Order 26.4B1 out of Ex Orde which indicated the resident had aEx Order 26.4B1 Ex Order 26.4B1 and NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 with a doctor or healthcare staff.

Further review of the qMDS developed by the facility to identify the resident's needs and implemented care interventions revealed that Resident #27 required extensive assistance (resident involved in activity; staff provide NJ Exec Order 26.4b1) with NJ Exec Order 26.4b1 [redacted] and NJ Exec Orl use (how the resident uses NJ Exec Orl room).

The individualized Care Plan (CP) revealed a focus that included, Resident #27 had an actual NJ Exec on Ex Order 26.4B1, related to Ex Order 26.4B1 and Ex Order 26.4B1 [redacted]. The interventions included:
A referral to an Ex Order 26.4B1 Ex Order 26.4B Ex Order 26.4B1 The resident was offered NJ Exec Order 26.4 before meals, at bedtime and as needed since the resident frequently NJ Exec Order 26.4b1 of

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NJ Exec O to go to the NJ Exec Order 26.4b1 initiated on Ex Order 26.4B1 and revised on Ex Order 26.4B1. The resident frequently NJ Exec Order 26.4b1 to go to the NJ Exec Order 26.4b1 and was on early up, the resident was offered NJ Exec Order 26.4 before meals, at bedtime and as needed initiated on Ex Order 26.4B1 and revised on: Ex Order 26.4B1.

A review of the Progress Note for Resident #27, created on NJ Exec Order 26.4 at 10:49 AM, by the US FOIA (b) documented the following:
Resident #27's roommate had called this nurse (US FOIA (b) and said the resident NJ Exec Order 26.4b1, the resident was wheeling the chair NJ Exec Order 26.4b1. The resident was on the floor, lying on their Ex Order 26 side, Ex Order 26.4B1, resident NJ Exec Ord saying Ex Order 26.4B1 " ...Ex Order 26.4B1 , resident was able to Ex Order 26.4B1 , Ex Order 26.4B1 , updated Ex Order 26.4B1 The resident was sent out for evaluation ...

A review of the Risk Management Report dated NJ Exec Order 26.4 at 11:46 AM, reflected the following:
Incident description by the nurse: the resident's roommate called for help. The resident was on Ex Order 26.4B1 Ex Order 26.4B1 , resident Ex Order 26.4B1

Immediate action description: Resident was in a NJ Exec Order 26.4b1, Ex Order 26.4B1. The Ex Order 26.4B1, and Ex Order 26.4B1 continued. The physician was informed. The resident was sent to the emergency room for possible Ex Order 26.4B1.
Level Ex Order 26.4B1.

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Ex Order 26.4B1 was blank.
NJ Exec Order 26 report post incident: NoNJ Exec Order 26.4b1 post incident
Predisposing environmental factors was blank.
Predisposing NJ Exec Order 26.4b1 factors was blank.
Predisposing situation factors was blank.
Witness was blank.
Family member and physician were notified.
Notes: On Ex Order 26.4B1, team note review, the resident had not had Ex Order 26.4 in NJ Exec Order 26.4b1, it appears the NJ Exec Order 26.4 schedule had worked. The incident although "not witnessed" the roommate with BIMS of Ex Orde and the resident were able to Ex Order 26.4B1.

A review of the Consultation note dated Ex Order 26.4B1 indicated the report was a follow up for the resident's Ex Order 26.4B1 from Ex Order 26.4B1 ago. The resident's Ex Order 26.4B1, and no significant Ex Order 26.4B1. No intervention was required.

A review of the electronic Medical Record, Assessment tab, under Interdisciplinary Team Conference (group of health care professionals working together to set goals and make decisions) reflected the team met on the following dates:
Ex Order 26.4B1

There was no documented meeting after Resident #27's fall on Ex Order 26.4B1 that resulted in a Ex Order 26.4B1.

A review of a facility provided unsigned and undated document indicated the Resident Ex Orde on Ex Order 26.4B1 in which the resident and sustained a

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Ex Order 26.4B1. The resident was sent to the hospital for evaluation and returned to the facility. The resident was in their room Ex Order 26.4B1, Ex Order 26.4B1. "Roommate did not see [Resident #27] Ex Order 26 The resident NJ Exec Order 26.4b1 and do their own activity. Was seen by Ex Order 26.4B1 as follow up. Ex Order 26.4B1.

On 10/12/23 at 11:23 AM, during a meeting with the surveyors, US FOIA (b)(6) stated that incidents of NJ Exec O and risk management were discussed during the morning meeting with the team.

At that time, the US FOIA (b) explained their process for investigating incidents and accidents. The team reviewed the particulars of the incident and accidents with or without a witness statement from the resident. When an NJ Exec Orde occurred from an incident or an accident the NJ Exec Order 26.4b1 department (NJ Exec Order 26.4b was involved to conduct a screening. A medical work up was conducted, and a member of the facility communicated with the medical doctor. The results of the screen and evaluation were documented on the notes section of the risk management report (RMR; also known as the Accident/Incident Report). The witness/staff statements were also uploaded into the electronic Medical Record (eMR). The US FOIA (b) stated the process could be a lot tighter.

On 10/12/23 at 01:06 PM, in the presence of two surveyors, the US FOIA (b) stated there was not a need for a witness statement from the resident since she documented what she learned from the resident and the roommate. The US FOIA (b) could not

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F 610	Continued From page 26 explain while utilizing the RMR, the root cause of the [redacted] why the resident [redacted], where the resident was [redacted], and exactly where in the room the [redacted]. At that time, the [redacted] did not have a signed witness statement(s). The [redacted] stated she would ask the [redacted] who documented on the PN to see what she recalled. On 10/13/23 at 11:28 AM, during a meeting with the surveyors, and the [redacted] stated the incident was not reported to the State Agency because the [redacted] by the roommate. At that time, the [redacted] stated she obtained a signed statement from the nurse yesterday [after surveyor inquiry] about the [redacted] that occurred on [redacted]. The [redacted] learned the resident [redacted] and the roommate with a BIMS of [redacted]) informed the same nurse that the roommate saw the resident [redacted] The nurse had mistakenly entered the incorrect information and checked [redacted] on the RMR. The [redacted] was unable to explain from the statement and the report why the [redacted] or where the resident was [redacted] to and the discrepancies from the investigation between the unwitnessed summary on the RMR and the witnessed signed statement provided that day. 2. The surveyor reviewed the medical records of Resident #208. A review of the the facility provided investigations showed incomplete investigations and missing witness statements for the following dates:	F 610		

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Ex Order 26.4B1 [redacted]

Resident #208's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to, Ex Order 26.4B1 [redacted]

A review of Resident #208's comprehensive MDS (cMDS) dated Ex Order 26.4B1, reflected that the resident had a BIMS score of Ex Order 26 out of 15, which indicated the resident had a Ex Order 26.4B1 Ex Order 26.4B1 status.

Further review of the cMDS developed by the facility to identify the resident's needs and implemented care interventions revealed that Resident #208 required extensive assistance (resident involved in activity; staff provide NJ Exec Order 26.4b1) with NJ Exec Order 26.4b1 [redacted] and NJ Exec Or use (how the resident uses NJ Exec Or room).

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F 610	Continued From page 28 The individualized CP revealed a focus that included, Resident #208, revealed resident was Ex Order 26.4B1, initiated on Ex Order 26.4B1 and revised on Ex Order 26.4B1. A review of the undated facility policy provided Incident/Occurrence Investigation policy included the following: Policy Statement 1. All incidences of alleged abuse, mistreatment, or neglect of a resident by staff, other residents, visitors, etc. will be investigated. 4. The results of investigations that indicates that abuse, neglect, or mistreatment has occurred, or cannot be conclusively ruled out, will be reported to the DOH utilizing standard reporting procedures. Procedure: 1. Following an occurrence or notification or a complaint the RN Manager or RN Supervisor will submit to the DON - Nursing/Designee a copy of the Accident/Incident report [RMR] with staff statements. If Social Services is notified regarding a complaint or occurrence, the DON - Nursing/Designee and Administrator will be promptly advised. If event occurs on the weekend the RNM or RN Supervisor will initiate an investigation and will advise the Administrator on Duty that an that an investigation is underway. 5. Administrator, DON- Nursing/Designee will meet to review the summary of the investigation and make a decision if an event is reportable to the DOH. The Medical Director or Director of Social Services may be asked to participate in the decision making process depending on the type of event that has occurred. A file with an investigation summary will be kept in all occurrences or complaints that meet criteria	F 610		

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F 610	Continued From page 29 for requiring an investigation. On 10/16/23 at 12:06 PM, during a meeting with the survey team, the US FOIA (b)(6) informed the surveyors that all the staff were educated along with the Interdisciplinary team about the risk management documentation and the expectation was to thoroughly document the record, collect witness statements, and root cause analysis would be completed at the time of investigation. The US FOIA (b)(6) stated that his lawyer did not want him to acknowledge the investigation was incomplete. At that time, the US FOIA (b)(6) stated we have identified the need to update the process as identified by the surveyors. The issue regarding thorough documentation was incorporated within the Quality Assurance Performance for Improvement (QAPI). Our process is for continued improvement.	F 610		
F 623 SS=C	NJAC-8.39-4.1(a)5 Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in	F 623		11/9/23

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F 623	Continued From page 30 accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which	F 623		

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F 623	Continued From page 31 receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as	F 623		

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F 623	Continued From page 32 well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide written notification of the emergency transfer to the resident representative and the Office of the Long-Term Care Ombudsman (LTCO) for one (1) of two (2) residents (Resident #46), reviewed for hospitalizations. This deficient practice was evidenced by the following: On 10/06/23 at 10:58 AM, the surveyor observed Resident #46 inside their room seated on a bed. The resident stated that there was no concern with care. The surveyor reviewed the hybrid (a combination of paper, scanned, and computer-generated records) medical records of Resident #46. The Admission Record (or face sheet, an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to Ex Order 26.4B1 [redacted]	F 623	Element One - Corrective Action: A notice of emergency transfer (NOET) was sent to the Office of the State Long Term Care Ombudsman (LTCO) for resident # 46 hospital transfers on NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 NJ Exec Order 26.4b1. Resident 46 is own responsible party. Responsible party was notified. Resident continues to reside at the facility. Element Two -Identification of at Risk Residents: All residents who require a NOET have the potential to be affected. ELEMENT THREE: SYSTEMIC CHANGES: The US FOIA (b)(6) was educated on providing a NOET in a timely manner to Long term care ombudsman and to family member/power of attorney/responsible party in writing. QUALITY ASSURANCE To maintain and monitor ongoing compliance, the Social Worker/Designee will audit all emergency transfers to confirm written and verbal (to responsible party) notification of incoming roommate was completed daily x7 days, weekly x4 and monthly x4 Needed corrections will be addressed as they are discovered. Findings to be reported monthly x 12 to Quality Assurance Performance	

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F 623	Continued From page 33 Ex Order 26.4B1 [redacted]). A review of Resident #46's most recent admission Minimum Data Set (aMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of Ex Order 26.4B1, showed in Section NJ Exec Order 26.4b1 a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted] which reflected that resident's NJ Exec Order 26.4b1 NJ Exec Order Ex Order 26.4B1 [redacted]. Further review of the MDS showed that the resident had a Discharge Return Anticipated (DRA) MDS on dates Ex Order 26.4B1 and Ex Order 26.4B1 The DRA MDS Section A Identification Information for dates Ex Order 26.4B1, and Ex Order 26.4B1 included that there was an unplanned transfer to the Ex Order 26.4B1 of the resident. A review of the facility's provided Notice of Emergency Transfer (NoET) that was provided by the US FOIA (b)(6) [redacted] on NJ Exec Order 26.4b1 at 11:33 AM from NJ Exec Order 26.4b1 through NJ Exec Order 26.4b1 revealed that there was no NoET on dates NJ Exec Order 26. and NJ Exec Order 25.[redacted]. Further review of the hybrid medical records showed that there was no documentation that the Responsible Party (RP) of the resident was notified of the NJ Exec Order 26.4 [redacted] transfer to the hospital. On 10/12/23 at 11:55 AM, the surveyor in the presence of the survey team interviewed the US FOIA (b)(6) [redacted] The US FOIA (b) [redacted] informed the surveyor that she was responsible for the NoET of the residents in the facility. The surveyor asked the US FOIA (b) [redacted] if she	F 623	Improvement team for review and action as necessary.	

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keeps a file of the Ombudsman Notification and she said "yes," and it was in a binder.

On that same date at 11:59 AM, the [US FOIA (b)] in the presence of the survey team showed her white binder where she filed all NoET. The surveyor asked the [US FOIA (b)] to check if there was a NoET of Resident #46 for [NJ Exec Order 26.4b1]. The [US FOIA (b)] checked and flipped the binder and she stated that she did not find it. The [US FOIA (b)] stated that she would check the copying machine and "probably" left it there. The [US FOIA (b)] did not find the [NJ Exec Order 26.4b1] NoET in the copying machine. Then the [US FOIA (b)] went inside her room and looked at her files.

On 10/12/23 at 12:07 PM, the [US FOIA (b)] in the presence of the survey team informed the surveyor that she did not find the NoET for [NJ Exec O] [redacted]. The surveyor asked the [US FOIA (b)] what the facility's practices and procedures about the resident's transfer to the hospital. The [US FOIA (b)] stated that once the resident is admitted to the hospital, it will be discussed in the morning meeting, and the [US FOIA (b)] knows who the resident needs to submit NoET. Also, the [US FOIA (b)] stated that she checked the electronic medical record.

On that same date and time, the [US FOIA (b)] informed the surveyor that she immediately faxed the NoET to the Office of the Ombudsman, at minimum at the end of the month. The [US FOIA (b)] stated "I call family for notification and sometimes I document also in the progress notes," in the electronic medical record that she notified the family.

At that same time, the surveyor notified the [US FOIA (b)] of the above findings that the NoET for [NJ Exec Order 26.] and [NJ Exec Order 26.] were missing and that on [NJ Exec Order 26.]

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there was no documentation that the RP was notified of transfer to the hospital. The [US FOIA (b)] acknowledged that there should be a Notice of Transfer for [NJ Exec Order 26.] and [NJ Exec Order 26.].

On 10/13/23 at 10:33 AM, the survey team met with the [US FOIA (b)(6)] The surveyor notified the facility management of the above findings. The surveyor asked for the facility's policy and procedure regarding the Notice of Transfer.

On 10/16/23 at 12:05 PM, the survey team met with the [US FOIA (b)(6)] informed the surveyor that she notified the RP on [NJ Exec Order 26.] about the resident's transfer to the hospital. The [US FOIA (b)] stated that she spoke to the RP and documented it in her ([US FOIA (b)(6)] personal notes. She further stated that she did not enter her communication of the transfer of the resident to the hospital on [Ex Order 26.4B1] in the resident's medical records, specifically in the progress notes.

On that same date and time, the surveyor then asked the [US FOIA (b)] if that was part of the resident's medical records the [US FOIA (b)(6)] paper notes, and the [US FOIA (b)] stated "No." The surveyor asked the facility management about the regulation requirement that the facility-initiated transfers or discharges of a resident, prior to the transfer or discharge, the facility must notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

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F 623	Continued From page 36 Additionally, the facility must send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman. The facility management did not respond. In addition, the [US FOIA (b)(6)] stated that the facility was not able to find the NoET for [NJ Exec Order 26.4b1]. The [US FOIA (b)(6)] further stated that the facility sent a NoET on [NJ Exec Order 26.4b1] for [US FOIA (b)(6)] transfers to the hospital after the surveyor's inquiry. On 10/17/23 at 12:51 PM, the survey team met with the [US FOIA (b)(6)], and no policy or procedure was provided. The facility management stated that there was no facility policy with regard to the Notice of Transfer. NJAC 8:39-4.1(a)(32), 5.3; 5.4	F 623		
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: Complaints # NJ00158985, NJ00156816 Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, for three (3) of 21 residents, (Resident #26, Resident #208, Resident #209) reviewed for MDS accuracy, and was evidenced by the following:	F 641	Element One To correct the deficiency as it relates to the residents noted in the deficiency: resident #26 has been offered [Ex Order 26.4b1] services and received [Ex Order 26.4b] consultation. Resident #208 offered [Ex Order 26.4b] services and received a [Ex Order 26.4b1] consultation. Resident #209 is no longer a resident at facility and the facility cannot retroactively correct this deficiency for this resident.	11/9/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 37 According to the Centers for Medicare & Medicaid Services (CMS) Minimum Data Set 3.0 Public Reports page last modified October.20.2023, included that the MDS is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. Care Area Assessments (CAAs) are part of this process and provide the foundation upon which a resident's individual care plan is formulated. MDS assessments are completed for all residents in certified nursing homes, regardless of the source of payment for the individual resident. MDS assessments are required for residents on admission to the nursing facility, periodically, and on discharge. All assessments are completed within specific guidelines and time frames. 1. On 10/18/23 at 12:17 PM, the surveyor observed and interview Resident #26. The surveyor observed the resident had Ex Order 26.4B1 and Ex Order 26.4B1 when he/she smiled. The resident stated that there was no NJ Exec O at this time. The surveyor asked if the resident had seen a NJ Exec Order 2 or had been offered since he/she was admitted. The resident stated "no, neither." On 10/16/23 at 11:46 AM, surveyor interviewed the assigned aide of the resident, US FOIA (b)(6) . The US FOIA (b) stated that Resident #26 was a set-up for morning (AM) care including care of resident's NJ Exec Orde The aide further stated that the resident did not have a complete Ex Order 26.4B1 and had some Ex Order 26.4B1	F 641	Element Two -Identification of at Risk Residents: All residents who have poor dentation have the potential to be affected. ELEMENT THREE: SYSTEMIC CHANGES: The US FOIA (b)(6) (including but not limited to US FOIA (b)(6)) was re-educated on proper assessment and documentation of resident dental status, ensuring dental consultation is made and completed as necessary. MDS coordinator corrected MDS for each resident. Element Four Measures the facility will take to ensure the problem does not recur include : Director of nursing/designee will audit all new admission assessments to ascertain dental status and ensure dental consult is completed as necessary for 2 months, then 2 randomly selected residents audit of these assessments will be performed 1x/month for 12 months. Needed corrections will be addressed as they are discovered. Findings to be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary.	

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On 10/10/23 at 9:45 AM, the surveyor reviewed Resident #26's electronic medical record (eMR).

A review of Resident #26's Admission Record (AR; or face sheet; an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to Ex Order 26.4B1 [redacted] Ex Order 26.4B1 [redacted]), need for assistance with NJ Exec Order 26.4B1 [redacted]

The Order Summary Report dated Ex Order 26.4B1 through Ex Order 26.4B1 revealed that there was not an order for a Ex Order 26.4B1 consultation.

A review of the NJ Exec Order 26.4B1 Assessment, dated Ex Order 26.4B1 "#12, Ex Order 26.4B1", letter " NJ Exec indicated Ex Order 26.4B1 Was answered Ex Order 26.4B [redacted]

A review of the Comprehensive Minimum Data Set (CMDS), dated Ex Order 26.4B1, revealed the resident had Brief Interview for Mental Status (BIMS), score of Ex Order out of Ex Order which reflected that the resident had a Ex Order 26.4B1 Ex Order 26.4B1 t. It further revealed under.
-section NJ E NJ Exec Order 26.4b1 status "none of the above were present."
-section NJ Exec O NJ Exec Order 26.4B1 abilities, and Goals, NJ Exec O

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F 641	Continued From page 39 [redacted] admission performance was coded '[redacted] meaning, NJ Exec Order 26.4b1 [redacted] A review of the resident's personalized Care Plan (CP), dated Ex Order 26.4B1 revealed a focus "resident has an ADL NJ Exec Order 26.4b1 related to (r/t) NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. date initiated Ex Order 26.4B1 revision date of Ex Order 26.4B1 The individualized care plan did not reflect a focus for Ex Order 26.4B1 . There was no documentation that Resident #26 was offered and refused Ex Order 26.4B1 services. 2. On 10/10/23 at 10:02 AM, the surveyor reviewed Resident #208's closed medical record. A review of Resident #208's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to unspecified Ex Order 26.4B1 [redacted] A review of the Quarterly MDS (QMDS), dated Ex Order 26.4B1 revealed: -section [redacted] NJ Exec Order 26.4b1 status as left blank -section [redacted] NJ Exec Order 26.4b1 abilities, and Goals, [redacted] admission performance was left blank - section [redacted] NJ Exec Order 26.4b1 Status was coded as '[redacted] (Extensive Assistance, resident involved in activity, staff provided [redacted] NJ Exec Order 26.4b1 and '[redacted] NJ Exec Order 26.4b1 Further review of the QMDS, dated Ex Order 26.4B1 revealed the resident had BIMS) score of [redacted] out	F 641		

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F 641	Continued From page 40 of [redacted] which reflected that the resident had a [redacted]. In addition: -section [redacted] status was left blank -section [redacted] Status was coded as '[redacted] (Extensive Assistance, resident involved in activity, staff provided [redacted] and '[redacted] ([redacted]) -section [redacted] abilities, and Goals, [redacted] admission performance was left blank The resident's personalized CP, dated [redacted] revealed a focus "resident has [redacted] There was no documentation that Resident #208 was offered and refused [redacted]. 3. On 10/10/23 at 10:20 AM, the surveyor reviewed Resident #209's closed medical record. Resident #209's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to, unspecified [redacted] A review of the Nursing admission assessment, dated [redacted] revealed section #12 [redacted] a) [redacted]	F 641		

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F 641	Continued From page 41 f) has Ex Order 26.4B1 (blank) A review of the Order Summary Report, dated Ex Order 26.4B1 revealed that there was an order for a Ex Order 26.4B1, initiated on Ex Order 26.4B1. A review of the NJ Exec Order 26.4b1 Assessment, dated NJ Exec Order 26.4b1, revealed in the assessment and plan section; "resident has been put on list to see the Ex Order 26.4B1 A review of a US FOIA (b)(6) progress note (PN), date Ex Order 26.4B1 labeled as "Ex Order 26.4B1" revealed resident was on a diet of; NJ Exec Order 26.4b1 Ex Order 26.4B1. It did not reflect the residents Ex Order 26.4B1 of having Ex Order 26.4B1. A review of the CMDS dated Ex Order 26.4B1, revealed the resident had BIMS score of Ex Order 4 out of Ex Order which reflected that the resident had a Ex Order 26.4B1 Ex Order 26.4B1. It further revealed under. -section NJ E Ex Order 26.4B1 status "none of the above were present." -Section NJ Exec O NJ Exec Order 26.4b1 abilities, and Goals, Ex Order 2 Ex Order 26.4B1 admission performance was coded "NJ Exe meaning, NJ Exec Order 26.4b1 A review of the resident's personalized CP, dated Ex Order 26.4B1 revealed a focus "Resident does not Ex Order 26.4B1. Resident receives consistency modifications. Ex Order 26.4B1 with acceptable Ex Order 26.4B1 is a Ex Order 26.4B1) on admit."	F 641		

