STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315124	A. BUILDING _____ B. WING _____	10/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLE CARE NURSING AND REHABILITATION CENTER	**439 BELLEVUE AVENUE TRENTON, NJ 08618**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		

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

Electronically Signed | 11/12/2022

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

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F 000	INITIAL COMMENTS Survey Date: 10/20/22 Census: 81 Sample: 19 + 1 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 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F 578		12/5/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/12/2022

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F 578	Continued From page 1 entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and review of other facility documentation, it was determined that the facility failed to accurately document and clarify a resident's NJ Exec Order 26.4b1 treatment preferences on physician's orders for one (1) of two (2) residents (Resident #47) reviewed for advanced directives. This deficient practice was evidenced by the following: According to Resident #47's Resident Face Sheet the resident was admitted to the facility with the diagnoses that included but were not limited to; *Ex Order 26. 4B1* *Ex Order 26. 4B1* and *Ex Order 26. 4B1* The annual Minimum Data Set (MDS), an assessment tool for managing the resident's care dated indicated that the resident had a good *Ex Order 26. 4B1*, poor *Ex Order 26. 4B1* and reflected that the resident required extensive to	F 578	I. Immediate action a) Resident # 47's POLST was reviewed for advanced directives. b) The family was contacted to ensure that what is completed on the POLST form was accurate and complete. Completion date 10/7/22 c) Doctor's orders were placed to match the POLST form completion date 10/12/22. d) The current advanced directives are: Full code. Completion date 10/12/22 e) The appropriate medical alerts were placed f) The Advanced Directives Care plan was revised 10/12/22. II. Identification of others: a) The facility respectfully submits that all residents are potentially affected. b) An audit was completed of all	

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F 578	Continued From page 2 NJ Exec Orde[redacted]care with all aspect of activities of daily living. The surveyor reviewed Resident #47's paper medical records as well and the electronic health record (EHR) which revealed the following conflicting information: The New Jersey Practitioner Orders for Life-Sustaining Treatment (POLST) form signed by the physician on[redacted], reflected that Resident #47 was to have full treatment and use of all appropriate *Ex Order 26. 4B1* [redacted] as indicated to NJ Exec Order 26.4b1 and if no [redacted] or is NJ Exec Order 26.4b1 and that *Ex Order 26. 4B1* [redacted] should be attempted. There was also a form undated and titled, NJ Exec Or[redacted] NJ Exec Order 26.4b1 located in the resident's medical records. This form indicated that Resident #47 was to have no[redacted] attempts in an event of *Ex Order 26. 4B1* [redacted] should occur. The Physician Orders (PO) dated[redacted] reflected a PO that the resident's advanced directive indicated: *Ex Order 26. 4B1* [redacted] and full Ex Order 26.[redacted]. On 10/07/22 at 12:58 PM, the surveyor interviewed the acting US FOIA (b)(6) US FOIA (b)(6) who confirmed that there were two PO put into the computer and one order indicated that the resident was to be a [redacted]" and another physician's order indicated Ex Order 26. 4B1 [redacted]. She stated that the nurse that put the PO in the EHR on [redacted] for Ex Order 26. and[redacted] Ex Order 26 did not know how to put the orders in. She stated that this was a "dilemma", but that	F 578	residents' charts to include : a. If the resident has a POLST form completed. b. Ensure the POLST form has been completed correctly and there are no other forms that contradict what is in the POLST form. c. If so, review all areas checked d. Compare requests to Medical Doctor orders under advanced directives e. If a discrepancy is noted, it will be immediately corrected by notifying the Primary Care Physician (PCP) to obtain the corresponding order f. If more than one form is discovered, it will be reviewed with resident or family to determine preference. g. If there is no family and resident is unable to validate, the fully executed form with the latest date should be used. h. All negative findings should be reported to the administrator. i. Completion date 11/1/22 III. Systemic Changes: a) The Policy and Procedure titled Advanced Directives was reviewed by the Administrator, Director of Nursing and Social Work and the Medical Director on 11/1/22 and revised to include review of the POLST form at monthly cycle by the physician. b) All Physicians, Nurse Practitioner (NP), Physician's Assistant (PA) , Registered Nurses (RN's), Licensed Practical Nurses (LPNs) and Social Workers will be re educated on the changes to the policy with a lesson plan entitled Advanced Directives. Completion	

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F 578	Continued From page 3 if need be, they would perform [NJ Exec Order] and send the resident to the hospital. On 10/07/22 at 01:48 PM, the surveyor interviewed the [US FOIA (b)(6)] who stated that she had been employed in the facility for [NJ Exec Order 26.4b1] and that if a resident "[redacted]" ([redacted]) and the physician orders were contradictory such as [redacted] verses [redacted], the responsible party (RP) would have to be called to clarify whether the code status was a [redacted] or if it was a [redacted]. She stated that when a resident returned from the hospital that the nurses would check for a new directive and the physician would need to clarify the code status for the resident. The [US FOIA (b)(6)] stated that she was unsure of where the confusion happened and indicated that it happened when the resident returned from the hospital. The [US FOIA (b)(6)] added that the resident was a [redacted], but when he/she returned from the hospital there was a "[redacted]" [redacted]. The [US FOIA (b)(6)] further added that if the resident was unable to decide then the family would needed to be contacted for clarification. On 10/12/22 at 09:15 AM, the surveyor attempted to telephone interview the resident's RP unable to reach and a phone message was left. On 10/12/22 at 09:40 AM, the surveyor interviewed the [US FOIA (b)(6)] who stated that the resident's code status was clarified with the doctor and that the resident's code status was changed to [redacted]. The [US FOIA (b)(6)] further stated that she informed the [US FOIA (b)(6)] of the need to closely review and accurately transcribe the resident's code status information in the residents' medical records.	F 578	date 11/15/22 IV. Quality Assurance: a) An audit form has been created ensure that all orders for advanced directives match the resident/family wishes as indicated in the POLST form. b) This audit will be done by the social worker weekly x 4 weeks, monthly x 2 months, and then quarterly x 3 quarters. c) Any negative findings will be corrected immediately and brought to the Administrator's attention. d) The results of all audits will be brought to the Quality Assurance committee quarterly x 4 quarters. V. Responsible person: Director of Social Work or designee	

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F 578	Continued From page 4 On 10/14/22 at 12:32 AM, the surveyor interviewed the [redacted] who stated that two (2) code statuses for a [redacted]" and [redacted] were put in the physician orders wrong during the admission process. The facility policy titled, "Advanced Directives" and dated 02/15/22 indicated: - The residents wishes will be communicated to the staff by way of the care Plan and to the resident physician. Request made for MD order. -A Medical alert symbol will be placed in the electronic medical record for appropriate advanced directive as indicated.	F 578		
F 604 SS=E	NJAC 8:39-4.1 (a) Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	F 604		12/5/22

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F 604	Continued From page 5 any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. 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 ensure that residents were free from NJ Exec Order 26.4b1 which included the use of NJ Exec Order 26.4b1 to both sides of a NJ Exec Order 26.4b1 resident's bed. This deficient practice was identified for one (1) of one (1) resident reviewed for *Ex Order 26. 4B1*, (Resident #63) and was evidenced by the following: On 10/06/22 at 11:06 AM, during the initial tour of the facility the surveyor observed Resident #63 lying in bed asleep with full metal NJ Exec Order 26.4b1 in place on both sides of the resident's bed. On 10/07/22 at 9:48 AM, the surveyor observed Resident #63 lying in bed asleep. The right side of the resident's bed was positioned tightly up against the wall. The NJ Exec Order 26.4b1 was pulled up and a NJ Exec Order 26.4b1 covered the entire length of the NJ Exec Order 26.4b1	F 604	I. Immediate Action a) Resident #63 was reassessed by NJ Exec Or on NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 ssessment completed and deemed that full side rails were not appropriate for this resident. b) NJ Exec Orc ssessment completed on NJ Exec Order 26.4b1 deemed that NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 were appropriate due to the resident's *Ex Order 26. 4B1*. c) Orders were placed for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 d) A bed safety assessment was performed by maintenance to ensure that there were no entrapment issues. Completed 10/13/22 e) Resident's #63's bed was repositioned away from the wall so both sides of the bed are accessible. Completed 10/13/22 f) NJ Exec Order 26.4b1 care plan was initiated on 10/13/22 g) C.N.A. instructions updated on 10/13/22	

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F 604	Continued From page 6 On 10/07/22 at 10:48 AM, the surveyor reviewed Resident #63's paper chart which failed to contain documented evidence of a physician's order for *Ex Order 26. 4B1* [redacted], a consent for [redacted], or a bed safety assessment to assess for the possibility of [redacted] with *Ex Order 26. 4B1* application. On 10/07/22 at 11:55 AM, the surveyor also reviewed the Electronic Health Record (EHR) which also failed to contain the aforementioned documentation to validate that Resident #63 was properly assessed for *Ex Order 26. 4B1* [redacted] use prior to implementation. A review of the Resident Face Sheet revealed that Resident #63 was admitted to the facility in [redacted] with diagnoses which included but were not limited to: *Ex Order 26. 4B1* [redacted] A review of the quarterly Minimum Data Set (MDS), an assessment to manage care dated [redacted] revealed that Resident #63 was readmitted to the facility from an acute care hospital in [redacted] with a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted] which indicated that the resident was severly *Ex Order 26. 4B1* [redacted]. The assessment identified that the resident required NJ Exec Order 26.4b1 of one person for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 of two persons for NJ Exec Order 26.4b1 Further review of the MDS revealed that the resident had functional limitation in range of motion of both the *Ex Order 26. 4B1* [redacted]. Review of section P of the MDS titled NJ Exec Order 26.4b1 revealed that the resident had bed rails that were used daily. On 10/12/22 at 11:08 AM, the surveyor interviewed Certified Nursing Assistant #2 who	F 604	h) Consent on file II. Identification of Others a) The facility respectfully submits that all residents with side rails on the bed could potentially been affected. b) An audit of all residents with side rails was done on 10/13/22 to ensure the following tasks/criteria have been completed/met: Side rail assessment by therapy. If determined by therapy as appropriate, MD orders obtained for the same A bed safety assessment was performed by maintenance to eliminate any entrapment issues. Side rail care plan initiated C.N.A. instructions updated to reflect side rails as ordered. Consent on file III. Systemic Changes a) The Policy and Procedure for Side Rails was reviewed and revised by the Administrator, Director of Therapy and Director of Nursing to include the proper procedures that must occur to determine if side rails are appropriate and safety. Completion date 11/4/22. b) An in service will be given for all maintenance personnel on the Proper Assessment of bed for entrapment. Completion date 11/16/22 c) An in service will be given to all clinical nursing personnel about the proper procedure for ordering side rails after OT side rails assessment is completed and recommendations made. Completion date 11/16/22	

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F 604	Continued From page 7 confirmed that Resident #63's NJ Exec Order 26.4b1 were NJ Exec Order 26.4b1 Ex Order 26. 4B1 and the resident was unable to assist with NJ Exec Order 26.4b1 CNA #2 stated that the resident had Ex Order 26. 4B1 and was required to have a [redacted] on the [redacted] because the resident tended to [redacted] the [redacted]. CNA #2 stated that the resident was transferred from the [redacted] with Ex Order 26. 4B1 in place. CNA #2 stated that the [redacted] did not need to be maintained in the upward position as the bed was also pushed firmly up against the wall on the right side. At 11:14 AM, the US FOIA (b)(6) US FOIA (b)(6) entered the room to assist CNA #2 to pull Resident #63 up in bed. US FOIA (b)(6) stated that the resident was unable to assist with NJ Exec Order 26.4b1 The US FOIA (b)(6) stated that the full NJ Exec Order 26.4b1 were in place for Ex Order 26. 4B1 precautions. The US FOIA (b)(6) stated that the use of Ex Order 26. 4B1 was not considered a Ex Order 26. 4B1. The US FOIA (b)(6) stated that the US FOIA (b)(6) was going to remove the Ex Order 26. 4B1 and change them to [redacted] instead so that it were not considered a Ex Order 26. 4B1. The US FOIA (b)(6) stated that she would pull the bed out away from the wall because it was not supposed to be like that because that was a Ex Order 26. 4B1. The US FOIA (b)(6) stated that a physician's order, care plan entry and a [redacted] assessment were required for full [redacted] placement. The US FOIA (b)(6) reviewed the resident's care plan and confirmed that an entry was placed for [redacted] use on [redacted]. The US FOIA (b)(6) stated that if the full NJ Exec Order 26.4b1 were utilized for bed mobility then a Care Plan should have done prior. The US FOIA (b)(6) further stated that because full NJ Exec Order 26.4b1 were implemented for Ex Order 26. 4B1 precautions, a care plan was not initiated.	F 604	d) An in service will be given to all OT responsible for completion of the side rail assessments. . Completion date 11/16/22 IV. Quality Assurance a) Audits will be completed on 10 residents on each floor weekly x 4 weeks, then monthly x 2 months, then quarterly x 3 quarters. b) All negative findings will be corrected immediately and brought to the administrator c) The results of all audits will be brought to the QA meetings quarterly x 4. V. Person Responsible: Director of Nursing or designee and Director of Rehab	

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F 604	Continued From page 8 The US FOIA (b)(6) stated that she did not know why a NJ Exec Order 26.4b assessment or family consent were not obtained prior to implementation. On 10/13/22 at 10:51 AM, the surveyor interviewed the US FOIA (b)(6) regarding the policy for *Ex Order 26. 4B1*. The US FOIA (b)(6) stated that Resident #63 had due to Ex Order 26. 4B1 activity and the family insisted on NJ Exec Order 26.4b1. The US FOIA (b)(6) explained that the resident had and were required for safety reasons. The US FOIA (b)(6) stated that there should have been a physician's order for the and a assessment should have been done. The US FOIA (b)(6) stated that the bed should not have been placed against the wall because that was an added Ex Order 26. 4B1. The US FOIA (b)(6) stated that, "The resident's NJ Exec Order 26.4b1 were removed and were replaced with NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 in order to decrease the Ex Order 26. 4B1 situation." On 10/18/22 at 9:01 AM, the surveyor observed Resident #63 lying in bed with *Ex Order 26. 4B1* on the bed with NJ Exec Order 26.4b and NJ Exec Order 26.4b1 were positioned on both sides of the resident's bed. On 10/18/22 at 12:15 PM, the surveyor interviewed the US FOIA (b)(6) US FOIA (b)(6) who stated that Resident #63 should have had an order for . The US FOIA (b)(6) stated that a assessment was required to determine if they were needed and definitely to look at the NJ Exec Order 26.4b1. The US FOIA (b)(6) who was present stated that the previous Rehabilitation Company insisted on and there was a trial on the use of a bumper, for , no Ex Order 26. 4B1 activity.	F 604		

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F 604	Continued From page 9 On 10/20/22 at 11:22 AM, the surveyor interviewed the US FOIA (b)(6) US FOIA (b)(6) who stated that Resident #63's family wanted NJ Exec Order 26.4b1 and a meeting was suggested after a NJ Exec Order 26.4b1 creening. The US FOIA (b)(6) stated that a assessment should have been done, as a Ex Order 26. 4B1 was indicated at that time. The US FOIA (b)(6) tated that she ran a Ex Order 26. 4B1 free facility and an order should have been obtained from the physician. The US FOIA (b)(6) stated that the facility was looking at family involvement so that everyone was involved in the determination. Review of Resident #63's Interdisciplinary Care Plan which contained both typed and hand written entries was provided by the US FOIA (b)(6) US FOIA (b)(6) on NJ Exec Order 26.4b1 at 9:58 AM, revealed an entry dated NJ Exec Order 26.4 which revealed an entry for At risk for Ex Order 26. 4B1 as evidenced by: history of *Ex Order 26. 4B1* at *Ex Order 26. 4B1*. Interventions included monitor resident for *Ex Order 26. 4B1*, NJ Exec Order 26.4b1 for safety and to prevent NJ Exec Order 26.4b1 Resident to be monitored for safety every shift. On 10/19/22 at 12:30 PM, the US FOIA (b)(6) US FOIA (b)(6) provided the surveyor with the resident's Care Plan Activity Report (CPAR) which contained an entry that was effective NJ Exec Order 26.4b1 but failed to contain a review date, indicated the Focus was for NJ Exec Order 26.4b1 Etiology: "I have requested NJ Exec Order 26.4b1 to get in and out of bed; I have requested NJ Exec Order 26.4b1 o assist in NJ Exec Order 26.4b and NJ Exec Order 26.4b1 myself in bed. As evidenced by: Ex Order 26. 4B . The Goals related to the entry effective on NJ Exec Order 26.4b1 included the following: I will maintain as much independence in NJ Exec Order 26.4b1 as possible through the use of NJ Exec Order 26.4b1 I will	F 604		

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	315124	A. BUILDING _____ B. WING _____	10/20/2022

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F 604	Continued From page 10	F 604		

maintain feeling of self esteem through active participation in NJ Exec Order 26.4b1 through the use of NJ Exec Order 26.4b1 My ability to safely participate in ADLs (Activity of Daily Living) in bed NJ Exec Order 26.4b1 will be enhanced through use of NJ Exec Order 26.4b1 Interventions included: Effective NJ Exec Order 26.4b1 We will explain risks and benefits of using NJ Exec Order 26.4b1 s enabler for NJ Exec Order 26.4b1 and getting in and out of bed to you and or family/designated representative so the safety of these NJ Exec Order 26.4b1 can be determined for me. We will ensure that you are able to safety demonstrate the use of s NJ Exec Order 26.4b1 to participate in NJ Exec Order 26.4b1 Complete a 24 hour NJ Exec Order 26.4b1 assessment to monitor behaviors and positions while in bed. We will ensure that you are able to demonstrate proper use of NJ Exec Orde NJ Exec O to assist self in NJ Exec Order 26.4b1 Through assistance of NJ Exec Order 26.4b1 will ensure that you can raise and lower s NJ Exec Order 26.4b1 ndependently.

Review of Resident #63's [redacted] Progress Report dated NJ Exec Order 26.4b1 revealed that the resident exhibited total dependence without attempts to *Ex Order 26. 4B1* of items and on NJ Exec Order 26.4b1 The resident progressed to maximum assistance for this task. Review of an [redacted] Evaluation and Plan of Treatment for Certification period NJ Exec Order 26.4b1 evealed the following Clinical Impression: Resident will benefit from skilled for *Ex Order 26. 4B1*, wheelchair NJ Exec Order 26.4b1 resident has a preexisting NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 *Ex Order 26. 4B1*, and NJ Exec Order 26.4b1 as per family request.

On 10/06/22 at 1:28 PM, the [redacted] documented changes in Assessment which included: *Ex Order 26. 4B1*

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F 604	Continued From page 11 NJ Exec Order 26.4b1 changed from [redacted] out of [redacted] to [redacted] out of [redacted] On 10/13/22 at 11:18 AM, the [redacted] Modified her Assessment to include the following changes: Clinical Impressions: Current Value changed from "Resident will benefit from skilled [redacted] for Ex Order 26. 4B1 [redacted] and wheelchair positioning to Resident will benefit from skilled [redacted] for Ex Order 26. 4B1 [redacted] and wheelchair positioning, resident has a NJ Exec Order 26.4b1 [redacted] Ex Order 26. 4B1 [redacted], and [redacted] as per family request. Review ofthe facility policy titled, "Side Rails" (Reviewed 04/18/22) revealed the following: Policy: It is the policy of the Rehabilitation Center to use side rails only to promote independence and well-being and not to restrict freedom of movement. Purpose: To assure safety and optimum bed mobility side rails may be utilized for some residents. We recognize that even if a side rail increases a resident's bed mobility it could have the effect of restraining him/her. ...If a resident can either exit bed freely around the rail or lower the rail independently it is not considered a restraint. Side rails recommended for facilitating bed mobility are not considered restraints if the resident is cognitively and physically able to exit bed on each side independently where side rails are present. If the side rails, despite facilitation of bed mobility, impede resident from exiting the bed they will be considered a restraint and procedure for restraint use must be followed. M. D. order will be obtained for [redacted] use. NJAC 8:39-4.1(a) 6	F 604		

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F 636	Continued From page 12	F 636		
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in	F 636		12/5/22

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F 636	Continued From page 13 assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interviews, review of medical records and other facility documentation, it was determined that the facility failed to a.) complete the Comprehensive Minimum Data Set (an assessment tool that accurately reflected the resident's status) in a timely manner for six (6) of 27 residents (Residents #9, #10, #11, #23, #30, and #33) reviewed for system selected MDS over 120 days for late submissions to CMS (Center for Medicare/Medicaid Services) and b.) complete the Comprehensive MDS in a timely manner for four (4) of 19 residents (Resident #22, #216, #217 and #266) reviewed. This deficient practice was identified by the	F 636	I. Immediate Action A. Late Submission a) Resident # 9- MDS completed [redacted] NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 b) Resident #10 -MDS completed [redacted] NJ Exec Order 26.4b1 Confirmation of transmission 10/18/22 c) Resident #11 -MDS Completed [redacted] NJ Exec Order 26.4b1 Confirmation of transmission 10/17/22 d) Resident #23 -MDS completed [redacted] NJ Exec Order 26.4b1 Confirmation of transmission 10/17/22.	

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F 636	Continued From page 14 following: a.) On 10/14/22 at 10:36 AM, surveyor #1 interviewed the US FOIA (b)(6) US FOIA (b)(6) regarding late, non-completed MDS assessments. The surveyor provided the US FOIA (b)(6) with a list of resident MDS assessments that were late or not submitted and the US FOIA (b)(6) stated that she would email the surveyor information regarding the late assessments and why the assessments were not completed or transmitted timely. She stated she would investigate the issue. On 10/17/22 at 10:06 AM, the surveyor interviewed the US FOIA (b)(6) who stated that she had been an US FOIA (b)(6) for NJ Exec Order 26.4b1 The US FOIA (b)(6) stated that she supervised NJ Exec Order 26.4b other sister facilities MDS departments for this company. She stated that the facility had per diems (as needed) Registered Nurses Minimum Data Set coordinators (RN/MDS) nurses that performed the MDS assessment for the residents in the facility. She stated that there has not been a full time MDS coordinator in the facility since NJ Exec Order 26.4b1 and that the RN/MDS per diem nurses come into the facility to assess the resident, interview the residents, review the medical record, and clarify and confirm that what was in the medical record was accurate. She stated that the MDS clinical assessment "opened" in the EMR for completion seven (7) days prior to the Assessment Reference Date (ARD, the date that signifies the end of the look back period). She stated that once the specific MDS opens, all disciplines can enter the MDS to complete their section. She stated that the quarterly, annuals and significant changes MDS were due to be completed 14 days from the ARD. She confirmed	F 636	e) Resident #30 -MDS completed NJ Exec Order 26.4b1 Confirmation of transmission 10/17/22 f) Resident #33-MDS completed NJ Exec Order 26.4b1 Confirmation of transmission 10/17/22 B. Completion in Timely Manner a) Resident #22-MDS completed NJ Exec Order 26.4b1 Confirmation of transmission 10/18/22 b) Resident #216-MDS completed NJ Exec Order 26.4b1 Confirmation of transmission 10/18/22 c) Resident #217 MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 11/9/22. d) Resident #266- MDS completed NJ Exec Order 26.4b1 Confirmation of transmission 10/18/22 II. Identification of Others a) The facility respectfully acknowledges that potentially all residents may be affected. b) A complete audit was performed on 10/16/22 of all residents with scheduled Minimum Data Set (MDS) to ensure completion. c) Any MDS determined to be overdue, were completed and submitted. d) All submissions were verified through final validation reports. e) All findings were brought to the attention of the Administrator III. Systemic Changes a) The Policy and Procedure on Minimum Date Set (MDS) was reviewed	

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F 636	Continued From page 15 that there were multiple MDS that were not completed or were late in the facility. She stated that the quarterly, annual, and significant change assessment were required to be submitted 14 days from the completion date. She stated that it was a challenge to try and find a full time MDS coordinator and that the facility corporate office was aware that the assessments were "overdue". She said that they were trying their best to have the MDS assessments done timely. She confirmed that there multiple comprehensive and quarterly assessments that were late but that they "were doing their best" to try and complete them. She stated that it would be important to assure timely completion and timely transmission of assessments because the MDS was a tool that was used for identification of problems, care plan accuracy, and to ensure proper services were provided to the residents. 1.) Resident #9's ARD was [redacted] the comprehensive assessment was not completed until [redacted] 51 days later, and was submitted on [redacted] 2.) Resident #10's ARD was [redacted] the comprehensive assessment was not completed until [redacted] 67 days later. The facility provided the surveyor with a CMS submission report MDS 3.0 final Validation report dated [redacted] which did not indicate that this assessment was submitted. 3.) Resident #11's ARD was [redacted] the comprehensive assessment was not completed until [redacted] 66 days later. The facility provided the surveyor with a CMS submission report MDS 3.0 final Validation report dated [redacted] which did not indicate that this	F 636	by Administrator, Director of Nursing and Regional MDS Coordinator and was updated to reflect notification to the Administrator if MDS are overdue or unable to complete in a timely manner. Completion date 11/11/22 b) The facility hired a new Registered Nurse for the Minimum Date Set (MDS) coordinator position. Start date [redacted] c) The facility will coordinate ARD dates and per diem MDS personnel to ensure timely completion of the MDS including submission within 14 days of the ARD date. Completion Date 11/15/22 d) All clinical personnel responsible for completion of any section of the MDS will be reeducated on the Timely Completion of MDS and of their respective sections of the MDS to ensure that it can be completed timely by MDS per diem nurses. Completion Date 11/21/22 IV. Quality Assurance: a) Audits will be done by the MDS coordinator of all Minimum Data Set (MDS) submitted to ensure that all are completed timely and submitted within 14 days of ARD date. b) Audits will be submitted to the administrator, c) Audits will be done weekly x 4 weeks, monthly x 2 months, and quarterly x 3 months. d) All negative findings, including late completion and or late submissions will be brought to the Administrator immediately. e) The results of all audits will be brought to the Quality Assurance committee quarterly x 4.	

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F 636	Continued From page 16 assessment was submitted. 4.) Resident #23's ARD was NJ Exec Order 26.4b1 the comprehensive assessment was not completed until NJ Exec Order 26.4b1 44 days later, and submitted on NJ Exec Order 26.4b1 5.) Resident #30's ARD was EX Order 26.4B1, the comprehensive assessment was not completed until EX Order 26.4B1 EX Orde days later. The facility provided the surveyor with a CMS submission report MDS 3.0 final Validation report dated EX Order 26.4B1, which did not indicate that this assessment was submitted. 6.) Resident #33's ARD was EX Order 26.4B1, the comprehensive assessment was not completed until EX Order 26.4B1, EX Ord days later. The facility provided the surveyor with a CMS submission report MDS 3.0 final Validation report dated EX Order 26.4B1, which did not indicate that this assessment was submitted. On 10/17/22 at 10:19 AM, the surveyor interviewed the US FOIA (b)(6) who stated that the most recent MDS coordinator resigned NJ Exec Order 26.4b1 and has not been replaced. She stated that the facility had per diem RN/MDS coordinators who were completing MDSs. She stated the RN/MDS coordinators were doing their best to assure timely completion and transmission of the MDS. She confirmed that there was an issue concerning the timeliness of MDS completion and submission. She stated that she had a conversation with the US FOIA (b)(6) US FOIA (b)(6) and facility "cooperate office" regarding the late assessments and that part time RN/MDS coordinators were working on the late assessment to get them	F 636	V. Person Responsible: Administrator and Regional MDS	

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F 636	Continued From page 17 completed. She stated that late MDS assessments were being discussed weeks after the last RN/MDS coordinator left. She stated, "We did not discuss specific late MDS, just the whole picture of what was happening with the MDS process, and I was told we had individuals were working both remotely and on site to get assessment completed". On 10/17/22 at 11:10 AM, the surveyor interviewed the US FOIA (b)(6) US FOIA (b)(6) regarding his knowledge of late completion and transmission of the MDS assessments. The US FOIA (b)(6) stated that he was not aware of that MDSs were late and was not informed by clinical staff that the MDSs were not completed or transmitted timely. He stated that he was not told that the MDS's were a major outstanding issue in the facility. He stated that the only issue that was a concern regarding MDS, was them being uploaded to the new electronic medical record (EMR). The US FOIA (b)(6) stated that the MDS/RMC should have notified him that there were MDS were not completed timely or transmitted timely. b.) 1.) Resident #22's ARD was EX Order 26.4B1, the Comprehensive MDS assessment was not completed until EX Order 26.4B1, EX Ord days later. 2.) Resident #217's ARD was EX Order 26.4B1, the Comprehensive MDS assessment was not completed until EX Order 26.4B1, EX Ord days later. b.) Resident #216's ARD was EX Order 26.4B1, the	F 636		

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F 636	Continued From page 18 Comprehensive MDS was not completed until [redacted], [redacted] days later. On 10/14/22 at 12:14 PM, surveyor #2 interviewed the [redacted] who stated that admission and annual MDS's should have been done within 14 days. The [redacted] stated that it was important to complete MDS's accurately and in a timely manner because they were assessment tools that guided the care plan and were used to identify any problems that could cause potential harm. On 10/18/22 at 12:36 PM, the [redacted] and the [redacted] were made aware of the late MDS's. The [redacted] stated the MDS's should have been done within 14 days so the rest of the team could have been exposed to the information on the MDS. 3. On 10/06/22 at 11:06 AM, during the initial tour, surveyor #3 observed Resident #266 lying in bed. Resident #266 was [redacted] but acknowledged the surveyor by nodding his/her head. The surveyor reviewed the medical record for Resident #266. A review of the Resident Face Sheet (an admission summary) included that the resident was admitted to the facility in [redacted], with diagnoses which included: *Ex Order 26. 4B1* [redacted]	F 636		

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F 636	Continued From page 19 A review of the Comprehesive Admission MDS, dated EX Order 26.4B1, it was completed on EX Order 26.4B1 EX Ord days later. On 10/19/22 at 11:42 AM, the surveyor interviewed the US FOIA (b)(6) who stated that the admission MDS for Resident #266 was due on EX Order 26.4B1 and acknowledged it was not completed until EX Order 26.4B1. The US FOIA (b)(6) stated, "it was late, and it should have been done". The surveyor reviewed the Resident Assessment Instrument (RAI) 3.0 manual (updated October 2019), Chapter 5: Submission and Correction of MDS Assessments, which indicated that the Annual MDS assessment has a completion date "No Later Than" the ARD +14 calendar days. The facility policy titled. "Minimum Data Set" with a revised date of 09/28/22, indicated that the RN MDS coordinator schedules the residents' assessments and care plan meetings in accordance with Center for Medicare and Medicaid Services (CMS) regulations and guidelines and resident's needs. The facility job description titled; Director of Clinical Reimbursement (MDS Coordinator) indicated that the MDS Coordinators duties included: -Ensuring that all assessments are completed and transmitted in a timely manner and to report problem areas to the Administrator. NJAC 8:39 - 11.2	F 636		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii)	F 637		12/5/22

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F 637	Continued From page 20 §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to complete a significant change in status (SCSA) Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care. This deficient practice was identified for one (1) of one (1) resident (Resident #266) reviewed, and was evidenced by the following: According to the Resident Assessment Instrument (RAI) Manual Version 3.0 Chapter 2 Assessment for the RAI pages 2-23 of CMS (Center for Medicare/Medicaid Services) guidelines, updated October 2019 included, "An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD [Assessment Reference Date] must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not	F 637	I. Immediate Action a) Resident #266: the facility respectfully submits that the Minimum Data Set (MDS) was completed on [redacted] and submitted on [redacted] for this resident. II. Identification of Others a) The facility respectfully submits that there are no other residents on [redacted] at this time, however, all residents have the potential to be affected. b) The facility will audit all significant changes in the last 30 days to ensure a Significant Change of Status Assessment was completed. Any negative findings will be reported to the Administrator and completed and submitted immediately upon discovery. Completion Date 11/15/22 III. Systemic Changes a) The Policy and Procedure titled	

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	315124	A. BUILDING _____ B. WING _____	10/20/2022

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F 637	Continued From page 21 earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident." On 10/06/22 at 10:50 AM, during the initial tour of the facility the surveyor interviewed Agency Licensed Practical Nurse (ALPN #1) who stated Resident #266 was the only resident on Ex Order 26. 4B1 at the facility. On 10/06/22 at 11:06 AM, during the initial tour, the surveyor observed Resident #266 lying in bed. Resident #266 was [redacted] but acknowledged the surveyor by nodding his/her head. The surveyor reviewed the medical record for Resident #266. A review of the Resident Face Sheet (an admission summary) included that the resident was admitted to the facility in [redacted], with diagnoses which included: *Ex Order 26. 4B1* [redacted] On 10/11/22 at 09:21 AM, the surveyor interviewed the US FOIA (b)(6) who stated Resident #266 was the only resident at the facility on Ex Order 26. 4B1. A review of the physician's order (PO) dated NJ Exec Order 26.4b1 reflected an order for a Ex Order 26. 4B1 evaluation. The PO further reflected on NJ Exec Order 26.4b1 an order to discontinue skilled [redacted] EX Order 26.4B1 services because the resident was on Ex Order 26. 4B1.	F 637	Minimum Date Set (MDS) was reviewed by the Administrator, Director of Nursing (DON) and Regional MDS Coordinator and updated to include Administrator notification for overdue MDS completion and or submission. Completion date 11/11/22. b) The facility hired a new Registered Nurse for the Minimum Date Set (MDS) coordinator position. Start date NJ Exec Order 26.4b1 c) Re-Education will be provided to all staff responsible for any section of the MDS upon the importance of identifying residents with Significant Change, especially for anyone picked up on [redacted], to ensure that MDS are completed and submitted within 14 days of being placed on [redacted] Completion date 11/21/22 d) The Administrator should be made aware of anyone being placed on [redacted] IV. Quality Assurance: a) Audits will be conducted on all residents identified with a significant change within the last 30 days to ensure that the MDS is completed and submitted within 14 days. b) These audits will be completed weekly x 4 weeks by the MDS nurses, then monthly x 2 months, then quarterly x 3 quarters. c) All negative findings, including late completion and or late submissions will be brought to the Administrator immediately. d) The results of all audits will be brought to the Quality Assurance committee quarterly x 4.	

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F 637	Continued From page 22 On 10/12/22 at 09:17 AM, the US FOIA (b)(6) US FOIA (b)(6) manager stated the Resident #266 was recently placed on Ex Order 26. 4B1. On 10/13/22 at 01:08 PM, Regional Nurse #2 confirmed Resident #266 was placed on Ex Order 26. 4B1 in EX Order 26.4B1. A review of the MDS's that were completed in the resident's electronic medical record (EMR) did not reflect that a significant change in status (SCSA) MDS was completed. On 10/17/22 at 09:55AM, the surveyor interviewed the US FOIA (b)(6) who stated Resident #266 was placed on Ex Order 26. 4B1 over a month ago. The US FOIA (b)(6) stated that if a resident had a decline and was placed on [redacted] that would have triggered for a SCSA MDS to be completed and that it would be started immediately. The US FOIA (b)(6) acknowledged that the resident's SCSA should have been completed within 14 days of the significant change. On 10/17/22 at 10:06 AM, the US FOIA (b)(6) US FOIA (b)(6) in the presence of the survey team stated that she had been an MDS coordinator for NJ Exec Order 26.4b1. The US FOIA (b)(6) stated that she supervised NJ Exec Order 26.4b1 other sister facilities MDS departments for this company. She stated that the facility had per diems (as needed) Registered Nurses Minimum Data Set coordinators (RN/MDS) nurses that performed the MDS assessment for the residents in the facility. She stated that there has not been a full time MDS coordinator in the facility since NJ Exec Order 26.4b1 and that the RN/MDS per diem nurses come into the facility to assess the	F 637	V. Person Responsible: Administrator and Regional MDS	

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F 637	Continued From page 23 resident, interview the residents, review the medical record, and clarify and confirm what was in the medical record was accurate. She stated that the MDS clinical assessment "opened" in the EMR for completion seven (7) days prior to the Assessment Reference Date (ARD, the date that signifies the end of the look back period). She stated once the specific MDS opens, all disciplines can enter the MDS to complete their section. She stated that the quarterly, annuals and significant changes MDS were due to be completed 14 days from the ARD. She confirmed that there were multiple MDS that were not completed or were late in the facility. She stated that the quarterly, annual, and significant change assessment and quarterly assessment were required to be submitted 14 days from the completion date. She stated that it was a challenge to try and find a full time MDS coordinator and that the facility corporate office was aware that the assessments were "overdue". She said that they were trying their best to have the MDS assessments done timely. She stated that it would be important to assure timely completion and timely transmission of assessments because the MDS was a that tool to identify problems and assure that care plans were completed accurately and provide the proper services to the residents. On 10/18/22 at 12:31 PM, the US FOIA (b)(6) US FOIA (b)(6) in the presence of the survey team acknowledged the MDS assessments should have been completed within the 14-day timeframe. He further stated it was important to complete the MDS because it ensured that staff was aware of the resident's needs.	F 637		

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F 637	Continued From page 24 The facility policy titled. "Minimum Data Set" with a revised date of 09/28/22 indicated that the RN MDS coordinator schedules the residents' assessments and care plan meetings in accordance with Center for Medicare and Medicaid Services (CMS) regulations and guidelines and resident's needs. The facility job description titled; Director of Clinical Reimbursement (MDS Coordinator) indicated that the MDS Coordinators duties included: -Ensuring that all assessments are completed and transmitted in a timely manner and to report problem areas to the Administrator. NJAC 8:39-11.2	F 637		
F 638 SS=F	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to a.) complete and submit to Centers for Medicare and Medicaid Services (CMS) a Quarterly Minimum Data Set (MDS), a resident assessment tool used to facilitate the management of care, in a timely manner for 16 of 27 residents (Resident #1, #3, #4, #5, #6, #7, #8, #14, #16, #17, #21, #27, #31, #35, #36, and #37) reviewed for system selected MDS over 120 days for late submissions b.) complete a Quarterly MDS in a timely manner for	F 638	I Immediate Action a. Resident # 1 -MDS completed [redacted] Confirmation of transmission received dated 10/17/22 b. Resident #3 MDS completed [redacted] Confirmation of transmission received dated 10/17/22 c. Resident #4 -MDS completed [redacted]	12/5/22

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F 638	Continued From page 25 three (3) of 19 residents reviewed (Resident #45, #57, and #63). This deficient practice was evidenced by: a.) On 10/14/22 at 10:36 AM, surveyor #1 interviewed the US FOIA (b)(6) US FOIA (b)(6) regarding late, non-completed MDS assessments. The surveyor provided the RMC with a list of resident MDS assessments that were late or not submitted and the US FOIA (b)(6) stated that she would email the surveyor information regarding the late assessments and why the assessments were not completed or transmitted timely. She stated she would investigate the issue. On 10/17/22 at 10:06 AM, the surveyor interviewed the US FOIA (b)(6) who stated that she had been an MDS coordinator for NJ Exec Order 26.4b1 The MDS/RMC stated that she supervised NJ Exec Order 26.4b other sister facilities MDS departments for this company. She stated that the facility had per diems (as needed) Registered Nurses Minimum Data Set coordinators (RN/MDS) nurses that performed the MDS assessment for the residents in the facility. She stated that there has not been a full time MDS coordinator in the facility since NJ Exec Order 26.4b1 and that the RN/MDS per diem nurses come into the facility to assess the resident, interview the residents, review the medical record, and clarify and confirm what was in the medical record was accurate. She stated that the MDS clinical assessment "opened" in the EMR for completion seven (7) days prior to the Assessment Reference Date (ARD, the date that signifies the end of the look back period). She stated once the specific MDS opens, all disciplines can enter the MDS to complete their	F 638	Confirmation of transmission received dated 10/17/22 d. Resident #5- MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 e. Resident #6- MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 f. Resident #7- MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 g. Resident #8- MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 h. Resident #14 - MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 i. Resident #16- MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 j. Resident #17- MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 k. Resident #21- MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 l. Resident #27- MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 m. Resident #31- MDS completed	

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F 638	Continued From page 26 section. She stated that the quarterly, annuals and significant changes MDS were due to be completed 14 days from the ARD. She confirmed that there were multiple MDS that were not completed or were late in the facility. She stated that the quarterly, annual, and significant change assessments were required to be submitted 14 days from the completion date. She stated that it was a challenge to try and find a full time MDS coordinator and that the facility corporate office was aware that the assessments were "overdue". She said that they were trying their best to have the MDS assessments done timely. She confirmed that there were multiple comprehensive and quarterly assessments that were late but that they "were doing their best" to try and complete them. She stated that it would be important to assure timely completion and timely transmission of assessments because the MDS was a tool that was used for identification of problems, care plan accuracy, and to ensure proper services were provided to the residents. 1.) Resident #1's ARD was NJ Exec Order 26.4b1 the quarterly assessment (QA) was not completed until NJ Exec Order 26.4b1 73 days later, and was submitted NJ Exec Order 26.4b1. 2.) Resident #3's ARD was EX Order 26.4B1, the QA was not completed until EX Order 26.4B1, EX Orde days later, and was submitted EX Order 26.4B1 3.) Resident #4's ARD was EX Order 26.4B1, the QA was not completed until EX Order 26.4B1 EX Orde days later. The facility provided the surveyor with a CMS submission report MDS 3.0 final Validation report dated EX Order 26.4B1 which did not indicate that this assessment was submitted.	F 638	NJ Exec Order 26.4b1 of transmission received dated 7/22/22 n. Resident 35 -MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/14/22 o. Resident #36- MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/18/22 p. Resident #37- MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 q. Resident #45 MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/18/22. r. Resident #57 MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 9/15/22. s. Resident #63 MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 11/9/22. II. Identification of Others: a. The facility respectfully submits that all residents may be potentially affected. b. An audit was completed of all Minimum Data Set (MDS) due in the last 30 days to ensure they are completed and submitted. Completion date 11/11/22 c. Any negative findings will be brought to the administrator's attention, will be completed and submitted immediately. III. Systemic Changes a. The Policy and Procedure on	

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F 638	Continued From page 27 4.) Resident #5's ARD was EX Order 26.4B1 the QA was not completed until EX Order 26.4B1 EX Ord days later, and was submitted EX Order 26.4B1. 5.) Resident #6's ARD was EX Order 26.4B1, the QA was not completed until EX Order 26.4B1 EX Ord days later. The facility provided the surveyor with a CMS submission report MDS 3.0 final Validation report dated EX Order 26.4B1 which did not indicate that this assessment was submitted. 6.) Resident #7's ARD was EX Order 26.4B1 the QA was not completed until EX Order 26.4B1 EX Ord days later. The facility provided the surveyor with a CMS submission report MDS 3.0 final Validation report dated EX Order 26.4B1, which did not indicate that this assessment was submitted. 7.) Resident #8's ARD was EX Order 26.4B1, the QA was not completed until EX Order 26.4B1 days later, and was submitted EX Order 26.4B1. 8.) Resident #14's ARD was EX Order 26.4B1 the QA was not completed until EX Order 26.4B1 days later. The facility provided the surveyor with a CMS submission report MDS 3.0 final Validation report dated EX Order 26.4B1 which did not indicate that this assessment was submitted. 9.) Resident #16's ARD was EX Order 26.4B1, the QA was not completed until EX Order 26.4B1 days later. The facility provided the surveyor with a CMS submission report MDS 3.0 final Validation report dated EX Order 26.4B1 which did not indicate that this assessment was submitted. 10.) Resident #17's ARD was EX Order 26.4B1, the QA was not completed until EX Order 26.4B1 days later. The facility provided the surveyor with a CMS	F 638	Minimum Date Set (MDS) was reviewed by Administrator, Director of Nursing and Regional MDS Coordinator and was updated to reflect notification to the Administrator if MDS are overdue or unable to complete in a timely manner. Completion date 11/11/22 . b. The facility hired a new Registered Nurse for the Minimum Date Set (MDS) coordinator position. Start date NJ Exec Order 26.4b1 c. All personnel involved in the completion of the quarterly assessments/MDS will be reeducated on the importance of timely completion of their respective section to ensure that all MDS assessments are submitted timely. Completion date 11/21/22 IV Quality Assurance: a. Audits will be conducted by the Minimum Data Set (MDS) coordinator on all residents with a quarterly assessment due within the last 30 days to ensure all assessments have been completed and submitted timely. b. Audits will be completed the Minimum Data Set (MDS) coordinator weekly x 4 weeks, then monthly x 2 months then quarterly x3 quarters c. All negative findings, including late completion and or late submissions will be brought to the Administrator immediately. d. The results of all audits will be brought to the Quality Assurance committee quarterly x 4. V Person Responsible: Administrator and Regional MDS	

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F 638	Continued From page 28 submission report MDS 3.0 final Validation report dated EX Order 26.4B1 which did not indicate that this assessment was submitted. 11.) Resident #21's ARD was EX Order 26.4B1, the QA was not completed until EX Order 26.4B1 days later. The facility provided the surveyor with a CMS submission report MDS 3.0 final Validation report dated EX Order 26.4B1, which did not indicate that this assessment was submitted. 12.) Resident #27's ARD was EX Order 26.4B1, the QA was not completed until EX Order 26.4B1 days later. The facility provided the surveyor with a CMS submission report MDS 3.0 final Validation report dated EX Order 26.4B1, which did not indicate that this assessment was submitted. 13.) Resident #31's ARD was EX Order 26.4B1, the QA was not completed until EX Order 26.4B1 days later, and was submitted EX Order 26.4B1 14.) Resident #35's ARD was EX Order 26.4B1, the QA was not completed until EX Order 26.4B1 days later, and was not submitted yet. 15.) Resident #36's ARD was EX Order 26.4B1, the QA was not completed until EX Order 26.4B1 days later, and was not submitted yet. 16.) Resident #37's ARD was EX Order 26.4B1, the QA was not completed until EX Order 26.4B1 days later. The facility provided the surveyor with a CMS submission report MDS 3.0 final Validation report dated EX Order 26.4B1, did not indicate that this assessment was submitted. On 10/17/22 at 10:19 AM, the surveyor interviewed the US FOIA (b)(6) who	F 638		

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F 638	Continued From page 29 stated that the most recent MDS coordinator resigned NJ Exec Order 26.4b1 and has not been replaced. She stated that the facility had per diem RN/MDS coordinators who were completing MDS's. She stated the RN/MDS coordinators were doing their best to assure timely completion and transmission of the MDS. She confirmed that there was an issue concerning the timeliness of MDS completion and submission. She stated that she had a conversation with the US FOIA (b)(6) US FOIA (b)(6) and facility "corporate office" regarding the late assessments and that part time RN/MDS coordinators were working on the late assessment to get them completed. She stated that late MDS assessments were being discussed weeks after the last RN/MDS coordinator left. She stated, "We did not discuss specific late MDS, just the whole picture of what was happening with the MDS process, and I was told we had individuals who were working both remotely and on site to get assessments completed". On 10/17/22 at 11:10 AM, the surveyor interviewed the US FOIA (b)(6) regarding his knowledge of late completion and transmission of the MDS assessments. The US FOIA (b)(6) stated that he was not aware that the MDS's were late and was not informed by clinical staff that the MDS's were not completed or transmitted timely. He stated that he was not told that the MDS's were a major outstanding issue in the facility. He stated that the only issue that was a concern regarding MDS, was them being uploaded to the new electronic medical record (EMR). The US FOIA (b)(6) stated that the MDS/RMC should have notified him that there were MDS's that were not completed timely or transmitted timely.	F 638		

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F 638	Continued From page 30	F 638		

b.)

1.) Resident #45's ARD was EX Order 26.4B1, the quarterly MDS assessment was not completed until EX Order 26.4B1 days later.

On 10/14/22 at 12:14 PM, Surveyor #2 interviewed the US FOIA (b)(6) who stated that Resident #45's last quarterly MDS was completed on NJ Exec Order 26.4b and that the next quarterly MDS was due on NJ Exec Order 26.4b1 it was not completed, and that it should have been done by NJ Exec Order 26.4b The US FOIA (b)(6) stated that it was important to complete MDS's accurately and in a timely manner because they were assessment tools that guided the care plan and were used to identify any problems that could cause potential harm.

On 10/18/22 at 12:36 PM, in the presence of the US FOIA (b)(6) the surveyor interviewed the US FOIA (b)(6) who acknowledged Resident #45's last quarterly MDS that was due on NJ Exec Order 26.4b1 was not completed. The US FOIA (b)(6) stated the MDS should have been done within 14 days so the rest of the team could have been exposed to the information on the MDS.

2.) Resident #57's ARD was EX Order 26.4B1, the quarterly MDS assessment was not completed until EX Order 26.4B1 days later.

3.) Resident #63's ARD was EX Order 26.4B1 the quarterly MDS assessment was not completed until EX Order 26.4B1 days later.

According to the CMS RAI Version 3.0 Manual Chapter 2 Assessment for the RAI pages 2-16: Quarterly (Non-Comprehensive) must be

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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 638	Continued From page 31 completed 14 calendar days after the ARD and submitted 14 calendar days after the assessment is completed. The facility policy titled. "Minimum Data Set" with a revised date of 09/28/22 indicated that the RN MDS coordinator schedules the residents' assessments and care plan meetings in accordance with Center for Medicare and Medicaid Services (CMS) regulations and guidelines and resident's needs. The facility job description titled; Director of Clinical Reimbursement (MDS Coordinator) indicated that the MDS Coordinators duties included: -Ensuring that all assessments are completed and transmitted in a timely manner and to report problem areas to the Administrator.	F 638		
F 640 SS=F	NJAC 8:39 - 11.2 Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment.	F 640		12/5/22

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F 640	Continued From page 32 §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to electronically submit the Minimum Data Set (MDS), a resident assessment tool, within 14	F 640	I. Immediate Action a. Resident # 1 -MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received	

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F 640	Continued From page 33 days after completion as required. This deficient practice was identified for 22 of 27 residents (Residents #1, #3, #4, #5, #6, #7, #8, #9, #10, #11, #14, #16, #17, #21, #23, #27, #30, #31, #33, #35, #36, and #37) reviewed for MDS record over 120 days . This was evidenced by the following: On 10/14/22 at 10:36 AM, the surveyor interviewed the US FOIA (b)(6) US FOIA (b)(6) regarding late, non-completed MDS assessments. The surveyor provided the US FOIA (b)(6) with a list of resident MDS assessments that were late or not submitted and the US FOIA (b)(6) stated that she would email the surveyor information regarding the late assessments and why the assessments were not completed or transmitted timely. She stated she would investigate the issue. On 10/17/22 at 10:06 AM, the surveyor interviewed the US FOIA (b)(6) who stated that she had been an MDS coordinator for NJ Exec Order 26.4b1 The MDS/RMC stated that she supervised NJ Exec Order 26.4b other sister facility's MDS departments for this company. She stated that the facility had per diems (as needed) Registered Nurses Minimum Data Set Coordinators (RN/MDS) nurses that performed the MDS assessment for the residents in the facility. She stated that there had not been a full time MDS coordinator in the facility since NJ Exec Order 26.4b1 and that the RN/MDS per diem nurses came into the facility to assess the resident, interview the residents, review the medical record, and clarify and confirm that what was in the medical record was accurate. She stated that the MDS clinical assessment "opened" in the EMR for completion seven (7) days prior to	F 640	dated 10/17/22 b. Resident #3 MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 c. Resident #4 -MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 d. Resident #5- MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 e. Resident #6- MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 f. Resident #7- MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 g. Resident #8- MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 h. Resident #9 -MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 i. Resident #10 -MDS completed NJ Exec Order 26.4b1 Confirmation of transmission 10/18/22 j. Resident #11 -MDS Completed NJ Exec Order 26.4b1 Confirmation of transmission 10/17/22 k. Resident #14 - MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22	

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F 640	Continued From page 34 the Assessment Reference Date (ARD, the date that signifies the end of the look back period). She stated once the specific MDS opens, all disciplines can enter the MDS to complete their section. She stated that the quarterly, annuals and significant changes MDS's were due to be completed 14 days from the ARD. She confirmed that there were multiple MDS's that were not completed or were late in the facility. She stated that the quarterly, annual, and significant change assessment were required to be submitted 14 days from the completion date. She stated that it was a challenge to try and find a full time MDS coordinator and that the facility corporate office was aware that the assessments were "overdue". She said that they were trying their best to have the MDS assessments done timely. She confirmed that there were multiple comprehensive and quarterly assessments that were late but that they "were doing their best" to try and complete them. She stated that it would be important to assure timely completion and timely transmission of assessments because the MDS was a tool that was used for identification of problems, care plan accuracy, and to ensure proper services were provided to the residents. 1.) Resident #1's ARD was EX Order 26.4B1, the assessment was not completed until EX Order 26.4B1, EX Ord days later, and was submitted EX Order 26.4B1 2.) Resident #3's ARD was EX Order 26.4B1, the assessment was not completed until EX Order 26.4B1 days later, and was submitted EX Order 26.4B1 3.) Resident #4's ARD was EX Order 26.4B1, the assessment was not completed until EX Order 26.4B1 days later. The facility provided the surveyor with	F 640	l. Resident #16- MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 m. Resident #17- MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 n. Resident #21- MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 o. Resident #23- MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 p. Resident #27- MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 q. Resident #30- MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 r. Resident #31- MDS completed NJ Exec Order 26.4b1 of transmission received dated 7/22/22 s. Resident 33 -MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 t. Resident 35 -MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/14/22 u. Resident #36- MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/18/22	

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F 640	Continued From page 35 a CMS submission report MDS 3.0 final Validation report dated EX Order 26.4B1, which did not indicate that this assessment was submitted. 4.) Resident #5's ARD was EX Order 26.4B1, the assessment was not completed until EX Order 26.4B1 days later, and was submitted EX Order 26.4B1 5.) Resident #6's ARD was EX Order 26.4B1, the assessment was not completed until EX Order 26.4B1 days later. The facility provided the surveyor with a CMS submission report MDS 3.0 final Validation report dated EX Order 26.4B1, which did not indicate that this assessment was submitted. 6.) Resident #7's ARD was EX Order 26.4B1, the assessment was not completed until EX Order 26.4B1 days later. The facility provided the surveyor with a CMS submission report MDS 3.0 final Validation report dated EX Order 26.4B1, which did not indicate that this assessment was submitted. 7.) Resident #8's ARD was EX Order 26.4B1, the assessment was not completed until EX Order 26.4B1 days later, and was submitted EX Order 26.4B1 8.) Resident #9's ARD was EX Order 26.4B1, the assessment was not completed until EX Order 26.4B1 days later, and was submitted on EX Order 26.4B1. 9.) Resident #10's ARD was EX Order 26.4B1 the assessment was not completed until EX Order 26.4B1 EX Orde days later. The facility provided the surveyor with a CMS submission report MDS 3.0 final Validation report dated EX Order 26.4B1, which did not indicate that this assessment was submitted. 10.) Resident #11's ARD was EX Order 26.4B1, the assessment was not completed until EX Order 26.4B1,	F 640	v. Resident #37- MDS completed NJ Exec Order 26.4b1 Confirmation of transmission received dated 10/17/22 II. Identification of Others a. The facility respectfully submitted that potentially all residents may be affected b. An audit was completed of all Minimum Data Set (MDS) due in the last 30 days to ensure they are completed and submitted. Completion date 11/11/22 c. Any negative findings will be brought to the administrator's attention, will be completed and submitted immediately. III. Systemic Changes a) The Policy and Procedure on Minimum Date Set (MDS) was reviewed by Administrator, Director of Nursing and Regional MDS Coordinator and was updated to reflect notification to the Administrator if MDS are overdue or unable to complete in a timely manner. Completion date 11/11/22. b) The facility hired a new Registered Nurse for the Minimum Date Set (MDS) coordinator position. Start date NJ Exec Order 26.4b1 c) All personnel involved in the completion of the quarterly assessments/MDS will be reeducated on the importance of timely completion of their respective section to ensure that all MDS are submitted timely. Completion date 11/21/22 IV. Quality Assurance a. Audits will be conducted by the Minimum Data Set (MDS) coordinator for all residents with assessments to ensure	

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F 640	Continued From page 36 66 days later. The facility provided the surveyor with a CMS submission report MDS 3.0 final Validation report dated 10/17/22, which did not indicate that this assessment was submitted. 11.) Resident #14's ARD was EX Order 26.4B1, the assessment was not completed until EX Order 26.4B1 days later. The facility provided the surveyor with a CMS submission report MDS 3.0 final Validation report dated 10/17/22, which did not indicate that this assessment was submitted. 12.) Resident #16's ARD was EX Order 26.4B1, the assessment was not completed until EX Order 26.4B1 days later. The facility provided the surveyor with a CMS submission report MDS 3.0 final Validation report dated 10/17/22, which did not indicate that this assessment was submitted. 13.) Resident #17's ARD was EX Order 26.4B1, the assessment was not completed until EX Order 26.4B1 days later. The facility provided the surveyor with a CMS submission report MDS 3.0 final Validation report dated 10/17/22, which did not indicate that this assessment was submitted. 14.) Resident #21's ARD was EX Order 26.4B1 the assessment was not completed until EX Order 26.4B1 days later. The facility provided the surveyor with a CMS submission report MDS 3.0 final Validation report dated 10/17/22, which did not indicate that this assessment was submitted. 15.) Resident #23's ARD was EX Order 26.4B1, the assessment was not completed until EX Order 26.4B1 EX Ord days later, and submitted on 10/17/2022. 16.) Resident #27's ARD was EX Order 26.4B1 the assessment was not completed until EX Order 26.4B1	F 640	completion and submission of the assessment. b. These audits will be conducted by the Minimum Date Set (MDS) coordinator weekly x 4 weeks, then monthly x 2 months then quarterly x 3 quarters. c. All negative findings will be brought to the Administrator's attention. d. The results of all audits will be brought to the Quality Assurance committee quarterly x 4 quarters. V. Person Responsible: Administrator and Regional Minimum Data Set (MDS) coordinator	

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F 640	Continued From page 37 days later. The facility provided the surveyor with a CMS submission report MDS 3.0 final Validation report dated 10/17/22, which did not indicate that this assessment was submitted. 17.) Resident #30's ARD was EX Order 26.4B1, the assessment was not completed until EX Order 26.4B1 EX Ord days later. The facility provided the surveyor with a CMS submission report MDS 3.0 final Validation report dated 10/17/22, which did not indicate that this assessment was submitted. 18.) Resident #31's ARD was EX Order 26.4B1, the assessment was not completed until EX Order 26.4B1 days later, and was submitted 07/22/22. 19.) Resident #33's ARD was EX Order 26.4B1, the assessment was not completed until EX Order 26.4B1 EX Ord days later. The facility provided the surveyor with a CMS submission report MDS 3.0 final Validation report dated 10/17/22, which did not indicate that this assessment was submitted. 20.) Resident #35's ARD was NJ Exec Order 26.4B1, the assessment was not completed until EX Order 26.4B1, EX Ord days later, and was not submitted yet. 21.) Resident #36's ARD was EX Order 26.4B1, the assessment was not completed until EX Order 26.4B1 days later, and was not submitted yet. 22.) Resident #37's ARD was EX Order 26.4B1, the assessment was not completed until EX Order 26.4B1 days later. The facility provided the surveyor with a CMS submission report MDS 3.0 final Validation report dated 10/17/22, which did not indicate that this assessment was submitted. On 10/17/22 at 10:19 AM, the surveyor	F 640		

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F 640	Continued From page 38 interviewed the US FOIA (b)(6) who stated that the most recent MDS coordinator resigned NJ Exec Order 26.4b1 and has not been replaced. She stated that the facility had per diem RN/MDS coordinators who were completing MDS's. She stated the RN/MDS coordinators were doing their best to assure timely completion and transmission of the MDS. She confirmed that there was an issue concerning the timeliness of MDS completion and submissions. She stated that she had a conversation with the US FOIA (b)(6) US FOIA (b)(6) and facility "corporate office" regarding the late assessments and that part time RN/MDS coordinators were working on the late assessment to get them completed. She stated that late MDS assessments were being discussed weeks after the last RN/MDS coordinator left. She stated, "We did not discuss specific late MDS, just the whole picture of what was happening with the MDS process, and I was told we had individuals who were working both remotely and on site to get assessments completed." On 10/17/22 at 11:10 AM, the surveyor interviewed the US FOIA (b)(6) regarding his knowledge of late completion and transmission of the MDS assessments. The US FOIA (b)(6) stated that he was not aware of that MDSs were late and was not informed by clinical staff that the MDSs were not completed or transmitted timely. He stated that he was not told that the MDS's were a major outstanding issue in the facility. He stated that the only issue that was a concern regarding MDS, was them being uploaded to the new electronic medical record (EMR). The US FOIA (b)(6) stated that the MDS/RMC should have notified him that there were MDS were not completed timely or transmitted timely.	F 640		

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F 640	Continued From page 39 According to the CMS RAI Version 3.0 Manual Chapter two (2) Assessment for the RAI pages 2-16: Quarterly (Non-Comprehensive) must be completed 14 calendar days after the ARD and submitted 14 calendar days after the assessment is completed. Annual (Comprehensive) assessment must be completed 14 calendar days after the ARD and submitted 14 calendar days after the assessment is completed. The facility policy titled. "Minimum Data Set" with a revised date of 09/28/22, indicated that the RN MDS coordinator schedules the residents' assessments and care plan meetings in accordance with Center for Medicare and Medicaid Services (CMS) regulations and guidelines and resident's needs. The facility job description titled; Director of Clinical Reimbursement (MDS Coordinator) indicated that the MDS Coordinators duties included: -Ensuring that all assessments are completed and transmitted in a timely manner and to report problem areas to the Administrator.	F 640		
F 641 SS=D	NJAC8:39-11.2 (e) Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to	F 641	I. Immediate Action a) Resident # 266: A corrected MDS for	12/5/22

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F 641	Continued From page 40 accurately complete the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care. This deficient practice was identified for one (1) of one (1) resident (Resident #266) reviewed for [redacted] and for one (1) of one (1) resident reviewed for [redacted] (Resident #63). This deficient practice was evidenced by the following: On 10/06/22 at 10:50 AM, during the initial tour of the facility the surveyor interviewed Agency Licensed Practical Nurse (ALPN #1) who stated Resident #266 was the only resident on [redacted] at the facility. On 10/06/22 at 11:06 AM, during the initial tour, the surveyor observed Resident #266 lying in bed. Resident #266 was [redacted] but acknowledged the surveyor by nodding his/her head. The surveyor reviewed the medical record for Resident #266. A review of the Resident Face Sheet (an admission summary) included that the resident was admitted to the facility in [redacted], with diagnoses which included: [redacted]. A review of the physician's order (PO) dated [redacted], reflected an order for a [redacted] evaluation. The PO further reflected on [redacted] an order to discontinue skilled [redacted] services because the resident was on [redacted]	F 641	admission was submitted to remove [redacted] from the initial book. Correction submitted 10/18/22. Confirmation of transmission 10/18/22. b) Resident #63: A corrected MDS was completed o[redacted] to indicate the use of [redacted] during the look back period for MDS dated [redacted] Submitted [redacted] II. Identification of Others All residents have the potential to be affected. a) The facility respectfully submits there are no other residents on [redacted] b) An audit of section 0, # 0100K of the MDS for all residents admitted in the last 6 months was done on 10/16/22 by the Regional MDS coordinator to determine if anyone was coded for [redacted] If coded for [redacted] will validate for MD order. c) An Audit of section P was done on 10/16/22 to determine if all residents with side rails are coded properly for all residents submitted in the last 30 days. d) If any errors noted, a corrected MDS to be submitted immediately. e) The administrator will be notified of any discrepancies and action taken. III. Systemic Changes a) The Policy and Procedure titled Minimum Data Set was reviewed and revised by the Administrator, DNS and Regional MDS Coordinator to include Administrator notification if MDS are overdue or unable to be completed in a timely manner. Completion Date 11/11/22 b) Section 0-#0100K of the MDS should	

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BELLE CARE NURSING AND REHABILITATION CENTER	**439 BELLEVUE AVENUE TRENTON, NJ 08618**

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F 641	Continued From page 41 A review of the admission MDS, dated EX Order 26.4B1 revealed under Section O: Special Treatment, Procedures, Programs that the resident was [redacted] care while not a resident and while a resident. A further review of the MDS revealed it was completed and signed on EX Order 26.4B1 On 10/19/22 at 11:59 AM, the surveyor interviewed the US FOIA (b)(6) US FOIA (b)(6) who stated that the admission MDS for Resident #266 was due on EX Order 26.4B1 and completed and signed on EX Order 26.4B1 She further stated that the Admission MDS was coded for Ex Order 26. 4B1 but could not confirm if the resident was admitted on Ex Order 26. 4B1. On 10/19/22 at 12:31 PM, the surveyor interviewed the US FOIA (b)(6) who stated Resident #266 was not admitted to the facility under Ex Order 26. 4B1 care. The US FOIA (b)(6) stated the resident was placed on Ex Order 26. 4B1 [redacted]. The US FOIA (b)(6) acknowledged the admission MDS was not accurately coded. On 10/19/22 at 12:33 PM, the US FOIA (b)(6) stated that the MDS assessments were a systemic issue and acknowledged that the MDS for Resident #266 was coded inaccurately. 2. On 10/06/22 at 11:06 AM, during the initial tour of the facility the surveyor observed Resident #63 lying in bed asleep with NJ Exec Order 26.4b1 in place on both sides of the resident's bed. On 10/07/22 at 09:48 AM, the surveyor observed Resident #63 lying in bed asleep. The right side	F 641	be completed by the Social Worker who will verify that the resident is on Ex Order 26. 4B1 and an MD order is in place. Completion date 11/16/22 c) All MDS and Social Workers will be in serviced on the designation of this section to Social Work. Completion date 11/16/22 d) The MDS assignment was changed to reflect the reassignment of this section. Completion Date 11/16/22 e) Reeducation to All MDS assessors regarding the importance of reviewing both electronic and paper records, and physically assessing the resident prior to completion is necessary to ensure accuracy. Completion Date 11/21/22 IV. Quality Assurance a) Audits will be conducted for section 0 # 0100K and Section P weekly by the Regional MDS coordinator /designee to ensure accuracy of coding for [redacted] care/ and Restraints and Alarms. b) Audits will be done weekly x 4 weeks, monthly x 2 months then quarterly x 3 quarters. c) All negative findings will be brought to the attention of the Administrator immediately. d) The results of all audits will be brought to the QAPI committee quarterly x 4 quarters. V. Person Responsible: Regional MDS Coordinator	

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F 641	Continued From page 42 of the resident's bed was positioned up tightly up against the wall. The NJ Exec Order 26.4b1 was pulled up and a NJ Exec Order 26.4b1 covered the entire length of the NJ Exec Order 26.4b1 On 10/12/22 at 11:08 AM, the surveyor interviewed Certified Nursing Assistant (CNA #2) who confirmed that Resident #63's NJ Exec Order 26 were NJ Exec Order 26.4b1 Ex Order 26. 4B1 and the resident was unable to assist to with NJ Exec Order 26.4b1 CNA #2 stated that the resident had Ex Order 26. 4B1 and was required to have a NJ Exec Order 26.4b1 side because the resident tended to NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 CNA #2 stated that the resident was transferred from the with Ex Order 26. 4B1 in place. CNA #2 stated that the EX Order 26.4B1 did not need to be maintained in the upward position as the bed was also pushed firmly up against the wall on the EX Order 2 side. On 10/12/22 at 11:14 AM, the US FOIA (b)(6) US FOIA (b)(6) entered the room to assist CNA #2 to pull Resident #63 up in bed. The US FOIA (b)(6) stated that the resident was unable to assist with NJ Exec Order 26.4b1 She stated that the EX Order 26.4B1 were in place for Ex Order 26. 4B1 precautions. The US FOIA (b)(6) stated that the use of Ex Order 26. 4B1 was not considered a Ex Order 26. 4B1. The US FOIA (b)(6) stated that the US FOIA (b)(6) US FOIA (b)(6) was going to remove the Ex Order 26. 4B1 and change them to half rails instead so that it were not considered a Ex Order 26. 4B1. She stated that she would pull the bed out away from the wall because it was not supposed to be like that because that was a Ex Order 26. 4B1. She stated that a physician's order, care plan entry and a NJ Exec Order 26.4b1 assessment were required for NJ Exec Order 26.4b NJ Exec Order acement. The US FOIA (b)(6) reviewed the	F 641		

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F 641	Continued From page 43	F 641		

resident's care plan in the electronic health record (EHR) and confirmed that an entry was placed for [NJ Exec Order 26.4b1] use on [NJ Exec Order 26.4b1]. The [US FOIA (b)(6)] stated that if the [NJ Exec Order 26.4b1] were utilized for bed mobility then a Care Plan should have done prior. The [US FOIA (b)(6)] further stated that because the [NJ Exec Order 26.4b1] were implemented for [Ex Order 26. 4B1] precautions a care plan was not initiated. The [US FOIA (b)(6)] stated that she did not know why a [NJ Exec Order] assessment or family consent was not obtained prior to implementation.

A review of the Resident Face Sheet revealed that Resident #63 was admitted to the facility in [redacted] with diagnoses which included but were not limited to: *Ex Order 26. 4B1* [redacted]

A review of the quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] revealed that Resident #63 was readmitted to the facility from an [redacted] hospital in [redacted] with a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted] which indicated that the resident was *Ex Order 26. 4B1* [redacted]. The assessment identified that the resident required [NJ Exec Order] dependence of one person for [NJ Exec Order 26.4b1] and [NJ Exec Order] assistance of two persons for [NJ Exec Order 26.4b1] Further review of the MDS revealed that the resident had functional limitation in range of motion of both the *Ex Order 26. 4B1* [redacted] Review of section P of the MDS titled [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1] revealed that the resident had [NJ Exec Order] [NJ Exec Order] that were used daily. According to the MDS, a physical restraint was defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or

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F 641		F 641		

Continued From page 44

normal access to ones' body.

A review of Resident #63's quarterly MDS dated EX Order 26.4B1 that was due for submission on NJ Exec Order 26.4b1 and was instead submitted 13 days later on NJ Exec Order 26.4b1 revealed under Section P, NJ Exec Order 26.4b1 that the assessment was coded to reflect that the resident had not used NJ Exec Order 26.4b1

On 10/19/22 at 12:17 PM, the surveyor interviewed the US FOIA (b)(6) who stated that when the MDS Coordinator completed Resident #63' MDS, there was a seven day look back period that was reviewed for Ex Order 26. 4B1 usage that corresponded to Section P, NJ Exec Order 26.4b1 The US FOIA (b)(6) stated that the MDS Coordinator was on-site and should have reviewed the resident's Care Plan, Treatment Assessment Record (TAR) and physically assessed the resident prior to completion. The US FOIA (b)(6) stated that since the facility recently transitioned from paper to electronic health record charting both records should have been reviewed prior to assessment completion. The US FOIA (b)(6) stated that she did not know this resident well, but if she observed that the resident had *Ex Order 26. 4B1* on his/her bed and the bed was pushed up against the wall, then she would have spoken to the team directly for clarification. The US FOIA (b)(6) stated that a restraint restricted someone from movement and according to section G of the MDS, the resident was totally dependent for care and had restricted movement. The US FOIA (b)(6) stated that the facility had not had a full-time MDS Coordinator since NJ Exec Order 26.4b1 and there were a few MDS Coordinators that helped out now.

The facility policy titled. "Minimum Data Set" with

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F 641	Continued From page 45 a revised date of 09/28/22, indicated that the RN MDS coordinator schedules the residents' assessments and care plan meetings in accordance with Center for Medicare and Medicaid Services (CMS) regulations and guidelines and resident's needs. The facility job description titled; Director of Clinical Reimbursement (MDS Coordinator) indicated that the MDS Coordinators duties included: -Ensuring that all assessments are completed and transmitted in a timely manner and to report problem areas to the Administrator.	F 641		
F 645 SS=E	NJAC 8:39-11.2 PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or	F 645		12/5/22

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F 645	Continued From page 46 (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental	F 645		

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F 645	Continued From page 47 disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to accurately complete and update a Preadmission Screening and Resident Review (PASARR) to include all [redacted] diagnoses to ensure the resident was referred to the appropriate state-designated authority for level II PASARR evaluation and determination. This deficient practice was identified for one (1) of five (5) residents (Resident #35) reviewed for level II PASARR and was evidenced by the following: According to the Resident Face Sheet, Resident #35 was admitted to the facility with the diagnoses that included but were not limited to: [redacted]. The quarterly Minimum Data Set (MDS) and assessment tool to manage the residents care, indicated that Resident #35 had both a [redacted] and [redacted] problem, was [redacted] and had [redacted]. The MDS also reflected that the resident required extensive assistance with all aspect of activities of daily living and indicated that the resident had the diagnoses of [redacted] On 10/07/22 at 09:42 AM, the surveyor observed the resident lying in bed awake, was dozing at	F 645	I. Immediate Action a) Resident #35: A level II PASAAR referral was completed on [redacted] for evaluation of resident #35 based on [redacted] diagnoses present on admission. b) The facility is awaiting the results of this referral. c) The Director of Social Services was reeducated on the proper completion of a level I screen, review of pertinent diagnoses and proper completion of the form. Completion date 10/28/22 II. Identification of others: All residents have the potential to be affected. a) An audit was completed for all residents in the past 90 days to ensure that a level PASAAR was in place and appropriate to determine if a level II PASAAR was required. If required, determine if level II was received and recommended services provided as indicated. Completion date 10/28/22 b) If any level II referrals were not completed, a new level II PASAAR referral will be made to OCCO for completion. Completion date 10/28/22 c) All negative findings will be brought to	

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F 645	Continued From page 48 intervals and responded to the surveyor with one-word answers, yes or no. On 10/07/22 at 09:42 AM, the surveyor interviewed the acting US FOIA (b)(6) US FOIA (b)(6) who stated that the resident had behaviors which included [redacted], and [redacted]. The US FOIA (b)(6) indicated that the resident had not required any [redacted] hospital admissions and was followed by the facility [redacted] The surveyor reviewed the PASARR level one (1) Screen dated NJ Exec Order 26.4b1 which reflected the following question: Does the individual have diagnoses or evidence of major NJ Exec Order 26.4b1 to the following disorders: [redacted] disability? According to the question asked, the facility US FOIA (b)(6) documented on the form that the resident did not have any [redacted] diagnoses. On 10/11/22 at 12:09 PM, the surveyor interviewed the US FOIA (b)(6) US FOIA (b)(6) who stated that a Medicaid worker came to the facility and requested a PASARR Level one (1) for Resident #35. The US FOIA (b)(6) stated that she completed a new one on NJ Exec Order 26.4b1 The US FOIA (b)(6) stated that while the resident was still *Ex Order 26. 4B1*, their behaviors had improved and was not documented on the PASARR level one (1) that she completed on the resident's behalf.	F 645	the Administrator's attention immediately. III. Systemic Changes a) The Policy and Procedure titled PASAAR was reviewed and found to be in compliance. Completion Date 11/6/22 b) Education to all Admission Staff and Social Work to ensure that appropriate level I PASAARs are completed prior to admission and if recommended, a level II PASAAR is completed prior to admission to determine if the facility is the appropriate setting for resident. Completion date 11/6/22 c) Education to Social work on the importance of reviewing all level I PASAARs for accuracy. If inaccurate or change in condition noted, a new level I PASAAR will be completed in accordance with 483.20 (k) (1)-(3) Completion date 11/6/22 IV. Quality Assurance: a) Audits will be conducted by social worker of all new admissions to ensure that a level I PASAAR is in place, reviewed for accuracy and if indicated a level II has been completed. b) Audits will be conducted weekly x 4 weeks, monthly x 2 weeks and quarterly x 3 quarters. c) All negative findings will be brought to the attention of the Administrator immediately. If needed a new level I will be completed or a level II referral to OCCO will be made immediately. d) The results of all audits will be brought to the QAPI committee quarterly x 4 quarters.	

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F 645	Continued From page 49 On 10/14/22 at 10:47 PM, the [US FOIA (b)(6)] confirmed that she completed the level one (1) PASARR dated [NJ Exec Order 26.4B1] and did not include the resident's [redacted] diagnoses of *Ex Order 26. 4B1* [redacted]. The [US FOIA (b)(6)] stated, "I screwed up." The [US FOIA (b)(6)] admitted that she did not include the *Ex Order 26. 4B1* diagnoses and therefore Resident #35 was not properly assessed for referral to the appropriate state agencies such as Office of Community Choice Options (OCCO), Division of Developmental Disabilities (DDD) and/or Division of Mental Health and Addiction Service (DMHAS) for a level two (2) PASARR. On 10/20/22 at 11:22 AM, The surveyor interviewed the [US FOIA (b)(6)] [US FOIA (b)(6)] who stated that the resident should have been referred to OCCO for level two PASARR screening due to [redacted] diagnoses. According to the facility policy titled, "Pre-Admission Screen and Resident Review (PASRR) dated 07/03/22, indicated that all residents must have a PASRR Screen prior to admission to the facility and thereafter when there is a significant change that has bearing on the resident's specialized service needs. The screen assesses residents for mental illness (MI), dementia and mental retardation. The screen is to determine if the person's ability to be cared for in a setting other, than Residential Health Care Facility (RHCF). The second purpose of the screen is to assess persons being recommended for RHCF placement for possible mental illness, mental retardation, developmental disability. The policy also indicated that in the event the completed PASRR screen reflects a need for further review please refer to appropriate agency	F 645	V. Person responsible: Director of Social Work or designee	

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F 645	Continued From page 50 and follow referral procedure. A resident who was previously identified as having a serious mental illness and or mental retardation/developmental disability and now is identified as having a significant change in physical or mental condition a new screen and level two (2) evaluation must be completed within 14 calendar days and a certified screener will complete the screen as necessary and an RN will complete a PASAR level one (1). NJAC 8:39-27.1(a)	F 645		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		12/5/22

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F 657	Continued From page 51 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of pertinent facility documentation, it was determined that the facility failed to update and revise the resident Care Plan (CP) to include goals and interventions for one (1) of one (1) resident (Resident #266) reviewed for Ex Order 26. 4B1 care. This deficient practice was evidenced by the following: On 10/06/22 at 10:50 AM, during the initial tour of the facility the surveyor interviewed Agency Licensed Practical Nurse (ALPN #1) who stated Resident #266 was the only resident on Ex Order 26. 4B1 at the facility. On 10/06/22 at 11:06 AM, during the initial tour, the surveyor observed Resident #266 lying in bed. Resident #266 was [redacted] but acknowledged the surveyor by nodding his/her head. The surveyor reviewed the medical record for Resident #266. A review of the Resident Face Sheet (an admission summary) included that the resident was admitted to the facility in [redacted], with diagnoses which included: Ex Order 26. 4B1 [redacted]	F 657	I. Immediate action a) Resident #266 A care plan for NJ Exec Order 26.4b [redacted] Care was initiated on NJ Exec Order 26.4b [redacted] to include all special needs related to Ex Order 26. 4B1 [redacted] care. b) Resident #266 Care plan with focus of Nutrition was reviewed by assigned dietician on NJ Exec Order 26.4b [redacted] and revised to include goals and interventions related to Ex Order 26. 4B1 [redacted] care II. Identification of others: The facility respectfully submits that there are no other residents on Ex Order 26. 4B1 [redacted] at this time. All patients have the potential to be affected. III. Systemic Changes: a) The Policy and Procedure on Care planning was reviewed and revised by the Administrator and Director of Nursing to include that entries into the "notes section " of the care plan in the EMR will be made at least quarterly to indicate that the plan of care has been reviewed and is appropriate for the current status of the resident. Completion date 11/3/22 b) All clinical staff responsible for updating any aspect of the resident's care plan were reeducated on the importance of reviewing and revising care plans to reflect the current status of all residents and how to do the quarterly review in the	

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F 657	Continued From page 52 A review of the physician's order (PO) dated [redacted], reflected an order for a [redacted] evaluation. The PO further reflected on [redacted] an order to discontinue skilled [redacted] services because the resident was on [redacted]. A review of the electronic individualized comprehensive CP for [redacted] of [redacted] reflected that there was no documentation of the current condition and needs related to [redacted] care for Resident #266. On 10/17/22 at 09:55AM, the surveyor interviewed the [redacted] who stated Resident #266 was placed on [redacted] over a month ago. The [redacted] stated that the CPs reflected "special services" that assisted the staff in providing the appropriate care for the resident. She further stated in the electronic medical record (EMR) that it would appear on the CP as [redacted] care. On 10/18/22 at 10:01 AM, the surveyor interviewed the [redacted] who stated she completed most of the CPs for the [redacted]. She further stated that other nurses had started to help with the CPs, since they transitioned to the EMR. The [redacted] stated it was important to create and update the CP because it was a tool to communicate the resident's plan of care to staff. The [redacted] stated that Resident #266 was on [redacted] and there should be a CP. She further stated that the [redacted] had taught her how to complete the CPs and with the [redacted] oversight they reviewed them every three (3) months for any revision. The [redacted] concluded the EMR was a new system and that the previous CPs	F 657	Notes section of the EMR care plan. Completion date 11/8/22 IV. Quality Assurance: a) Audits will be conducted for all residents on [redacted] and recent Significant changes to ensure that the care plans reflect the current status of the resident as well as ensuring that it is reviewed at least quarterly with update in Note section of care plan in EMR. b) Audits will be conducted weekly x 4 weeks, monthly x 2 months, then quarterly x 3 quarters. VI. Person Responsible: Director of Nursing	

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F 657	Continued From page 53 were on paper and she would provide it to the surveyor. On 10/19/22 at 10:57 AM, the US FOIA (b)(6) provided the paper CP that was dated NJ Exec Order 26.4b1 A review of the CP reflected a [redacted] CP dated NJ Exec Order 26.4b1 A further review of the CP reflected there was no documented signature on the CP for the NJ Exec Order 26.4b1 revision. On 10/19/22 at 01:34 PM, the US FOIA (b)(6) in the presence of the US FOIA (b)(6) the US FOIA (b)(6) [redacted] US FOIA (b)(6) and the survey team acknowledged that the paper CP for Resident #266 should have been signed and dated on the day it was reviewed and revised. On 10/20/17 at 11:38 AM, the US FOIA (b)(6) provided the electronic CP for Resident #266. A review of the provided electronic CP from the scheduled NJ Exec Order 26.4b1 with corrections reflected under "Focus Nutrition - Additional Detail: Resident on [redacted] service's overall goal is comfort." A further review reflected the Nutrition focus was effective on NJ Exec Order 26.4b1 with no revision date but was noted entered on NJ Exec Order 26.4b1 The electronic CP revealed that there was no specified documentations of goals or interventions related to [redacted] care. A review of the undated facility's Hospice Program policy reflected, "4. When a resident participates in a hospice program, a coordinated plan between the facilities, hospice agency/family will be developed ....The care plan shall be revised and updated as necessary to reflect the resident current status."	F 657		

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F 657	Continued From page 54 A review of the facility's Care Planning policy last review dated 05/26/22, reflected "to provide an individualized comprehensive care plan (CCP) for each resident based on assessments done at the time of admission, quarterly, annually, and when there is a change in condition .....A new care plan will be initiated for significant change ...If the current care plan reflects the actual need of the resident the CCP will be revised to reflect the aspect of the resident's condition that triggered the significant change ... .Registered Nurse Responsibility 4. Makes an entry into the "outcome column" of the care plan to indicate that the care plan has been reviewed and is appropriate for the current status of the resident .....9. Formulates care plans for specific discipline on admissions, quarterly, significant change, return from the hospital and as needed with change in condition." NJAC 8:39:11.2 (1)(2); 27.1(a)	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to follow professional standards of practice by ensuring a.) that staff did not utilize personal equipment, a personal blood pressure (BP) monitor for resident care and b.) that staff	F 658	I. Immediate Action a) Resident #268 was assessed by the Registered Nurse to determine if any harm came to the resident for receiving Ex Order 26. 4B1 meds when Ex Order 26. 4B1 are below the parameters. No	12/5/22

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F 658	Continued From page 55 obtained vital signs prior to administering a medication and hold a medication used to treat [redacted]) in accordance with the physician's order (PO). This deficient practice was identified for one (1) of two (2) Licensed Practical Nurses (LPN) observed during medication administration. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." The deficient practice was evidenced by the following: a.) On 10/13/22 at 08:22 AM, the surveyor began	F 658	change in condition noted. Completion date 10/13/22 b) A medication error form was completed and MD notified. Completion date 10/13/22 c) Licensed Practical Nurse (LPN) #1 was re in serviced on the importance of reading the complete MD order including parameters before giving ANY medications. Completion date 10/13/22 d) Licensed Practical Nurse (LPN) #1 was also in serviced on use of only facility equipment for monitoring the resident's vital signs. Use of personal equipment does not ensure proper calibration and accuracy as well an infection control issue. She was also advised to notify the maintenance via facility protocol to repair or replace any broken machinery. Completion date 10/13/22 II. Identification of others: All residents have the potential to be affected. a) An audit was completed for all residents receiving blood pressure medications to determine if parameters are ordered and being followed. Completion date 10/13/22 b) All negative findings to be reported to the Administrator and the resident's Primary Care Physician (PCP). c) An immediate reeducation /medication error to be given to any nurse who did not follow the parameters. III. System Changes a) The Policy and Procedure on Vital Signs was reviewed and revised by the	

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F 658	Continued From page 56 the medication administration on the [redacted]. On 10/13/22 at 08:28 AM, the surveyor observed LPN #1 obtain a [redacted] result of [redacted] for Resident #268. On 10/13/22 at 08:31 AM, the surveyor observed LPN #1 return to her medication cart and then cleaned the BP monitoring machine with a disinfectant wipe. LPN #1 then placed it inside of a bag that had her name handwritten on the outside of the bag. On 10/13/22 at 08:46 AM, the surveyor interviewed LPN #1 who stated that she used her personal BP monitoring machine because the one for the unit was currently broken. She further stated it was reported but until the facility provide one, she would utilize her personal BP monitoring machine. On 10/13/22 at 11:54 AM, the surveyor interviewed Agency Licensed Practical Nurse (ALPN #2) on the [redacted] who stated the facility provided a BP monitoring machine which worked. He further stated there was "no need" to bring in his own BP machine. On 10/13/22 at 12:01 PM, the surveyor interviewed LPN #2 on the [redacted] who stated that she utilized the facility's BP machine which was provided because the standing tower vital signs machine was broken. LPN #2 also showed the surveyor a second BP machine she used for the residents on Transmission Based Precautions (TBP). She stated the standing tower BP machine had been broken for a few days but that the supervisors were aware. LPN #2 stated she never had to bring a personal BP machine to the	F 658	Administrator, Director of Nursing (DON) and Medical Director to include that only facility equipment should be used to assess vital signs for accuracy and infection control purposes. Completion date 11/4/22 b) Reeducation will be given to all nurses by Director of Nursing or designee on Following the Medical Doctor's orders with attention to parameters and obtaining required vital signs (V/S) prior to administration of medication. Additionally, nurses will be reeducated on using only facility equipment for obtaining vital signs and that person equipment cannot be used. Maintenance must be notified immediately if any equipment needs to be repaired or replaced. Completion date 11/17/22 IV: Quality Assurance a) Audits will be conducted for all residents on Blood Pressure medications with parameters weekly x 4 weeks, monthly x 2 months, then quarterly x 4 quarters. b) Random audits will be conducted by the nursing to observe what equipment is being used to obtain vital signs and ensure that all facility equipment is being used. This will be done weekly x 4. Monthly x 2 and then quarterly x3. c) All negative findings will be brought to the Director of Nursing (DON) and administrator immediately. d) The results of all audits of both personal equipment and ensuring blood pressure parameters are followed as per Medical doctor's orders will be brought to the Quality Assurance committee quarterly	

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F 658	Continued From page 57 facility because they provided one. She further stated the facility did not allow staff to bring in a personal BP machine. On 10/13/22 at 12:07 PM, the surveyor conducted a follow up interview with LPN #1 who stated she was unsure if she was allowed to bring in her personal BP machine. LPN #1 stated she brought in her personal BP machine because her residents needed their BP taken and the facility's machine was broken. She further stated that the facility should have provided a BP machine since the one for the first floor was broken. LPN #1 concluded she was unsure if other nurses brought in their own personal medical equipment, but she concluded she does. On 10/14/22 at 11:48 AM, the surveyor interviewed the US FOIA (b)(6) US FOIA (b)(6) who stated that the facility provided the medical equipment to the staff and that staff was not allowed to bring in their own. She stated staff should not use their personal BP machines because of infection control. She further stated there was a risk for cross contamination and that staff needed to follow the facility's policy and protocol. The US FOIA (b)(6) stated she was unsure if the policy addressed staff utilizing personal medical equipment. On 10/14/22 at 02:09 PM, Regional Nurse #2 provided the facility's policy regarding obtaining vital signs. Regional #2 stated she was unable to find a policy that specifically addressed staff utilizing personal medical equipment. On 10/17/22 at 11:30 AM, the US FOIA (b)(6) US FOIA (b)(6) stated the facility provided staff with medical equipment. She stated it was not	F 658	x 4 quarters. IV. Person responsible: Director of Nursing or designee	

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recommended for staff to bring in their personal medical equipment because, "we don't know if the equipment is accurate and working properly." The [US FOIA (b)(6)] stated that staff were informed not to bring in their own medical equipment and emphasized that staff should not have utilized their own personal medical equipment to obtain vital signs.

A review of the facility's policy, "Vital Signs," date reviewed 03/01/22, does not reflect staff utilizing their personal medical equipment.

b.) On 10/13/22 at 08:27 AM, the surveyor observed LPN #1 administer two (2) [Ex Orde] medications, *Ex Order 26. 4B1* [redacted] to Resident #268. LPN #1 then went back into the electronic Medication Administration Record (EMAR) to sign that the medications were administered to Resident #268. LPN #1 then grabbed her personal [Ex Orde] machine which was located on top of the medication cart to obtain Resident #268's *Ex Order 26. 4B1* which included the [Ex Orde].

On 10/13/22 at 08:28 AM, the surveyor observed LPN #1 obtain a [redacted] result of [redacted]

On 10/13/22 at 08:31 AM, the surveyor asked LPN #1 if it was the first time she checked the resident's [Ex Orde] today (10/13/22). LPN #1 confirmed that was the first time that she checked the resident's [Ex Orde] today. LPN #1 then proceed to document the resident's VS in the EMAR.

On 10/13/22 at 09:05 AM, the surveyor and LPN #1 reviewed the EMAR for Resident #268. LPN

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F 658	Continued From page 59 #1 stated that according to the physician's order (PO) on the EMAR, the [redacted] medications [redacted] and [redacted] had physician ordered parameters which included to hold the [redacted] medication for a [redacted] less than [redacted]. At that time, the surveyor interviewed LPN #1 who stated the [redacted] should be checked prior to administering the medication. She stated she thought she checked the resident's [redacted] prior to administering the medications but "could not recall". LPN #1 then confirmed the resident's [redacted] was [redacted] The surveyor continued to interview LPN #1 regarding the process for administering blood pressure medications. LPN #1 stated she should have held the [redacted] medications because of the ordered parameters indicated that the medication should be held for [redacted] less than [redacted] She stated if the [redacted] was less than [redacted], she should have rechecked the resident's [redacted] and if the [redacted] was greater than [redacted] and it was within the appropriate timeframe of one hour before or one hour after of the scheduled dose that she would administer the medication. LPN #1 further stated she would also inform the primary care physician (PCP). On 10/13/22 at 11:51 AM, LPN #1 stated after her interview with the surveyor, she immediately rechecked the resident's [redacted] and the result was [redacted]. She further stated that she monitored the resident for any adverse reactions and that the resident stated he/she was "okay". On 10/14/22 at 11:47 AM, the surveyor interviewed the [redacted] who stated staff should "never give medications prior to checking the BP". She further stated they checked the BP prior	F 658		

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F 658	Continued From page 60	F 658		

to administering medication because the medication could have parameters and the medication may have needed to be held.

On 10/17/22 at 11:28 AM, the US FOIA (b)(6) US FOIA (b)(6) stated the process for administering [redacted] medications was to first review the PO to check if there were parameters. The US FOIA (b)(6) stated staff should always follow the PO as it could be [redacted]" if staff were not administering the medication according to the PO. She further stated administering [redacted] medication prior to checking the [redacted] and administering the [redacted] medication without regards to the hold parameters was "not the proper practice and not safe". The US FOIA (b)(6) explained because it put the resident at risk for [redacted]) if the [redacted] was already low.

A review of the in-service 'Medication Administration" with regards to meds [medications] hold parameter dated 12/01/21 provided by the US FOIA (b)(6) revealed, "Review of medications with hold parameters and separation requirements of meds." A further review reflected LPN #1 was not in attendance as she was not employed as a nurse at that time.

A review of the Medication Pass Observation for LPN #1 conducted by the US FOIA (b)(6) US FOIA (b)(6) on 09/14/22, reflected LPN #1 obtained VS per policy before medications were administered.

A review of the facility's policy titled, " Medication Administration and Documentation" Policies, Procedures and information dated effective 7/1/22, reflected ... ."7. Monitors vital signs when appropriate prior to medication

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F 658	Continued From page 61 administration ...." A review of the facility's policy titled, " Blood Pressure Medication Administration" dated and reviewed 04/15/22, reflected ... ..."contact the physician/NP [nurse practitioner] when resident's blood pressure is outside the parameters set by the doctor of [or] if it is below a standard reading."	F 658		
F 688 SS=E	NJAC 8:39-27.1(a) Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other pertinent facility documents, it was determined that the facility failed to provide a [redacted] for a resident with decreased range of	F 688	I. Immediate Action a) Resident #63 was reassessed and determined to still need the [redacted] [redacted] Completion date 10/28/22	12/5/22

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F 688	Continued From page 62 [redacted] elated to a *Ex Order 26. 4B1* [redacted] in accordance with [redacted] recommendations and physician's orders. This deficient practice was identified for one (1) of two (2) residents reviewed for *Ex Order 26. 4B1* [redacted], (resident #63) and was evidenced by the following: On 10/06/22 at 11:06 AM, during the initial tour of the facility the surveyor observed Resident #63 lying in bed asleep. The resident's [redacted] was *Ex Order 26. 4B1* [redacted] and the resident did not wear any type of [redacted] to hold his/her [redacted] On 10/07/22 at 9:46 AM, Resident #63 was observed lying in bed asleep. The surveyor observed a *Ex Order 26. 4B1* that was hung on a hook on the outside of the resident's closet door and was not utilized by the resident at that time. On 10/11/22 at 9:57 AM, the surveyor observed Resident #63 lying in bed asleep. The resident did not have a *Ex Order 26. 4B1* on and the [redacted] was not observed within the resident's immediate surroundings. Review of the Resident Face Sheet revealed that Resident #63 was admitted to the facility in [redacted] with diagnoses which included but were not limited to: *Ex Order 26. 4B1* [redacted].	F 688	b) Resident #63 orders were revised on [redacted] at 6:35pm to read "Apply [redacted] to *Ex Order 26. 4B1* daily. Only to be removed during AM/PM care." This was designated to the TAR (treatment administration record) for the nurse to validate and sign that the device is being used. c) The Nursing instructions were reviewed to ensure that the [redacted] was indicated with the proper wearing schedule which is to be signed by the Certified Nursing Assistant (C.N.A.) that it is in use. Completion date 11/11/22 d) Certified Nursing Assistant (C.N.A.). #2 was reeducated on properly reading the Certified Nursing Assistant (C.N.A.) instructions to provide all adaptive equipment needed as per the wearing schedule. Completion date 10/12/22 II. Identification of others a) The facility respectfully submits that all residents with splints/braces etc. could potentially be affected. b) An audit was done for all residents with splints/braces/orthosis etc. to ensure that the device was ordered, in place, in nursing instructions, in care planned. Completion date 11/10/22 Any negative findings to be reported to the Director of Nursing (DON) and Administrator immediately. Immediate corrections to be made as needed. III. Systemic Changes a) The Policy and Procedure titled Splints and Devices was reviewed and revised by the Director of Therapy,	

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F 688	Continued From page 63 Review of the quarterly Minimum Data Set (MDS), an assessment to manage care dated [NJ Exec Order 26.4b1] revealed that Resident #63 was readmitted to the facility from an acute care hospital in [redacted] with a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted] which indicated that the resident was severly [Ex Order 26. 4B1] [redacted]. The assessment identified that the resident required [NJ Exec Order] dependence of one person for [NJ Exec Order 26.4b1] and [NJ Exec Orde] assistance of two persons for [NJ Exec Order 26.4b1] Further review of the MDS revealed that the resident had [Ex Order 26. 4B1] [redacted] in [NJ Exec Order 26.4b1] of both the [Ex Order 26. 4B1] [redacted]. Review of section O of the MDS revealed that the resident had not received any [NJ Exec Order 26.4b1] or [Ex Order 26. 4B1] application during the seven day look back record review period. Review of the Physician's Orders revealed a written order dated [redacted] which indicated, "Per [NJ Exec Order 26.4b1] please place order for [Ex Order 26. 4B1] [redacted]. Pt s/p (status post) [NJ Exec O] [redacted] and it is needed for [NJ Exec Order 26.4b1] [redacted]. On 10/12/22 at 11:08 AM, the surveyor interviewed Certified Nursing Assistant (CNA) #2 who stated that she was not assigned to the resident today, but had given report to the agency CNA who was assigned to the resident but who was not available for interview. CNA #2 stated that the resident's [NJ Exec Order 26] [redacted] were [Ex Order 26. 4B1] and the resident was unable to assist with [NJ Exec Order 26.4b1] when the resident was placed on the [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1] She stated that the resident did not have any [Ex Order 26. 4B1] to her knowledge. The resident's room mate who was present at that time, stated that the resident wore a [NJ Exec Order 26.4b1] on his/her [NJ Exec Order 26] when the staff assisted the resident to get out of bed into the	F 688	Administrator and Director of Nursing (DON) to include proper notification of the Director of Nursing (DON) if therapist observes non-compliance with wearing schedule for any device. Completion date 11/9/22 b) The Director of Rehab will provide education to all therapists ordering devices and Staff Education will provide education to all nurses and Certified Nursing Assistants (C.N.A.s) on the process for ordering and discontinuation of devices, updating and reading the Certified Nursing Assistant (C.N.A.) accountability record for guidance on these devices and what to do if something listed for the resident is not found, broken or resident refuses etc. Completion date 11/22/22 IV. Quality Assurance a) Audits will be conducted by therapy for all devices ordered to ensure the presence of an MD order with wearing schedule designated to Treatment Administration Record (TAR), documentation of therapy for need for the device with wearing schedule, education of nursing staff related to the device, the Certified Nursing Assistant (C.N.A.) instructions for the device, care plan update. b) Audits will be conducted weekly x 4 weeks, monthly x 2 months, then quarterly x 3 quarters. c) All negative findings will be brought to the attention of the administrator and Director of Nursing (DON) . d) Results of all audits will be brought to	

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F 688	Continued From page 64 chair. The room-mate further stated that the [NJ Exec Order 2] was kept in the top drawer of Resident #63's bureau. CNA #2 opened the drawer and thanked the room mate. She stated, "Here it is in the top drawer." On 10/12/22 at 11:14 AM, the [US FOIA (b)(6)] [US FOIA (b)(6)] came into Resident #63's room to assist CNA #2 to pull the resident up in the bed. When interviewed, she stated that the staff placed the [Ex Order 26.] on the resident when they got the resident out of bed. She further stated that she was unsure how the [Ex Order 26.] was ordered. The [US FOIA (b)(6)] then proceeded to review the order in the presence of the surveyor and stated that the palm guard should be worn by the resident at all times unless the resident received AM care. She stated that the order should have been on the Treatment Administration Record (TAR) to document resident usage. She further stated that she would put it on the resident now. On 10/13/22 at 10:58 AM, the surveyor interviewed the [US FOIA (b)(6)] who stated that Resident #63 was expected to wear his/her [Ex Order 26.] as ordered. The [US FOIA (b)(6)] stated that the resident could have *Ex Order 26. 4B1* if the [Ex Order 26.] was not maintained as ordered. The [US FOIA (b)(6)] stated that the [Ex Order 26. 4B1] should have been monitored every shift for usage. The [US FOIA (b)(6)] further stated that the nurse on the unit was responsible to ensure that the [Ex Order 26. 4B1] or supportive devices that were ordered were in use. On 10/13/22 at 12:59 PM, the surveyor interviewed the [US FOIA (b)(6)] who stated that she had to tell the agency aides to put Resident #63's [Ex Order 26. 4B1] on. The [US FOIA (b)] stated that	F 688	the Quality Assurance committee meeting quarterly for 4 quarters. V. Person responsible: Director of Rehabilitation or designee	

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F 688	Continued From page 65	F 688		

when she observed the resident without the [Ex Order 26.] on in-services were provided to the staff. The [US FOIA (b)] provided the surveyor with an In-Service form dated 10/4/22 which specified that the resident required a [Ex Order 26.] at all times except with AM/PM care and also required range of motion exercises to the left elbow. The [US FOIA (b)] did not provide any additional in-services to substantiate that she observed Resident #63 without the [Ex Order 26. 4B] on more than one occasion as previously described.

On 10/14/22 at 10:13 AM, the surveyor observed Resident #63 lying in bed without a [Ex Order 26.] on his/her right hand as required.

On 10/18/22 at 12:10 PM, the [US FOIA (b)(6)] [US FOIA (b)(6)] stated that [US FOIA] was responsible to obtain physician orders for [Ex Order 26.] usage and educate the nursing staff on use. He further stated that it was then up to to nursing to ensure that it was being properly used. The [US FOIA (b)(6)] further stated that that the [US FOIA (b)(6)] would then be responsible at that point. The [US FOIA (b)(6)] who was present, stated that nursing should have been aware that Resident #63 required a [Ex Order 26. 4B1] and ensured that it was utililized. The [US FOIA (b)(6)] stated that [US FOIA] should have sent an e-mail to to the [US FOIA (b)(6)] and [US FOIA (b)(6)] to inform them that the nursing staff was non-compliant. The [US FOIA (b)(6)] further stated that the order must be on the TAR in order to document usage.

On 10/19/22 at 8:48 AM, the surveyor interviewed the [US FOIA (b)(6)] who stated that Resident #63's [Ex Order 26.] order was noted on [NJ Exec Order 26.4B1]. The [US FOIA (b)(6)] stated that she found out on 10/18/22 that the way the [US FOIA] placed the order in the electronic health record, it was not visible to the nursing staff on the TAR for signage. The [US FOIA (b)(6)]

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F 688	Continued From page 66 acknowledged that the resident was on [NJ Exec Order 26.4b1] services prior to [NJ Exec Order 26.4b1] and the [Ex Order 26.] should have been utilized prior to the new order being written on [NJ Exec Order 26.4b1] The [US FOIA (b)(6)] confirmed that the order was improperly transcribed by the nurse who reviewed the order. On 10/19/22 at 10:54 AM, the surveyor interviewed the [US FOIA (b)(6)] who stated that Resident #63 was issued a [Ex Order 26.] in [NJ Exec Order 26.4b1] when the company took over from the previous [NJ Exec Order 26.4b1] provider. The [US FOIA] stated that she did not note any [Ex Order 26.] or [Ex Order 26. 4B1] in the resident's [NJ Exec Order 26.4b1] as a result of the resident not wearing the [Ex Order 26.] as directed by [NJ Exec Order 26.4b1] Review of the Care Plan Activity Report (CPAR) provided on [NJ Exec Order 26.4b1] from the Electronic Health Record (EHR), revealed an entry dated [NJ Exec Order 26.4b1] which indicated that the focus of the entry was for ADL (activities of daily living) Functional/Rehab Potential and etiology of transfers was [NJ Exec Order 26.4b1] Further review of the CPAR illustrated that the goal of the entry was: "I will have all my needs anticipated and my ADLS will be provided to me, wear [Ex Order 26. 4B1] on right hand at all times except AM/PM care as tolerated." On 10/19/22 at 9:58 AM, the [US FOIA (b)(6)] provided the surveyor with a hand written Interdisciplinary Care Plan (ICP) which contained an entry dated [NJ Exec Order 26.4b1], which indicated that Resident #63 would continue to wear his/her *Ex Order 26. 4B1* [Ex Order 26.] at all times except for AM and PM care as tolerated. Staff educated on [Ex Order 26.] application. The evaluation included that the resident's *Ex Order 26. 4B1* on the [NJ Exec Order 26.4b1] would not worsen in the next 90 days.	F 688		

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F 688	Continued From page 67 On 10/19/22 at 12:30 PM, the DON provided the surveyor with a Physician's Order Sheet from the EHR which contained the following orders: On NJ Exec Order 26.4b1 an order was placed by the US FOIA (b)(6) for [redacted] every day at 11:00 PM-7:00 AM, 3:00 PM-11:00 PM, and 7:00 AM-3:00 PM. A second entry and interim order was entered on 10/04/22 at 6:12 PM by US FOIA (b) for: Resident to wear Ex Order 26. 4B1 Ex Order 26. 4B1, at all times except AM and PM care, as tolerated. Lastly, a third interim order was placed by the US FOIA (b)(6) on NJ Exec Order 26.4b1 at 6:38 PM for the following Treatment: Apply Ex Order 26. to Ex Order 26. 4B1 daily. Only to be removed fro AM and PM Care... On 10/19/22 at 12:30 PM, the US FOIA (b)(6) provided the surveyor with the TAR which revealed an entry dated NJ Exec Order 26.4b1 at 6:36 PM, was placed for nursing to document that Resident #63 received the following treatment: Apply Ex Order 26. to Ex Order 26. 4B1 daily. Only to be removed for AM and PM Care. Start Date: NJ Exec Order 26.4b1 at 6:36 PM. The entry was only signed out for the 3:00 P-11:00 P and 11:00 P-7:00 A shifts on 10/18/22. Review of an Occupational Discharge Summary (ODS) dated NJ Exec Order 26.4b1 indicated that Resident #63 received NJ Exec Order 26.4b1 services from NJ Exec Order 26.4b1 Summary since last progress report section of the ODS revealed that Caregivers were educated on NJ Exec Order 26.4b1 management in order to reduce Ex Order 26. 4B1 and NJ Exec Order 26.4b1 for safe functional task participation. Discharge recommendations included: Functional maintenance program recommended in order to reduce Ex Order 26. 4B1 NJ Exec Order 26.4b1 and promote NJ Exec Order 26.4b1 for increased task participation. The facility failed	F 688		

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F 688	Continued From page 68 to provide the surveyor with any documented evidence that the [redacted] was utilized as directed by [redacted] services prior to NJ Exec Order 26.4b1 Review of the facility policy titled, "Splints and Devices Policy) (Reviewed 08/17/22) revealed the following: Policy: All...Splints/orthoses/prostheses that are issued by the Rehabilitation Dept. will be issued after the therapist assesses the resident and recommends the appropriate device. Procedure: 1. The issuing therapist will recommend a wearing schedule for the device 2. Orders will be obtained from the MD/NP for the wearing schedule. 3. The issuing therapist will document in the EMR-an interdisciplinary note detailing the recommended resident's wearing schedule of the device....5. The Nursing department will take responsibility for daily applications/removal of device and Nurse Manager will be responsible to ensure that the information is entered in the CNA Accountability record...	F 688		
F 698 SS=E	NJAC 8:39-27.2(m) 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, record review and review of other facility documentation, it was	F 698	I. Immediate Action a) Resident #116- physician's orders	12/5/22

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F 698	Continued From page 69 determined that the facility failed to a.) identify and monitor the [redacted] b.) consistently maintain ongoing complete communication notes between the facility and the [redacted] center and, c.) follow physician ordered *Ex Order 26. 4B1*, and d.) update the care plan to include the [redacted] for one (1) of one (1) resident (Resident #116) reviewed for [redacted] and was evidenced by the following: On 10/06/22 at 10:27 AM during tour, Resident # 116 was observed in bed. The resident stated that he/she goes to [redacted] and his/her [redacted] was in the [redacted]. The resident could not explain to surveyor what days he/she went to [redacted], what time he/she went or what the name of the [redacted] center was. The resident was not a [redacted] and could not be interviewed regarding a [redacted] The surveyor did not observe any liquids or cups at the resident's bedside. The resident Face Sheet (FS) indicated that Resident # 116 was admitted to the facility with the diagnoses that included but was not limited to *Ex Order 26. 4B1* and [redacted] The admission Minimum Data Set (MDS) and assessment tool dated [redacted] indicated that Resident # 116 required extensive assistance with activities of daily living. The MDS also reflected that the resident had severe [redacted], exhibited no behaviors, and received *Ex Order 26. 4B1* [redacted] On 10/07/22 09:10 AM, the surveyor interviewed	F 698	were obtained to identify and monitor the [redacted] site. Completion date 10/15/22 b) The resident's orders for [redacted] were amended to designate Medication Administration Record (MAR) for recording of *Ex Order 26. 4B1* each shift by nursing. Completion date 10/14/22 c) Resident #116-*Ex Order 26. 4B1* plan was updated to include *Ex Order 26. 4B1*, identify site of [redacted] and monitoring the [redacted] site. Completion date 10/18/22 d) A communication book has been provided for resident #116 to communicate with the [redacted] center. Nurses will be required to sign off after each treatment that the book has been reviewed. Completion date 10/18/22 e) Resident #116 care plan for [redacted] was initiated on 10/10/22 f) The facility contacted the [redacted] Center and reviewed all pertinent information about resident #116 to ensure that resident's history and current status is communicated properly. In return the [redacted] center updated the facility on the resident's status at [redacted]. II. Identification of others; All residents have the potential to be affected. a) An audit was done on 10/15/22 for all residents on [redacted] to ensure that there are orders for identification and monitoring of [redacted] site, [redacted] care plan reflects *Ex Order 26. 4B1* and monitoring of site (identified) and a communication book is in place for each resident to ensure effective communication signed off each treatment day by the nurse. [redacted]	

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F 698	Continued From page 70 the Certified Nursing Assistant (CNA #1) who stated that she was employed for the facility for [redacted] She stated that Resident # 116 was *Ex Order 26. 4B1* , however could express basic needs such as hunger, thirst, pain or if needed toileting. She stated that the resident was *Ex Order 26. 4B1* [redacted] of bladder and bowel and required of one (1) staff member for total care with all aspects of activities of daily living (ADLs). She stated that the resident could NJ Exec Order 26.4b1 after setting up of food tray. She stated that the resident was on [redacted] but not on a *Ex Order 26. 4B1* and explained to the surveyor that she was never told by the nurses that the resident was on *Ex Order 26. 4B1*. She then added that the resident went to the [redacted] center on Monday, Wednesday, and Friday at 10:30 AM and returned around 2:30 PM. She stated that the resident had a [redacted] on the NJ Exec Order 26.4b1 where he/she received [redacted] On 10/07.22 at 09:15 AM, the surveyor reviewed the Medication Administration Record (MAR) and Treatment Administration Record (TAR) and there was no documentation that the resident was on a [redacted] or that the nurses were following the physician orders for a NJ Exec Order 26.4b1 On 10/07/22 09:35 AM, the surveyor interviewed the License Practical Nurse (LPN #1) who provided care for Resident # 116 today (10/07/22). LPN #1 stated that she had been employed at the facility for [redacted] however has only been an LPN in the facility for [redacted] and [redacted] She stated that Resident # 116 went to [redacted] three (3) times a week on Monday, Wednesday, and Friday and that the	F 698	*Ex Order 26. 4B1* are followed and documented by the nurse each shift. III. Systemic Changes a) The Policy and Procedure titled Hemodialysis was reviewed and revised by the Administrator and Director of Nursing to include requirements for orders for fluid restriction to be designated to the Electronic Medication Administration Record with clinical monitor of intake q shift. Additionally, nurses will provide all dialysis residents with a communication book to be sent with patient to and from dialysis. The nurse must now sign off that all communication has been reviewed and carried out as needed. Completion Date: 11/7/22 b) The Policy and Procedure entitled Fluid Restriction was reviewed and revised by the Administrator, Director of Nursing (DON) and Registered Dietician to include entering a Request for orders for fluid restriction in EMR. Completion date 11/7/22 c) An order template for patients on dialysis to be updated to include all the above. Completion date 11/15/22 d) The Contract between the [redacted] Center and the Facility was reviewed and revised to include that written communication between the [redacted] center and facility must be reviewed by both parties before and after [redacted] sessions. Nurses will be required to sign off and acknowledge the communication. e) Education will be provided to all nurses, physicians, Nurse practitioners (NPs) and Physician Assistants (PAs)	

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F 698	Continued From page 71 resident was transported to [NJ Exec Order 26.4b1] at 10:30 AM and the chair time at the [Ex Order 26. 4B1] center was at 11:30 AM. She stated that the resident was given a communication form to take to the [Ex Order 26. 4B1] center. She explained that the form was utilized for communication between the [Ex Order 26. 4B1] center and the facility. She stated that she would complete the [Ex Order 26. 4B1] section of the form which included, [Ex Order 26. 4B1], what the resident ate, if the resident was compliant with medications and if the [Ex Order 26. 4B1] [NJ Exec Order 26.4b1] She stated that the [Ex Order 26. 4B1] center filled out their section on the form and when the resident returned to the facility, the nurse would fill out the [Ex Order 26. 4B1] section area of the communication form. She confirmed that it was important to complete the form in its entirety because it was a communication tool used between the facility and [Ex Order 26. 4B1] center regarding residents status. LPN #1 reviewed Resident #116's [Ex Order 26. 4B1] communication forms with the surveyor, and she confirmed that the form was not always completed by the facility nurse [Ex Order 26. 4B1]. The LPN stated that she monitored the resident's [Ex Order 26. 4B1] access site on her shift but could not speak to what the other nurses monitor on their shifts. She added that the only place that there was documentation regarding the [Ex Order 26. 4B1] access site was on the [Ex Order 26. 4B1] communication form. She stated that there should be a physician's order of what type of [NJ Exec Order 26.4b1] the resident what was required for monitoring such as [Ex Order 26. 4B1] or signs and symptoms of infection. LPN #1 also stated that the resident was not on a [Ex Order 26. 4B1]. LPN #1 reviewed the physician orders and the MAR and TAR with the surveyor and confirmed that there was not an order to monitor the [Ex Order 26. 4B1] [NJ Exec Order 26.4b1] and confirmed that there was not an	F 698	about required orders for resident on dialysis, care planning, fluid restrictions and updating of Certified Nursing Assistant (C.N.A.) accountability to reflect same. An order set will be provided in the EMR to ensure consistency. Completion date 11/17/22 f) Education will be provided for all Certified Nursing Assistant (C.N.A.) and nurses about monitoring resident's intake while on fluid restriction. Certified Nursing Assistant (C.N.A.) should notify the nurse about resident's non-compliance with fluid restriction if applicable. Completion date 11/17/22 IV. Quality Assurance a) An audit of all residents on dialysis will be done by Nurse manager/supervisors to ensure all orders are complete and followed. b) Audits will be done weekly x 4 weeks, monthly x 2 months, then quarterly x 3 quarters. c) All negative findings will be brought to the Director of Nursing (DON) and Administrator immediately. d) The results of all audits will be brought to the Quality Assurance committee quarterly x 4. V. Person Responsible: Director of Nursing (DON) or designee	

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F 698	Continued From page 72 order on the MAR for the resident to be on a [NJ Exec Order 26.4b1]. She stated that the nurses should be signing out in the MAR that they were adhering to the resident's fluid restriction that was ordered by the physician. The Physician Order Sheet (POS) dated [NJ Exec Order 26.4b1] at 03:10 PM, reflected a physician's order for Resident #116 to go to the [Ex Order 26. 4B1] center on Monday, Wednesday, and Friday at 7:00 AM to 3:00 PM. Pick up was at 10:30 AM and chair time for [Ex Order 26. 4B1] was at 11:30 AM. The POS dated [NJ Exec Order 26.4b1] at 03:10 PM, reflected a physician's order for the resident to be on a [Ex Order 2] *Ex Order 26. 4B1* total volume as follows: Dietary: *Ex Order 26. 4B1* (24-hour total volume) Nursing: [Ex Order 26. 4B1] (24-hour total volume) -On the 7:00 AM-3:00 PM shift the resident was ordered to only have [Ex Order 26. 4B1] during the shift. -On the 3:00 PM-11:00 PM shift the resident was ordered to have [Ex Order 26. 4B1] during the shift. -On the 11:00 PM-7:00 AM shift the resident was ordered to have [Ex Order 26. 4B1] during the shift. During review of the POS the surveyor could not find physician orders in medical record regarding Resident # 116's location of [Ex Order 26. 4B1] access site or [Ex Order 26. 4B1] [NJ Exec O] monitoring. On 10/07/22 at 10:00 AM, the surveyor interviewed US FOIA (b)(6) US FOIA (b)(6) for the [NJ Exec] floor who explained the [Ex Order 26. 4B1] process to the surveyor. She stated that [Ex Order 26. 4B1] should be set up for the resident prior to admission to the facility as well as transportation. She stated that the [Ex Order 26. 4B1] access site should be identified and monitored every shift	F 698		

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F 698	Continued From page 73	F 698		

for functioning, Ex Order 26. 4B1 and signs and symptoms of infection. She confirmed that Ex Order 26. 4B1 NJ Exec Order 26.4b NJ Exec Orde monitoring should be documented on the TAR and signed out by the nurses that it was completed. She then explained to the surveyor that if a resident was on a *Ex Order 26. 4B1* there would be an order on the POS explaining the "breakdown of amounts" provided for each shift between nursing and dietary and that would be documented on the MAR. She stated that it would be important to make sure that the *Ex Order 26. 4B1* was adhered to because you would want to make sure the resident did not develop a *Ex Order 26. 4B1* [redacted] She explained that the Ex Order 26. 4B1 communication form was a form utilized to communicate between the facility and Ex Order 26. 4B1 center. She stated that all sections of the Ex Order 26. 4B1 communication sheet was to be completed to assure the resident was getting the proper Ex Order 26. 4B1 care and to facilitate care for the resident. The LPN/UM confirmed that the nurses were not completing the *Ex Order 26. 4B1* section of the Ex Order 26. 4B1 communication form and that it should be completed after the resident returned from Ex Order 26. 4B1 to assure that the resident was stable.

On 10/07/22 10:15 AM, the surveyor interviewed the US FOIA (b)(6) [redacted] who stated that she had been employed in the facility since NJ Exec Order 26. The US FOIA (b)(6) stated that the facility process for residents receiving NJ Exec Order 26.4b1 would include the following:
1.) Prior to admission to the facility arrangements would be made for time and days the resident would receive dialysis, facility that the resident would receive dialysis, transportation to dialysis and obtain a schedule for dialysis.

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F 698	Continued From page 74 2.) A physician's order was required for the resident to receive dialysis. 3.) Dialysis communication book and communication forms were required to be completed and that there were three sections to be completed: pre-dialysis section, a section that the facility completed and then a post dialysis that the facility completed. She stated that the importance of the communication form was so that the resident received quality of care and necessary services and that the resident needed and that the resident remained stable going to the center and returning from the dialysis center. 4.) Access site: the nurse was to assess the site every shift and immediately following dialysis. Dialysis access site identification and monitoring requires a physician's order, and the nurses were required to document that they performed the monitoring on the Treatment Administration record. 5.) Diet should be ordered, and any fluid restriction should be ordered by the physician and followed be the dietary department and the nursing department to assure that the resident received the proper amounts of fluids. The nurses should be signing out the TAR that they followed the resident's fluid restriction. The DON confirmed that the nurses were not following the physician ordered fluid restrictions because there was no documentation that they were doing it. On 10/07/22 at 10:51 AM, the surveyor interviewed the US FOIA (b)(6) US FOIA (b)(6), who was covering for the facility's US FOIA (b)(6) who was not in the facility at this time. She stated that when the nurse obtained a dietary order, the order was put into the electronic medical record (EMR) which linked to meal tracker and produced	F 698		

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F 698	Continued From page 75	F 698		

a resident's food ticket. She stated that the [US FOIA (b)(6)] was notified by meal tracker and that the food ticket was printed and put on the tray line. She stated that the dietary staff then scan the ticket and the meal was prepared. She stated that fluid restrictions orders were written on the meal ticket.

On 10/07/22 at 10:55 AM, the surveyor interviewed the [US FOIA (b)(6)] who reviewed Resident # 116's physician orders and [Ex Order 26. 4B1] communication sheets with the surveyor and confirmed that the *Ex Order 26. 4B1* section of the [Ex Order 26. 4B1] communication form was not being completed and that there were not physician orders to indicate where the resident's [Ex Order 26. 4B1] [NJ Exec Order 26.4b1] location was or that the [NJ Exec Order 26.4b1] was being monitored. The [US FOIA (b)(6)] stated that the communication sheets were the communication tool used for communication between the [Ex Order 26. 4B1] center and the facility and that all sections were to be completed *Ex Order 26. 4B1*, at the [Ex Order 26. 4B1] center and *Ex Order 26. 4B1*. She stated the nurse were responsible to assure completion of these sheets. The surveyor showed the incomplete communication sheets to the [US FOIA (b)(6)] and she confirmed that the [Ex Order 26. 4B1] communication sheets were not consistently filled out correctly and added that there were many [Ex Order 26. 4B1] communication sheets missing from the resident's [Ex Order 26. 4B1] communication book. The [US FOIA (b)(6)] then added the [Ex Order 26. 4B1] [NJ Exec Order 26.4b1] should be monitored every shift for *Ex Order 26. 4B1* [redacted], signs and symptoms of [NJ Exec Order 26.4b1] She stated that it was important to assure that the [Ex Order 26. 4B1] access site was being monitored. The surveyor questioned the [US FOIA (b)(6)] regarding the physician's order that indicated that Resident #116 was on a [Ex Order 2] [redacted] and why the [US FOIA (b)(6)] caring for

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F 698	Continued From page 76	F 698		

the resident did not know that the resident was on a Ex Order 26. 4B1. She stated that the nurse should have known that the resident was on a Ex Order 26. 4B1 because she was responsible to review the residents medical record and should know what care was to be provided to the resident. She stated that the Ex Order 26. 4B1 should have been written on the MAR and that the nurses should be signing the MAR which would have indicated that they were following the resident's Ex Order 26. 4B1.

On 10/07/22 at 11:41, the US FOIA (b)(6) US FOIA (b)(6) provided the surveyor with Resident #116's meal ticket that indicated that dietary was providing the correct Ex Order 26. 4B1 of Ex Order 26. 4B1 and according to the "Resident Profile Detail (RPD)" the Ex Order 26. 4B1 for dietary of Ex Order 26. 4B1 was ordered on NJ Exec Order 26.4b1 and documented on the RPD on NJ Exec Order 26.4b1 The US FOIA (b)(6) was interviewed at this time and stated that the US FOIA (b)(6) ordered the recommended Ex Order 26. 4B1 and inserted the information onto the meal ticket. The US FOIA (b)(6) stated that she was not sure what the process was for the "nursing" part of the Ex Order 26. 4B1 order.

On 10/07/22 12:16 PM, the surveyor interviewed the US FOIA (b)(6) for 1st floor who stated that the Care Plan (CP) that was being utilized was in the EMR and that they were not using paper written care plans. She stated that Resident #116 confirmed that Resident #16 should have had a care plan initiated for Ex Order 26. 4B1 and Ex Order 26. 4B1 NJ Exec Order 26. NJ Exec monitoring, however, could not locate that information on the resident's CP.

On 10/11/22 at 01:16 PM, the surveyor interviewed the facility US FOIA (b)(6) who stated that she worked "part time" which was

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F 698	Continued From page 77 approximately NJ Exec Order 26.4b1 n the facility. She stated that she recommended a *Ex Order 26. 4B1* for Resident #116 and added it into the meal tracker program and EMR. She stated that any recommendations she had for residents were filled out on a recommendation form or she sent an email to the nurses and the US FOIA (b)(6) so that the recommendations would be put in the EMR as an order. She added that if she was in the facility, she would completed a recommendation form and she was working off-site she would have emailed the facility with her recommendations. She stated that the nurses were responsible to put the recommendation in the EMR so that the physician order would populate onto the MAR or the TAR. The US FOIA stated that the only way she would know if a recommendation was not followed was when she reviewed the resident again which was usually quarterly and monthly for residents with Ex Order 26.4B1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 and NJ Exec Order 26.4 residents. The explained that she recommended a *Ex Order 26. 4B1* for Resident # 116 because the resident was on Ex Order 26. 4B1 and does not want the resident to have *Ex Order 26. 4B1* , or *Ex Order 26. 4B1*. She stated that if the nurses did not follow the *Ex Order 26. 4B1* recommendations it could cause the resident to experience edema or *Ex Order 26. 4B1* which is detrimental to the resident. The US FOIA (b)(6) reviewed the residents medical record and stated that Resident #116 NJ Exec Order 26.4b1 effects from nursing not adhering to recommended *Ex Order 26. 4B1* from NJ Exec Order 26.4b1 and that the resident was NJ Exec Order 2 at *Ex Order 26. 4B1* . On 10/18/22 at 12:08 PM, the surveyor interviewed the US FOIA (b)(6) who stated that the communication forms that were provided to the	F 698		

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F 698	Continued From page 78 surveyor were the only communication forms that facility had and that they did not have a Ex Order 26. 4B1 contract with any Ex Order 26. 4B1 facility. The US FOIA (b)(6) US FOIA (b)(6) also confirmed that he could not find any contract with a Ex Order 26. 4B1 center. The facility policy titled, "Hemodialysis" and dated 04/06/22, indicated that it was the policy of the facility to assess and develop a care plan to meet the special clinical and emotional needs f resident receiving dialysis. Responsibilities include the following: -Provide a notebook to be used as a communication book between the dialysis center and the center. -If shunt or fistula is mature, assesses bruit and thrill every shift and document the same on the treatment record. -Upon return from dialysis reviews the communication book for any orders, concerns etc. From the dialysis center. -Upon return for dialysis, monitor access site for signs and symptoms of bleeding or infection. -Notified Medical Doctor (MD) or Nurse Practitioner (NP) all items requiring review and obtains orders as appropriate. - Notes and carries out orders as appropriate and notified all disciplines as needed. -Maintains effective communication between the dialysis center and the facility. The facility policy titled, "Fluid Restrictions" dated 11/07/22 indicated that it was the facility policy to maintain fluid restrictions as per Medical Doctor (MD) or Nurse Practitioner (NP) order and an accordance with the recommendations from nephrology or dialysis. The procedure is as follows:	F 698		

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F 698	Continued From page 79 -The Dietician communicates with nursing and dietary and inform both departments of their respective daily allotted fluid amounts. -Educate nursing staff on fluid restrictions and the total amounts allotted for each medication pass. -Utilizing the fluid restriction order set, and place the order for fluids to be given, including fluid breakdown. -Nursing to review fluids consumed during medication pass. -Document fluid restrictions and updates the CP. NJAC 8:39-27.1(a)	F 698		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.	F 756		12/5/22

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F 756	Continued From page 80 (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, and review of other pertinent facility documentation, it was determined that the facility to respond to comments and recommendations made by the Consultant Pharmacist (CP) in a timely manner. This deficient practice was identified for one (1) of five (5) residents reviewed for unnecessary medications, (Resident #57) and was evidenced by the following: On 10/07/22 at 11:30 AM, the surveyor reviewed the Electronic Health Record (EHR) of Resident #57 which failed to contain specific CP recommendations. The surveyor requested to view the CP reviews and recommendations that were provided to the facility. The surveyor received and reviewed Resident #57's CP "Summary Report" which revealed that the CP made a recommendation directed to Nursing on 01/25/22, 02/09/22, 03/15/22, and 04/25/22 to "separate [redacted] from [redacted] by two	F 756	I. Immediate Action a) Resident #57 Medication plotting was revised to ensure that [redacted] and [redacted] orders were scheduled at least 2-hour apart. [redacted] was changed to 5pm while [redacted] was ordered for 11am. Completion date 10/14/22 b) The consultant pharmacist was contacted to send all recommendations for this resident for the last 6 months to ensure that all issues have been addressed. Completion date 10/14/22 II. Identification of others a) The facility respectfully submits that all residents are potentially affected. b) An audit was done on 10/14/22 of all recommendations from the pharmacy consult over the past 3 months to ensure that all issues have been addressed. c) The pharmacy consultant was contacted to send any recommendations	

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F 756	Continued From page 81 hours as *Ex Order 26. 4B1* should not be given at the same time as [redacted] or it will reduce the absorption. When replotting, please make sure [redacted] is plotted at meal times." Further review of the "Summary Report" revealed that on [redacted] the CP made the following recommendation directed to Administration: "Recommendation repeated for the 6th time please address: Nursing: Separate [redacted] from [redacted] by 2 hours. *Ex Order 26. 4B1* should not be given at the same time as [redacted] as [redacted] is as they will reduce absorption. When replotting, please make sure [redacted] is plotted at meal times." The same recommendation was made to Nursing again on [redacted] A review of Resident #57's Resident Face Sheet revealed that the resident was admitted to the facility with diagnoses which included but were not limited to: *Ex Order 26. 4B1* [redacted] On 10/12/22 at 11:31 AM, the surveyor interviewed the [redacted] who stated that the CP notified the [redacted] of any CP recommendations and then nursing was informed . The [redacted] was unable to provide the surveyor with documented evidence that she reviewed the monthly CP recommendations that were made on behalf of Resident #57 or that the resident's physician was informed of the recommendations. The [redacted] stated that she had a book where she maintained resident	F 756	that have not been addressed in the last 3 months to the Director of Nursing (DON) for review and correct. Completion date 10/14/22 III. System Changes a) The Policy and Procedure on Pharmacy Drug Regimen Reviews were reviewed and revised by the Administrator, Director of Nursing and Medical Director to change method of addressing pharmacy recommendations and physician' s role in addressing the recommendations including changes with Electronic Medical Record (EMR). All clinical providers will be given a copy of the recommendations by the Director of nursing or designee to be returned within 7 days. The Medical Director will be notified of all outstanding recommendations for follow up to ensure compliance within 7-14 days. This will also include retaining of recommendations by the facility since it is considered part of the medical record. Completion Date 11/18/22 b) Education will be given by the Medical Director to all providers (Physicians, Nurse practitioners (NP), Physician Assistants (PA)) about their responsibility in addressing recommendations. Completion date 11/18/22 c) All nurses will be in serviced by the Director of Nursing or designee on their role in ensuring that issues are addressed within 7-14 days by the clinical provider. Completion date 11/18/22 IV: Quality Assurance	

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BELLE CARE NURSING AND REHABILITATION CENTER	439 BELLEVUE AVENUE TRENTON, NJ 08618

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F 756	Continued From page 82 records of the CP recommendations and related interventions and someone from Corporate threw the book away when the new computer system was recently implemented. The [US FOIA (b)(6)] further stated that she changed the time for [Ex Order 26. 4B1] administration to 12 Noon. The surveyor reviewed Resident #57's Medication Administration Record (MAR) in the presence of the [US FOIA (b)(6)] which revealed that the [Ex Order 26. 4B1] was ordered at 5:00 PM and the [Ex Order 2] was ordered at 11 AM. The [US FOIA (b)(6)] stated at one point she changed the [Ex Order 26. 4B1] administration time to noon and when the computer system was implemented the administration times were changed. The [US FOIA (b)(6)] stated that she did not know why the CP made six separate recommendations to change the aforementioned medications times because, "when the [US FOIA (b)(6)] informed her of CP recommendations, she got it done." On 10/13/22 at 11:26 AM, the surveyor interviewed the [US FOIA (b)(6)] who stated that the CP completed resident medications assessments, wrote recommendations, then sent the recommendations to the [US FOIA (b)(6)] [US FOIA (b)(6)] [US FOIA (b)(6)]. The [US FOIA (b)(6)] stated that the [US FOIA (b)(6)] did not have e-mail access, so the copies of the CP recommendations were brought to the unit and the [US FOIA (b)(6)] reviewed the recommendations with the Unit Managers and the physician was notified. The [US FOIA (b)(6)] stated that in the morning meeting there was an opportunity to discuss the CP recommendations as a team. The [US FOIA (b)(6)] stated that once reviewed, the physician was notified of required changes. The [US FOIA (b)(6)] stated that the CP recommendations were initialed once reviewed	F 756	a) An audit of all recommendations received after 11/1/22 will be done to ensure that if Medical Doctor agreed, changes were made but if he/she disagrees, the appropriate documentation is provided as to why he/she disagreed. b) Audits will be performed by the Director of Nursing or designee weekly x 4 weeks, monthly x 2, then quarterly x 3 quarters. c) All negative findings will be brought to the Administrator and Director of Nursing immediately. d) The results of all audits will be brought to the Quality Assurance committee quarterly x 4. IV. Person Responsible: Director of Nursing (DON) or designee and Medical Director	

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F 756	Continued From page 83	F 756		

and the information was sent to the primary physician. The [US FOIA (b)(6)] stated that as of 09/16/22, the facility implemented a new computer system. The [US FOIA (b)(6)] further stated that she did not recall that the CP had made six or seven requests to change Resident #57's medication administration times related to both [Ex Order 26. 4B1] and [Ex Order 2] administration.

On 10/14/22 at 8:49 AM, the surveyor conducted a phone interview with the [US FOIA (b)] via Speakerphone in the presence of the survey team. The [US FOIA (b)] stated that when he made a recommendation and repeated it, he then sent the recommendations to the US FOIA (b)(6) The [US FOIA (b)] stated that in [NJ Exec Order 26.4b1] the failure to change Resident #57's medications times may have been related to the implementation of the new computer system. He further stated that in previous months the failure to change the medication times may have been due to noncompliance. The [US FOIA (b)] stated that he addressed the failure to change the medication administration times on [NJ Exec Order 26.4b1], it was at that point the facility addressed the repeated requests. The [US FOIA (b)] stated that he documented that nursing was notified because it was a repeated recommendation.

On 10/18/22 at 12:21 PM, the surveyor interviewed the [US FOIA (b)(6)] who stated that the facility required that audits be done once the [US FOIA (b)] brought repeat recommendations to his attention. The [US FOIA (b)(6)] who was present at that time, stated that she did not conduct an audit. The [US FOIA (b)(6)] stated that an audit was necessary to do due to change in personnel. The [US FOIA (b)(6)] stated that he also followed up on the [US FOIA (b)] recommendations so there should have been two different audits or

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F 756	Continued From page 84 weigh-ins. The [US FOIA (b)(6)] stated that the [US FOIA (b)(6)] records should not have been destroyed by Corporate as they could be needed. The [US FOIA (b)(6)] stated that record destruction should not have occurred with the implementation of the new computer system. The [US FOIA (b)(6)] further stated that the [US FOIA (b)(6)] was also copied on the [US FOIA] recommendations and had not questioned any of the recommendations recently. On 10/18/22 at 1:52 PM, the surveyor phoned the [US FOIA] in the presence of the survey team. The [US FOIA (b)] stated that he had served in the [NJ Exec Order 26.4b1]. The [US FOIA (b)(6)] stated that he did not receive [US FOIA] recommendations for this facility. The [US FOIA] stated that the [US FOIA] recommendation to separate the administration of both [Ex Order 26. 4B1] and [Ex Order] was of minor significance as it could make a precipitation of the [Ex Order 26. 4B1] and became more thick when mixed with [Ex Order] and definitely posed an issue with [NJ Exec Order 26.4b1] because there was competition in the A review of the facility policy titled, "Pharmacy Consultant Services" (Reviewed 04/05/22) revealed the following: Purpose: To ensure that all medications and pharmacy services are in compliance with NJ Department of Health Guidelines and provide direction to physicians, NP and nurses when irregularities are noted. Pharmacy Consultant Duties: ...If irregularities are noted, communicates suggestion for physician to assist to the DON and cc. to DON and the Medical Director including a coversheet indicating who has irregularities noted to ensure all information has been received. The attending physician must document in the resident's medical record that the identified	F 756		

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F 756	Continued From page 85 irregularity has been reviewed and what if any action will be taken to address it. If there is no change to the medication, the attending physician should document his or her rationale in the resident's medical record. ...Nurse Managers review consultant recommendation and contacts MD/NP to address as soon as possible...	F 756		
F 759 SS=D	NJAC 8:39-29.3(a)1,(b) Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication administration observation performed on 10/13/22 and 10/14/22, the surveyor observed two (2) nurses administer medication to six (6) residents. There were 28 opportunities, and two (2) errors were observed which calculated to a medication administration error rate of 7.14%. This deficient practice was identified for one (1) of six (6) residents, (Resident #268), that were administered medications by one (1) of two (2) nurses. The deficient practice was evidenced by the following: On 10/13/22 at 08:22 AM, the surveyor conducted the medication administration task and observed	F 759	I. Immediate action: a) Resident # 268 was assessed by the Registered Nurse (RN) supervisor for any adverse reactions from receiving the [redacted] with a [redacted] of [redacted] when parameters were to hold with [redacted] less than [redacted] was retaken after the incident and [redacted] was [redacted] b) The resident's primary Medical Doctor notified and recommended to observe or monitor [redacted] x 24 hours. c) No harm noted d) Licensed Practical Nurse (LPN) #1 was reeducated about the importance of taking vital signs prior to administering medications with parameters and determining if the drug should be given or	12/5/22

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F 759	Continued From page 86 the Licensed Practical Nurse (LPN #1) reviewing the electronic medication administration record (EMAR) for Resident #268. At that time, the surveyor observed Resident #268 NJ Exec Order 26.4b1 in the wheelchair towards LPN#1 and the medication cart located in the hallway. LPN #1 proceeded to remove the following medications from the medication cart and placed them into a medication cup: *Ex Order 26. 4B1* [redacted] On 10/13/22 at 08:27 AM, LPN #1 administered all five (5) medications to the resident whole with water. LPN #1 then went back into the EMAR to sign that all five (5) medications were administered to Resident #268. LPN #1 then grabbed the *Ex Order 26. 4B1* machine which was located on her medication cart to obtain Resident #268 *Ex Order 26. 4B1* which included the [redacted]. On 10/13/22 at 08:28 AM, the surveyor observed LPN #1 obtain a [redacted] result of [redacted] On 10/13/22 at 08:31 AM, the surveyor asked LPN #1 if that was the first time she checked the resident's [redacted] today (10/13/22) and the LPN stated that it was the first time she checked the resident's [redacted] today. LPN #1 then proceed to document the resident's VS in the EMAR. On 10/13/22 at 09:05 AM, the surveyor and LPN #1 reviewed the EMAR for Resident #268. LPN	F 759	held based on the current vital signs. e) A medication error form was completed and Medical Doctor notified. Completion date 10/13/22 f) Licensed Practical Nurse (LPN) #1 will be monitored for medication observation on multiple residents on [redacted] with parameters by Staff Educator. Completion date 10/14/22 II. Identification of others All residents have potential to be affected. a) An audit will be done for all residents on blood pressure medications with attention paid to residents with orders for hold parameters. Completion date. b) All negative findings will be brought to the attention of the Director of Nursing (DON) and Administrator III. System Changes: c) The Policy and Procedure on Medication Administration and Documentation Policies were reviewed by the Director of Nursing and Administrator and found to be in compliance. Completion date 11/4/22 d) An in service on Medication Administration and Documentation medication administration including medications with parameter, taking vital signs prior to administering medications as ordered will be given to all nurses by the Staff Educator. Completion date: 10/25/22 IV. Quality Assurance a) Audits will be done for all residents on Blood Pressure meds ensure proper	

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F 759	Continued From page 87 #1 stated that according to the physician's order (PO) on the Medication Administration Record (MAR), the Ex Order 26. 4B1 and Ex Order 26. 4B1 had parameters which included instructions to hold the Ex Order 26. 4B1 for a Ex Order 26. 4B1 less than 110. At that time, the surveyor interviewed LPN #1 who stated the [redacted] should have been checked prior to administering the medication. She stated that she thought she checked the resident's [redacted] prior to administering the medications but "could not recall". LPN #1 then confirmed that the resident's [redacted] was 102. The surveyor continued to interview LPN #1 regarding the process for administering [redacted]. LPN #1 stated she should have held the [redacted] medications because of the [redacted] parameters. She stated if the [redacted] was less than [redacted] she should have rechecked the resident's [redacted] and if the [redacted] was greater than [redacted] and it was within the appropriate timeframe of one hour before or one hour after of the scheduled dose she would administer the medication. LPN #1 further stated she would also inform the primary care physician (PCP). On 10/13/22 at 11:51 AM, LPN #1 stated after her interview with the surveyor, she immediately rechecked the resident's [redacted] and the result was [redacted] She further stated that she monitored the resident for any adverse reactions and that the resident stated he/she was [redacted] On 10/13/22 at 12:05 PM, the surveyor interviewed Resident #268 who stated he/she was NJ Exec Order 26.4b1 and that they get their [redacted] checked twice a day.	F 759	holding of meds according to the parameters in physician's orders. b) Audits will be done by nurse managers/supervisors weekly x 4 weeks, then monthly x 2 months then quarterly x 3 quarters. c) All negative findings will be brought to the Director of Nursing (DON) and Administrator immediately. d) The results of all audits will be brought to the Quality Assurance committee quarterly x 4 quarters. V. Person Responsible: Director of Nursing (DON) or designee	

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F 759	Continued From page 88 On 10/14/22 at 11:47 AM, the surveyor interviewed the US FOIA (b)(6) US FOIA (b)(6) who stated staff should "never give medications prior to checking the NJ Exec Or She further stated they checked the NJ Exec O prior to administering medication because the medication could have parameters and the medication may needed to be held. On 10/17/22 at 11:28 AM, the US FOIA (b)(6) US FOIA (b)(6) stated the process for administering NJ Exec O medications was to first review the PO to check if there were parameters. The US FOIA (b)(6) stated staff should always follow the PO as it could be "detrimental to the resident" if staff was not administering the medication according to the PO. She further stated administering NJ Exec O medication prior to checking the NJ Exec O and administering the NJ Exec medication without regards to the hold parameters was "not the proper practice and not safe". The US FOIA (b)(6) explained because it put the resident at risk for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 was already low. A review of the in-service Medication Administration with regards to meds [medications] hold parameter dated 12/01/21 provided by the US FOIA (b)(6) revealed, "Review of medications with hold parameters and separation requirements of meds." A further review reflected LPN #1 was not in attendance as she was not employed as a nurse at that time. A review of the in-service dated 06/30/22 reflected safety regarding medication administration (making sure resident swallowed meds whole, not leaving medication at bedside, on top of med cart, at nursing station or anywhere else) provided by the US FOIA (b)(6) reflected that LPN #1	F 759		

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F 759	Continued From page 89 was in attendance. A review of the Medication Pass Observation for LPN #1 conducted by the US FOIA (b)(6) [redacted] US FOIA (b)(6) [redacted] NJ Exec Order 26.4b1 on [redacted] reflected LPN #1 obtained VS per policy before medications were administered. A review of the facility's policy Medication Administration and Documentation Policies, Procedures and information dated effective 07/01/22, reflected ... ."7. Monitors vital signs when appropriate prior to medication administration ...." A review of the facility's policy Blood Pressure Medication Administration dated reviewed 04/15/22, reflected ... ..."contact the physician/NP [nurse practitioner] when resident's blood pressure is outside the parameters set by the doctor of [or] if it is below a standard reading."	F 759		
F 761 SS=D	NJAC 8:39 - 29.2(d) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		12/5/22

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F 761	Continued From page 90 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documents, it was determined that the facility failed to ensure medications were appropriately dated when opened and implement a comprehensive policy to address dating medication after opening. This was observed for one (1) of two (2) medication carts reviewed during the medication storage and labeling task. This deficient practice was evidenced by the following: On 10/13/22 from 09:11 AM to 09:25 AM, the surveyor, in the presence of the Licensed Practical Nurse (LPN#1), observed the following within the first-floor on medication cart one (1): -One (1) opened and undated box of [redacted] was located inside a plastic bag for unsampled Resident #1. LPN #1 confirmed that the [redacted] was opened and that it did not have an opened date written on the plastic bag, the box, or the bottle. At that time, LPN #1 acknowledged the [redacted] should have been dated once the medication was opened and that the	F 761	I. Immediate Action a) Resident #1 [redacted] delivered on [redacted] since that was the original date of delivery for this resident. [redacted] will be discarded after 28 days. Completed 10/13/22 b) Licensed Practical Nurse (LPN) #1 was reeducated that all insulins/inhalers should be dated when opened and discarded according to the recommended storage time frames based on the type of [redacted]. Each nurse is responsible for checking to ensure all medications are labeled and dated appropriately even if not opened by self. If unable to determine when opened, the medication should be discarded according to facility policy. Completion date 10/13/22 c) Resident #1 and Resident #2 [redacted] bottles were opened and undated. Resident #1 [redacted] was delivered [redacted] The bottle was then dated for [redacted] which is the earliest it could be opened. Resident #2	

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F 761	Continued From page 91 resident was just readmitted to the facility. LPN #1 stated the [Ex Order 26. 4B1] was "good" for 28 days and that the [Ex Order 26. 4B1] was delivered on [EX Order 26.4B1]. She further stated the [Ex Order 26. 4B1] was within the 28 days timeframe and that it could still be used. LPN #1 then pulled out a black marker from her pocket and dated the plastic bag with a date of [EX Order 26.4B1] and placed the [Ex Order 26. 4B1] back inside of the medication cart. -Two (2) opened and undated bottles of *Ex Order 26. 4B1* for Resident #1 and unsampled Resident #2. LPN #1 acknowledged the two (2) bottles of *Ex Order 26. 4B1* were opened and undated and that the medications should have been dated once they were opened. LPN #1 stated Resident #1's medication was delivered on [NJ Exec Order 26.4b1] and unsampled Resident #2's medication was delivered on [NJ Exec Order 26.4b1]. She further stated when she opened a medication she dated them, but "it seems like other nurses don't do that." - One (1) opened and undated *Ex Order 26. 4B1* *Ex Order 26. 4B1* for Resident #37. LPN #1 confirmed the [Ex Order 26. 4B1] was opened and undated. -One (1) opened and undated *Ex Order 26. 4B1* for unsampled Resident #3. LPN #1 confirmed the [Ex Order 26. 4B1] was opened and undated. - One (1) opened and undated *Ex Order 26. 4B1*	F 761	*Ex Order 26. 4B1* delivered [NJ Exec Order 26.4b1] but not dated was then labeled for [NJ Exec Order 26.4b1] which was the earliest time it could be opened (to prevent wasting the medication) Completion date 10/13/22 d) Resident #37 *Ex Order 26. 4B1* inhalation not dated. Delivery date could not be confirmed so it was discarded and reordered. Completion date 10/13/22 e) Resident #3 *Ex Order 26. 4B1* was opened and undated. Delivery date could not be confirmed so it was discarded and reordered. Completion date 10/13/22 f) Resident #46 *Ex Order 26. 4B1* Tablets opened and undated labeled [NJ Exec Order 26.4b1] The *Ex Order 26. 4B1* do not have to be dated. The manufacturer was contacted and confirmed that the [Ex Order 26. 4B1] [Ex Order 26. 4B1] have no expiration dates and bottle should be discarded when finished. II. Identification of others: All residents have the potential to be affected. a) An audit of all injectables, and inhalers for proper dating upon opening were done and there were no other undated [Ex Order 26. 4B1] or *Ex Order 26. 4B1*. Completion date 10/13/22 III. Systemic Changes: a) The Policy and Procedure on Storage of Injectable Medications was reviewed and revised by the Administrator and Director Of Nursing (DON) to include the labeling of [Ex Order 26. 4B1] and [Ex Order 26. 4B1] upon opening and to discard as per Manufacturers recommendations. Completion date 10/13/22	

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F 761	Continued From page 92 *Ex Order 26. 4B1* equals EX Order 26.4B1 tabs for Resident #46. LPN #1 confirmed the medication was opened and undated. LPN #1 checked for an expiration on the bottle, but she stated she was "unsure and couldn't find it." The surveyor and LPN #1 observed a date of 12/17/21 on the bottle but LPN #1 was unable to confirm what that date meant. On 10/17/22 at 12:27 PM, the surveyor interviewed the US FOIA (b)(6) who stated that when a medication such as NJ Exec Order 26.4 or an NJ Exec Order 26.4 was opened, the nurse should immediately write the date it was opened on the medication. She further stated that if a medication was opened and undated then the medication should have been discarded immediately "because you don't know when it was opened." The US FOIA (b)(6) stated she could not remember off the top of her head the expiration date for insulin and inhalers once they were opened. However, she stated she believed they had an expiration date of 30 days after the medication was opened. On 10/20/22 at 11:35 AM, the US FOIA (b)(6) US FOIA (b)(6) US FOIA (b)(6) Regional Nurse #1, and survey team that the NJ Exec Order 26.4b1 tablets did not have to be dated. The US FOIA (b)(6) US FOIA (b)(6) further stated she spoke with the manufacturing company who confirmed that the NJ Exec Order 26.4b1 tablets had no expiration date. A review of the NJ Exec Order 26.4b1 Medication - Expiration Dates After Opening provided by Regional Nurse #2 reflected, EX Order 26.4B1 expiration date after opening was 28 days.	F 761	b) An updated list of all recommended storage limits were obtained and placed in a binder on each unit labeled Medication Storage for easy reference for nurses. Completion Date 10/13/22 c) An in service on dating of all insulins, inhalers and eye drops and when to discard according to manufacturers' recommendations will be given to all nurses by the Staff Educator. Completion Date 10/25/22 IV. Quality Assurance a) Audits will be done of all insulins, and inhalers to ensure that each bottle/ pen or inhaler is dated and discarded according to manufacturer's recommendation will be completed by Nurse managers/supervisors. b) Audits will be done weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters. c) All meds not labeled appropriately or beyond manufacturers recommendations will be discarded and reordered if unable to determine when opened. d) All negative findings will be brought to the attention of the Director of Nursing (DON) and Administrator immediately. e) The results of all audits will be brought to the Quality Assurance committee quarterly x 4. V. Person Responsible: Director of Nursing or designee.	

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F 761	Continued From page 93 A review of the Expiration Dates of Opened NJ Exec Order 26.4b1 Packaging provided by Regional Nurse #2 reflected, EX Order 26.4B1 expiration date after opening was 42 days and to date all devices with first use. A review of the email correspondence provided by the US FOIA (b)(6) reflected, "As a stable compound, glucose has no expiration....." A review of the facility's policy Medication Storage, last review date 5/26/22 revealed, "To make sure all medications and medical supplies are checked before using meds [medication] or supplies on a patient .....1. Checks medication storage at least monthly to ensure all meds and supplies are checked for labels, expiration date and to ensure the labels are legible ... .3 ....the nurse administering the meds or performing IV [intravenous - administered into a vein] activities is responsible for checking all meds and supplies at the time of use to ensure no expired meds or supplies are used on any patient." A further review of the facility's policy Medication Storage revealed there was no comprehensive implementation related to dating medications after opening. The facility was unable to provide additional information that addressed the process for dating medications after opening until 10/26/22. On 10/26/22 at 01:26 PM, Regional Nurse #1 provided Storage of injectable Medication's policy dated last reviewed 05/23/22, which reflected "all bottles of injectables will be inspected for manufacturer's expiration date prior to use and	F 761		

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F 761	Continued From page 94 will be initialed and dated when opened." NJAC 8:39-29.4(a)(g)	F 761		
F 812 SS=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. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and review of facility documentation it was determined that the facility failed to a.) properly handle and store potentially hazardous foods in a manner that is intended to prevent the spread of food borne illnesses and b.) maintain equipment and kitchen areas in a manner to prevent microbial growth and cross contamination. This deficient practice was observed and evidenced by the following:	F 812	I. Immediate Attention COMPLETION DATE: 10/6/22 a) 5 sealed 10 lbs. of ground beef unlabeled was discarded b) Chicken drumsticks were discarded. c) The 2 bags of pork loins were discarded. d) Brown debris on top inside of the door to full ice machine: ice machine cleaned of debris e) Red bucket: liquid changed and	12/5/22

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F 812	Continued From page 95 On 10/06/22 from 09:49 AM until 10:47 AM, the surveyor toured the kitchen in the presence of the US FOIA (b)(6) and observed the following: 1. In the walk-in freezer, there were five sealed ten pound frozen logs of ground beef with manufacturer marked "best before or freeze by Aug 18, 22" with no received or use by date. There were two sealed ten pound frozen tan and white packages of meat, that the US FOIA (b) identified as pork loins, with no label and no received or use by dates. There was one tied large clear plastic bag that contained frozen tan meat, that the US FOIA (b)(6) identified as chicken drumsticks, with no label and no received or use by dates. There were three holes in the bag of chicken drumsticks with the meat visible and exposed to air. During an interview with the surveyor at that time, the US FOIA (b)(6) acknowledged that there were no received or use by stickers on the meats, and that there were no labels on the pork loins nor on the chicken drumsticks. She stated that it was important to label and date all food products when they were delivered to know when they were received and to tell how long they had been in storage. The US FOIA (b)(6) acknowledged the holes in the bag of chicken drumsticks and stated they should not have been packaged that way and that it was important to package food correctly so that bacteria was kept out, freezer burn was prevented, and the product was kept intact. The US FOIA (b)(6) removed the bag of chicken drumsticks and instructed the cook to throw them in the garbage. 2. On the top inside rim of the door to the full ice machine there was brown debris observed. The	F 812	bucket removed f) 2 Stacked 6 inch hotel pans were rewashed and allowed to dry without nesting to prevent bacterial growth and then put away. g) Inside door of left upper convection oven: oven doors were cleaned to decrease the chance of contamination. h) Bucket on bottom shelf on two-tiered table: the cook was instructed to replace the bucket and he did immediately. i) Can section of dry storage: dented can removed from dry storage and placed in dented can section for disposal. II. Identification of others All residents have the potential to be affected. a) The Certified Dietary Manager (CDM)/ Food Service Director performed an audit of all areas identified with issues and no additional findings were noted. Completion date 10/6/22 III. Systemic Changes a) The Policy and Procedure titled Dating and Labeling was reviewed by the Administrator and Certified Dietary Manager (CDM)/Food service director and found to be in compliance. Completion date 11/5/22. b) The Policy and Procedure titled Receivable and Storage Policy was reviewed by the Administrator and Certified Dietary Manager (CDM) and found to be in compliance. Completion date 11/5/22 c) The Policy and Procedure titled Sanitizing Food Surfaces was reviewed by	

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F 812	Continued From page 96 US FOIA (b)(6) acknowledged the debris and stated it should not have been there and that the ice machine was cleaned weekly and as needed and that every month it was emptied and sanitized. 3. On the bottom shelf of a two-tiered metal table in the prep area was a white rag with a brown spot lying in a red bucket that contained clear liquid and a white rag lying in a green bucket that contained clear liquid. The US FOIA (b)(6) stated the red bucket was sanitizer and the green bucket was soap and that the liquids were used to clean and sanitize the prep area before use, as needed, and when finished. The US FOIA (b)(6) used test strips to check the liquid in the red sanitizer bucket which read 50 parts per million (ppm). The US FOIA (b)(6) stated the ppm should be over 200 ppm and that the liquid would be changed and the bucket was removed. 4. On the drying rack were 2 stacked six-inch hotel pans with clear liquid observed between pans. The US FOIA (b)(6) acknowledged the wetness and stated they should not have been stacked and should have been dry to prevent bacterial growth. 5. On the inside doors of the left upper convection oven there was a brown greasy residue. On the inside doors of the left lower convection oven there was a brown greasy residue. The US FOIA (b)(6) acknowledged the residue and stated, "there is a lot of carbon on them" and that it should not have been there. The US FOIA (b)(6) further stated it was important to keep the ovens clean to decrease the chance of contamination. 6. On the bottom shelf of a two-tiered metal table in the cook prep area was a white rag lying in a red bucket that contained cloudy liquid. The US FOIA (b)(6) identified it as sanitizer and used LaMotte test	F 812	the Administrator and Certified Dietary Manager (CDM) and found to be in compliance. Completion date 11/5/22 d) The Policy and Procedure titled Ice Machine Sanitation Policy was reviewed by the Administrator and Certified Dietary Manager (CDM) and found to be in compliance. Completion date 11/5/22 . e) The Policy and Procedure titled Kitchen Equipment/ General Cleaning was reviewed by the Administrator and Certified Dietary Manager (CDM)and found to be in compliance. Completion date 11/5/22 f) The Policy and Procedure titled Dented Can Policy was reviewed by the Administrator and Certified Dietary Manager (CDM) and found to be in compliance. Completion date 11/5/22 . g) The Policy and Procedure titled Wet Nesting Policy was reviewed by the Administrator and Certified Dietary Manager (CDM) and found to be in compliance. Completion date 11/5/22 . h) The Policy and Procedure titled Pot Washing Policy was reviewed by the Administrator and Certified Dietary Manager (CDM) and found to be in compliance. Completion date 11/5/22. i) All kitchen staff will be reeducated by the Certified Dietary Manager on the following topics. a. Dating and Labeling of Food Items procedure b. Receivable and Storing procedures c. Sanitizing Surfaces procedures d. Ice Machine Sanitation Procedures e. Kitchen Equipment General Cleaning procedures	

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F 812	Continued From page 97 strips to check the liquid in the red sanitizer bucket which had no reading. The [US FOIA (b)(6)] stated that it should have read 200 ppm and that it was important to clean and sanitize after using the station to prevent bacterial growth. The [US FOIA (b)(6)] instructed the cook to replace the bucket. 7. In the can section of the dry storage area there was one ten pound six ounce can of pineapple tidbits with a large dent. The [US FOIA (b)(6)] acknowledged the dent and stated it should not have been stored there and removed the can to the dented can section. The [US FOIA (b)(6)] stated it was important to not serve from dented cans because a resident could have gotten sick or gotten botulism. The surveyor reviewed the facility's policy, "Dating and Labeling Policy," revised 4/2019, which revealed Policy: Kitchen will assure food safety by maintaining proper dates and labels to all ready to eat food products. Procedure: 2. Label products in storage with date the package was opened or expiration date with no more than 48 hours after opening, whichever is appropriate ...4. Use the Pinnacle address label dating and labeling system to date all items. 6. Foods marked with manufactures (sic) use by date maybe used and stored until expiration date. The surveyor reviewed the facility's policy, "Receivable and Storage Policy," revised 6/3/2013, which revealed Procedure: 11. Ensure that all foods are securely covered, dated, and labeled. The surveyor reviewed the facility's policy, "Sanitizing Food Surfaces," revised 10/6/22, which revealed Policy: To ensure food safety, all food related surfaces will be cleaned and	F 812	f. Dented Can procedure g. Wet nesting policy h. Pot washing procedure Completion date 11/21/22 IV. Quality Assurance a) Audits will be conducted by the Certified Dietary Manager (CDM) of all areas of the kitchen including but not limited to dating and labeling of food, receivables and storage of food items, sanitizing food services, ice machine maintenance, general kitchen cleaning, dented cans, wet nesting, pot washing. b) Audits will be done by the Certified Dietary Manager (CDM)/supervisor weekly x 4 weeks, monthly x 2 months, quarterly x 3 quarters. c) Any negative findings will be brought to the Administrator immediately. d) The results of all audits will be brought to the Quality Assurance committee quarterly x 4 quarters. V. Person Responsible: Certified Dietary Manager (CDM)/Food Service Director or designee	

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F 812	Continued From page 98	F 812		

sanitized. Procedure: 3. Test sanitizer using a test strip to ensure proper concentration. Repeat every 2 hours. Follow instructions on test tube. 4. Repeat step 1 every shift or if solution becomes visibly dirty.

The surveyor reviewed the facility's undated policy, "Ice Machine Sanitation Policy," which revealed Procedure: 7. Spray inside of bin and lid with sanitizing solution. 8. Wipe bin and lid with clean disposable kitchen wipe.

The surveyor reviewed the facility's undated policy, "Kitchen Equipment General Cleaning Policy," which revealed Policy: the Director of Dining Services or designee will ensure that all equipment is maintained, kept clean, and in a sanitary condition before and after each use. Procedure: 1. Conventional/Convection Ovens, a. Clean after each use, inside and out, using soap and water. b. For heavy carbon build up, use easy-off (oven grill cleaner) or blend rite (degreaser) ...5. Convection Oven- a. Clean after each use, both inside and out, using soap and water. b. For heavy cleaning, as needed, use the self clean feature (using the chemical specified in its instructions).

The surveyor reviewed the facility document marked kitchen cleaning list that was dated 10/2-10/8. The document revealed Position: am cook, Clean and maintain daily: ...inside and outside of ovens ...10/2-10/6 initials were noted that task was completed. Position: pm cook, Clean and maintain daily: ...inside and outside of ovens ...10/2-10/5 initials were noted that task was completed.

The surveyor reviewed the facility's policy,

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F 812	Continued From page 99 "Dented Can Policy," revised 6/3/2013, which revealed Policy: ...will identify cans with dents ...Procedure: 2. ...cans have been placed on the appropriate shelf labeled "Dented Cans." The surveyor reviewed the facility's policy, "Wet Nesting Policy," revised 4/2019, which revealed Policy: ...cooking ware, and equipment they must be air dried completely before being placed into storage for use. Procedure: Place items on drying rack and allow them to air dry. Do not stack. The surveyor reviewed the facility's undated policy, "Pot Washing Policy," which revealed Procedure: 10. Air dry all clean and sanitized pots and wares (place in angle at least 20*-30*). Do not wipe dry. Do not stack. NJAC 8:39 17.2(g)	F 812		
F 838 SS=E	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to,	F 838		12/5/22

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F 838	Continued From page 100 (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.	F 838		

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F 838	Continued From page 101 §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documents, it was determined that the facility failed to ensure that the facility-wide assessment identified the required services and procedures necessary to protect the health, safety, and welfare of all residents prior to the admission of NJ Exec Order 26.4b1 and residents admitted from the correctional facility. On 10/06/22 from 10:07 AM to 10:43 AM, the surveyor conducted the entrance conference with US FOIA (b)(6) Regional Nurse #1 and requested a copy of the Facility Assessment. On 10/13/22 at 01:03 PM, after multiple requests the US FOIA (b)(6) provided the Facility Assessment to the surveyor. At that time, the surveyor reviewed the Facility Assessment which revealed in the Person (names/titles) involved in completing assessment section the US FOIA (b)(6) had crossed out the previous US FOIA (b)(6) and wrote in blue ink his name and initials. In the Date(s) of assessment or update section it was dated NJ Exec Order 26.4b1 and th US FOIA (b)(6) wrote in blue ink the date NJ Exec Order 26.4b1 and his initials in blue ink. In the Date(s) assessment reviewed with QAA [Quality Assessment and Assurance]/QAPI [Quality Assurance and Performance Improvement] committee the LNHA had crossed out 1st [first] Quarter and wrote "3" [third] Quarter in blue ink. A further review of the Facility Assessment revealed that it did not address the	F 838	I. Immediate Action a) The Facility Assessment was re written by the Administrator to include what the facility will be doing to protect residents from NJ Exec Order 26.4b1 in accordance with current federal, state and local standards. Completion date 11/20/22. II. Identification of Others: a) The facility performed an audit of all current residents to identify any sex offenders and all residents from correctional facilities and ensure there is an appropriate plan in place to protect other residents. Based on resident history of incarceration, charges/convictions Completion date 10/26/22. All residents have the potential to be affected. III. System Changes: a) The Policy and Procedure titled Facility Assessment was reviewed and revised to include Identification of Sex Offenders prior to admission and review of all potential admissions for the facility's ability to protect other residents. If the facility cannot ensure that safety of other residents this candidate will not be accepted. b) Education will be provided to all Admission Personnel on screening for Potential Sex Offenders for all potential	

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F 838	Continued From page 102 identified required services and procedures necessary to protect the health, safety, and welfare of all residents prior to the admission of registered sex offenders and residents admitted from the correctional facility. On 10/18/22 at 11:44 AM, the US FOIA (b)(6) in the presence of the US FOIA (b)(6) and the survey team stated that the facility had admitted registered NJ Exec Order 26.4b1 and from the correctional facility for years. He further stated that NJ Exec Order 26.4b1 of the facility's population were from correctional facilities or NJ Exec Order 26.4b1 The US FOIA (b)(6) acknowledged it was not addressed in the Facility Assessment. He stated it should have been a part of the Facility Assessment because "we are identifying the needs to care for the particular population". The US FOIA (b)(6) stated the Facility Assessment should have been updated but emphasized that "this has been happening for years in this facility". The US FOIA (b)(6) stated the facility had no contract with the correctional facilities and that the corporate company "sold us a bill of goods". He further stated, "we were supposed to have contracts with the prison; however, we do not have them and corporate said we had them." On 10/18/22 at 11:59 AM, the surveyor continued to interview the US FOIA (b)(6) in the presence of the US FOIA (b)(6) and survey team. The US FOIA (b)(6) stated he had NJ Exec O years of experience as an US FOIA (b)(6) but he had just started NJ Exec Order 26.4b1 at this facility. The US FOIA (b)(6) tated he had reviewed the Facility Assessment in NJ Exec Ord and he was "confident" that the Facility Assessment did not address the residents that were NJ Exec Order 26.4b1 and from the correctional facilities. The US FOIA (b)(6) acknowledged he should have reviewed the Facility Assessment and ensured it was addressed.	F 838	residents prior to admission and discussing with Administrator/Director of Nursing (DON) to determine if the facility can ensure the safety of others if admitted. Completion date 11/16/22. c) Education will be provided to all staff by the Staff Educator regarding monitoring all residents for sexual behaviors, immediate notification to the nurse/supervisor/Administration if behaviors noted. Completion date 11/16/22 d) The facility will seek contracts with the prisons before taking any patients. Completion date 11/16/22 IV. Quality Assurance a) Audits of all new admissions for the sex offender registry search will be done by the Administrator or designee to ensure that any potential sex offenders or other candidates for admission from correctional facilities have been identified and appropriate interventions are in place to protect others. b) Audits will be done by Administrator or designee weekly x 4 weeks, monthly x 2 months and Quarterly x 3 quarters. c) Any negative findings will be brought to the Regional Administrator. d) The results of all audits will be brought to the Quality Assurance committee quarterly x 4 quarters. V. Person Responsible: Administrator or designee	

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	315124	A. BUILDING _____ B. WING _____	10/20/2022

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F 838	Continued From page 103 A review of the Administrator's Job Description reflected, "The primary purpose of your position is to direct the day to the Facility in accordance with current federal, state and local standards guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times .....Develop and maintain written policies and procedures and professional standards of practice that govern the operation of the facility."	F 838		
F 865 SS=E	NJAC 8:39-5.1(a) QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the	F 865	I. Immediate Attention a) The QAPI Meeting Agenda of 8/29/22	12/5/22

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F 865	Continued From page 104 facility failed to ensure that their Quality Assurance and Performance Improvement (QAPI) Program was being implemented, and sources of quantitative data was being analyzed to identify quality deficiencies and evaluate program effectiveness. This deficient practice was identified during the standard survey, and was evidenced by the following: On 10/14/22 at 09:45 AM, the US FOIA (b)(6) US FOIA (b)(6) provided the surveyor with only one (1) quarterly Quality Assurance (QA) meeting from NJ Exec Order 26.4b1, which reflected the following: -QAPI Meeting Minutes: The COVID-19 (a contagious respiratory infection) outbreak in the month of August. It further reflected they discussed infection control precautions related to COVID-19. The QAPI Meeting Minutes for August did not reveal other topics were discussed. On 10/17/22 at 08:43 AM, the surveyor inquired additional information regarding the Quality Assurance Performance Improvement (QAPI) quarterly meetings. On 10/17/22 at 10:01 AM, the US FOIA (b)(6) US FOIA (b)(6) in the presence of the survey team stated that the QAPI committee met quarterly with all the department heads. The US FOIA (b)(6) stated that at the QA meetings they discussed antibiotic stewardship and immunizations. She further stated that the US FOIA (b)(6) had provided education on COVID-19 and vaccinations. The US FOIA (b)(6) stated that the department heads discussed issues related to their departments but was unable to elaborate on the topics that were discussed. The surveyor	F 865	was revised to include all topics actually discussed at that meeting. Antibiotic Stewardship, hospital transfers, readmissions, dietary concerns, physical therapy and pharmacy consultant statistics. II. Identification of Others: a) The facility respectfully submits that QAPI meeting agendas must reflect all topics discussed to identify quality deficiencies and evaluate program effectiveness. All residents have the potential to be affected. III. System Changes a) The Policy and Procedure titled Quality Assurance Performance Improvement was reviewed and revised by the Administrator, Medical Director and Director of Nursing to include that all topics for the QAA meeting by all disciplines should be sent to the Administrator or designee so it can be placed on the agenda for the meeting. A copy of all data with analysis will be maintained in the QAA binder for future reference. Completion Date 11/11/22 a) Education was provided to all Administrative Staff, Department Heads, Nurse Managers, Infection preventionist and Medical Director about the importance of QAPI in identifying areas of concern which need improvement. Completion date 11/11/22 b) The Administrator, DON or designee will be responsible for putting together an agenda of all topics that will be discussed at the meeting, including a copy of all data	

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F 865	Continued From page 105 inquired about other topics that may have been discussed such as falls. The [US FOIA (b)(6)] then stated they discussed falls, and issues related to activities but was still unable to elaborate. On 10/17/22 at 10:19 AM, the surveyor interviewed the [US FOIA (b)(6)] in the presence of the survey team regarding the facility's completion and submission of the Minimum Data Set (MDS) which was identified as a concern during the standard survey. The [US FOIA (b)(6)] confirmed that there was an issue concerning the timeliness of the MDS completion and submission and that she had a conversation with the [US FOIA (b)(6)] and facility "cooperate office" regarding the late assessments. She further stated that the late assessments were being discussed but that they "did not discuss specific late MDS, just the whole picture of what was happening with the MDS process". The [US FOIA (b)(6)] emphasized "I was told we had individuals were working both remotely and on site to get assessments completed". The [US FOIA (b)(6)] acknowledged the MDS was an identified concern and that it should have been brought to the QAPI committee. On 10/17/22 at 11:08 AM, the [US FOIA (b)(6)] in the presence of the [US FOIA (b)(6)] and the survey team stated that the QAPI committee met quarterly. The [US FOIA (b)(6)] stated he was not in attendance at the [NJ Exec Order 26.4b] QAPI meeting and had started as [US FOIA (b)(6)] for the facility on [NJ Exec Order 26.4b] he [US FOIA (b)(6)] indicated that at previous QA meetings they discussed the transition to the new electronic medical record which started in [NJ Exec Order 26.4b] and went "live" on [NJ Exec Order 26.4b] On 10/17/22 at 12:55 PM, Regional Nurse #2 provided the surveyor with a second QA meeting	F 865	compiled and analyzed. All QAPI agendas, data and analysis, attendance sheets will be maintained in a QAPI binder for easy reference. Completion date 11/11/22 IV. Quality Assurance a) Audits of the QAPI process / binder will be done quarterly x 4 quarters by the Administrator to ensure compliance. b) All results of those audits will be brought to the QAPI committee quarterly x 4 quarters. c) Any negative findings will be discussed immediately with the Department head to ensure correction. V. Person Responsible: Administrator or designee	

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F 865	Continued From page 106 held 04/13/2022, which reflected the following topics were discussed: -Review of COVID vaccination/Immunization statistics -QAPI on Activities of Daily Living (ADLs), Medication Administration Record (MAR), Treatment Administration Record (TAR) documentation missing signatures. -Successful Prevention of resident infections -Review of resident council meetings -Audit on COVID-19 vaccinations of residents completed by the DON on [NJ Exec Order 26.4b1] -Audit on COVID-19 vaccinations on staff completed by the DON on [NJ Exec Order 26.4b1] -Education for both residents and employees who refused vaccination. At that same time, Regional Nurse #2 stated the facility was unable to provide the survey team with additional quarterly QAPI meetings. On 10/18/22 at 12:04 PM, the [US FOIA (b)(6)] in the presence of the [US FOIA (b)(6)] and survey team stated they only had the QAPI meetings for April and [NJ Exec Order 26.4b1] The [US FOIA (b)(6)] confirmed there was no QAPI for [NJ Exec Order 26.] and that she was unable to provide additional information for QAPI. On 10/18/22 at 01:52 PM, the surveyor interviewed the [US FOIA (b)] on the telephone who stated he was involved and attended the quarterly QAPI meetings. The [US FOIA (b)(6)] stated he had conducted educations with the staff related to infections, falls and COVID. He further stated in [NJ Exec Or] they discussed infection control and COVID and that in [NJ Exec Order 26.4b] he did the presentation for the antibiotic stewardship to ensure that the facility was following the appropriate criteria. The [US FOIA (b)]	F 865		

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F 865	Continued From page 107 concluded additional QA topics included hospital transfers, readmissions, dietary concerns, physical therapy, and the pharmacy consultant's statistics. On 10/18/22 at 02:02 PM, the surveyor continued to interview the [US FOIA (b)] who stated the QAPI committee generally met every three (3) months unless something occurred. He stated he remembered the last two QAPI meetings but could not confirm if there was a meeting in [NJ Exec Order 26.4b1] The [US FOIA (b)] explained since it was a change in ownership in [NJ Exec Order 26.4b1] it probably delayed the QAPI meeting. He concluded the meeting could have been towards the end of [NJ Exec Order 26.4b] but again he could not confirm. On 10/19/22 at 09:41 AM, the [US FOIA (b)(6)] informed the surveyor she had a QAPI book that showed their root cause analysis and would provide it. On 10/20/22 at 11:37 AM, the [US FOIA (b)(6)] [US FOIA (b)(6)] in the presence of the [US FOIA (b)(6)] Regional Nurse #1 and the survey team confirmed that the facility was unable to provide additional information regarding the quarterly QAPI meetings. There were no sources of quantitative data provided that showed the facility had analyzed and identified quality deficiencies and evaluate program effectiveness. A review of the facility's Quality Assurance Performance Improvement policy date reviewed 5/15/22, reflected "To study, plan analyze, validate specific areas of improvement for positive resident care outcomes .....Guiding	F 865		

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F 865	Continued From page 108 Principles: 3.We will use QAPI to make decisions to guide our day to day operations. 4. We will set goals for performance and measure progress towards those goals ....7. We will use root cause analysis to identify specific areas to target and systems that need revision ....Feedback, Data Systems and Monitoring: 4. The facility will utilize multiple data sources to monitor performance including Quality Measures. State and National Benchmarks as well as tracking and investigating and adverse events affecting residents .... Procedure: Person Responsible QAPI committee members duties: 8. Complete audit tools as indicated to track progress. 9. Analyzes the data. 10. Determines interventions needed to improve the situation." NJAC 8:39-33.1(a)(c)(e); 33.2(a)(b)(c)(d)	F 865		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §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; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary.	F 868		12/5/22

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F 868	Continued From page 109 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure the US FOIA (b)(6) attended the quarterly Quality Assurance (QA) meetings. This was identified for one (1) of two (2) QA meetings reviewed. This deficient practice was evidenced by the following: On 10/12/22 at 12:30 PM, the US FOIA (b)(6) provided a list of the QA committee which revealed that the US FOIA (b)(6) US FOIA (b)(6) attendance was mandatory at the quarterly meetings. On 10/14/22 at 09:45 AM, the US FOIA (b)(6) provided the surveyor with only one (1) quarterly QA meeting sign-in sheet for NJ Exec Order 20.461 which reflected the following: US FOIA (b)(6) reflected that the US FOIA (b)(6) did not sign the attendance sheet. On 10/17/22 at 08:43 AM, the surveyor inquired additional information regarding the Quality Assurance Performance Improvement (QAPI) quarterly meeting.	F 868	I. Immediate Action a) All future QAA meetings will be scheduled at a time that all required members can attend. This includes the Medical Director, Administrator, Director of Social Work and Director of Nursing. II. Identification of others a) The facility respectfully submits that all mandatory attendees will be in attendance for all future QAA meetings. All residents could be potentially affected. III. System Changes b) The Policy and Procedure for Quality Assurance Performance Improvement was reviewed and revised by the Administrator, Medical Director and Director of Nursing to include scheduling of QAA meeting in advance to ensure all required members can attend. Completion Date 11/11/22 c) Education of all Department Heads, Director of Nursing, Administrator and Medical Director of the importance of Quality Assurance and Performance Improvement in identifying quality issues and their participation and attendance is vital to the success of the program. Completion date 11/11/22 IV. Quality Assurance a) Audits will be done of each QAA meeting by the Administrator or designee to ensure the required members were in attendance. b) Audits will be done Quarterly x 4	

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F 868	Continued From page 110 On 10/17/22 at 10:01 AM, the US FOIA (b)(6) in the presence of the survey team stated that the QAPI committee met quarterly with all the department heads which included the mandatory attendees: the US FOIA (b)(6). On 10/17/22 at 11:08 AM, the US FOIA (b)(6) in the presence of the US FOIA (b)(6) and the survey team stated that the QAPI committee met quarterly. The US FOIA (b)(6) acknowledged he was not in attendance at the August QAPI meeting. He stated the reason he was not in attendance was because he had just started as the new US FOIA (b)(6) for the facility on NJ Exec Order 26.4b1 He then stated he was on vacation during the scheduled QAPI meeting in NJ Exec Order 26.4b and did not feel that the committee should have rescheduled the meeting because of his "scheduling conflict". The US FOIA (b)(6) stated it was mandatory for the US FOIA (b)(6) to be in attendance, but he did not think it was mandatory for the US FOIA (b)(6) The surveyor presented th US FOIA (b)(6) with the QA committee list he provided on NJ Exec Order 26.4b1 which supported that the US FOIA (b)(6) was a mandatory attendee. The US FOIA (b)(6) was unable to speak on the mandatory attendance any further but concluded that in his absence that the US FOIA (b)(6) was his designee for the QAPI meetings. On 10/17/22 at 11:12 AM, the surveyor inquired about the US FOIA (b)(6) attending the August QAPI meeting. The US FOIA (b)(6) stated she was unsure and could not remember if the US FOIA (b)(6) was in attendance for the NJ Exec Order 26.4b QAPI meeting. On 10/17/22 at 12:55 PM, Regional Nurse #2 provided the surveyor with the sign-in sheet for a second QA meeting held 04/13/2022, which reflected the following:	F 868	quarters and for any Additional QAA meetings that were scheduled. V. Person Responsible: Administrator or designee	

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F 868	Continued From page 111	F 868		

US FOIA (b)(6)

attendance. At that time, Regional Nurse #2 stated the facility was unable to provide the survey team with additional quarterly QAPI meetings.

On 10/18/22 at 01:52 PM, the surveyor interviewed the [US FOIA (b)] on the telephone who stated he was involved in the quarterly QAPI meetings and attended the meeting in [NJ Exec Order 26.4b1] He further stated that he may have forgotten to sign the attendance sheet at the meeting.

On 10/20/22 at 11:37 AM, the [US FOIA (b)(6)] US FOIA (b)(6) the presence of the [US FOIA (b)(6)] Regional Nurse #1 and the survey team stated that the [US FOIA] did attend the meeting. The [US FOIA (b)(6)] further stated the [US FOIA (b)] attested that he failed to sign the attendance sheet in August. The [US FOIA (b)(6)] confirmed that the facility was unable to provide additional information regarding the quarterly QAPI meetings.

There were no further meeting attendance or agenda records provided.

A review of the facility's Quality Assurance Performance Improvement policy date reviewed 5/15/22, indicated "2. The QA Steering Committee will consist of the Administrator [LNHA], Director of Nursing, Medical Director, and Department Heads." A further review of the policy did not specify the mandatory attendees for the quarterly QAPI meetings.

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F 868	Continued From page 112 NJAC: 8:39-33.1(b)	F 868		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment 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	F 880		12/5/22

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F 880	Continued From page 113 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of 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, record review, and review of facility documentation, it was determined that the facility failed to maintain infection control standards and procedures to address the risk of infection transmission by failing to: a.) perform proper hand hygiene and perform a [redacted] treatment in a safe and sanitary manner for one (1) of one (1) nurse observed	F 880	I. Immediate Action 1. Resident #57 a) The [redacted] was re in serviced on the proper procedure for performing a dressing change using infection control techniques and identified deficient practices noted when observed. Completion date 10/12/22	

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	315124	A. BUILDING _____ B. WING _____	10/20/2022

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F 880	Continued From page 114 providing a Ex Order 26. 4B1 treatment to one (1) of one (1) resident (Resident #57); b.) maintain and store Personal Protective Equipment (PPE) and non-sterile resident care equipment in a safe and sanitary manner; and, c.) follow appropriate hand hygiene practices for one (1) of two (2) nurses who administered medications to two (2) of six (6) residents (Resident #4, and #5) during the medication pass. This deficient practice was evidenced by the following: 1. On 10/06/22 at 11:26 AM, the surveyor observed Resident #57 who was seated in a wheelchair in the dining room prior to meal service. The resident was NJ Exec Order 26.4b1 when interviewed and NJ Exec Order 26.4b1 On 10/07/22 at 9:40 AM, the surveyor observed Resident #57 lying in bed awake on a NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 in treatment of Ex Order 26. 4B1). The resident stated that he/she received Ex Order 26. 4B1 treatments to their Ex Order 26. 4B1 daily. Review of the Resident Face Sheet revealed that Resident #57 was admitted to the facility with diagnoses which included but were not limited to: Ex Order 26. 4B1 Review of Resident #57's quarterly Minimum	F 880	b) Resident #57 was monitored and no signs of infection noted. Completion date 10/12/22 2. Facility Storage of PPE (60 day Backup) Completion date 10/16/22: a) All non-patient care items such as soiled take out container, loose surgical mask and disposable gowns that were directly on ground were discarded. b) All supplies were inspected for possible contamination. Any supplies that appeared weathered, contaminated in any way were discarded. c) All supplies were removed from the outside storage container and placed inside d) All back up PPES were placed on pallets that were elevated above the ground, and in boxes with covers. e) The boxes were restacked to ensure that there is at least 14 inches from the ceiling. f) No additional supplies will be placed in this area. 3. Hand hygiene 3a) ALPN #2 was re in serviced appropriate Hand Hygiene, including when and how to perform hand hygiene. Completion date 10/17/22 II. Identification of Others: a) The facility respectfully submits that all residents can potential be affected by this deficient practice. III. Systemic Changes 1 a) The Policy and Procedure titled	

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F 880	Continued From page 115 Data Set (MDS), an assessment tool dated [redacted] revealed that the Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted] indicated that the resident was moderately [redacted]. Further review of the MDS revealed that the resident required extensive assistance of one person for [redacted] and required extensive assistance of two (2) persons for [redacted] the MDS indicated that the resident had diagnoses which included complete [redacted] between the [redacted] and complete [redacted] of the [redacted]. Review of Section M of the MDS revealed that the the resident had one (1) facility acquired stage four [redacted]. Review of a Report of Consultation dated [redacted] revealed that the [redacted] Consultant documented that Resident #57 had a [redacted] that measured [redacted] (unit of measurement not specified) and a [redacted] that measured [redacted] (unit of measurement not specified) with a diagnosis of [redacted]. Recommendations:...Continue [redacted] (daily). On 10/12/22 at 11:49 AM, the surveyor interviewed the [redacted] who stated that she was about to do Resident #57's [redacted] treatment and agreed to permit the surveyor to observe. The RN/AUM stated that the resident was a [redacted] and had a [redacted]. The [redacted] then proceeded to go into the medication room	F 880	Clean/Aseptic Dressing Changes was reviewed by the DNS and Infection Preventionist and found to be in compliance. Completion Date 11/10/22 1b) Education will be provided to all nurses on Clean/Aseptic Dressing Techniques by the Infection Preventionist. Completion date 11/22/22 2a) The Policy and Procedure titled PPE: 60 day back up was reviewed and revised by the Administrator and Director of Housekeeping to include that all supplies must be maintained in an area which is protected from contamination or weather. All supplies will be checked for contamination prior to distribution. Completion date 10/28/22 2b) Education will be provided to all staff responsible for the storage of PPEs for 60 -day back to ensure proper procedures to prevent contamination are followed. Completion date 10/31/22 3a) The Policy and Procedure titled Hand Hygiene was reviewed by the DNS and infection preventionist and found to be in compliance. Completion date 10/18/22 3b) Education on Hand Hygiene will be given to all staff in all departments. Completion date 11/20/22 IV. Quality Assurance 1a) Treatment observation Audits will be done for at least 3 nurses on every unit, one per shift who perform treatments by the Infection Preventionist, Staff Educator and/ or Designee. 1b) Audits will be performed weekly x 4	

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F 880	Continued From page 116 where she accessed the treatment cart and obtained supplies to be used during the treatment. At 12:01 PM, the US FOIA (b)(6) washed her hands for 34 seconds and donned (put on) a pair of gloves after. At 12:03 PM, the US FOIA (b)(6) picked up a bottle of hand sanitizer and poured some onto Resident #57's over bed table and immediately wiped it off with a bath towel afterward. She stated that the hand sanitizer contained alcohol and was used to clean the table. The US FOIA (b)(6) then placed the bath towel used to clean the table in a trash bag when finished. At 12:04 PM, the US FOIA (b)(6) placed a Ex Order 26. pad EX Order 26.4B1) on the resident's overbed table before she arranged the Ex Order 26. 4B1 Ex Order 26. supplies on the table. The US FOIA (b)(6) then removed a previously opened tube of Ex Order 26. 4B1 from her uniform pocket which was in the same pocket as the keys to the medication room. She then dispensed Ex Order 26. 4B1 into a plastic medication cup before she laid the tube of Ex Order 26. 4B1 on the resident's night stand. At 12:06 PM, the US FOIA (b)(6) used her gloved hands as she searched through Resident #57's top drawer of the night stand for Ex Order 26. 4B1 treatment supplies. The US FOIA (b)(6) then stated that she forgot to get cotton tipped applicator sticks from the treatment cart in order to apply the Ex Order 26. 4B1 to the resident's Ex Order 26. 4B1 bed. The US FOIA (b)(6) then reached into her uniform pocket with her gloved hand and pulled out a cell phone and proceeded to attempt to call a staff member to request cotton tipped	F 880	weeks, monthly x 2 and quarterly x 3 to ensure all nurses have been observed. 1c) All negative findings will be addressed with the nurse immediately, additional education provided and will be scheduled for another observation. The DNS/Administrator will be notified of all negative findings. 1d) The RN/AUM identified with resident #57 will be observed weekly x 4, monthly x 2 and then quarterly x 3 quarters to ensure sustained compliance. 1e) The results of all audits will be brought to the QAA meeting quarterly x 4 quarters. 2a) Inspection audits will be performed to ensure that PPE 60 days supplies are maintained in a matter that prevents contamination of the supplies so they can be used as needed. 2b) Audits will be performed by the Director of Housekeeping/designee weekly x 4 weeks, monthly x 2 weeks and then Quarterly x 3 quarters. 2c) All negative findings will be brought to the Administrator's attention immediately. 2d) The results of all audits will be brought to the QAPI committee quarterly x 4 quarters. 3a) Hand hygiene observations will be performed by all department heads for their respective departments using the audit tool. 3b) Audits will be conducted for 10 nursing staff members per shift , all other departments 25 % of staff weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters.	

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F 880	Continued From page 117 applicators. At 12:13 PM, the US FOIA (b)(6) again used her gloved hands and attempted to call another staff member for assistance. The US FOIA (b)(6) stated that she did not want to leave the site in order to obtain the cotton tipped applicators. At 12:17 PM, the US FOIA (b)(6) doffed (removed) her gloves, used hand sanitizer and donned gloves. At 12:23 PM, the US FOIA (b)(6) stated that the Certified Nursing Assistant (CNA) had previously removed Resident #57's dressing prior to the observation as the resident was soiled. The US FOIA (b)(6) then stated that she intended to use Ex Order 26. 4B to cleanse the EX Order 26.4B1 that were present on the resident's EX Order 26 and Ex Order 26. 4B1 prior to Ex Order 26. 4B application. At 12:26 PM, the US FOIA (b)(6) stated that the tube of Ex Order 26. 4B fell off of the top of Resident #57's night stand and into the resident's drawer. The US FOIA (b)(6) stated that she would return the tube of Ex Order 26. 4B to the treatment cart after the Ex Order 26. 4B1 treatment. At 12:28 PM, the US FOIA (b)(6) doffed her gloves, failed to first perform hand hygiene after, and used her cell phone in an attempt to call a staff member for assistance. At 12:30 PM, the US FOIA (b)(6) stated that EX Order 26.4B treatment competencies were last done at the facility by a EX Order 26.4B1 consultant prior to the pandemic but had not been done since. At 12:41 PM, the US FOIA (b)(6) used hand sanitizer to perform hand hygiene and donned gloves. A staff	F 880	V. Person Responsible: 1. Infection Preventionist/Staff Educator 2. Director of Housekeeping 3. Infection Preventionist	

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F 880	Continued From page 118 member responded at that time with the cotton tipped applicators. The US FOIA (b)(6) used her gloved right hand and retrieved the cotton tipped applicators directly at the tips from the package. At 12:43 PM, the US FOIA (b)(6) pulled back Resident #57's sheets and applied Ex Order 26. 4B to a 4 x 4 NJ Exec Order 26.4b1 that she used to cleanse the resident's Ex Order 26. 4B1. At 12:44 PM, the US FOIA (b)(6) used a cotton tipped applicator stick and applied Ex Order 26. 4B1 to the EX Order 26.4B1 bed. She then folded a NJ Exec Order 26.4b1 and lined the inside of the NJ Exec Order 26.4b1 with the folded 4 x 4 and placed the NJ Exec Order 26.4b1 over the Ex Order 26. 4B1 on the EX Order 26.4B1. At 12:45 PM, the US FOIA (b)(6) doffed her gloves, and used hand sanitizer. At 12:46 PM, the US FOIA (b)(6) donned new gloves, applied Ex Order 26. 4B1 to a 4 x 4 NJ Exec Order 26.4b1 and cleansed the Ex Order 26. 4B1. She then proceeded to use another NJ Exec Order 26.4b1 to blot the Ex Order 26. 4B1 dry. At 12:47 PM, the US FOIA (b)(6) used a cotton tipped applicator stick to apply Ex Order 26. 4B1 to Resident #57's Ex Order 26. 4B1. She then folded a NJ Exec Order 26.4b1 and placed it beneath a Ex Order 26. 4B1 and applied it to the Ex Order 26. 4B1. At 12:49 PM, the US FOIA (b)(6) doffed her gloves and washed her hands. She dried her hands on a paper towel and did not discard the paper towel in the trash can bedside the sink as she stated that the lid on the trash can was not utilized to discard the paper towel as it was a swing top lid and she did not want to recontaminate her hands. The	F 880		

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F 880	Continued From page 119 US FOIA (b)(6) then proceeded to carry the soiled paper towel out of the bathroom and discarded it in the trash can beside Resident #57's bed. At 12:56 PM, the US FOIA (b)(6) gathered Resident #57's Ex Order 26. 4B1 treatment supplies and disposed of them in the soiled utility room. When the US FOIA (b)(6) and surveyor returned to the resident's room, the resident had already been served lunch and had began to eat on top of the over bed table which had not been cleaned Ex Order 26. 4B1 treatment. At 12:58 PM, the US FOIA (b)(6) obtained a canister of disinfectant bleach wipes and used them to clean the outside of a stainless steel container that the US FOIA (b)(6) stated was used to store 4 x 4 NJ Exec Order 26.4b1 At 1:01 PM, the NJ Exec Order 26.4b1 emoved a set of keys from her pocket and unlocked the door to the medication room. The US FOIA (b)(6) stated that Resident #57's tube of Ex Order 26. 4B1 was in her pocket and she then proceeded to remove the Ex Order 26. 4B1 from her pocket and returned the tube to an unsecured area of the top drawer of the treatment cart before she left the medication room. At 1:03 PM, the US FOIA (b)(6) attempted to sign out the treatment but was unable to do so. She stated that she intended to write a note to document that the treatment was administered instead. When interviewed at that time, the US FOIA (b)(6) stated that she should have checked the order for the Ex Order 26.4B1 treatment prior to administration. She also stated that, "She used hand sanitizer to clean Resident #57's over bed table because it was closest item to her at that time and since it contained alcohol, it was Okay." The US FOIA (b)(6) stated that she should have used disinfectant wipes to clean the over	F 880		

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bed table after the [redacted] treatment because it was an infection control issue. The [redacted] stated that it was also an infection control risk when she used her gloved hands and touched the tube of [redacted], the keys to the medication room and her cell phone. The [redacted] stated that she should have cleaned the tube of [redacted] before she returned it to the treatment cart.

At 1:17 PM, in a later interview with the [redacted] she stated that she should have doffed her gloves and washed her hands after she cleansed Resident #57's [redacted] with [redacted] and patted the [redacted] dry prior to [redacted] and dressing application. The [redacted] stated that she did not know what the facility [redacted] treatment policy specified and added that she would have to review it. The [redacted] stated that she was not going to lie, but her usual practice was to doff her gloves and perform hand hygiene after she cleansed the [redacted] immediately prior to [redacted] application.

On 10/13/22 at 11:03 AM, the surveyor interviewed the [redacted] who stated that the [redacted] should have cleaned the table prior to performing Resident #57's [redacted] treatment with disinfectant wipes and allowed the table to dry for three minutes in accordance with the manufacturers instructions for disinfection. The [redacted] stated that the [redacted] was required to cleanse the resident's [redacted] by swiping once and discarding the [redacted] doffing her gloves and washing her hands after. The [redacted] stated that the purpose was to maintain an aseptic technique to prevent contamination before treatment application. She stated that the next step was to pat the [redacted] dry and apply the [redacted] The [redacted] stated that application of

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hand sanitizer to clean the table was not usual practice and a bath towel should not have been used to to clean a dirty surface as the towels were to be used for resident care. The [redacted] stated that that the [redacted] should have allowed the surface of the table to dry before she applied a [redacted] on top of it to prevent contamination. The DON stated that the [redacted] should not have placed the tube of [redacted] into her pocket with her cell phone and retrieved it with her gloved hands as the tube was considered contaminated. She further stated that if the resident's over bed table was not cleaned prior to meal service it could have potentially resulted in contamination.

On 10/14/22 at 12:33 PM, the surveyor interviewed the [redacted] who stated that Resident #57's over bed table should have been cleaned with disinfectant wipes as it was not acceptable to use hand sanitizer to clean the table to ensure that all germs were killed, because hand sanitizer did not kill everything. The [redacted] stated that she would not have placed the tube of [redacted] on Resident #57's night stand. The [redacted] stated that it was not appropriate to touch [redacted] treatment supplies with gloved hands and then touch your cell phone as whatever was in the room was now transferred onto the phone. The [redacted] stated that the [redacted] should have doffed her gloves and washed her hands and donned new gloves prior to the treatment after the [redacted] was cleansed with [redacted] because the gloves were considered dirty and there was a big risk of contamination. She further stated that if the [redacted] removed the tube of [redacted] from her pocket and placed it back into the treatment cart there was a risk of infection.

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F 880	Continued From page 122 2. On 10/14/22 at 11:21 AM, the surveyor interviewed the US FOIA (b)(6) who stated that the facility stored their 60 day emergency back up supply of Personal Protective Equipment (PPE, clothing and equipment worn to provide protection against hazardous substances or environments) outside in trailers. On 10/18/22 at 2:35 PM, the US FOIA (b)(6) US FOIA (b)(6) agreed to show the surveyors the emergency back up supply of PPE. The US FOIA (b)(6) ed the surveyors through the laundry area and called for the US FOIA (b)(6) US FOIA (b)(6) to unlock the door to access the PPE storage area which was kept outside of the facility. The US FOIA (b)(6) and a member of Housekeeping responded and led the surveyors outdoors to a locked fence that led to a covered area beneath the building. The surveyors observed multiple boxes of PPE, and resident care supplies such as adult briefs, egg crate foam (used to cover and cushion a mattress surface), and respiratory tubing which were stacked on pallets that were placed directly on the ground. The boxes were not covered and were stacked to a level that was just below the ceiling of the area that was adjacent to the refuge storage and the covered parking area under the building. The PPE that was observed was verified by the US FOIA (b)(6) which he stated consisted of KN-95 masks (face mask that blocks 95% of particles), gowns, and gloves. There was a soiled take-out food container, a loose surgical mask and a box of plastic disposable gowns that laid directly on the ground in direct contact with the pallets that held the PPE. The PPE storage area was in the same area that contained discarded medical equipment and furniture that was stacked high in the densely	F 880		

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F 880	Continued From page 123 packed, crowded area. Some of the equipment observed was covered by tarps. A portion of the ceiling that was closest to the outside perimeter of the storage area had collapsed and hung in place and both furniture and equipment were positioned directly below the hole in the ceiling. When interviewed at that time, the [US FOIA (b)(6)] stated,"Technically, we are outside under the building." He stated that the PPE was kept outdoors because the building was 60 years old and did not have enough storage. He stated that the supplies were maintained on skids and were technically off of the ground. The [US FOIA (b)(6)] stated that there was no other place to store the PPE and various medical equipment. The [US FOIA (b)(6)] opened a box of KN-95 masks and stated, "See, they are sealed in plastic and the integrity is preserved." The [US FOIA (b)(6)] further stated that there were fences around the area so "critters" could not get in. On 10/20/22 at 9:22 AM, the surveyor interviewed the [US FOIA (b)(6)] in the presence of the survey team, who stated that she knew that the PPE was stored outside in the cages since she began working at the facility in [NJ Exec Order 26.4b1] The [US FOIA (b)(6)] stated that she did not go into the area where the PPE was stored due to "a fear of bugs." The [US FOIA (b)(6)] stated that though the area was locked, squirrels, raccoons or anything could get in there. The [US FOIA (b)(6)] further stated that if there were heavy rain or snow it could compromise the integrity of the PPE and supplies. She further stated that the PPE was moved out of the cages and into the building yesterday (10/19/22). On 10/20/22 at 12:03 PM, the surveyor	F 880		

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F 880	Continued From page 124 interviewed the [US FOIA (b)(6)] who stated that he worked at the facility for [NJ Exec Order 26.4B1] He stated that while he did not have an inventory sheet to validate the quantity of PPE and the duration that the PPE was kept outdoors, he was certain that the PPE was moved to the outdoor area in [NJ Exec Order] under previous administration. Both the [US FOIA (b)(6)] and the US FOIA (b)(6) ed the surveyor to the Barber Shop where the PPE had been moved to. The Housekeeper stated that the boxes that were stacked high on pallets that were previously kept outdoors contained: gloves, gowns, respirator masks, COVID-19 rapid test kits, and hand sanitizer. The surveyor requested the [US FOIA (b)] to open one of the boxes whose cardboard exterior appeared weathered and the texture of the box was not smooth in appearance. When the [US FOIA (b)] opened the box it contained individually wrapped, disposable isolation gowns. The [US FOIA (b)] stated that he would open the boxes and examine the contents for mold and mildew prior to the PPE being released to the nursing units. c.) On 10/14/22 at 8:37 AM, the surveyor observed an Agency Licensed Practical Nurse (ALPN #2) reviewing medications in the Electronic Medication Administration Record (EMAR) for Resident #4. ALPN #2 stated prior to administering medications he had to check Resident #4's *Ex Order 26. 4B1* . ALPN #2 then went down the hallway and returned with a standing tower *Ex Order 26. 4B1* machine. On 10/14/22 at 08:39 AM, ALPN #2 and the surveyor entered the room of Resident #4. ALPN #2 informed the resident that he was there to check the [Ex Orde] prior to administering the medication. ALPN #2 then donned (put on)	F 880		

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F 880	Continued From page 125 gloves without performing hand hygiene. On 10/14/22 at 08:42 AM, ALPN #2 obtained the [redacted] results of 125/76 and removed his gloves. He then proceeded out of the room and immediately applied alcohol-based hand rub (ABHR) at the medication cart. On 10/14/22 at 08:46 AM, ALPN #2 gathered all the medications for Resident #4 from the medication cart and entered back into the resident's room and administered the medications. He then returned to the medication cart and applied ABHR. On 10/14/22 at 08:52 AM, ALPN #2 stated he needed to waste the [redacted] medication [redacted] and proceeded to the medication storage room and obtained a medication disposable bottle to be placed in the medication cart. ALPN #2 returned to his medication cart and informed the surveyor he "forgot" to administer the resident's [redacted]. On 10/14/22 at 08:56 AM, ALPN #2 entered the room of Resident #4 without performing hand hygiene, donned a pair of gloves, and administered the [redacted] to the resident. He removed his gloves and immediately applied alcohol-based hand rub (ABHR) at the medication cart. On 10/14/22 at 08:57 AM, ALPN #2 donned a new pair of gloves and opened the medication disposable bottle and disposed of the [redacted] inside of the bottle. He then removed his gloves and applied ABHR.	F 880		

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F 880	Continued From page 126 On 10/14/22 at 09:03 AM, the surveyor observed ALPN #2 prepare five (5) medications which included *Ex Order 26. 4B1* for Resident #5. The ALPN #2 placed the *Ex Order 26. 4B1* medications inside a medication cup. He then placed the *Ex Order 26. 4B1* inside his pocket. On 10/14/22 at 09:12 AM, the surveyor observed ALPN #2 administered the oral medications to Resident #5. At that time, ALPN #2 took the *Ex Order 26. 4B1* out of his pocket and without performing hand hygiene donned a pair of gloves. ALPN #2 then cleaned the resident's *Ex Order 26. 4B1* with an alcohol pad and administered the *Ex Order 26. 4B1*. ALPN #2 placed the syringe into the sharp's container, removed his gloves and applied ABHR. On 10/14/22 at 09:17 AM, ALPN #2 went down the hallway again and obtained the *Ex Orde* machine. ALPN #2 then entered Resident #5's room to obtain the vital signs. ALPN #2 donned a new pair of gloves without performing hand hygiene. At that time, ALPN #2 obtained the *Ex Orde* results, removed his gloves, and applied ABHR. On 10/14/22 at 09:21 AM, the surveyor interviewed ALPN #2 who stated hand hygiene should be performed before donning gloves and after removing them. He further stated since he was agency, he had been to so many facilities and was not sure if he had an in-service at this facility. When the surveyor asked if he used the appropriate hand hygiene technique before and after glove useage ALPN #2 concluded "hopefully I did" but was not sure because he was nervous since the surveyor watched him during medication pass.	F 880		

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F 880	Continued From page 127 On 10/14/22 at 12:17 PM, in the presence of the survey team the US FOIA (b)(6) US FOIA (b)(6) stated she in-serviced all staff including agency regarding hand hygiene. The US FOIA (b)(6) stated staff should have used hand hygiene before donning gloves and after they removed the gloves. She further stated that staff should perform appropriate hand hygiene because they constantly touched surfaces and interacted with residents during care and medication administration. The US FOIA (b)(6) concluded the importance of appropriate hand hygiene was to prevent the spread of infections. On 10/17/22 at 11:39 AM, the US FOIA (b)(6) US FOIA (b)(6) acknowledged ALPN #2 should have applied ABHR before he donned his gloves and after he removed them. She further stated that ALPN #2 should have performed hand washing both before and after he administered the injection. The US FOIA (b) stated that it was important to appropriately perform hand hygiene to ensure their hands were properly sanitized before and after contact with residents. The US FOIA (b)(6) concluded improper hand hygiene increased the risk for infection. A review of the in-service "Handwashing" on 10/3/22, that was provided by the US FOIA (b)(6) reflected that ALPN #2 was in attendance and revealed "handwashing is to be performed for at least 20 seconds ... ...or after 3 [three] uses of hand sanitizer." It further reflected "Hand washing during Medication Administration: Soap and water must be used [for] the following circumstances: 3. After any direct physical contact with any resident ..."	F 880		

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F 880	Continued From page 128 A review of the facility's policy, "Handwashing/Hand Hygiene," revised date 08/06/2020, provided by the Regional Nurse #2, reflected "6. Use an alcohol-based hand rub ...;or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations.: b. Before and after contact with residents; c. Before and after preparing or handling medications; d. Before performing any non-surgical invasive procedures; f. Before and after donning/doffing; g. Before handling clean or soiled dressings, gauze pads, etc.; h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a resident's intact skin; l. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; m. After removing gloves; ....9. Single-use disposable gloves should be used: a. Before aseptic procedures." A review of the facility's policy, "Infection Control: Wound Management," last reviewed 06/12/22, that was provided by the [redacted], revealed the following: Policy: It is the policy of this center to ensure that all appropriate personnel receive training and competency validation on wound management. Purpose: To comply with the Department of Health guidelines promote healing of wounds and prevent nosocomial infections related to wounds. 6. The Licensed Nurse: Gathers all supplies needed...9. Clean wound supplies are handled in a way to prevent cross contamination...10. Follow MD/NP for specific treatment, frequency and dressing covers. 11. Multi-dose creams and ointments should be dedicated to one resident whenever possible (maintain in plastic bag with resident's name)...and should not enter the resident	F 880		

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F 880	Continued From page 129 treatment area. For example, a small allocation of medication can be dispensed into a clean container for single resident use.	F 880		
F 881 SS=D	NJAC 8:39-27.1(a); NJAC 8:39:19.4 (a)(n) Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and review of other pertinent facility documentation, it was determined that the facility failed to ensure full implementation of the antibiotic stewardship program including ongoing monitoring and use of a nationally recognized surveillance criteria prior to consulting the prescriber. This deficient practice was identified for One (1) of one (1) resident reviewed for antibiotic stewardship, (Resident #11) and was evidenced by the following: On 10/11/22 at 11:34 AM, the surveyor interviewed the US FOIA (b)(6) US FOIA (b)(6) who stated that she had worked in the role since NJ Exec Order 26.4b1 and did not have previous IP experience. On 10/14/22 at 11:21 AM, the surveyor interviewed the US FOIA (b)(6) who stated that she	F 881	I. Immediate Action a) Resident #11- The US FOIA (b)(6) US FOIA (b)(6) was re educated about the Antibiotic Stewardship Program and use of the McGeer's criteria. Completion date 10/28/22 II. Identification of others a) The facility respectfully submits that there are no other residents currently on antibiotics although all residents can potentially be affected. III. Systemic Changes a) The Policy and Procedure on Antibiotic Stewardship was reviewed by the Medical Director and Director of Nursing and found to be in compliance.	12/5/22

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F 881	Continued From page 130 utilized a "Monthly Antibiotic Summary" form that she placed on the front of the Medication Administration Record (MAR) for the nurses to complete when they initiated an antibiotic. The US FOIA (b)(6) stated that the nurse phoned the physician and reported resident signs and symptoms of possible infection and if an antibiotic was ordered the nurse would e-mail, text or call the US FOIA (b)(6) to advise that an antibiotic was ordered for further evaluation. The US FOIA (b)(6) stated that the US FOIA (b)(6) recently reviewed the aforementioned process utilized by the US FOIA (b)(6) and informed her of a new computer program that she had not yet begun to utilize which tracked antibiotic usage over a three month time span. The US FOIA (b)(6) stated that she also just learned about the McGeer Criteria for Infection Surveillance Checklist form (surveillance checklist used for retrospectively counting true infections) a week prior to survey, when the RN informed the US FOIA (b)(6) that she was required to utilize the form in order to assess for appropriateness for antibiotic treatment prior to antibiotic initiation. The US FOIA (b)(6) stated that she had not utilized the McGeer Form previously, but it was now included within the computer software utilized by the facility. The US FOIA (b)(6) stated that she intended to do an in-service to educate the nursing staff regarding the McGeer Criteria so that nursing can complete the form at the time an antibiotic was ordered. The US FOIA (b)(6) further stated that at this time Resident #11 was the only resident who was ordered an Ex Order 26. 4B1. The US FOIA (b)(6) stated that the resident was ordered Ex Order 26. 4B1 to treat an Ex Order 26. 4B which was diagnosed with a Ex Order 26. 4B1. The US FOIA (b)(6) stated that on NJ Exec Order 26.4b1 the RN "began training me on how to do antibiotic	F 881	Completed 10/28/22 b) Additional training was provided to the Licensed practical nurse/Infection preventionist on her responsibilities for identifying, tracking and analyzing antibiotic usage. Completed by 10/28/22 c) Education will be provided to all nurses and Medical providers on Antibiotic Stewardship by the Staff Education/Medical Director. Completion date 11/22/22 IV. Quality Assurance a) Audits will be performed by the Licensed practical nurse/Infection preventionist for all residents placed on Antibiotics. b) This audit will be performed by the Licensed practical nurse/Infection preventionist weekly x 4 weeks, monthly x 2 weeks then quarterly x 3 quarters. c) All negative finding will be brought to the Medical Director and Director of Nursing (DON) immediately. d) The results of all Audits will be brought to Quality Assurance committee meeting quarterly x 4 quarters. V. Person Responsible: Director of Nursing (DON) or designee	

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stewardship and I was provided with access to the computer software and the required McGeer Form at that time." The [US FOIA (b)(6)] stated that she was still learning and was informed by the RN that she needed to expand on the process that she currently utilized to track [Ex Order 26. 4B1] usage at the facility because "the process entailed more than what I was doing."

On 10/17/22 at 12:51 PM, the [US FOIA (b)(6)] provided the surveyor with a copy of the "Monthly Antibiotic Summary" which was reviewed and revealed that Resident #11 was ordered [Ex Order 26. 4B1] (frequency and duration not specified) on [NJ Exec Order 26.4b1] The form did not list the end date for [Ex Order 26. 4B1], resident's signs and symptoms [Ex Order 26. 4] result, origin of illness, or whether or not the resident met the criteria for [Ex Order 26. 4B1] stewardship which were required elements of the form.

A review of Resident #11's Resident Face Sheet revealed that the resident was readmitted to the facility in [NJ Exec Order 26.4b1] with diagnoses which included but were not limited to: [Ex Order 26. 4B1] , and *Ex Order 26. 4B1* .

A review of Resident #11's Progress notes revealed that on [NJ Exec Order 26.4b1] at 1:40 PM, Nursing documented that the resident was examined by the [US FOIA (b)(6)] on clinical rounds and a new order was transcribed for an *Ex Order 26. 4B1* for the resident to begin *Ex Order 26. 4B1* for 10 days, [Ex Order 26. 4B1] revealed a diagnoses of [Ex Order 26. 4B1].

A review of Resident #11's Medication

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F 881	Continued From page 132	F 881		

Administration Record (MAR) revealed that the resident received [redacted] once daily from [redacted].

On 10/18/22 at 1:52 PM, the surveyor phoned the [redacted] in the presence of the survey team. The [redacted] stated that he provided education to the facility staff related to antibiotic stewardship during the Quality Assurance (QA) Meeting in [redacted]. The [redacted] stated that he informed the staff that nursing should have a process in place when they phoned the physician to initiate an antibiotic as we were fighting to avoid providing the wrong information. The [redacted] stated that nursing was required to provide the resident's [redacted], presentation, appropriateness for treatment such as diagnostic testing prior to antibiotic usage. The [redacted] stated that the nursing department had a tool that they showed him at the QA meeting and he was okay with it, though he did not recall the name of the tool.

On 10/19/22 at 11:19 AM, the surveyor interviewed the [redacted] who stated that the [redacted] informed her that she was required to utilize a spreadsheet as she was reportedly, "Just writing stuff down on notes in a notebook." The [redacted] further stated that that was when she started typing up the antibiotic monitoring. The [redacted] was unable to furnish the surveyor with the notebook for review when requested.

The [redacted] further stated that on [redacted] the [redacted] came to the facility and assessed the process that she had in place for antibiotic stewardship as "they had told me prior that I was required to use the McGeer Criteria, but I was not using it." The [redacted] stated that the [redacted] then "showed me how

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F 881	Continued From page 133 to use the McGeer Criteria in the computer and I am going to begin using it going forward this month to get comfortable with the process." The US FOIA (b)(6) ntended to assist her with the transition to organize the antibiotic stewardship program. On 10/20/22 11:22 AM the US FOIA (b)(6) US FOIA (b)(6) who stated that education was conducted with the US FOIA (b)(6) last night, in the past, and this past Monday on NJ Exec Order 26 4b1 regarding full Antibiotic Stewardship implementation. The US FOIA (b)(6) stated that as of Monday, the staff nurses were in-serviced and were expected to utilize the McGeer Criteria for all antibiotic orders and the Director of Nursing (DON) stated that the McGeer SBAR (Situation, Background, Assessment, Recommendation) should have already be in use as of 10/17/22. The US FOIA (b)(6) stated that she had documentation of the in-services which were left on her desk. When requested by the surveyor prior to exit, the facility failed to provide the surveyor with documented evidence that the nursing staff was in-serviced as previously described by the US FOIA (b)(6) Review of the facility policy titled, "Antibiotic Stewardship," reviewed 01/2022, revealed the following: Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program. 1. The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents. 2. Orientation, training and education of staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects individual residents and the overall community.	F 881		

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F 881	Continued From page 134 Review of the facility policy titled, "Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcomes," reviewed 01/2022, revealed the following: Policy Statement: Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. 1. As part of the facility Antibiotic Stewardship Program, all clinical infections treated with antibiotics will undergo review by the Infection Preventionist, or designee. 2. The IP, or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. a. Therapy may require further review and possible changes if: 1. The organism is not susceptible to antibiotic chosen; 2. The organism is susceptible to narrower spectrum antibiotic 3. Therapy was ordered for prolonged surgical prophylaxis; or 4. Therapy was started awaiting culture, but culture results and clinical findings do not indicate continued need for antibiotics. 3. At the conclusion of the review, the provider will be notified of the review findings. 4. All resident antibiotic regimens will be documented on the the facility-approved antibiotic surveillance tracking form. The information gathered will include: a. Resident name and medical record number; b. Unit and room number; c. Date symptoms appeared; d. Name of antibiotic (see approved surveillance list); e. Start date of antibiotic; f. Pathogen identified (see approved surveillance	F 881		

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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 881	Continued From page 135 list); g. Site of infection; h. Date of culture; i. Stop date; j. Total days of therapy; k. Outcome; and i. Adverse events.	F 881		
F 888 SS=D	NJAC 8:39-19.4(a)(d) COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with	F 888		12/5/22

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	315124	A. BUILDING _____ B. WING _____	10/20/2022

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F 888	Continued From page 136 residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination	F 888		

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F 888	Continued From page 137 requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully	F 888		

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F 888	Continued From page 138 vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of other facility documentation, it was determined that the facility failed to ensure that mitigation measures were followed to prevent the potential spread of COVID-19, a contagious respiratory infection. This deficient practice was identified for two (2) of three (3) unvaccinated staff, and was evidenced by the following: On 10/06/22 at 09:07 AM, the survey team was greeted by the US FOIA (b)(6) US FOIA (b)(6) who stated that there were three Ex Order 26. 4B1 residents at the facility. He clarified that two of the residents were Ex Order 26. 4B1 upon admission and one resident tested Ex Order 26. 4B1 at the facility. He stated that staff were expected to wear a surgical mask throughout the facility and were required to wear full Personal Protective Equipment (PPE, protective clothing or equipment worn to minimize exposure to hazards that cause injuries or illness) which included an N-95 mask (filters at least 95% of airborne particles), surgical mask, eye protection, gown	F 888	I. Immediate attention a) Food Service Director (FSD) was reeducated on the requirement to wear N95 mask at all times due to being unvaccinated. The FSD was fit tested for an N95 mask. FSD signed a new attestation form requiring N95 was reviewed, signed and dated. Completion date 10/20/22 b) Human Resources Staffing Coordinator (HRSC) was reeducated on the requirement to wear N95 mask at all times due to being unvaccinated. The HRSC had already been fit tested. The HRSC signed a new attestation form requiring N95 was reviewed, signed and dated. Completion date 10/20/22 II. Identification of others: a) The facility respectfully submits that there are no other employees at this time with a medical exemption for COVID-19 vaccine requirement, however, all residents could be affected by this deficient practice .	

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F 888	Continued From page 139 and gloves when they entered the area designated for NJ Exec Order 26.4b1 residents and Persons Under Investigation (PUI, persons who were under observation for signs and symptoms of NJ Exec Order 26.4b1 On 10/11/22 at 11:34 AM, the surveyor interviewed the US FOIA (b)(6) US FOIA (b)(6) who stated that she was new to the role as of NJ Exec Order 26.4b1 The US FOIA (b)(6) stated that Human Resources (HR) determined staff vaccination status prior to hire and informed her of their status. The US FOIA (b)(6) presented the surveyor with the completed NJ Exec Order 26.4b1 Staff Vaccination Status for Providers form which indicated that there were two staff members who were not vaccinated that were granted an exemption. On 10/18/22 at 11:26 AM, the surveyor interviewed the US FOIA (b)(6) and requested to view the vaccination status of the contracted staff. At 2:25 PM, in a later interview with the US FOIA (b)(6), she provided the surveyor with the requested vaccination status of contracted staff. At that time, the newly hired US FOIA (b)(6) who wore only a surgical mask and eye glasses, presented to the lobby of the facility and informed the surveyor that she was not vaccinated against NJ Exec Order 26.4b1 and was granted an exemption. The US FOIA (b)(6) showed the surveyor documented evidence of exemption on her cell phone. On 10/19/22 at 10:34 AM, the surveyor interviewed the US FOIA (b)(6) who wore only a surgical mask and eye glasses. The US FOIA (b)(6) stated that she began working at the facility a week ago. She stated that she was required to wear a surgical	F 888	III. System Changes a) The Policy and Procedure COVID-19 Employee vaccination were reviewed and revised to ensure that if employee is hired with a medical exemption for COVID-19 vaccine, he/she will be fit tested immediately upon hire. Completion date 10/28/22 b) Education will be provided to both the FSD and HRSC about requirements for wearing N95 mask at all times while in the facility regardless of where they are in the building. Completion date 10/20/22. IV. Quality Assurance a) Audits will be done of all unvaccinated/medical exemption employees to monitor compliance with the COVID -19 medical exemption mandate to wear N95 masks at all times. b) These audits will be done at random times both in their departments and when out of their respective departments by various department heads to ensure that the mandate is complied with at all times. These audits will be done weekly x 4, monthly x 2 months and then quarterly x 3 quarters. V. Person Responsible: Infection Preventionist, DON or designee	

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F 888	Continued From page 140	F 888		

mask unless she were to go upstairs to the nursing units, then she was required to wear an N-95 mask. She further stated that she was required to be tested twice weekly for [NJ Exec Order 26.4b1] due to her vaccination status.

On 10/19/22 at 10:42 AM, the surveyor interviewed the [US FOIA (b)(6)] [US FOIA (b)(6)] who confirmed that the mask that she wore was a surgical mask. The [US FOIA (b)(6)] stated that she was hired six months ago. The [US FOIA (b)(6)] stated that due to her vaccination status she was required to wear a surgical mask unless she went up to the first floor, then she was required to wear an N-95 mask due to positive [NJ Exec Order 26.4b1] cases on the unit. The [US FOIA (b)(6)] stated that she was tested twice weekly for [NJ Exec Order 26.4b1] and once weekly if there were no cases of [NJ Exec Order 26.4b1] n the building. The [NJ Exec Order 26.] stated that due to her vaccination status she was told to practice social distancing, perform hand hygiene and was told that N-95 mask use was optional. The [US FOIA (b)(6)] confirmed that she was not fit tested for N-95 mask usage. The survey team who was present at that time, confirmed that the [US FOIA (b)(6)] wore a surgical mask each day of the survey when she dropped off the daily staffing sheets to the team.

On 10/20/22 at 8:35 AM, the [US FOIA (b)(6)] entered the conference room and wore only a surgical mask when she dropped off the daily staffing sheet. The [US FOIA (b)(6)] stated that she spoke to the [US FOIA (b)(6)] yesterday and was informed of the need to perform hand hygiene and wear an N-95 mask when there were positive [NJ Exec Order 26.4b1] cases on the first floor. The [US FOIA (b)(6)] further stated that was the only guidance that she received regarding N-95 mask usage.

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F 888	Continued From page 141 On 10/19/22 at 11:20 AM, the surveyor interviewed the [US FOIA (b)(6)] who stated that staff who were not vaccinated and were granted an exemption were informed that they were required to wear a surgical mask and that an N-95 mask was only required if someone tested positive on the first floor. The [US FOIA (b)(6)] stated that staff were fit tested for N-95 use with the exception of the [US FOIA (b)(6)] as she was newly hired. The [US FOIA (b)(6)] stated that she received guidance regarding PPE usage of unvaccinated staff from a former nurse colleague who precepted her and no longer worked at the facility. The facility was unable to provide the surveyor with a contingency plan or policy related to required PPE usage for unvaccinated staff to prevent the spread of [NJ Exec Order 26.4b1] On 10/20/22 at 11:22 AM, the [US FOIA (b)(6)] stated that Fit testing was required for N-95 usage and that an attestation was signed by all exempted employees of the need to wear an N-95 mask at all times within the facility. At that time, the [US FOIA (b)(6)] provided the surveyor with an undated attestation form that was signed by the [US FOIA (b)(6)] which indicated that she was required to wear an N-95 mask at all times, in addition to weekly [NJ Exec Order 26.4b1] testing. The [US FOIA (b)(6)] also provided the surveyor with an attestation form that was signed by the [US FOIA (b)(6)] that was dated [NJ Exec Order 26.4b1] which indicated that the [US FOIA (b)(6)] was educated to wear an N-95 at all times at work and was fit tested for appropriateness to wear an N-95 mask on 10/19/22. NJAC 8:39-5.1(a), 19.4	F 888		

New Jersey Department of Health

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	061101	A. BUILDING: _____ B. WING _____	10/20/2022

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to: a) maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey. This was evident for three (3) of 14 day shifts reviewed, b) ensure that the facility complied with applicable state rules and regulations with regard to the New Jesey Department of Health (NJDOH) Vaccination Mandate for COVID-19 to mitigate the spread of COVID-19. There were a total of 4 of 74 total staff that were eligible for a COVID-19 booster as of 10/14/22 , and c) ensure that the facility Outbreak Response Plan for COVID-19 was posted to their website as required in accordance with the State of New Jersey Department of Health Executive Directive No 20-026-1 dated October 20, 2020,	S 560	I. Immediate Action 1. The facility respectfully submits that staff to resident ratios will be reviewed to ensure compliance with the state of New Jersey's new minimal staffing requirements dated 1/28/21. Completion date 10/28/22 2. There are no other medically exempt employees for COVID vaccine. 3. The facility Website was updated to include the COVID Outbreak response plan. Completion date 10/28/22 II. Identification of Others: i. The facility respectfully submits that all residents may be affected by this practice. ii. There is no other medically exempt	12/5/22

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

Electronically Signed — 11/12/22

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S 560	Continued From page 1 revealed the following: Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: 1. One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. a) As per the "Nurse Staffing Report" completed by the facility for the weeks of 09/18/22-09/24/22 and 09/25/22-10/01/22, the staffing-to-resident ratios that did not meet the minimum requirement of one (1) CNA to eight (8) residents for the day shift are documented below: -09/19/22 had 10 CNAs for 85 residents on the day shift, required 11 CNAs. -09/22/22 had 9 CNAs for 83 residents on the day	S 560	employees for COVID vaccination iii. There are no other required documentation missing from the Website. III. System Changes 1. Policy and Procedure for Minimal Staffing was reviewed and revised by Administrator and Director of Nursing (DON) to include staffing ratio of Certified Nursing Assistants (C.N.A.s) of 1:8 for day shift, 1:10 for evening shift and 1:14 for the night shift. Completion date 10/28/22 2. Policy and Procedure for COVID medical exemption were reviewed and revised to include N95 masks required at all times for the unvaccinated staff with COVID medical exemption regardless of the unit/floor assignment. Completion date 10/28/22 3. Policy and Procedure for COVID Outbreak Response Plan was reviewed and revised by the Administrator to include posting plan on facility website for public viewing. Completion date 10/28/22 4. Director of Nursing (DON) or Administrator will review open positions and applications plus results of any interviews weekly to look for opportunities to hire. 5. The Administrator and Director of Nurses will continue to utilize all possible means to increase the facility staff. This will include continued timely interviews, job fairs, reaching out to agencies for supplemental staff, setting up booths at nursing schools, utilization of all possible avenues to increase staffing in the facility. IV. Quality Assurance	

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S 560	Continued From page 2 shift, required 10 CNAs. -09/24/22 had 9 CNAs for 83 residents on the day shift, required 10 CNAs. On 10/18/22 at 10:51 AM, the surveyor interviewed the Staffing Coordinator (SC) who stated that the required staffing ratios were 1:6 for day shift, 1:8 for evening shift and 1:10 for night shift and that she was staffing appropriately. The SC acknowledged that the facility was sometimes short staffed due to last minute call outs. The SC then stated she remembered that the staffing ratio was 1:8 for day shift, 1:10 for evening shift and 1:14 for night shift. On 10/18/22 at 12:38 PM, the surveyor interviewed the Director of Nursing (DON), in the presence of the Licensed Nursing Home Administrator (LNHA), who stated that the facility staffing ratios were 1:8 for the day shift, 1:10 for the evening shift and 1:12 for the night shift. The DON stated that she was made aware of changes in staffing through Human Resources personnel who were responsible for the scheduling, and that she communicated about staffing daily with the LNHA. The DON stated that if there were staffing issues that she would have contacted the LNHA and that they both would have attempted to staff appropriately by utilizing the staff that were on duty, they would have called in staff or they would have used agency staff to cover. The DON further stated that they may have been short staffed if they had last minute call outs that were not replaced but that they were staffing appropriately. The DON continued that the correct ratio for staffing was 1:8 for day shift, 1:10 for evening shift and 1:14 for night shift.	S 560	1a) Audits will be completed by the staffing coordinator to ensure that all staffing complies with new staffing ratios. 1b) Audits will be done by the staffing coordinator and submitted to the Director of Nursing or Administrator weekly x 4 weeks, monthly x 2 weeks and quarterly x 3 quarters. 1c) All negative findings will be brought to the Director of Nursing/Administrator's attention immediately. 1d) The results of all audits will be brought to the Quality Assurance committee quarterly x 4 quarters. 2a) Audits of all staff vaccination status will be performed by Licensed Practical Nurse (LPN)/Infection Preventionist (IP) and Human Resources/staffing coordinator to ensure that all employees except exempt employees are up to date with COVID vaccinations. 2b) Audits will be performed weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters. 2c) All negative findings will be brought to the Administrator immediately. 2d) The results of all audits will be brought to the Quality Assurance meeting quarterly x 4 quarters. 3a) An audit will be conducted of the facility website by Administrator /designee to ensure all new changes that require facility website posting are included. 3b) These audits will be conducted weekly x 4 weeks, then monthly x 2 months and quarterly x 3 quarters. 3c) All negative findings will be brought to the Administrator immediately	

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S 560	Continued From page 3 2) According to the NJDOH Executive Directive No. 21-011, 2nd Revised, dated 09/02/22, Protocols for COVID-19 Testing and Vaccination Reporting for Covered Settings reflected "WHEREAS, Executive Order No. 294 continues to require workers in covered health care and high-risk congregate care settings to be up to date with their COVID-19 vaccinations, including the first booster dose for which they are eligible, in order to help prevent outbreaks and reduce transmission to vulnerable individuals who may be at higher risk of severe disease..." According to the Centers for Disease Control (CDC) updated boosters are recommended for some people. CDC recommends that people ages 5 years and older receive one updated (bivalent COVID-19 vaccine, includes a component of the original virus strain to provide broad protection against COVID-19 and a component of the omicron variant) if it has been at least two (2) months since their last COVID-19 vaccine dose, whether that was: Their final primary series dose, or an original (monovalent) were also recommended to get an updated (bivalent) booster. Licensed Practical Nurse/Infection Preventionist (LPN/IP) regarding the completed COVID-19 Staff Vaccination Status for Provider form that she provided on 10/12/22. Review of the matrix revealed that there were four employees who were eligible and had not received a booster dose when eligible. The surveyor requested to view the employee vaccination cards which were provided and revealed the following: 1. Housekeeper #1 was eligible for a second dose of a primary series vaccine on [NJ Exec Order 26.4b1] which was administered on [NJ Exec Order 26.4b1] 2. Housekeeper #2 received a second dose of a primary series vaccine on [NJ Exec Order 26.4b1] 3.	S 560	3d) The results of all audits will go to the Quality Assurance meeting quarterly x 4 quarters. V. Responsibility 1. Director of Nursing 2. LPN/IP 3. Administrator	

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	061101	A. BUILDING: _____ B. WING _____	10/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLE CARE NURSING AND REHABILITATION	439 BELLEVUE AVENUE TRENTON, NJ 08618

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S 560	Continued From page 4 Housekeeper #3 received a second dose of a primary series vaccine on [NJ Exec Order 26.4b1] 4. Maintenance #1 received a second dose of a primary series vaccine on [NJ Exec Order 26.4b1] On 10/18/22 at 2:25 PM, during an interview with the LPN/IP, she stated that she just realized after surveyor inquiry that staff could have been boosted two months after they received their second dose of a primary series vaccine rather than the previously recommended time frame of five months. At that time, she provided the surveyor with a notice she received from the facility pharmacy provider dated 09/01/22, titled, "Memo: New Bivalent COVID-19 Vaccine Update" which specified that the original primary series vaccines were no longer authorized for use as a booster and may only be used for primary series dosing. The guidelines for the new booster were as follows: Moderna: Individuals 18 years of age and older are eligible for a single booster dose of the Moderna COVID-19 Vaccine, Bivalent if it has been at least two months since they received primary vaccination or have received the most recent booster dose with any authorized or approved monovalent COVID-19 vaccine (Pfizer, Moderna or Janssen). Pfizer: Individuals 12 years of age and older are eligible for a single booster dose of the Pfizer-BioNtech COVID-19 Vaccine, Bivalent if it as been at least two months since they completed primary vaccination or have received the most recent booster dose with any authorized or approved monovalent COVID-19 vaccine (Pfizer, Moderna or Janssen). The LPN/IP stated that she had since vaccinated Maintenance #1 and agreed to furnish the employee's COVID-19 Vaccination Record Card for review. Review of Maintenance #1's COVID-19 Vaccination Record Card revealed that the LPN/IP administered the recommended	S 560		

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S 560	Continued From page 5 bivalent booster on 10/14/22. On 10/20/22 at 9:22 AM, the surveyor interviewed the LPN/IP who clarified that she received guidance from the Pharmacy provider in September of 2022 that she should wait to boost residents and staff until October when the new booster was released. The LPN/IP stated that four employees were eligible for boosters as of 10/14/22, one of which was scheduled to be boosted today. The LPN/IP stated that the remainder of the employees that were due for boosters were notified and would be boosted as soon as possible. c. On 10/05/22 prior to survey, the surveyor reviewed the facility website and noted that the COVID-19 Outbreak Response Plan was not posted for public view as required in accordance with the State of New Jersey Department of Health Executive Directive No 20-026-1 dated October 20, 2020. On 10/19/22 at 10:34 AM, during an interview with the LPN/IP, the surveyor reviewed each page of the facility website with the LPN/IP to clarify if the COVID-19 Outbreak Response Plan had been posted to the facility website and neither the LPN/IP nor the surveyor were able to locate the document. The LPN/IP stated that the COVID-19 Outbreak Response Plan was posted on the old website when the facility was under different ownership. The LPN/IP stated that she was unsure who was responsible to ensure that the new website remained current. On 10/27/22 at 2:39 PM, in a post-survey e-mail, the surveyor asked the Regional Nurse (RN) who was responsible to ensure that the COVID-19 Outbreak Response Plan was posted to the	S 560		

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S 560	Continued From page 6 facility website? On 10/27/22 at 4:04 PM, the RN responded to the surveyor via e-mail and stated that the COVID-19 Outbreak Response Plan was posted on the website. The surveyor reviewed the site and noted that the COVID-19 Outbreak Response Plan was posted in an area that was previously reviewed with LPN/IP who also confirmed that it was not available for public view at that time as required. NJAC 8:39-5.1(a)	S 560		

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/19, 20/2022 and Belle Care Nursing and Rehabilitation was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Belle Care Nursing and Rehabilitation three story, Type II Fire Resistant building. The facility is divided into 5 smoke zones.	K 000		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 10/19/2022 in the presence of facility management, it was determined that the facility failed to ensure that illuminated exit signs were in four (4) locations to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the	K 293	1. An exit sign next to room [redacted] was installed. Additionally, an exit sign next to room [redacted] was installed so as to ensure that the Direction of exit is visible when the fire doors are closed. The rest of the building was inspected to ensure that all exit signs are visible in the path of egress. 2. This deficient practice affects all	11/10/22

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

Electronically Signed | 11/12/2022

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K 293	Continued From page 1 following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 During the survey entrance at 08:59 AM, a request was made to the facility US FOIA (b)(6) and US FOIA (b)(6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. A review of the facility provided lay-out identified there is a Basement, Ground floor, First floor and Second floor in the facility. Later starting at 09:22 AM, during a tour of the building with the US FOIA (b)(6) US FOIA (b)(6) and US FOIA (b) the surveyor observed that the facility failed to provide four (4) illuminated exit signs in the following locations, 1) At approximately 09:39 AM, on the 2nd. floor two (2) illuminated exit signs above the corridor double smoke doors next to Resident room EX Order. When the fire alarm was activated the magnetic hold open devices release the corridor doors and you could not see the illuminated exit sign located beyond the double smoke doors.	K 293	residents and personnel in the building due to the fact that it can potentially be a life safety issue should the direction of egress not be clearly marked and become confusing during an emergency evacuation. This confusion can potentially result in the loss of life. 3. An in-service was done with the maintenance staff as to the importance of clearly marked path of egress so as to ensure safe evacuation. The Administrator as well as the Maintenance Director will do weekly rounds to ensure that all exit signs are visible to assure a safe path of egress. Completion date 11/10/22 4. All findings will be reviewed with the quality assurance committee on a monthly basis.	

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K 293	Continued From page 2 A review of an emergency evacuation diagram posted near the dining room, identify you would need to pass through the double smoke doors this was a primary and secondary exit access route to reach an exit. 2) At approximately 10:37 AM, on the 1st. floor two (2) illuminated exit signs above the corridor double smoke doors next to Resident room #1. When the fire alarm was activated the magnetic hold open devices release the corridor doors and you could not see the illuminated exit sign located beyond the double smoke doors. A review of an emergency evacuation diagram posted near the dining room, identify you would need to pass through the double smoke doors this was a primary and secondary exit access route to reach an exit. The US FOIA (b)(6) confirmed the findings at the time of observations. The US FOIA (b)(6) was notified of the deficiency at the Life Safety Code exit conference on 10/20/2022 at approximately 01:35 PM. Fire Safety Hazard. NJAC 8:39 -31.1 (c) NFPA Life Safety Code 101	K 293		
K 311 SS=E	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction	K 311		11/10/22

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K 311	Continued From page 3 having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations on 10/19/2022 in the presence of facility Management, it was determined that the facility failed to ensure that two (2) of eight (8) exit access stairwell doors tested were capable of maintaining the 1-1/2 hour fire rated construction. This is evidenced by the following, On 10/19/2022 starting at 09:22 AM, a tour of the building in the presence of the Corporate Regional Maintenance (CRM) and Maintenance Director (MD) was performed. Along the tour the MD and surveyor performed a closure test of the eight (8) 1-1/2 hour fire rated doors leading into the stairwells, two (2) 1-1/2 hour fire rated doors did not positive latch into their frame as required by code to maintain the fire rated construction in the following location, 1. At 10:17 AM, on the second floor during a closure test of the exit access door next to Resident room #40 leading into the stairwell when tested and allowed to self-close into its frame, the door did not positive latch into its frame. This test was repeated two additional times with the same results. 2. At 10:52 AM, on the first floor during a closure test of the exit access door next to Resident room #17 leading into the stairwell when tested and	K 311	1. The exit door to the stairwell located near room [redacted] as well as the exit door located near room [redacted] where repaired so that they positive latch even when the magnet is disengaged. The rest of the building exit doors to the stairwell were checked to ensure that the doors positive latch even when the magnets are disengaged. 2. This deficient practice effect all residents and personnel in the facility due to the fact that it can be a life safety issue should the fire doors not maintain proper fire resistance. 3. An in-service was done with the maintenance staff as to the importance of all fire exit doors having to maintain proper fire resistance even when the magnets are disengaged. The Administrator as well as the Maintenance director will do weekly rounds to test the doors so that they properly Latch when the magnets are disengaged. Completion date 11/10/22 4. All findings will be reviewed with the quality assurance committee on a monthly basis.	

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K 311	Continued From page 4 allowed to self-close into its frame, the door did not positive latch into its frame. This test was repeated two additional times with the same results. The stairwell doors would need to positive latch into its frame to maintain the fire rated construction to prevent fire, smoke and poisonous gases to enter the exit stairwell in the event of a fire. The US FOIA (b)(6) onfirmed the findings at the time of observations. The US FOIA (b)(6) was notified of the deficiency at the Life Safety Code exit conference on 10/20/2022 at approximately 01:35 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 311		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 321		11/10/22

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K 321	Continued From page 5 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation on 10/19/2022 in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following: On 10/19/2022 during the survey entrance at 08:59 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. During the building tour with the US FOIA (b)(6) US FOIA (b)(6) at approximately 11:05 AM, an inspection of the Medical records storage room was performed.	K 321	1. The door to the medical records storage room was repaired to assure that the door closes and latches automatically and is not impeded by the floor. Alt other storage rooms throughout the facility with potentially hazardous storage were checked to assure that the doors self-close and latch properly, automatically with a self-closer. 2. An in-service was done with all the staff in the facility as to the importance of the self-closing and latching of these hazardous storage room doors. A malfunction can result in the spreading of fire into the corridor. In addition, the staff was in serviced not to hold open or block these doors with objects so that they can automatically close. The staff was instructed to report any doors that do not self-close or. Latch properly, to the maintenance department. Completion date: 11/10/22 3. The Maintenance Director as well as the Administrator will do weekly rounds to	

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K 321	Continued From page 6 The surveyor observed the corridor door was in the open position. A closure test of the corridor door was performed. When the door was opened to a 90 degree opening to the doors frame and release the door did not close. The door rubbed on the floor and did not close into its frame. This test was performed a second time with the same result. The surveyor observed inside the room had multiple combustible products in the room. The surveyor recorded the room to be eight (8) feet seven (7) inches by ten (10) feet four (4) inches (88 square feet) which is larger than 50 square feet. The door failed to self-close into its frame as required by code. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. The US FOIA (b)(6) confirmed the findings at the time of observations. The US FOIA (b)(6) was notified of the deficiency at the Life Safety Code exit conference on 10/20/2022 at approximately 01:35 PM. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321	ensure that all these doors, self-close and latch properly and that none of these doors are held open with devices. 4. All findings will be reviewed with the quality assurance committee on a monthly basis.	
K 531 SS=E	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated	K 531		11/10/22

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K 531	Continued From page 7 monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 10/19/22 and 10/20/2022, in the presence of facility management it was determined that the facility failed to maintain elevator emergency communications for one (1) of two (2) elevators tested, in accordance with ASME/ANSI A17.3. This deficient practice was evidenced by the following: On 10/19/2022 during the survey entrance at 8:59 AM, a request was made to the US FOIA (b)(6) and US FOIA (b)(6) how many elevators are in the building. The Administrator told the surveyor that there are two (2) elevators. On 10/19/2022 during a tour of the building in the presence of the facility US FOIA (b)(6) US FOIA (b)(6) at 10:24 AM, a test of elevator #1 emergency telephone was performed. When the surveyor tested the emergency phone it did not function properly. This test was repeated a second time with the same result.	K 531	1. A new telephone was installed for elevator number one. Elevator number two was also tested to assure that the telephone works. 2. This deficient practice effects all residents and personnel in the building due to the fact that anybody that is stuck in the elevator cannot call for help, which can potentially be a life safety issue. 3. All the staff in the building were in-serviced as to the importance of a working telephone in the elevator. They were also instructed to report to the maintenance department should the elevator fail to work. The Administrator as well as the Maintenance Director will test the telephones in the elevators on a weekly basis to ensure that they work properly. Completion date 11/10/22 4. All findings will be reviewed with a quality assurance committee on a monthly basis.	

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BELLE CARE NURSING AND REHABILITATION CENTER	**439 BELLEVUE AVENUE TRENTON, NJ 08618**

(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 531	Continued From page 8 At this time the [US FOIA (b)(6)] told the surveyor that they are aware of the none functioning emergency phone and that a technician is coming in today to repair the phone. On 10/20/2022 (day two of survey) at 12:20 PM, a test of elevator #1 emergency telephone was performed. When the surveyor tested the phone it did not function properly. This test was repeated a second time with the same result. An interview was conducted during the two observations with the [US FOIA (b)(6)] He acknowledged and confirmed that the emergency communication telephone in elevator #1 did not function. The [US FOIA (b)(6)] was notified of the deficiency at the Life Safety Code exit conference on 10/20/2022 at approximately 01:35 PM. NJAC 8:39-31.2(e) ASME/ANSI A17.3	K 531		
K 918 SS=E	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	K 918		11/10/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315124	A. BUILDING **01 - CAPITAL NURSING CENTER** B. WING _____	**10/20/2022**

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K 918	Continued From page 9 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: Based on observation and interview on 10/19/2022 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for one (1) of one (1) emergency generator was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice was evidenced by the following: On 10/19/2022 during the survey entrance at 08:59 AM, a request was made to the [redacted] if the facility had an emergency generator. The [redacted] stated, yes we have one.	K 918	1. The remote emergency shut off switch to the generator was installed. 2. This deficient practice can potentially affect all residents and personnel in the building. Due to the fact that should the generator be engulfed in flames or smoke condition while in operation, it cannot be shut off quickly because the shut off switch is not located remotely for easy access. 3. The Maintenance Director and staff were in serviced as to the importance of a remote emergency shut off switch to the generator. This switch will be tested on a monthly basis by the Maintenance Director as well as the Administrator, to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315124	A. BUILDING **01 - CAPITAL NURSING CENTER** B. WING _____	**10/20/2022**

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K 918	Continued From page 10 During the building tour with the US FOIA (b)(6) US FOIA (b)(6) at approximately 11:12 AM, an inspection inside the boiler room where the Natural Gas emergency generator was located was performed. At that time the surveyor asked the US FOIA (b), where was the remote emergency shut off for the generator. The US FOIA (b) informed the surveyor, that there was no remote emergency shut off. The surveyor observed that the emergency shut off was located on the generator's control panel. The US FOIA (b)(6) confirmed the findings at the time of observations. The US FOIA (b)(6) was notified of the deficiency at the Life Safety Code exit conference on 10/20/2022 at approximately 01:35 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	ensure its proper operating function. Completion date 11/10/22 4. All findings will be reviewed with the quality assurance committee on a monthly basis.	