STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315119	A. BUILDING _____ B. WING _____	C 12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARNOLD WALTER NURSING & REHABILITATION CENTER	622 S LAUREL AVENUE HAZLET, NJ 07730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ 156328, NJ 160219, NJ 160755, NJ 161020, NJ 165400, NJ 166083, NJ 166916, NJ 167185 Survey Date: 12/14/2023 Census: 137 Sample: 28+3 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		1/19/24

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

Electronically Signed | 12/28/2023

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F 609	Continued From page 1 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #NJ 161020 Based on interview, record review, and review of pertinent documents, it was determined that the facility failed to report an allegation of abuse to the New Jersey Department of Health (NJDOH) for 1 of 5 residents reviewed for investigations and was evidence by the following: On 12/4/23 at 12:30 PM, the surveyor interviewed Resident #93, who stated that while at the facility, they had EX Order 26.4B1. The resident further said a resident had EX Order 26.4B1 at the nurse's station and caused the EX Order 26.4B1 A review of Resident #93's Face Sheet (an Admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to EX Order 26.4B1 [redacted]. A review of Resident #93's Annual Minimum Data Set (MDS), an assessment tool, dated EX Order 26.4B1 revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, indicating EX Order 26.4B1 [redacted]. A review of a nursing progress note dated	F 609	I. Immediate correction action: Resident #93 a) A new BIMS score was assessed by the Social Worker on EX Order 26.4B1 and revealed BIMS score of [redacted] Resident unable to recall details of the incident and vividly remembers [redacted]. b) The resident #93 was assessed by Interim DON on EX Order 26.4B1 c) Interview were conducted with staff and Nursing Supervisor who worked 12/4/22 on the 3-11 shift. e) A reinvestigation is in progress and at this time there is no reason to suspect that abuse and mistreatment has occurred. f) We respectfully submit that resident #237 is no longer a resident at this facility. k) The person responsible for completing the initial investigation is no longer working at this facility. Interim DON was reinserviced by Regional Nurse on the importance of a complete and thorough investigation before concluding that no abuse occurred. Completion date:12/27/23 II. Identification of other residents with	

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F 609	Continued From page 2 12/5/22 at 12:24 AM, revealed at 5:00 PM, on 12/4/22, the Registered Nurse Night-shift Supervisor (RNS#2) was "summoned" from down the hall, and Resident #93 was lying on their EX Order against the nurses station. The resident stated that they were assisting another resident from EX Order 26.4B1. Resident #93 injured their EX Order 26.4B1 and was sent to the hospital. Further review revealed a progress note on EX Order 26.4B1 indicated that the resident sustained a Ex.Order 26.4(b)(1) EX Order 26.4B1. A review of the nursing progress note dated EX Order 26.4B1 revealed that RNS#2 had asked the resident how they felt. The resident responded, "EX Order 26.4B1 I'm gonna get that [other resident] because they EX Order 26.4B1 " On 12/5/23 at 10:00 AM, the surveyor reviewed a facility document titled "Incident/Accident Report" for Resident #93. The report revealed that on Ex.Order 26.4(b)(1) at 5:00 PM, the resident EX Order while attempting to help another resident (Resident #237) from EX Order 26.4B from their wheelchair, and Resident #93 EX Order 26.4B1 EX Order 26.4B1 A review of a facilities' document titled "Incident Accident Report" for Resident #237 revealed that on Ex.Order 26.4(b)(1) at 5:00 PM, the resident was trying to get up from their wheelchair and EX Order A review of the attached Employee Statement dated Ex.Order 26.4(b)(1) revealed that the Licensed Practical Nurse (LPN) heard a loud voice yelling "help, help". The LPN then "rushed" to the nurses station and saw the resident on the floor. The resident stated that resident #93 EX Order 26.4B1. Resident #93 stated	F 609	potential to be affected: a) An audit by Interim Director of Nursing will be conducted of all accident reports within the last 60 days where the resident sustained a serious injury to see if abuse, mistreatment, neglect or injury of unknown origin was reported as appropriate within the required time frame. Completion date: 1/3/23 b)all residents have the potential to be affected III. Systemic Change: a) Policy and Procedure for Abuse Mistreatment and Neglect was reviewed by the Interim and Administrator on 12/28/23 and found to be in compliance. c) An inservice on Accident/Incident investigation will be given by Interim DON to all nurses, nursing supervisors and C.N.A.s to ensure a complete and thorough investigation is completed for all resident incidents. Completion Date: 1/19/24 d) All incidents with serious injury will be reviewed by the Interim Director of Nursing/Designee to ensure that it is investigated properly to ensure compliance. Completion Date: 1/19/24 e) All incidents regarding alleged or possible abuse and serious injuries of unknown origin will be reported within 2 hours. All other incidents will be reported according to the CMS guidelines for reporting. IV. QA monitoring: a) An audit tool was developed to review	

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F 609	Continued From page 3 that they were trying to stop Resident #237 from [redacted] Further review of the statement revealed that "it appears both residents EX Order 26.4B1 [redacted] with no further documentation that the [redacted] was witnessed. Attached to Resident #237's Incident Accident Report" revealed an attached document with an investigation date of [redacted] completed by the previous DON titled, "Summary of Investigation" dated 12/4/22. The summary indicated Resident #93 stated that they attempted to hold Resident #237 to prevent Resident #237 from standing up. Resident #237 landed on top of Resident #93, and Resident #93 sustained a EX Order 26.4B1 Further review revealed that Resident #93 later referenced to being pushed by Resident #237. The DON determined that both residents lost their balance based on how both residents were "found on the floor." On 12/4/23 at 1:42 PM, the surveyor interviewed the Interim Director of Nursing (DON), who stated when an incident occured the nurses would evaluate the residents and begin an incident report. They would then gather statements from witnesses, notify the physician and the family and send the resident out to the hospital if needed. For Resident #93, the team summary indicated that the incident was isolated and was aware Resident #93 changed their story of being pushed. On 12/8/23 at 7:00 AM, the surveyor interviewed the RNS#2, the nurse at the time of the incident, who stated that if there was an allegation of a resident-to-resident incident or staff-to-resident incident, she would start an investigation. RNS#2	F 609	all accidents/incidents to ensure all are investigated promptly and thoroughly to determine if it is a reportable event. b) A log has been created to record all reportable events to include the time of the incident and the time reported. Any reports outside the appropriate time frame will be brought to the attention of the Administrator. b) Audits will be completed by the Interim Director of Nursing/Designee weekly on all accident reports with injury x 4, monthly x2, then quarterly x 3. c) Any negative findings will be brought to the Administrator immediately. d) The results of all audits and reporting log will be brought to the QAPI committee meeting quarterly x 4 Quarterly V. Responsible Party: Interim Director of Nursing	

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F 609	Continued From page 4 stated that in Resident #93's incident, she witnessed the resident Ex Orde with another resident but did not know the identify of the other resident involved. She further acknowledged that Resident #93 changed their story to include being pushed, but RNS#2 stated that did not happen and administration was made aware that the resident had changed their story. However, a review of the documentation that the facility provided to the surveyor did not address that the incident was witnessed. On 12/8/23 at 9:30 AM, the surveyor interviewed the Interim DON, who stated that she was under the impression that RNS#2 witnessed the Ex Orde and Resident #93's allegation was not investigated further. During a follow up interview on 12/8/23 at 11:30 AM, the Interim DON confirmed RNS#2's documentation was conflicting and that she would investigate further since she became aware that the Ex Orde was not witnessed. On 12/14/23 at 10:25 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), the Regional Nurse, and the Interim DON. The Regional nurse stated that a summary and reinvestigation were completed yesterday (12/13/23). The LNHA stated that if this incident happened today, "100% an investigation would have been done", and the incident would have been reported to the New Jersey Department of Health. A review of the facility's policy labeled Abuse, Mistreatment, Neglect, exploitation, and	F 609		

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F 609	Continued From page 5 Misappropriation of Residents Property dated 1/20/23, which included under Section VI: Reporting: the Director of Nursing/Designee was responsible for reporting all alleged violations and all substantiated incidents to the State Agency (NJDOH) and to all other agencies as required to take all necessary corrective actions dependent on the results of the results of the investigation. Further review of the policy revealed that the facility will ensure that allegations/violations involving abuse, neglect, exploitation, or mistreatment, including injuries from an unknown source and misappropriation of residents' property, are reported immediately but no later than 2 hours after allegations made, if the event that causes allegation involves abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including the State Survey Agency and adult protective services where State Law provides for jurisdiction in long term care facilities) by State Law through established procedures. The results of all investigations will be reported [...] by State Law, including the State Survey Agency, within five working days of the incident. NJAC 8:39-4.1(a)(5)	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610		1/19/24

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F 610	Continued From page 6 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #NJ 161020 Based on interviews, record review, and review of pertinent documents, it was determined that the facility failed to thoroughly investigate an allegation of abuse for 1 of 5 residents reviewed for investigations and was evidenced by the following: On 12/4/23 at 12:30 PM, the surveyor interviewed Resident #93, who stated that while at the facility, they had EX Order 26.4B1 The resident further said a resident had pushed them at the nurse's station and caused the EX Order 26.4B1 A review of Resident #93 Face Sheet (an Admission summary) reflected that the resident was admitted to the facility with a diagnosis that included Ex.Order 26.4(b)(1)	F 610	I. Immediate correction action: Resident #93 a) A new BIMS score was assessed by the Social Worker on EX Order 26.4B1 and revealed BIMS score of [redacted]. Resident unable to recall details of the incident and vividly remembers EX Order 26.4B b) The resident #93 was assessed by Interim DON on 12/27/23. c) Interview were conducted with staff and Nursing Supervisor who worked 12/4/22 on the 3-11 shift. e) A reinvestigation is in progress and at this time there is no reason to suspect that abuse and mistreatment has occurred. f) We respectfully submit that resident #237 is no longer a resident at this facility. k) The person responsible for completing the initial investigation is no longer working at this facility. Interim DON was	

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F 610	Continued From page 7 A review of Resident #93's Annual Minimum Data Set (MDS), an assessment tool, dated EX Order 26.4B1 revealed that the resident had a Brief Interview for Mental Status (BIMS) score of EX Orde out of 15, indicating EX Order 26.4B1 . A review of a nursing progress note dated Ex.Order 26.4(b)(1 at 12:24 AM, revealed at 5:00 PM on Ex.Order 26.4(b)(1, the Registered Nurse Night-Shift Supervisor (RNS#2) was "summoned" from down the hall, and noted Resident #93 lying on their EX Order 26.4B1 against the nurse's station. The resident stated that they were assisting another resident from EX Order 26.4B1, and EX Order 26.4B1 Resident #93 EX Order 26.4B1 and was sent to the hospital. Further review revealed a progress note on Ex.Order 26.4(b)(1 at 4:19 PM indicating the resident sustained a closed EX Order 26.4B1 of the EX Order 26.4B1 . A review of the nursing progress note from the time of the incident dated Ex.Order 26.4(b)2 at 7:28 AM, revealed that RNS#2 had asked the resident how they felt. The resident responded, "Not good at all. EX Order 26.4B1; I'm gonna get that "another resident" because they EX Order 26.4B1 and EX Order2 EX Order 26.4B1". On 12/5/23 at 10:00 AM, the surveyor reviewed a facility document titled "Incident/Accident Report" for Resident #93. The report revealed that on Ex.Order 26.4(b)(1 at 5:00 PM, the resident EX Orde while attempting to help another resident EX Order 26.4B1 from their wheelchair, and Resident #93 EX Orde onto EX Order 26.4B1. The attached EX Orde review dated Ex.Order 26.4(b)(1 revealed the EX Orde was an isolated incident. A review of a facility's document titled	F 610	reinserviced by Regional Nurse on the importance of a complete and thorough investigation before concluding that no abuse occurred. Completion date:12/27/23 II. Identification of other residents with potential to be affected: a) An audit by Interim Director of Nursing will be conducted of all accident reports within the last 60 days where the resident sustained a serious injury to see if abuse, mistreatment, neglect or injury of unknown origin was reported as appropriate within the required time frame. Completion date: 1/3/23 b)all residents have the potential to be affected III. Systemic Change: a) Policy and Procedure for Abuse Mistreatment and Neglect was reviewed by the Interim and Administrator on 12/28/23 and found to be in compliance. c) An inservice on Accident/Incident investigation will be given by Interim DON to all nurses, nursing supervisors and C.N.A.s to ensure a complete and thorough investigation is completed for all resident incidents. Completion Date: 1/19/24 d) All incidents with serious injury will be reviewed by the Interim Director of Nursing/Designee to ensure that it is investigated properly to ensure compliance. Completion Date: 1/19/24 e) All incidents regarding alleged or possible abuse and serious injuries of	

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F 610	Continued From page 8 "Incident/Accident Report" for Resident #237 revealed that on 1[Ex.Order 26.4(b] at 5:00 PM, the resident was trying to get up from their EX Order 26.4B1. A review of the attached "Employee Statement" dated[EX Order 26.4B1], revealed that the Licensed Practical Nurse (LPN) heard a loud voice EX Order 26.4B1 " . The LPN then rushed to the nurses station and saw the resident EX Order 26.4B1. The resident stated that Resident #93 EX Order 26.4B1. Resident #93 stated that they were trying to stop Resident #237 from [EX Order 26.4B]. Further review of the "employee statement" revealed that it "appeared both residents lost their balance and [EX Orde] and there was no further documentation that would indicate that the [EX Orde] was witnessed. Attached to Resident #237's Incident Accident Report" revealed an attached document with an investigation date of [Ex.Order 26.4(b)(1)] completed by the previous DON, titled, "Summary of Investigation" dated[Ex.Order 26.4(b)(1)] The summary indicated Resident #93 stated that they attempted to hold Resident #237 to prevent Resident #237 from standing up. Resident #237 EX Order 26.4B1 of Resident #93, and Resident #93 sustained a EX Order 26.4B1. Further review revealed that Resident #93 later referenced to being pushed by Resident #237. The DON determined that EX Order 26.4B1 [redacted] There were no statements from staff included with the investigation regarding Resident #93's allegation that they were pushed by Resident #237. On 12/4/23 at 1:42 PM, the surveyor interviewed	F 610	unknown origin will be reported within 2 hours. All other incidents will be reported according to the CMS guidelines for reporting. IV. QA monitoring: a) An audit tool was developed to review all accidents/incidents to ensure all are investigated promptly and thoroughly to determine if it is a reportable event. b) A log has been created to record all reportable events to include the time of the incident and the time reported. Any reports outside the appropriate time frame will be brought to the attention of the Administrator. b) Audits will be completed by the Interim Director of Nursing/Designee weekly on all accident reports with injury x 4, monthly x2, then quarterly x 3. c) Any negative findings will be brought to the Administrator immediately. d) The results of all audits and reporting log will be brought to the QAPI committee meeting quarterly x 4 Quarterly V. Responsible Party: Interim Director of Nursing	

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F 610	Continued From page 9	F 610		

the Interim Director of Nursing (DON), who stated when an incident occured, the nurses would evaluate the residents and start an incident report, they would gather statements from witnesses, notify the physician and the family and send the resident out to the hospital if they needed.

On 12/8/23 at 7:00 AM, the surveyor interviewed the RNS#2 who stated if there were an allegation of the resident-to-resident incident or staff-to-resident incident, she would start an investigation. The RNS#2 said that in Resident #93's incident, she witnessed the resident [redacted] with another resident. The RNS#2 stated she did not know who the other resident was. She stated that she was aware that Resident #93 did change their story and said they were pushed, but the RNS#2 stated that was not what happened. The RNS#2 stated that the administration were aware the resident had changed the story.

On 12/8/23 at 9:30 AM, the surveyor interviewed the Interim DON, who stated that she thought the nursing supervisor witnessed the [redacted] and that the claim was not investigated further. She said that she was not the DON at the time but was the Assistant Director of Nursing (ADON).

During a follow up interview on 12/8/23 at 11:30 AM, the Interim DON stated RNS#2's documentation was conflicting and that she would investigate further since she became aware that the [redacted] was not witnessed.

On 12/14/23 at 10:25 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), the Regional Nurse, and the Interim

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F 610	Continued From page 10 DON. The Regional nurse stated that a summary and reinvestigation were done yesterday (12/13/23). The LNHA stated that if this incident had happened today, "100% an investigation would have been done". A review of the facility's policy labeled Abuse, Mistreatment, Neglect, exploitation, and Misappropriation of Residents Property dated 1/20/23, Included under the Section V Investigation: The Director of Nursing/Designee's responsibilities are to coordinate the investigation of alleged violations and, upon receipt of the resident's accident/incident report, will continue the investigation ... the investigation shall include statements from all parties involved ... and findings from the investigation shall be documented and collected for a formal and comprehensive review. NJAC 8:39-4.1(a)5	F 610		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records and other facility documentation, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS), an assessment tool, for 2 of 27 residents reviewed (Resident #116 and #97). This deficient practice was evidenced by the	F 641	I. Immediate correction action: a) Regional MDS completed and submitted a correction to the MDS for resident # 116 dated [EX Order 26.4B1] to include under section O that resident is on [EX Order 26.4B1] b) Regional MDS completed and submitted a correction to the MDS for	1/19/24

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F 641	Continued From page 11 following: 1. On 11/30/2023 at 9:40 AM, the surveyor observed Resident #116 in bed eating lunch. The surveyor reviewed the medical record for Resident #116. A review of the Resident Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included EX Order 26.4B1 [redacted] A review of Resident #116's August 2023 Nursing Progress Notes included an entry dated Ex.Order 26.4(b)(1) at 12:37 PM, which indicated the resident was admitted to the facility for EX Order 26.4B1 EX Order 26 and was receiving EX Order 26.4B1. A further review of the resident's medical record revealed hospital records dated EX Order 26.4B1 PM, which indicated the hospital case manager had requested the EX Order 26.4B1 team forward a copy of the resident's signed contract for EX Order 26.4B1 services be forwarded to the facility. A review of the Admission Minimum Data Set (MDS), dated Ex.Order 26.4(b)(1) reflected a Brief Interview for Mental Status (BIMS) score of EX Order which meant that the resident was Ex.Order 26.4(b)(1) [redacted]. Section "O" of the MDS did not identify the resident was receiving EX Order 26.4B1 special services. 2.) On 11/29/2023 at 1:02 PM, the surveyor observed Resident #97 sitting on their bed eating lunch. The surveyor observed the resident was	F 641	resident #97 dated 12/13/23 to include that resident is receiving EX Order 26.4B1 [redacted] under section O. II. Identification of other residents with potential to be affected: a) An audit will be conducted by Regional MDS Coordinator of all residents with MDSs submitted within the last 6 months for accuracy in documentation related to section O for hospice and oxygen administration. Completion date: 1/3/24 b) All residents have the potential to be affected III. Systemic Change: a) Policy entitled MDS (Minimum Data Set) reviewed by the Regional MDS and interim DON on 12/28/23 and found to be in compliance. b) Inservice will be given to all staff members by Regional MDS who are responsible for completing sections O 0100 on the importance of accurate reporting (MDS Coordinator, Unit Managers, Social Worker) Completion Date:12/23/23 IV. QA monitoring: a) An audit tool was developed by the MDS Coordinator to ensure the accuracy of entries in the MDS for sections O (or we can do section O 0100 section C and O 0100 section K. b) Audits will be conducted by the MDS Coordinator weekly x4 for all submissions	

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F 641	Continued From page 12 wearing [EX Order 26.4B1]. The surveyor reviewed the medical record for Resident #97. A review of the Resident Face Sheet reflected that the resident was admitted to the facility with diagnoses that included EX Order 26.4B1 [redacted]. A review of the most recent Quarterly MDS dated [EX Order 26.4B1], reflected a BIMS score of 15 out of [EX Orde] which demonstrated an intact [EX Order 26.4B1] Section "O" of the MDS did not identify the resident was receiving EX Order 26.4B1 services. During an interview with the surveyor on 12/13/23 at 11:36 AM, Regional Minimum Data Set Coordinator (RMDS) stated that the current MDS Coordinator was not available, and she was currently overseeing the MDS process in the facility. The RMDS confirmed that coding of the MDS was based upon the CMS RAI Manual. The surveyor reviewed Resident #116 and Resident #97's MDS with the RMDS. The RMDS responded that she would have to review the clinical information and return with a response. During an interview with the surveyor on 12/14/23 at 10:27 AM, the Regional MDS Coordinator (RMDS), in the presence of the Licensed Nursing Home Administrator (LNHA), Regional Nurse (RN), and Director of Nursing (DON), acknowledged that Section "O" of the MDS should have identified [EX Order 26.4B1] for Resident #116 and EX Order 26.4B1 for Resident #97. A review of the facility provided undated "MDS"	F 641	in the past 7 days. then monthly for all submissions in the last 30 days, then quarterly x3 for all submissions in the last 90 days. c) Any discrepancies will be brought to the Administrators attention immediately. d) The results of all audits will be brought to the QAPI meeting quarterly x 4. V. Responsible Party: MDS Coordinator	

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F 641	Continued From page 13 policy documented with "Subject: RAI Process/MDS", last revised 10/11/2023, revealed ... Nursing and Rehabilitation is responsible for completing Section "O". NJAC 8:39-33.2(d)	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, review of medical records and other facility documentation, it was determined that the facility failed to a) properly transcribe a physician's order for 2 of 27 residents reviewed for medications (Resident #59 and #388); b) failed to follow physician's order to Ex.Order 26.4(b)(1) for 1 of 27 residents reviewed for medications (Resident #388). These deficient practices were evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist."	F 658	I. Immediate correction action: a) Resident #388 was seen and assessed by the RN Unit Manager Ex.Order 26.4(b)(1) 3 and no change in condition noted. b) Resident #388 was seen and examined by the MD on EX Order 26.4B1 and no change in condition noted c) Resident #388□s EX Order 26.4B1 orders were reviewed by RD and carried out by RN to separate all portions of the task to require nurse to sign off for all tasks involved in the process which includes 1. Ex.Order 26.4(b)(1) d) Resident #388 Ex.Order 26.4(b) order was revised to include Ex.Order 26.4(b)(1) results for each administration.	1/19/24

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F 658	Continued From page 14 Reference: New Jersey Statutes, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." A.) On 11/29/2023 at 12:47 PM, the surveyor observed Resident #59 seated in reclining chair as the Certified Nursing Assistant (CNA) provided feeding support for lunch. The surveyor reviewed the medical record for Resident #59. A review of the Resident Face Sheet reflected that the resident was admitted to the facility with diagnosis that included EX Order 26.4B1 [redacted] A review of the Admission MDS, dated EX Order 26.4B1 reflected a BIMS score of [redacted] out of 15, which demonstrated an EX Order 26.4B1. The MDS also identified that the resident had a EX Order 26.4B1 (a Ex.Order 26.4(b)(1) into the EX Order 26.4B1 or [redacted] to help receive Ex.Order 26.4(b)(1)) upon admission.	F 658	II. Identification of other residents with potential to be affected: a) An audit was conducted of all residents on tube feedings by the Ex.Order 26 [redacted] (Regional Nurse) on 12/27/23 and determined that some portion of the tube feeding orders were bundled together and would require separation of each task. b) All tube feeding orders were revised to separate all portions of the task to require nurse to sign off for all tasks involved in the process which includes. 1. The formula to be used, strength, volume and rate of flow. 2. Checking tube for patency 3. Checking for residual prior to each feeding 4. Flushes before and after feeding c) An audit will be conducted of all resident receiving insulin based on the results of a finger stick (point of care blood sugar) to ensure all orders contained a requirement for blood sugar clinical monitoring in the order. d. Any order without the requirement for blood sugar clinical monitoring in the order was revised to include blood sugar documentation requirement within the order. e. All residents have the potential to be affected III. Systemic Change: a) Policy entitled Medication Administration and Documentation Policies, Procedures and Information was reviewed and revised by Interim Director	

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F 658	Continued From page 15 A review of Resident #59's December 2023 Resident Medication Administration Record (MAR) established that the nurse's initials under the corresponding date established that the physician's order had been completed. Upon further review, the MAR revealed the following single order: Ex.Order 26.4(b)(1) [redacted] Ex.Order 26.4(b)(1) [redacted] Ex.Order 26.4(b)(1) [redacted] Ex.Order 26.4(b)(1) [redacted] Ex.Order 26.4(b)(1) [redacted] Ex.Order 26.4(b)(1) [redacted] Start Date: Ex.Order 26.4(b)(1) [redacted]	F 658	of Nursing and Administrator on 12/28/23 to include tube feeding orders to be written separately for each task and to include clinical monitoring within the order for anyone insulin requiring point of care blood sugar monitoring. b) The tube feeding order template was placed into an order set which will indicate each task in a tube feeding order as separate and not batched together. c) Inservice will be given to all licensed nurses and dieticians on the proper method of writing orders for Tube feedings. d) Inservice will be given by Interim Director of Nursing to all licensed nurses and medical providers on the proper writing of orders for insulin with finger sticks. Completion Date: 1/19/24 IV. QA monitoring: a) An audit was created to review all residents on tube feedings to ensure that all orders for tube feedings using the tube feeding order set which will separate all tasks that require separate sign off. b) These audits will be completed by the Unit Manager/Designee weekly x 4 weeks, then monthly x 2 months and then quarterly x 3 quarters. c) All negative findings will be brought to the attention of the Director of Nursing and will be immediately corrected. d) the results of all audits will be brought to the QAPI committee quarterly x 4	

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F 658	Continued From page 16 The surveyor identified that the facility failed to properly transcribe the physician's order into separate individual orders so that each seperate order could be carried out and documented as administered. B.) On 11/29/2023 at 12:42 PM, the surveyor observed Resident #388 in bed. The resident did not respond to the surveyor presence or inquiry. The surveyor reviewed the medical record for Resident #388. A review of the Resident Face Sheet reflected that the resident was admitted to the facility with diagnoses that included EX Order 26.4B1 [redacted] A review of the MDS, with an Assessment Reference Date of EX Order 26.4B1, reflected a brief interview for mental status (BIMS) of EX Order which meant that the resident was Ex.Order 26.4(b)(1) [redacted] The MDS also identified that the resident had a EX Order 26.4B1 A review of Resident #388's December 2023 Medication Administration Record (MAR) revealed a nurse's initials under a corresponding date established the nurse had carried out the physician's order. Upon further review the MAR revealed the following single order for: EX Order 26.4B1: EX Order 26.4B1 to start at Ex.Order 26.4(b)(1) [redacted].	F 658	quarters. V. Responsible Party: Interim Director of Nursing	

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Ex.Order 26.4(b)(1)

Ex.Order 26.4(b)(1)

Ex.Order 26.4(b)(1)

Ex.Order 26.4(b)(1)

Ex.Order 26.4(b)(1)

Further review of the resident's MAR revealed the following order:

EX Order 26.4B1

hours EX Order every EX O hours- 150=0,
Ex.Order 26.4(b)(1)
s,
greater than Ex.Order 26.4(b)(1)

Start Date: Ex.Order 26.4(b)(1) 02:57 am

Upon review of the December 2023 MAR revealed that the following dates included nurse's initials under the ordered date and times, but did

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F 658	Continued From page 18 not document the resident's Ex.Order 26.4(b)(1) [redacted] During an interview with the surveyor on 12/11/23 at 12:30 PM, LPN#1 confirmed that nurses were responsible for documenting everything they said and did for the resident. When asked about physician's orders, LPN#1 confirmed that nursing was responsible for inputting new orders into the EMR. During an interview with the surveyor on 12/12/23 at 11:13 AM, Registered Nurse (RN #1) reviewed the resident's EMR and confirmed that the way the Ex.Order 26.4(b)(1) orders had been entered did not provide the ability to document that each step of the multi-step process had been completed and individually accounted for. During an interview with the surveyor on 12/13/23 at 12:11 PM, the Director of Nursing (DON), in the presence of the Registered Nurse Unit Manager (RNUM#1), confirmed that the Ex.Order 26.4(b)(1 order should not be bundled together, but rather separated into individual orders. The DON also confirmed that nurse's initials on the Ex.Order 26.4 [redacted] accounts that the Ex.Order 26.4 was obtained, but due to numerous documenting areas in the MAR they will have to	F 658		

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F 658	Continued From page 19	F 658		

closely review the administration record to determine if there were missed documentation.

During an interview with the surveyor on 12/14/23 at 10:27 AM, the Regional Nurse (RN) in the presence of the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and MDS Coordinator, acknowleged that each section of the order should have been entered separately to allow the nurses to sign for each order independently.

A review of the facility provided undated "Licensed Practical Nurse Job Description" document, included: [...] Review medication cards for completeness of information, accuracy in the transcription of the physician's order [...].

A review of the facility provided "Medication Administration and Documentation Policies, Procedures, & Information", with an Effective Date of 7/1/22 and Last Reviewed on 6/22/23 included under the heading Licensed Nurse:...16. Documents administration of medication in the [MAR] immediately following administration. Notes in [MAR] medications not administered (i.e. refused, etc) and identifies reason ... 21. Upon completion of the medication pass and prior to end of the shift the medication nurse will check dash board to ensure all medications and monitoring is completed as per assignment time.

A review of the facility provided "Physician's Orders" policy, with an Effective Date of 1/21/22 and Last Reviewed on 6/20/23, included:...monitoring: orders including monitoring of height, weight, vital signs, blood sugars, pulse ox, etc. This including entering a

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F 658	Continued From page 20 value for the monitoring.... NJAC 8:39-27.1(a)-29.2(d)	F 658		
F 684 SS=E	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: Complaint # NJ166916 Based on interview, medical record review and other pertinent documentation, it was determined that the facility failed to a.) ensure Ex.Order 26.4(b)(1) were addressed in accordance with professional standards by failing to obtain physician's orders and treatments for a surgical site dressing, EX Order 26.4B1 and EX Order 26.4B1; assess and document monitoring of a surgical site, EX Order 26.4B1 and EX Order 26.4B1 b.) ensure a care plan was in place which addressed actual Ex.Order 26.4(b)(1) c.) complete an incident report for a [redacted] and d.) ensure timely physician notification and timely transfer of a resident to the hospital. This deficient practice was identified for 1 of 28 residents (Resident #287) reviewed for quality of care and was evidenced by the following: 1. According to the Resident Face Sheet,	F 684	I. Immediate correction action: We respectfully submit that resident #287 is no longer a resident at this facility. II. Identification of other residents with potential to be affected: a. An audit of all residents admitted within the last 30 days will be completed by Interim Director of Nursing to include a complete body check to ensure that all skin impairments were identified and appropriate treatments obtained as necessary. Completion date 1/12/24 b. Any skin impairments identified after the initial admission will be handled as new and an incident report and investigation will be initiated. c. All residents have a potential to be affected III. Systemic Change:	1/19/24

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F 684	Continued From page 21 Resident #287 was admitted to the facility with diagnoses which included but were not limited to; EX Order 26.4B1 According to the resident's Admission Minimum Data Set, (MDS) an assessment tool dated, EX Order 26.4B1, included that the resident had a Brief Interview for Mental Status (BIMS) of "EX Order 26.4B1" which indicated that the resident's cognition was EX Order 26.4B The MDS further included that the resident had a EX Order 26.4B1. The care plan decision was signed as completed on EX Order 26.4B1 A review of the resident's Universal Transfer Sheet from the hospital dated EX Order 26.4B revealed that the resident had a EX Order 26.4B1 to their EX Order 26.4B1. A review of Resident #287's hospital records included a EX Order 26.4B1 consult dated EX Order 26.4B. The consult indicated the physician was requested for EX Order 26.4B1 EX Order 26.4B1. The EX Order 26.4B1 plan of care revealed that local EX Order 26.4B1 care was rendered with EX Order 26.4B1 (EX Order 26.4B1) to the EX Order 26.4B1 and elastic strechable bandage wraps to EX Order 26.4B1. A review of the hospital's "After Visit Summary" included instructions for EX Order 26.4B1 EX Order 26.4B1 to be started on EX Order 26.4B1 Additional instructions included to change dressing to EX Order 26.4B1 every other day with EX Order 26.4B1. According to the facility's "Nursing-	F 684	a) Policy and Procedure entitled Admission: Nursing was reviewed on 12/28/23 by the Interim Director of Nursing and Administrator and found to be incompliance. b) Policy and Procedure entitled Resident□s Baseline Care Plan was reviewed on 12/28/23 by theInterim Director of Nursing and Administrator and found to be incompliance b) Policy and Procedure entitled Skin and Wound Assessment Management was reviewed on 12/28/23 by the Director of Nursing and Administrator and found to be incompliance c) Policy and Procedure entitled Change in condition was reviewed on 12/28/23 by the Director of Nursing and Administrator and found to be incompliance d) The Policy and Procedure entitled Incident Report - Resident was reviewed on 12/28/23 by the Director of Nursing and Administrator and found to be incompliance s) The Policy and Procedure entitled Documentation in the EMR was reviewed on 12/28/23 by the Director of Nursing and Administrator and found to be incompliance e) Inservices entitled SKIN INSPECTION /Notification to Provider will be given to all licensed nurses by Interim Director of Nursing/Designee about the proper identification of skin impairments, proper notification to medical provider and the importance of the obtaining the necessary treatments for all areas identified. Completion Date: 1/19/24	

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F 684	Continued From page 22 Admission/Readmission Assessment" form dated, [redacted], the "general [redacted] condition" revealed that the resident had no [redacted], had Ex.Order 26.4(b)(1) to [redacted] where [redacted]s were removed, and had EX Order 26.4B1 [redacted] with intact elastic stretchable bandage wraps. There was no documentation regarding the resident's EX Order 26.4B1. A review of Resident #287's Progress Notes (PN) revealed that on EX Order 26.4B1, the resident was newly admitted at [redacted]. The PN included that the resident had EX Order 26.4B1, [redacted] EX Order 26.4B1 and that the resident's EX Order 26.4B1) were removed on that day. There was no futher documentation regarding the elastic stretchable bandage wraps to the resident's EX Order 26.4B1. A review of the History and Physical completed by the resident's physician dated [redacted] included the plan was to continue all treatment and [redacted] care. A review of the Physical Medicine and Rehab Consult, dated [redacted] indicated that the resident was hospitalized, had EX Order 26.4B1, EX Order 26.4B1 and [redacted] EX Order 26.4B1. The resident had EX Order 26.4B1 [redacted]. A review of a PN dated [redacted] at 8:29 AM revealed, "Dressings removed from [redacted]. No open areas or [redacted] noted. Dressing to EX Order 26.4B1 changed. It is a [redacted]. Slowly healing."	F 684	f) Inservice entitled Change in Condition will be given to all licensed nurses by Interim DON regarding the importance of communicating to Medical Provider if the resident and or family requests that the resident be hospitalized for any reason. Completion Date: 1/19/24 IV. QA monitoring: a) An audit was created to review all new admissions to ensure all skin impairments are identified and documented properly and necessary treatments are obtained. b) These audits will be completed by the Unit Manager/Designee weekly x 4 weeks, then monthly x 2 months and then quarterly x 3 quarters. c) All negative findings will be brought to the attention of the Director of Nursing and will be immediately corrected. d) The results of all audits will be brought to the QAPI committee quarterly x 4 quarters. V. Responsible Party: Interim Director of Nursing	

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F 684	Continued From page 23 A review of Resident #287's January 2023 Treatment Administration Record (TAR), included the following physicians orders: An order dated Ex.Order 26.4(b)(1) at 2:15 PM, for EX Order 26.4B1 EX Order 26.4B1 monitor every shift. (discontinued on EX Order 26.4B1); An order dated 1/26/23 at 9:59 AM, to clean EX Order 26 [redacted] Further review of Resident #287's January 2023 TAR revealed that there were no orders for the resident's Ex.Order 26.4(b)(1) to the EX Order 26.4B1 elastic stretchable bandage wraps documented on admission, the EX Order 26.4B1 (from the discharge paperwork) or the EX Order 26.4B1 to the resident's EX Order 2 EX Order 26.4B1 . A review of the medical record revealed that there were no other progress notes between Ex.Order 26.4(b)(1) that addressed the resident's dressings EX Order 26.4B1 . In addition, there were no progress notes that addressed the elastic stretchable bandage wraps that were documented on the admission assessment, or the EX Order 26.4B1 A review of the resident's Baseline Care Plan, created on Ex.Order 26.4(b) , indicated that the resident recently had Ex.Order 26.4(b)(1) and was at risk for developing EX Order 26.4B1 . The goal was to keep the resident's EX Order 2 intact. An intervention was that the resident required an air mattress. A review of the resident's Care Plan Activity Report included a focus of EX Order 26 Prevention	F 684		

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dated Ex.Order 26.4(b)(1) that the resident will have no Ex.Order 26 Ex.Order 26 surfaces for changes every shift, be provided with regular Ex.Order 26.4(b)(1), daily bed bath and shower twice weekly, Ex.Order 26.4(b)(1) every two to four hours.

There was no indication on the resident's care plans that addressed the resident's Ex.Order 26.4(b)(1) site, elastic stretchable bandage wraps, EX Order 26.4B1, EX Order 26.4B1 to the EX Order 26.4B1 or EX Order 26.4B1 EX Order 26.4B.

Review of a PN dated, Ex.Order 26.4(b) 3 at 4:02 PM written by Licensed Practical Nurse Unit Manager #1 (LPNUM #1), revealed that the resident's family member alerted LPNUM #1 that the resident was in EX Order 26.4B1. The LPNUM #1 entered the room and the resident stated that their EX Order 26.4B1 and they wanted to go to the hospital. The resident's vital signs were Ex.Order 26.4(b), the resident was not in EX Order 26.4B1 EX Order 26.4B1 was offered EX Order 26.4B1 but declined. LPNUM #1 further documented that the resident's EX Order 26.4B1, and the resident voiced that their EX Order 26.4B1.

There was no documentation that the physician was notified that the resident requested to go to the hospital.

On the same day at 6:19 PM, two hours later, a PN written by the Registered Nurse (RN) Supervisor revealed that the resident's family member requested to send the resident to the hospital. The resident was complaining of EX Order 26.4 EX Order 26.4B1 The physician was notified, and

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transportation was made to send the resident to the hospital.

The resident was transported to the hospital at 6:48 PM.

Review of a PN dated [redacted] at 10:43 PM, indicated the resident was admitted with a diagnosis [redacted]. An additional PN dated, [redacted], indicated that the resident was admitted with [redacted].

During an interview with the surveyor on 12/06/23 at 10:54 AM, LPNUM#1 stated when there was a new admission, the nurse would complete a full body assessment and review the hospital orders with the physician. LPNUM#1 stated that the assessments would be documented in the computer. If a resident was admitted with dressings, the nurse would check if the dressings were intact and if there was any drainage. There would be a physician's order (PO) for a treatment, and to monitor the site which would then be transcribed on the TAR. If the physician did not want the dressing to be touched, there would be an order and it would documented in the PN. If the resident had elastic stretchable bandage wraps or a wound, the nurse would assess the skin and get an order for the physician for a treatment.

LPNUM#1 further stated that Baseline Care plans were started on admission, and areas such as skin would be completed and updated. If a resident developed a skin tear, the nurse would complete an incident report (IR) with statements from the CNAs and nurses, call the physician and obtain a treatment order. Any skin change would

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F 684	Continued From page 26 be documented. If a resident wanted to go to the hospital, the nurse would assess the resident, take vital signs, and notify the physician. On 12/06/23 at 11:08 the surveyor reviewed Resident #187's medical record with LPNUM #1. LPNUM #1 confirmed that there was no order or treatment for the dressings to the resident's EX Order 26.4B1 elastic stretchable bandage wraps, and EX Order 26.4B1 She stated that there should have been an order. Additionally, there should have been documentation for the EX Order 26.4B1. LPNUM #1 stated that the care plan should have included the EX Order 26.4B1 dressings, elastic stretchable bandage wraps, EX Order 26.4B1, and EX Order 26.4B1. LPNUM#1 reviewed the PN she wrote when the resident requested to be sent to the hospital on EX Order 26.4B1. LPNUM#1 stated she was waiting on the RN to assess the resident, and confirmed she did not notify the physician at that time. During an interview with the surveyor on 12/06/23 at 12:28 PM, the Interim Director of Nursing (DON) stated the process for new admissions included an admission head to toe assessment, baseline care plan , and verifying and obtaining physicians orders. If a resident had skin issues, dressings, or wounds on admission, the nurse would remove the dressing unless there was an order not to touch the dressing. The nurse would assess the skin, measure, and check if there was any drainage, notify the physician and initiate an order. The DON stated orders would be checked for wounds and they would be monitored. If a resident developed a skin tear, an IR with statements would be completed, the physician would be notified, and a	F 684		

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treatment would be on the TAR. If a resident requested to go to the hospital, the physician would be notified and the resident would be sent to the hospital.

On 12/06/23 at 12:40 PM, the surveyor reviewed Resident #187's medical record with the Interim DON. The DON stated that the [Ex.Order 26.4(b)(1)] site to the resident's EX Order 26.4B1 to the residents [EX Order 26] should have had an order and should have been on the TAR, unless it was a do not touch order. The [EX Order 26.4B] to the resident's [EX Order 2] should have been documented in the PN, the [EX Order 26.4B1] should have had an order and IR completed. In addition, the DON stated the [EX Order 2] concerns should have been the resident's care plan. The DON further stated that LPNUM#1 should have notified the physician that the resident wanted to go to the hospital at that time.

During a telephone interview with the surveyor on 12/11/23 at 4:39 PM, the Registered Nurse Supervisor (RNS) stated residents arrive with orders from the hospital. If the resident arrived with a dressing with no order, the nurse would call the hospital for the order, and it would go on the facility PO and TAR. If there was any skin impairment, the nurse would document, get an order and put on the TAR. An IR would be completed for a skin tear. If a resident wanted to go to the hospital, the physician would be notified and the resident would be sent at that time.

During a follow up interview with the surveyor on 12/12/23 at 10:41 AM, LPNUM#1 confirmed she did not notify the MD when Resident #287 initially requested to go to the hospital and that the protocol was to have the supervisor assess the

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resident. She stated she had then left for that day and didn't know how long it was before the RNS came. She stated if the resident had a follow up appointment a PO for a consult would be entered or it would be in the PN. The surveyor reviewed #287's discharge orders and universal transfer sheet with LPNUM#1. She stated there should have been a PO for the EX Order 26.4B1, and EX Order 26.4B1 and it should have been on the TAR. If the physician did not want that ordered, it should have been documented.

During a follow up interview with the surveyor on 12/12/23 at 12:15 PM, the DON reviewed the MR for Resident #287 and stated it was "messy" and confirmed there was no order for the Ex.Order 26.4(b)(1) site EX Order 26.4B1 or documentation in the PNs. There was no IR provided for the resident's EX Order 26.4B1. The DON reviewed the hospital discharge instructions and stated she did not know why the treatment wasn't ordered for the EX Order 26.4B1 on admission and that the physician should have been notified for treatments to the EX Order 26.4B1 and the Ex.Order 26.4(b)(1) site dressings. She stated, "if it was not documented, I can't say it was done."

During a telephone interview with the surveyor on 12/13/23 at 11:00 AM, Resident #287's physician stated he would expect to be notified if a resident had a surgical EX Order 26.4B1, or any EX Order 26.4B1 and he would give an order for a treatment. In addition, if a resident wanted to go to the hospital, he would want to know why, the nurse's assessment of the resident, and would give an order to send the resident to the hospital. The physician stated Resident #287's discharge orders and recommendations should have been addressed

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and due to the complex history of the resident, the resident could go to the hospital at any time.

A review of a facility policy titled, Admission: Nursing dated 1/3/23, included that it was the policy of the facility that a resident was received, assessment completed and orders written upon admission. The purpose was to ensure all needs were identified, medications/treatment ordered based on assessment and transfer documentation. Nursing instructions would be added based on the new admission assessment. A baseline care plan would be initiated and completed with in 48 hours of admission.

A review of a facility policy titled, "Resident's Baseline Care Plan", reviewed on 9/20/2023, revealed that it is the policy of the center to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care. Duties include to complete admission assessment, begin initial baseline care plan based on information obtained during the initial assessment, reviews all admission documents and documentation and meets with resident for initial assessment, initiate or updates applicable section of the baseline care plan based on review of documents/assessments. The facility may provide a comprehensive care plan in place of the baseline care plan if the comprehensive care plan is developed with in 48 hours and includes: Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; any updated information based on the details of the comprehensive care plan as

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F 684	Continued From page 30 necessary. A review of a facility policy titled, "Skin and Wound Management" dated 1/17/23 included, "Any new wound/skin breakdown must be addressed as soon as discovered: Steps to Follow: Assess/evaluate site, inform MD and obtain treatment order, complete investigation/incident report, write progress note, update care plan." A review of a facility policy titled, "Change in Condition" dated 6/7/23, included that it was the policy of the facility to identify and communicate changes in condition to the physician and other team members. A complete assessment will be conducted of all systems and the nurse would contact the physician or nurse practioner to discuss findings and formulate a plan. A review of a facility policy titled, "Incident Report- Resident" reviewed on 7/12/23, included an investigation will be initiated whenever an untoward event occurs which may or may not result in injury to a resident. Incidents may include skin tears. The procedure included to initiate an incident report. A review of a facility policy titled, "Documentation in the EMR [electronic medical record] reviewed on 5/11/23, included that it was the policy of the center to document all information related to the patient's medical record in the EMR. NJAC- 8:39-27.1	F 684		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		1/19/24

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F 755	Continued From page 31 §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 by: Complaint # NJ166083 Based on observation, interview, and record review, it was determined that the facility failed to	F 755	I. IMMEDIATE CORRECTION ACTION: a. We respectfully submit that resident #187 is no longer a resident at this facility. b. A medication error was initiated for	

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F 755	Continued From page 32 provide pharmaceutical services in accordance with professional standards to ensure that a dispensed and administered Ex.Order 26.4(b)(1) [redacted] was accurately accounted for 1 of 1 residents reviewed, Resident #187. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." On 12/13/23 at 11:54 AM, the surveyor reviewed the closed medical record for Resident #187. A review of the Admission Record revealed that Resident #187 was admitted to the facility in EX Order 26.4B1 with diagnoses that included EX Order 26.4B1 [redacted] A review of the Admission Minimum Data Set (MDS), an assessment tool, dated EX Order 26.4B1, reflected the resident had short-term memory problems and further assessed that Resident #187's EX Order 26.4B1 for daily decision-making	F 755	RN and RN Night Supervisor (RNS#2) for the 6/19/23 and 6/21/23. A reinservice will be given to both RN and RNS#2 on accurate recording of administered narcotic medication. II. IDENTIFICATION OF OTHER RESIDENTS: 1) All residents have the potential to be affected by this deficient practice. 2) All narcotics currently being used will be audited by Interim Director of Nursing to ensure that dose given reflects accurate documentation in the narcotic decreasing log. Any discrepancies will be corrected immediately.. Completion date: 1/5/24 III. SYSTEMIC CHANGES 1) The policy and procedure for Narcotics: Ensuring the Security of Narcotics was reviewed by the Interim Director of Nursing and Administrator on 12/28/23 and found it to be in compliance. 2) The Interim Director of Nursing/Designee will reinservice all nurses on ensuring accurate recording of administered narcotic medication on narcotic declining sheets. Completion Date:1/19/2024 IV. MONITORING CORRECTIVE ACTION: 1) The Interim Director of Nursing/Designee will conduct an audit on 5 narcotic medications used weekly x 4 weeks, monthly x 2 and quarterly x 3. 2) All negative findings will be	

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F 755	Continued From page 33 were Ex.Order 26.4(b)(1). A review of the EX Order 26.4B1 Order Summary Report reflected a physician's order (PO) with a start date of EX Order 26.4B1 (milligram) EX Order 26 tablet by mouth every EX O hours as needed for EX Order 26.4B1. A review of the EX Order 26.4B1 Medication Administration Record (MAR) revealed a PO dated EX Order 26.4B1 take EX Order 2 tablet EX Order 26.4B1 every EX hours for EX Ord days as needed. The MAR was signed on EX Order 26.4B1 and EX Order 26.4B1 which indicated that Resident #187 had received EX Order 26.4B1 of the EX Order 26.4B1 on each of those days. A review of the Individual Patient Controlled Substance Administration Record (declining inventory log) reflected that the facility received #42 EX Order 26.4B1 tablets for Resident #187 on Ex.Order 26.4(b)(1) the declining inventory record revealed that #42 EX Order 26.4B1 tablets were unused and disposed of by the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). A review of the Ex.Order 26.4(b)(1) Transaction Report obtained from the pharmacy reflected no documentation indicating that the EX Order 26.4B1 EX Order 26.4B1 doses were obtained from the facility's medication dispensing machine. On 12/12/23 at 6:44 AM, during a telephone interview with the surveyor, the Registered Nurse Night Supervisor (RNS#2), who signed the MAR indicating that she had administered the	F 755	addressed immediately with staff re-education. 3) Outcome of the audits will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee x 4. V. Responsible Party: Interim Director of Nursing	

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F 755	Continued From page 34	F 755		

medication on 6/21/23 stated that she could not recall where she got the EX Order 26.4B1 from or why she had not signed the declining inventory record. RNS#2 further stated that sometimes a Ex.Order 26.4(b)(1) was taken out and the nurse "forgets to sign for it." The surveyor asked RNS#2 supervisor if she counted the Ex.Order 26.4(b)(1) with the incoming nurse. RNS#2 replied it was her regular practice to count the Ex.Order 26.4(b)(1) medications with the incoming nurse.

On 12/12/23 at 11:00 AM, during an interview with the surveyor, the Interim DON stated that following the facility policy, she and the former DON destroyed #42 EX Order 26.4B1 tablets in the facility drug buster. She further stated that they were not aware that there were any discrepancies which was why they had not conducted an investigation. At that time, the surveyor requested a copy of the Change of Shift Controlled Medication Accountability Record for the month of June 2023. The Interim DON stated that she was not able to locate it.

On 12/12/23 at 11:30 AM, the surveyor left a voicemail for the previous DON requesting a call back. The DON did not return the surveyor's phone call.

On 12/13/23 at 11:41 AM, the surveyor attempted to contact the RN who had signed the MAR indicating she had administered one of the doses of EX Order 26.4B1. The RN did not return the surveyor's call.

On 12/13/23 at 11:46 AM, the surveyor placed a second call to the previous DON and left a voice message. The DON did not return the surveyor's

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F 755	Continued From page 35 call. On 12/13/23 at 1:35 PM, the survey team met with the administration to discuss the above observations and concerns. On 12/14/23 at 10:26 AM, the Interim DON stated that there was no further information. Review of the Facility's policy entitled, "NARCOTICS: ENSURING THE SECURITY OF NARCOTICS" dated 11/28/16 and reviewed on 10/25/23 reflected, "...It is the policy of this facility to ensure that narcotics are maintained in a manner that ensures the safekeeping and integrity of the narcotics: All nurses must ensure that the narcotic count is accurate at the time they receive the keys and at the time they are handing over the keys to the oncoming shift. At no time should any nurse perform narcotic count alone. Each nurse is responsible for ensuring that the count is correct by standing side by side during the narcotic count. NJAC 8:3929.7(C)	F 755		
F 756 SS=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	F 756		1/19/24

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F 756	Continued From page 36 facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (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 and review of other facility documentation, it was determined that the facility failed to address the recommendations made by the Consultant Pharmacist (CP) in a timely manner. This deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications (Resident #116), and was evidenced by the	F 756	DRUG REGIMEN REVIEW I. Immediate Corrective Action: a) Resident #97: All medication orders were reviewed on 11/29/23 and found that all recommendations from consultant pharmacist are currently implemented as suggested. II. Identifying others affected	

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F 756	Continued From page 37 following: On 11/29/2023 at 1:02 PM, the surveyor observed Resident #97 sitting on the bed eating lunch. The surveyor observed the resident wearing [redacted] The surveyor reviewed the medical record for Resident #97. A review of the Resident Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnosis that included [redacted] A review of the most recent Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], reflected a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which demonstrated an [redacted]. On 12/12/2023 at 12:56 PM, the surveyor reviewed the facility's Medication Regime Review (MRR) for Resident #97. The surveyor observed that the resident had a review completed on [redacted] by the Consultant Pharmacist which stated, "currently receiving [redacted] ([redacted]) tablet once daily which is not long acting and not recommended for once daily dosing. Please evaluate and switch to [redacted] once daily, if appropriate." The box next to the recommendation which identified "Physician/Prescriber Response: Agree; Will do or Disagree/State Reason", was not filled out and a signature was not present on the MRR form. During an interview with the surveyor on	F 756	a. The Interim Director of Nursing/Designee reviewed all admissions/readmissions in the last 60 days for DRR performed on admission to determine if all discrepancies were addressed appropriately. All recommendations were addressed with physician or NP and EMR updated accordingly. Completion Date: 1/3/24 b. All residents have the potential to be affected. III. Systemic Changes a) The policy and procedure for pharmacy consultants was reviewed by the Administrator and Interim Director of Nursing and found to be in compliance. b) The Unit Managers were reinserviced by Interim Director of Nursing/Designee to thoroughly review Pharmacy consultant recommendations with MD/NP and make changes as per recommendations. Completion Date: 1/3/24 c) The facility will collaborate with the Pharmacy Consultant to ensure all drug regimen reviews are checked for timely completion. IV. Quality Assurance a.Interim DON will review 20 new recommendations per month of new admission/readmission drug regimen review to ensure all recommendations have been addressed appropriately as per policy. This will be performed monthly x 3 months then quarterly x 3. b. The Interim Director of Nursing/Designee will report all audits to	

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F 756	Continued From page 38 12/13/23 at 12:11 PM, the Interim Director of Nursing (DON), in the presence of the Registered Nurse Unit Manager (RNUM#1), stated that the unit managers were responsible for ensuring all MRR were completed. When asked what the turn around time frame for the MRR was, the DON responded that the facility "tries to give them one week, but up to 2". The surveyor inquired about the role of the consultant pharmacist and the DON indicated that they were in the building weekly to complete different tasks, but would review all the recommendations monthly. The DON reported that this resident was on a different wing of the building at the time of this MRR and it would have to have been reviewed with the previous unit manager. The DON stated that the MRR should have been addressed. During an interview with the surveyor on 12/14/23 at 10:27 AM, the Regional Nurse (RN), in the presence of the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Regional MDS Coordinator (RMDS), acknowledged that the unit manager was responsible and that the MRR was not completed and should have been addressed within 14 days. A review of the facility provided undated "Pharmacy Consultant Services" Policy, with Effective Date of 1/10/20 and Last Review Date: 2/10/23, documents that under the Heading of Nurse Manager/Designee: [...] 8. Review consultant recommendations and contacts MD/NP to address as soon as possible [...] 13. Reviews all pharmacy recommendations and ensures that MD/NP see the recommendations, address the recommendations, signs, responds, and acts on the recommendations as appropriate	F 756	the QAPI committee quarterly x 4. V. Responsible Party: Interim Director of Nursing	

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F 756	Continued From page 39 and returns all recommendations within 2 weeks of receipts [...]. NJAC 8:39-29.3 (a)	F 756		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		1/19/24

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F 880	Continued From page 40 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and 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 documentation, it was	F 880	Plan of Correction F880 I. IMMEDIATE CORRECTION ACTION:	

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F 880	Continued From page 41 determined that the facility failed to maintain infection control standards and procedures when performing a EX Order 26.4B1 care treatment for 1 of 1 residents (Resident #4) performed by 1 of 1 nurses observed providing a EX Order 26.4B1 care treatment. This deficient practice was evidenced by the following: On 11/29/23 at 11:41 am, the surveyor observed Resident #4 sitting in bed eating lunch. A review of the Resident Face Sheet, Resident #4 was admitted to the facility in EX Order 26.4B1 with diagnoses that included EX Order 26.4B1 [redacted] A review of Resident #4's Annual Minimum Data Set (MDS), an assessment tool dated EX Order 26.4B1, revealed that the resident's Brief Interview EX Order [redacted] 15 indicated that the resident had EX Order 26.4B1 EX Order 26.4B1. Further review revealed the resident required Ex.Order 26.4(b)(1) for activities of daily living (ADL) and review of the skin portion of the MDS indicated that the resident had a EX Order 26.4B1 EX Order 26.4B1 [redacted] A review of the Physician's Order Sheet revealed an order dated EX Order 26.4B1 to cleanse the EX Order 26.4B EX Order 26.4B1 with EX Order 26.4B1 pat dry, apply EX Order 26.4B1 powder mixed with EX Order 26 to the EX Order 26.4B1 bed and undermining, lightly pack the	F 880	1. The Licensed Practical Nurse was reinserviced on the proper steps on Ex.Order 26.4(b)(1) relating to EX Order 26.4B1 care treatment with return demonstration by the Infection Control Nurse and Interim DON Gcompleted on 12/7/23. 2. (Primary Care Physician) assessed the resident□s Ex.Order 26.4(b)(1) and no signs of Ex.Order 26.4(b)(1) was noted. Completion Date: 1 Ex.Order 26.4(b) [redacted] II. IDENTIFICATION OF OTHER RESIDENTS: 1) All residents have the potential to be affected by this deficient practice. III. SYSTEMIC CHANGES 1) The policy and procedure for Infection Control: Wound Management was reviewed by the Interim Director of Nursingand Administrator on 12/26/23 and found to be in compliance. 2) All nurses will be reinserviced by INfection Control Nurse Infection Control: Wound Management policy with special attention to changing of gloves and hand hygiene. Completion Date: 1/19/24 IV. MONITORING CORRECTIVE ACTION: 1) The Interim Director of Nursing/Designee will conduct infection control wound care competency on 2 nurses weekly x 4, monthly x 2 months and quarterly x 3. 2) All negative findings will be addressed immediately with re-education. 3) Outcome of the competencies will be	

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F 880	Continued From page 42 EX Order 26.4B1 with EX Order 26.4B1 to the EX Order 26.4B1 and cover with a silicon-bordered dressing daily and when needed. On 12/6/23 at 10:30 am, the surveyor observed the Licensed Practical Nurse (LPN) in the presence of the Infection Preventionist LPN perform a EX Order 26.4B1 care treatment on Resident #4 and observed the following: The LPN used alcohol-based hand rub (ABHR) and donned gloves. She poured Ex.Order 26.4 onto 4x4 gauze and cleansed the EX Order 26.4B1. The LPN, without removing her gloves and performing hand hygiene, opened and mixed the triple helix powder with Ex.Order 26.4 in a plastic medication cup, using a tongue depressor, and applied the mixture to the EX Order 26.4B1 She then cut a piece of EX Order 26.4B1 and packed the EX Order 26.4B1 with a cotton-tipped applicator. The LPN then covered the EX Order 26.4B1 with a border gauze. During an interview with the surveyor on 12/6/23 after the EX Order 26.4B1 treatment was completed, the LPN stated that after cleansing the EX Order 26.4B1, she should have changed her gloves and used ABHR before continuing. The LPN stated that she thought she had changed her gloves because thats what she would usually have done. During an interview with the surveyor on 12/6/23 at 11:00 am, the Interim Director of Nursing (DON) stated that gloves should have been changed after cleansing the EX Order 26.4B1 and hand hygiene should have been performed. She would have expected the nurse to have changed her gloves because the nurse's gloved hands would	F 880	reported to the Quality Assurance and Performance Improvement (QAPI) Committee x 4. V. Responsible Party: Director of Nursing	

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F 880	Continued From page 43 have been dirty. During an interview with the surveyor on 12/13/23 at 11:51 am, the IP/LPN stated that after EX Order 26.4B1, the nurse should have changed gloves and sanitized her hands to prevent contamination and infection. On 12/13/23 at 1:37 pm, the surveyor informed the Licensed Nursing Home Administrator (LNHA) of the findings. The surveyor reviewed the facility's policy titled, "Infection Control: Wound Management," with a review date of 6/12/23, which revealed the facility would apply clean gloves during an aseptic dressings procedure. NJAC 8:39-19.4(a)	F 880		

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ARNOLD WALTER NURSING & REHABILITATIC	622 S LAUREL AVENUE HAZLET, NJ 07730

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S 000	Initial Comments Complaint # NJ 160219; NJ160755; 165400, NJ 166916, NJ 166083 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint # NJ 160219; NJ160755; 165400, NJ 166916, NJ 166083 Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: 1. Reference: New Jersey Department of Health	S 560	S560 I. Immediate Action: 1. The Administrator and Interim Director of Nursing met with Human Resource Director Stephanie and Staffing Coordinator to determine current staffing vacancies in the nursing department to ensure accuracy of facility needs. 2. The facility has reviewed current salaries in comparison to other facilities in the immediate area to ensure salary competitiveness within the community.	1/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061301	A. BUILDING: _____ B. WING _____	C 12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARNOLD WALTER NURSING & REHABILITATIC	622 S LAUREL AVENUE HAZLET, NJ 07730

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S 560	Continued From page 1 (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift; One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties; and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of the "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 10/29/23 and 11/5/23 revealed the facility was deficient in CNA staffing for residents as follows: 1. For the week of Complaint staffing from 12/04/2022 to 12/10/2022, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -12/04/22 had 14 CNAs for 130 residents on the day shift, required at least 16 CNAs. -12/05/22 had 13 CNAs for 130 residents on the	S 560	3. The facility contacted the current agencies utilized by the facility to emphasize the facility's immediate needs. 4. The facility maintains daily contact with these agencies to assist in meeting the needs of the facility. 5. Nursing Administration is available for interviews, hiring and training as needed to ensure all potential candidates are interviewed, evaluated and offered positions if appropriate. 6. The facility continues to offer incentives including referral bonuses and other incentives. 7. The facility advertises on various platforms such as social media, posted flyers in various community establishments, colleges and schools. We have partnered with C.N.A. schools, hung banners across facility property to enhance our recruitment efforts. We have encouraged word of mouth referrals to employees and the community. 8. The facility works with a full-time recruiter whose sole responsibility is to recruit nurses and C.N.A.s. II. Identification of Others: The facility respectfully submits that all residents may be affected by this practice. III. Systemic Changes 1. The Administrator, Interim Director of Nursing, Human Resource have reviewed the state staffing ratios with the Staffing Coordinator to ensure meeting the state required ratios is the primary focus for staffing the facility. 2. The Staffing Coordinator was	

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S 560	Continued From page 2 day shift, required at least 16 CNAs. -12/07/22 had 15 CNAs for 128 residents on the day shift, required at least 16 CNAs. -12/07/22 had 15 CNAs for 128 residents on the day shift, required at least 16 CNAs. -12/08/22 had 15 CNAs for 128 residents on the day shift, required at least 16 CNAs. -12/09/22 had 15 CNAs for 127 residents on the day shift, required at least 16 CNAs. -12/10/22 had 12 CNAs for 127 residents on the day shift, required at least 16 CNAs. 2. For the week of Complaint staffing from 01/08/2023 to 01/14/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -01/08/23 had 13 CNAs for 140 residents on the day shift, required at least 17 CNAs. -01/09/23 had 12 CNAs for 140 residents on the day shift, required at least 17 CNAs. -01/10/23 had 15 CNAs for 140 residents on the day shift, required at least 17 CNAs. -01/11/23 had 15 CNAs for 140 residents on the day shift, required at least 17 CNAs. -01/12/23 had 15 CNAs for 140 residents on the day shift, required at least 17 CNAs. -01/13/23 had 16 CNAs for 139 residents on the day shift, required at least 17 CNAs. -01/14/23 had 15 CNAs for 138 residents on the day shift, required at least 17 CNAs. 3. For the week of Complaint staffing from 02/26/2023 to 03/04/2023, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -02/26/23 had 13 CNAs for 127 residents on the day shift, required at least 16 CNAs.	S 560	instructed to notify the Interim Director of Nursing and/or the Administrator when staffing ratios are not being met so they can lend assistance in fulfilling those ratios. 3. Human Resource Director will complete exit interviews for all nursing employees who have vacated their positions in an attempt to address any issues which could be affecting retention of employees. 4. Orientation frequency will be increased to ensure that all potential candidates for employment will have opportunities to complete the orientation as soon after accepting a facility offer. IV. Quality Assurance The Administrator/designee will have weekly meetings x 4, monthly x 2, and quarterly x 3 with Human Resource and Staffing Coordinator to review staffing schedules, needs, and the efficacy of the systems in place to fill needs. The findings of the audits will be presented by Human Resource at the Quarterly QA meeting x 4. V. Responsible Party: Administrator, Interim Director of Nursing, Human Resource Director	

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S 560	Continued From page 3 -02/27/23 had 13 CNAs for 124 residents on the day shift, required at least 15 CNAs. -02/28/23 had 12 CNAs for 124 residents on the day shift, required at least 15 CNAs. -03/01/23 had 14 CNAs for 124 residents on the day shift, required at least 15 CNAs. -03/03/23 had 14 CNAs for 124 residents on the day shift, required at least 15 CNAs. -03/04/23 had 13 CNAs for 124 residents on the day shift, required at least 15 CNAs. 4. For the week of Complaint staffing from 06/18/2023 to 06/24/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -06/18/23 had 12 CNAs for 133 residents on the day shift, required at least 17 CNAs. -06/19/23 had 12 CNAs for 133 residents on the day shift, required at least 17 CNAs. -06/20/23 had 15 CNAs for 131 residents on the day shift, required at least 16 CNAs. -06/21/23 had 14 CNAs for 131 residents on the day shift, required at least 16 CNAs. -06/22/23 had 15 CNAs for 131 residents on the day shift, required at least 16 CNAs. -06/23/23 had 12 CNAs for 131 residents on the day shift, required at least 16 CNAs. -06/24/23 had 14 CNAs for 131 residents on the day shift, required at least 16 CNAs. 5. For the 2 weeks of staffing prior to survey from 11/12/2023 to 11/25/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -11/12/23 had 10 CNAs for 148 residents on the day shift, required at least 18 CNAs. -11/13/23 had 11 CNAs for 148 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061301	A. BUILDING: _____ B. WING _____	C 12/14/2023

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S 560	Continued From page 4 day shift, required at least 18 CNAs. -11/14/23 had 14 CNAs for 143 residents on the day shift, required at least 18 CNAs. -11/15/23 had 14 CNAs for 140 residents on the day shift, required at least 17 CNAs. -11/16/23 had 12 CNAs for 140 residents on the day shift, required at least 17 CNAs. -11/17/23 had 13 CNAs for 139 residents on the day shift, required at least 17 CNAs. -11/18/23 had 12 CNAs for 137 residents on the day shift, required at least 17 CNAs. -11/19/23 had 11 CNAs for 137 residents on the day shift, required at least 17 CNAs. -11/20/23 had 13 CNAs for 137 residents on the day shift, required at least 17 CNAs. -11/21/23 had 14 CNAs for 137 residents on the day shift, required at least 17 CNAs. -11/22/23 had 13 CNAs for 137 residents on the day shift, required at least 17 CNAs. -11/23/23 had 12 CNAs for 139 residents on the day shift, required at least 17 CNAs. -11/24/23 had 11 CNAs for 139 residents on the day shift, required at least 17 CNAs. -11/25/23 had 13 CNAs for 137 residents on the day shift, required at least 17 CNAs. On 12/121/23 at 12:55 PM, during an interview with the survyeor, the Staffing Coordinator stated that they were aware of the staffing ratio requirements. Review of the facility's Staffing policy with an effective date of 1/12/21 and reviewed on 10/14/23 reflected...Our facility provides adequate staffing to meet needed care and services for our resident population.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315119 Y1	A. Building B. Wing Y2	1/22/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARNOLD WALTER NURSING & REHABILITATION CENTER	622 S LAUREL AVENUE HAZLET, NJ 07730

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0609	Correction	ID Prefix F0610	Correction	ID Prefix F0641	Correction
Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.20(g)	Completed
LSC	01/19/2024	LSC	01/19/2024	LSC	01/19/2024
ID Prefix F0658	Correction	ID Prefix F0684	Correction	ID Prefix F0755	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	01/19/2024	LSC	01/19/2024	LSC	01/19/2024
ID Prefix F0756	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	01/19/2024	LSC	01/19/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/14/2023	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315119 Y1	A. Building B. Wing Y2	1/22/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0609	Correction	ID Prefix F0610	Correction	ID Prefix F0684	Correction
Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.25	Completed
LSC	01/19/2024	LSC	01/19/2024	LSC	01/19/2024
ID Prefix F0755	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/19/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/14/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061301 Y1	A. Building B. Wing Y2	1/22/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARNOLD WALTER NURSING & REHABILITATION CENTER	622 S LAUREL AVENUE HAZLET, NJ 07730

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 01/19/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 12/14/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: 6RTU12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315119	A. BUILDING **01** B. WING _____	**12/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARNOLD WALTER NURSING & REHABILITATION CENTER	**622 S LAUREL AVENUE** **HAZLET, NJ 07730**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 12/14/2023. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/14/23 and was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Arnold Walter Nursing and Rehabilitation Center is a one-story building with a partial basement that was built in 1969. It is composed of Type II protected construction. The facility is divided into 11 - smoke zones. The generator does approximately 80 % of the building per the Maintenance Director. The current occupied beds are 145 of 169.	K 000		

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

Electronically Signed | 12/22/2023

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