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F 641	Continued From page 42 date initiated [redacted], revision date of [redacted]. There was no documentation that the resident [redacted] services. Surveyor requested MDS policy 10/12/2023. The facility was unable to provide a policy. The [redacted] stated, "they refer to the RAI manual by CMS guidelines." A review of the Dental Services policy, dated 1/2018, revealed; statement; To ensure a resident's diet is appropriate, optimal hydration and nutritional status are maintained and risk of choking is avoided. Speech therapy (via screen) and dietary (via alert) must be notified of the following circumstances: -Missing/ broken dentures -Recent extractions -Refusal to wear dentures -New dentures If a resident's dentures are lost or damaged, they must be referred to a dentist within 3 days for services. If a referral does not occur within 3 days, supportive documentation of what was done to ensure the resident could still eat and drink adequately and the extenuating circumstances behind the delay of services will be noted. A review of the policy "Interdisciplinary Care Planning Protocol" revealed; #3. Activities and Dietary provide an overview of their assessment of resident needs and problems. #8. Problems established by the team with the resident/ family input MUST be specific and individualized.	F 641		

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F 641	Continued From page 43 On 10/19/23 at 11:36 AM, the surveyor interviewed the US FOIA (b)(6) who stated, the US FOIA (b)(6) was unavailable and NJ Ex Order 26.4b1 and she could answer surveyor's question regarding coding. She stated coding of the MDS was based on what is found in the record and Interdisciplinary Care Plan (IDCP) note. The IDCP should be a synopsis of the MDS.	F 641		
F 686 SS=D	NJAC 8:39-33.2(d) Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to a.) maintain NJ Exec Order 26.4b NJ Exec Order 26.4b control practices to reduce the risk of during a Ex Order 26.4B1) treatment; and b.) ensure an individualized comprehensive care plan interventions were developed and implemented to a Ex Order 26.4B1 ;	F 686	Element One - Corrective Action: LPN #1 and C.N.A. were immediately re-educated in hand washing and a hand washing competency was completed. Resident #81's care plan was updated to include interventions to NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 provided and NJ Exec Order 26 and NJ Exec Order 26.4b1 program in	11/9/23

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F 686	Continued From page 44 and c.) ensure an individualized comprehensive care plan with interventions were developed and implemented in a timely manner after a [NJ Exec O] [redacted] occurred for one (1) of three (3) residents reviewed for [NJ Exec] [redacted] (Resident #81). This deficient practice was evidenced by the following: On 10/16/23 at 10:00 AM, the surveyor observed Resident #81's assigned Licensed Practical Nurse (LPN #1) perform a [Ex Order 26.4b1] [redacted] treatment. Prior to handwashing (HW), LPN #1 pulled the lever on the paper towel dispenser downward and upward multiple times to dispense the paper towel. LPN #1 then performed HW for 20 seconds. After LPN #1 dried her hands with the paper towel, she turned off the faucet with the used wet paper towel. She did not use a clean dry paper towel to turn off the faucet. LPN #1 donned (put on) gloves and proceeded to wipe the top of the treatment cart with a disinfectant wipe. LPN #1 then wiped the bedside table with a new disinfectant wipe. She doffed (took off) her gloves. LPN #1 performed HW for 20 seconds. She then used her elbow to move the lever downward and upward to dispense the paper towel from the towel dispenser. After LPN #1 dried her hands with the paper towel, she turned off the faucet with the used wet paper towel. She did not use a clean dry paper towel to turn off the faucet. She put a blue disposable barrier sheet on the bedside table, gathered the supplies needed for the treatment and placed them on top of the barrier sheet. At 10:16 AM, LPN #1 dispensed the paper towel from the dispenser then performed HW for 20 seconds. After the she dried her hands with the	F 686	place. [Ex Order 26.4b1] [redacted] has [NJ Exec Order 26.4b1] [redacted] on resident 81. Element Two -Identification of at Risk Residents: All residents who are at high risk of skin impairment have the potential to be affected. An audit was completed on all new admissions /readmissions in the last 30 days to ensure residents at high risk for skin breakdown have preventative skin care interventions in place. ELEMENT THREE: SYSTEMIC CHANGES: All staff were re-in-serviced by infection preventionist on infection control including handwashing. Handwashing competencies were completed. [US FOIA (b)(6)] [redacted] team (including but not limited to [US FOIA (b)(6)] [redacted]) were in serviced on communicating resident information, coding information in MDS and updating care plans in a timely manner. QUALITY ASSURANCE To maintain and monitor ongoing compliance, Infection Preventionist (IP)/designee will audit/observe wound care treatment on 2 residents to ensure proper infection control process' are practiced, 3 times per week for 2 weeks, 1 time per week for 2 weeks and monthly x 4. In addition, IP/designee will audit 2 random employees handwashing technique daily x7 days, weekly x4 and monthly x12.	

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F 686	Continued From page 45 paper towel, she turned off the faucet with the used wet paper towel. She did not use a clean dry paper towel to turn off the faucet. LPN #1 donned a new pair of gloves and removed the NJ Exec Order 26.4b that was on Resident #81's Ex Order 26.4B1. She doffed her gloves. After LPN #1 dispensed the paper towel with her hand, she performed HW for 20 seconds. After LPN #1 dried her hands with the paper towel, she turned off the faucet with the used wet paper towel. She did not use a clean dry paper towel to turn off the faucet. At 10:22 AM, the US FOIA (b)(6) doffed her gloves and performed HW for 20 seconds which was mostly under the flow of water. She then dried her hands with a paper towel that she had dispensed prior to HW. Afterward, she used her right hand to dispense more paper towels by pushing the lever downward and upward. She then dried her hands with the additional paper towel and then used the used wet paper towel to turn off the faucet. She did not use a clean dry paper towel to turn off the faucet. She then donned gloves and continued to hold the resident. At 10:24 AM, LPN #1 donned a new pair of gloves and then wiped Resident #81's Ex Order 26.4B Ex Order 26.4B1 with a NJ Exec Order 26.4b1 that was moistened with Ex Order 26.4B1. She then patted NJ Exec the Ex Order 26.4B1 with a NJ Exec Order 26.4b1. LPN #1 then used a cotton tipped applicator to Ex Order 26.4B1 and then used a second applicator to place additional Ex Order 26.4B1 on the Ex Order 26.4B1 LPN #1 applied a NJ Exec Order 26.4b1 over the Ex Order 26.4B1 LPN #1 did not change	F 686	The interdisciplinary team (including but not limited to director of nursing, unit managers, MDS nurse, wound nurse, social services, infection preventionist, registered dietitian, therapy director) will audit all new admission charts to ensure all have appropriate skin preventative measures are in place. Needed corrections will be addressed as they are discovered. Random audits of residents with high risk for skin breakdown will be performed Bi-weekly x 4 weeks and then monthly x 4 months. Findings to be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary.	

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F 686	Continued From page 46	F 686		

her gloves or perform HW after she cleansed the [Ex Order 26.4b1] prior to applying the medication and dressing. She doffed her gloves and performed HW for 20 seconds. After drying her hands, LPN #1 used the used wet paper towel to turn off the faucet. She did not use a clean dry paper towel to turn off the faucet.

At 10:26 AM, after removing the used supplies from the bedside table and placing them in the garbage, LPN #1 performed HW and again turned off the faucet with the used wet paper towel. She did not use a clean dry paper towel to turn off the faucet. She then signed off the treatment as being performed in the computer.

At 10:29 AM, the surveyor asked LPN #1 if she was finished with the [Ex Order 26.4b1] treatment. LPN #1 stated yes. LPN #1 had not wiped the used bedside table with a disinfectant wipe. The surveyor then asked if she would wipe the bedside table at the end of a [Ex Order 26.4b1] treatment. LPN #1 stated that she did not usually wipe the bedside table after because the [NJ Exec Order 26.4b1] was there. The surveyor then asked if she always used the used wet paper towel to turn off the faucet. LPN #1 stated that she usually used the wet paper towel and that she was probably not supposed to use it. She added that she was supposed to use a clean one. She then confirmed that she had done it wrong and that she was supposed to use a clean one. She added that she just had an inservice. The surveyor then asked LPN #1 if she should have changed her gloves after cleaning the [Ex Order 26.4b1] and before applying the medication and [NJ Exec Order 26.4b1] LPN #1 stated the she did not usually change her gloves between cleaning the [Ex Order 26.4b1] and applying the medication.

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F 686	Continued From page 47 At 10:46 AM, the surveyor interviewed the US FOIA (b) regarding her HW. The US FOIA (b) stated that she does it inside the sink under the water. A review of Resident #81's Admission Record (or face sheet; admission summary) indicated that the resident was admitted to the facility with medical diagnoses that included but were not limited to; Ex Order 26.4B1 [redacted] A review of Resident #81's Significant Change in status Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Ex Order 26.4B1, indicated a Brief Interview for Mental Status (BIMS) score of Ex Order out of 15, which reflected that the resident's NJ Exec Order 26.4b1 was Ex Order 26.4B1. Further review of Section M-NJ Exec Order 26.4b1 indicated that Resident #81 had Ex Order 26.4B1 [redacted] A review of Resident #81's entry MDS dated Ex Order 26.4B1 indicated that Resident #81 was readmitted to the facility after an unplanned discharge to the hospital. A review of Resident #81's Discharge Return Anticipated MDS dated Ex Order 26.4B1, indicated that the resident had an unplanned discharge to an acute hospital. Further review of NJ Exec Order 26.4b1 Conditions indicated that Resident #81 did not have an Ex Order 26.4B1 [redacted].	F 686		

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F 686	Continued From page 48	F 686		

A review of Resident #81's Quarterly MDS dated [redacted], Section [redacted] indicated that Resident #81 did not have an [redacted] Section [redacted] and Treatments indicated that a [redacted] device for bed was being utilized.

A review of the facility provided Order Summary Report, dated [redacted] included the following orders:

1. [redacted])
Apply to [redacted] topically every day shift for [redacted], pat dry, apply layer of [redacted] and cover with [redacted]

2. [redacted] every two hours while in bed every shift for [redacted] every two hours while in bed with a start date of [redacted]

A review of Resident #81's individualized care plan (CP) included the following:

1. At risk for: Potential for [redacted] related to: [redacted] process with an initiated date of [redacted] and a revision on [redacted]
The interventions included:
Consult [redacted] (as needed) and follow MD (physician) orders
Date Initiated: [redacted]
Revision on: [redacted]
Monitor for [redacted] daily with am (morning) care and PRN
Date Initiated: [redacted]
Instruct staff/family on [redacted].
Date Initiated: [redacted]

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2. NJ Exec Order 26.4b1 (related to) NJ Exec Order 26.4b1 status Ex Order 26.4B1 [redacted].
The interventions included:
Encourage NJ Exec Order 26.4b and NJ Exec Order 26.4b1
Date Initiated: NJ Exec Order 26.4b1
Keep NJ Exec Order 26.4b and NJ Exec Order 26.4b
Date Initiated: NJ Exec Order 26.4b1
Monitor for signs of NJ Exec Order 26.4b
Date Initiated: NJ Exec Order 26.4b1
Perform necessary Ex Order 26.4B1 care as per MD's ordered
Date Initiated: NJ Exec Order 26.4b1
Provide NJ Exec Order 26.4b1.
Date Initiated: NJ Exec Order 26.4b1
NJ Exec Order 26.4b care consult in place to treat and evaluate
Date Initiated: NJ Exec Order 26.4b1

A review of the NJ Exec Order 26.4b1 [redacted], dated Ex Order 26.4B1 indicated a score of [redacted] and that Resident #81 was at risk.

A review of the NJ Exec Order 26.4b1 Tools dated NJ Exec Order 26.4b and NJ Exec Order 26.4b indicated that Resident #81 had an observation of the Ex Order 26.4B1 that had a Ex Order 26.4B1 Ex Order 26.4B1 [redacted] with a measurement of [redacted] and [redacted].

A review of the NJ Exec Order 26.4b1 Tools dated NJ Exec Order 26.4b indicated that Resident #81 had an

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F 686	Continued From page 50 observation of the Ex Order 26.4B1 with a NJ Exec Order 26.4b1 which measured Ex Order 26 NJ Exec Order 2 and Ex Order 26.4 NJ Exec Ord but did not indicate the NJ Exec Order 2 A review of the NJ Exec Order 26.4b1 Tools dated NJ Exec Order 26.4b1 indicated that Resident #81 had an observation of the Ex Order 26.4B1 with a NJ Exec Order 26.4b1 that measured Ex Order 26.4 length, Ex Order 26.4B1 width and Ex Orde Ex Orde depth and a Ex Order 26.4B1 Ex Order 26.4B1 . May also present as an intac Ex Order 26.4B1 A review of the Ex Order 26.4B1 CNA Task documentation, that was provided by the facility, did not include any intervention of NJ Exec Order 26 or applying a NJ Exec Order 26.4b1. A review of the Ex Order 26.4B1 CNA Task documentation, that was provided by the facility, included an intervention of NJ Exec Order 26.4b1 q (every) shift. The intervention was started on Ex Order 26.4B1 There was no documented evidence that the CP was updated with any additional interventions to prevent Resident #81's NJ Exec Order 26.4b from becoming a Ex Order 26.4B1 when the resident was readmitted to the facility on Ex Order 26.4B1 There was no documented evidence that the CP for the NJ Exec O was initiated in a timely manner when Resident #81 was found to have the impairment on Ex Order 26.4B1. There was no documented evidence that Resident #81 was being from Ex Order 26.4B1 to Ex Order 26.4B1 On 10/16/23 at 10:55 AM, the surveyor interviewed the US FOIA (b)(6)) of the NJ Exec O	F 686		

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wing unit, regarding the process of HW and [redacted] treatment. The [redacted] stated that after the person washes their hands for 20 seconds, they would dry their hands with a paper towel and throw it in the garbage. The [redacted] stated that the person should take another paper towel to turn off the water. The surveyor asked the [redacted] if the hand washing part was outside the flow of water. The [redacted] stated that it was outside the flow of water. The surveyor asked the [redacted] if a nurse should change gloves and perform hand hygiene after the [redacted] is cleaned and before applying medication. The [redacted] stated that after the [redacted] is cleaned, the nurse should remove the gloves, wash their hands and put on clean gloves before medication is placed. The surveyor asked the [redacted] if the bedside table should be cleaned at the end of the treatment. The [redacted] stated that the bedside table should be washed at the end because you do not know what fell on table. She added that the resident is going to use the table after, so you would make sure it is clean.

On 10/17/23 at 10:08 AM, the surveyor interviewed the assigned [redacted] regarding the care of Resident #81. The [redacted] stated that she did everything for the resident. She added that she would put the resident back to bed after lunch and that she would reposition the resident when the resident was in bed. The surveyor asked the [redacted] if Resident #81 had a Ex Order 26.4B1. The [redacted] stated that the resident had a [redacted] and NJ Exec Order 26.4b1. The surveyor asked the [redacted] if she documented the care of the resident. The [redacted] stated that she would document on the laptop.

On 10/17/23 at 10:27 AM, the surveyor interviewed the assigned LPN #2 regarding the

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process for preventing Ex Order 26.4B1 and CP. LPN #2 stated that for person at NJ Exec Order 26.4b1 , the resident would be NJ Exec Order 2 every couple hours. The surveyor asked what the process was if a resident was a readmission to the facility and had NJ Exec Order 26.4 on their NJ Exec Or LPN #2 stated that all residents have a general assessment when they come to the facility. She added that a NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1 , is performed and if there is NJ Exec Order 26.4 it is documented on the NJ Exec Order 26.4b1 tool. She then stated that she would also document it in a progress note. The surveyor asked if a CP with interventions would be initiated. LPN #2 stated that "of course" it would be but that she did not do anything with the CP. She stated that she believed it was the US FOIA that did the CP.

On 10/17/23 at 10:38 AM, the surveyor interviewed the US FOIA regarding the process related to a resident's NJ Exec O when there was NJ Exec Order 26.4b noted. The US FOIA stated that when a nurse checked the NJ Exec O and there was NJ Exec Order 26.4b the nurse would contact the physician and get an order for a NJ Exec O NJ Exec Order 2 and NJ Exec Order 26.4b1 and document it. She added that there would be a CP for risk of NJ Exec Order 26.4b1 and interventions may include NJ Exec Order 26 when in bed and a NJ Exec Order 26.4 for the wheelchair. The US FOIA stated that she would do the CP and that also the US FOIA (b)(6) and US FOIA (b)(6)).

On that same date and time, the US FOIA added that anyone that has NJ Exec Order 26.4b there would be an order for NJ Exec Order 26 every 2 hours. The surveyor asked about Resident #81's CP. The US FOIA stated that the resident had an order for NJ Exec Order 26 but that she just did not update the CP. The surveyor asked the US FOIA if the order to NJ Exec O every 2 hours should have

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been done prior to NJ Exec Order 26.4b1. The US FOIA stated that it should have been ordered the first day the Ex Order 26.4B1). The surveyor asked the US FOIA how the tasks on the US FOIA (b) documentation are put in the system. The US FOIA did not know and stated that she would have to check with the US FOIA (b)(6)

On 10/17/23 at 11:53 AM, the surveyor interviewed the US FOIA (b) regarding the process of CP for a resident's NJ Exec Or The US FOIA (b) stated that it was done by the interdisciplinary team. She stated that if someone was at risk for a NJ Exec Order 26.4b1 that there would be a CP with preventative interventions that might include NJ Exec Order 26.4 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. The surveyor asked what the expectation would be if a resident had NJ Exec Order 26.4b1 The US FOIA (b) stated that the expectation would be that they would be NJ Exec Order 2 and NJ Exec Order 26.4b1 and that with each NJ Exec Order 26.4b1 , a NJ Exec Order 26.4b1 would be applied. The surveyor asked if those interventions would be listed on the CP. The US FOIA (b) stated yes.

At that same time, the surveyor asked about the documentation of the CP and the CNAs. The US FOIA (b) stated that the nursing staff put in interventions. She added that if you put an intervention in the CP, it gives you an option to put it in the tasks for the US FOIA (b) documentation. She added that it is not an automatic entry but that it has to be prompted by individual that is adding to the CP. The US FOIA (b) stated that not everything was always on the CP and that some were standards of practice like the NJ Exec Order 26.4b1. The surveyor asked if the NJ Exec Order 26.4b1 was an order and if it was documented anywhere. The US FOIA (b) stated that it was not an order and that it was not documented anywhere.

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Furthermore, the surveyor asked the [US FOIA (b)] about the process of the [NJ Exec Order 2] treatment and HW. The [US FOIA (b)] stated that the HW process of lathering was mostly outside the flow of water, but that if you did not have enough lather that you could add a little water. She stated that after you dried your hands, you would take another paper towel to turn off the faucet. The [US FOIA (b)] stated that after cleaning the wound the nurse should change gloves before placing medication.

On that same date and time, the surveyor notified the [US FOIA (b)] about the concern of Resident #81's CP that there were no interventions to prevent an [NJ Exec Order 26.4b1] The [US FOIA (b)] stated that interventions were being done and that they just were not documented. She added that Resident #81 was being [NJ Exec Order 2] and [NJ Exec Order 26.4b] had [NJ Exec Order 26.4b1] and had an [NJ Exec Order 26.4b1]. She then stated that the [NJ Exec Order 2] was [NJ Exec Order 26.4b1].

On 10/17/23 at 01:40 PM, in the presence of the survey team, the surveyor notified the [US FOIA (b)(6)]) the concerns that Resident #81 did not update the at risk CP to include interventions to prevent a [Ex Order 26.4B1] to develop into a [Ex Order 26.4B1], the actual impairment of [NJ Exec Order 26.4b1] CP was not initiated at the time of the [NJ Exec Order 26.4b1] and the [NJ Exec Order 26.4b] control issues that were observed during the [Ex Order 26.4B1] treatment.

On 10/19/23 at 11:28 AM, in the presence of the survey team, [US FOIA (b)(6)] stated that she educated the nurse on the

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F 686	Continued From page 55 Ex Order 26.4B treatment and HW. She added that the nurse should have used a clean towel, changed her gloves after cleaning and wiped the bedside table. The surveyor asked if the facility had a response regarding the CP and if Resident #81's should have been updated. The US FOIA (b)(6) stated that the staff would be inserviced on the proper CP and timely updating. The surveyor then asked how often the CP should be updated. The US FOIA (b) stated as needed and quarterly. The US FOIA (b)(6) stated that any change that warrants the CP to be changed. A review of the undated facility provided policy titled, "Wound Care Protocol" included the following: 1. Use disposable towel to establish a clean field on resident's over-bed table. 2 ...Wash and dry your hands thoroughly following standards of practice ... 4. Put on gloves ... 5. Apply treatments and dress wound as indicated. 6. Discard disposable items into the designated container. 7. Remove gloves and wash hands following standards of practice. A review of the undated facility provided policy titled, "Handwashing/Hand Hygiene" included the following: Washing Hands Procedure 2. Wet hands with warm (not hot) running water. 3. Apply soap and vigorously rub hands together, creating friction to all surfaces, for at least twenty (20) seconds. 4. Rinse hands thoroughly under running water .... 5. Dry hands thoroughly with paper towels and	F 686		

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F 686	Continued From page 56 then turn off faucets with a clean, dry paper towel. A review of the undated facility provided policy titled, "Pressure Ulcer Prevention," included the following: The Nursing Department's goal is to ensure that a resident does not develop pressure ulcers unless clinically unavoidable and provide care to: Promote the prevention of pressure ulcer development; Promote the healing of pressure ulcers that are present (including prevention of infection to the extent possible); and Prevent development of additional pressure ulcers .... The licensed nurse on admission will complete a comprehensive skin assessment within 2 hours, initiating interventions based upon the resident's risk level and risk factors. Interventions will be documented on the care plan ... The Certified Nursing Assistant will reposition residents according to their needs and based on their ability to reposition themselves to promote circulation and prevent as much as possible skin breakdown/or to aid in the healing of any skin breakdown ... A review of the undated facility provided policy titled, "Interdisciplinary Care Planning Protocol", included the following: Interdisciplinary Care Planning ..2. Nursing provides overview of medical and nursing care regimes. Nursing Assistants must provide input especially related to ADL (activities of daily living), skin, weights, and safety needs ... 7. CAA Summary triggers are reviewed by the team to decide whether or not to proceed with care planning for each triggered area. 9. Problems established by the team with	F 686		

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F 686	Continued From page 57 resident/family input MUST be specific and individualized. N.J.A.C. 8:39-27.1	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and review of other pertinent facility provided documentation, the facility failed to implement and document in the resident's care plan a new intervention after each [redacted] in order to prevent any additional [redacted] for one (1) of five (5) residents reviewed for [redacted] (Resident #22). This deficient practice was evidenced by the following: On 10/10/23 at 12:12 PM, the surveyor observed resident #22 in their room, seated in a wheelchair eating lunch. Resident #22 NJ Exec Order 26.4b1 [redacted] at this time. The surveyor reviewed Resident #22's medical records. The Admission Record (or face sheet; an admission summary) reflected that Resident #22	F 689	Element One - Corrective Action: Resident #22 care plan has been updated to reflect new interventions. Element Two -Identification of at Risk Residents: An audit was completed on the last 3monts of incidents to ensure new interventions were in place for residents who have to potential to be affected. ELEMENT THREE: SYSTEMIC CHANGES: 3) Education provided by LNHA/designee to US FOIA (b)(6) (including but not limited to: US FOIA (b)(6) [redacted].) to ensure that all incidents/accidents have an updated intervention.	11/9/23

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F 689	Continued From page 58 was admitted to the facility with diagnoses that included but not limited to Ex Order 26.4B1 [redacted] A review of the facility Incident/Accident Report dated Ex Order 26.4B1 indicated that the resident had an Ex Order 26.4B1 The investigation documentation revealed the Ex Order 26.4B1 and the resident was transferred to Ex Order 26.4B1 for further evaluation. Further review of the facility Incident/Accident Report dated Ex Order 26.4B1 indicated that the resident had another Ex Order 26.4B1. The investigation documentation revealed there NJ Exec Order 26.4b1 noted. The Quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of Ex Order 26.4B1, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of Ex O out of Ex Ord, which reflected a Ex Order 26.4B1 The NJ Exec Order 26.4b Evaluation (an assessment tool) reflected that anytime there was a total score of 10 or greater, the resident should be considered at 'NJ Exec Order 26.4b1 . It also indicated that a prevention practice should be initiated "immediately" and recorded on the resident's care plan. A review of the resident's Ex Order risk assessment score dated Ex Order 26.4B1 revealed the	F 689	4) Risk management and incidents are reviewed daily by the interdisciplinary care team (which can include but is not limited to the Director of nursing or designee, therapy, licensed nursing home administrator or designee). Interventions and investigations will be randomly audited 2 incidents per week/ weekly x 4 weeks then randomly audited 2 incidents monthly for 4 months to ensure compliance. Needed corrections will be addressed as identified. 5) Audits will be reviewed at QAPI for 12 months.	

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F 689	Continued From page 59 resident score of [NJ Exec] Further review of the resident's [Ex Order 26.4B1] assessment score dated [Ex Order 26.4B1] revealed the resident score of [Ex Orde] Upon review of the resident's care plan (CP) which included that the resident at [NJ Exec Order 26.4b1] related to (r/t) [NJ Exec Order 26.4] process, date initiated: [NJ Exec Order 26.4b1] and was revised on: [NJ Exec Order 26.4b1] The CP was not updated or revised to include new interventions for [NJ Exec Order 26.4b1] that happened on [NJ Exec Order 26.4] to prevent further [NJ Exec] on [NJ Exec Order 26.4b] During Interview on 10/16/23 at 11:30 AM with the [US FOIA (b)(6)]) she stated, a CP should have been initiated immediately following the investigation of the [NJ Exec] and interventions should have been adjusted with the second [NJ Exec] The [US FOIA (b)] and facility management were unable to provide a fall policy upon surveyor request. NJAC 8:39-27.1(a)	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 695		11/9/23

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F 695	Continued From page 60 Based on observation, interview, and review of other pertinent provided facility documents, it was determined that the facility failed to ensure that Ex Order 26.4B1) care and services were provided according to the standard of clinical practice for one (1) of one (1) resident (Resident #18) reviewed for Ex Order 26.4B1. This deficient practice was evidenced by the following: On 10/06/23 at 10:37 AM, the surveyor observed Resident #18 seated in a Ex Order 26 chair (a Ex Order 26.4B1) in their room eyes Ex Order 26.4B1 (Ex Order 26.4B1 . The surveyor reviewed the medical records of Resident #18. The resident's Admission Record (or face sheet; an admission summary) revealed that the resident was admitted to the facility with diagnoses that included but were not Ex Order 26.4B1	F 695	Element One - Corrective Action: Resident #18□s Ex Order 26.4B1 order was updated to include the size of NJ Ex Order 26.4b1 Garbage was emptied in the resident□s room. LPN provided with Ex Order 26 education re Ex Order 26 care, disinfecting surfaces before use and disposal of paper towel post handwashing. Element Two -Identification of at Risk Residents: All residents with a tracheostomy have the potential to be affected. ELEMENT THREE: SYSTEMIC CHANGES: Nursing staff were educated on tracheostomy care including complete tracheostomy orders and disinfecting workspace. Tracheostomy care competencies were completed on all RN□s and LPN□s . QUALITY ASSURANCE: To maintain and monitor ongoing compliance, DON/designee will audit tracheostomy care 3times per week x1 week2 weeks, then monthly x 2. Needed corrections will be addressed as they are discovered. Findings to be reported monthly to Quality Assurance Performance Improvement team for review and action as necessary.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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According to the most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care with an assessment reference date (ARD) of Ex Order 26.4B1 revealed that the resident had a Brief Interview for Mental Status (BIMS) score of Ex Orde which indicated that the resident's NJ Exec Order 26.4b1 status was Ex Order 26.4B1 The qMDS also showed that the resident had Ex Order 26 care for the last Ex Orde days.

A review of the Ex Order 26.4B1 orders showed that there was an order to change the Ex Order 26.4B1 Ex Order 26.4B1 daily on days one time a day with a start date of Ex Order 26.4B1.

Further review of the above Ex Order 26.4B1 order showed that it was signed by nurses daily. The order for the Ex Order 26.4B1 did not include the size.

On 10/11/23 at 11:01 AM, the surveyor observed the US FOIA (b)(6) performed handwashing inside the resident's room, introduced himself to the resident, and explained that he will be doing Ex Order 26.4B care. The resident was at the Ex Order chair at this time, then the US FOIA (b) left the room and read the order in the electronic treatment administration record (eTAR) in his treatment cart as follows:
"change Ex Order 26.4B1 daily on days one time a day."
The US FOIA (b) informed the surveyor that the order was to change the Ex Order 26.4B1 daily and that he does it every day.

On that same date and time, the US FOIA (b) performed handwashing inside the resident's toilet room, donned gloves, and placed a blue liner on top of

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the table without disinfecting the table first. The garbage container inside the toilet room was full. US FOIA (b) then removed gloves, performed handwashing, dried his hands with a paper towel, and discarded the used paper towel on top of the full garbage slightly pressing the garbage. The US FOIA (b) then took the supplies from the treatment cart that was outside of the resident's room and opened the NJ Exec Order 26.4b1, packets of gauze, and Ex Order 26 mask on top of the blue liner. The US FOIA (b) opened the Ex Order 26 kit and put the white liner on top of the blue liner. The US FOIA (b) accidentally dropped the paper cover of gauze inside the sterile kit container and stated to the surveyor that he had to discard it and get another sterile Ex Order 26 kit. The US FOIA (b) discarded the first sterile Ex Order 26.4B kit and performed handwashing, dried his both hands with a paper towel, and slowly placed directly the used paper towel on top of the garbage that was full to prevent it from spilling.

After discarding the first sterile Ex Order 26 kit, the US FOIA (b) opened another sterile kit. The US FOIA (b) opened the NJ Exec Order 26.4b1. The US FOIA (b) informed the surveyor that he would change the Ex Order 26.4B1 "with this" (showing opening the Ex Order 26.4B1). The surveyor asked the US FOIA (b) what was the size order for the Ex Order 26.4B1 for the resident. The US FOIA (b) asked the surveyor where he could find that information in the Ex Order 26.4B1 container. He further stated "Is it in the expiration date?" The US FOIA (b) was unable to state the complete order and what size of the Ex Order 26.4B1.

At that time, the US FOIA (b) informed the surveyor that he always changed the resident's Ex Order 26.4B1 and he knew that it was the same Ex Order 26.4B1 even though he was not aware of the size of the Ex Order 26.4B1. He further stated that it was the

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Ex Order 26.4B1 who provided the supplies for Ex Order 26 care of the resident that included the Ex Order 26.4B1. The surveyor asked the US FOIA (b) as a standard of practice, if should there be an order for what size to use for the resident's Ex Order 26 Ex Order 26.4B1. The US FOIA (b) had no response.

On 10/11/23 at 11:34 AM, the surveyor immediately interviewed the US FOIA (b)(6) regarding the order and what should be included. The US FOIA (b)(6) informed the surveyor in the presence of another surveyor that there should be an order for the NJ Exec Order 26.4b1. This time the surveyor notified the US FOIA (b)(6) of the above findings. The US FOIA (b)(6) further stated that she will talk to the US FOIA (b) "right now."

On 10/11/23 at 12:25 PM, the US FOIA (b)(6) in the presence of the survey team confirmed to the surveyor that the order for NJ Exec Orde should be part of the resident's order as a standard of practice.

On 10/13/23 at 9:22 AM, the surveyor interviewed the US FOIA (b) regarding the Ex Order 26.4 care observation on 10/11/23. The surveyor asked the US FOIA (b) why he did not disinfect the table prior to putting the blue liner and treatment supplies? The US FOIA (b) stated "I could but since I put another sterile liner on top of the NJ Exec Order 26.4b1 he thinks that would be fine not to disinfect the table. The surveyor asked what the US FOIA (b)(6)) education provided to him and other staff about disinfecting frequently touched surfaces, does he include the table as frequently touched surfaces? The US FOIA (b) stated that he did not consider the resident's table as frequently touched surface because the

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resident was a total care and did not get out of bed to be able to reach the table and touch it. The surveyor then asked the [US FOIA (b)] how about the Certified Nursing Assistants (CNAs) who take care of the resident do they not use the table or touch the table when providing care, or how about visitors and other facility staff who enter the room?

On that same date and time, the [US FOIA (b)] acknowledged that the CNAs use at times the table for providing care, that the resident received visitors, and that the resident's responsible party visits almost every day. In addition, he indicated that other staff entered the room as well. The [US FOIA (b)] also stated that he can not remember the education provided to him about disinfecting tables, maybe he had but can not remember because there was a lot of education provided already.

Furthermore, the [US FOIA (b)] acknowledged that the garbage receptacle of the resident inside the toilet room at that time was full.

On 10/13/23 at 10:33 AM, the survey team met with the [US FOIA (b)(6)] [redacted]. The surveyor notified the facility management of the above findings.

A review of the undated facility's Tracheostomy Care Policy that was provided by the [US FOIA (b)(6)] included in the procedure guidelines to check the physician's order and to remove gloves and discard them into the appropriate receptacle.

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F 695	Continued From page 65 On 10/19/23 at 12:55 PM, the survey team met with the US FOIA (b)(6) and the facility management stated that there was no additional information and survey team could proceed with decision-making.	F 695		
F 698 SS=D	NJAC 8:39-25.2(b),(c)4 Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a) consistently monitor the resident's vital signs (VS) and Ex Order 26.4B1 NJ Exec Order 26.4b1 and b) complete the Ex Order 26.4B1 Communication Record (NJ Exec Orde according to the facility's policy and standard of clinical practice. This deficient practice was observed for one (1) of one (1) resident reviewed. The deficient practice was evidenced by the following: On 10/06/23 at 9:48 AM, the surveyor observed that Resident #60 was not in their room. The US FOIA (stated that the resident was at the Ex Order 26.4B1 center. On 10/10/23 11:48 AM, the surveyor observed the resident in bed asleep.	F 698	Element One - Corrective Action: Resident # 60 was discharged from Ex Order 26.4B1 . Element Two -Identification of at Risk Residents: All residents on hemodialysis have the potential to be affected. An audit was completed to ascertain any other residents on dialysis. (0) ELEMENT THREE: SYSTEMIC CHANGES: Education provided from LNHA/designee to nursing staff to review hemodialysis paperwork pre and post hemodialysis appointments. A new dialysis communication sheet was created, and staff educated on the communication sheet. Dialysis centers that are most often used by residents at	11/9/23

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F 698	Continued From page 66 The surveyor reviewed the hybrid medical records (a combination of paper, scanned, and computer generated record) of Resident #60. The Admission Record (or face sheet; admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to Ex Order 26.4B1 [redacted] A review of the Annual Minimum Data Set (AMDS), an assessment tool used to facilitate the management of care with assessment reference date (ARD) Ex Order 26.4B1 showed that the resident's Brief Interview for Mental Status (BIMS) score was [redacted] out of 15 which indicated that the resident's Ex Order 26.4B1 status was Ex Order 26.4B1 . The Physician Order Set (POS), dated Ex Order 26.4B1 revealed an order that resident #60 Ex Order 26.4B1 days were on a Ex Order 26.4B1 [redacted] The Ex Order 26.4B1 days order was discontinued (d/c) on Ex Order 26.4B1 On 10/10/23 at 9:20 AM, the surveyor reviewed the NJ Exec Order 26.4 Communication Log (a binder on the unit which contains a resident's NJ Exec Ord forms) of Resident #60. The surveyor reviewed the communication book documents from NJ Exec Order 26.	F 698	the facility are aware of new dialysis communication sheet. Element Four: Currently there are no dialysis residents at the facility. However, when/if a resident is admitted to the facility requiring dialysis the following will occur: The facility will monitor hemodialysis patient paperwork weekly x 4 weeks and then Bi-weekly x 4 months to ensure compliance. Needed corrections will be addressed as they are discovered. Findings to be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary.	

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F 698	Continued From page 67 through and including [redacted]. The facility provided the documentation that was scanned into the computer from the [redacted] log. (The resident was discharged from [redacted] on [redacted] and started on [redacted] on [redacted].) The facility also provided a manual progress notes as part of [redacted] communication. There were missing information in the provided manually written progress notes as part of [redacted] communication as follows: -signature of sending nurse to [redacted] communication of [redacted], vital signs (clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions), pre [redacted] signs, and symptoms (s/s) of resident or [redacted], medications given, and [redacted]. -communications from the [redacted] center VS, and [redacted] vitals, [redacted] new orders for [redacted] medications, [redacted] order, and signature of [redacted] nurse. According to the provided [redacted] Communication Record Policy that was provided to the surveyor, the [redacted] forms must be utilized as communication record between the facility and the [redacted] center. On 10/11/23 at 9:31 AM, the surveyor interviewed the US FOIA (b)(6) The [redacted] confirmed that the communication between the facility and the [redacted] center documentation should be completed upon the residents return to	F 698		

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F 698	Continued From page 68 the facility. The [US FOIA (b)] also stated that the [NJ Exec Ord] form that was provided to the surveyor with the facilities [NJ Exec Order 26] Communication Book policy was not being used for this resident since [NJ Exec Order 26]. The [US FOIA (b)(6)] provided the surveyor with the facility policy titled "Dialysis Communication Book Policy", updated 5/18/2022. During review, it revealed: Policy: It is the policy of this facility to maintain an ongoing communication between the dialysis center and [facility] regarding the resident's care and progress. Procedure: 2. The book will be initiated from the facility to include but not limited to the following: a. Residents name b. Vital signs prior to leaving. c. medication changes since last visit d. lab work and results since last visit e. any notes or comments 3. Upon return from dialysis treatment, the dialysis center will provide the following: a. weight at start/ending weight. b. fluid removed. c. Blood Pressure (BP) at start / ending BP. d. notes /comments: (i.e.) medications, labs, any unusual occurrences Attached to the facilities Communication Book Policy was a [facility] Dialysis Communication Record" it was in grid format to include residents' name / room # /Extension of the nurses station / date / VS prior to leaving the facility/ Medications changes since last visit / lab work since last visit / any notes or comments. N.J.A.C. 8:39-2.7(a)	F 698		

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F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews, and record review, it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents conducted face-to-face visits and wrote progress notes (PN) at least once every sixty days in a timely manner. This deficient practice was identified for three (3) of six (6) residents reviewed for physician visits, Residents #1, #8, and #18. This deficient practice was evidenced by the following: 1. On 10/17/23 at 8:51 AM, the surveyor and the US FOIA (b)(6) both observed Resident	F 712	Element One - Corrective Action: The US FOIA (b)(6) for residents #1, #8,#18 was educated on the requirements of physician visits including the last day acceptable for a late entry (10 days post due date). Element Two -Identification of at Risk Residents: All residents under the care of the above referenced MD have the potential to be affected. ELEMENT THREE: SYSTEMIC CHANGES: In addition to re-education to	11/9/23

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F 712	Continued From page 70 #1 lying on the bed. The surveyor reviewed Resident #1's medical records. The Admission Record (AR; or face sheet; an admission summary) showed that the resident was admitted to the facility with diagnoses that included but were not limited to Ex Order 26.4B1 [redacted] down). According to the most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) Ex Order 26.4B1 Section [redacted] NJ Exec Order 26.4b1 Patterns had a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted] which reflected that the resident's Ex Order 26.4B1 NJ Exec Order was Ex Order 26.4B1 . A review of Resident #1's PN showed that the Physician Note's most recent documentation was a late entry on NJ Exec Order 26.4b for a date of service of NJ Exec Order 26.4b The following were other Physician Notes documented in the PN: NJ Exec Order 26.4 For date of NJ Exec Order 26.4 (late entry on NJ Exec Order 26.4) For date of NJ Exec Order 26.4b1 (late entry on NJ Exec Order 26.4b1 For date of NJ Exec Order 26.4b (late entry on NJ Exec Order 26.4b) For date of NJ Exec Order 26.4 (late entry on NJ Exec Order 26.4b1 Further review of the above PN revealed that	F 712	US FOIA D the facility along with MD, created an excel shared spreadsheet to aide MD in keeping track od exam due dates and enables facility access to also keep track of MD visits. QUALITY ASSURANCE To maintain and monitor ongoing compliance, LNHA/DON/Designee will monitor MD visit due dates twice monthly at the beginning of the month and midway through the month to ensure MD documentation is on time while ensuring it will not be late (q2week monitoring) x 6m. Needed corrections will be addressed as they are discovered. Findings to be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary.	

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F 712	Continued From page 71 there was no Physician Note after [redacted].	F 712		

2. On 10/06/23 at 11:04 AM, the surveyor observed Resident #8 inside their room with a [redacted] providing care.

The surveyor reviewed the resident's medical record as follows:

The AR showed that the resident was admitted to the facility with diagnoses that included but were not limited to [redacted]

The qMDS with an ARD of [redacted] had a BIMS score of [redacted] out of 15 which indicated that the resident's [redacted]

A review of Resident #8's PN showed that the most recent documented Physician Note was on [redacted]. The following were other Physician Notes documented in the PN:

[redacted]

For date of [redacted] (late entry on [redacted])
For [redacted] (late entry on [redacted])
[redacted]
For [redacted] (late entry on [redacted])
For [redacted] (late entry on [redacted])

3. On 10/06/23 at 10:37 AM, the surveyor observed Resident #18 seated in a [redacted] chair (a [redacted]

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F 712		F 712		

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[redacted]) in their room eyes [redacted] with a [redacted] and [redacted]) in use.

The surveyor reviewed the medical records of Resident #18.

The resident's AR revealed that the resident was admitted to the facility with diagnoses that included but were not limited to dependence on [redacted]

The most recent qMDS with an ARD of [redacted] revealed that the resident had a BIMS score of [redacted] which indicated that the resident's [redacted] status was [redacted].

A review of Resident #18's PN showed that the most recent documented Physician Note was for [redacted] as a late entry on [redacted]. The following were other Physician Notes documented in the PN:
For [redacted] (late entry on [redacted])
For [redacted] (late entry on [redacted])
For [redacted] (late entry on [redacted])
For [redacted] (late entry on [redacted])

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F 712	Continued From page 73 For [redacted] (late entry on [redacted]) On 10/17/23 at 12:51 PM, the survey team met with the US FOIA (b)(6) [redacted]) and were notified of the above findings. At that same time, the surveyor asked the facility management about the facility's policy and practice regarding physician visits. The [redacted] informed the surveyors that the physician visits should be within 48-72 hours upon admission, the following month, monthly x3 months. The [redacted] stated that it was an expectation that the face to face visit notes of the physician then will be every two months minimally if there is a Nurse Practitioner (NP). Then the surveyor asked the facility management if the facility had an NP, then the [redacted] and the [redacted] stated that the facility did not have an NP. The [redacted] then stated that it would be monthly physician visits and notes at least because there was no NP in the building. The facility management informed the surveyors that the resident's doctor was also the facility's US FOIA (b)(6) [redacted] who also takes care of all residents in the facility. On 10/19/23 at 10:49 AM, the survey team met with the US FOIA (b)(6) [redacted], and the [redacted]. The VPoCS informed the surveyors that the [redacted] was educated regarding the missing documentation of the physician. The [redacted] stated that the facility complied with the every two months notes of the [redacted]. The surveyor notified again the facility of the above missing notes. At this time, the US FOIA (b)(6) reviewed the electronic	F 712		

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F 712	Continued From page 74 medical records for the physician's PN and confirmed that there were missing notes and that the physician documented PN and entered the notes late. At this time, the surveyor asked for the facility's policy and procedure with regard to physician visits and notes. The US FOIA (b)(6) stated that the facility did not have a policy and that the facility followed the regulations. On 10/19/23 at 12:55 PM, the survey team met with the US FOIA (b)(6), and US FOIA (b)(6) and the facility management stated that there was no additional information and that the survey team could proceed with decision making. NJAC 8:39-23.2(d)	F 712		
F 728 SS=D	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b).	F 728		11/9/23

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F 728	Continued From page 75 §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documentation, it was determined that the facility allowed one (1) of one (1) Non-Certified Nursing Aides (NA) to continue working as an NA after the specified 120 days. This deficient practice was identified during new hire employee review. This deficient practice was evidenced by the following: On 10/18/23 at 9:16 AM, the surveyor reviewed the facility provided new hire employee files. The review included the following: The NA had a date of hire (doh) Ex Order 26.4B1. The NA completed a Certified Nurses Aide (CNA) Program on NJ Ex Order 26.4B. The NA passed the Skills	F 728	Element one- Resident #13, #82, #84, #and #95 were offered the Ex Order 26.4B1 and accepted. Resident # 28 and #30 were offered the subsequent Ex Order 26.4B1 Ex Order 26.4B1 and accepted. Element two- All residents who need the pneumococcal or influenza vaccine have the potential to be affected. An audit was completed to ascertain if any residents were due for pneumococcal or influenza vaccine. Element three- Education provided to nursing staff have been provided education regarding residents needing the pneumococcal or	

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F 728	Continued From page 76 Evaluation on [US FOIA (b)(6)]. There was no documented evidence that the NA was licensed as a Certified Nursing Assistant. On 10/18/23 at 11:13 AM, the surveyor interviewed the [US FOIA (b)(6)] and the [US FOIA (b)(6)]) regarding the NA. The [US FOIA (b)] stated that the NA was under the 190 days after her skills test. She added that when a NA came from the school that the school "told us" that the NA could work for 190 days after the skills test. The [NJ Ex Order] stated that the NA was going to take her test to become a licensed CNA at the end of the month and that if the NA does not pass the test she would no longer be employed at the facility. She added that this would be the third time that she would be taking the test. The surveyor asked the [NJ Ex Order] if she could provide the survey team the reference that she was using that indicated the timeframe was 190 and not 120 days. The surveyor reviewed the facility provided staffing schedule for that day (10/18/23) and the NA was listed on the schedule as working on the [Ex Order] wing unit with a CNA. The NA had provided direct resident care past the allotted 120 days. On 10/18/23 at 01:02 PM, in the presence of the survey team, the surveyor notified the [US FOIA (b)(6)] and [US FOIA (b)(6)]) the concern that the NA was working after the specified 120 days. The surveyor asked if the [US FOIA (b)(6)] could locate a signed job description for the NA in the NA's employee file. The [US FOIA (b)(6)] confirmed that the NA did not have a signed job description in the employee's file. The surveyor requested the facility's job description for NA.	F 728	influenza vaccines from Director of nursing. All residents who needed vaccination were offered pneumococcal vaccine and vaccination clinic was completed 11/3/23. Pneumonia vaccines will be offered upon admission and quarterly thereafter if residents declined. Element four- To monitor performance to make sure solutions are sustained, 2 residents Pneumococcal and influenza vaccination status will be randomly audited by the don/designee for completion monthly x 3 months, then quarterly x6 months. Findings will be reported monthly x 12 to quality assurance performance improvement team for review and action as necessary.	

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F 728	Continued From page 77 A review of the facility provided NA job description included the following: Education & Qualifications ...Be employed for less than 120 days and is currently enrolled in an approved nurse aide in long term care facilities training course and scheduled to complete the competency evaluation program (skills and written/oral examinations) within 120 days of employment. Or been employed for no more than 120 days, completed the required training and has been granted a conditional certificate by the Department while awaiting clearance from the criminal background. On 10/19/23 at 11:51 AM, in the presence of the survey team, US FOIA (b)(6), the [redacted] stated that he had spoken to the [redacted] and that he thought it was a mistake from when COVID-19 was and the timeframes were different. The surveyor asked the [redacted] if the NA should have been working after 120 days. The [redacted] stated that the NA should not have been working. He added that the NA was offered another position until the NA obtained the license but that she declined and she was terminated. The facility did not provide a reference. The facility did not have a policy regarding NA's.	F 728		
F 791 SS=D	N.J.A.C. 8:39-43.1 Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care.	F 791		11/9/23

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F 791	Continued From page 78 §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.	F 791		

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F 791	Continued From page 79 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review it was determined that the facility failed to provide the mandatory annual dental care services. This deficient practice was observed for two (2) of 21 residents, (Resident #26, Resident #209) reviewed for dental care services, and was evidenced by the following: 1. On 10/18/23 at 12:17, PM the surveyor observed the resident had Ex Order 26.4B1 and Ex Order 26.4B1 when Resident #26 Ex Order 26.4B1 The resident stated that there was not any Ex Order 26 at this time. The surveyor asked the resident if he/she had seen a Ex Order 26.4B1 or had been offered since the resident was admitted. The resident stated "no, neither". On 10/16/23 at 11:46 AM, surveyor interviewed the Certified Nursing assistant (CNA). The CNA informed the surveyor that Resident #26 was a set-up for morning (AM) care including care for resident's Ex Order 26.4. She further stated that the resident had Ex Order 26.4B1 Ex Order 26.4B1 . On 10/10/23 at 9:45 AM, the surveyor reviewed Resident #26's electronic medical record (eMR). Resident #26's Admission Record (AR; or face sheet; an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to Ex Order 26.4B1	F 791	Element One Resident #26 received a NJ Exec Order 26.4b1. Resident #209 is no longer a resident at the facility and the facility can not retroactively correct this deficiency. Element Two : All residents who have poor dentation have the potential to be affected. ELEMENT THREE: SYSTEMIC CHANGES: The US FOIA (b)(6) (including but not limited to US FOIA (b)(6)) were re-educated on proper assessment and documentation of resident dental status, ensuring dental consultation is made and completed as necessary. MDS coordinator corrected MDS QUALITY ASSURANCE To monitor performance to make sure solutions are sustained the director of nursing or designee will conduct a random audit of 2 new admissions for assessments to ascertain dental status and ensure dental consult is completed as necessary. Random audit will be monthly x 3 months and then every 3 months for 9 months. Needed corrections will be addressed as they are discovered. Findings to be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary.	

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F 791	Continued From page 80	F 791		

Ex Order 26.4B1 [redacted]

A review of the Order Summary Report (OSR), dated Ex Order 26.4B1 revealed that there was not an order for a Ex Order 26.4B consultation.

A review of the Nutrition Assessment, dated Ex Order 26.4B1 ," letter indicated Ex Order 26.4B1 ? Was answered "Yes."

A review of the Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate the management of care, dated Ex Order 26.4B1, Section NJ E NJ Exec Order 26.4b1 Patterns had Brief Interview for Mental Status (BIMS) score of Ex Order out of 15 with indicated that the resident's NJ Exec Order 26.4b1 was Ex Order 26.4B1. The CMDS also included the following:
-section NJ E NJ Exec Order 26.4b1 status "none of the above were present."
-section NJ Exec O NJ Exec Order 26.4b1 abilities, and Goals, NJ Exec O admission performance was coded NJ Exe meaning, NJ Exec Order 26.4b1

A review of the resident's personalized Care Plan (CP), dated NJ Exec Order 26.4b revealed a focus "resident has an ADL NJ Exec Order 26.4b1 related to (r/t) NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1, date initiated NJ Exec Order 26.4b, revision date of NJ Exec Order 26.4b1 The individualized CP did not reflect a focus and interventions for current status of the

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F 791	Continued From page 81 resident's [redacted] Further review of the resident's medical record showed that there was no documentation that the resident was offered and [redacted] services. 2. On 10/10/23 at 10:20 AM, the surveyor reviewed Resident #209's closed medical record. Resident #209's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to, [redacted] A review of the Nursing Admission Assessment (NAA) dated [redacted] revealed section # [redacted] and [redacted] a) [redacted], b) [redacted]) c) [redacted] d) [redacted]) e) [redacted]) f) [redacted]) Further review of the above NAA showed that assessment was incomplete and with multiple blanks in the areas of assessment. On 10/10/2023 a review of the OSR, dated [redacted] through [redacted] revealed that there was an order for a [redacted] consult, initiated on [redacted]. A review of the [redacted] Assessment, dated	F 791		

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F 791	Continued From page 82 NJ Exec Order 26.4b1, revealed in the assessment and plan section; "resident has been put on list to see the NJ Exec Order as resident does not NJ Exec Order 26.4b1 due to NJ Exec Order 26.4b. It also revealed # NJ Exec Order 26.4b1 answered as # NJ Exec Order 26.4b1 (NJ Exec Order 26.4b1). A review of a US FOIA (b)(6) progress note (PN), date NJ Exec Order 26.4b1, labeled as "72-hour meeting" revealed resident was on a NJ Exec O of NJ Exec Order 26.4b1 (NJ Exec Order 26.4b1 . It did not reflect the residents NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 but not NJ Exec Order 26.4b1 . A review of the CMDS, dated NJ Exec Order 26.4b1, revealed the resident had BIMS score of NJ Exec O out of 15 which reflected that the resident's NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1. The CMDS included the following: -section NJ Ex NJ Exec Order 26.4b1 status "none of the above were present." -Section NJ Exec O NJ Exec Order 26.4b1 abilities, and Goals, NJ Exec O admission performance was coded " NJ Exe meaning, NJ Exec Order 26.4b1 The resident's personalized CP, dated Ex Order 26.4B1 revealed a focus "Resident does Ex Order 26.4B1 Ex Order 26.4B1 Resident receives NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 with acceptable NJ Exec Order 26.4b1 on admit." date initiated Ex Order 26.4B1, revision date of Ex Order 26.4B1 Further review of the resident's medical record showed that there was no documentation that the resident was Ex Order 26.4B1 . On 10/19/23 at 11:36 AM, the surveyor	F 791		

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F 791	Continued From page 83 interviewed the [redacted] who stated, the [redacted] was unavailable and out on personal leave. The [redacted] stated that she could answer question regarding MDS coding. She further stated that the coding of the MDS is based on what is found in the record and Interdisciplinary Care Plan (IDCP) note. The IDCP should be a synopsis of the MDS. A review of the [redacted] Associates signed contract with facility, dated [redacted] revealed under the "facility agrees to" section #[redacted] --obtain a physician's order for [redacted] care and consent from patients sponsor before instructing the consultant to render any and all [redacted] services. The facility was unable to provide a policy regarding MDS. The [redacted] stated, "they refer to the RAI (Resident Assessment Instrument/Minimum Data Set (RAI/MDS) is a comprehensive assessment and care planning process used by the nursing home industry since 1990 as a requirement for nursing home participation in the Medicare and Medicaid programs) manual by CMS guidelines." A review of the Dental Services policy, dated 01/2018, included that, to ensure a resident's diet is appropriate, optimal hydration and nutritional status are maintained and risk of choking is avoided. Speech therapy (via screen) and dietary (via alert) must be notified of the following circumstances: -Missing/ broken dentures -Recent extractions -Refusal to wear dentures -New dentures If a resident's dentures are lost or damaged, they	F 791		

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F 791	Continued From page 84 must be referred to a dentist within three (3) days for services. If a referral does not occur within three (3) days, supportive documentation of what was done to ensure the resident could still eat and drink adequately and the extenuating circumstances behind the delay of services will be noted. A review of the policy "Interdisciplinary Care Planning Protocol" revealed. #3. Activities and Dietary provide an overview of their assessment of resident needs and problems. #8. Problems established by the team with the resident/ family input MUST be specific and individualized. NJAC 8:39-33.2(d)	F 791		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that resident's dietary preferences were consistently identified and implemented for one	F 806	Element One - Resident #8 was reissued a weekly menu as well as the alternatives available and the always available. Element Two Identification of at Risk	11/9/23

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F 806	Continued From page 85 (1) of six (6) residents (Resident #8) reviewed for dietary preferences. This deficient practice was evidenced as follows: On 10/06/23 at 11:04 AM, the surveyor observed Resident #8 inside their room with a Certified Nursing Assistant providing care. On 10/11/23 at 9:04 AM, the surveyor observed the resident seated on a NJ Exec Order 26.4b1, covered with a blanket, and with water on top of a tray table in front of the resident. The resident stated that the resident had a NJ Exec Order 26.4b1 because the resident was not being provided with a menu in advance to choose what the resident NJ Exec Order 26.4b1. The resident further stated that the resident was not provided with an option to NJ Exec Order 26.4b1. On that same date and time, the surveyor asked the resident if the resident informed the facility management and if the US FOIA (b)(6) was aware of the resident's concern with regard to the resident's preferences and menu options. The resident responded that the resident informed the US FOIA (b)(6) and the US FOIA (b)(6) about the resident's concerns on a few occasions and during the care plan meeting. The resident further stated that he/she was told in the meeting which the resident can not remember when, and that there was nothing that they (facility management) could do about it because it was a corporate decision on what to order and what to bring in the facility. The surveyor then asked the resident if he/she did not like the food that was being served and, if was there an alternative that the resident could choose and ask for. The resident stated that 'NJ Exec O there was an alternative but it was all	F 806	Residents: All residents who require a menu have the potential to be affected. ELEMENT THREE: 3) Education provided to residents at resident council in regards to alternative menu options by the registered dietitian or designee. Education to staff distributing menus provided by administrator/designee to ensure menus are provided to all residents. To maintain and monitor ongoing compliance, The dietitian / designee will audit 3 random rooms per week for 4 weeks and then monthly for 4 months. Needed corrections will be addressed as they are discovered. Findings to be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary.	

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F 806	Continued From page 86	F 806		

the same every day. The resident did not have a copy of the select menu inside the room and no posted menu.

In addition, the resident informed the surveyor that he/she used to receive a select menu to choose from weekly and that the resident was unable to remember when he/she stopped receiving the weekly select menu.

The surveyor reviewed the resident's medical record as follows:

The Admission Record (or face sheet; and admission summary) showed that the resident was admitted to the facility with diagnoses that included but were not limited to Ex Order 26.4B1 [redacted]

The most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of Ex Order 26.4B1 Section NJ E NJ Exec Order 26.4b1 had a Brief Interview for Mental Status (BIMS) score of Ex Orde out of 15 which indicated that the resident's Ex Order 26.4B1 status was Ex Order 26.4B

A review of the Progress Notes (PN), NJ Exec Order 26.4b1 Note a Quarterly Nutrition Note, Ex Order 26.4B1 showed that the US FOIA (b)(6) documented that the resident had a copy of the menu with alternate in their room and utilized this

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F 806	Continued From page 87 to inform staff of desired alternate meals. On 10/16/23 at 10:55 AM, the surveyor interviewed the US FOIA (b)(6) in the presence of the survey team and the US FOIA (b)(6) The US FOIA (b)(6) informed the surveyor that select menus with alternate menus were being distributed weekly on a Sunday. The US FOIA (b)(6) further stated, that in addition to the select menu, there is always an available menu that the resident can choose from. On 10/16/23 at 11:16 AM, the two surveyors, US FOIA (b)(6) and US FOIA (b)(6) went to the resident's room. The US FOIA (b)(6) asked the resident about the menu and if the resident got it on Sunday. The resident responded that he/she had not gotten the menu. The US FOIA (b)(6) asked the resident if the resident was sure about the menu, and the resident responded "I will know if got one." The resident asked when the alternate has to be ordered and the US FOIA (b)(6) stated that it has to be ordered at least two hours prior. The US FOIA (b)(6) then asked the resident if it was okay for the facility management to go on to the resident's personal things and belongings to verify if the menu was provided to the resident. The US FOIA (b)(6) searched the resident's table in front of the resident while the resident was lying on the bed and the US FOIA (b)(6) did not find a copy of the menu. The US FOIA (b)(6) searched the resident's drawers and did not find a copy of the menu. At this time, the US FOIA (b)(6) asked the resident if there were other concerns the resident wanted to tell the facility management, and the resident stated that NJ Ex 0[illegible] did not like the food that the resident was getting and that was why the	F 806		

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F 806	Continued From page 88 resident wanted to have an option to choose from ahead of time and to get a copy of select menu and other menu options. On 10/16/23 at 12:05 PM, the survey team met with the US FOIA (b)(6) [redacted], the surveyor notified the facility management of the above findings. On 10/19/23 at 12:55 PM, the survey team met with the US FOIA (b)(6) [redacted] and the facility management stated that there was no additional information.	F 806		
F 812 SS=F	NJAC - 17.4(a)1,(c),(e) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		11/9/23

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F 812	Continued From page 89 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) store foods in a manner intended to prevent the spread of food borne illness and b.) maintain a clean storage for food and cooking utensils as evidenced by the following: On 10/06/23 at 9:44 AM, the surveyor toured the kitchen with the US FOIA (b)(6)), observed the following: 1. In the freezer the surveyor found; one opened box of carrots without an open and a use by date. The interior bag holding the carrots was opened and unlabeled. The US FOIA (b) stated, "that the exterior of the box should be labeled with the open and used by date." He also stated, "the interior bag once opened should be labeled and dated." 2. In the freezer the surveyor found; one opened box of chopped celery. The exterior of the box was unlabeled. The interior bag was unlabeled, wide open to the elements with large ice crystals. The US FOIA (b) stated, "that the exterior of the box should be labeled with the open and used by date. He also stated, the interior bag once opened should be labeled and dated." 3. In the freezer the surveyor found; one opened box of chicken tenders that was unlabeled. Inside the box was an interior bag of chicken tenders that was opened and unlabeled. Also, inside the chicken tender box was a bag labeled garlic bread. There was not a label or date on the garlic bread. The US FOIA (b) stated, "that the exterior of the box should be labeled with the open and used by date. He also stated, the interior bag once	F 812	Element one: Frozen food found open and/or unlabeled was disposed of. The tilt skillet catch tray, toaster catch tray, convection oven, microwave over and refrigerator gaskets were immediately cleaned. Element two: Residents receiving any food item from the kitchen are at risk. Element three: Kitchen staff re-educated on proper storing and labeling of food, as well as proper cleaning of kitchen equipment. Quality Assurance: To maintain and monitor ongoing compliance, food service director or designee will routinely in the kitchen to ensure cleanliness and proper storage of food. This will be performed weekly x 4 weeks and then bi weekly x 4 months Findings to be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary.	

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F 812	Continued From page 90 opened should be labeled and dated." Surveyor and [US FOIA (b)] continued the kitchen tour, and the surveyor observed the following: 1. The tilt skillet was observed to have white slimy substance covering most of the surface area. The [US FOIA (b)] stated, "it had not been used since he was hired a week prior." The surveyor asked the [US FOIA (b)] to wipe it with a paper towel. The sediment was removable with a dry paper towel indicating it had not been cleaned after previous use. 2. Convection oven: was covered with thick baked on brown streaks and sediment. [US FOIA (b)] acknowledged it was not cleaned. The [US FOIA (b)] stated, it should be cleaned daily but did not know when the tray was last cleaned and was unable to provide an accountability chart for staff. 3. The oven/stovetop range catch tray was covered with sediment, burnt on food and white congealed substance. The [US FOIA (b)] stated, it should be cleaned daily but did not know when the tray was last cleaned and was unable to provide an accountability chart for staff. 4. Microwave: the interior was not clean with sediment on all the walls, door and top. The [US FOIA (b)] did not have a cleaning schedule in place and was unable to provide an accountability chart for staff. 5. Toaster crumb tray was not clean and had thick built-up sediment that was burnt on. The [US FOIA (b)] did not have a cleaning schedule in place and was unable to provide an accountability chart for staff. 6. Utility refrigerator gasket seals were covered with black discoloration that was filled with sediment within the ridges of the seal. The [US FOIA (b)] stated, it should be cleaned daily but did not know when the tray was last cleaned and was unable to provide an accountability chart for staff.	F 812		

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F 812	Continued From page 91 On 10/10/23 at 9:40 AM, the surveyor toured the kitchen for second time with the [US FOIA (b)] Surveyor observed in the walk-in freezer an opened box of minute steaks, the box was dated 9/27. The inside bag was wide open, not dated, and the meat was exposed. The [US FOIA (b)] had no response to why the meat was not sealed and open to the elements. The [US FOIA (b)] was unsure of what the date of 9/27 meant, (i.e., received, opened, or expired). He did state, "I was in the freezer all weekend." A review of the facility's Food Storage Procedure, undated, given to surveyor by [US FOIA (b)(6)] on 10/13 at 10:12 AM included the following: 1. Food services, or other designated staff, will maintain clean food storage areas at all times. ... 5. All foods stored in the refrigerator or freezer will be covered, labeled, and dated... 8. Uncooked and raw animal products and fish will be stored separately and below fruits, vegetables and other ready to eat foods. A review of the policy Labeling and Dating Procedure in the Dietary Department review date 4/17/2023, included the following: Procedure: 1. Food items, as appropriate, will be labeled and dated by dietary staff using the facility labeling system, and the Food Service Director / designee will oversee labeling and dining. Label System Process: 1. Received Date 2. Pulled Date 3. Opened date; a) Food items will be labeled with an open date once the individual item is opened for use. A review of the Food Service Manager Position Summary dated revised 6/01, revealed:	F 812		

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F 812	Continued From page 92 2. Adheres to all the sanitary regulations governing handling and serving of food. 5. Develops, revises, and adapts work techniques and methods for more efficient operation of unit and for training employees. On 10/13/23 at 10:33 AM, the survey team met with the US FOIA (b)(6) [redacted], and the facility management were made aware of the above findings and concerns.	F 812		
F 835 SS=F	NJAC 8:39-17.2(g) Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of medical records, and review of facility documents, it was determined that the facility's US FOIA (b)(6) [redacted] failed to ensure: a) accurate documentation of the needed information in the Nurse Staffing Report, b) minimum State staffing requirements were met for 14 of 14 day shifts and on 3 of 14 overnight shifts reviewed, c) physician responsible for supervising the care of residents conducted face-to-face visits and wrote progress notes (PN) at least once every sixty days in a timely manner,	F 835	Element One - Corrective Action: The Vice President of Operations and The Vice President of Clinical Services educated the US FOIA (b)(6) on minimal staffing requirements, Medical Director visit frequency requirements, CNA annual in-service requirements, and administer and Medical Director QAPI attendance requirement. Element Two: All residents in the facility have the potential to be affected. ELEMENT THREE: SYSTEMIC	11/9/23

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F 835	Continued From page 93 d) that nurse aides received the minimum required number of in-service hours, and e) US FOIA (b)(6) and US FOIA (b)(6) attended the QAPI (Quality Assurance and Performance Improvement) meeting routinely necessary to provide for the needs of residents. This failure had the potential to affect all 105 residents who currently live in the facility. The evidence was as follows: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which 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. 1. On 10/06/23 at 9:54 AM, the survey team met with the US FOIA (b)(6)	F 835	CHANGES: VP of Operations and VP of Clinical will audit Administrator attendance at QAPI, oversight of minimal staffing requirements, medical director attendance at QAPI and Medical director/physician visit frequency per regulation. QUALITY ASSURANCE To maintain and monitor ongoing compliance, The Vice President of Clinical Services/designee will present audit results at QAA monthly x6 and at quarterly QAPI x2. Needed corrections will be addressed as they are discovered. Findings to be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary.	

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F 835	Continued From page 94	F 835		

US FOIA (b)(6)) during the Entrance Conference. The facility management confirmed that the US FOIA (b)(6) will be coming in later and will proceed with the Entrance Conference meeting without the US FOIA (b)(6)

On that same date and time, the surveyor provided a copy of a blank Nurse Staffing Report to the facility management to be used to fill out information for the weeks of 10/17/23-10/23/23, 10/24/23-10/30/23, 01/01/23-01/07/23, and 12/25/2022-01/07/2023. The surveyor also notified the facility management to submit the Nurse Staffing Report as soon as possible to the surveyor and to send it via email in order for the NJ Department of Health to run the provided reports to determine compliance with NJ mandated staffing law.

On 10/11/23 at 9:51 AM, the survey team met with US FOIA (b) and the US FOIA (b)(6) The surveyor notified the facility management of concerns regarding the requested documents that were asked by the surveyor during the Entrance Conference on 10/06/23. The surveyor mentioned that the requested documents were asked also yesterday (10/10/23) and followed up by the surveyor to the US FOIA (b)(6) which included the Nurse Staffing Report.

On 10/12/23 at 8:33 AM, the surveyor reviewed the provided Nurse Staffing Report via email (scanned documents) and showed that on the week of 01/01/23-01/07/23, the US FOIA (b)(6) who signed the Nurse Staffing Report did not include the census on each day. The surveyor immediately notified the US FOIA (b)(6) to review the submitted document and advised them to follow the

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F 835	Continued From page 95 directions on how to accurately fill out the form. On 10/19/23 at 9:08 AM, the surveyor in the presence of the survey team notified the US FOIA (b) of the concern regarding the submitted revised Nurse Staffing Report because there were discrepancies in the previously submitted reports (included NAs and TNAs) and new reports (did not include the previously counted NAs and TNAs), the missing census on 01/01/23-01/07/23, and multiple non-legible numbers. The surveyor notified the US FOIA (b) that the facility had to follow the correct and accurate way of submitting the Nurse Staffing Report and that the TNAs (temporary nursing assistants) and the NAs (non-certified nursing assistants) must not be counted as CNAs. On 10/19/23 at 9:26 AM, the surveyor in the presence of the survey team notified the US FOIA (b)(6) of the above concerns regarding the submitted Nurse Staffing Report. The US FOIA (b)(6) stated that he thought that during the time of the pandemic, the TNAs and CNAs could be counted as CNAs which was why the facility added them to the CNAs ratio. The surveyor referred the US FOIA (b)(6) again to the website NJ Portal where the instructions and how to properly submit an accurate report. The US FOIA (b)(6) stated that it was fine and that he would just check and revise the submitted forms. On 10/19/23 at 10:49 AM, the survey team met with the US FOIA (b)(6) of the facility according to the US FOIA (b)(6)), and US FOIA (b)(6) and the surveyor notified of the above findings and concerns.	F 835		

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F 835	Continued From page 96 On 10/19/23 at 01:32 PM, the US FOIA (b)(6) [redacted] submitted via email the revised Nurse Staffing Report that was signed by the US FOIA (b)(6) [redacted] 2. As per the "Nurse Staffing Report" completed by the facility for the two (2) weeks of staffing prior to survey from 9/17/2023 to 9/30/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 3 of 14 overnight shifts as follows: -09-17-23 had 7 CNAs for 101 residents on the day shift, required at least 13 CNAs. -09/18/23 had 8 CNAs for 101 residents on the day shift, required at least 13 CNAs. -09/19/23 had 7 CNAs for 101 residents on the day shift, required at least 13 CNAs. -09/20/23 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs. -09/20/23 had 6 total staff for 101 residents on the overnight shift, required at least 7 total staff. -09/21/23 had 9 CNAs for 100 residents on the day shift, required at least 12 CNAs. -09/22/23 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. -09/23/23 had 9 CNAs for 100 residents on the day shift, required at least 12 CNAs. -09/24/23 had 8 CNAs for 100 residents on the day shift, required at least 12 CNAs. -09/25/23 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -09/26/23 had 9 CNAs for 107 residents on the day shift, required at least 13 CNAs. -09/26/23 had 7 total staff for 107 residents on the overnight shift, required at least 8 total staff. -09/27/23 had 11 CNAs for 107 residents on the	F 835		

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COUNTRY ARCH CARE CENTER	114 PITTSTOWN ROAD PITTSTOWN, NJ 08867

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day shift, required at least 13 CNAs.
-09/28/23 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs.
-09/29/23 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs.
-09/30/23 had 9 CNAs for 106 residents on the day shift, required at least 13 CNAs.
-09/30/23 had 7 total staff for 106 residents on the overnight shift, required at least 8 total staff.

On 10/17/23 at 12:51 PM, the survey team met with the US FOIA (b)(6) [redacted]. The US FOIA (b)(6) [redacted] acknowledged that there was a concern with short staffing.

On 10/18/23 at 9:54 AM, the surveyor interviewed the US FOIA (b)(6) [redacted] regarding staffing. The US FOIA [redacted] acknowledged that the facility was aware of the number of CNAs required but did not always have the required number of CNAs.

3. A review of Resident #1's Progress Notes (PN) showed that the Physician Note's most recent documentation was a late entry on NJ Exec Order 26.4 [redacted] for a date of service of NJ Exec Order 26.4b [redacted]. The following were other Physician Notes documented in the PN: NJ Exec Order 26.4 [redacted]
For date of NJ Exec Order 26.4b [redacted] (late entry on NJ Exec Order 26.4 [redacted])
For date of NJ Exec Order 26.4b [redacted] (late entry on NJ Exec Order 26.4b [redacted])
For date of NJ Exec Order 26.4b [redacted] (late entry on NJ Exec Order 26.4b [redacted])
For date of NJ Exec Order 26.4 [redacted] (late entry on NJ Exec Order 26.4b [redacted])

Further review of the above PN of Resident #1 revealed that there was no Physician Note after NJ Exec Order 26.4 [redacted].

A review of Resident #8's PN showed that the

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most recent documented Physician Note was on [NJ Exec Order 26.4]. The following were other Physician Notes documented in the PN:
[NJ Exec Order 26.4]
[NJ Exec Order 26.]
For date of [NJ Exec Order 26.] (late entry on [NJ Exec Order 26.])
For [NJ Exec Order 26.4b1] (late entry on [NJ Exec Order 26.4b1])
[NJ Exec Order 26.4b1]
For [NJ Exec Order 26.4b1] (late entry on [NJ Exec Order 26.4b1])
For [NJ Exec Order 26.4b1] (late entry on [NJ Exec Order 26.4b1])

A review of Resident #18's PN showed that the most recent documented Physician Note was for [NJ Exec Order 26.4b] as a late entry on [NJ Exec Order 26.]. The following were other Physician Notes documented in the PN:
For [NJ Exec Order 26.] (late entry on [NJ Exec Order 26.4b1])
For [NJ Exec Order 26.] (late entry on [NJ Exec Order 26.])
For [NJ Exec Order 26.] (late entry on [NJ Exec Order 26.])
For [NJ NJ Exec Order 26.4] (late entry on [NJ NJ Exec Order 26.4])
For [NJ Exec Order 26.4b1] (late entry on [NJ Exec Order 26.4b1])

On 10/17/23 at 12:51 PM, the survey team met with the [US FOIA (b)(6)] and were notified of the above findings.

At that same time, the surveyor asked the facility management about the facility's policy and practice regarding physician visits. The [US FOIA (b)] informed the surveyors that the physician visits should be within 48-72 hours upon admission, the following month, monthly x 3 months. The [US FOIA (b)(6)] stated that it was an expectation that the [US FOIA] visits and notes then every two months minimally if there is a [US FOIA (b)(6)]). Then the surveyor asked the facility management if the facility had an [US FOIA (b)(6)] stated that the facility did not have an NP. The [US FOIA (b)(6)] then stated that it would be monthly physician

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visits and notes at least because there was no NP in the building. The facility management informed the surveyors that the resident's doctor was also the facility's US FOIA (b)(6) who also takes care of all residents in the facility.

On 10/19/23 at 10:49 AM, the survey team met with the US FOIA (b)(6) . The US FOIA (b)(6) informed the surveyors that the US FOIA was educated regarding the missing documentation of the physician. The US FOIA (b)(6) stated that the facility complied with the every two months note of the US FOIA The surveyor notified again the facility of the above missing notes. At this time, the US FOIA (b)(6) reviewed the electronic medical records for the physician's PN and confirmed that there were missing notes and that the physician documented PN and entered the notes late.

On that same date and time, the surveyor asked the US FOIA (b)(6) if he was aware that the US FOIA did not have PN documented in the timely manner, and the US FOIA (b)(6) stated that now he knew.

At this time, the surveyor asked for the facility's policy and procedure with regard to physician visits and notes. The US FOIA (b)(6) stated that the facility did not have a policy and that the facility followed the regulations.

4. The surveyor reviewed five (5) randomly chosen nurse aides' for their mandatory in services and showed the following information:

CNA #1 was hired NJ Exec Order 26.4b1
CNA #2 was hired NJ Exec Order 26.4b1
CNA #3 was hired NJ Exec Order 26.4b1
CNA #4 was hired NJ Exec Order 26.4b1

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F 835	Continued From page 100 CAN #5 was hired [redacted] The facility could not provide the in services completed from the CNAs' hiring date to their anniversary date for CNAs#1, #2, #3, #4, and #5. On 10/18/23 at 11:30 AM, the [redacted] and the [redacted] informed the team that they (facility management) could not find documentation that the 12 hours of competencies were completed. In addition, the [redacted] stated that she reviewed the in-service training book and that information documented on the Continuing Education Record did not meet the 12-hour requirements. 5. On 10/06/23 at 9:54 AM, the survey team met with the [redacted] and the [redacted] during the Entrance Conference. The facility management confirmed that the [redacted] will be coming in later time and will proceed with the Entrance Conference meeting without the [redacted] At this time, the surveyor asked for a copy of the last three quarters' QAPI sign-in sheets, policy, and procedure. A review of the facility provided QAPI sign-in sheets showed the following information: QAPI 2023 1st Quarter dated [redacted] and [redacted] did not attend the meeting QAPI Q2 (2nd Quarter) dated [redacted] and [redacted] did not attend the meeting QAPI dated [redacted] did not attend the meeting A review of the QAPI Program Plan that was provided by the [redacted] revealed that the	F 835		

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QAPI Plan was adopted on 11/01/19 and signed by the previous US FOIA (b)(6) [redacted] that included the following:
Governance & Leadership: The Administration assures the QAPI plan is reviewed on an annual basis by the QAPI team and approved by the governing body...The facility QAA Committee meets a minimum of quarterly and functions under the direction of the QAPI team. The QAPI team monitors data monthly from QAA findings and identifies areas for improvement to assure the achievement of the highest level of quality throughout the organization.
QAPI Framework: The Administrator, DON, Infection Control and Prevention Officer, medical director, and three additional staff from the QAPI team. The QAPI coordinator is responsible for identifying projects, planning meetings, and document activities.
Responsibility and Accountability: The administrator and/or QAPI coordinator has responsibility and is accountable to the governing body for ensuring that QAPI is implemented throughout our organization.

On 10/19/23 at 10:49 AM, the survey team met with the US FOIA (b)(6) [redacted]. The surveyor asked the US FOIA (b)(6) [redacted] if he was aware of the missing physician's visit notes, and the US FOIA (b)(6) [redacted] stated that he was not aware not until the surveyor's inquiry. The surveyor also asked the US FOIA (b)(6) [redacted] if he was aware that the US FOIA [redacted] was not also present during the last three quarters' QAPI meeting, the US FOIA (b)(6) [redacted] stated "I am very aware now."

On that same date and time, the US FOIA (b)(6) [redacted] confirmed that they (the facility) knew now that the governing body should be in the QAPI meeting as

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F 835	Continued From page 102 well. The US FOIA (b)(6) acknowledged that the governing body was not present in the QAPI meeting. A review of the Administrator's signed job description included the following: Position Summary: The Administrator is responsible for planning and is accountable for all activities and departments of the facility subject to rules and regulations promulgated by government agencies to ensure proper healthcare services to residents. The Administrator administers, directs, and coordinates all activities of the facility to assure that the highest degree of quality of care is consistently provided to the residents. Responsibilities/Accountabilities: Meet with licensing authorities as required and accompany them throughout any survey of the facility; superintend physical operation of the facility; oversee and guide department managers in the development and use of departmental policies and procedures; conduct committee meetings such as Quality Assurance, Infection Control, Pharmaceutical Services, and Safety Committee. On 10/19/23 at 12:55 PM, the survey team met with the US FOIA (b)(6) and the facility management stated that there was no additional information and that the survey team could proceed with decision making. NJAC 8:39-23.2(d); NJAC 8:39-25.2(a)(b); NJAC 8:39-27.1(a); NJAC 8:39-33.1(a)(b)	F 835		
F 841 SS=F	Responsibilities of Medical Director CFR(s): 483.70(h)(1)(2) §483.70(h) Medical director.	F 841		11/9/23

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F 841	Continued From page 103 §483.70(h)(1) The facility must designate a physician to serve as medical director. §483.70(h)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on the interview, record review, and review of other pertinent facility documentation it was determined that the facility US FOIA (b)(6) failed to provide clinical oversight and guidance regarding resident care policies and procedures that affect resident care, medical care, and resident quality of life related to a) required physician visits and notes, b) attends mandatory quarterly QAPI (Quality Assurance and Performance Improvement) meetings, and c) minimum State staffing requirements were met. This failure had the potential to affect all 105 residents who currently live in the facility. This deficient practice was evidenced by the following: 1. A review of Resident #1's Progress Notes (PN) showed that the Physician Note's most recent documentation was a late entry on NJ Exec Order 26.4 for a date of service of NJ Exec Order 26. . The following were other Physician Notes documented in the PN: NJ Exec Order 26.4 For date of NJ Exec Order 26.4 (late entry on NJ Exec Order 26.4b) For date of NJ Exec Order 26.4b (late entry on NJ Exec Order 26.4b) For date of NJ Exec Order 26.4b (late entry on NJ Exec Order 26.4b) For date of NJ Exec Order 26.4 (late entry on NJ Exec Order 26.4b) Further review of the above PN of Resident #1 revealed that there was no Physician Note after	F 841	F841 SS F Element One - Corrective Action: The US FOIA (b)(6) for residents #1 ,#8, and #18,was educated on the requirements of physician visits including the last day acceptable for a late entry (10 days post due date). The was also educated on Medical Directors responsibility regarding attendance and participation in the QAPI process. the facility US FOIA (b)(6) was reeducated by the Licensed Nursing Home Administrator (LNHA) on the components of this regulation with an emphasis on CNA to resident ratios. Element Two: All residents have the potential to be affected. ELEMENT THREE: SYSTEMIC CHANGES: The US FOIA (b)(6) re-educated on requirements of Medical Director Role including Charting deadlines and participation in the QAPI process. US FOIA (b)(6) and US FOIA (b)(6) have been re-educated on staffing guidelines. To increase CNA staffing: Jobs posted on internet job boards and purchase the add to be elevated. Professional recruiters actively recruiting.	

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F 841	Continued From page 104 NJ Exec Order 26.4b A review of Resident #8's PN showed that the most recent documented Physician Note was on NJ Exec Order 26.4. The following were other Physician Notes documented in the PN: NJ Exec Order 26.4 NJ Exec Order 26.4 For date of NJ Exec Order 26.4 (late entry on NJ Exec Order 26.4) For NJ Exec Order 26.4b1 (late entry on NJ Exec Order 26.4b1) NJ Exec Order 26.4b1 For NJ Exec Order 26.4b1 (late entry on NJ Exec Order 26.4b1) For NJ Exec Order 26.4b1 (late entry on NJ Exec Order 26.4b1) A review of Resident #18's PN showed that the most recent documented Physician Note was for NJ Exec Order 26.4 as a late entry on NJ Exec Order 26.4b1 The following were other Physician Notes documented in the PN: For NJ Exec Order 26.4b (late entry on NJ Exec Order 26.4) For NJ Exec Order 26.4 (late entry on NJ Exec Order 26.4) For NJ Exec Order 26.4 (late entry on NJ Exec Order 26.4) For NJ Exec Order 26.4b1 (late entry on NJ Exec Order 26.4b1) For NJ Exec Order 26.4b1 (late entry on NJ Exec Order 26.4b1) On 10/17/23 at 12:51 PM, the survey team met with the US FOIA (b)(6) and were notified of the above findings. At that same time, the surveyor asked the facility management about the facility's policy and practice regarding physician visits. The US FOIA (b) informed the surveyors that the physician visits should be within 48-72 hours upon admission, the following month, monthly x 3 months. The US FOIA (b)(6)	F 841	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 Pay for transportation Contracted bus company to assist with transportation Contacted local transportation authority to add a public bus stop QUALITY ASSURANCE To maintain and monitor ongoing compliance, LNHA/designee will monitor 4 random charts per week x 4 weeks , followed by 4 random charts x 4 months for completion of MD documentation per guidelines/regulation. VP of Clinical Operations will monitor QAPI process including attendance of mandatory personnel monthly x 12 months. 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 Needed corrections will be addressed as they are discovered. Findings to be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary.	

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then stated that it was an expectation that there would be a face-to-face visit and notes every two months minimally if there is a Nurse Practitioner (NP). Then the surveyor asked the facility management if the facility had an NP, then the US FOIA (b) and the US FOIA (b)(6) stated that the facility did not have an NP. The US FOIA (b)(6) then stated that it would be monthly physician visits and notes at least because there was no NP in the building. The facility management informed the surveyors that the resident's doctor was also the facility's US FOIA (b)(6)), who also takes care of all residents in the facility.

On 10/17/23 at 01:48 PM, the surveyor interviewed the US FOIA in the presence of the survey team. The US FOIA informed the surveyor that she started working at the facility in NJ Exec Orde and she "probably" has NJ Exec Order 26.4b1 , that "NJ Exec Order 26.4b1 and this was her main facility. The US FOIA stated "Sometimes it's my fault I'm behind," with notes. She further stated that she does see all residents and addresses the problem. The US FOIA acknowledged that she missed some notes.

On 10/19/23 at 10:49 AM, the survey team met with the US FOIA (b)(6) informed the surveyor that the US FOIA was educated regarding the missing documentation of the physician. The US FOIA (b)(6) stated that the facility complied with the every two months notes of the US FOIA (b) The surveyor notified again the facility of the above missing notes.

At this time, the US FOIA (b)(6) reviewed the electronic medical records for the physician's PN and confirmed that there were missing notes and that the physician documented PN and the PN

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were entered late. The facility management acknowledged that the facility did not comply with the required visit notes.

At this time, the surveyor asked for the facility's policy and procedure with regard to physician visits and notes. The [US FOIA (b)(6)] stated that the facility did not have a policy with regard to physician visits. The [US FOIA (b)(6)] further stated that instead they (facility management) follows the regulations as guidance about physician visits.

A review of the provided typewritten responses for the concerns that were discussed on 10/17/23 that were provided by the [US FOIA (b)(6)] included that the [US FOIA] Visits missing in documentation were acknowledged by the [US FOIA] and that the facility had no [US FOIA] Visit policy.

2. On 10/06/23 at 9:54 AM, the survey team met with the [US FOIA (b)(6)] during the Entrance Conference. The surveyor asked for a copy of the last three quarters' QAPI sign-in sheets, policy, and procedure.

A review of the facility provided QAPI sign-in sheets showed the following information:

QAPI 2023 1st Quarter dated [NJ Exec Order 26] = [US FOIA] and [US FOIA (b)(6)] did not attend the meeting
QAPI Q2 (2nd Quarter) dated [NJ Exec Order 26] = [US FOIA] and [US FOIA (b)(6)] did not attend the meeting
QAPI dated [NJ Exec Order 26] = [US FOIA (b)(6)] did not attend the meeting

On 10/17/23 at 01:48 PM, the surveyor interviewed the [US FOIA] in the presence of the survey team. The surveyor asked the [US FOIA] if she attended quarterly meetings in the facility, and the [US FOIA]

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stated "If I'm available I attend the meeting." The surveyor then asked the [US FOIA] if she was not able to attend if she sent someone to represent her in the meeting, and the [US FOIA] responded that she did not send someone to represent her in the quarterly QAPI meeting.

On that same date and time, the surveyor asked the [US FOIA] who was in charge of Infection Control in the facility and who attended the QAPI that reports for Infection Control. The [US FOIA] stated that "I think usually [US FOIA (b)(6)] is in charge," of the Infection Control and who attended the QAPI meeting. The [US FOIA] further stated that at this moment she was not sure who was Infection Preventionist of the facility was.

At this time, the surveyor asked the [US FOIA] who discussed vaccinations in the QAPI meeting, and the [US FOIA] responded "Frankly I don't remember who reported it." The [US FOIA] stated that she would go to the facility tomorrow to verify the QAPI sign-in sheets.

On 10/18/23 at 10:37 AM, the survey team met with the [US FOIA] The [US FOIA] verified the sign-in sheets for QAPI in the presence of the survey team and the MD confirmed that her signature was on the [NJ Exec Order 26.4] QAPI meeting and not on [NJ Exec Order 26.4] and the [NJ Exec Order 26.4] QAPI sign-in sheets. The surveyor asked the doctor if she knew why she was not present on the dates of [NJ Exec Order 26.4] and [NJ Exec Order 26.4] and the doctor had no response.

On that same date and time, the surveyor asked the [US FOIA] how often the QAPI meetings were and what was the expectation with regard to her attendance. The [US FOIA] stated that when the [US FOIA (b)(6)] came in as the new [US FOIA (b)(6)] in

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NJ Exec Order 26.4b1, "the big classic" quarterly meetings were changed to more frequent meetings because there was so much stuff to go over and things had changed with the meeting. The US FOIA further stated that she was not sure how and when the frequent meeting. She further stated that the quarterly QAPI meeting used to be a set date one Thursday in certain month not sure how it was set up the date. The US FOIA informed the surveyors that the facility was working toward arranging the set schedule for QAPI meetings.

At this time, the surveyor asked the US FOIA if the US FOIA (b)(6) was the NJ Exec Order 26.4b1 who was the US FOIA (b)(6) The US FOIA stated that the US FOIA (b)(6) whom the surveyor was referring to was the US FOIA (b)(6) The US FOIA further stated that the US FOIA (b)(6) whom the survey team was referring to was not at the facility every day and the US FOIA (b)(6) was the one who was at the facility every day.

3. On 10/06/23 at 9:54 AM, the survey team met with the US FOIA (b)(6) and the US FOIA (b)(6) The facility management confirmed that the census (counts all residents in a facility) was 105 plus one bed hold.

On 10/11/23 at 9:10 AM, the surveyor interviewed Certified Nursing Assistant #1 (CNA#1) who informed the surveyor that he's been working at the facility as a regular NJ Exec Order 26.4b1 for the 7-3 shift and at times at 3-11 shift with no regular wing assignment, been at the facility NJ Exec Order 26.4b1. Then CNA#2 joined the interview and both stated they were aware of the NJ (New Jersey) mandated staffing law of a 1:8 ratio (one CNA to eight residents). Both CNAs informed the surveyor that the mandated staff-to-resident ratio was not always being followed.

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F 841	Continued From page 109 At this time, CNA#1 informed the surveyor that he had 10 residents on his assignment today at [NJ Exec] wing. CNA#1 stated that the usual ratio in the 7-3 shift was around nine to ten residents per CNA. He further stated that on a worse day with calls out can reach up to "11 per piece per CNA." Furthermore, the surveyor asked both CNAs if they were able to finish their assignments, and CNA#2 stated that they still take care of the resident but it takes time for them to finish their assignments. The surveyor asked the CNAs if they notified their management about their concerns with staffing and CNA#1 stated that they (facility management) were aware. The surveyor then asked CNAs what was the facility management responded to their concern, CNA#2 stated that the facility management told them that they were doing something about it but they did not know what was the plan. A review of the [NJ Exec] Wing 7-3 shift Assignments that were provided by the [US FOIA (b)(6)] for date 10/06/23 showed the following: Census: 46 residents Nurses: Licensed Practical Nurse #1 (LPN#1), LPN#2 CNAs: CNA#3 with nine (9) residents, CNA#4 with nine residents, CNA#5 with nine residents, CNA#6 with 10 residents, CNA#7 with nine residents A review of the [NJ Exec] Wing 7-3 shift Assignments that were provided by the [US FOIA (b)(6)] for date 10/11/23 showed the following: Census: 47 residents CNAs: CNA#3 with nine residents, CNA#4 with nine residents, CNA#6 with 10 residents, CNA#2	F 841		

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F 841	Continued From page 110 with nine residents, CNA#1 with 10 residents Further review of the above 10/06/23 and 10/11/23 assignments revealed that the NJ mandated law ratio for 1:8 was not followed. On 10/17/23 at 12:51 PM, the survey team met with the US FOIA (b)(6) [redacted]. The US FOIA (b)(6) [redacted] acknowledged that there was a concern with short staffing. On 10/18/23 at 9:54 AM the surveyor interviewed the US FOIA (b)(6) [redacted]) regarding staffing. The US FOIA [redacted] acknowledged that the facility was aware of the number of CNAs required but did not always have the required number of CNAs. On 10/18/23 at 10:37 AM, the survey team met with the US FOIA [redacted] The surveyor asked the US FOIA [redacted] if staffing issues were discussed during the QAPI meeting. The US FOIA [redacted] stated "I am not sure" about staffing being discussed in the QAPI. Then the US FOIA [redacted] asked the surveyor if there was an issue with staffing at the facility. The US FOIA [redacted] also asked the survey team if the facility management notified the surveyor that there was a problem with staffing. At this time, the surveyor notified the US FOIA [redacted] of the above findings, and that the facility management acknowledged the concern. On 10/18/23 at 11:03 AM, the surveyor asked the US FOIA (b) [redacted] in the presence of the survey team for a copy of the US FOIA [redacted] policy and signed job description of the US FOIA [redacted] and she stated that she would get back to the surveyor. On the same date and time, the US FOIA (b) [redacted] informed	F 841		

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F 841	Continued From page 111 the surveyor that the US FOIA was not an employee of the facility and was only a contracted service US FOIA which was why the facility had no signed job description and policy. A review of the facility's Medical Director Agreement that was provided by the US FOIA (b)(6) showed in Section II Obligations of Medical Director 2.3 (a) To attend and participate in quarterly Quality Improvement Committee, Infection Control, Pharmacy, and Therapeutics meetings as scheduled. This was signed by the previous Administrator. On 10/19/23 at 12:55 PM, the survey team met with the US FOIA (b)(6) and the facility management stated that there was no additional information and that the survey team could proceed with decision making. N.J.A.C 8:39-23.1, 2, 3	F 841		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and	F 868		11/9/23

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F 868	Continued From page 112 assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, the facility failed to have: a) the US FOIA (b)(6)) present for two out of three Quality Assurance and Performance Improvement (QAPI) meetings, b) the US FOIA (b)(6) present for three out of three QAPI meetings, and c) set QAPI meeting schedule. This failure had the potential to affect all 105 residents who currently live in the facility. The deficient practice was evidenced by the following: On 10/06/23 at 8:57 AM, the survey team entered the facility and met with the US FOIA (b)(6) who	F 868	F868 SS F Element One - Corrective Action: Facilities medical director and licensed nursing home administrator signed attendance sheets for QAPI acknowledging their understanding of QAPI focus items for those months. Element Two: The Vice President of Operations and The Vice President of Clinical Services educated all staff at the facility on the QAPI process which was developed utilizing The Center for Medicare and Medicaid Services (CMS) QAPI at a glance framework and tool kit.	

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F 868	Continued From page 113 instructed the surveyors to use the touchless thermometer attached to a wall to check the surveyors' temperature, log in the binder temperature, and answer the COVID-19 screening questions. Later on, an employee introduced herself to the survey team as the facility's US FOIA (b)(6) . The US FOIA (b)(6) provided a business card that included her name with the title of US FOIA (b)(6) On 10/06/23 at 9:54 AM, the survey team met with the US FOIA (b)(6) and the US FOIA (b)(6) The facility management confirmed that the census (counts all residents in a facility) was 105 plus one bed hold. The surveyor asked for a copy of the last three quarters' sign-in sheet for QAPI, policy, and procedure. The facility management informed the surveyor that it was the US FOIA (b)(6)) who was the facility's designated US FOIA (b)(6) who attended the QAPI meeting and was responsible for the facility's infection control. The surveyor asked for a copy of the US FOIA (b)(6)s resume, signed job description, and certificate of completion for infection control. A review of the facility provided QAPI sign-in sheets showed the following information: QAPI 2023 1st Quarter dated NJ Exec Order 26 US FOIA and US FOIA (b)(6) did not attend the meeting QAPI Q2 (2nd Quarter) dated NJ Exec Order 26.4b1 US FOIA and US FOIA (b)(6) did not attend the meeting QAPI dated NJ Exec Order 26 US FOIA (b)(6) and US FOIA (b)(6) did not attend the meeting A review of the license verification site in New Jersey (NJ) revealed that US FOIA (b)(6) had an	F 868	The US FOIA (b)(6) were also educated about the need for the QAPI team to include administrator and medical director. ELEMENT THREE: SYSTEMIC CHANGES: US FOIA (b)(6) and other staff who attend QAPI (including at a minimum the director of nursing services, the medical director or his/her designee, at least 3 other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role, and the US FOIA (b)(6) . were re-educated on the QAPI process, a QAA was initiated, and audits completed. QAPI is scheduled for the third Thursday of each month with facility team and quarterly with team and vendors. QUALITY ASSURANCE QAPI attendance will be audited by the vice president of clinical services or designee, monthly to ensure that medical director and licensed nursing home administrator have attended QAPI. These audits will proceed monthly x 6 months. Findings to be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary.	

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F 868	Continued From page 114	F 868		

NJ Exec Order 26.4b1 in another state and a pending reinstatement of [redacted] license in NJ.

A review of the NJ license verification for US FOIA (b)(6) in NJ showed that the [redacted] had no current [redacted] license in NJ.

On 10/10/23 at 11:58 AM, the surveyor followed up with the [redacted] the documents that were asked during the Entrance Conference which included the [redacted]s resume, signed job description, and certificate of completion for [redacted]. The [redacted] stated that she wanted to correct the [redacted] had a clerical assistant job and not functioning as a nurse. The [redacted] further stated that the facility's [redacted] was the US FOIA (b)(6) The [redacted] informed the surveyor that the [redacted] will eventually be the [redacted] once the NJ license is available.

On 10/11/23 at 12:32 PM, the survey team met with the US FOIA (b)(6) The surveyor asked the [redacted] about the QAPI meetings. The [redacted] informed the surveyors that he attended QAPI meetings. The [redacted] was unable to state how often the QAPI meeting was, who attended the meetings, and how he knew the next QAPI meeting schedule. The [redacted] stated to the surveyor that the surveyor should check the records.

Later on, the [redacted] stated that all department heads attend QAPI meetings. Then the surveyor asked who else besides the department heads attended the meeting and [redacted] asked the surveyor to check the QAPI sheet.

On 10/18/23 at 10:37 AM, the survey team met with the [redacted] The [redacted] verified the sign-in sheets

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for QAPI in the presence of the survey team and the [US FOIA] confirmed that her signature was on the [NJ Exec Order 26.4] QAPI meeting and not on [NJ Exec Order 26.4] and the [NJ Exec Order 26.4] QAPI sign-in sheets. The surveyor asked the [US FOIA] if she knew why she was not present on the dates of [NJ Exec Order 26.4] and [NJ Exec Order 26.4] and the [US FOIA (b)(6)] had no response.

On that same date and time, the surveyor asked the [US FOIA] how often the QAPI meetings were and what was the expectation with regard to her attendance. The [US FOIA] stated that when the [US FOIA (b)(6)] came in as the new [US FOIA (b)(6)] in [NJ Exec Order 26.4b1], "the big classic" quarterly meetings were changed to more frequent meetings because there was so much stuff to go over and things had changed with the meeting. The [US FOIA] further stated that she was not sure how and when the frequent meetings, used to be set date on Thursdays in the month not sure how it was set up the date. The [US FOIA] informed the surveyors that the facility was working toward arranging the set schedule for QAPI meetings.

On 10/19/23 at 9:39 AM, the surveyor met with the [US FOIA (b)(6)] for a QAPI interview in the presence of the survey team. The surveyor asked the [US FOIA (b)(6)] how often the QAPI meetings, and the [US FOIA (b)(6)] responded that it was used to be quarterly then recently four months ago it was done monthly. He further stated that it was consistently quarterly every Thursday before, but the [US FOIA (b)(6)] was unable to state when every Thursday. The [US FOIA (b)(6)] was unable also to state when every month the scheduled QAPI meetings. The [US FOIA (b)(6)] indicated that the QAPI meeting was being announced in the morning meeting when the next QAPI meeting, not written, communication of the schedule was verbal. The surveyor asked the

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F 868	Continued From page 116 US FOIA (b)(6) if the US FOIA attended morning meetings, and the US FOIA (b)(6) stated "No." The surveyor then asked the US FOIA (b)(6) how will the US FOIA know the schedule meetings for QAPI if the US FOIA does not attend morning meetings, and the US FOIA (b)(6) had no response. On that same date and time, the US FOIA (b)(6) confirmed after checking the provided last three-quarters sign-in sheets for QAPI meetings, and US FOIA (b)(6) stated that he was not in the meeting on NJ Exec Order 263, NJ Exec Order 251, and NJ Exec Order 251. Furthermore, the surveyor asked the US FOIA (b)(6) who the key person must be present during QAPI meetings, the US FOIA (b)(6) stated that it was the US FOIA (b)(6) US FOIA (b)(6) and "I am not 100% sure" if the US FOIA and "maybe" the US FOIA (b)(6). The surveyor notified the US FOIA (b)(6) of the above concerns. On 10/19/23 at 10:49 AM, the survey team met with the US FOIA (b)(6). The surveyor asked the US FOIA (b)(6) if he was aware of the missing and late physician's visit notes, and the US FOIA (b)(6) responded that not until the surveyor's inquiry. The surveyor also asked the US FOIA (b)(6) if he was aware that the US FOIA was not also present during the last three quarters' QAPI meeting, the US FOIA (b)(6) stated "I am very aware now." On that same date and time, the US FOIA (b)(6) confirmed that they (the facility) knew now that the governing body should be in the QAPI meeting as well. The US FOIA (b)(6) acknowledged that the governing body was not present in the QAPI meeting. A review of the QAPI Program Plan that was	F 868		

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F 868	Continued From page 117 provided by the US FOIA (b)(6) revealed that the QAPI Plan was adopted on NJ Exec Order 26:4b and signed by the previous US FOIA (b)(6) [redacted] that included the following: Governance & Leadership: The Administration assures the QAPI plan is reviewed on an annual basis by the QAPI team and approved by the governing body...The facility QAA Committee meets a minimum of quarterly and functions under the direction of the QAPI team. The QAPI team monitors data monthly from QAA findings and identifies areas for improvement to assure the achievement of the highest level of quality throughout the organization. QAPI Framework: The Administrator, DON, Infection Control and Prevention Officer, medical director, and three additional staff from the QAPI team. The QAPI coordinator is responsible for identifying projects, planning meetings, and document activities. Responsibility and Accountability: The administrator and/or QAPI coordinator has responsibility and is accountable to the governing body for ensuring that QAPI is implemented throughout our organization. On 10/19/23 at 12:55 PM, the survey team met with the US FOIA (b)(6) [redacted] and the facility management stated that there was no additional information.	F 868		
F 880 SS=D	NJAC 8:39-33.1 (a)(b) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		11/9/23

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F 880	Continued From page 118 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 §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	F 880		

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F 880	Continued From page 119 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility provided documents, it was determined that the facility failed to ensure: a) appropriate use of personal protective equipment (PPE) for two (2) of three (3) staff observed during meal observation and b) linen carts were maintained and cleaned for proper storage of clean supplies for four (4) out of five (5) linen carts according to facility policy and Centers for Disease Control and Prevention (CDC) guidelines. This deficient practice was evidenced by the following:	F 880	Element One - Corrective Action: Linen Carts #3, #5, #7, #4 were immediately cleaned. Element Two: All residents who utilize facility laundry and who eat in the dining room have the potential to be affected. ELEMENT THREE: SYSTEMIC CHANGES: Housekeeping staff and nursing staff were educated on cleaning the linen carts and observing and reporting if cart is dirty. A tracking log was created to assist in monitoring cleanliness	

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F 880	Continued From page 120 According to the CDC, Appendix D - Linen and laundry management, last reviewed May 4, 2023, Best practices for management of clean linen: Sort, package, transport, and store clean linens in a manner that prevents risk of contamination by dust, debris, soiled linens or other soiled items. Each floor/ward should have a designated room for sorting and storing clean linens. Transport clean linens to patient care areas on designated carts or within designated containers that are regularly (e.g., at least once daily) cleaned with a neutral detergent and warm water solution. 1. On 10/06/23 at 10:39 AM, the surveyor toured the [redacted] wing. In rooms [redacted] through [redacted], both the surveyor and Licensed Practical Nurse #1 (LPN#1) observed linen cart #3 with a dirty cover. The surveyor asked LPN#1 about linen cart #3 and the [redacted] stated that linen cart #3 was considered a clean linen cart of linens, blankets, and gowns. The surveyor asked what was the dried brownish discoloration on the linen cart. The [redacted] stated that she did not know what the brownish discoloration was. The [redacted] further stated that it looked like something had spilled over the linen cart cover and extended inside the cart. On that same date and time, LPN#1 informed the surveyor that the linen cart should have been cleaned and she would ask the housekeeping to clean it and wash again everything that was inside the cart. On 10/06/23 at 11:00 AM, the surveyor observed linen cart #5 parked next to the [redacted] treatment cart in the [redacted] wing in rooms [redacted] through [redacted] The [redacted] informed the	F 880	of linen carts and [redacted] educated on utilizing chart. [redacted], activities staff and the [redacted] were immediately in serviced on not wearing gloves while passing out food/drink. Thereafter all staff were re-in serviced on proper wearing of gloves including when gloves should be worn. QUALITY ASSURANCE To maintain and monitor ongoing compliance, The Housekeeping Director /designee will audit linen carts daily x7, weekly x 4 and monthly x 4 for cleanliness. LNHA/designee will monitor tray distribution in the main dining room, and activities programs where food is distributed, daily x 7, weekly x4 and monthly x 4 to ensure staff is following proper use of gloves. Needed corrections will be addressed as they are discovered. Findings to be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary.	

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surveyor that linen cart #5 was being used by staff to get clean linens, blankets, and gowns. The [US FOIA] confirmed that there was a brownish-discolored spill that dried up outside the linen cart cover. The [US FOIA] further stated that it looked like it had been there for a couple of days and should have been cleaned.

At that same time, both the surveyor and the [US FOIA] observed linen cart #7 with the same unidentified brownish-colored spill over the linen cart cover. A few steps away was a clean linen cart #8.

On 10/06/23 at 11:08 AM, both the surveyor and LPN#2 in 100 wing in the area from rooms [Ex Order] through [Ex Order] observed linen cart #4 parked in front of room [Ex Order] with brownish substances on the cover of the linen cart which was confirmed by LPN#2. LPN#2 stated that he did not know what was the brown substance and there was wear and tear on the back of the cover, and that it should have been cleaned.

On 10/13/23 at 10:25 AM, the [US FOIA (b)(6)] stated that the facility had no policy with regard to the environment and storage of linens and care of the linen carts.

On 10/16/23 at 12:05 PM, the survey team met with the [US FOIA (b)(6)]. The [US FOIA (b)(6)] stated that the [US FOIA (b)(6)] was responsible for basic cleaning and thorough cleaning of the linen carts was the housekeeping. The surveyor asked who was responsible for following up and checking if the linen cart cleaning was done. The [US FOIA (b)(6)] stated that it was the [US FOIA (b)(6)] who made

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sure that it was clean. The surveyor asked if there was accountability for cleaning the linen carts and the [US FOIA (b)(6)] stated that there was no checklist "just" spot-checking. The facility management acknowledged that the linen carts should have been cleaned.

2. On 10/13/23 at 12:21 PM, the surveyor observed the main dining with 19 residents, two Dietary Staff, and the [US FOIA (b)(6)] Dietary Aide #1 (DA#1) and DA#2 were both serving hot and cold drinks to the residents. Both DA #1 and #2 were wearing gloves while serving drinks. The surveyor asked the [US FOIA] if it was appropriate for two staff to serve drinks with gloves, and the [US FOIA] responded that it was okay because the activity team also uses gloves while serving during coffee time. The surveyor asked the [US FOIA] who were the two staff with gloves in use while serving drinks.

On 10/13/23 at 12:24 PM, both the surveyor and the [US FOIA (b)] went to the main dining room and observed DA#1 and DA#2 with gloves while serving drinks to the residents. The surveyor asked the [US FOIA (b)] if it was appropriate for the two Dietary staff with gloves while serving drinks in the dining area for lunch to the residents. The [US FOIA] explained to the [US FOIA (b)] that they were doing the same thing (with gloves) even the coffee time with recreation, the [US FOIA (b)] then stated "I think it was okay because I have seen that too."

On 10/13/23 at 12:27 PM, the surveyor observed five residents in the [NJ Exec (b)] wing small dining area during lunch. The surveyor interviewed a [US FOIA (b)] who informed the surveyor that she assisted in serving lunch earlier. The surveyor asked if she wore gloves when serving lunch to the resident,

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and at this time LPN#3 joined the interview. Both the [US FOIA (b)(6)] and LPN#3 stated "No we don't wear gloves," because of infection control and cross-contamination.

On 10/13/23 at 12:32 PM, the surveyor asked the [US FOIA (b)(6)] in the presence of the survey team if it was appropriate for DA#1 and #2 to use gloves when serving drinks to the residents. The [US FOIA (b)(6)] stated "no" due to infection control. The surveyor notified the [US FOIA (b)(6)] of the above findings.

On 10/16/23 at 12:05 PM, the survey team met with the [US FOIA (b)(6)] and [US FOIA (b)(6)] and were made aware of the above findings.

A review of the facility's Bare Hand Contact with Food and Use of Plastic Gloves Policies and Procedures dated 5/10/23 that was provided by the [US FOIA (b)(6)] included that gloves hands are considered a food contact surface that can get contaminated or soiled. If used, single-use gloves shall be used for only one task (such as working with ready-to-eat food or with raw animal food), used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.

A review of the undated facility's Housekeeping Policy that was provided by the [US FOIA (b)(6)] included that it is the policy of this facility to provide and maintain a safe, clean, orderly, and homelike environment for residents. Procedures: all equipment and environmental surfaces shall be clean to sight and touch.

On 10/19/23 at 12:55 PM, the survey team met with the [US FOIA (b)(6)] and the facility

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F 880	Continued From page 124 management stated that there was no additional information.	F 880		
F 882 SS=D	NJAC 8:39-19.4 (a)(1) Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on the interview and review of pertinent facility documents, it was determined that the facility failed to ensure that the designated US FOIA (b)(6) dedicated solely to the infection prevention and control program (IPCP) for three (3) of three (3) staff in accordance with the facility policy and Centers for Medicare and Medicaid Services (CMS) and New Jersey (NJ) guidelines. This deficient practice was evidenced by the	F 882	Element 1: US FOIA (b)(6) is currently still working at the facility in a role performing tasks within scope of practice of current licensure. US FOIA (b)(6) still works for the facility within the scope of practice for registered nurse. CRN is no longer working at the facility. Element two: All residents that require an IP have potential to be affected. To address this for the other residents in a	11/9/23

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F 882	Continued From page 125 following: According to the NJ Executive Directive 21-012 (revised 12/22/22) included "ii. The facility's designated individual(s) with training in infection prevention and control shall assess the facility's IPCP by establishing or revising the infection control plan, annual infection prevention and control program risk assessment, and conducting internal quality improvement audits." According to the CMS QSO-22-19-NH Memo dated 6/29/22 and Fact Sheet, Updated Guidance for Nursing Home Resident Health and Safety dated 6/29/22, effective date on October 24, 2022 Overview of New and Updated Guidance, Summary of Significant Changes, included that in Infection Control, requires the facilities to have a part-time IP. While the requirement is to have at least a part-time IP, the IP must meet the needs of the facility. The IP must physically work onsite and cannot be an off-site consultant or work at a separate location. IP's role is critical to mitigating infectious diseases through an effective infection prevention and control program. IP specialized training is required and available. On 10/06/23 at 8:57 AM, the survey team entered the facility and met with the US FOIA (b)(6) who instructed the surveyors about the COVID-19 screening. Later on, an employee introduced herself to the survey team as the facility's US FOIA (b)(6) The US FOIA (b)(6) provided a business card that included her name with the title of US FOIA (b)(6) On 10/06/23 at 9:54 AM, the surveyor met with the US FOIA (b)(6) and the US FOIA (b)(6)).	F 882	similar situation the facility now employees an infection preventionist complying with F483.80(b)(1)(2)(3)(4). Element Three: To monitor ongoing compliance, the director of nursing/designee will perform an audit to ensure that the facility complies with the requirements of the Infection preventionist identified in F483.80(b). To ensure compliance. These audits will be performed weekly x 4 weeks, then monthly x 4 months. To ensure that the solutions are sustained, findings of these audits will be reported to QAPI monthly x 12 months and corrections will be made as necessary.	

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The facility management informed the surveyor that it was the full time US FOIA (b)(6) who was the facility's designated US FOIA (b)(6) who attended the QAPI meetings and was responsible for the facility's infection control. The surveyor asked for a copy of the US FOIA (b)(6) resume, signed job description, and certificate of completion for infection control.

A review of the license verification site in New Jersey (NJ) revealed that US FOIA (b)(6) had an NJ Exec Order 26.4b1 in another state and a pending reinstatement of US FOIA (b) license in NJ.

A review of the NJ license verification for Administrators in NJ showed that the US FOIA (b)(6) had no current US FOIA (b)(6) license in NJ.

On 10/10/23 at 11:58 AM, the surveyor followed up with the US FOIA (b) the documents that were asked during the Entrance Conference which included the US FOIA (b)(6) resume, signed job description, and certificate of completion for US FO The US FOIA (b) stated that she wanted to correct herself because the US FOIA (b)(6) had a clerical assistant job and not functioning as a nurse. The US FOIA (b) clarified that the US FOIA (b)(6) was not the US FOIA (b) of the facility. The US FOIA (b) further stated that the facility's US FOIA was the US FOIA (b)(6) The US FOIA (b) informed the surveyor that the US FOIA (b) will eventually be the US FOIA (b)(6) once the NJ license is available. The surveyor asked for the employee files of the US FOIA (b)(6) and the US FOIA (b)(6).

On that same date and time, the US FOIA (b) informed the surveyor that since the US FOIA (b) started working in the facility, it was the US FOIA (b)(6) who was the

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designated US FOIA (b)(6)). The surveyor asked the US FOIA (b) for a timeline of who was the designated US FO of the facility from NJ Exec Order 26 up to NJ Exec Order 26.4b1 and the US FOIA (b) stated that she would get back to the surveyor. The surveyor also asked the US FOIA (b) if the facility complied with the regulation with regard to US FO requirements, and the US FOIA (b) responded that she had to get back to the surveyor.

On 10/10/23 at 12:26 PM, the surveyor interviewed the US FOIA (b)(6)) who also claimed that she was the US FOIA (b)(6) of the facility. The US FOIA (b) informed the surveyor that her responsibilities were the hiring process, payroll, central supply, receptionist, staff nursing, and helping other departments with guidance.

At that same time, the surveyor asked the US FOIA (b) who was the facility's US FO the US FOIA (b) responded that it was the US FOIA (b)(6)) before, then the US FOIA (b)(6) and now it was the US FOIA (b)(6). The surveyor asked for US FOIA (b)(6) employee files, and the US FOIA (b) stated that she had to ask for them from corporate office. The US FOIA (b) further stated that the US FOIA (b)(6) was the assistant of the US FOIA (b) who does paperwork and keeps files together.

On 10/10/23 at 12:59 PM, the surveyor interviewed Licensed Practical Nurse #1 (LPN#1) in the presence of the survey team who informed the surveyor that she had been working in the facility for NJ Exec Order 26.4b1 as a NJ Exec Order 26.4b 7-3 shift nurse in NJ Exec O Wing, and at times works in 3-11 shift. LPN#1 stated that it was the US FOIA (b) who was the designated US FO of the facility. LPN#1 further stated

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that the [redacted] was responsible for infection control education, and competencies. LPN#1 informed the surveyor that a month ago in the office of the [redacted] they (staff) had competency done. She further stated that the [redacted] was the facility's [redacted]) and that "usually" the [redacted] was also the [redacted] LPN#1 indicated that the [redacted] did not do patient care.

On that same date and time, the surveyor asked LPN#1 if the [redacted] was also the [redacted] LPN#1 stated that the [redacted] was not the facility's designated [redacted] and was not involved in infection control education and training.

On 10/10/23 at 01:29 PM, the two surveyors interviewed the [redacted] The [redacted] informed the surveyors that her job descriptions included as an assistant to the [redacted] doing audits, answering questions on the floor/unit/wing, a lot of copying for the [redacted] and helping the [redacted] providing training in infection control. She further stated that she does not do patient care. The surveyor asked the [redacted] if she was the [redacted] and she responded "Not technically." She further stated that the [redacted] was the designated [redacted]

A review of the signed Job description of [redacted] for the job title of [redacted] on [redacted] did not include the designated job title for [redacted]

A review of the provided List of Employees that were hired since the last recertification by the [redacted] included the following information: [redacted] was hired on [redacted] as the [redacted] [redacted] was hired on [redacted] as an [redacted] [redacted] was hired on [redacted] as a [redacted].

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F 882	Continued From page 129 US FOIA (b) was hired on NJ Exec Order 25.4b as US FOIA (b)(6) On 10/10/23 at 01:45 PM, the surveyors interviewed the US FOIA (b)(6) informed the surveyors that her title was a US FOIA (b)(6) waiting for a reciprocity for US FOIA (b)(6) She further stated that she was a licensed US FOIA (b)(6) in another state and that she was the acting US FO of the facility. On that same date and time, the surveyor asked the US FOIA (b)(6), if she was not the US FOIA (b)(6) of the facility, why she signed the offer letter of the US FOIA (b) to be the facility's US FOIA (b)(6) on NJ Exec Order 25. wherein she signed her name with a title of US FOIA (b)(6) The US FOIA (b)(6) stated that she did not know why the facility US FOIA (b)(6) did not sign the offer letter. She further stated that she did not realized the offer letter that she signed had a title of an US FOIA (b)(6) in her name. Furthermore, the surveyor asked the US FOIA (b)(6) why the employee files that were provided to the surveyor showed that she US FOIA (b)(6)) had no signed job description for being an US FO and that the signed job description in the file was for an US FOIA The US FOIA (b)(6) stated that "technically" she was the designated US FO of the facility and the US FOIA (b) was covering US FO prior to her US FOIA (b)(6) assuming the position of an US FO On 10/13/23 at 9:22 AM, the surveyor interviewed LPN#2 regarding the US FOIA of the facility. LPN#2 informed the surveyor that it had been the practice of the facility that the US FOIA (b)(6) was the designated US FO and at this time it was the US FOIA (b) that was the designated US FO LPN#2 further stated that the US FOIA (b) provided education, in-service, and	F 882		

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competencies about infection control that included handwashing and the use of PPE (personal protective equipment).

On that same date and time, the surveyor asked about the [redacted] and the US FOIA (b)(6) as an [redacted] LPN#2 stated that "to be honest, she was seldom here, not even once a week," the [redacted] "probably" did one or couple of education and it was always the [redacted] LPN#2 also stated that the US FOIA (b)(6) was not the designated [redacted] because she was the US FOIA (b)(6) He further stated that [redacted] does not deal with us nurses because she is the US FOIA (b)(6) The surveyor then asked who was the [redacted] LPN#2 stated that he was also their US FOIA (b)(6) The surveyor then asked what the US FOIA (b)(6), and LPN#2 responded that he did not know.

On 10/13/23 at 9:37 AM, the surveyor interviewed the [redacted] Nurse ([redacted]). The surveyor asked the [redacted] what was the job responsibility of the [redacted] at the facility and she stated that the [redacted] was the US FOIA (b)(6) of the facility.

On 10/13/23 at 10:33 AM, the survey team met with the US FOIA (b)(6) [redacted]). The surveyor notified the facility management of the above findings and concerns regarding the Infection Preventionist role from [redacted] through [redacted].

On 10/13/23 at 11:47 AM, the survey team met with the US FOIA (b)(6) [redacted] According to the [redacted] the US FOIA (b)(6) was the facility's US FOIA (b)(6) and the [redacted] whom the surveyors were talking about was the facility's [redacted] The [redacted] stated that she discussed her

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F 882	Continued From page 131	F 882		

concerns and questions with the US FOIA (b)(6) because the US FOIA (b)(6) was introduced to her as the facility's US FOIA (b)(6) and that she had a business card with the US FOIA (b)(6) as an US FOIA (b)(6)

On 10/16/23 at 12:05 PM, the survey team met with the US FOIA (b)(6) . The US FOIA (b)(6) stated that the facility staff was used to having an US FOIA (b)(6) as the facility practice before as the US FO but since the facility's bed number, we are not required to have an US FOIA (b)(6) anymore. The US FOIA (b)(6) further stated that the US FOIA (b) fills in if there will be no US FO which was why it was the US FOIA (b) the US FO of the facility from NJ Exec Order 26.4b . The facility management acknowledged that the US FOIA (b) was the designated US FO from NJ Exec Order 26.4b1 until the US FOIA (b)(6) came in NJ Exec Order 26.4b1

On 10/18/23 at 9:34 AM, the surveyors interviewed the US FOIA (b) regarding staff education and who was responsible. The US FOIA (b) stated, "I am, I do everything here." She further stated that the US FOIA (b) tracks the in-service. The US FOIA (b) informed the surveyors that the US FOIA (b) was the administrative assistant to the US FOIA (b)(6)

On that same date and time, the US FOIA (b) informed the surveyor that in NJ Exec Order 26.4b1 there was no US FOIA (b)(6) and it was the US FOIA (b) covered as the US FO The US FOIA (b) stated that when there was a vacancy in the facility management, it was the corporate people who covered for the vacant position. She further stated that the US FOIA (b) oriented the US FOIA (b) and the US FOIA (b) covered for an US FO when the US FOIA (b) started in the facility until NJ Exec Order 26.4b1 The US FOIA (b) also stated that from NJ Exec Order 26.4b1 through NJ Exec Order 2 it was the US FOIA (b) who was the US FO and when the US FOIA (b)(6) started on NJ Exec Order 26.4b1, the

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F 882	Continued From page 132 US FOIA (b)(6) was the designated US FOIA up to this time. A review of the Position Title: Infection Control Coordinator with a revision date of 6/01 that was provided by the US FOIA (b) included the following information: Department: Nursing Reports to: DON Position Summary: The Infection Control Coordinator assists and supports the translation of the nursing philosophy of the facility into nursing practice by participating in the planning, implementation, and evaluation of the nursing care delivery system. In addition, he/she provides residents and personnel with established guidelines to follow in the prevention and spread of contagious, infectious, or communicable diseases. Responsibilities/Accountabilities: Coordinates regular in-services on infection control practice at least quarterly; Assumes responsibility for detecting and reworking nosocomial infections on a systematic and current basis; Conducts rounds throughout the nursing facility to assure compliance with State, Federal, and [another name of the facility was entered]; a report on findings will be submitted to the DON and to the LNHA; Maintains active involvement in facility Quality Improvement Policy; Performs other duties as requested. Specific Educational/Vocational Requirements: The Infection Control Coordinator must be a graduate of an accredited School of Nursing with current registered nurse licensure by the NJ State Board of Nursing. Essential Job Functions: Location of Job Conditions: Outside 0%, Inside 100%.	F 882		

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F 882	Continued From page 133 On 10/19/23 at 12:55 PM, the survey team met with the US FOIA (b)(6) and the facility management stated that there was no additional information. NJAC 8:39-19.1(b)	F 882		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility	F 883		11/9/23

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F 883	Continued From page 134 must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of other pertinent provided facility documents, it was determined that the facility failed to: a) identify residents in need of, offer a NJ Exec Order 26.4b1 for four (4) of six (6) residents, (Residents #13, #82, #84, and 95), and offer the subsequent NJ Exec Order 26.4b1 for two (2) of six (6) residents, (Residents #28 and #30) and b) follow the facility NJ Exec Order 26.4b1 policy in accordance with the Advisory Committee on Immunization Practices and the CDC (Centers for Disease Control and Prevention) guidelines.	F 883	Element one- Resident #13, #82, #84, #and #95 were offered the NJ Exec Order 26.4b1 and accepted. Resident # 28 and #30 were offered the NJ Exec Order 26.4b1 [redacted] and accepted. Element two- All residents who need the pneumococcal or influenza vaccine have the potential to be affected. An audit was completed to ascertain if any residents were due for pneumococcal or influenza vaccine.	

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F 883	Continued From page 135 This deficient practice was evidenced by the following: Reference: A review of the CDC guidelines for Pneumococcal vaccination included: Age 65 years or older who have: -Not previously received a dose of PCV13, PCV15, or PCV20 or whose previous vaccination history is unknown: 1 dose PCV15 OR 1 dose PCV20. If PCV15 is used, this should be followed by a dose of PPSV23 given at least 1 year after the PCV15 dose. A minimum interval of 8 weeks between PCV15 and PPSV23 can be considered for adults with an immunocompromising condition,* cochlear implant, or cerebrospinal fluid leak to minimize the risk of invasive Pneumococcal disease caused by serotypes unique to PPSV23 in these vulnerable groups. -Previously received only PPSV23: 1 dose PCV15 OR 1 dose PCV20 at least 1 year after the PPSV23 dose. If PCV15 is used, it need not be followed by another dose of PPSV23. 1. On 10/06/23 at 10:44 AM, the surveyor observed Resident #82 inside their room seated in a wheelchair while watching television. The resident stated that NJ Exec Order 26.4b1 with care. The surveyor reviewed the medical records of Resident #82. The Admission Record (AR; or face sheet, an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to unspecified Ex Order 26.4B1	F 883	Element three- Education provided to nursing staff have been provided education regarding residents needing the pneumococcal or influenza vaccines from Director of nursing. All residents who needed vaccination were offered pneumococcal vaccine and vaccination clinic was completed 11/3/23. Pneumonia vaccines will be offered upon admission and quarterly thereafter if residents declined. Element four- To monitor performance to make sure solutions are sustained, 2 residents Pneumococcal and influenza vaccination status will be randomly audited by the don/designee for completion monthly x 3 months, then quarterly x6 months. Findings will be reported monthly x 12 to quality assurance performance improvement team for review and action as necessary.	

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Ex Order 26.4B1 [redacted]

A review of Resident #82's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) Ex Order 26.4B1 Section NJ Exec Order 26.4b1 with a Brief Interview for Mental Status (BIMS) score of Ex O out of Ex Ord which reflected that the resident's Ex Order 26.4B1 status was Ex Order 26.4B1 . Section NJ E Special Treatments, Procedures, and Programs included that the resident's Ex Order 26.4B1 was not assessed and there was no information.

The NJ Exec Order 26.4b1 record in the electronic medical record showed that the resident NJ Exec Order 26.4b was NJ Exec Order 26.4b Further review of the medical records showed that there was no NJ Exec Order 26.4b1 NJ Exec Order 26.4b documentation that the resident NJ Exec Order 26.4b the NJ Exec Order 26.4b

On 10/13/23 at 10:33 AM, the survey team met with the US FOIA (b)(6) [redacted]), and the surveyor notified the facility management of the above findings.

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2. On 10/10/12 at 01:45 PM, during an interview with the surveyors, the[US FOIA (b)(6)] stated that she was waiting for her reciprocity from another state, and was the acting[US FOIA (b)(6)] since[NJ Exec Order 26.4b1].

At that time, the[US FOIA (b)(6)] explained the process for the[NJ Exec Order 26.4b1] for the facility to the surveyors. She stated that upon admission the resident should have been offered the[NJ Exec Order 26.4b1], if there was no history the resident should have been offered the[NJ Exec Or] and administered if they wanted it. Ideally it should be re-offered quarterly or biennially.

At that time, the[US FOIA (b)(6)] stated that the surveillance was conducted by running a report on the [electronic medical record (eMR)/brand redacted] as to who needed or wanted the[NJ Exec Or]

At that time, the surveyors had asked the[US FOIA (b)(6)] if she had run the report.
The[US FO] stated that she did not recall but should have as part of the surveillance to ensure better resident outcomes.

At that time, the[US FOIA (b)(6)] stated that the facility protocol was dependent on the physician's order and what was available at the pharmacy.

The surveyor reviewed the medical records for Resident #13.

The resident's AR reflected that Resident #13 was admitted to the facility with diagnoses that included but were not limited to[Ex Order 26.4B1]

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NJ Exec Order 26.4b1 [redacted].

According to the qMDS dated [redacted] with a BIMS score of three ([redacted] out of 15, indicating that the resident had a NJ Exec Order 26.4b1 [redacted].

Further review of the qMDS section [redacted] NJ Exec Order 26.4b1 revealed the following:
A. Resident's NJ Exec Order 26.4b1 up to date, was blank, [not assessed/no information].
B. If not received, state reason:
1. for not eligible, [blank]
2. offered and declined, [blank]
3. not offered, [blank]

The MDS record did not reflect any actions taken for assessment of eligibility for the [redacted], that it was [redacted] and [redacted] or that it was not [redacted].

A review of the Resident #13's eMR under NJ Exec Order 26.4b1 record did not indicate a record for NJ Exec Order 26.4b1 or that it was [redacted] and [redacted].

A review of the resident's Care Plan (CP) and Order Summary Report (OSR) did not indicate the resident was care planned or had an active order for NJ Exec Order 26.4b1

3. The surveyor reviewed the medical record for Resident #95.

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F 883	Continued From page 139 The resident's AR reflected that Resident #13 was admitted to the facility with diagnoses that included but were not limited to Ex Order 26.4B1 [redacted] According to the qMDS dated Ex Order 26.4B1 with a BIMS score of Ex Order 26.4B1 out of Ex Orde, indicating that the resident had a Ex Order 26.4B1 . Further review of the qMDS section NJ Exec Order 26.4b NJ Exec Order 26.4b1 revealed the following A. Resident's NJ Exec Order 26.4b1 up to date, was blank, [not assessed/no information]. B. If not received, state reason: 1. for not eligible, [blank] 2. offered and declined, [blank] 3. not offered, [blank] The record did not reflect any actions taken for assessment of eligibility for the NJ Exec Order 26.4b1, that it was NJ Exec Order 26 and NJ Exec Order 26.4b or that it was not NJ Exec Order 26.4 A review of the Resident #95's eMR under NJ Exec Order 26.4b1 record did not indicate a record for NJ Exec Order 26.4b1 or that it was NJ Exec Order 26 and NJ Exec Order 26.4b1 A review of the resident's CP and OSR did not indicate the resident was care planned or had an active order for NJ Exec Order 26.4b1 4. The surveyor reviewed the medical record for	F 883		

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F 883	Continued From page 140	F 883		

Resident #28.

The resident's AR reflected that Resident #28 was admitted to the facility with diagnoses that included but were not limited to unspecified Ex Order 26.4B1 [redacted].

According to the qMDS dated Ex Order 26.4B1 with a BIMS score of Ex Order 26.4B1 out of Ex Order, indicating that the resident had a Ex Order 26.4B1 [redacted].

Further review of the qMDS section NJ Exec Order 26.4b NJ Exec Order 26.4b1 revealed the following:
A. Resident's NJ Exec Order 26.4b1 up to date, indicated yes.
B. If not received, state reason:
1. for not eligible, [blank]
2. offered and declined, [blank]
3. not offered, [blank]

A review of the Resident #28's eMR under NJ Exec Order 26.4b1 record did not indicate a record for NJ Exec Order 26.4b1 indicated the resident received NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1.

A review of the Resident #28's eMR under NJ Exec Order 26.4b1 record did not indicate a subsequent NJ Exec Or or NJ Exec Order 26.4b1 of an NJ Exec Or for the NJ Exec Order 26.4b1.

A review of the resident's CP and OSR did not indicate the resident was care planned or had an active order for NJ Exec Order 26.4b1

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F 883	Continued From page 141 A review of the Resident #28's eMR under Immunizations record did not indicate a record for NJ Exec Order 26.4b1 or that it was NJ Exec Order 26 and NJ Exec Order 26.4b1 5. The surveyor reviewed the medical record for Resident #30. The resident's AR reflected that Resident #30 was admitted to the facility with diagnoses that included but were not limited to Ex Order 26.4B1 [redacted] According to the qMDS dated Ex Order 26.4B1 with a BIMS score of [redacted] out of 15, indicating that the resident had Ex Order 26.4B1 Further review of the qMDS section NJ Exec Order 26.4b NJ Exec Order 26.4b1 revealed the following: A. Resident's NJ Exec Order 26.4b1 up to date, was marked [redacted] The record did not reflect any actions taken for assessment of eligibility for the NJ Exec Order 26.4b1, that it was NJ Exec Order 26 and NJ Exec Order 26.4b or that it was not NJ Exec Order 26.4 A review of the Resident #30's eMR under NJ Exec Order 26.4b1 record revealed a recorded NJ Exec Order 26.4b1 given on NJ Exec Order 26.4b1. It did not indicate that the subsequent NJ Exec Order 26.4b1 NJ Exec Order 26.4 was NJ Exec Order 26 and NJ Exec Order 26.4b1	F 883		

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A review of the resident's CP and OSR did not indicate the resident was care planned or had an active order for NJ Exec Order 26.4b1

6. The surveyor reviewed the medical record for Resident #85.

The resident's AR reflected that Resident #85 was admitted to the facility with diagnoses that included but were not limited to Ex Order 26.4B1 [redacted]

According to the comprehensive MDS dated NJ Exec Order 26.4 with a BIMS score of Ex Order 26.4B1) out of 15, indicating that the resident had Ex Order 26.4B1 Ex Order 26.4B1 .

Further review of the qMDS section NJ Exec Order 26.4b NJ Exec Order 26.4b1 revealed the following:
A. Resident's NJ Exec Order 26.4b1 up to date, was blank, [not assessed/no information].
B. If not received, state reason:
1. for not eligible, [blank]
2. offered and declined, [blank]
3. not offered, [blank]

The MDS record did not reflect any actions taken for assessment of eligibility for the NJ Exec Or [redacted], that it was NJ Exec Order 26 and NJ Exec Order 26.4b or that it was not NJ Exec Order 26.4

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F 883	Continued From page 143 The record did not reflect any actions taken for assessment of eligibility for the NJ Exec Order 26.4b1, that it was NJ Exec Order 26 and NJ Exec Order 26.4b or that it was not NJ Exec Order 26.4 A review of the Resident #85's eMR under NJ Exec Order 26.4b1 record did not indicate a record for NJ Exec Order 26.4b1 or that it was NJ Exec Order 26 and NJ Exec Order 26.4b1 A review of the resident's CP and OSR did not indicate the resident was care planned or had an active order for NJ Exec Order 26.4b1 On 10/12/23 at 12:31 PM, during a follow-up interview with the surveyors, the US FOIA (b)(6) stated that the facility had a NJ Exec Order 26.4b1 from NJ Exec Or to NJ Exec Or and the facility has been cleared since by the State Agency. At that time, the US FOIA (b)(6) stated that she had a working relationship with the US FOIA (b)(6) who was not comfortable to administer the NJ Exec Order 26.4b1 to the residents at that time of the NJ Exec Order 26.4b1. The US FOIA and the US FOIA (b)(6) did not document this discussion on the eMR of the residents who did not receive the NJ Exec Or. The US FOIA (b)(6) also stated that se did not want to risk exposure to the resident by administering the NJ Exec Order 26.4b1. The US FOIA (b)(6) did not provide documentation regarding the guidelines used for the decision to not offer the administration of the appropriate NJ Exec Order 26.4b1 based on the CDC's guidelines. At that same time, the US FOIA (b)(6) informed the surveyors that she followed the CDC guidelines for the NJ Exec Order 26.4b1.	F 883		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 144	F 883		

Furthermore, the [US FOIA (b)(6)] stated that she would revisit the consent. If it was not uploaded into the eMR the resident or resident representative was not given the consent form. "Moving forward we will revisit the offering of the [NJ Exec Order 26.4b1] quarterly and update tracking of the consent, [NJ Exec Order 26.4b1] She further stated that the concern would be included into the Quality Assurance Performance for Improvement (QAPI).

A review of the [US FOIA (b)(6)] surveillance report revealed Resident (#13, #95, and #85) were without consent forms.

On 10/16/23 at 10:03 AM, during a meeting with the survey team, [US FOIA (b)(6)], the surveyor discussed the concern regarding the missing consent forms (proof of offer and/or declination), the surveillance of who needed [NJ Exec Order 26.4b1] Resident (#13, #95, and #85), the surveillance of who needed the subsequent dose, Resident #28 and #30 and the concern regarding the facility policy.

On 10/16/23 at 12:05 PM, the survey team met with the [US FOIA (b)(6)] stated that we (facility management) went around and offered [NJ Exec Order 26.4b1] to all residents and informed the family. The [US FOIA (b)(6)] stated that a QAPI (Quality Assurance and Performance Improvement) plan and tracking was started after surveyor's inquiry.

A review of the facility provided policy Pneumococcal Vaccination, dated 5/18/23 included the following: It is the policy of this facility to provide vaccination against Pneumococcal Disease for all residents who are 65 years of age

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	315433	A. BUILDING _____ B. WING _____	C 10/19/2023

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F 883	Continued From page 145 or older in accordance with the Recommendations of the Advisory Committee for an Immunization Practices and the Centers for Disease Control, unless such vaccination is medically contraindicated or the resident has refused the vaccine. Under, procedure included, The the facility will provide the provisions of Pneumococcal vaccinations for all residents 65 years of age or older, who have not been previously immunized prior to admission unless the resident refuses offer of the vaccine, or the vaccine is medically contraindicated. Pneumococcal Vaccinations will be recorded in the resident medical record under immunizations, or it will be documented that the resident did not receive the vaccine due to medical contraindication or refusal. NJAC 8:39-19.4 (a) (i)	F 883		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.	F 947		11/9/23

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F 947	Continued From page 146 §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility provided documents, it was determined that the facility failed to ensure that all Certified Nursing Assistant (CNA) received the mandated 12-hours annual competency training as required. This deficient practice was identified in five (5) of five (5) CNAs reviewed and was evidenced by the following: On 10/17/23 at 02:25 PM, the surveyor asked the US FOIA (b)(6)) for the mandated education and annual competency training of five (5) randomly chosen CNA. On 10/18/23 at 9:16 AM, the US FOIA (b)(6) provided the requested mandatory education and annual competency training documents that included the following: CNA #1 was hired NJ Exec Order 26.4b1; total of eight hours of education CNA #2 was hired NJ Exec Order 26.4b1; total of eight hours of education CNA #3 was hired NJ Exec Order 26.4b1; total of eight hours of education CNA #4 was hired NJ Exec Order 26.4b1 total of 6.5 hours of education CAN #5 was hired NJ Exec Order 26.4b1; total of eight hours of education Further review of the above documents showed that the five CNAs did not have mandated 12-hours annual competency training as required.	F 947	Element one- All C.N.A staff that were due for annual education had their education completed. Element two- All residents that are cared for by a C.N.A have the potential to be affected. An audit was completed to identify C.N.A's that required any part of their mandatory education completed. Element 3: Education performed by licensed nursing home administrator/designee to nursing staff and human resources to ensure that all mandatory education are completed on initial hire and then on a rolling basis. Element 4: Plan to monitor performance to make sure that solutions are sustained include: The licensed nursing home administrator or designee will randomly audit 2 employee files to be conducted monthly for 8 months to ensure compliance. Findings will be reported monthly x 8 months to Quality Assurance performance improvement team for review and action as necessary.	

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F 947	Continued From page 147 On 10/18/23 at 11:30 AM, the US FOIA (b)(6) and the US FOIA (b)(6) informed the survey team that they (facility management) could not find documentation that the 12 hours of competencies were completed. In addition, the US FOIA (b) stated that she reviewed the in-service training book and that information documented on the Continuing Education Record did not meet the 12-hour requirements. NJAC 8:39-43.10	F 947		

New Jersey Department of Health

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #NJ00160546 Based on observations, interviews, review of medical records, and review of facility documents, it was determined that the facility's failed to ensure: a) minimum State staffing requirements were met for 14 of 14-day shifts and on 3 of 14 overnight shifts reviewed and b) that 7 AM-3 PM shift was staffed to provide ADLs (activities of daily living) for three (3) of three (3) dates reviewed according to facility practice, required minimum direct care staff to shift ratios as mandated by the state of NJ (New Jersey), and facility assessment. The evidence was as follows:	S 560	S560 Element One- There was no negative outcome to residents on the shifts identified as not meeting the NJ staffing requirements 9/17/23 day shift, 9/18/23 day shift, 9/19/45 day shift, 9/20/23 day shift, 9/20/23 overnight shift, 9/21/23 day shift, 9/22/23 day shift, 9/23/23 day shift, 9/24/23 day shift, 9/25/23 day shift, 9/26/23 day and overnight shifts, 9/27/23 day shift, 9/28/23 day shift, 9/29/23 day shift, 9/30/23 day shift and overnight shift. Element Two: All residents have the potential to be affected. Element Three: US FOIA (b)(6) was reeducated by licensed nursing home	11/9/23

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

Electronically Signed | 11/08/23

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S 560	Continued From page 1 Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which 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. 1. As per the "Nurse Staffing Report" completed by the facility for the 2 weeks of staffing prior to survey from 09/17/2023 to 09/30/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 3 of 14 overnight shifts as follows: -09-17-23 had 7 CNAs for 101 residents on the day shift, required at least 13 CNAs. -09/18/23 had 8 CNAs for 101 residents on the day shift, required at least 13 CNAs. -09/19/23 had 7 CNAs for 101 residents on the day shift, required at least 13 CNAs. -09/20/23 had 11 CNAs for 101 residents on the	S 560	administrator (LNHA) on the components of this regulation with an emphasis on C.N.A to resident ratios. 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 Element Four: - The Licensed Nursing Home Administrator/designee will conduct an audit 2 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.	

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day shift, required at least 13 CNAs.
-09/20/23 had 6 total staff for 101 residents on the overnight shift, required at least 7 total staff.
-09/21/23 had 9 CNAs for 100 residents on the day shift, required at least 12 CNAs.
-09/22/23 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs.
-09/23/23 had 9 CNAs for 100 residents on the day shift, required at least 12 CNAs.

-09/24/23 had 8 CNAs for 100 residents on the day shift, required at least 12 CNAs.
-09/25/23 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs.
-09/26/23 had 9 CNAs for 107 residents on the day shift, required at least 13 CNAs.
-09/26/23 had 7 total staff for 107 residents on the overnight shift, required at least 8 total staff.
-09/27/23 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs.
-09/28/23 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs.
-09/29/23 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs.
-09/30/23 had 9 CNAs for 106 residents on the day shift, required at least 13 CNAs.
-09/30/23 had 7 total staff for 106 residents on the overnight shift, required at least 8 total staff.

For the week of Complaint staffing from 01/01/2023 to 01/07/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts, deficient in total staff for residents on 3 of 7 evening shifts, and deficient in total staff for residents on 6 of 7 overnight shifts as follows:

-01/01/23 had 10 CNAs for 116 residents on the day shift, required at least 14 CNAs.
-01/01/23 had 10 total staff for 116 residents on the evening shift, required at least 12 total staff.

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S 560	Continued From page 3 -01/01/23 had 4 total staff for 116 residents on the overnight shift, required at least 8 total staff. -01/02/23 had 10 CNAs for 116 residents on the day shift, required at least 14 CNAs. -01/02/23 had 11 total staff for 116 residents on the evening shift, required at least 12 total staff. -01/02/23 had 5 total staff for 116 residents on the overnight shift, required at least 8 total staff. -01/03/23 had 10 CNAs for 116 residents on the day shift, required at least 14 CNAs. -01/03/23 had 7 total staff for 116 residents on the overnight shift, required at least 8 total staff. -01/04/23 had 9 CNAs for 113 residents on the day shift, required at least 14 CNAs. -01/04/23 had 10 total staff for 113 residents on the evening shift, required at least 11 total staff. -01/05/23 had 10 CNAs for 113 residents on the day shift, required at least 14 CNAs. -01/05/23 had 7 total staff for 113 residents on the overnight shift, required at least 8 total staff. -01/06/23 had 9 CNAs for 113 residents on the day shift, required at least 14 CNAs. -01/06/23 had 7 total staff for 113 residents on the overnight shift, required at least 8 total staff. -01/07/23 had 9 CNAs for 113 residents on the day shift, required at least 14 CNAs. -01/07/23 had 7 total staff for 113 residents on the overnight shift, required at least 8 total staff. On 10/17/23 at 12:51 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Administrator in Training/Registered Nurse/Infection Preventionist Nurse (AiT/RN/IPN), Director Of Nursing (DON), and Vice President of Clinical Services (VPoCS). The LNHA acknowledged that there was a concern with short staffing. On 10/18/23 at 9:54 AM, the surveyor interviewed the Staffing Coordinator (SC) regarding staffing.	S 560		

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S 560	Continued From page 4 The SC acknowledged that the facility was aware of the number of CNAs required but did not always have the required number of CNAs. 2. On 10/06/23 at 9:54 AM, the survey team met with the AiT/RN/IPN and the DON. The facility management confirmed that the census (counts all residents in a facility) was 105 plus one bed hold. A review of the 100 Wing 7-3 shift Assignments that were provided by the AiT/RN/IPN for date 10/06/23 showed the following: Census: 46 residents Nurses: Licensed Practical Nurse #1 (LPN#1), LPN#2 CNAs: CNA#1 with nine (9) residents, CNA#2 with nine residents, CNA#3 with nine residents, CNA#4 with 10 residents, CNA#5 with nine residents A review of the 100 Wing 7-3 shift Assignments that were provided by the LNHA for date 10/11/23 showed the following: Census: 47 residents CNAs: CNA#1 with nine residents, CNA#2 with nine residents, CNA#4 with 10 residents, CNA#6 with nine residents, CNA#7 with 10 residents A review of the 01/03/23 100 Wing 7-3 shift Assignments that were copied by the surveyor from the provided binder of the LNHA revealed the following: Census: 55 residents CNAs: CNA#1 with seven residents, CNA#2 with seven residents, CNA#3 with six residents, CNA#4 with seven residents, Agency CNA#1 (A/CNA#1) with seven residents TNAs (Temporary Nursing Assistants): TNA#1 with seven residents, TNA#2 with seven	S 560		

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S 560	Continued From page 5 residents, TNA#3 with seven residents Further review of the above 10/06/23, 10/11/23, and 01/03/23 for 7-3 shift assignments revealed that the NJ mandated law ratio for 1:8 was not followed. On 10/11/23 at 9:10 AM, the surveyor interviewed CNA#7 who informed the surveyor that he's been working at the facility as a regular floater for the 7-3 shift and at times at 3-11 shift with no regular wing assignment, been at the facility [NJ Ex Order 26.4b1]. Then CNA#6 joined the interview and both stated they were aware of the NJ (New Jersey) mandated staffing law of a 1:8 ratio (one CNA to eight residents). Both CNAs informed the surveyor that the mandated staff-to-resident ratio was not always being followed. At this time, CNA#7 informed the surveyor that he had 10 residents on his assignment today at 100 wing. CNA#1 stated that the usual ratio in the 7-3 shift was around nine to ten residents per CNA. He further stated that on a worse day with calls out can reach up to "11 per piece per CNA." Furthermore, the surveyor asked if the facility was utilizing an agency CNA and both stated that no, both responded that it used to be but it stopped. The surveyor asked if they were able to finish their assignments, and CNA#6 stated that they still take care of the resident but it takes time for them to finish their assignments. CNA#6 asked the surveyor what are the surveyors doing about the shortage staff of in the facility since surveyors had come several times to the facility and it was the same problem, the surveyor notified both CNAs that it should be reflected in the survey results and this should be discussed by them with their facility management their concern with	S 560		

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S 560	Continued From page 6 staffing. The surveyor asked the CNAs if they notified their management about their concerns with staffing and CNA#7 stated that they (facility management) were aware. The surveyor then asked CNAs what was the facility management responded to their concern, CNA#6 stated that the facility management told them that they were doing something about it but they did not know what was the plan. On 10/17/23 at 12:51 PM, the survey team met with the LNHA, AiT/RN/IPN, DON, and the VPoCS. The LNHA stated that he acknowledged that there was concern with short staffing. On 10/19/23 at 12:55 PM, the survey team met with the LNHA, DON, and VPoCS and the facility management stated that there was no additional information.	S 560		
S 720	8:39-7.3(d) Mandatory Resident Activities (d) Resident activities shall be scheduled for seven days each week, and during at least two evenings per week. Religious services shall be considered resident activities for purposes of complying with this requirement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to provide residents two evening activity programs per week. This deficient practice was identified for two (2) of two (2) activities calendar ([NJ Exec Order 26] speaking and [NJ Exec Order 26 redacted] residents) reviewed for [NJ Exec Order 26.4]	S 720	Element One - Corrective Action: The [US FOIA (b)(6)] was immediately educated to ensure 2 evening activities per week are happening. Element Two Identification of At Risk Residents: All residents that wish to have an evening activity have the potential to be affected.	11/9/23

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S 720	Continued From page 7 On 10/17/23 at 11:02 AM, during a tour of the facility, the surveyor asked Resident #50 if the facility provided any activities in the evening. The resident stated he/she did puzzles and thought movies were offered as a nighttime activity. On 10 /17/23 at 11:04 AM, during an interview with the surveyor, Activities Aid #1(AA #1) stated she worked from 9:00 AM to 5:00 PM and the other AA #2 worked on the weekend from 9:00 AM to 5:00 PM. AA #1 also stated that AA #2 was off that day. At that time, AA #1 stated that the nighttime activities would be implemented in November on Tuesday and Thursday. We currently have a movie night on Tuesday. On 10/17/23 at 11:07 AM, during an interview with the surveyor, the Director of Activities (DA) stated she had [NJ Exec Order 26.4b1], activities aid on staff. The [NJ Exec Order 26.4b1] staff took care of the nighttime activity. The DA confirmed a movie was offered on Tuesday as part of the evening activity and that was all they had at that time. The surveyor asked for additional calendars offered to both of the resident population. A review of the [NJ Exec Order 26.] - [NJ Exec Order 26.4b1] resident's activity calendar reflected the residents were offered a movie every Tuesday night. For Saturday and Sunday, the last evening activity was offered at 2:00 PM. For Monday, Wednesday, Thursday and Friday, the last evening activity was offered at 3:00 PM. The [NJ Exec Order 26.] - [NJ Exec Order 26.4b1] population had one (1) evening activity.	S 720	ELEMENT THREE: SYSTEMIC CHANGES:. Evening activities are scheduled twice weekly. QUALITY ASSURANCE To maintain and monitor ongoing compliance, Activities director/designee will monitor activity calendar monthly x 12 to ensure evening activities are scheduled , in addition AD will monitor attendance to ensure all residents are aware of evening activities and continue to alert residents via calendar and resident council. Needed corrections will be addressed as they are discovered. Findings to be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary.	

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 _____	C 10/19/2023

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 720	Continued From page 8 A review of the [NJ Exec Order 26.4b1] resident's activity calendar reflected the last activity for Saturday and Sunday was offered at 2:00 PM. For Monday, Tuesday, Wednesday, Thursday and Friday, the last evening activity was offered at 3:30 PM. The activity's calendar for the [NJ Exec Order 26.4b1] population did not reflect evening activities were offered. On 10/17/23 at 12:51, in the presence of the survey team, the Registered Nurse (RN)/Infection Preventionist (IP), Director of Nursing (DON), Licensed Nursing Home Administrator (LNHA), and the Vice President of Clinical Services (VPoCS), the surveyor discussed the concerns of the one evening activity for the [NJ Exec Order 26.4b1] population and no evening activity scheduled for the [NJ Exec Order 26.4b1] residents. On 10/19/23 at 11:01 AM, in the presence of the survey team, the DON, the LNHA, and the VPoCS, the RN/IP stated [dialect redacted] speaking staff also [NJ Exec Order] [NJ Exec Order 26.] and that same staff would put on a movie in the evening or do an activity. The surveyor asked if this activity was documented since both of the resident population's activity calendar did not reflect her response. The RN/IP/iLNHA stated that it was not documented. On 10/19/23 at 11:01 AM, the RN/IP/iLNHA stated that the facility did not have a policy for Activities.	S 720		
S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux	S1410		11/9/23

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 _____	C 10/19/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1410	Continued From page 9 tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to perform a NJ Exec Order 26.4b1 [redacted] as required for new employees hired for NJ Exec Order 26.4b1 for NJ Exec Order 26.4b and NJ Exec Order 26.4 screening. This deficient practice was identified for one (1) of ten (10) employee files (Staff #10) reviewed. This deficient practice was evidenced by the following: On 10/10/23 at 11:58 AM, the surveyor met with the Director of Nursing (DON) who informed the	S1410	Element one: Corrective action: Employee received NJ NJ Exec Order 26.4b1 with NJ Exec Order 26.4b NJ Exec Order 26. Element Two: All residents that are taken care of by staff members that do not have a Mantoux skin test are at risk. Element Three: Education provided to US FOIA (b)(6) [redacted] on reviewing each new employee, including members of medical staff employed by the facility upon employment shall receive a two-step Mantoux tuberculin skin test with 5 tuberculin units of purified protein derivative. The exception shall be	

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 _____	C 10/19/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1410	Continued From page 10 surveyor that she wanted to correct that the previously mentioned designated Infection Preventionist (IP), which the Licensed Practical Nurse's (LPN) license was pending approval from New Jersey Consumer Affairs and will assume the position of the designated IP once the license for LPN was approved. The surveyor asked the DON for the unlicensed Practical Nurse's (uPN's) employee file for the surveyor's review and the DON stated that she would get back to the surveyor. On 10/10/23 at 02:38 PM, the surveyor reviewed the provided copies of the uPN's employee files and included the following information: Signed Job Description dated [redacted] for the job title of LPN Personnel Action Form date of hire [redacted] NJ Exec Order 26.4b1 [redacted] administered on [redacted] and read on [redacted] and [redacted] administered on [redacted] and read on [redacted] Both results were [redacted] The above copies of employee files were provided by the Human Resource Director (HRD). On 10/11/23 at 01:33 PM, the Licensed Nursing Home Administrator (LNHA) provided a copy of the Daily Time Cards (in and out) of the uPN that showed that the staff started to work on 5/30/23, punched in at 7:00 AM and out punch 3:20 PM. On 10/13/23 at 10:33 AM, the survey team met with the LNHA, DON, Administrator in Training/Registered Nurse/Infection Preventionist Nurse (AiT/RN/IPN), and Vice President of Clinical Services (VPoCS), and the surveyor notified the facility management of the above findings.	S1410	employees with documented negative 2 step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 millimeters of induration, the second step of the two step Mantoux test shall be administered one to three weeks later. Element Four: To monitor performance and make sure that solutions are sustained random audits, performed by director of nursing or designee, of 2 new employee files will be performed for Mantoux test results 1x/ week for 4 weeks and then monthly for 8 months. Findings will be reported monthly x 8 months to QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S1410	Continued From page 11 On that same date and time, the AiT/RN/IPN stated that they (facility management) knew that the uPN's PPD was late. The AiT/RN/IPN further stated that "we" tried to obtain uPN's previous PPD record from the uPN previous company where the uPN worked and it was not provided which was why the facility had to administer the [redacted NJ Exec Order 26.4b1]. On 10/16/23 at 12:05 PM, the survey team met with the VPoCS, DON, and LNHA. The VPoCS stated that the PPD of uPN was late. Both the LNHA and DON stated that they should have not let uPN work without the medical [redacted NJ Exec Order 26.4b1]. A review of the undated facility provided policy, titled "New Hire and Onboarding Process" included the following: Prior to a start date: The new hire will need to provide a Physical and PPD within a year prior to hire and complete their employee health file with the Nursing Department. On 10/19/23 at 12:55 PM, the survey team met with the LNHA, DON, and VPoCS, and the facility management stated that there was no additional information.	S1410		

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	12/1/2023 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0558	Correction	ID Prefix F0559	Correction	ID Prefix F0584	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.10(e)(4)-(6)	Completed	Reg. # 483.10(i)(1)-(7)	Completed
LSC	11/09/2023	LSC	11/09/2023	LSC	11/09/2023
ID Prefix F0607	Correction	ID Prefix F0610	Correction	ID Prefix F0623	Correction
Reg. # 483.12(b)(1)-(5)(ii)(iii)	Completed	Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.15(c)(3)-(6)(8)	Completed
LSC	11/09/2023	LSC	11/09/2023	LSC	11/09/2023
ID Prefix F0641	Correction	ID Prefix F0686	Correction	ID Prefix F0689	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	11/09/2023	LSC	11/09/2023	LSC	11/09/2023
ID Prefix F0695	Correction	ID Prefix F0698	Correction	ID Prefix F0712	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.30(c)(1)-(4)	Completed
LSC	11/09/2023	LSC	11/09/2023	LSC	11/09/2023
ID Prefix F0728	Correction	ID Prefix F0791	Correction	ID Prefix F0806	Correction
Reg. # 483.35(d)(1)-(3)	Completed	Reg. # 483.55(b)(1)-(5)	Completed	Reg. # 483.60(d)(4)(5)	Completed
LSC	11/09/2023	LSC	11/09/2023	LSC	11/09/2023

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

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	12/1/2023 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0812	Correction	ID Prefix F0835	Correction	ID Prefix F0841	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.70	Completed	Reg. # 483.70(h)(1)(2)	Completed
LSC	11/09/2023	LSC	11/09/2023	LSC	11/09/2023
ID Prefix F0868	Correction	ID Prefix F0880	Correction	ID Prefix F0882	Correction
Reg. # 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80(b)(1)-(4)	Completed
LSC	11/09/2023	LSC	11/09/2023	LSC	11/09/2023
ID Prefix F0883	Correction	ID Prefix F0947	Correction		
Reg. # 483.80(d)(1)(2)	Completed	Reg. # 483.95(g)(1)-(4)	Completed		
LSC	11/09/2023	LSC	11/09/2023		

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
10/19/2023	

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	12/1/2023 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0610 Reg. # 483.12(c)(2)-(4) LSC	Correction Completed 11/09/2023	ID Prefix F0641 Reg. # 483.20(g) LSC	Correction Completed 11/09/2023	ID Prefix F0791 Reg. # 483.55(b)(1)-(5) LSC	Correction Completed 11/09/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/19/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061006 (Y1)	A. Building B. Wing (Y2)	12/1/2023 (Y3)

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

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ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 11/09/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	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	
10/19/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061006 Y1	A. Building B. Wing Y2	12/1/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 11/09/2023	ID Prefix S0720 Reg. # 8:39-7.3(d) LSC	Correction Completed 11/09/2023	ID Prefix S1410 Reg. # 8:39-19.5(b)(1) LSC	Correction Completed 11/09/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 10/19/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ **YES** ☐ **NO**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**10/19/2023**

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 An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 10/18/2023. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/18/23 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 Country Arch Care Center is a one-story building with a partial basement that was built in 1950's. It is composed of Type V protected construction. The facility is divided into seven - smoke zones. The generator does approximately 50 % of the building as per the Maintenance Director. The current occupied beds are 102 of 129.	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.	K 345		11/10/23

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

Electronically Signed | 11/10/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315433	A. BUILDING **01** B. WING _____	**10/19/2023**

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 345	Continued From page 1 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, the facility failed to ensure smoke detection sensitivity testing of the smoke detectors was completed every alternate year in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice had the potential to affect all 102 residents. Findings include: A document review of the facility binder for the calendar year 2023, provided by the US FOIA (b)(6) [redacted], revealed the fire alarm "Inspection and Testing Reports" dated 08/21/23 had no reference to a smoke detection sensitivity test. Observations of the facility smoke detectors on 10/18/23 from 12:30 PM to 2:30 PM revealed smoke detectors were in the corridors at the smoke barriers, in all sleeping rooms, and other concealed areas throughout the building. At the time of observations, the US FOIA (b)(6) [redacted] was present and confirmed that the smoke sensitivity testing was not completed on the smoke detectors. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	K345 Element One - Corrective Action: All smoke detectors were checked by the maintenance director to ensure that its sensitivity is within normal limits. Element Two -Identification of at Risk Residents: All residents have the potential to be affected by this deficient practice. ELEMENT THREE: SYSTEMIC CHANGES: US FOIA (b)(6) [redacted] was re-educated on the components of this regulation, with an emphasis on the requirements to perform an annual inspection of the sprinkler's sensitivity. Our fire alarm inspection company will monitor the nominal sensitivity of the fire alarms semiannually and document any deficiencies and or inconsistencies. Maintenance director will also monitor for system identification that sensitivity is not correct. QUALITY ASSURANCE: Maintenance Director will monitor fire alarm sensitivity monthly x 6 months with findings to be reported monthly x 6 to Quality Assurance Performance Improvement team for review and action as necessary.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors	K 761		11/10/23

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 _____	**10/19/2023**

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

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K 761	Continued From page 2 Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure the fire doors were inspected annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 102 residents. Findings include: Observations of the facility's fire doors on 10/18/23 from 12:30 PM to 2:30 PM revealed the doors lacked the required inspection tags to be placed on the doors after completed inspections. The US FOIA (b)(6) was present at the time of the observations and confirmed the fire doors were not inspected annually. NJAC 8:39-31.2(e) NFPA 80	K 761	Element One - Corrective Action: Maintenance Director checked fire doors in accordance with NFPA 80 standards. Element Two -Identification of at Risk Residents: All residents have the potential to be affected by this deficient practice. ELEMENT THREE: SYSTEMIC CHANGES: US FOIA (b)(6) was educated on the components of this regulation with an emphasis on inspection of the fire doors. An audit tool was created to assist the maintenance director with the inspection process. QUALITY ASSURANCE: Maintenance Director will inspect fire doors weekly x 4 then monthly x 5 months with findings to be reported monthly x 6 to Quality Assurance Performance Improvement team for review and action as necessary.	

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 _____	**10/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 3	K 918		
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) This REQUIREMENT is not met as evidenced by:	K 918		12/1/23

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 _____	**10/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 4 Based on record review and interview, the facility failed to ensure the three-year load bank test was completed on the emergency generator in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 4.9.1 This deficient practice had the potential to affect all 102 residents. Findings include: A document review of the generator reports for 2022 and 2023 provided by the US FOIA (b)(6) revealed a three-year load bank test had not been completed for the emergency generator. During an interview on 10/18/23 at 2:48 PM, the US FOIA (b)(6) confirmed the three-year load bank test had not been completed on the emergency generator. NJAC 8:39-31.2(e). 31.2(g) NFPA 99, 110	K 918	Element One - Corrective Action: Facility scheduled 3-year load bank test with vender to take place on 12/1/2023. Element Two -Identification of at Risk Residents: All residents have the potential to be affected by this deficient practice. ELEMENT THREE: SYSTEMIC CHANGES: US FOIA (b)(6) was educated on the components of this regulation with an emphasis on the requirements of the 3-year load bank test. QUALITY ASSURANCE: Maintenance Director will report findings of the 3-year load bank test to the Quality Assurance Performance Improvement team for review and action as necessary during the following monthly QAPI meeting.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315433	A. Building 01 - MAIN BUILDING 01 B. Wing	12/1/2023

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 Reg. # NFPA 101 LSC K0345	Correction Completed 11/10/2023	ID Prefix Reg. # NFPA 101 LSC K0761	Correction Completed 11/10/2023	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 12/01/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
10/19/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO