STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315113	A. BUILDING _____ B. WING _____	C 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHABILITATION CENTE	112 FRANKLIN CORNER ROAD LAWRENCEVILLE, NJ 08648

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Survey: 10/31/23 This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaints: NJ00154446, NJ00152357, NJ00164964, NJ00167976, NJ00165907, NJ00167863 STANDARD SURVEY: 10/31/23 CENSUS: 89 SAMPLE: 18 + 3 closed records The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550		12/13/23

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

Electronically Signed | 11/28/2023

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F 550	Continued From page 1 promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of other facility documentation, it was determined that the facility failed to provide privacy and promote dignity during resident assessment and medication administration. This deficient practice was identified for 2 of 2 residents (#20 and #52) reviewed for dignity and	F 550	1.Resident #20 & #52 were both affected by this deficient practice - There were no ill effects to either resident as a result of this deficient practice.Resident Rights reviewed with #20 and due to *Ex Order 26. 4B1* with resident #52 has no recollection of the event.	

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F 550	Continued From page 2 was evidenced by the following: 1. During the initial tour of the facility on 10/24/23 at 10:45 AM, the surveyor observed Resident #20 seated in the wheelchair in the hallway outside of their room. When interviewed, the resident reported a Ex Order 26. 4B1 last evening. Review of Resident #20's Admission Record revealed that the resident was readmitted to the facility in Ex Order 26. 4B1 with diagnosis which included but were not limited to: Ex Order 26. 4B1 [redacted]. Review of Resident #20's Quarterly Minimum Data Set (MDS), an assessment tool dated Ex Order 26. 4B1, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that the resident was Ex Order 26. 4B1. On 10/26/23 at 11:48 AM, the surveyor observed Resident #20 seated in a wheelchair at the bedside with their lunch tray on the bedside table in front of them. The resident reported a Ex Order 26. 4B1 [redacted] and stated that they did not feel well and did not feel hungry, but the food was good. The resident lifted the lid that covered their plate which revealed that the resident had only eaten rice and beans and pudding for lunch. At 12:15 PM, the surveyor observed Resident #20 seated in the wheelchair in the hallway outside of their room. The resident was accompanied by	F 550	-One on one in-servicing r/t resident rights/dignity involving assessing resident in hallway and administering medications in hallway, provided to MD and nurse involved in these occurrences. 2.All residents have the potential to be affected by this deficient practice. 3.Nursing staff and MD□s in-serviced on resident rights/dignity. Spontaneous audits of medication pass and audits of MD rounds to ensure compliance with privacy/dignity. 4.DON and/or designated person will complete these audits & in-servicing. - DON and/or designated person will complete this audit. Medication Pass Audits r/t administration of medication in privacy will be completed twice weekly x 1 month, then once weekly x 1 month, then x2 x 1 month. The medication pass audits r/t administration of medication in privacy will be continued through the pharmacy consultant on a monthly basis along with other tasks that get reviewed. -DON and/or designated person will complete this audit. Audit 1 MD□s rounds/week x 1 month, then observe 2 MD rounds x 1 month, Then 1 MD round/month x 3 months. These rounds will be reviewed for privacy in assessing the resident. -Resident rights/dignity will be reviewed as part of the QAPI x 3 months then ongoing with privacy/dignity as a focus as needed. The results of these audits will be presented quarterly to the QAPI	

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F 550	Continued From page 3 Licensed Practical Nurse (LPN) #3 and their attending physician. The physician used a stethoscope and listened to the resident's [redacted] in the hallway with both residents and staff nearby. The surveyor observed that the Director of Nursing (DON) was present in the nurse's station. The surveyor motioned to the DON to view the physician as he assessed the resident's [redacted] in the hallway. The DON approached the physician and told him that he should not have listened to the resident's [redacted] in the hallway. The physician stated that the residents moved around a lot and sometimes it was hard to find them when they were in the dining room. When the surveyor asked the physician if he examined residents in the dining room previously, he stated, [redacted] " The surveyor informed the physician that the resident had already eaten lunch in their room. At that time, the resident was observed seated in the dining area with friends, but was not eating. On 10/27/23 at 9:57 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated that Resident #20 was set in their ways. LPN/UM #1 further stated that she assumed that the resident should have been brought back to their room to do whatever needed to be done for privacy. On 10/30/23 at 11:11 AM, the surveyor interviewed the DON who stated that Resident #20 was sometimes difficult, but she would not make excuses and maintained that she had spoken with the physician after the surveyor's observation. The DON stated that if the resident	F 550	committee.	

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F 550	Continued From page 4 had given the physician a hard time, he should have asked a staff member for assistance. 2. On 10/26/23 at 9:02 AM, the surveyor observed Licensed Practical Nurse (LPN) #1 as she administered four oral medications to Resident #52 in the hallway in plain view of multiple staff members who were nearby. LPN #1 then wheeled the resident back to their room and knocked on the door before she entered. The resident's room mate answered the door and denied the resident access to the room as they were not dressed. LPN #1 then proceeded to administer the resident's Ex Order 26. 4B1 in the hallway in the presence of staff. At 9:23 AM, in a later interview with LPN #1, she stated that she should have administered Resident #52's medications and Ex Order 26. 4B1 in their room to ensure privacy. LPN #1 further stated that she did not think about it at the time. On 10/30/23 at 11:06 AM, the surveyor interviewed the DON who stated that when LPN #1 administered medications and Ex Order 26. 4B1 to Resident #52 in the hallway it was a privacy issue. Review of the facility policy "Privacy and Dignity" (Reviewed 06/23) revealed the following: Residents have the right to be treated with courtesy, consideration, and respect for the resident's dignity and individuality. Residents have the right to have physical privacy. The resident shall be allowed, for example, to maintain the privacy of his or her body during medical treatment and personal hygiene	F 550		

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F 550	Continued From page 5 activities, such as bathing and using the toilet, unless the resident needs assistance for his or her own safety.	F 550		
F 569 SS=D	NJAC 8:39-4.1(a) 12 Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to transfer discharged or expired resident's personal needs account (PNA) funds back to the appropriate jurisdiction within 30 days of death or discharge and ensure that the total amount in the PNA	F 569	1. a. RESIDENT #7 AND RESIDENT #9 MADE PURCHASES AND ARE BELOW THE *Ex Order 26. 4B1* [redacted]. b. RESIDENT #298, RESIDENT #299,	12/13/23

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F 569	Continued From page 6 account did not exceed the Supplemental Ex Order 26. 4B1 . This deficient practice was identified for 7 of 7 residents reviewed for Ex Order 26. 4B1 (Resident #7, #9, #298, #299, #300, #301, and #302). This deficient practice was evidenced by the following: The surveyor reviewed the "Clover Meadows Healthcare and Rehabilitation Center Funds Balance Report - Resident Trust Liability" (RTL) dated Ex Order 26. 4B1 . The RTL indicated the following balances: Resident #7 had Ex Order 26. 4B1 , Resident #9 had Ex Order 26. 4B1 , Resident #298 had Ex Order 26. 4B1 , Resident #299 had Ex Order 26. 4B1 , Resident #300 had Ex Order 26. 4B1 , Resident #301 had Ex Order 26. 4B1 , and Resident #302 had Ex Order 26. 4B1 . Further review of these resident's medical records indicated that Resident #298 expired on Ex Order 26. 4B1 , Resident #299 was discharged on Ex Order 26. 4B1 , Resident #300 was discharged on Ex Order 26. 4B1 , Resident #301 expired on Ex Order 26. 4B1 , and Resident #302 was discharged on Ex Order 26. 4B1 . Resident #7 and Resident #9 still resided at the facility. On 10/27/23 at 11:05 AM, the surveyor interviewed the Director of Social Services (DSS) who informed that she is currently responsible for monitoring the resident's PNA accounts and ensures that the resident's PNA balance does not exceed the Ex Order 26. 4B1 , confirmed that Resident #7 and Resident #9 should not have balances above that amount, and was unaware that they had exceeded that amount. The DSS could not speak to why the other residents still had a balance as they were no longer residing in the facility, and informed the surveyor that the	F 569	RESIDENT #300, RESIDENT #301, AND RESIDENT #302 A CHECK FOR THEIR Ex Order 26. 4B1 WERE SENT TO THE STATE ON Ex Order 26. 4B1 . 2. ALL LONG-TERM RESIDENTS WITH MEDICAID HAVE THE POTENTIAL OF BEING AFFECTED BY THIS DEFICIENT PRACTICE. 3. a. SOCIAL SERVICE WORKERS WERE EDUCATED BY ADMINISTRATOR TO NOTIFY THE RESIDENTS WHEN THEY ARE APPROACHING EXCEEDING THE SSI RESOURCE LIMIT. b.BUSINESS OFFICE MANAGER WAS IN-SERVICED by ADMINISTRATOR ON ENSURING RESIDENTS THAT WERE DISCHARGED OR EXPIRED WITH REMAINING PNA FUNDS GOES BACK TO THE APPROPRIATE JURISDICTION WITHIN 30 DAYs 4- ADMINISTRATOR OR DESIGNEE WILL AUDIT PNA BALANCES OF CURRENT RESIDENTS THAT ARE LONG-TERM AND RECEIVING MEDICAID TO ENSURE THAT THEY ARE NOT EXCEEDING THE SSI RESOURCE LIMIT. ADMINISTRATOR OR DESIGNEE WILL ALSO AUDIT EXPIRED AND DISCHARGED RESIDENTS PNA ACCOUNTS TO ENSURE THAT THEY ARE RETURNED TO THE APPROPRIATE JURISDICTION WITHIN 30 DAYS. THESE AUDITS WILL BE CONDUCTED WEEKLY x 1 MONTH	

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F 569	Continued From page 7 business office is responsible for ensuring the accounts for those residents are handled appropriately. On 10/27/23 at 11:58 AM, the surveyor interviewed the Accounts Receivable Manager (ARM) in the business office by phone. The ARM stated that when residents are discharged or expire, their remaining balances are released to the appropriate jurisdiction or responsible party and are not kept by the facility. The ARM stated he would have to review these files. On 10/30/23 at 1:29 PM, the surveyor had a follow up call with the ARM, who acknowledged that these funds were behind and "did not get to them as quickly as we should have," and that they should not have been in the fund balance at the facility this long. On 10/31/23 at 10:29 AM, the Licensed Nursing Home Administrator (LNHA) acknowledged that these funds were overlooked and late in being sent out. Review of the facility's "Personal Fund" policy with review date 6/2023 included "any resident who is receiving benefits under any assistance program that has an asset level limit will be informed by the social worker or designee whenever the personal account balance is within $2,000 of the allowable limit.	F 569	AND MONTHLY X3 MONTHS AND RESULTS WILL BE REPORTED AT THE QUARTERLY QUALITY ASSURANCE COMMITTEE MEETINGS.	
F 610 SS=D	NJAC 8:39-4.1 (a) 8-10 Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse,	F 610		12/13/23

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F 610	Continued From page 8 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint # NJ00167863 Based on observation, interviews, review of medical records, and other facility documentation, it was determined that the facility failed to thoroughly investigate an allegation of resident to resident abuse for 2 of 2 residents (Residents #52 and #64) reviewed for resident to resident abuse. This deficient practice was evidenced by the following: The surveyor reviewed Resident #64's electronic health record (EHR) and noted a Behavior Note within the Progress Notes (PN) that was documented on [redacted] at 6:38 PM, that was written by the Registered Nurse (RN) and revealed that the resident was observed taking food off of the food cart. Certified Nursing	F 610	1.Resident #52 and #64 were both affected by this deficient practice - There were no ill effects to either resident as a result of this deficient practice. Interventions for this event reviewed for appropriateness and effectiveness. 2.All Residents have the ability to be affected by this deficient practice 3.All follow up for any resident to resident events will be included in the EHR to include but not limited to nursing notes, skin assessments, & care plans. Staff interviews will be included along with the person that visualized the event with investigation of the incident.	

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F 610	Continued From page 9 Assistant (CNA) covered the food cart and the resident became argumentative, cursed at another resident and a confrontation occurred with the same resident. No injuries were noted. CNA intervened, removed resident from the area and resident was taken back to his/her room. The RN indicated that both the resident's physician and responsible party were notified and Ex Order 26. 4B1 was reconsulted. On 10/25/23 at 10:44 AM, the surveyor interviewed CNA #3 who stated that while not assigned to Resident #64 today, she was familiar with the resident. CNA #3 stated that the resident cursed her out and hollered at her when she offered the resident a shower. CNA #3 further stated that awhile ago, she heard a noise and came out of a room and saw Resident #64 who Ex Order 26. 4B1 another resident who was seated in a wheelchair. CNA #3 was unable to recall who the resident had Ex Order 26. 4B1. On 10/25/23 at 10:55 AM, the surveyor interviewed CNA #4 who stated that Resident #64 tried to get into the food cart every other day and cussed and swung at staff who tried to redirect the resident away from the food cart. CNA #4 stated that the staff tried to pass out food as fast as they could to ensure that the resident did not access the food cart. CNA #4 further stated that Resident #64 once Ex Order 26. 4B1 Resident #52 and the incident was reported. Review of Resident #52's Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnosis which included but were not limited to: Ex Order 26. 4B1 [redacted]	F 610	4.DON and/or designee will follow up on resident to resident events to ensure documentation in EHR which will include but is not limited to nursing notes, skin assessments, & care plans weekly x 1 month, then monthly x 3 months. DON or designee will audit resident to resident care plans to ensure interventions are in place weekly x1 month then monthly x 3 months. Unit managers or designee will audit resident to resident skin assessments to ensure accuracy weekly x 1 month then monthly x 3 months. All audits will be presented to Administrator during quarterly/QAPI meeting X2 and then ongoing as needed.	

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F 610	Continued From page 10	F 610		

Ex Order 26. 4B1 .

Review of Resident #52's Quarterly Minimum Data Set (MDS), an assessment tool dated *Ex Order 26. 4B1*, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of "[redacted] out of 15", which indicated that the resident's cognition was *Ex Order 26. 4B1* . Further review of the MDS revealed that the resident required extensive assistance of one person for transfers to the wheelchair.

The surveyor reviewed a Nursing Note written by a RN within the Progress Notes (PN) in the EHR dated *Ex Order 26. 4B1* at 6:43 PM, which revealed that another resident was observed taking food off of the food cart. CNA covered the food cart and the same resident became argumentative, cursed at this resident and a confrontation occurred with the same resident. CNA intervened and separated both residents. Supervisor assessed resident. NJ Ex.Order 26.4(b)(1) were noted. The RN indicated that the resident's physician and responsible party were notified. Further review of the PN revealed that there was no further documentation written within the PNs until *Ex Order 26. 4B1* at 3:37 PM, when a Monthly Nursing Comprehensive Summary was documented. At that time, the resident's skin was described as [redacted]

On 10/25/23 at 12:44 PM, the surveyor observed Resident #52 seated in a wheelchair at the nurse's station. The resident was pleasant, but was *Ex Order 26. 4B1* to situation when interviewed.

On 10/27/23 at 9:55 AM, the surveyor interviewed the Director of Social Services (DSS) who stated that when a *NJ Ex Order 26. 4B1* [redacted]

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occurred she spoke with the residents involved and made a mitigation plan to prevent recurrence. DSS stated that she had not spoken with Resident #52 because the resident did not recall after three minutes due to NJ Ex.Order 26.4(b)(1) and had no recollection and it may have been traumatic for the resident. DSS stated that she had spoken with Resident #64 who denied the incident. DSS stated that the incident may have been over a sandwich. DSS stated that interventions to prevent recurrence would be in the care plan.

Review of Resident #52's Care Plan (CP) revealed that there was no entry that corresponded to the *Ex Order 26. 4B1* that was documented within the resident's PN on *Ex Order 26. 4B1*, until after surveyor inquiry on *Ex Order 26. 4B1*. Review of the CP entry revealed that the resident was involved in a *Ex Order 26. 4B1* on *Ex Order 26. 4B1*, in which another resident *Ex Order 26. 4B1* him/her per statement. The goal indicated that the resident would not be involved in future *Ex Order 26. 4B1* involving injury. Interventions included: (*Ex Order 26. 4B1*) Resident was immediately separated and assessed for injury with NJ Ex.Order 26.4(b)(1) apparent. (*Ex Order 26. 4B1*) Reassessed for any injuries-none apparent, resident does not recall event. (*Ex Order 26. 4B1*) Resident reassessed by Unit Manager/Director of Nursing (UM/DON) with no injuries or ill effects...

On 10/30/23 at 10:50 AM, the surveyor requested and reviewed the investigation that pertained to the *Ex Order 26. 4B1* that occurred on *Ex Order 26. 4B1*. Review of the Incident/Accident Report that was completed by the RN indicated that Resident became belligerent after CNA covered food tray and started cursing and NJ Ex.Order 26.4

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another resident in the [redacted]. [redacted] obtained by resident. A statement was obtained from CNA #4 on [redacted], who also confirmed that Resident #64 got upset when the cover was pulled down on the food cart and started to yell. Resident #64 backed up and Resident #52 was behind him/her. Resident #64 told Resident #52 to move and called the resident a [redacted] and [redacted] and [redacted] him/her on the [redacted].

Review of the Reportable Event Record/Report dated [redacted] at 5:30 PM, revealed that the DON indicated that the following interventions were implemented after the incident/event: Resident #52's [redacted] was reassessed the next day with NJ Ex.Order 26.4(b)(1) noted. The same upon assessment for Monday [redacted]. The surveyor reviewed both the PN and the Skin Assessments within Resident #52's EHR and did not find documented evidence that Resident #52's [redacted] was assessed as described. Review of the weekly [redacted] indicated that a Weekly [redacted] was completed by a Licensed Practical Nurse (LPN) on [redacted], and [redacted] abnormalities were noted at that time.

On 10/30/23 at 10:50 AM, the surveyor interviewed the Director of Nursing (DON) who maintained that Resident #52 was assessed for several days with [redacted] and [redacted] was noted. The DON further stated that she was unsure if it actually happened because there was [redacted].

On 10/30/23 at 1:14 PM, in a later interview with the DON, she stated that she did not have [redacted] documentation to validate that Resident #52's [redacted] was assessed

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F 610	Continued From page 13 daily after the resident was [Ex Order 26. 4B1] by Resident #64 as previously described and reported to the New Jersey Department of Health. The DON stated that the [Ex Order 26. 4B1] should have been documented within the resident's EHR. Review of the facility policy, "Nursing Documentation" (Reviewed 06/23) revealed: It is the policy of the facility to document by exception. All documentation confirms that care was provided. It assists in communication to other team members; it also identifies resident's status and clinical findings and interventions. Your responsibility in documentation acts as proof care was provided. All documentation is done in EHR. ...Documenting your assessment post event includes interactions and any resulting actions taken to care for the resident.	F 610		
F 622 SS=D	NJAC 8:39-13.4(c)2 i-vi Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;	F 622		12/13/23

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F 622	Continued From page 14 (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)	F 622		

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F 622	Continued From page 15 (i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Complaint #NJ00151166 Based on interviews, medical records review, and review of other pertinent facility documentation on 10/30/23, it was determined that the facility failed to follow their policies and procedures for a facility-initiated discharge. A resident (Resident #243) left the facility *NJ Ex Order 26. 4B1*	F 622	1.Resident #243 is no longer a resident at the facility 2.All Residents have the potential to be affected by this deficient practice.	

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F 622	Continued From page 16 NJ Ex Order 26. and ended up at the Ex Order 26. 4B1. The Ex Order 26. 4B1 reached out to the facility when the resident was ready for discharge from the Ex Order 26. 4B1 and the facility would not permit Resident #243 to return back to the facility. The deficient practice was identified for Resident #243, 1 of 1 residents reviewed for transfer/discharge and was evidenced by the following: According to the "Admission Record," Resident #243 was admitted to the facility with diagnoses which included but were not limited to Ex Order 26. 4B1 [redacted]. Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Ex Order 26. 4B1, revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated Resident #243 was Ex Order 26. 4B1. On Ex Order 26. 4B1, Resident #243 was examined by a Ex Order 26. 4B1 who determined that the resident was competent to make their own decisions. The Progress Note (PN) revealed the initial incident occurred on Ex Order 26. 4B1 when Resident #243 left Ex Order 26. 4B1 and presented back to the facility on the same day and was permitted to return to the facility. The Ex Order 26. 4B1 for Resident #243 came back Ex Order 26. 4B1 [redacted]. Another PN written by the Social Worker (SW) dated for Ex Order 26. 4B1 revealed there was an	F 622	3.Social workers were in serviced by Administrator on proper Against medical advice (AMA) discharges policy and procedure. The resident and family/legal representative will be informed of the risks involved, benefits of staying at the facility, and the alternatives to both. The physician will be notified of the intended AMA discharge and be encouraged to speak with the resident to encourage them to stay at the facility. Documentation of this notification will be entered in the nurses□ notes by the nursing department. The social service or designee will document any discussions held with the resident/family in the social service progress notes, if present. Adult Protection Services will be notified, or other entity, as appropriate if self-neglect is suspected. All AMA discharges will be discussed with the IDC team to ensure all policies and procedures are being followed. 4.Administrator/ designee will audit all (Against medical advice)AMA discharges to ensure all policies and procedures are being followed weekly X 4 and then monthly X 3. Findings of these audits will be presented at the quarterly quality assurance meetings.	

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Interdisciplinary Team (IDT) care conference note which stated the purpose of the meeting with sister, the Power of Attorney (POA) to discuss future sign-outs and inability to potentially readmit moving forward. [redacted] was increased from [redacted], the POA indicated that Resident #243's judgement was lacking and the SW noted that Resident #243 demonstrated recent inappropriate behaviors due to frustrations and ultimately resulted in Resident #243 signing out of the facility [redacted].

Care plan interventions included an additional meeting with [redacted] in order to change medication, increase effective ways in coping with frustrations, and the next review would include following meeting with [redacted], medication change, allowing time for it to take effect, and review ability to process frustrations.

The timeline received from the facility revealed that the POA was not in agreeance and asked the facility for specific areas of care to be implemented, asked the facility to retrieve the medical records, and asked for Resident #243 to be seen by his/her [redacted] and asked that Resident #243 not get discharged without placement since the facility helped Resident #243 get out of their apartment lease so the resident had nowhere else to go and further noted that Resident #243 was not compliant with medications.

The PN revealed the second incident occurred on [redacted] when Resident #243 left the facility [redacted] again and refused to sign the release form.

The surveyor reviewed the files and could not find any incident reports for Resident #243. The

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F 622	Continued From page 18 surveyor requested a copy of the incident reports from the facility for the first incident which occurred on Ex Order 26. 4B1 which was documented in the progress note by the SW and the second incident which occurred on Ex Order 26. 4B1 which was documented in the PN by the Case Manager. The facility was unable to provide any incident reports regarding the resident leaving Ex Order 26. and in addition, was unable to provide notification to the Department of Health. The Case Manager confirmed with the surveyor that she followed up with the Ex Order 26. 4B1 and the Ex Order 26. 4B1 asked if the facility would take the resident back. The Case Manager stated that after speaking with the Director of Nursing (DON), who is currently the Regional DON (RDON), the Case Manager was advised by the former DON that the facility would not take Resident #243 back to the facility because they could no longer accommodate Resident #243's needs. Review of the Physician's orders did not reveal an order for a discharge and there was no written 30-day notification available to the surveyor that was sent to the POA and/or Resident #243 whom the Ex Order 26. 4B1 deemed NJ Ex.Order 26.4(b)(1) [redacted] The policy updated for 01/2023, titled "Discharge/Transfer Out of the Building" revealed the objective was to facilitate safe, effective transfer of residents for provision of services not available in this facility. 1. Nursing will notify MD, DON/ADON and Social Services with the request for a transfer. 2. The nurse will document physician orders in PCC.	F 622		

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F 622	Continued From page 19	F 622		
F 636 SS=D	NJAC 8:39 5.1(d) 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	F 636		12/13/23

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F 636	Continued From page 20 the Minimum Data Set (MDS). (xviii) Documentation of participation in 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 interview and record review, it was determined that the facility failed to complete the Comprehensive Assessment in accordance with the Resident Assessment Instrument (RAI) for 2 of 19 residents reviewed for comprehensive assessments (Residents #29 and #143). This deficient practice was evidenced by the following: Reference: The Centers For Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual classified	F 636	1-Residents #29 and #143 outstanding assessments were completed. 2- All residents have the potential to be affected by this deficient practice. MDS staff audited for any further outstanding assessments and MDS staff completed them 3-Regional MDS coordinator in-serviced the MDS coordinator on timely assessments.	

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F 636	Continued From page 21 the Observation (Look Back) Period as the time period over which the resident's condition or status was to be captured by the MDS. The Assessment Reference Date (ARD) referred to the last day of the observation (or "look back") period that the assessment covered for the resident. At a minimum, facilities are required to complete a comprehensive assessment for each resident within 14 calendar days after admission to the facility and not less than once every 12 months while a resident, where 12 months refers to a period within 366 days. The MDS completion date for an annual assessment must be no later than 14 days after the ARD (ARD + 14 calendar days). 1) According to the Face Sheet, Resident #29 was admitted to the facility with diagnoses including but not limited to Ex Order 26. 4B1 [redacted]. A review of the most recent Annual Minimum Data Set (MDS), an assessment tool, for Resident #29 revealed an ARD of Ex Order 26. 4B1 with a completion date of Ex Order 26. 4B1. A review of the medical record on Ex Order 26. 4B1 reflected that the annual MDS assessment for Resident #29 had not been completed according to the RAI manual (ARD + 14 days would be Ex Order 26. 4B1). On 10/30/23 during surveyor interview with the Regional MDS Coordinator and facility MDS Coordinator, they stated a comprehensive MDS should be completed within 14 days of the Assessment Reference Date and acknowledged that the annual assessment for Resident #29 was completed late. 2. According to the Face Sheet, Resident #143	F 636	4- For the next four weeks, the MDS coordinator will complete a daily audit of the in-progress list of MDS assessments in our software to ensure the MDS assessments are completed in a timely fashion X 4 weeks. The regional MDS coordinator will audit the in-progress list weekly for the x 4 weeks. The MDS coordinator will also run the iQIES validation report weekly x 4 weeks for any late submissions. The MDS coordinator will audit the in-progress list weekly x 1 month for 3 months to ensure the timely completion of the MDS. The results of these audits will be presented to the Administrator at the quarterly QAPI committee meetings for 4 quarters.	

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F 636	Continued From page 22 was admitted to the facility with diagnoses including but not limited to: Ex Order 26. 4B1 . A review of the Minimum Data Set (MDS) Admission Assessment for Resident #143 revealed an ARD of Ex Order 26. 4B1 with a completion date of Ex Order 26. 4B1. A review of the medical record on Ex Order 26. 4B1 reflected that the MDS for Resident #143 had not been completed in accordance with RAI manual. During an interview on 10/31/23 at 10:17 AM, the Registered Nurse/MDS Coordinator (RN/MDS) confirmed the admission assessment had not been completed by Ex Order 26. 4B1 as required. She confirmed that the admission assessment was completed on Ex Order 26. 4B1 two days past due. A review of the facility provided MDS policy reviewed 10/2023 reflected that it is the policy and procedure of this facility to follow the latest version of the Resident Assessment Manual and CMS regulations and requirements.	F 636		
F 637 SS=D	NJAC-11.2(e) Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §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	F 637		12/13/23

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F 637	Continued From page 23 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 observations, interviews, and review of medical records and other facility documention, it was determined that the facility failed to complete a Significant Change in Status Assessment (SCSA) using the Resident Assessment Instrument (RAI) process on a resident who elected hospice benefits. This deficient practice was identified for 1 of 1 resident reviewed for Ex Order 26. 4B1 (Resident #9). This deficient practice was evidenced by the following: During the initial tour of the facility on 10/24/23 at 10:31 AM, the surveyor observed Resdient #9 lying in bed with the bed positioned up against the wall and a fall mat was placed on the left side of the resident's bed. The resident smiled but did not respond when spoken to. Review of Resident #9's Admission Record revealed that the resident was readmitted to the facility in Ex Order 26. 4B1, with diagnosis which included Ex Order 26. 4B1 [redacted]. Review of Resident #9's Order Summary Report revealed an order dated Ex Order 26. 4B1, admit to Ex Order 26. 4B1. Further review of the resident's Minimum	F 637	1-Significant change assessment was completed for Resident #9 on Ex Order 26. 4B1 after surveyor inquiry. 2- All residents have the potential to be affected by this deficient practice. 3- Regional MDS coordinator educated MDS coordinator on the need for new MDS assessment upon significant change. Unit managers/designee will communicate hospice elections to interdisciplinary team, including MDS coordinator, in real time at daily morning clinical meetings. The unit managers/designee will also update the MDS coordinator once weekly on any resident□s significant changes in condition. 4- The regional MDS coordinator/designee will conduct audits weekly x4 x1 month, then monthly x3 months for any significant changes and to ensure that new assessments have been completed. The results of these audits will be presented quarterly to the QAPI committee.	

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	315113	A. BUILDING _____ B. WING _____	C 10/31/2023

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F 637	Continued From page 24 Data Set (MDS) 3.0 Assessment History, an assessment tool contained within the resident's Electronic Health Record (EHR), revealed that a SCSA was not completed for the resident within 14 calendar days from the residents Ex Order 26. 4B1 [redacted] as required. Review of an Addendum To Initial Certification contained within the Resident #9's Ex Order 26. 4B1 revealed that the resident's Date of Initial Certification for Ex Order 26. 4B1 was Ex Order 26. 4B1, with a primary Ex Order 26. 4B1 of Ex Order 26. 4B1 [redacted]. On 10/23/23 at 10:23 AM, the surveyor observed the Hospice Licensed Practical Nurse (HLPN) at Resident #9's bedside. When interviewed, HLPN confirmed that the resident received Ex Order 26. 4B1 [redacted] from an outside Ex Order 26. 4B1 and all of the documentation related to the resident's Ex Order 26. 4B1 was kept current within the resident's Ex Order 26. 4B1. On 10/30/23 at 9:52 AM, the surveyor interviewed the MDS Coordinator (MDSC) in the presence of the survey team. The MDSC stated that if a resident elected to go on Ex Order 26. 4B1 a Significant Change Assessment was completed. MDSC explained that she was new to the position and did not have a lot of experience with it and relied on nursing to keep her informed. On 10/30/23 at 10:53 AM, the surveyor interviewed the Director of Nursing (DON) who stated that she would have imagined that the MDSC should have completed the SCSA for Resident #9 within the required time frame. The DON further stated that the MDSC was new to the position.	F 637		

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F 637	Continued From page 25 On 10/30/23 at 11:25 AM, the Regional MDSC clarified that the SCSA was required to be completed within 14 days of a significant change in resident condition, such as Ex Order 26. 4B1. On 10/30/23 at 12:51 PM, in a later interview with the MDSC, she stated that a SCSA MDS was not completed for Resident #9 until today after surveyor inquiry. MDSC further stated that there was some confusion as to when the resident went on Ex Order 26. 4B1. Review of the facility policy, "Significant Change in MDS Policy" (Updated 09/23) revealed the following: Policy: It is the policy and procedure of the facility to ensure that each resident who experiences a significant change in status is comprehensively assessed during he CMS(Centers Medicare/Medicaid Services)-specified Resident Assessment Instrument (RAI) process. ...A significant Change in Status MDS is required when: A resident enrolls in a hospice program... Review of the facility policy, "MDS Policy" (Reviewed 10/23) revealed the following: It is the policy and procedure of this facility to follow the latest version of the Resident Assessment Manual and CMS regulations and requirements. Purpose: ...To provide information on the resident's condition. To facilitate development of a comprehensive	F 637		

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F 637	Continued From page 26 care plan. To ensure care delivery that enhances the resident's quality of life. To help achieve the highest and practical level of self sufficiency. Procedure: ...Assures the completeness and accuracy of the information in the MDS... NJAC 8:39-11.2(i)	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of medical records and other facility documentation, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS), an assessment tool, for 2 of 19 residents reviewed (Resident #40 and #56). This deficient practice was evidenced by the following: 1.On 10/24/23 at 12:21 PM, the surveyor observed Resident #40 in the room sitting on the bedside. Resident #40 stated he/she had been at the facility for five years and had no concerns. Resident #40 told the surveyor they were pleased that they could smoke at the facility. Resident # 40 was admitted to the facility in [redacted]. Medical diagnoses included but were not limited to [redacted]	F 641	1.Documentation updated across all relevant areas to accurately reflect resident status for resident #40 and resident #5 2.All residents have the potential to be affected by this deficient practice. All residents audited to ensure proper smoking status is currently documented and coded. 3.Education will be provided to the MDS coordinator by the regional MDS coordinator regarding location of smoking evaluations and smoking status to ensure correct coding on MDS assessments. 4.MDS coordinator/designee will conduct	12/13/23

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F 641	Continued From page 27 Ex Order 26. 4B1. Review of the annual Minimum Data Set (MDS), an assessment tool, dated Ex Order 26. 4B1 indicated that the resident had a Brief Interview of Mental Status score of Ex Ord, meaning the resident was Ex Order 26. 4B1. On 10/24/23 the surveyor reviewed Resident #40 care plan which showed the focus of the resident being a Ex Order 26. 4B1. The care plan was initiated on Ex Order 26. 4B1. On 10/27/23 at 11:50 AM, the surveyor reviewed Resident #40 MDS list. The resident's entry MDS dated Ex Order 26. 4B1 section NJ, titled health conditions was marked "Ex Ord" for NJ Ex Order 26. 4B1. Review of the annual MDS dated Ex Order 26. 4B1 section NJ was marked "NJ Ex" for NJ Ex Order 26. 4B1. On 11/01//23 at 11:15 AM, the surveyor reviewed the resident smoking Safety Evaluation. The evaluation had an effective date of Ex Order 26. 4B1 and indicated at that time the resident was an independent Ex Order 26. 4B1 and did not require assistance. 2.On 10/24/23 at 10:33 AM, during the initial tour of the facility the surveyor observed Resident #56 was out of bed in a wheelchair. The resident told the surveyor they were going outside to "Take care of things." The surveyor asked if the resident was a Ex Order 26. 4B1 and they replied, "NJ Ex Or". Review of the Admission Record revealed that Resident #56 was admitted to the facility in Ex Order 26.. Medical diagnoses included but were not limited to Ex Order 26. 4B1. Review of the most recent quarterly Minimum Data Set (MDS), an	F 641	monthly audits x 3 months of current residents□ smoking status from Activities Department records and verify that MDS assessments for those residents are coded correctly and carefully planned for. These audits will be presented to the Administrator at the Quarterly Qapi meeting. After three months, MDS coordinator/designee will conduct audits on a quarterly basis as part of the QAPI. All audit findings will be presented to the Administrator at the quarterly QAPI meeting.	

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F 641	Continued From page 28	F 641		

assessment tool, dated Ex Order 26. 4B1 indicated the resident had a Brief Interview of Mental Status score of [redacted], meaning the resident was Ex Order 26. 4B1 [redacted].

On 10/25/23 at 01:21 PM, the surveyor reviewed Resident #56 care plan which showed a focus that the resident had a potential Ex Order 26. 4B1 in safety related to Ex Order 26. 4B1. The care plan was initiated on Ex Order 26. 4B1.

On 10/25/23 at 01:51 PM, the surveyor reviewed Resident #56 entry MDS dated Ex Order 26. 4B1, section [redacted] titled Health Conditions was marked "[redacted]" for Ex Order 26. 4B1. The surveyor then reviewed the annual MDS dated Ex Order 26. 4B1 [redacted]. All three annual MDS were marked as "[redacted]" for NJ Ex Order 26. 4B1 under section [redacted].

On 10/26/23 at 12:10 PM, the surveyor reviewed Resident #56 smoking assessment dated Ex Order 26. 4B1 which revealed the resident was an independent Ex Order 26. 4B1 and did not need assistance.

On 10/30/23 at 09:52 AM, the surveyor interviewed the MDS Coordinator (MDSC) regarding Resident #40 and Resident #56 MDS. The surveyor asked the MDSC how new admission Ex Order 26. 4B1 were communicated to her department. The MDSC stated that nursing, activities, and the MDS department all do resident assessments. The surveyor then asked who was responsible for section [redacted] of the MDS which included Ex Order 26. 4B1 and she said, "Section [redacted] is done by MDS department, that could have been an oversight".

On 11/01/23 at 12:20 PM, the surveyor reviewed

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F 641	Continued From page 29 the MDS policy with a revision date of 10/2023. Under the procedure section, number three stated that the facility assures the completeness and accuracy of the information in the MDS. NJAC 8:39-11.1	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to conduct a new Preadmission Screening and Resident Review (PASARR) level one assessment after a resident was newly diagnosed with a Ex Order 26. 4B1. This deficient practice was identified in 1 of 1 resident reviewed for PASARRs (Resident #56) and was evidenced by	F 644	1-RESIDENT #56 HAD A NEW PASARR NJ Ex.Order 26.4(b)(1) ON Ex Order 26. 4B1 2- ALL RESIDENTS HAVE THE POTENTIAL OF BEING AFFECTED BY THIS DEFICIENT PRACTICE. 3-TO PREVENT F644 FROM	12/13/23

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F 644	Continued From page 30 the following: On 10/24/23 at 10:33 AM, during the initial tour of the facility the resident was out of bed in a wheelchair. The resident told the surveyor they were going outside to "Take care of things". The surveyor asked if the resident was a Ex Order 26. 4B1 and Resident #56 replied, "Ex Order". On 10/24/23 at 12:18 PM, during resident record review the surveyor reviewed Resident #56 Pre-admission Screening and Resident Review (PASARR) one which was completed prior to admission to the facility on Ex Order 26. 4B1. Under the section of Ex Order 26. 4B1, it was marked "Ex Ord", meaning the resident did not have a diagnosis or evidence of a Ex Order 26. 4B1. Review of the Admission Record revealed that Resident #56 was admitted to the facility in Ex Order 26. Medical diagnoses included but were not limited to Ex Order 26. 4B1. Review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated Ex Order 26. 4B1 indicated the resident had a Ex Order 26. 4B1 score of Ex Ord, meaning the resident was Ex Order 26. 4B1. The surveyor then reviewed Resident #56 entry MDS dated Ex Order 26. 4B1 section N, titled active diagnoses. The section for the diagnosis of NJ Ex Order 26. 4B1 was marked "Ex Ord", review of the annual MDS dated Ex Order 26. 4B1 was marked "Ex Ord" for Ex Order 26. 4B1. The surveyor then reviewed the annual MDS dated NJ Ex Order 26. 4B1 which was marked as "NJ Ex Or" for a diagnosis of NJ Ex Order 26. 4B1. On 10/25/23 at12:03 PM, the surveyor requested	F 644	RECURRING, ALL SOCIAL SERVICE DEPARTMENT STAFF WILL BE EDUCATED ON THE PASRR REQUIREMENTS OF INITIAL IDENTIFICATION OF MENTAL ILLNESS (MI) AND/OR INTELLECTUAL DISABILITY /DEVELOPMENTAL DISABILITY/ RELATED CONDITION (ID/DD/RC) FOR THE COMPLETION OF A NEW PASARR LEVEL 1. 4-SOCIAL WORKER OR DESIGNEE WILL CONDUCT AUDITS OF THE PSYCHIATRY CONSULTS TO ENSURE NEW DIAGNOSIS ARE ADDRESSED IN A TIMELY FASHION AND A NEW PASRR IS INITIATED WEEKLY x 1 MONTH THEN MONTHLY x 3 MONTHS. THE RESULUTS OF THESE AUDITS WILL BE REPORTED QUARTERLY TO THE QAPI COMMMITTEE .	

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F 644	Continued From page 31	F 644		

to view the residents PASARR two. The facility provided surveyor with the PASARR one. Review of the PASARR one indicated that Resident #56, on admission to the facility on Ex Order 26. 4B1, did not have a diagnosis of or Ex Order 26. 4B1 [redacted]

On 10/27/23 at 10:50 AM, the surveyor interviewed the Director of Social Services (DSS) who had been with the facility since Ex Order 26. 4B1 regarding PASARRs. The DDS said, "new admissions come in with a PASARR one and if not, I will complete one".

The surveyor then asked the process if a resident had a new diagnosis after admission to the facility. The DDS told the surveyor, "I would complete a new PASARR one in that event and if positive I would alert mental health, I access all diagnoses on the residents face sheets". The surveyor asked the DDS how she would be alerted to a new Ex Order 26. 4B1 on an admitted resident, and she stated that she would be told in the "morning meeting". The DDS could not speak to why a new PASARR one was not completed again at the time of Resident #56 new diagnosis.

On 11/01/2023 at 10:10 AM, the surveyor reviewed the policy titled PASRR with a revised date of 06/2023. Number five, under the procedure section of the policy read that if a resident is admitted and the team identifies a PASRR needs revision a new PASRR will be initiated.

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F 644	Continued From page 32 NJAC 8:39-27.1 (a)	F 644		
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: NJ Complaint #NJ00165907 Based on observation, interview, and review of pertinent facility documentation it was determined that the facility failed to ensure that the job description of a Certified Nursing Assistant (CNA) was followed by allowing the cutting of a residents hair. This was indentified in 1 of 1 resident reviewed (Resident #40) and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing a medical regimen 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	F 658	1-Resident #40 was advised that should he need a haircut the facility will facilitate an appointment with the beautician that comes to the facility as it is not in the CNA job description for CNAs to give hair cuts. LPN/UM#1 , LPN/UM#2 and CNA#1 received one on one education on CNA job description and the need to ensure they work within their job description. 2- all residents have the potential to be affected by this deficient practice. 3- All nursing staff were re in-serviced on the CNA job description as well as ensuring they work within their job description 4- ADON/Designee will do audits on CNAs by conducting weekly rounds X4 and then monthly X3 to ensure CNAs are working within their job descriptions. Findings of these audits will be presented at the quarterly quality assurance	12/13/23

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F 658	Continued From page 33 Practice Act for the State of New Jersey state: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 12/24/23 at 12:21 PM, the surveyor observed Resident #40 in the room. The resident voiced no concerns to the surveyor during the interview. On 10/25/23 at 10:05 AM, the surveyor reviewed a complaint filed by Resident #40 regarding a Certified Nursing Assistant (CNA) cutting of the resident's hair. Resident # 40 was admitted to the facility in [redacted]. Medical diagnoses included but were not limited to *Ex Order 26. 4B1* [redacted]. Review of the annual Minimum Data Set (MDS) an assessment tool dated *Ex Order 26. 4B1* indicated that the resident had a Brief Interview of Mental Status score of [redacted], meaning the resident was *Ex Order 26. 4B1*. On 10/25/23 at 10:46 AM, the surveyor, with the resident's permission entered Resident #40's room. The surveyor asked the resident if he/she ever had an issue with the CNA's cutting his/her hair. The resident told the surveyor, "*Ex Order 26. 4B1* [redacted]	F 658	meeting.	

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F 658	Continued From page 34	F 658		

Ex Order 26. 4B1 [redacted]". The surveyor asked the resident how much hair was cut off and the resident said, "*Ex Order 26. 4B1* [redacted]", pointing to the back of the [redacted]. The surveyor observed that the resident had hair in a folded ponytail held by a rubber band.

On 10/25/23 at 11:10 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #2) regarding the resident's hair. The LPN/UM #2 said the resident never showered, and one day she/he agreed with two CNAs to be given a shower and they talked about his/her hair. LPN/UM #2 said the ponytail went to the resident's [redacted] and was "dirty and matted". Resident #40 agreed, according to the CNAs to get hair washed and the ponytail [redacted] while in the shower. When they all (two CNAs and the resident) came out of the shower and after the ponytail was [redacted] by the CNAs the resident stated that he/she did not want the haircut.

On 10/25/23 at 11:30 AM, the surveyor reviewed the Certified Nurse Aide Job Description. Under accountabilities the job description indicated that the CNA bathes the resident in the bed, tub or shower, combs hair, cleans fingernails and gives shampoos. Cutting a resident's hair was not a part of a Certified Nurses Aides Job description.

On 10/25/23 at 01:27 PM, the surveyor interviewed CNA #2, who was caring for the resident on that day. The surveyor asked CNA #2 what was including in the job description, and she told the surveyor, "Teeth, hair, (wash hair, comb hair, cut hair, dye hair), and basic hygiene)". CNA #2 told the surveyor the resident agreed to hair being [redacted] because it "*NJ Ex Order 26. 4B1* [redacted]".

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The surveyor then asked CNA#2 if she normally cuts hair and she stated, "Yes, I paint nails, cut hair, and dye hair". The surveyor asked CNA#2 if she was trained on hair cutting and she responded, "No I thought it was part of my job description. I always ask the family first, but now we are no longer able to cut hair. I don't know why he didn't go to the hair salon."

On 10/25/23 at 1:40 PM, the surveyor interviewed the Director of Nursing (DON) regarding staff education and who was responsible. The DON told the surveyor that it was a shared responsibility of herself, the Assistant Director of Nursing (ADON), the Unit Managers, and Administration.

On 10/27/23 at 10:07 AM, the surveyor interviewed LPN/UM #1 regarding CNA job responsibilities. The LPN/UM #1 said the CNAs do activities of daily living, morning care, render oral hygiene, dressing, linens, beds, hydration and are the eyes and ears to the nursing staff. The surveyor asked LPN/UM #1 to define morning care and she said, "hair brushing, dressing, showers, and shampoo their hair". The surveyor asked the LPN/UM #1 if CNAs can cut a resident's hair and she replied, "I am not aware of the policy here, if the resident were to ask. I have never witnessed hair cutting. I would ask the ADON or the DON. I would suggest the beautician at the facility to the resident".

On 10/27/23 at 10:20 AM, the surveyor interviewed the ADON regarding a CNA job description. The ADON said, "The CNAs do washing and grooming of the whole body, shampoo hair on shower days, brush hair, and get the residents dressed and out of bed." The

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F 658	Continued From page 36 surveyor asked the ADON if a CNA can cut a resident's hair and the ADON responded, "No, no that's why we have a hairdresser come in".	F 658		
F 689 SS=D	NJAC 8:39-27.1 (a) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, medical record review and review of other pertinent facility documentation, it was determined that the facility failed to properly assess and monitor a resident that was previously identified as a high risk for falls after a fall occurred in accordance with professional standards and the facility policy for 1 of 1 resident (Resident #9) reviewed for falls. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health	F 689	1.Resident #9 was affected by this deficient practice. All interventions reviewed for appropriateness 2.All the residents are affected by this deficient practice. 3.Measures or systemic changes to ensure that the deficiencies will not recur All falls will be followed up on and documented x 3 days post incident in the progress notes. This note will include info about neuro checks being completed but not limited to just that. All incidents will be reported immediately to direct UM/Supervisor/RN for assessment with Neuro checks initiated as needed. After assessment has been completed all statements will be obtained and reviewed	12/13/23

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F 689	Continued From page 37 counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." During the initial tour of the facility on 10/24/23 at 10:31 AM, the surveyor observed Resident #9 lying in bed with the bed positioned up against the wall and a fall mat was placed on the left side of the resident's bed. The resident smiled when spoken to but did not speak when spoken to. On 10/25/23 at 10:23 AM, the surveyor observed the Hospice Licensed Practical Nurse (HLPN) #1 at Resident #9's bedside. When interviewed, HLPN #1 stated that the resident had fallen at the facility which resulted in a *Ex Order 26. 4B1* . HLPN #1 explained that the resident was deemed not to be a surgical candidate and was admitted to *Ex Order 26. 4B1* with *Ex Order 26. 4B1* . HLPN #1 was unable to state when the fall occurred. The surveyor reviewed an *Ex Order 26. 4B1* form that was noted within the resident's *Ex Order 26. 4B1* which indicated that the resident was admitted to *NJ Ex Order 26. 4B1* in *Ex Order 26. 4B1* with a primary diagnosis of *Ex Order 26. 4B1* . On 10/25/23 at 12:34 PM, the surveyor interviewed CNA #2 who stated that she worked at the facility for NJ Ex.Order 26.4(b)(1). CNA #2 stated that Resident #9 was dependent for all aspects of care and required assistance to NJ Ex.Order 26.4(b)(or a couple of years now. CNA #2 stated that the resident and was NJ Ex.Order 26.4(b)(1) or attempt to get out of bed and required a *Ex Order 26. 4B1* for transfers. CNA #2 further stated that she was not at the facility when the resident had Ex Order 26. 4 and did not know how the Ex Orde	F 689	by direct UM/Supervisor/RN. 4.All falls will be reviewed at the am meeting to ensure that post fall charting is occurring and it continues to be included on the 24hr report. Falls will also be reviewed for assessment by Supervisor/RN along with documentation of such. Neuro checks if required for a fall will also be included in the 3 day review. All Follow up r/t the fall will be documented in the EHR including but not limited to progress notes, indication of neuro checks being performed, & skin checks. This will be reviewed weekly x 4, then monthly x 3, then ongoing. This will be completed by DON and /or designee. All audit findings will be presented to the quarterly QAPI committee.	

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occurred.

Review of Resident #9's Admission Record (an admission summary) revealed that the resident was readmitted to the facility in Ex Order 26. 4B1 with diagnosis which Ex Order 26. 4B1 [redacted].

Review of Resident #9's Annual Minimum Data Set (MDS), an assessment tool dated Ex Order 26. 4B1, revealed that the resident's Brief Interview for Mental Status (BIMS) score was unable to be completed as the resident was NJ Ex.Order 26.4(b)(1) [redacted]. Further review of the assessment revealed that the resident required extensive assistance of two persons for Ex Order 26. 4B1 and transfers and required supervision of one person for Ex Order 26. 4B1 [redacted] on the unit. Review of Section [redacted] of the MDS revealed active diagnosis which included but was not limited to: Ex Order 26. 4B1 [redacted].
Review of Section [redacted] of the MDS revealed that the resident had not had any Ex Order [redacted] since admission /entry or reentry or the prior assessment. The surveyor then reviewed Resident #9's Quarterly MDS Assessment, dated Ex Order 26. 4B1, under Section [redacted] which revealed that the resident had a [redacted] within the last month which did not result in Ex Order 26. 4B1.

Review of Resident #9's Fall Risk Assessment effective Ex Order 26. 4B1, revealed that Resident #9 had

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a score of [redacted] on the assessment which indicated that the resident was a high risk for [redacted] and a second Fall Risk Assessment dated [redacted], had a score of [redacted] which indicted that the resident as a high risk for [redacted].

Review of Resident #9's Progress Notes (PN) revealed an entry dated [redacted] at 10:29 PM written by Licensed Practical Nurse (LPN) #4, indicated that LPN #4 was notified by the Certified Nursing Assistant (CNA) that Resident #9 had an unwitnessed [redacted] of their wheelchair at the base of the door. LPN #4 documented that he assessed the resident for any visible injuries and there [redacted] as the resident did not verbalize or gesture to indicate the presence [redacted]. LPN #4 documented that both he and the CNA assisted the resident back into their chair and two CNAs then used a [redacted] to assist the resident into bed for further [redacted]. LPN #4 documented that both the MD (Medical Doctor) and family were contacted with no response. There was no documented evidence within the resident's medical record to indicate that the resident was assessed by a Registered Nurse (RN) immediately post-[redacted] prior to transfer back into the chair or bed for the presence [redacted].

Further review of the PNs revealed that the next PN was a Behavior Note, was written on [redacted] at 3:58 PM, by a RN which failed to contain documentation to indicate that post-[redacted] monitoring was in place. The RN documented that the resident was awake, alert and oriented x 2-3 (self, place, time) with [redacted] noted. A second Behavior Note dated [redacted] at 9:53 PM, was written by an LPN and indicated that it was shift [redacted] post [redacted], and [redacted] were

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noted, and the resident was NJ Ex.Order 26.4(b)(1) as ordered. There was no documented evidence within the PNs that were reviwed in the twenty-four hour period that followed the resident's [redacted] to indicate that the resident's Ex Order 26. 4B1 was assessed post-[redacted] with Ex Order 26. 4B1 [redacted] to rule out head trauma for an unwitnessed [redacted] and post-[redacted] notes for shifts Ex Order 26. 4B1 were not found.

Review of the Resident #9's Care Plan (CP) revealed an entry that was initiated on Ex Order 26. 4B1 and revised on 1[redacted], which revealed that the resident had potential for [redacted] related to poor safety awareness,NJ Ex.Order 26.4(b)(1) , Ex Order 26. 4B1 , and Ex Order 26. 4B1 problems. Further review of the CP revealed an entry dated Ex Order 26. 4B1 and revised [redacted], which revealed that the resident [redacted] the bed intentionally, witnessed by nurse. Staff will assist him/her out of bed during the morning rounds into his/her wheelchair. The goal was revised on [redacted] by the former Unit Manager, for the resident to be free from injuries related to [redacted] accidents through the next review date. Review of Interventions included an entry dated Ex Order 26. 4B1 , Staff to check on Resident #9 frequently and offer him/her to go back to bed around mealtimes. On Ex Order 26. 4B1 , an intervention was added to the CP which indicated that prior to the end of 7-3 pm shift assess for any immediate needs such as: hunger, toileting, pain etc. and assist with the same.

Review of Resident #9's Order Summary Report (OSR) revealed an order dated Ex Order 26. 4B1 , for floor mat to left side of bed every hour of sleep at

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bedtime for preventative measures. Further review of the OSR revealed that the resident was admitted to [Ex Order 26. 4B1] on [Ex Order 26. 4B1].

On 10/26/23 at 1:20 PM, the surveyor phoned LPN #4 who identified as an agency nurse via speaker phone in the presence of the survey team with his permission. LPN #4 denied any recollection of Resident #9's [Ex Orde]. LPN #4 stated that as an LPN, he was permitted under his scope of nursing practice to assess residents' post-[Ex Orde]. When the surveyor asked what a post-[Ex Orde] assessment entailed, LPN #4 stated that he was busy, and it was not a good time to talk. LPN #4 failed to provide the surveyor with a more convenient time to be interviewed when offered.

On 10/27/23 at 9:50 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated that she began working at the facility on [Ex Order 26. 4B1]. LPN/UM #1 stated that when a resident [NJ Ex O] the nurse was required to perform an assessment and complete an incident report. LPN/UM #1 stated that while she was unsure of what the facility policy indicated, under the scope of practice of an LPN an RN was required to perform a resident assessment post-[Ex Orde].

On 10/30/23 at 10:53 AM, the surveyor interviewed the Director of Nursing (DON) who stated that Resident #9 was admitted to [Ex Order 26. 4B1] due to *Ex Order 26. 4B1*, there was no [Ex Orde]. The DON stated that the resident's [Ex Orde] that occurred on [Ex Order 26. 4B1] was addressed with an [Ex Order 26.] company who stated that the [Ex Order 26. 4B1] was more acute. The DON stated that she probably documented the conversation that she had with the *Ex Order 26. 4B1* somewhere. The DON

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F 689	Continued From page 42 stated that technically, an LPN could not perform a resident assessment under their scope of practice. The DON stated that the Registered Nurse Unit Manager who was here the next day would have assessed the resident. The DON further stated that there also would have been a supervisor here as well. The surveyor informed the DON that there was no documented evidence contained within the resident's medical record to indicate that the resident was immediately assessed by an RN after the [redacted] that was sustained on [redacted], nor was there documented evidence that [redacted] were performed to rule out [redacted]. The DON agreed to provide the surveyor with all investigations related to Resident #9. The surveyor reviewed an Incident/Accident Report (I/AR) dated [redacted] at 3:45 PM, that was initiated by LPN #4 which indicated that Resident #9 [redacted] of their wheelchair during an unwitnessed [redacted]. No injury occurred. Resident able to move [redacted] without difficulty. No [redacted] noted. Denies [redacted], [redacted] in progress. Further review of the I/AR revealed that the physician was notified at 4:30 PM and the resident's responsible party was notified at 7:30 PM. The surveyor reviewed an Investigation of Incident/Accident Statement dated [redacted] that was written by a CNA, which indicated that Resident #9 was up in the wheelchair after she changed the resident around 2:30 PM. The CNA documented that when she left at the end of her shift the resident was in the chair in the day room. There were no further statements attached to the investigation other than the CNA's and LPN #4's. There was no [redacted] sheet attached to the investigation or contained within the	F 689		

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resident's medical record to demonstrate that [redacted] were performed for a 24-hour period post-[redacted].

On 10/30/23 at 1:14 PM, the DON presented the surveyor with an [redacted] report dated [redacted], which had a note written at the bottom of it which she stated proved that Resident #9's [redacted] on [redacted], had nothing to do with the resident's diagnosis of [redacted] as it was an [redacted] The hand written entry dated [redacted], revealed [redacted], stated this was an [redacted] occurrence. The DON stated that the interview should have been documented within the resident's medical record but was not. The DON further stated that she received a statement today from the RN Charge Nurse (RN/CN) who worked on [redacted], who stated that LPN #4 did not let the supervisor know about the resident's [redacted] until a few hours later and she assessed the resident at that time. The DON stated that the RN/CN also should have documented the resident assessment in the resident's medical record and the RN Unit Manager should have also documented that she assessed the resident the following day. There was no documented evidence within the resident's medical record to confirm that the resident was assessed by a RN as described by the DON. On 10/30/23 at 3:57 PM, the surveyor attempted to phone the RN/CN for clarification, but was unable to reach her.

On 10/30/23 at 8:15 PM, the surveyor interviewed the [redacted] who stated that on [redacted], the facility requested that he read Resident #9's [redacted] and his impression was an unhealed recent [redacted] extending from the medial [redacted]

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Ex Order 26. 4B1 and recommended that the facility correlate the impression with a trauma history. The Ex Order 26. 4B1 explained that in the elderly with Ex Order 26. 4B1 you do not know the exact time frame of the injury. The Ex Order 26. 4B1 further stated that the injury was recent and unhealed up to one month and the Ex Order 26. 4B1 could have been up to a month old.

On 10/31/23 at 8:49 AM, the surveyor interviewed the DON who stated that perhaps she did not speak with the same Ex Order 26. 4B1 as the surveyor, though the DON provided the surveyor with the Ex Order 26. 4B1 contact information. The DON further stated that LPN #4 should have immediately called for the RN Supervisor to assess Resident #9 for NJ Ex.Order 26.4(b)(1) , as she was not called to assess the resident until after the resident had already been placed back in bed. When the surveyor asked how the RN Supervisor assessment and post-NJ Ex Order 26. 4B1 could be verified? The DON stated that if it was not documented, then it was not done.

On 10/31/23 at 10:24 AM, the surveyor interviewed the Speech Language Pathologist/Director of Rehabilitation (SLP/DOR) who stated that Resident #9 was seen by NJ Ex Order 26. 4B1 on NJ Ex Order 26. 4B1 and an assessment was done to look at positioning after the resident NJ Ex O from the wheelchair. The SLP/DOR reviewed the NJ Ex Order 26. 4B1 in the presence of the surveyor and stated that the resident did not NJ Ex.Order 26.4(b)(1) during the assessment. The SLP/DOR explained that pain was assessed through nonverbal methods such as gestures and grimacing and there was

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nothing. The SLP/DOR stated that the resident was very loud, so she would have imagined there would have been yelling if the resident had pain. The SLP/DOR explained that the resident self-propelled backward in their wheelchair and used their feet to do so at the time of the assessment. The SLP/DOR further stated that whenever the resident was up in the wheelchair it was in the dayroom in a supervised area with a back cushion in place for fall prevention.

On 10/31/23 at 10:53 AM in a later interview with the DON, she stated that a three-day post [redacted] documentation was required to be documented within Resident #9's electronic health record every shift for [redacted] days. The surveyor conveyed that the documentation contained within the resident's medical record did not reflect that the documentation was completed as described. The DON stated, "It is not there?" The DON stated that the [redacted] were documented on the 24-hour report. The DON provided the surveyor with the 24-hour report dated [redacted], which revealed the following: Resident #9 [redacted] at 3:45 PM. MD notified; Family contacted with no answer. Follow up. [redacted]. There was no documented evidence contained within the resident's medical record to suggest that the recommendation for [redacted] checks and follow-up with the resident's responsible party or physician was completed.

On 10/31/23 at 12:03 PM, the DON stated that she did not find a [redacted] sheet within the investigation or within Resident #9's medical record. The DON further stated that the purpose of the [redacted] was to rule out a brain bleed or injury after a [redacted].

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHABILITATION CENTE	112 FRANKLIN CORNER ROAD LAWRENCEVILLE, NJ 08648

(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 689	Continued From page 46 Review of the facility policy, "Incident/Accident Reporting Policy And Procedure (Reviewed 03/2023) revealed the following: It is the policy of this facility to provide a system whereby residents' incidents/accidents are reported, their causes identified when possible, and timely interventions are established to reduce the probability of repeated incidents. Procedure: It is the responsibility of the Lisenses [Sic.] Nurse who first witnessed the incident/accident to initiate and complete the Incident/Accident Report in its entirety utilizing input form the staff present at the time of the incident/accident. The Nurse assesses the residents' condition, renders appropriate treatment, i.e., first aid or calls the Physician who orders specific treatment or decides if the resident is to be transferred to the Emergency Room. The nurse also informs the responsible party immediately of any injury that may require residents to be transferred from the facility. In case of a fall, a Fall Risk Assessment and a Post Fall Inspection Tool is completed. In case of an actual or suspected neurological involvement, a 24-hour Neurological Assessment is completed. ...A 3-day post fall monitoring and documentation will be done by all shift nurses assigned to residents who sustained a fall. A 3-day post incident monitoring and documentation will be done by all shift nurses for residents with a reported incident or injury of unknown etiology. Review of the facility policy, "Nursing Documentation" (Reviewed 06/23) revealed the following: It is the policy of this facility to document by	F 689		

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F 689	Continued From page 47 exception. All documentation confirms that care was provided. It assists in communication to other team members; It also identifies resident's status and clinical findings and interventions. Your responsibility acts as proof care was provided ... Gather information and prepare to chart, it is your responsibility as the professional or long term care staff member to document what you found, what you did or did not do for the resident. ...Proper nursing documentation provides evidence that the nurse has acted as required or ordered. ...Document all Events including falls, skin tears, any skin abnormalities etc. ...tell the whole story, be concise, stay limited to the facts. Review of the facility policy, "Injury of Unknown Origin Policy and Procedure" (Revised 04/23) revealed the following: ...A 3-day post fall monitoring and documentation will be done by all shift nurses assigned to residents who sustained a fall... Review of the facility Position Summary (Job Description) for Position Title, "Licensed Practical Nurse" revealed the following: In conjunction with the RN/Unit Director, the Licensed Practical Nurse utilizes a general understanding of the principles of nursing and basic physical assessment skills in the development of and implementation of individualized nursing care plans to ensure that the needs of residents are met. He/she assists in the orientation of and supervision of nursing personnel, attends to the daily operations of the unit per shift, unit level, and assumes responsibilities of a leadership role. Responsibilities/Accountabilities:	F 689		

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F 689	Continued From page 48 ...Communicates pertinent data to charge nurse, superior and/or physician; Review of the facility Position Summary (Job Description) for Position Title, " Registered Nurse" revealed the following: Takes an active role in direct resident assessment and care; ...Assesses each resident daily and implements a change in the course of action as needed; ...Maintains accurate resident care records and documents pertinent data reflecting the use of the nursing process; NJAC 8:39-27.1(a)	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to properly document the correct amount of [redacted] in the progress notes. This deficient practice was identified for 1 of 1 resident (Resident #2) reviewed for [redacted], and was evidenced by the following: On 10/26/23 at 11:50 AM, the surveyor observed	F 695	1.Resident #2 was affected by this deficient practice. There were no ill effects related to [redacted]. [redacted] with an avg [redacted] all days in question. This resident is no longer at the facility. 2.All residents on oxygen are affected by this deficient practice	12/13/23

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F 695	Continued From page 49 Resident #2 receiving NJ Ex Order 26. 4B1 with a setting of NJ Ex Order 26. 4B1. A review of the face sheet revealed that Resident #2 was admitted to the facility with diagnoses including, but not limited to, NJ Ex Order 26. 4B1 [redacted]. The Admission Minimum Data Set, an assessment tool, dated NJ Ex Order 26. 4B1 indicates a NJ Ex Order [redacted] score of NJ Ex Order 26. 4B1 and utilized NJ Ex Order 26. 4B both while a resident and while not a resident (prior to admission to facility). The physician orders included an order for NJ Ex Order 26. 4B1 with at NJ Ex Order 26. 4B1 dated NJ Ex Order 26. 4B1 and review of Medication Administration Records (MARs) for NJ Ex Order 26. 4B1 [redacted], indicated NJ Ex Order 26. 4B1 [redacted] at NJ Ex Order 26. 4B1 was administered on each day. A review of the progress notes with dates of NJ Ex Order 26. 4B1 [redacted] indicated that Resident #2 received NJ Ex Order 26. 4B1 [redacted] at NJ Ex Order 26. 4B1. On 10/27/23 at 06:55 PM, the surveyor interviewed Licensed Practical Nurse # 2 (LPN #2) via telphone, who wrote the progress notes indicating Resident #2 received NJ Ex Order 26. 4B1 [redacted] at NJ Ex Order 26. 4B1. She stated that she believed Resident #2 utilized NJ Ex Order 26. 4B1 of	F 695	3.Audit of documentation for oxygen use. In-servicing for nursing staff r/t documentation of O2 in mar and progress notes for accuracy. 4.UM□s or designee will complete an audit of residents on oxygen for appropriate documentation in MAR and in progress notes weekly x 1 month, with review completed at quarterly meeting. The results of these audits will be presented quarterly to the QAPI committee.	

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F 695	Continued From page 50 NJ Ex Order 26. 4B1 at one point. She also stated that the notes with NJ Ex Order 26. 4B1 at NJ Ex Order 26. 4B1 were written in error. On 10/30/23 at 10:31 AM, the surveyor interviewed the Director of Nursing, who stated that if the order is for NJ Ex Order 26. 4B1 and the MAR is signed for NJ Ex Order 26. 4B1, then the progress notes should state NJ Ex Order 26. 4B1. A review of the facility provided policy titled " Nursing Documentation" revised 6/23, indicated "proper nursing documentation provides evidence that the nurse has acted as required or ordered." and "use accurate information".	F 695		
F 755 SS=E	NJAC-29.2 (d) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755		12/13/23

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F 755	Continued From page 51 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and pertinent record review, it was determined that the facility failed to ensure the accountability of the Narcotic Shift Count logs were completed in accordance with facility policy. This deficient practice was identified on 2 of 2 medication carts reviewed for medication storage and labeling and was evidenced by the following: On 10/26/23 at 10:27 AM, the surveyor, in the presence of the Licensed Practical Nurse #3 (LPN #3), reviewed the narcotic logbook for the "North Wing Back Hall" medication cart. The "Controlled Drugs Accountability/Count Sheet" for August, September, and October 2023 shift logs revealed the following incomplete or blank sections: 8/5/23 - 11 PM -7 AM total incoming count section containing counts for "Bingo, Boxes, Bottle, and Sheet." 8/6/23 - 11 PM -7 AM total incoming counts for "Bingo, Boxes, Bottle, and Sheet."	F 755	1.No residents were affected by this deficient practice. All residents received medications as ordered. 2.All residents on narcotic medication have the potential to be affected by this deficient practice. All Narcotics were checked and available for distribution as needed and the count was correct. 3. Staff will be re-educated by DON on the count sheet and the proper way to complete. Audits of count sheets for completeness/accuracy will be completed by UM and/or designee daily x 3 weeks, then weekly ongoing. Monthly review of count sheets Between UM and DON to ensure the deficient practice does not recur. 4. The UM and/or designee will review	

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F 755	Continued From page 52 8/19/23 - 11 PM -7 AM total incoming and total outgoing counts for "Bingo, Boxes, Bottle, and Sheet." 8/22/23 - 7 AM - 3 PM outgoing nurse signature 8/27/23 - 3 - 11 PM outgoing nurse signature 8/31/23 - 11 PM -7 AM total incoming and total outgoing counts for "Bingo, Boxes, Bottle, and Sheet," and incoming and outgoing 11-7 nurse signature. 10/1/23 - 7 AM - 3 PM total incoming and outgoing bottle count, 3 - 11 PM total incoming and outgoing sheet count, 11 PM - 7 AM total incoming counts for "Bingo, Boxes, Bottle, and Sheet." 10/7/23 - 11 PM -7 AM total incoming and total outgoing counts for "Bingo, Boxes, Bottle, and Sheet." 10/9 - 10/17, 10/21 - 10/22/23 - 11 PM -7 AM total incoming counts for "Bingo, Boxes, Bottle, and Sheet." 10/9, 10/13, 10/14, 10/17/23 - 11 PM -7 AM total outgoing counts for "Bingo, Boxes, Bottle, and Sheet." At this time, the surveyor interviewed LPN #3 who stated that both the incoming and outgoing nurses on the shift were to complete the narcotic count and the narcotic count log together at the time of the count. On 10/26/23 at 11:19 AM, the surveyor in the presence of the Registered Nurse #1 (RN #1) reviewed narcotic logbook for the "East Wing Front Hall" medication cart. The "Controlled Drugs Accountability/Count Sheet" for August, September, and October 2023 shift log revealed the following incomplete or blank sections: 8/20/23 - 11 PM -7 AM total incoming and total	F 755	count sheets daily x 3 weeks for completeness and accuracy, then weekly ongoing for the same. At the beginning of each month the count sheets will be collected and reviewed for overall completeness and accuracy by UM's then reported to DON/designee to ensure solutions are sustained and continue to be effective. Count sheet completeness/accuracy will further be reviewed for completeness/accuracy @ QAPI/Quarterly Meeting by DON/designee.	

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F 755	Continued From page 53 outgoing counts for "Bingo, Boxes, Bottle, and Sheet." Incoming and outgoing nurse signatures for 7 AM - 3PM and 11 PM - 7 AM. 8/21/23 - 11 PM -7 AM total incoming and 7 AM - 3 PM total outgoing counts for "Bingo, Boxes, Bottle, and Sheet." 8/23/23 - 11 PM -7 AM total incoming counts for "Bingo, Boxes, Bottle, and Sheet." 8/26/23 - 11 PM - 7 AM outgoing nurse signature 8/27/23 - 3 - 11 PM, 11 PM - 7 AM total incoming and 3 - 11 PM total outgoing counts for "Bingo, Boxes, Bottle, and Sheet." 8/28 - 8/29/23 - 11 PM -7 AM total incoming counts for "Bingo, Boxes, Bottle, and Sheet." 8/29/23 - 11 PM - 7 AM incoming and outgoing nurse signatures 8/30/23 - 7 AM - 3 PM and 3 - 11 PM total outgoing counts for "Bingo, Boxes, Bottle, and Sheet." 8/30/23 - 7 AM - 3 PM outgoing nurse signature 8/31/23 - 11 PM -7 AM total incoming counts for "Bingo, Boxes, Bottle, and Sheet." 9/8/23 - 3 - 11 PM total incoming and 7 AM - 3PM and 3 - 11 PM total outgoing counts for "Bingo, Boxes, Bottle, and Sheet." 7 AM - 3 PM, and 3 - 11 PM outgoing nurse signatures 9/9/23 - 3 - 11 PM and 11 PM - 7 AM outgoing nurse signatures 9/10/23 - 3 - 11 PM, 11 PM -7 AM total incoming and total outgoing counts for "Bingo, Boxes, Bottle, and Sheet." 3 - 11 PM incoming and outgoing nurse signatures 9/11/23 - 11 PM -7 AM total incoming, 7 AM - 3PM, 3 - 11 PM, and 11 PM - 7 AM total outgoing counts for "Bingo, Boxes, Bottle, and Sheet." 7 AM - 3 PM, and 11 PM - 7 AM incoming and outgoing nurse signatures 9/12/23 - 11 PM -7 AM total incoming counts for "Bingo, Boxes, Bottle, and Sheet." 11 PM - 7 AM	F 755		

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F 755	Continued From page 54 incoming and outgoing nurse signatures 9/19/23 - 7 AM - 3 PM total outgoing counts for "Bingo, Boxes, Bottle, and Sheet." 9/20/23 - 11 PM -7 AM total incoming and total outgoing counts for "Bingo, Boxes, Bottle, and Sheet." 11 PM - 7 AM incoming and outgoing nurse signatures 9/23/23 - 3 - 11 PM, 11 PM -7 AM total incoming counts for "Bingo, Boxes, Bottle, and Sheet." 7 AM - 3 PM outgoing nurse signature 9/24/23 - 11 PM -7 AM total incoming, 3 - 11 PM, and 11 PM - 7 AM total outgoing counts for "Bingo, Boxes, Bottle, and Sheet." 11 PM - 7 AM incoming and outgoing nurse signatures 9/25/23 - 7 AM - 3 PM total incoming and total outgoing counts for "Bingo, Boxes, Bottle, and Sheet." 9/27/23 - 11 PM -7 AM total incoming and total outgoing counts for "Bingo, Boxes, Bottle, and Sheet." 9/29/23 - 3 - 11 PM total outgoing counts for "Bingo, Boxes, Bottle, and Sheet." 3 - 11 PM, and 11 PM - 7 AM incoming and outgoing nurse signatures 9/30/23 - 7 AM - 3 PM total incoming counts for "Bingo, Boxes, Bottle, and Sheet." 7 AM - 3 PM incoming and outgoing nurse signatures 10/12/23 - 11 PM - 7 AM incoming and outgoing nurse signatures 10/13/23 - 7 AM - 3 PM total outgoing counts for "Bingo, Boxes, Bottle, and Sheet." At this time, the surveyor interviewed RN #1 who stated that both the incoming and outgoing nurses on the shift were to complete the narcotic count and the narcotic count log together at the time of the count, and there should not be any blanks on the logs.	F 755		

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F 755	Continued From page 55 On 10/26/23 at 11:48 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager #2 (LPN/UM #2), who confirmed the incomplete sections of the logs, and stated they should not be blank and "if not documented, then not done." On 9/6/23 at 12:47 PM, the surveyor interviewed the Director of Nursing (DON). The DON stated that the narcotic shift log should be completed and signed by two nurses together, the incoming and the outgoing nurses, when the shift-to-shift narcotic count is completed. She confirmed that this process is in place to "keep track of accountability, which is very important because you're dealing with narcotics." A review of the facility's "Narcotic and Controlled Substance" policy with a reviewed date of 1/2023, included, "It is the policy and procedure of this facility to comply with the Controlled Substance Act. As well as to monitor narcotic administration and to ensure accountability for all narcotics." The section titled "procedure" included, "a narcotic count will be completed by two licensed nurses prior to the end of each shift, opening of a unit and closing of a unit." NJAC 8:39-29.7(c)	F 755		
F 761 SS=E	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	F 761		12/13/23

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F 761	Continued From page 56 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to properly store medications and properly label opened multidose medications. This deficient practice was observed in 1 of 1 medication storage rooms and 2 of 2 medication carts reviewed for medication storage and labeling and was evidenced by the following: On 10/26/23 at 10:27 AM, the surveyor, in the presence of the Licensed Practical Nurse #3 (LPN #3), reviewed the "North Wing Back Hall" medication cart. The following was observed: One (1) opened aluminum envelope of dorzolamide hydrochloride and timolol maleate ophthalmic solution, usp 2%/0.5% preservative free (a prescription eye drop medication used to	F 761	1.Residents that are currently on dorzolamide hydrochloride, timolol maleate ophthalmic, artificial tears, nitroglycerin, fluticasone propionate and salmeterol, budesonide, albuterol sulfate were audited. All items were labeled appropriately, discarded if expired, checked for appropriate amount in manufacturers inner packaging. 2. All residents have the potential to be affected by this deficient practice 3. Nurses will be in-serviced by DON or designee on storage/labeling/count/transferring product from opened packaging. Cart/Med room checks by UM or designee 2 x weekly x 3	

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F 761	Continued From page 57 treat glaucoma) labeled from the manufacturer to contain 15 single use containers, opened and contained 18 single use containers. The opened envelope had the date 10/24 written on it but was not labeled with a resident's name. One (1) opened bottle of artificial tears eye drops in its box with the opened date of 10/23 and no resident identifier or name. Two (2) vials of nitroglycerin (a prescription medication used to treat heart disease and chest pain) without a pharmacy label on the medication vials. At this time, the surveyor interviewed LPN #3, who acknowledged that these medications should have all been labeled with resident names. On 10/26/23 at 11:19 AM, the surveyor in the presence of the Registered Nurse #1 (RN #1), reviewed the "East Wing Front Hall" medication cart. The following was observed: Two (2) opened fluticasone propionate and salmeterol 250 micrograms (mcg) /50 mcg inhalation powder inhalers (a medication used to treat lung disease), each one inhaler was dated as being opened on 10/26/23 with no resident name on the inhaler device, and the second was in its opened box which was labeled as being opened on 10/26/23 with no opened date and no resident name on the inhaler device. At this point, RN #1 informed the surveyor that the inhalers themselves should be labeled with the date opened as well as resident name.	F 761	weeks, then weekly x 4 weeks for any issues with storage/labeling/count in any opened packaging, along with medication not transferred from other opened packaging. Monthly review with DON to ensure the issue does not recur. After initial audits will be ongoing of 2 cart audits/ 1 med room audit by UM/designee for each unit per month auditing for storage/labeling/count/transferring product from open packaging. 4. UM/designee will check medication carts/medication rooms 2 x weekly x 3 weeks, then weekly x 4 weeks for any issues with storage.labeling/count in any opened packaging, along with medication not transferred from other opened packaging. Monthly review with DON to ensure the issue does not recur. After initial audits will be ongoing of 2 cart audits/ 1 med room audit for each unit per month by UM/designee auditing for storage/labeling/count/transferring product from open packaging. Audits will be reviewed by DON @ QAPI/QUARTERLY Meeting to ensure the solutions are sustained for continued compliance.	

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	315113	A. BUILDING _____ B. WING _____	C 10/31/2023

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F 761	Continued From page 58	F 761		

On 10/26/23 at 12:25 PM, the surveyor, in the presence of Licensed Practical Nurse/Unit Manager #1 (LPN/UM #1) reviewed the "North Wing" medication storage room and the following was observed:

One (1) box of budesonide inhalation susp 1 milligram (mg) /2 milliliter (ml) (a medication used to treat lung disease) containing one opened foil pouch which contained 3 single use vials. The pouch was labeled as being opened 10/5 with instructions on box from manufacturer to use within two weeks of opening.

One (1) box albuterol sulfate inhalation solution 2.5 mg / 3 ml (a medication used to treat lung disease) with one opened foil pouch dated [redacted] containing two single use vials. LPN/UM #1 informed the surveyor this medication pouch should be only good for seven days after opening.

On 9/6/23 at 12:47 PM, the surveyor interviewed the Director of Nursing (DON). The DON stated that all nursing staff are responsible to ensure medication storage are kept in good order, medications are labeled appropriately, and not expired. The DON confirmed that inhalers and other multiuse medication devices should be labeled with resident name and date opened "so that they don't get mixed up if separated from the box."

A review of the facility's "Medication Storage" policy with reviewed date 3/2023, included, "medications are stored in the containers which they are received. Transfer between containers is performed only by the issuing pharmacy. Drug containers that are soiled, illegible, worn, makeshift, incomplete, damaged, or missing

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F 761	Continued From page 59 labels, are returned to the pharmacy. No discontinued, outdated, or deteriorated medications are available for use in this facility. All such medications are destroyed." A review of the facility's "Medication Labeling" policy with reviewed date of 3/2023, included "contents of one container may not be transferred to another container."	F 761		
F 812 SS=D	N.J.A.C. 8:39-29.4 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, interview and review of pertinent facility documents, it was determined that the facility failed to a.) properly label, date,	F 812	1) -Hair/beard nets were placed by both entrance doors of the dietary department.	12/13/23

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F 812	Continued From page 60 and store potentially hazardous foods in a manner that was intended to prevent the spread of food borne illnesses, and b.) maintain equipment and dishware in a manner to prevent microbial growth and cross contamination and c.) discarding food items. This deficient practice was observed and evidenced by the following: On 10/24/2023 at 09:43 AM, the surveyor toured the kitchen in the presence of the Director of Culinary Services (DCS) and observed there were no hair nets available at the entrance of the kitchen. The DCS stated no hair nets were kept at the entrance because it was the only way to deter staff from entering the kitchen, staff must ask for a hair net first. The surveyor asked if this was the policy and the DCS confirmed it was. In the walk-in freezer the surveyor observed four long hoagie rolls that were in a plastic bag unlabeled and three boxes of ice cream unlabeled. The DCS confirmed the items were unlabeled but stated the label tends to fall off because it is cold and showed the surveyor one label which was laying on the shelf but could not produce the other two. On that same day at 9:47 AM, in the dry storage area there were two packs of muffins that did not have labels to include the date received or an expiration date. There was also a 20 pound (lb) box of fettuccine, a box of mandarin oranges, and two boxes of decaffeinated tea with no labels on any of the items. On the dry storage rack there were three plate	F 812	10/24/23 -The four long hoagie rolls were discarded. 10/24/23 - 3 boxes of ice cream were discarded. 10/24/23 - The two packages of muffins in dry storage were discarded. 10/24/23 - 20lbs of fettuccini was discarded. 10/24/23 - The box of mandarin oranges was discarded. 10/24/23 - Two boxes of decaffeinated tea were discarded. 10/24/23 - The three plate lids were washed, sanitized and air dried.10/24/23 - The basil and curry powder were discarded.10/24/23 -The romaine lettuce was discarded. 10/24/23 - The fresh garlic was discarded. 10/24/23 - The bananas were discarded. 10/24/23 2) All residents have the potential to be affected by this deficient practice. 3) Dietary staff received an in-service regarding Air drying policy and Procedures. FSD placed Hair/beard nets near both entrances□ doors of the dietary department. Dietary staff received an in-service regarding Food Service Employee Hygiene. Dietary staff received an in-service regarding Labeling and Dating system	

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F 812	Continued From page 61 lids that were pulled off the rack. The surveyor asked if this was the clean rack and the DCS confirmed the items on the rack were clean but upon review, the three plate lids removed from the clean rack had a white flaky substance on each of them. The surveyor showed the substance to the DCS and upon swiping the finger the substance moved. This was observed by the DCS at the time of observation. On 10/24/2023 at 10:08 AM, the surveyor observed a shelf with a container of basil leaves that was labeled from June to December 2023. The DCS stated items are labeled for three months and then discarded. The curry powder was labeled from February to August 2023. The DCS confirmed the basil leaves and the curry powder should have been labeled for only three months and the curry powder should have been discarded. There was also a pan located under the serving table which had five containers of cereal. The DCS confirmed the cereal should have been labeled or returned to the box back in the dry storage. On 10/24/2023 at 10:15 AM, in the walk-in refrigerator, the surveyor observed a pack of romaine lettuce in a plastic bag that was unlabeled and a container of fresh garlic with an expiration date of 10/18/2023. The DCS confirmed the romaine lettuce should have been labeled with a receipt and an expiration date and the fresh garlic should have been discarded on 10/18/2023. On 10/24/2023 at 10:21 AM, the surveyor observed a tray of bananas sitting on the kitchen counter, several with brown coloring on them that were all unlabeled. The DSC confirmed the tray	F 812	Protocol. A comprehensive Food Safety Sanitation Checklist was developed to audit the kitchen. 4)- FSD/designee will conduct sanitation audits of the kitchen using Food safety Sanitation Checklist.¿x3 times per week x 3 months. After the first three months FSD or designee will be performed weekly x 3 months. Monthly sanitation audit will be conducted by an outside food service consultant group x 12 months.¿¿ The results of the audits will be reported quarterly by the QAPI Committee.	

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F 812	Continued From page 62	F 812		

of bananas should have included a received and an expiration date.

A review of a facility's undated policy titled, "Food Service Employee Hygiene" included that good personal hygiene and a neat appearances are essential for the food service employees. The following practices and procedures should be observed to prevent the spread of microorganisms to residents, staff and visitors.

A review of the facility's policy dated for 06/2023 titled, "Air Drying Policy and Procedures" revealed to ensure that all dishes, utensils, pans and pots are dried after being cleaned and sanitized.

The surveyor reviewed the facility's policy dated 07/2023 titled, "Labeling and Dating Policy" which revealed all food items must be labeled and dated to ensure foods are being used in a proper time frame. 1. All food products upon receiving, must be dated with the receiving date. 2. All food items must be labeled with either a manufacturer label or handwritten label. C. once prepared or portioned (individually wrapped) food items will be dated with compliance of the 72-hour rule and labeled with a "use on or by" date. Examples: Applesauce, pudding, and sandwiches.

An additional policy dated 11/12/2019 titled, " Labeling and Dating System Protocol" revealed that opened Mayo, dressings, garlic, sauces ....must be dated with the date it was received in the kitchen with day one as the first day of labeling and discarded 30 days from the open date.

NJAC 8:39-17.2(g)

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F 880	Continued From page 63	F 880		
F 880 SS=D	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 to be followed to prevent spread of infections;	F 880		12/13/23

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F 880	Continued From page 64 (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 observations, interviews, review of medical records and other facility documentation, it was determined that the facility failed to: 1) maintain proper infection control practices identified during the: a) medication administration observation and 2) follow their policy for Personal Protective Equipment (PPE, equipment worn to minimize exposure to hazards that may cause serious illnesses and injuries) usage and hand	F 880	1.Resident #52 was seen by [redacted] for follow-up on [redacted], [redacted] felt her orders were appropriate for [redacted] & to continue them. She displayed NJ Ex.Order 26.4(b)(1) within normal limits. Resident #31 was d/c□d from [redacted] as of [redacted]. VS□s [redacted]	

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F 880	Continued From page 65 hygiene to prevent the possible spread of infection. This deficient practice was identified during the: a) medication administration observation on 2 of 2 nursing units (North and East) for 2 of 2 nurses (Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #1) observed during the medication pass and b) for 1 staff member on 1 of 2 nursing units (North) and for 1 of 1 resident reviewed for NJ Ex Order 26. 4B1 [redacted] (Resident #31), and was evidenced by the following: 1. On 10/26/23 at 8:33 AM, the surveyor observed RN #1 who performed hand hygiene with the use of NJ Ex Order 26. 4B1 before she proceeded to obtain NJ Ex Order 26. 4B1 [redacted] from an unsampled resident. RN #1 donned (put on) gloves and used disinfectant wipes to clean the NJ Ex Order 26. 4B1 [redacted] probe when finished. RN #1 then doffed (removed) the gloves and failed to perform hand hygiene before she accessed the medication cart, poured water into a cup from a water pitcher that was on top of the medication cart, accessed the medication cart and prepared and administered eight oral medications to the unsampled resident. RN #1 then donned gloves without first performing hand hygiene and applied a NJ Ex Order 26. 4B1 [redacted] to the resident's NJ Ex Order 26. 4B1. RN #1 then doffed the gloves and used NJ Ex Order 26. [redacted] to perform hang	F 880	One on one in-servicing completed with the staff involved. 2.All residents have the potential to be affected by this deficient practice. 3.Staff re-inserviced regarding isolation procedures and ppe ongoing. Nurses re-inserviced on hand washing when handling equipment and handling medications. Re-education to the nursing staff regarding transmission based precautions. 4.Infection Preventionist and/or designee will complete handwashing competencies/isolation-ppe competencies/ to ascertain the effectiveness of education. This will be completed with all nursing staff. Results will be reported at the QAPI meeting. Any discrepancies noted during competency will be corrected immediately with re-education and/or counseling of the individual. This will be completed x 1 month. Unit manager/designee will complete weekly audits X4, then monthly X 3 of staff completing care on isolation residents. DON/Designee will complete medication pass audits that include handling of medications/equipment, and administration of medication in privacy weekly X4 and then monthly X 3.	

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F 880	Continued From page 66 hygiene when she returned to the medication cart. When interviewed at that time, RN #1 did not recall that she had not performed hand hygiene before she donned gloves, cleaned the blood pressure and pulse oximetry device and doffed her gloves prior to medication administration and stated, "I am sorry, I thought that I did." RN #1 stated that if hand hygiene were not performed after she cleaned the blood pressure machine and pulse oximetry probe when she doffed her gloves prior to medication preparation and administration it could result in contamination. On 10/26/23 at 9:02 AM, the surveyor observed LPN #1 as she prepared medications for Resident #52, which included NJ Ex Order 26. 4B1 one drop in each NJ Ex Order 26. 4B1 [redacted] that LPN #1 dropped on the floor. LPN #1 then proceeded to pick up the NJ Ex Order 26. 4B1 and placed it on top of the medication cart. LPN #1 then proceeded to return bingo cards (medication contained in blister packs) to the medication cart, used a pill crusher to crush the resident's medications, prepared apple sauce, poured water from the water pitcher that was on the medication cart and opened a straw and placed it in the cup of water before she administered the oral medications to the resident without first performing hand hygiene. LPN #1 then picked up the NJ Ex Order 26. 4B1 from the medication cart and carried them into the food pantry while she washed her hands. LPN #1 then proceeded to donn gloves, picked up the NJ Ex Order 26. 4B1 from the counter and administered the NJ Ex Order 26. 4B1 to Resident #52.	F 880	All audits will be presented to the Administrator during quarterly/QAPI meeting X2 and then ongoing as needed.	

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F 880	Continued From page 67	F 880		

At 9:23 AM, in a post-medication pass observation interview, LPN #1 stated that if she dropped Resident #52's [redacted] on the floor and placed the vial on top of the medication cart and did not perform hand hygiene before she returned medications to the cart and administered medications to the resident without first performing hand hygiene it could result in contamination. LPN #1 further stated that if she administered [redacted] from a vial that was dropped on the floor to the resident it could also result in contamination.

On 10/27/23 at 9:59 AM, the surveyor interviewed LPN/UM (Licensed Practical Nurse/Unit Manager) #1, who stated that if [redacted] were dropped on the floor, they should have been tossed for infection prevention. LPN/UM #1 further stated that hand hygiene should have been performed after handling [redacted] that were dropped on the floor before medications were prepared for infection prevention.

On 10/27/23 at 10:17 AM, the surveyor interviewed the Assistant Director of Nursing/Infection Preventionist (ADON/IP) who stated that hand washing was required when gloves were doffed after equipment was cleaned and before handling medications. ADON/IP explained that when gloves were doffed it was important to wash your hands to avoid moving infection or bacteria from one area to another. ADON/IP stated that if an [redacted] were dropped on the floor nursing was required to throw it out, wash their hands, and get a new one as failure to do so was, "a big no, no." ADON/IP stated that the [redacted] should not have been placed on top of the medication cart or in the pantry due to infection control. ADON/IP further

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F 880	Continued From page 68	F 880		

stated that nursing should not have administered those eye drops to the resident because it was wrong to do and could have posed a risk to the resident.

On 10/30/23 at 11:06 AM, the surveyor interviewed the Director of Nursing (DON) who stated that once gloves were doffed after cleaning a [redacted] if hand hygiene were not performed there was a chance of contamination from surface to surface. The DON further stated that if an [redacted] were dropped on the floor, she would have thrown it out for sure.

2. During the initial tour of the facility on 10/24/23 at 10:40 AM, the surveyor observed Resident #31 lying in bed asleep with signage outside of the room which cautioned to stop, [redacted] that was hung above a three-drawer plastic storage unit which contained PPE. At that time, the surveyor interviewed LPN #3 who stated that the resident was [redacted]. A [redacted] presented to the room and LPN #3 advised the PT to donn PPE as a precaution. The [redacted] then proceeded to donn a gown, gloves and mask before she entered the resident's room as directed.

Review of Resident #31's Admission Record revealed that the resident was readmitted to the facility in [redacted], with diagnosis which included but were not limited to: [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315113	A. BUILDING _____ B. WING _____	C 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHABILITATION CENTE	112 FRANKLIN CORNER ROAD LAWRENCEVILLE, NJ 08648

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 69 NJ Ex Order 26. 4B1 [redacted].	F 880		

Review of Resident #31's Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated that the resident's cognition was NJ Ex Order 26. 4B1.

Review of Resident #31's Order Summary Report revealed an order dated [redacted], for [redacted]

On 10/26/23 at 11:53 AM, the surveyor observed Certified Nursing Assistant (CNA) #1 as she entered Resident #31's room without first donning PPE and proceeded to move the resident's bedside table and fed the resident. CNA #1 then placed her hands on her hips over top of her uniform. CNA #1 then picked up the tray and carried it out of the room and placed it on a food cart in the hall. CNA #1 then proceeded to push the food cart to the other end of the hall before she performed hand hygiene with [redacted].

At 11:56 AM, the surveyor interviewed CNA #1 who stated that Resident #31 had a [redacted] and was on [redacted]. CNA #1 stated that she did not think that she was required to wear gloves when she fed the resident. CNA #1 further stated that she did clean her hands after she moved the food cart.

On 10/26/23 at 12:04 PM, the surveyor interviewed LPN #3 who stated that Resident #31 was on NJ Ex.Order 26.4(b)(1) and staff should wear PPE when they fed the resident. LPN #3 stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315113	A. BUILDING _____ B. WING _____	C 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHABILITATION CENTE	112 FRANKLIN CORNER ROAD LAWRENCEVILLE, NJ 08648

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 70	F 880		

that she would have performed hand hygiene after feeding the resident, but the spread of infection was limited to contact with the resident's urine. LPN #3 further stated that if you touched the resident, then PPE should have been worn.

On 10/27/23 at 10:03 AM, the surveyor interviewed LPN/UM #1 who stated that Resident #31 had NJ Ex Order 26. 4B1 [redacted]. LPN/UM #1 stated that she would expect hand hygiene to be performed before and after feeding the resident. LPN/UM #1 further stated it was an infection risk if hand washing were not done after feeding the resident and before handling the food cart.

On 10/27/23 at 10:17 AM, the surveyor interviewed the ADON/IP who confirmed that Resident #31 was on contact precautions for NJ Ex Order 26. 4B1. ADON/IP stated that staff were supposed to wash their hands when they fed the resident so that they did not transfer whatever the resident had to someone else. ADON/IP stated that the resident's NJ Ex Order 26. 4B1 [redacted], and an Infectious Disease Consultant only recommended to continue the antibiotic that was previously ordered and did not specify whether the resident had an active infection or was NJ Ex Order 26. 4B1 [redacted].

On 10/30/23 at 11:02 AM, the surveyor interviewed the DON who stated that staff were required to donn gloves when they fed a resident who was on contact precautions. DON stated that staff were also required to wash their hands before they left the resident's room so that things were not passed along from their hands to other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315113	A. BUILDING _____ B. WING _____	C 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHABILITATION CENTE	112 FRANKLIN CORNER ROAD LAWRENCEVILLE, NJ 08648

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 71	F 880		

surfaces.

Review of the facility policy, "Medication Administration" (Reviewed 03/23) revealed the following:

...Hand Washing: ...Hands must be disinfected immediately before and after eye drops ...and patch administration.

Miscellaneous: Medication disposal: If medication is dropped on top of the cart, dropped on the floor, or is refused-disposal should be in such a way as to avoid resident or others usable access ...

Review of the facility policy, "Infection Control/Standard Precautions/Transmission-Based Precautions" (Revised 07/23) revealed the following:
Purpose: To control the spread of infection.
Procedure:
Contact Precautions: Transmission of disease can occur through direct and indirect contact ...Indirect-contact transmission involves contact of a susceptible host with a contaminated intermediate object.
...Wear gloves when coming in direct contact with a patient ...Wash hands immediately after removing ...

Review of the facility policy Standard and Transmission-Based Precautions, Handwashing/Hand Hygiene (Reviewed (08/29/23) revealed the following:

The purpose of this procedure is to provide guidelines for effective handwashing and hand hygiene techniques that will aid in the prevention

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315113	A. BUILDING _____ B. WING _____	C 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHABILITATION CENTE	112 FRANKLIN CORNER ROAD LAWRENCEVILLE, NJ 08648

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 72 of the transmission of infections. Appropriate twenty (20) seconds hand washing with antimicrobial soap and water must be performed under the following conditions: ...Before and after direct contact with residents ... Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: ...After touching a patient or the patient's immediate environment ...After glove removal NJAC 8:39-19.4	F 880		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061104	A. BUILDING: _____ B. WING _____	C 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHA	112 FRANKLIN CORNER ROAD LAWRENCEVILLE, NJ 08648

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint: NJ00154446 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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: NJ00154446 Based on interview and review of other facility documents, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day and overnight shifts as mandated by the State of New Jersey for: 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	S 560	1.There were no care issues reported on the 22 shifts that were identified. 2.All residents have the potential to be affected by this practice. The Director of Nursing/designee reviewed the last 30 days of the C.N.A. staffing report. The interdisciplinary team reviewed the grievance logs and care conference meetings and no care issues were identified. 3.Administrator in □ serviced the staffing	12/13/23

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

Electronically Signed — 11/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061104	A. BUILDING: _____ B. WING _____	C 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHA	112 FRANKLIN CORNER ROAD LAWRENCEVILLE, NJ 08648

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) 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 (1) direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the week of Complaint staffing from 04/24/2022 to 04/30/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 1 of 7 overnight shifts as follows: -04/24/22 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs. -04/25/22 had 8 CNAs for 88 residents on the day shift, required at least 11 CNAs. -04/26/22 had 8 CNAs for 88 residents on the day shift, required at least 11 CNAs. -04/27/22 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs. -04/28/22 had 8 CNAs for 89 residents on the day shift, required at least 11 CNAs. -04/29/22 had 9 CNAs for 89 residents on the day	S 560	coordinator regarding the requirement for S560 to ensure C.N.A. staffing needs are reviewed daily and addressed as needed to meet the staffing requirement. Recruitment efforts are in place to assist the facility in recruiting, C.N.A. receive sign on bonuses, referral bonuses, reimbursement for C.N.A. tuition, and transportation service from certain locations, Facility also has contracts with agencies to recruit C.N.As. The Director of Nursing/designee also reviews staff attendance records to ensure that excessive absences are addressed accordingly. 4.The Administrator/designee will have weekly meetings x 4 then monthly for 3 months and quarterly thereafter with the staffing coordinator to review staffing schedules, needs, and the efficacy of the systems in place to fill needs. The findings of the audits will be presented at the Quarterly QAPI meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061104	A. BUILDING: _____ B. WING _____	C 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHA	112 FRANKLIN CORNER ROAD LAWRENCEVILLE, NJ 08648

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 shift, required at least 11 CNAs. -04/29/22 had 5 total staff for 89 residents on the night shift, required at least 6 total staff. -04/30/22 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs. 2. For the 2 weeks of staffing prior to survey from 10/08/2023 to 10/21/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -10/08/23 had 8 CNAs for 92 residents on the day shift, required at least 11 CNAs. -10/09/23 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. -10/10/23 had 8 CNAs for 91 residents on the day shift, required at least 11 CNAs. -10/11/23 had 9 CNAs for 91 residents on the day shift, required at least 11 CNAs. -10/12/23 had 9 CNAs for 91 residents on the day shift, required at least 11 CNAs. -10/13/23 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. -10/14/23 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. -10/15/23 had 9 CNAs for 91 residents on the day shift, required at least 11 CNAs. -10/16//23 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. -10/17/23 had 8 CNAs for 91 residents on the day shift, required at least 11 CNAs. -10/18/23 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. -10/19/23 had 9 CNAs for 89 residents on the day shift, required at least 11 CNAs. -10/20/23 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. -10/21/23 had 9 CNAs for 89 residents on the day shift, required at least 11 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061104	A. BUILDING: _____ B. WING _____	C 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHA	112 FRANKLIN CORNER ROAD LAWRENCEVILLE, NJ 08648

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S 560	Continued From page 3 On 10/31/23 at 08:41 AM, the surveyor interviewed the Director of Nursing (DON) and the Licensed Nursing Home Administrator. They both stated they were aware of the staffing requirements. When asked if the facility was meeting the requirements the DON stated we are following the ratios to the best of their abilities. On 10/31/23 at 08:57 AM, the surveyor interviewed the staffing coordinator. She was able to verbalize the staffing requirement. When asked if the facility was meeting the requirements, she stated that we try to follow them. Review of facility provided policy titled staffing with a revised date of 2/2023 reflects that it is the policy and procedure of this facility to adequately staff the facility in accordance with the recommended guidelines.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315113 Y1	A. Building B. Wing Y2	12/19/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHABILITATION CENTE	112 FRANKLIN CORNER ROAD LAWRENCEVILLE, NJ 08648

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550 Reg. # 483.10(a)(1)(2)(b)(1)(2) LSC	Correction Completed 12/13/2023	ID Prefix F0569 Reg. # 483.10(f)(10)(iv)(v) LSC	Correction Completed 12/13/2023	ID Prefix F0610 Reg. # 483.12(c)(2)-(4) LSC	Correction Completed 12/13/2023
ID Prefix F0622 Reg. # 483.15(c)(1)(i)(ii)(2)(i)-(iii) LSC	Correction Completed 12/13/2023	ID Prefix F0636 Reg. # 483.20(b)(1)(2)(i)(iii) LSC	Correction Completed 12/13/2023	ID Prefix F0637 Reg. # 483.20(b)(2)(ii) LSC	Correction Completed 12/13/2023
ID Prefix F0641 Reg. # 483.20(g) LSC	Correction Completed 12/13/2023	ID Prefix F0644 Reg. # 483.20(e)(1)(2) LSC	Correction Completed 12/13/2023	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 12/13/2023
ID Prefix F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 12/13/2023	ID Prefix F0695 Reg. # 483.25(i) LSC	Correction Completed 12/13/2023	ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 12/13/2023
ID Prefix F0761 Reg. # 483.45(g)(h)(1)(2) LSC	Correction Completed 12/13/2023	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 12/13/2023	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 12/13/2023

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/31/2023	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315113	A. Building B. Wing	12/19/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHABILITATION CENTE	112 FRANKLIN CORNER ROAD LAWRENCEVILLE, NJ 08648

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0610 Reg. # 483.12(c)(2)-(4) LSC	Correction Completed 12/13/2023	ID Prefix F0622 Reg. # 483.15(c)(1)(i)(ii)(2)(i)-(iii) LSC	Correction Completed 12/13/2023	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 12/13/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/31/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
061104	A. Building B. Wing	12/19/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHABILITATION CENTE	112 FRANKLIN CORNER ROAD LAWRENCEVILLE, NJ 08648

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 12/13/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/31/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315113	A. BUILDING **01** B. WING _____	**10/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHABILITATION CENTE	**112 FRANKLIN CORNER ROAD** **LAWRENCEVILLE, NJ 08648**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/25/23 and 10/26/23, Clover Meadows Healthcare 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. Clover Meadows Healthcare is a single story Type III Protected building with a partial basement that houses the facility boiler room, laundry room, electrical closet, folding room, maintenance shop, medical records, and 5 storage rooms. The facility was built in January 1969. The facility is divided into 8 smoke zones. The Onan 50 KW exterior generator does approximately 80% of the facility: emergency lighting, life support system, heating, hot water, cooling, fire protection, refrigerator, nurse call system, phone system, and sump pumps. The facility has 100 licensed beds currently at 89.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING	K 222		12/13/23

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

Electronically Signed | 11/20/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315113	A. BUILDING **01** B. WING _____	**10/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHABILITATION CENTE	**112 FRANKLIN CORNER ROAD** **LAWRENCEVILLE, NJ 08648**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 1 Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be	K 222		

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K 222	Continued From page 2 permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, in the presence of the Director of Facilities (DOF) and Regional Plant Operations Director (RPOD) on 10/26/23, it was determined that the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. This deficient practice was identified for 1 set of sliding doors and was evidenced by the following. At 11:15 AM, the surveyor, DOF and RPOD observed at the main entrance, that the outer set of sliding doors had a lockset that engaged a hook-type deadbolt. The device on the door could restrict emergency use of the exit. The current evacuation plan indicated that the front doors were designated an exit/egress route. The sliding door had a sign indicating push to open in an emergency, but with the thumb-latch locks engaged this procedure would not open the doors as stated on the signs.	K 222	1-The latching mechanism on the outer set of sliding doors at the front door was removed and the doors do not have the ability to be locked. 2- All residents have the potential to be affected by this deficient practice 3- All Maintenance staff were in serviced by administrator on 11/6/2023 that the facility must provide exit doors in the means of egress readily accessible and free of all obstructions. 4. The maintenance director or designee will monitor, by making rounds on a weekly basis X 4 weeks and then monthly X 3 months that exit doors in the means of egress are readily accessible and free of all obstructions to ensure this deficiency does not reoccur. All findings will be reported to the Administrator at the QAPI meeting for the next three quarters.	

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K 222	Continued From page 3 At the time of the observation, the surveyor interviewed the DOF and RPOD who both stated that the lockset (hook type deadbolt) could restrict use of the exit from the egress-side in the event of an emergency. The DOF and RPOD were notified of the findings at the Life Safety Code Exit Conference on 10/26/23. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section - 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. NFPA 101:2012 Edition, Section - 7.2.1.6.1.1(3)C	K 222		
K 321 SS=E	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 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)	K 321		12/13/23

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K 321	Continued From page 4 c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/20/23, in the presence of the Director of Facilities (DOF) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled 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 practice was identified in five (5) of nine (9) hazardous storage areas in the partial basement and one (1) of nine (9) hazardous doors on floor 1, in the the facility and was evidenced by the following: Boiler room door: painted label. Sprinkler room: double doors W/painted labels. Laundry room door #1: painted label, door #2 no label. PPE storage room: no label on door. Chute room: no label on door. Floor #1 kitchen storage room: painted label. NFPA 80: standard for Fire Doors and other Opening Protectives states that all fire door openings are required to have a permanent fire	K 321	1- The boiler room door and laundry room door # 1 were serviced by a certified vendor that ascertained they are fire rated/ and labeled them as such. New fire rated doors were ordered from a vendor to replace the Sprinkler room double doors, the laundry room door #2, the ppe storage room door , the chute room door and the kitchen storage room door. 2- All residents have the potential to be affected by this deficient practice. 3- All maintenance staff were in-serviced by the administrator on 11/6/2023 that all fire door openings are required to be permanent fire rated and certification label clearly visible. 4- The maintenance director or designee will monitor, by making rounds on a weekly basis X 4 weeks and then monthly X 3 months, that all fire doors are fire rated and with certification label visible to ensure that these deficiencies does not reoccur. All findings will be reported to the Administrator at the quarterly QAPI meeting for the next three quarters.	

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K 321	Continued From page 5 rated certification label clearly visible for the AHJ (Authority Having Jurisdiction). If a label is missing or painted over, it needs to be replaced immediately by a qualified inspection agency. The DOF and RPOD both confirmed the findings, during the observations The DOF and RPOD were informed of the findings at the Life Safety Code Exit Conference on 10/25/23. NJAC 8:39-31.2(e)	K 321		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on interview and document review on 10/25/23 and 10/26/23, in the presence of the Director of Facilities (DOF) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure that their building's fire alarm system was maintained in accordance with the requirements of NFPA 70 and 72. This deficient practice was evidenced from the most recent document provided by the facility from the fire alarm vendor dated: 6/7/23.	K 345	1- All 108 heat detectors that were needed to be replaced have been replaced by the fire alarm vendor. 2- All residents have the potential to be affected by this deficient practice 3- All maintenance staff were in-serviced on 11/6/23 by the administrator on maintenance and inspection of fire alarm system and the importance of completing	12/13/23

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K 345	Continued From page 6 At 9:45 AM, on 10/25/23 the DOF produced the fire alarm inspection and testing form dated 6/7/23. The report indicated 108 Heat Detectors were found to be over 30 years old and recommended replacing them. The DOF confirmed the finding during document review of the fire alarm inspection and testing form dated 6/7/23. NFPA 72 indicates that every 15 years the whole bunch of heat detectors in the building need to be replaced. The replacement is required because when the heat detector is tested, the fixed temperature solder ring can't be restored. On 10/25/23 at 11:30 AM the DOF indicated the facility was in the beginning process of updating the fire alarm system. The surveyor informed the DOF and RPOD at the Life Safety Code Exit Conference on 10/25/23. NFPA 70 NFPA 72 NJAC 8:39-31.2(e) NFPA 101- 2012 edition 9.6.1.3- 9.6.1.5	K 345	items listed for repair on fire alarm vendor reports timely. 4- The administrator or designee will monitor by reviewing fire alarm vendor inspection paperwork for needed repairs, monthly X 3 months and then quarterly X3 , that this deficiency does not reoccur. All findings will be reported to the Administrator at the quarterly QAPI meeting for the next three quarters.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this	K 918		12/13/23

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K 918	Continued From page 7 capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/26/23, in the presence of the Director of Facilities (DOF) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to ensure a remote manual stop station for one of one outside diesel Onan generator (50 KW), providing emergency power to approximately 80% of Health Care facility, was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient	K 918	1.An electrician installed a remote manual stop station outside the area of the generator. 2.The deficiency cited under K918, if not corrected, would potentially present a hazard to all residents. 3.All maintenance staff were in-serviced on the requirements for generator testing	

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K 918	Continued From page 8 practice was evidenced for 1 of 1 generators by the following: On 10/26/23 at 10:40 AM, the surveyor, DOF and RPOD, observed the exterior 60 KW (kilowatt) diesel generator. The observation indicated that there was no remote manual stop station observed outside the area of the generator location. An interview was conducted during the time of the observation with the DOF, who stated and confirmed that the exterior generator did not have a remote manual stop station to prevent inadvertent or unintentional operation that was located outside the area of the enclosure housing the prime mover for the current generator in service. The DOF and RPOD were informed of the findings at the Life Safety Code exit conference on 10/25/23. 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	and maintenance in a facility including the need to have a remote manual stop station. 4-The administrator or designee will monitor compliance with generator testing and maintenance , by auditing generator testing and maintenance logs and by making rounds on a weekly basis X 4 weeks and then monthly X 3 months, that this deficiency does not reoccur. All findings will be given to the quarterly quality assurance committee for the next three quarters.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal	K 920		12/13/23

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K 920	Continued From page 9 electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/26/23, in the presence of the Director of Facilities (DOF) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to prohibit the use of extension cords and power cords, beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.5, 19.5.1, 9.1, 9.1.2. NFPA 70, 2011 LSC Edition, Section 400.8 and 590.3 (D). NFPA 99, 2012 LSC Edition, Section 10.2.3.6 and 10.2.4. This deficient practice does not ensure prevention of an electrical fire or electric shock hazard and was identified in two (2) of six (6) areas observed and was evidenced by the following: 1). At 10:33 AM, the surveyor, DOF and RPOD observed in the physical therapy room, that the hydroculator was plugged into a white multi-outlet power strip. The power strip was then plugged	K 920	1.An electrician installed a GFCI outlet which the Hydrocollator was plugged directly into. The Keurig coffee machine was unplugged from the power strip and is no longer used at the facility. Step 2 2.All residents have the potential to be affected by this deficient practice 3.All maintenance staff were in-serviced on 11/6/23 by administrator on maintenance and inspection of electrical equipment and on proper usage of Power Cords and Extension Cords. 4. The maintenance director or designee will monitor compliance to ensure this deficiency does not reoccur, by making rounds on a weekly basis X 4 weeks and then monthly X 3 months, to ensure	

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K 920	Continued From page 10 into a non-GFCI duplex wall outlet. The finding was observed by the DOF and RPOD, and both confirmed that the hydroculator must be plugged into a GFCI protected outlet. 2). At 10:35 AM, the surveyor, DOF and RPOD observed in the physical therapy office that a Keurig coffee maker was plugged into a multi-outlet power strip. The power strip was then plugged into a duplex wall outlet. The 7-plug multi outlet power strip was completely utilized with electronic devices and the coffee maker. The DOF and RPOD both confirmed the finding, during the [hysical therapy room office observation. The DOF and RPOD were informed of the findings at the Life Safety Code Exit Conference on 10/26/2023. NJAC 8:39-31.2(e)	K 920	proper usage of power cords and extension cords. All findings will be reported to the Administrator at the QAPI meeting for the next three quarters.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315113	A. Building 01 - MAIN BUILDING 01 B. Wing	12/19/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHABILITATION CENTE	112 FRANKLIN CORNER ROAD LAWRENCEVILLE, NJ 08648

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0222	Correction Completed 12/13/2023	ID Prefix Reg. # NFPA 101 LSC K0321	Correction Completed 12/13/2023	ID Prefix Reg. # NFPA 101 LSC K0345	Correction Completed 12/13/2023
ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 12/13/2023	ID Prefix Reg. # NFPA 101 LSC K0920	Correction Completed 12/13/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 10/31/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			