STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315223	A. BUILDING _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON REHABILITATION AND HEALTHCARE CENTER	1059 EDINBURG ROAD HAMILTON, NJ 08690

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F 000	INITIAL COMMENTS Survey date: 04/13/22 Census: 124 Sample: 29 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 641 SS=B	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 interview and record review, it was determined that the facility failed to accurately complete a Minimum Data Set (MDS) assessment for 1 of 2 residents (Resident #32) reviewed for accidents. This deficient practice was evidenced by the following: According to the Admission Record, Resident #32 was admitted with diagnoses that included, but were not limited to, EX. Order 26.(4) B1 [redacted] Review of the resident's Quarterly MDS, an assessment tool used to facilitate the management of care, dated [redacted], revealed in EX. Order 26.(4) B1, that the resident	F 641	DISCLAIMER STATEMENT Preparation and/or execution of this Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and /or executed solely because it is required by the provisions of federal and state law. The Plan of Correction represents the facility's credible allegation of compliance as of 5/27/2022. -One, actions taken for the resident identified:	5/27/22

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

Electronically Signed | 05/06/2022

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F 641	Continued From page 1 had no EX. Orde since admission/entry or reentry or the prior assessment, whichever was more recent. Review of the resident's MDS list included that the last MDS assessment prior to the EX. Order 26.(4) B1 Quarterly MDS was dated EX. Order 26.(4) B1. Review of the resident's Care Plan (CP), revised EX. Order 26.(4) B1, included that the resident was a risk for EX. Orde related to EX. Order 26.(4) B1, EX. Order 26.(4) B1 and EX. Order 26.(4) B1. The CP also included that the resident had EX. Order 2 on EX. Order 26.(4) B1 Review of the resident's Interdisciplinary Progress Notes, dated EX. Order 26.(4) 1 at 1:00 PM, included the "resident EX. Orde on 7-3 shift on [his/her] EX. Order 26.(4) witness by [his/her] CNA's" and that the physician was called. Review of the resident's Incident/Accident Report, dated EX. Order 26.(4) B1, included the "resident got up in EX. t Or on [his/her] EX. Order 26.(4)." The document was signed by the person preparing the report, the Director of Nursing (DON) and the Medical Director. Review of the Resident's Interdisciplinary Team Discussion, dated EX. Order 26.(4) B1, included discussion related to the EX. Order 26.(4) B1. The document was signed by the Nurse, Rehab, Dietary, and Nursing Director and included that the physician and family member were made aware. During an interview with the surveyor on 04/07/2022 at 1:49 PM, the MDS Coordinator (MDSC) acknowledged that she was the person who was responsible for filling out Resident #32's	F 641	Resident #32 - The resident had no adverse reaction from the MDS coordinator not noting that a EX. Orde of EX. Order 26.(4) B1 had occurred on the MDS dated EX. Order 26.(4) B1 The MDS coordinator was in-serviced and reinforced regarding the importance of an accurate MDS and the MDS was immediately corrected per RAI manual guidelines. The MDS was revised to note that a fall had occurred. Two, identification of other residents who have the potential to be affected: -The facility recognizes that residents who have history of f EX. Orde could have the potential to be affected from an incomplete MDS. All residents have a potential to be effected from an inaccurate MDS. Please refer to Sections Three and Four. Three, system changes and measures that will be made: 1. The MDS nurse will be in-serviced and reinforced by administration on importance of proper coding on the MDS. 2. As part of the resident□s quarterly and as a change in condition warrants care plan meeting the MDS will be reviewed for accuracy prior to locking and transmitting the MDS. 3. Unit managers will submit a log with residents change in condition and any falls occurring on weekly basis to the MDS	

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F 641	Continued From page 2 MDS assessment and stated that the resident did not have any [EX. Order] since [EX. Order 26.(4) B1]. The MDSC stated she would be made aware of resident [EX. Order] by completing daily rounds on each unit, reading the 24-hour report, receiving verbal report from the Unit Manager, and by reading progress notes. The surveyor reviewed, with the MDSC, the facility documentation from the resident's [EX. Order 26.(4) B1] and the MDSC acknowledged that the resident did not have any [EX. Order] documented on the Quarterly MDS dated [EX. Order 26.(4) B1], and that it should have been documented. She further stated that it was important to document accurate data for resident safety and for the resident to receive therapy. During an interview with the surveyor on 04/11/22 at 09:38 AM, the DON stated that it was the MDSC's responsibility to complete the MDS and that it was important to fill out the MDS correctly because it represented the resident. When asked if the [EX. Order] documented on [EX. Order 26.(4) B1] should have been documented on the MDS, the DON stated that she would "look into it" and get back to the surveyor. During an interview with the surveyor on 04/12/21 at 12:37 PM, the DON acknowledged that the [EX. Order] that took place on [EX. Order 26.(4) B1] should have been documented on the Quarterly MDS dated [EX. Order 26.(4) B1]. Review of the facility's policy, "MDS Coordination," with a review date of [EX. Order 26.(4) B1] revealed, "Implementation: 3. The MDS Coordinator is responsible for ensuring that appropriate edits are made prior to transmitting MDS data," and "6. All MDS are completed following the guidelines of RAI Manual."	F 641	coordinator Four, monitoring mechanisms to assure compliance: DON or designee will monitor weekly MDS completion report against the fall log. As part of the residents quarterly and as a change in condition warrants care plan meeting the MDS will be reviewed for accuracy prior to locking and transmitting the MDS. Concerns will be addressed by the Director of Nursing. Director of Nursing or Designee will audit monthly 10% of completed MDS□s for accuracy and report the data to Quality Assurance Committee on quarterly basis. The outcome of the data collection will be used for the staff education	

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F 641	Continued From page 3 Review of the Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2019, included instructions for Section J, Health Conditions. According to the manual, staff are to, "Review all available sources for any [redacted] since the last assessment," and, "review nursing home incident reports and medical record (physician, nursing, therapy, and nursing assistant notes) for falls and level of injury." The manual further includes to "Determine the number of [redacted] that occurred since admission/entry or reentry or prior assessment and code the level of [redacted] for each." NJAC 8:39-11.1	F 641		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documents, it was determined that facility staff failed to complete [redacted] checks for a resident who sustained a [redacted] with [redacted]. This deficient practice was identified for 1 of 3 residents (Resident #83) reviewed for incidents and accidents and was	F 684	DISCLAIMER STATEMENT Preparation and/or execution of this Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of	5/27/22

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F 684	Continued From page 4 evidenced by the following: During the initial tour of the EX. Order Unit on 04/01/22 at 11:47 AM, the surveyor observed Resident #83 sitting in a wheelchair visiting with a family member. The surveyor observed that Resident #83 had a EX. Order 26.(and EX. Order 26.(4) B1 to his/her EX. Order 26.(4) B1 The resident was EX. Order 26.(4) B1 and was EX. Order 26.(4) B1 any additional information about his/her injuries. According to the Resident Profile, Resident #83 had diagnoses that included, but were not limited to, EX. Order 26.(4) B1 . Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated EX. Order 26.(4) B1 revealed the resident had a Brief Interview for Mental Status of EX. O, which indicated that the resident was EX. Order 26.(4) B1 . Review of Resident #83's Interdisciplinary Plan of Care, dated EX. Order 26.(4) B1 , revealed a problem that "I am at risk for EX. Order 26.(4 [related to] EX. Order 26.(4) B1 and EX. Order 26.(4) B1 . EX. Order 26.(4) B1 witnessed." Review of Resident #83's EX. Order 26.(4) B1 "Incident/Accident Report," (incident report) provided by the Registered Nurse/Unit Manager (RN/UM), revealed that Resident #83 lost his/her balance while trying to pick up a piece of paper off the floor. As a result, the resident EX. Ord and sustained a EX. Order 26.(4) B1 to his/her EX. Order 26.(4) B1 during the EX. Order The incident report indicated that Resident #83 was EX. Order 26.(4) B1 , had a EX.. Order 26.(4) B1 to the EX. Order 26 and the apparent cause of	F 684	Deficiencies. The Plan of Correction is prepared and /or executed solely because it is required by the provisions of federal and state law. The Plan of Correction represents the facility's credible allegation of compliance as of 5/27/2022. -One, actions taken for the resident identified: Resident #83 - The resident had no adverse reaction from nurse not completing the EX. Order 26.(checks EX. Order 26.(4) B1 Two, identification of other residents who have the potential to be affected: The facility recognizes that any resident who sustains a EX. Ord and requires neuro checks could have the potential to be affected. Please refer to Sections Three and Four. All other residents who required a EX. Order 26 check were reviewed and no deficient practices were identified. Please refer to Sections Three and Four. Three, system changes and measures that will be made: 1. All licensed nurses will be in-serviced and reinforced by nursing administration in the importance of completing EX. Order 26 checks per direction. 2. Unit Managers or designee will monitor	

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F 684	Continued From page 5 the EX. Ord was EX. Order 26.(4) B1. "Treatment/Follow up" included cleansing and EX. Order 26.(4) B1 l checks (an assessment of an individual's EX. Order 26.(4) B1 functions and EX. Order 26.(4) B1) EX. Order 26.(4) B1 EX. for 24 hours. A review of Resident #83's EX. Order 26.(4) B1 Assessment sheet EX. Order 26.(4 check sheet), instructed under the "EX. Order 26.(4) B1 Assessment Post Incident Required Frequency and Duration" section that EX. Order 26.(checks should be completed at the following frequency and duration: every 15 minutes times four, every 30 minutes times four, every hour times eight, and every eight hours times four. Further review of the EX. Order 26 -check sheet revealed EX. Order 26 -checks were conducted for a period beginning on EX. Order 26.(4) B1 at 6:45 PM until 10:30 PM on the same date and that the resident's EX. Order 26.(4) B1 status and EX. Order 26.(were not assessed. A review of Resident #83's Interdisciplinary Progress Notes from EX. Order 26.(4) B1 to EX. Order 26.(4) B1 did not reveal documentation that EX. Order 26.(checks had been initiated or were in progress for Resident #83. During an interview with the surveyor on 04/07/22 at 12:45 PM, Licensed Practical Nurse #3 (LPN) described the resident EX. Order 26.(4) incident process. LPN #3 stated the nurse would evaluate and assessed the resident from head to toe after any EX. Ord LPN #3 further stated that the nurses checked the resident for any discomfort, medicated for pain as needed, and informed the physician and family. LPN #3 added that EX. Order 26.(checks were initiated for unwitnessed EX. Ord and the nurse would follow the frequency and duration instructed on the EX. Order 26.(check sheet.	F 684	and audit all residents on a daily basis that had an unwitnessed fall for completion of EX. Order 26.(checks. Concerns will be addressed by the Director of Nursing or designee. 3. The EX. Order 26.(check flow sheet will be attached to the 24 hour report so the next shift will continue the process FOUR, MONITORING MECHANISMS TO ASSURE COMPLIANCE: As part of the daily review of 24-Hour Tour Reports, as well as daily resident care rounds, nursing and facility administration, as well as shift supervisors, will monitor the delivery of resident care, services, and staff practices. Special attention will be given to those residents who had sustained a EX. Ord and required EX. Order 26 check monitoring. Concerns will be addressed, as warranted. As part of the quarterly Quality Improvement Committee meeting, the Director of Nursing or designee will present the collected data of the audits and will reinforce the importance of completing neuro checks as per professional standards of practice, as described in the Section Three, Number One in-servicing agenda.	

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F 684	Continued From page 6 During an interview with the surveyor on 04/07/22 at 1:15 PM, the RN/UM stated that EX. Order 26-checks were initiated for unwitnessed EX. Order and for residents who sustained a EX. Order 26.(4) B1 during a EX. Order. The RN/UM further stated that a EX. Order 26-check sheet was included in the incident report packet and that copies were kept on all of the units. The RN/UM added that she expected the EX. Order 26-check sheet to be completed in its entirety unless the resident was sent out to the hospital. The RN/UM reviewed Resident #83's EX. Order 26.(4) B1 incident report, in the presence of the surveyor. At which time, the RN/UM stated that Resident #83 was not transferred to the hospital EX. Order 26.(4) on EX. Order 26.(4) B1 and that the EX. Order 26-checks should have been completed. During an interview with the surveyor on 04/12/22 at 2:18 PM, in the presence of the survey team, the Director of Nursing (DON) stated that she expected EX. Order-checks to be initiated post fall, if necessary, and that the nurse would follow the instructions on the EX. Order 26-check sheet. The surveyor questioned why Resident #83's EX. Order 26-checks were not completed for the EX. Order 26.(4) B1 with EX. Order 26.(4) B1 and the DON stated she would have to get back to the surveyor. During a follow up interview with the surveyor on 04/13/22 at 9:44 AM, in the presence of the survey team, the DON stated that EX. Order 26-checks monitor for any changes in the resident's mental status. The DON further stated that she had no additional information in reference to Resident #83's EX. Order 26.(4) B1-checks and did not provide any further explanation regarding the matter. The DON further stated that EX. Order 26-checks should have been completed for Resident #83.	F 684		

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F 684	Continued From page 7 Review of the facility's [EX. Order 26.(4)]-Check Guideline" policy, with the effective date of 08/21, indicated that [EX. Order 26.(4)]-checks may be completed for follow up for all unwitnessed [EX. Order 26.(4) B1] in which the [EX. Order 2] was struck. NJAC 8:39-29.2(d)	F 684		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		5/27/22

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F 690	Continued From page 8 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documents, it was determined that the facility failed to consistently document EX. Order 26.(4) B1 care according to the physician's orders. This was identified for 1 of 2 residents (Resident #8) reviewed for EX. Order 26.(4) EX. Order 26.(4) B1 This deficient practice was evidenced by the following: The surveyor observed Resident #8 sitting up in bed with a EX. Order 26.(4) B1 and EX. Order 26.(4) at the side of the bed on the following dates and times: 04/01/22 at 11:53 AM, 04/05/22 at 9:39 AM, 04/06/22 at 9:50 AM, 04/08/22 at 9:45 AM, 04/11/22 at 10:12 AM, and 04/12/22 at 9:35 AM. According to the Admission Record, Resident #8 had diagnoses that included, but were not limited to, EX. Order 26.(4) B1 A review of the Physician's Order Sheet for EX. Order 26.(and EX. Order 26.(4) B1 revealed an order for EX. Order 26.(care; EX. Order 26.(4) B1 care - Maintain EX. Order 26.(4) B1 at all times. Observe and record EX. Order 26.(4) B1 every shift, dated EX. Order 26.(4) B1	F 690	DISCLAIMER STATEMENT Preparation and/or execution of this Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and /or executed solely because it is required by the provisions of federal and state law. The Plan of Correction represents the facility□s credible allegation of compliance as of 5/27/2022. -One, actions taken for the residents identified: -Resident #8 - The resident had no adverse reaction from not having nurses consistently document her/his EX. Order 26.(EX. Order 26.(and that EX. Order 26.(4) B1 care had been completed. -Residents order was revised to trigger the nurse to include the EX. Order 26.(4) B1 into the EMAR	

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F 690	Continued From page 9 A review of the Treatment Administration Record revealed incomplete documentation for Resident #8, as related to EX. Order 26.(4) B1 care, for the months of EX. Order 26.(4) B1 as follows: On 03/23/22 during the night shift, there was no documentation for EX. Order 26.(4) B1 care, which included maintaining the EX. Order 26.(4) B1 EX. Order 26.(4) B1 and observing and recording EX. Order 26 EX. Order 26.(4 every shift. On 04/02/22 and 04/03/22 during the night shift, there was no documentation for EX. Order 26.(4) B1 care, which included maintaining the EX. Order 26.(4) B1 EX. Order 26.(4) B1 and observing and recording EX. Order 26.(4) B1 every shift. During an interview with the surveyor on 04/11/22 at 10:18 AM, the Certified Nursing Assistant #6 (CNA), stated she was familiar with Resident #8 and his/her care needs. CNA #6 confirmed that she emptied the EX. Order 26 from the EX. Order 26.(4) B1 bag for Resident #8. She further clarified that she did not record the EX. Order 26.(4) B1. CNA #6 also stated that if there is anything needed beyond emptying the EX. Order 26.(4) B1 bag, the nurse is responsible for such tasks. During an interview with the surveyor on 04/11/22 at 10:30 AM, the Licensed Practical Nurse #1 (LPN) described the needs associated with EX. Order 26.(4) B1 care for Resident #8. LPN #1 stated that CNAs are responsible for emptying resident EX. Order 26.(4) B1 bags; and if there is any aspect related to care or treatment of the EX. Order 26.(4) B1 bag, such tasks would be completed by nursing staff. LPN #1 further stated that EX. Order 26.(4) B1 documentation would be recorded on the resident's paper chart, clarifying that such	F 690	-MD was informed of residents EX. Order 26.(4 not being consistently recorded Two, identification of other residents who have the potential to be affected: The facility recognizes that any residents who has a EX. Order 26.(4) B1 could have the potential to be affected. Please refer to Sections Three and Four. All other residents with a EX. Order 26.(4) B1 were reviewed and no deficient practices were identified. Three, system changes and measures that will be made: 1. Residents with orders to monitor EX. Order 26.(4 EX. Order 26 will include a trigger in the EMAR (electronic medication administration record) to input the amount of the out put every shift 2. All licensed nurses will be in-serviced and reinforced by nursing administration regarding the importance of consistently documenting that EX. Order 26.(4) B1 care has been completed and recording the EX. Order 26.(4) EX. Order 26.(as ordered by the physician. 3. Policy will be revised to include recording of output as ordered by the physician 4. Unit Managers will audit treatment administration records and medical records of residents on a weekly basis that have EX. Order 26.(4) B1 to ensure proper documentation reflective of	

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AVALON REHABILITATION AND HEALTHCARE CENTER	1059 EDINBURG ROAD HAMILTON, NJ 08690

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F 690	Continued From page 10 documentation would not be recorded anywhere in the electronic record. LPN #1 also stated it was the CNA's responsibility to report the EX. Order 26.(4) B1 EX. Order 26 emptied from the bag to the nurse, so that the nurse could record the EX. Order 26.(4) B1 the paper chart, specifically within the "Interdisciplinary Progress Notes" related to nursing care. At that time, LPN #1 confirmed that a failure to record a EX. Order 26.(4) B1 would be considered a problem, especially if there was a physician's order to do so. Review of the "Interdisciplinary Progress Notes" for Resident #8 from EX. Order 26.(4) B1 revealed an absence of documentation related to EX. Order 26.(4) B1 volumes. There was no instance in which the EX. Order 26.(4) B1 EX. Order 26.(4) B1 was recorded for every shift, as ordered by the physician, on any of the days within the referenced period. In addition, there were multiple days in EX. Order 26.(4) B1 nursing progress notes for which there were no progress notes related to Resident #8's care. During an interview with the surveyor on 04/13/22 at 9:50 AM, the Director of Nursing, in the presence of the survey team, acknowledged that the EX. Order 26.(4) B1 care and EX. Order 26.(4) B1 EX. Order 26.(4) B1 were not documented in accordance with the physician's orders. Review of the facility's policy titled, "EX.EX. Order 26.(4) B1 the female/male EX. Order 26.(4) B1 and EX. Order 26.(4) B1 " revealed it was implemented on 10/18 and most recently revised on 09/21. According to the policy, EX. Order 26.(4) B1 is initiated to relieve EX. Order 26.(4) B1 EX. Order 26.(4) B1 of EX. Ord ml or greater and for those residents who may have EX. Order 26.(4) B1 . In addition, the policy referenced a need for at least	F 690	EX. Order 26.(4) B1 and EX. Order 26.(4) B1 as per professional standards of practice. Concerns will be addressed with the Director of Nursing. Four, monitoring mechanisms to assure compliance: As part of the daily review of 24-Hour Tour Reports, 10%of clinical records of residents with EX. Order 26.(4) B1 , as well as daily resident care rounds, nursing and facility administration, as well as shift supervisors, will monitor the delivery of resident care, services, and staff practices. Special attention will be given to those residents who have orders for EX. Order 26.(4) B1 and require EX. Order 26.(monitoring and EX. Order 26.(4) B1 . Concerns will be addressed, as warranted. 2. As part of the quarterly Quality Improvement Committee meetings, the Director of Nursing or designee will present the collected data of the audits and will reinforce the importance of providing EX. Order 26.(4) r care and recording the EX. Order 26.(4) B1 as per professional standards of practice.	

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F 690	Continued From page 11 EX. Order 26.(4) B1 to be draining, without further detail. NJAC 8:39-27.1(a)	F 690		
F 755 SS=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 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	F 755		5/27/22

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F 755	Continued From page 12	F 755		

by:
Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to administer medication in accordance with a physician's order. This deficient practice was identified for 1 of 1 nurse, on 1 of 5 units [EX. Order] Unit) observed during the medication pass and was evidenced by the following:

1. The surveyor observed the Licensed Practical Nurse #2 (LPN) administer medication to Resident #66 on 04/04/22 at 8:44 AM. The resident's medications included [EX. Order 26.(4) B1] milligrams (mg), a medication used to [EX. Order 26.(4) B1]. During the medication pass, LPN #2 stated that the [EX. Order 26.(4) B1] was not available in the medication supply, and she would need to obtain it from the automated pharmacy dispensing machine, where back-up supplies of medication are stored. LPN #2 administered all other medication to Resident #66 as ordered but did not follow-up to obtain the missing [EX. Order 26.(4) B1] medication.

During an interview with surveyor, at the conclusion of the medication pass observation, at approximately 9:25 AM, LPN #2 did not address the missing [EX. Order 26.(4) B1] mg medication for Resident #66.

Review of the Physician's Order Sheet revealed an order for Resident #66 for [EX. Order 26.(4) B1] mg, administer one tablet twice daily (every 12 hours) by mouth with food times five days for [EX. Order] [EX. Order 26.(4) B1]

Review of the Medication Administration Record (MAR), a recording document. revealed a red, unmarked square on the date and time that the

DISCLAIMER STATEMENT

Preparation and/or execution of this Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and /or executed solely because it is required by the provisions of federal and state law.

The Plan of Correction represents the facility□s credible allegation of compliance as of 5/27/2022.

-One, actions taken for the residents identified:

-Resident #66 - The resident had no adverse reaction from not receiving [EX. Order 26.(4) B1] on [EX. Order 26.(4)] at 9 am. The resident denied any complaints [EX. Order 26.(4)] on assessment. The nurse contacted the physician and changed the order to [EX. Order 26.(4)] at 11:25 am. The resident had no adverse reaction from the nurse accidently marking the EMAR (electronic medication administration record) that the Medication [EX. Order 26.(4) B1] was administered at 11 am.

Two, identification of other residents who have the potential to be affected:

The facility recognizes that all residents have the potential to be affected from a medication administration and documentation perspective. Please refer

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F 755	Continued From page 13 EX. Order 26.(4) B1 mg tablet was due for administration. According to the MAR, the referenced medication was due on EX. Order 26.(4) B1 at 9:00 AM. During an interview with the surveyor on 04/04/22 at 11:11 AM, Resident #66 stated that he/she was doing well and thanked the surveyor for checking on him/her. Review of the MAR on the same date at 11:50 AM revealed a green square with a checkmark on the date and time that the EX. Order 26.(4) B1 mg tablet was due for administration. During an interview with the surveyor on 04/04/22 at 11:55 AM, LPN #2 confirmed that the EX. Order 26.(4) B1 was not available in the medication back-up supply and as a result, could not be administered. LPN #2 further stated that the presence of a blank, red-colored square on the MAR indicated that the medication was late. A green-colored square on the MAR, with a check mark, indicated that a medication was given. When asked about the observed change on the MAR, LPN #2 stated that she checked off the medication as given accidentally at approximately 11:00 AM, after the medication pass and while sitting down at the nursing unit. LPN #2 acknowledged that medication was supposed to be documented as administered only once it was actually given and that not properly signing the MAR would be a problem because it could lead to confusion as to whether the medication was given. LPN #2 acknowledged that the EX. Order 26.(4) B1 EX. Orde mg was marked as given to Resident #66, even after she knew it was not available in the back-up supply, that this was an error, and done mistakenly.	F 755	to Sections Three and Four. All other residents with medication orders were reviewed and no deficient practices were identified. Three, system changes and measures that will be made: 1. All licensed nurses will be in-serviced and reinforced by nursing administration in the following areas: - The seven (7) rights of medication and treatment administration [right resident, right medication, right dosage, right route, right method, right time/frequency, and right position]; _ Pharmacy consultant will perform Competencies with 5 nurses a month for compliance of proper Medication administration to the residents - Nursing administration rein-serviced and reinforced licensed nursing staff regarding the importance of calling the MD timely to change medication order if medication is not available -Nursing administration rein-serviced and reinforced licensed nursing staff regarding the importance of accurately signing the EMAR in a timely manner according to the facility□s policy and procedure -Weekly, Unit Managers will audit medication administration records for timely medication administration as per professional standards of practice.	

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F 755	Continued From page 14 LPN #2 further stated that she obtained a discontinuation order for the EX. Order 26.(4) B1 mg tablet for Resident #66, and it was replaced with an order for a different, similar EX. Orde medication. Review of the Interdisciplinary Progress Note for Resident #66, dated EX. Order 26.(4) B1 at 11:25 AM, revealed a discontinuation order for EX. Order 26.(4) B1 EX. Orde mg and new order for EX. Order 26.(4) B1 mg by mouth EX. Order 26 per day times five days, with the first dose as administered. During an interview with the surveyor on 04/04/22 at 12:30 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) showed the surveyor the automated pharmacy dispensing machine, which served as storage for back-up medication supplies and confirmed there was no EX. Order 26.(4) B1 present within the unit. The LPN/UM further stated that if the medication was not present, it could not be given to Resident #66. The LPN/UM further acknowledged that if medication was not documented as administered properly, this would be a problem because there is no way of knowing whether it was given, which may lead to over-dosing or under-dosing a resident. She further acknowledged that the medication should not have been documented as administered, if it was not available in supply, and was told by LPN #2 that it was marked as given accidentally. When asked why the medication was also documented as given on the previous evening, on EX. Order 26.(4) B1 at 9:00 PM, LPN/UM stated she would investigate the matter further and follow-up with the surveyor. During an interview with the surveyor on 04/04/22	F 755	Concerns will be addressed by the Director of Nursing or designee. -Medication administration proficiency audits will be conducted by nursing administration on a monthly basis. Concerns will be addressed, as warranted Four, monitoring mechanisms to assure compliance: As part of the daily review of 24-Hour Tour Reports, EMR (electronic medical record) record as well as daily resident care rounds, nursing and facility administration, as well as shift supervisors, will monitor the delivery of resident care, services, and staff practices. Special attention will be given to the timely administration of medication. Concerns will be addressed, as warranted. As part of the quarterly Quality Improvement Committee meetings, the Director of Nursing or designee will present the collected data of the audits and will reinforce the importance of providing proper medication administration as per professional standards of practice. as described in the Section Three, Number One in-servicing agenda. Weekly, Unit Managers will audit medication administration records for qualitative and quantitative accuracy. Concerns will be addressed by the Director of Nursing or designee.	

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F 755	Continued From page 15 at 12:44 PM, the Director of Nursing (DON) stated that a nurse should document a medication as administered on the MAR when it is given to the resident. When asked by the surveyor, the DON stated it would not be a problem if a medication was signed off as given on the MAR in error and then corrected afterwards. According to the DON, if such an event did occur, it was probably a mistake. During the same date and time, the surveyor asked the DON to describe the process for documenting medication administration on the MAR. The steps included the following per the DON: the nurse must log into the computer, locate the resident's record in the database and pull up the record, find the MAR within the resident's record, and then find the appropriate medication to check it off as administered. The DON could not explain why a medication that was unavailable would be signed off as administered in error, given all the steps involved in the process. Further, when it was established through observation and interview that there was no supply of Naproxen available, the DON stated she did not know how or why the medication was given to Resident #66 on the previous evening. The DON acknowledged that medication documentation inaccuracies on the MAR would be a problem, if not documented properly. The DON also stated she would like to investigate the matter further. During a follow-up interview with the surveyor on 04/05/22 at 10:07 AM, the LPN/UM stated, in the presence of the survey team, that a medication supply of [redacted] mg tablets for Resident #66 was found, with one dose missing, since it was given on the evening of [redacted]. The	F 755	Medication administration proficiency audits will be conducted by nursing administration on a monthly, random basis. Concerns will be addressed, as warranted.	

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LPN/UM stated the card was found last night.

Review of the medication supply and associated documentation for Resident #66 revealed the presence of nine tablets of EX. Order 26.(4) B1 mg, with the order filled and delivered by the provider pharmacy on EX. Order 26.(4) B1, according to the delivery manifest.

During the same interview with the surveyor at 10:15 AM, the LPN/UM stated that she spoke to the evening shift nurse, who administered the EX. Order 26.(4) B1 mg dose to Resident #66 on the evening of EX. Order 26.(4) B1 at 9:00 PM, as recorded on the MAR. The LPN/UM stated that the referenced interview caused facility staff to find the resident's supply of medication, which was not found by LPN #2 during the observed medication pass. The LPN/UM further confirmed that Resident #66 was supposed to receive EX. Order 26.(4) B1 mg tablet by mouth EX. Order 2 per day times five days, for a total of 10 doses, but only received one dose on the evening of EX. Order 26.(4) B1 due to the events described and there were nine doses remaining in the supply.

During an interview with surveyor on 04/13/22 at approximately 9:45 AM, the Assistant Director of Nursing/Infection Preventionist (ADON/IP) and DON asked the surveyor follow-up questions regarding the medication pass and the surveyor described the process for medication pass observation. The surveyor explained LPN #2's missed opportunity to administer the medication to the resident and the failure to follow-up on the missing medication, as indicated, during the medication pass itself. The ADON/IP and DON stated they understood the surveyor and survey team's concerns regarding the matter.

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F 755	Continued From page 17 Review of the facility's policy titled, "Medication Administration" revealed an effective date of 05/11 and a most recent revision date of 09/21. The policy revealed a need to administer medication at a time that is one hour before or one hour after the ordered time. A review of LPN #2's most recent "MEDICATION ADMINISTRATION OBSERVATION REPORT" dated 12/09/21 and conducted by the Consultant Pharmacist revealed criteria that included a need to ensure there were no missing supplies on the medication cart and that the medication record is charted immediately after administration.	F 755		
F 756 SS=E	NJAC 8:39 - 29.2(d) Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist	F 756		5/27/22

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F 756	Continued From page 18 during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to act on or respond to comments made by the Consultant Pharmacist (CP) in a timely manner during the Medication Regimen Review (MRR). This deficient practice was identified for 1 of 6 residents (Resident #42) reviewed for MRR and was evidenced by the following: According to the Resident Profile, Resident #42 had diagnoses that included, but were not limited to, EX. Order 26.(4) B1 . Review of the EX. Order 26.(4) B1 CP report, dated EX. Order 26.(4) B1, revealed that the CP reviewed Resident	F 756	DISCLAIMER STATEMENT Preparation and/or execution of this Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and /or executed solely because it is required by the provisions of federal and state law. The Plan of Correction represents the facility's credible allegation of compliance as of 5/27/2022.	

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F 756	Continued From page 19 #42's medication management and recommended to "Make PRN [redacted] order for 14 days & then evaluate continued need." The CP report had a handwritten notation of "[redacted] med [medication]. Will discuss with [redacted] nurse." Review of Resident #42's [redacted] Physician Order Sheet revealed a physician order (order) dated [redacted] for [redacted] Order 26.(4) B1 medication) [redacted] milligrams (mg) every [redacted] hours as needed (prn) for [redacted]. The surveyor observed the order did not contain a duration. Review of the EX. Order 26.(4) B1, and [redacted] Medication Administration Record (MAR) reflected the aforementioned order. The order did contain a duration. Review of Resident #42's "Interdisciplinary Progress Notes" from [redacted] to [redacted] did not reveal documentation that the CP recommendation was discussed or addressed with the [redacted] nurse or the physician. Review of the [redacted] CP report, dated 03/02/22, revealed a CP recommendation to "Consider D/C [discontinuing] [redacted] for no use - not used since order was written." The CP report had a handwritten notation that "MD wants to keep." Review of Resident #42's "Physician Progress Notes," dated [redacted] revealed that Resident #43 was assessed by the physician but did not document a rationale for the continued use of the PRN [redacted] Review of the [redacted] CP report, dated	F 756	-One, actions taken for the residents identified: -Resident #42 - The resident had no adverse reaction from [redacted] not having a stop date. Consultant pharmacist recommendation to obtain a stop date or to consider discontinuation was discussed with MD on multiple occasions via phone conversations and on 4/12/22 the MD came in and wrote a note stating to continue PRN Ativan due to resident being on [redacted] and may need the medication as [redacted] EX. Order 26.(4) B1. Two, identification of other residents who have the potential to be affected: 1. The facility recognizes that all residents have the potential to be affected from physician not addressing consultant pharmacist recommendation in a written form. All other residents with consultant pharmacist□s recommendation were reviewed and no deficient practices were identified. Please refer to Sections Three and Four. Three, system changes and measures that will be made: All licensed nurses will be in-serviced and reinforced by nursing administration in the following areas: To review consultant pharmacists□ recommendations with the MD Document in a progress note MD□s rational for not following the consultant	

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F 756	Continued From page 20 EX. Order 26.(4) B1, revealed that the CP repeated the aforementioned recommendation and added that "No changes noted this month." During an interview with the surveyor on 04/12/22 at 10:38 AM, the Registered Nurse/Unit Manager (RN/UM) stated the CP reviewed the residents' medication lists monthly and forwarded a CP report via email to herself and the Director of Nursing (DON). The RN/UM added that it was her responsibility to make sure the CP recommendations were completed in a timely manner. When questioned about Resident #42's PRN EX. Order 26.(4) order, the RN/UM stated that she had a discussion with the EX. Order 26.(4) nurse and that the hospice nurse wanted to continue the medication. The RN/UM stated she did not document in the resident's medical record but made notations on the CP report to keep track. When questioned about the use of PRN EX. Order 26.(4) B1, the RN/UM stated that PRN EX. Order 26.(4) B1 medications should have a duration of EX. O days and then re-evaluated. During an interview with the surveyor on 04/12/22 at 2:10 PM, in the presence of the survey team, the DON stated that she expected nursing to review the CP recommendations with the physician. The DON stated the CP emailed the CP report to the UM and herself and that the nurse or nurse manager would notify the physician. The DON added that the physician would then agree or decline the recommendation. The DON further stated that PRN EX. Order 26.(4) B1 medications were ordered for 14 days and the re-evaluated. During a follow up interview with the DON on 04/13/22 at 9:38 AM, in the presence of the survey team, the DON stated that both the	F 756	pharmacists recommendation In-service physicians on documenting in their progress note rational for not following consultant pharmacists recommendations. Weekly, Unit Managers will audit consultant pharmacists recommendations for qualitative and quantitative accuracy of completion by physician. Concerns will be addressed by the Director of Nursing or designee. as per professional standards of practice. Four, monitoring mechanisms to assure compliance: Unit Managers will audit monthly 10% of medical records for completion of consultants pharmacist recommendation for qualitative and quantitative accuracy. Concerns will be addressed by the Director of Nursing or designee. Unit Managers will audit monthly 10% of medical records for completion of physician notes to include reason if consultants pharmacist recommendations were not approved. Concerns will be reported to the DON, Administrator who will discuss with the Consultant Pharmacist As part of the quarterly Quality Improvement Committee meetings, the Director of Nursing or designee will present the collected data of the audits and will reinforce the importance of timely	

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F 756	Continued From page 21 [redacted] nurse and physician wanted to continue the PRN [redacted] order. The DON added that the physician and [redacted] nurse came to the facility yesterday, [redacted], after surveyor inquiry, to write a note indicating that the resident needed the medication. The DON stated that the RN/UM had a discussion with the [redacted] nurse prior to yesterday about Resident #42's PRN [redacted] order, and the [redacted] nurse did document in the resident's medical the continued need for the medication at that time. The DON further stated that the RN/UM did not document in the resident's medical record because it was not a new order, and the order was just a continuation of the initial [redacted] PRN [redacted] order. The DON added that the RN/UM would have documented in the resident's medical record if there was a change to the order. The DON further stated the physician did not want to add a duration to the PRN [redacted] order because the resident was on [redacted] and that it was up to the physician on how to proceed. Review of the facility's "Pharmacy Consultant" policy, reviewed on 10/21, indicated that the CP provides clinical guidance to providers and staff on the appropriate use of medications. The policy further indicated that the CP collaborates with the health care team to promote safe and effective drug therapy, and to ensure compliance with state and federal regulations. NJAC 8:39 - 29.3(a)	F 756	addressing consultant□s pharmacist recommendations and documentation in the medical record. as described in the Section Three, Number One in-servicing agenda	
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides-	F 806		5/27/22

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F 806	Continued From page 22 §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documents, it was determined that the facility failed to ensure that resident dietary preferences were accurately identified and implemented for 1 of 5 residents (Resident #84) reviewed for dining. This deficient practice was evidenced by the following: On 04/01/22 at 12:22 PM, during the initial tour of the facility, the surveyor observed Resident #84 seated in a wheelchair at the bedside. The surveyor noted that the resident's meal tray was on an overbed table outside of the room in the hallway and appeared to have been untouched. When interviewed, the resident stated that the chicken was inedible because it was too hard. The resident's Certified Nursing Assistant #1 (CNA) observed that the resident had not eaten and offered an alternative meal selection, but the resident refused. The resident stated the kitchen staff could not cook and indicated that he/she intended to eat egg salad that was stored in the resident's personal refrigerator instead. The resident further stated that he/she was always served "sweet gravy" on his/her meats even though the meal ticket specified "No Gravy." The surveyor reviewed the resident's meal ticket	F 806	DISCLAIMER STATEMENT Preparation and/or execution of this Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and /or executed solely because it is required by the provisions of federal and state law. The Plan of Correction represents the facility's credible allegation of compliance as of 5/27/2022. -One, actions taken for the residents identified: -Resident #84 - The resident had no adverse reaction from receiving a lunch tray with gravy. The meal ticket had been updated to reflect resident□s preferences and staff was immediately in-serviced on the importance of honoring food preferences. Two, identification of other residents who have the potential to be affected:	

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F 806	Continued From page 23 which revealed that the resident was ordered a Regular Diet and the only preference or dislike listed on the bottom portion of the meal ticket was "NO GRAVY." Review of the Resident #84's Resident Profile (an admission summary) revealed that the resident was readmitted to the facility with diagnoses which included, but were not limited to, EX. Order 26.(4) B1). Review of Resident #84's Quarterly Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care, dated EX. Order 26.(4) B1 reflected the resident had a Brief Interview for Mental Status (BIMS) of "EX. O," which indicated that the resident was EX. Order 26.(4) B1. Further review of the MDS revealed that the resident was independent with bed mobility and transfers and required set up help with eating. Review of a Nutrition Services Progress Note (NSPN) dated EX. Order 26.(4) B1 written by the Dietician, revealed that the resident's food preferences were assessed and the resident's new dislikes included honey, carrots, and gravy. Further review of the NSPN revealed that the resident informed the Dietician at that time that he/she also received rice on meal trays. The Dietician noted that rice was previously flagged as an existing dislike, not appearing on tray tickets. On 04/06/22 at 12:16 PM, the surveyor observed Resident #84 seated in a wheelchair at the bedside eating lunch. The resident was served sliced roasted turkey which had turkey gravy on it, dry mashed potatoes, and green beans. The	F 806	The facility recognizes that all residents have the potential to be affected from their food preferences not being honored. All other residents with food preferences were reviewed and no deficient practices were identified. Please refer to Sections Three and Four. Three, system changes and measures that will be made: All Kitchen and nursing staff will be in-serviced and reinforced by nursing administration and dietary manager in the following areas: To review resident□s food preferences To make sure food preferences are listed on the meal ticket To double check the tray prior to leaving the kitchen To double check the tray prior to giving it to the resident Replace the tray immediately if wrong tray was delivered Update meal ticket when residents□ preferences change Weekly, Unit Managers and Dietary Manger will audit meal tray for qualitative and quantitative accuracy of honoring resident□s food preferences. Concerns will be addressed by the Administrator, Director of Nursing and Dietary Manger. Four, monitoring mechanisms to assure compliance: Unit Managers will audit monthly 10% of	

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F 806	Continued From page 24 resident used two slices of white bread as he/she attempted to wipe the gravy off of the turkey. The resident ate only two bites of the mashed potatoes before he/she pushed the tray away and stated, "it was terrible." The resident obtained a bowl of egg salad that was in the room and began to eat that instead. On 04/07/22 at 9:37 AM, the surveyor interviewed the Dietician who stated that Resident #84 did not like the food at the facility. He stated that the resident did not like rice and that the resident cursed at him every time that he went into the resident's room. The Dietician further stated that the resident's food dislikes were entered into the meal tracking computer system and they appeared on the meal tickets when they were printed out. He also stated that the facility should have followed the ticket system which detailed that the resident did not like gravy. The Dietician added that the CNAs were supposed to check the resident's trays prior to serving to ensure that it was the proper consistency for the resident. On 04/08/22 at 12:24 PM, the surveyor interviewed Resident #84 who stated that he/she did not eat lunch today because the facility served two hamburger patties (Salisbury steak) with gravy and dry mashed potatoes. The resident stated that he/she sent the meal back and was unable to eat any of it. The resident reportedly ate a can of sardines and a roll for lunch instead. The resident further stated that he/she planned to eat a peanut butter and jelly sandwich later if necessary. On 04/08/22 at 12:55 PM, the surveyor interviewed the Dietary Aide (DA) who stated that if "NO GRAVY" was specified on Resident #84's	F 806	all meal trays for qualitative and quantitative accuracy for honoring food preferences. Concerns will be addressed by the Director of Nursing or designee. Dietary manger will audit monthly 10% of meal trays for qualitative and quantitative accuracy for honoring food preferences. Concerns will be addressed by the Administrator, Director of Nursing and Dietary Manger. As part of the quarterly Quality Improvement Committee meetings, the Dietician or designee will present the collected data of the audits and will reinforce the importance of timely addressing resident□s complains related to food preferences as described in the Section Three, Number One in-servicing agenda	

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F 806	Continued From page 25	F 806		

meal ticket, then the request should have been honored. The DA attempted to retrieve the resident's tray from the meal truck but was unable to locate it when requested to do so.

On 04/08/22 at 1:03 PM, the surveyor interviewed the Licensed Practical Nurse (LPN)/Nurse Manager (NM) who retrieved Resident #84's tray from the food truck and confirmed that it contained gravy as described by the resident. She stated that when staff passed trays they should review the ticket to ensure there was no gravy on the food as specified on the ticket. She further stated that they should have sent the tray back and got another without gravy. The LPN/NM spoke with the resident's assigned CNA #3 in the presence of the surveyor and informed her that the resident received a a tray with gravy and asked CNA #3 if she checked the tray first. CNA #3 stated that she did not know that she was supposed to.

On 04/08/22 at 1:09 PM, the surveyor interviewed CNA #3 who stated that she did not know that she was supposed to check the resident's food preferences for accuracy prior to the meal delivery. She stated that the LPN/NM just informed her that she was required to do so.

On 04/08/22 at 1:28 PM, the surveyor interviewed the District Manager (DM) of Dietary who stated that he saw Resident #84's meal tray and confirmed that it had more gravy than desired given the resident's meal preferences indicated no gravy. He stated that the resident's preferences were called out when the tray came down the line and and the chef prepared the tray accordingly. He further stated that the person who loaded the tray onto the food truck was a

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F 806	Continued From page 26	F 806		

second set of eyes to check the tray for accuracy and that nursing was the last set of eyes to check the resident's tray for accuracy prior to delivery. He also stated that "we should have done a better job," and that he would also update the ticket to ensure that the resident was not served rice as he did not know why rice was not listed as a dislike on the ticket. The DM stated that resident preferences were important and should be honored.

On 04/12/22 at 10:28 AM, the DM provided the surveyor with a copy of Resident #84's meal ticket which was updated and specified "NO GRAVY/NO RICE."

The surveyor reviewed the facility's policy, "Dining and Food Preferences," revised 09/2017, which revealed the following:

"Policy Statement: Individual dining, food, and beverage preferences are identified for all residents/patients."

"Food allergies, food intolerance, food dislikes, and food and fluid preferences will be entered into the resident profile in the menu management software system."

"The individually tray assembly ticket will identify all food items appropriate for the resident/patient based on diet order, allergies & intolerances, and preferences."

"Upon meal service, any resident/patient with expressed or observed refusal of food and/or beverage may be offered an alternate selection of comparable nutritional value."

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F 806	Continued From page 27 "The alternate meal and/or beverage selection will be provided in a timely manner." NJAC 8:39-17.4(a)(1)	F 806		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documents, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe, consistent manner designed to prevent foodborne illness. This deficient practice was evidenced by the following: On 04/01/22 at 10:40 AM, the surveyor, in the presence of the Food Service Director (FSD),	F 812	DISCLAIMER STATEMENT Preparation and/or execution of this Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and /or executed solely because it is required by the provisions of federal	5/27/22

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F 812	Continued From page 28 observed the following during the kitchen tour: 1. A food service worker (FSW) was observed prepping food. The FSW had a beard and was not wearing a beard guard. 2. The surveyor requested to be directed to the designated handwashing sink. The surveyor observed there was no plastic bag lining the trash can. When interviewed, the FSD stated there was usually a bag inside of the trash can. 3. In the cook's walk-in refrigerator, an opened and undated 32-ounce carton of liquid whole egg was stored on a multitiered shelf. When interviewed, the FSD stated that the carton should have been labeled when opened and that it should not have been stored in the cook's walk-in refrigerator. 4. In the cook's walk-in refrigerator, a pan with cooked pork covered with aluminum foil, dated 03/31-04/06, was stored on a multitiered shelf. The aluminum foil had a hole in the middle exposing the contents inside. When interviewed, the FSD stated the pan of pork should not have been stored in that manner. 5. In the cook's walk-in refrigerator, a pan with diced red peppers, dated 03/25-03/31 was stored on a multitiered shelf. When interviewed, the FSD stated the pan of diced red peppers should not have been stored in the refrigerator. 6. In the walk-in freezer, a box containing cooked breaded chicken breast was stored on a multitiered shelf. The plastic wrap and box lid were open exposing the contents inside. When interviewed, the FSD stated the cooked breaded	F 812	and state law. The Plan of Correction represents the facility's credible allegation of compliance as of 5/27/2022. One, actions taken for the situations identified: -The FSW immediately put on a beard restraint to cover his facial hair and recognizes the importance of following this practice per policy. -After the interview was completed, the hand washing sink trash can was cleaned and sanitized and a liner was placed inside the trash can. -The unlabeled carton was immediately discarded. -The pan of pork was immediately discarded -The pan of diced red peppers was immediately discarded -The box of cooked breaded chicken was immediately discarded -The opened and undated package of chicken breast was discarded. -The box of meat product was immediately discarded. -The items from the dairy box were immediately discarded. -The coffee filters stored directly on the shelf as observed were immediately discarded. -The yellow cake mix was discarded. -The FSW immediately put on a beard restraint to cover his facial hair and	

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F 812	Continued From page 29 chicken breast should not have been stored in that manner and that the plastic wrap and the box should be kept closed. 7. In the walk-in freezer, an open and undated package of chicken breast tenders was stored on top of a box. 8. In the walk-in freezer, a pan containing a meat product was stored on a multitiered shelf. The meat product was unlabeled and undated. When interviewed, the FSD was unable to identify the meat product and stated that it should have been labeled. 9. In the dairy box, the surveyor observed a tray stored on a rolling cart. The tray contained the following: seven chocolate mighty shakes labeled and dated 03/14/22, two chocolate mighty shakes labeled and dated 02/24/22, one chocolate mighty shake labeled and dated 03/07/22, three vanilla mighty shakes labeled and dated 03/27/22 and two undated vanilla mighty shakes. When interviewed, the FSD stated the tray containing the multiple cartons of mighty shakes should not have been stored in the dairy box. The FSD added that the mighty shakes had a shelf-life of 14 days once thawed. 10. A stack of coffee filters was stored directly on a multitiered shelf. When interviewed, the FSD stated they normally stored the coffee filters in that manner. 11. In the dry storage room, an open and undated package of yellow cake mix was stored on a multitiered shelf. When interviewed, the FSD stated the package should have been labeled.	F 812	recognizes the importance of following this practice per policy. -The FSD immediately put on a hair restraint to cover his head and recognizes the importance of following this practice per policy. Two, identification of other residents who have the potential to be affected: -The facility recognizes that all residents have the potential to be affected by not wearing hair restraints in the kitchen. -The facility recognizes that all residents have the potential to be affected by not having a clean hand washing sink & trash can at all times. -The facility recognizes that improper food labeling and dating could have the potential to affect all residents. -The facility recognizes that improper covering of food and labeling & dating could have the potential to affect all residents. -The facility recognizes that all residents have the potential to be affected by not wearing beard restraints in the kitchen. -The facility recognizes that all residents have the potential to be affected by not wearing hair restraints in the kitchen. Three, system changes and measures that will be made: All kitchen staff have been in-serviced on the necessity of beard restraints and hairnets and how and when to wear them effectively at all times in the kitchen. In-servicing to continue monthly for all staff. All kitchen staff were in-serviced on	

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F 812	Continued From page 30 12. The surveyor observed a second FSW walk into the dry storage room. The FSW had a beard and was not wearing a beard guard. 13. The FSD conducted the initial tour of the kitchen with the surveyor, without a hairnet or beard guard. When interviewed, the FSD stated that staff should have a beard guard on if they have a beard and a hairnet on if they have hair. A review of the facility's "Staff Attire" policy, revised on 02/05/18, indicated that all staff members would have their hair off the shoulders, confined in a hair net and facial hair properly restrained. A review of the facility's "Food Storage: Cold Foods" policy, revised on 09/2017, indicated that all foods would be stored wrapped or in covered containers, labeled and dated and arranged in a manner to prevent cross contamination. A review of the facility's "Food Storage: Dry Goods" policy, revised on 09/2017, indicated that storage areas will be neat, arranged for easy identification, and date marked as appropriate. A review of the facility's "Dispose of Garbage and Refuse" policy, dated 08/2017, indicated the Dining Service Director would ensure that appropriately lined containers would be available within the food service area for disposal of garbage and other refuse. NJAC 8:39-17.2(g)	F 812	garbage and trash disposal. The manager's daily checklist has been updated to include monitoring of lining of all kitchen trash cans. All Dietary Staff has been in-serviced on the labeling & dating policy. Re In-servicing will be completed monthly for 6 months and continue quarterly. Review of all labeling & dating of all food items will continue 2x daily by managers to ensure compliance. Four, monitoring mechanisms to assure compliance: Daily Checklist will include monitoring of the effective wearing of beard restraints. Monitoring has been added to the FSD's QA checklist and will be monitored 3x/week for 3 months. Findings will be reported at the quarterly quality improvement meetings. Monitoring of the sink area has been added to the Manager's QA checklist and will be monitored 3x/week for 3 months. Findings will be reported at the quarterly quality improvement meetings. Monitoring of Labeling & Dating has been added to the Manager's QA checklist and will be monitored 3x/week for 3 months. Findings will be reported at the quarterly quality improvement meetings. Daily Checklist will include monitoring of the effective wearing of beard restraints. Monitoring has been added to the FSD's QA checklist and will be monitored 3x/week for 3 months. Findings will be reported at the quarterly quality improvement meetings. Daily Checklist will include monitoring of	

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F 812	Continued From page 31	F 812	the effective wearing of hair restraints. Monitoring has been added to the FSD's QA checklist and will be monitored 3x/week for 3 months. Findings will be reported at the quarterly quality improvement meetings..	
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documents, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to cover the opening of 2 of 3 outside garbage dumpsters. This deficient practice was evidenced by the following: On 04/01/22 at 10:40 AM, the surveyor toured the kitchen with the Food Service Director (FSD) and requested to see the outside garbage receptacle area. The surveyor observed three garbage containers (GC) on a cement slab. The surveyor observed that one of the three GC was uncovered and exposed to the elements. The GC had a closed lid on the right-side, but the left-side lid was open exposing multiple trash bags inside. When interviewed at that time, the FSD stated the GC lids should be closed when not in use. A review of the facility's "Dispose of Garbage and Refuse" policy, dated 08/2017, indicated all	F 814	DISCLAIMER STATEMENT Preparation and/or execution of this Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and /or executed solely because it is required by the provisions of federal and state law. The Plan of Correction represents the facility's credible allegation of compliance as of 5/27/2022. One, actions taken for the residents identified: 1. The dumpster lid was immediately closed on Dumpster #2 so that all 6 lids were closed. Two, identification of other residents who have the potential to be affected: The facility recognizes that failure to	5/27/22

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F 814	Continued From page 32 garbage and refuse would be collected and disposed of in a safe and efficient manner. NJAC 8:39-19.7	F 814	properly keep the lid closed at all times when not in use can affect all residents in the facility Three, system changes and measures that will be made: All kitchen staff were re in-serviced on keeping the facilities dumpster lid closed. The Food Service Director's daily checklist will include monitoring the closure of the facilities dumpster lid after meal service Environmental Service Manager's daily check list will include the monitoring and proper closure of the facility dumpster lid 3 times a day. Four, monitoring mechanisms to assure compliance: Monitoring of keeping the facility's dumpster lid closed will be included in the Food Service Director's and Environmental Services Director's daily rounds and findings will be reported at the facility's quarterly quality improvement meeting.	
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	F 880		5/27/22

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F 880	Continued From page 33	F 880		

program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(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

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F 880	Continued From page 34 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documents, it was determined that the facility failed to a.) ensure that staff wore the appropriate Personal Protective Equipment (PPE) and performed proper hand hygiene for a resident on Transmission Based Precautions (TBP) and b.) follow appropriate infection control procedures related to hand hygiene during the medication pass. This deficient practice was identified for 1 of 1 residents (Resident # 420) reviewed for TBP and 1 of 1 nurse, on 1 of 5 units [redacted] Unit) observed during the medication pass and was evidenced by the following: 1. During entrance conference with the Team Coordinator (TC) on 04/01/22 at 9:15 AM, the Director of Nursing (DON) stated that the facility had one new admission on the [redacted] Unit who was unvaccinated for [redacted] and was on TBP (isolation). The DON further stated that the PPE	F 880	DISCLAIMER STATEMENT Preparation and/or execution of this Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and /or executed solely because it is required by the provisions of federal and state law. The Plan of Correction represents the facility's credible allegation of compliance as of 5/27/2022. One, actions taken for the residents identified: -Resident #420 - The resident had no	

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F 880	Continued From page 35 required for the resident on TBP was a gown, gloves, N-95 mask, and goggles or a face shield. During the initial tour of the [redacted]0 Unit on 04/01/22 at 11:14 AM, the surveyor observed Resident #420 lying in bed with his/her eyes closed. The surveyor observed a plastic curtain at the doorway of Resident #420's room, a three-tier plastic storage bin that contained PPE, and signage attached to the walls outside the resident's room. The signage indicated "ATTENTION PUI ROOM (PERSON UNDER INVESTIGATION) All staff entering this room must have following PPE before entering the room, sequencing for putting on: Gown, N95 mask, Goggles/face shield, gloves." At that time, the surveyor interviewed a Certified Nursing Assistant (CNA) who stated that the resident was on TBP because he/she was not vaccinated (for [redacted]. According to the Resident Profile (Face Sheet), Resident #420 was admitted to the facility with diagnoses that included, but were not limited to, [redacted]. Review of the [redacted] Physician Order Sheets revealed an order, dated [redacted], for isolation precautions every shift. Review of the Care Plan revealed, "I am on [redacted]) related to [redacted] because [redacted]" and interventions included, "Please wear N-95 mask, face shield, gown and gloves when entering my room and please wash your hands before and after going in room."	F 880	adverse reaction from receiving a lunch tray from a CNA that did not have full PPE in place when entering the resident□s room. The resident also had no adverse reaction from the CNA not washing his hands upon leaving the room. The staff member was immediately in-serviced on importance of proper PPE usage and hand washing procedure. -Resident #101 - The resident had no adverse reaction from LPN not washing her hands prior to administering his/her medication. The staff member was immediately in-serviced on importance of proper hand washing procedure. Two, identification of other residents who have the potential to be affected: The facility recognizes that all residents have the potential to be affected from staff not wearing proper PPE and not washing hands. Please refer to Sections Three and Four. Three, system changes and measures that will be made: All nursing staff will be in-serviced and reinforced by nursing administration in the following areas: Employees will be re-educated on Why Donning & Doffing PPE is important part of stopping the introduction of infections. What PPE is required prior to entering the PUI room The infection control importance of proper hand washing protocols	

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F 880	Continued From page 36 On 04/04/22 at 12:01 PM, the surveyor observed Resident #420 lying in bed awake and alert. The surveyor observed a plastic curtain at the doorway of Resident #420's room, a 3-tier plastic storage bin that contained PPE, and signage attached to the walls outside the resident's room which indicated "ATTENTION PUI ROOM (PERSON UNDER INVESTIGATION) All staff entering this room must have following PPE before entering the room, sequencing for putting on: Gown, N95 mask, Goggles/face shield, gloves." On 04/04/22 at 12:38 PM, the surveyor observed CNA #4, wearing only a surgical mask as his PPE, deliver a lunch tray to Resident #420. CNA #4 did not don (put on) a gown, gloves, N-95 mask, or eye protection. The surveyor observed CNA #4 place the lunch tray on the overbed table, move the table towards the resident, reposition the resident in bed and open containers on the lunch tray. CNA #4 then exited the room at 12:45 PM without performing hand hygiene. During an interview with the surveyor on 04/04/22 at 12:45 PM, CNA #4 stated he was not sure why the resident was on isolation. CNA #4 then stated that he should have put on a gown, gloves, a N-95 mask, and washed his hands. During an interview with the surveyor on 04/04/22 at 12:47 PM, CNA #5 stated that when a resident is on isolation the staff are to put on a gown, eye protection, gloves, and a N-95 mask anytime they enter an the room and that staff need to wash their hands before they exit the room. During an interview with the surveyor on 04/04/22	F 880	All nursing staff educated on hand hygiene and the importance of being mindful of prevention transmission of infections. Unit Manager/ Supervisor or designee will daily perform random check staff□s adherence to hand hygiene especially following tasks. Infection control importance of proper hand washing protocols, as well as donning and doffing PPE when entering the [redacted] rooms. The facility□s Hand Washing and PPE policies and procedures were reviewed. Four, monitoring mechanisms to assure compliance: Unit manager/Supervisor will monitor staff daily on facility rounds for staff compliance with PPE and hand hygiene Weekly, Unit Managers will perform competencies of 10 staff members on the accurate usage of PPE and hand hygiene. Concerns will be addressed by the Director of Nursing or designee. As part of the quarterly Quality Improvement Committee meetings, the DON or designee will present the collected data of the audits and will reinforce the importance of hand hygiene and PPE usage as described in the Section Three, Number One in-servicing agenda The DPOC and Root cause analysis was completed. The nurse did not realize she did not wash her hands due to being	

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F 880	Continued From page 37 at 12:53 PM, the Licensed Practical Nurse #1 (LPN) stated that Resident #420 was on isolation because he/she was not vaccinated for EX. Order 26.(4) B1 and that when staff enter the room, they must wear full PPE which included a gown, gloves, N-95 mask, and eye protection. The LPN further stated that the staff are to remove their PPE and perform hand hygiene prior to exiting the room. The LPN added that residents on EX. Orde are kept on isolation for 14 days and PPE is available in a bin outside the resident's room. LPN #1 then stated that, "it is important to wear the proper PPE for EX. Order residents so there is no cross contamination." During an interview with the surveyor on 04/05/22 at 10:48 AM, CNA #7 stated that Resident #420 was on isolation for EX. Or days because he/she was EX. Order 26.(4) B1. CNA #7 further stated that staff need to wear full PPE whenever they enter the resident's room, whether it's delivering a food tray or doing care. The CNA also stated that staff are to remove and dispose of PPE and then perform hand hygiene prior to exiting the room. During an interview with the surveyor on 04/08/22 at 10:47 AM, the Assistant Director of Nursing/Infection Preventionist (ADON/IP) stated that the EX. Orde Unit was located at the end of the hallway on the 700 Unit and that the PUI rooms were for new admissions that were not vaccinated for EX. Order 26.(4) B1 or partially vaccinated and would remain on isolation for 14 days. The ADON/IP further stated that the sign on the resident's door would indicate EX. Orde and what PPE was needed to be worn for the resident and there would be a bin of PPE located outside the resident's room. The ADON/IP explained that PPE, which included a N-95 mask, gown,	F 880	overwhelmed and anxious during the survey. The CNA felt anxious during the survey and realized the mistake. Frontline staff watched the following video Clean Hands EX. Order 26.(4) B1 6.(4) B1 Use PPE correctly for EX. Order 26.(4) B1 Closely monitor residents and Top Line staff watched Frontline and Topline staff watched the following videos Module 6A Principles of standard precautions Module 6B Principles of transmission based precautions Module 7 Hand Hygiene Topline staff watched the following videos Module 1 infection prevention and control program Module 4 Infection Surveillance Module 5 Outbreak The facility completed the LTC Self-Assessment	

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F 880	Continued From page 38	F 880		

goggles, and gloves, would be put on prior to entering the isolation room and then staff would remove and discard the PPE and wash their hands prior to leaving the isolation room.

During an interview with the surveyor in the presence of the survey team on 04/08/22 at 11:22 AM, the ADON/IP stated that "if the CNA was in the resident's room for more than one minute, I would expect him to wear full PPE prior to entering the isolation room."

During an interview with the surveyor, in the presence of the survey team on 04/12/22 at 12:07 PM, the ADON/IP stated that if residents are not "up to date" or vaccinated for [redacted], they are considered PUI and placed in a separate room with TBP. The ADON/IP further stated that when there are signs on the residents' doors that indicate isolation and there is PPE in a bin outside a residents' room, that she would expect the staff to "gear up" which meant to put on a gown, gloves, N-95 mask, and goggles prior to entering the isolation room. The ADON/IP also stated that she would expect the staff to perform hand washing or use hand sanitizer whenever they performed resident care or touched anything contaminated.

Review of the facility's policy titled "[redacted] Transmission-Based Precautions," revised 03/22, revealed that staff should use Standard Precautions and Transmission Based Precautions when the center may have a person under investigation for [redacted] and that staff should wear a N-95 mask, face shield, gloves, and gown upon entry into the room of a resident for whom Droplet Precautions are indicated or when in close contact (within 3 feet) with such

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F 880	Continued From page 39	F 880		

resident. The policy further included that full PPE for EX. Ord[redacted]EX. Order 26.(4) B1 includes donning (applying) before entering residents' room and doffing (removing) before exiting.

2. On 04/04/22 at 8:17 AM, the surveyor observed LPN #2 administer medication to Resident #17. Further, LPN #2 checked Resident #17's heart rate using a stethoscope, in conjunction with a required parameter for one of the medications, [redacted] (a medication used to treat various EX. Order 26.(4) B1).

On the same date at 8:37 AM, LPN #2 prepared medication for a second resident (Resident #101) and administered it to him/her, without performing any hand hygiene between residents.

During an interview with the surveyor on 04/04/22 at 9:29 AM, LPN #2 stated that she usually performs hand hygiene, referencing hand washing and the use of alcohol-based rubbing gel. When asked about the medication administration to the first resident and subsequently to his/her roommate, she stated she did not realize she forgot to perform hand hygiene between residents.

During an interview with the surveyor on 04/13/22 at 9:50 AM, in the presence of the survey team, the Director of Nursing (DON) acknowledged that she understood the surveyor's concerns regarding hand hygiene during the medication pass. She further stated that she had no other questions regarding this matter.

Review of the facility's policy titled, "Hand Washing," revised April 2021, revealed a need to

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F 880	Continued From page 40 use alcohol-based rub or hand washing before and after any resident contact. NJAC 8:39 - 19.4(a)(1)	F 880		

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on 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 shift as mandated by the State of New Jersey. This was evident for 7 of 14 day shifts as follows: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. "Direct care staff member" means any registered professional nurse,	S 560	DISCLAIMER STATEMENT Preparation and/or execution of this Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and /or executed solely because it is required by the provisions of federal and state law. The Plan of Correction represents the facility's credible allegation of compliance as of 5/27/2022. One, actions taken for the situations	5/27/22

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

Electronically Signed | 05/06/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061111	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON REHABILITATION AND HEALTHCARE CENTI	1059 EDINBURG ROAD HAMILTON, NJ 08690

(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 licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 03/13/22-03/19/22 and 03/20/22-03/26/22, the staffing-to-resident ratios that did not meet the minimum requirement of one CNA to eight residents for the day shift are documented below: -03/20/22 had 15 CNAs for 122 residents on the day shift, required 16 CNAs. -03/21/22 had 15 CNAs for 122 residents on the day shift, required 16 CNAs. -03/22/22 had 15 CNAs for 122 residents on the day shift, required 16 CNAs. -03/23/22 had 15 CNAs for 122 residents on the day shift, required 16 CNAs. -03/24/22 had 15 CNAs for 122 residents on the day shift, required 16 CNAs.	S 560	identified: None of the residents had any adverse reaction from facility not having the correct number of CNA. The staffing coordinator reviewed the schedule and made sure that the facility CNA to resident ratio was within the required standards moving forward. All resident care was completed and no resident had any negative outcomes. Two, identification of other residents who have the potential to be affected: -The facility recognizes that all residents have the potential to be affected from facility not having the required number of CNA Three, system changes and measures that will be made: - Staffing coordinator will review daily census the previous night -Staffing coordinator and nursing management will ensure the correct number of CNA□s on day shift by reviewing daily census. -Any call outs will be replaced by per-diem staff or agency Four, monitoring mechanisms to assure compliance: -Daily nursing administration will meet with staffing coordinators to review staffing ratios - Nursing administration will monitor daily the utilization of Per-Diem and agency staff to ensure correct ratio - Daily statistics will be compiled and	

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	061111	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON REHABILITATION AND HEALTHCARE CENTI	1059 EDINBURG ROAD HAMILTON, NJ 08690

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S 560	Continued From page 2 -03/25/22 had 15 CNAs for 122 residents on the day shift, required 16 CNAs. -03/26/22 had 15 CNAs for 122 residents on the day shift, required 16 CNAs. During an interview with the surveyor on 04/06/22 12:50 PM, the Staffing Coordinator stated that the required CNA ratio for day shift was one CNA to seven or eight residents, for evening shift was one CNA to 10 residents, and for night shift was one CNA to nine or 10 residents. She further stated she can use agency staff when there are call outs and she would base her staffing on the census for the day. During an interview with the surveyor on 04/12/22 11:05 AM, the Administrator stated that in order to increase staffing, the facility had advertisements on hiring websites and is aggressive with hiring staff . The Administrator further stated that the facility had increased health packages, pension plans, and offered sign on bonuses for nurses. The administrator added that the facility had not used agency staff since January, but would if the facility had staffing needs. NJAC 8:39-5.1(a)	S 560	reviewed at quarterly QA meeting	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061111 Y1	A. Building B. Wing Y2	6/3/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON REHABILITATION AND HEALTHCARE CENTER	1059 EDINBURG ROAD HAMILTON, NJ 08690

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 05/27/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 4/13/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO