STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315282	A. BUILDING _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT MANALAPAN	**104 PENSION ROAD MANALAPAN, NJ 07726**

(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 This facility is not in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
E 001 SS=E	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness	E 001		4/16/24

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

Electronically Signed | 03/31/2024

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

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E 001	Continued From page 1 program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on interview, and review of pertinent documentation, it was determined that the facility failed to maintain a comprehensive Emergency Preparedness (EP) program on 2 of 2 facility units and the facility EP manual. This deficiency was evidenced by the following: On 02/20/24, the survey team entered the facility. The maintenance director was asked to provide the EP manual for the team to review. The main facility EP manual was provided to the survey team on 03/06/24. On 03/06/24 at 8:05 AM, in the presence of the Registered Nurse Unit Manager (RN UM) the surveyor reviewed the EP manual which was located on the 100 unit of the facility. The RN UM and surveyor reviewed the following missing, inaccurate, or not updated information: The EP manual's most recent update had been 02/22/23. The Disaster Telephone Tree had 10 names,	E 001	E001 SS-E 1. Corrective Action: " The disaster telephone tree was updated on March 18, 2024, by the Administrator for the main EP manual and the 100 and 200 units to reflect the correct employee names and phone numbers. " The mutual agreements with receiving facilities were updated on March 18, 2024, by the Administrator for main EP manual and the 100 and 200 units with the updated names of the Licensed Nursing Home Administrators. " The employee phone list was updated on March 18, 2024, by the Administrator for the main EP manual and the 100 and 200 units, with the correct employee phone numbers. " On March 18, 2024, the LNHA was educated on the importance of maintaining an up-to-date EP manual. 2. Identification of other residents or areas having the potential to be affected	

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E 001	Continued From page 2 titles, and phone numbers. The Administrator's name was incorrect; the Director of Nursing (DON)'s name was incorrect; the Assistant DON's name/Infection Preventionist's name was incorrect; and the Director of building services name was incorrect. The mutual agreement with receiving facilities listed five facilities in the state. The five Licensed Nursing Home Administrators (LNHA) names were incorrect as they were no longer at the facilities. The employee phone list documented the previous DON, Activities director, LNHA, Assistant DON, and maintenance director. The RN UM confirmed the contact information was not up to date and stated, "oh these are the wrong people listed, that's not good". On 03/06/24 at 8:21 AM, the surveyor reviewed the EP manual on the facility 200 units. The EP manual contained the following missing or inaccurate information: The most recent update had been 02/22/23. The mutual agreement with receiving facilities listed five facilities in the state. The five Licensed Nursing Home Administrators (LNHA) names were incorrect as they were no longer at the facilities. The employee phone list documented the previous DON, Activities director, LNHA, Assistant DON, and maintenance director. On 03/06/24 at 11:00 AM, the current LNHA in the presence of the survey team stated that he was responsible for the EP program. All three EP manuals were available for review by the LNHA. He stated that the purpose of the EP plan was so	E 001	due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " The EP main manual and those located on the 100 and 200 units will be reviewed and updated as required and/or weekly when information within the facility changes by the Human Resources Director and/or designee. " The EP manual will be audited monthly by the Administrator and/or designee to assure that all sections are up to date. 4. How Will These Actions Be Measured: The results of the weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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E 001	Continued From page 3 that the entire staff would know what to do in an emergency. The LNHA stated that the Human Resources staff would keep an updated employee list and that the correct information/list should be in the books. The LNHA stated he was unable to explain "why the EP books were not complete or the same". On 03/06/24 at 8:35 AM, the facility main EP manual was reviewed by the surveyor. The manual noted an update of 01/02/24. The mutual agreement with receiving facilities listed five facilities in the state. The five Licensed Nursing Home Administrators (LNHA) names were incorrect as they were no longer at the facilities. The facility failed to maintain all three EP manuals, and failed to update the two EP manuals on both resident units. The facility was afforded the opportunity to provide additional information but did not have additional information to provide. NJAC 8:39-31.6	E 001		
E 007 SS=E	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.542(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every	E 007		4/16/24

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E 007	Continued From page 4 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent documentation, it was determined that the facility Emergency Preparedness (EP) program and manuals failed to address the facility resident population and the residents at risk to determine the services needed to provide for those residents during an emergency. This deficient practice was identified facility wide and was evidenced by the following: On 03/06/24 from 8:05 AM through 8:49 AM, the surveyor reviewed the main facility EP manual and the two resident unit EP manuals. The EP	E 007	E007 SS-E 1. Corrective Action: " Upon identification, the main Emergency Preparedness manual and the two located on units 100 and 200 were updated on March 18, 2024, by the Director of Nursing to ensure that the facility-wide risk assessment evaluated its resident population and the residents at risk to determine the services needed to provide for those residents during an emergency. " On March 18, 2024, the LNHA was	

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E 007	Continued From page 5 manuals failed to identify and document at risk residents. On 03/06/24 at 11:10 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team, stated that the facility had a risk assessment to address the resident population and identify the residents at risk. All three EP manuals were present and available for the LNHA to review. The LNHA stated he was unable to explain "why the EP books were not complete or the same". On 03/06/24 at 11:49 AM, the LNHA provided facility Assessments that included the following: Natural Events, the probability, the risk, and the facility preparedness to address these events. The Natural Events failed to identify any at risk residents. Human Events, the probability, the risk, and the facility preparedness to address these events. The Human Events failed to identify any at risk residents. Technological Events, the probability, the risk, and the facility preparedness to address these events The Technological Events failed to identify any at risk residents. Physical Environment, Assessment items, yes, no, and comments and specific items not meeting standards. The Physical Environment Assessment failed to identify any at risk residents. The facility failed to provide specific information to identify at risk residents and address their needs	E 007	educated on the importance of maintaining an up-to-date EP manual. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " The EP main manual and those located on the 100- and 200-unit□s facility-wide risk assessment evaluation will be reviewed and updated as required and/or weekly for changes in resident risk within the facility changes by the Director of Nursing and/or designee. " The Administrator and/or designee will audit the Emergency Preparedness manual monthly to assure the facility-wide risk assessment to evaluate the resident population is up to date. 4. How Will These Actions Be Measured: The results of the weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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E 007	Continued From page 6 during an emergency. NJAC 8:39-31.6	E 007		
E 018 SS=E	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.542(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and	E 018		4/16/24

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E 018	Continued From page 7	E 018		

sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.

*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.
(ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.
(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.

*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.

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E 018	Continued From page 8 *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent documentation, it was determined that the facility failed to have a system in place in the Emergency Preparedness (EP) manuals to track the location of on duty staff and sheltered residents during an emergency. This deficient practice was identified for 2 of 2 resident units and the facility main EP manual and was evidenced by the following: On 03/06/24 from 8:05 AM, the surveyor in the presence of the Registered Nurse Unit Manager (RN UM) reviewed the 100-unit EP manual. When asked how to contact staff during the off-hours in an emergency, the RN UM stated the staff would use the Disaster Telephone Tree. The RN UM confirmed the Disaster Telephone Tree listed the previous Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant DON/Infection Preventionist, and Director of Building Services. The RN UM confirmed the staff contact list included the previous LNHA, DON, Maintenance Director, and ADON. The list documented the previous Activities director. A review of the 200-unit EP manual confirmed the Disaster Telephone Tree and staff contact list were the same as the 100-unit and both were incorrect. On 03/06/24 at 9:50 AM, the Licensed Practical Nurse UM (LPN UM) on the 200-unit, stated that if there were an emergency, the staff would refer	E 018	E018 SS-E 1. Corrective Action: " The disaster telephone tree and staff contact list was updated by the Administrator on March 18, 2024, for the main EP manual and the 100 and 200 units, with the correct employee phone numbers. " The resident rosters were updated on March 18, 2024, by the Administrator for the main EP manual and the 100 and 200 units with the correct resident names commensurate with the facility census. In addition, step by step directions on how to access the most up to date resident rooster was also placed in the binder for staff to access as needed. " The Administrator was educated on March 18, 2024, related to the importance of maintaining accurate employee contact information and an accurate resident census in the EP manual. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: The EP main manual and those located on the 100 and 200 units will be reviewed and updated when information changes	

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E 018	Continued From page 9 to the resident roster at the nursing desk. She stated the roster would be updated daily. When asked for a copy, the resident roster list was dated 03/02/24 and noted a total of 60 residents. On 03/06/24 at 9:56 AM, the unit secretary working on the 100-unit stated if the residents needed to be evacuated, the staff would refer to the resident roster kept at the nursing desk. The unit secretary was unable to locate the resident roster, but stated she kept her own copy with her and provided that copy. The resident roster provided was dated 03/04/24, had three resident names crossed out, and noted a total of 18 residents. The resident census that had been provided to the survey team on 03/06/24, was 77. The two combined resident rosters provided by both resident units totaled 78. On 03/06/24 at 11:00 AM, the LNHA in the presence of the survey team, stated that he was responsible for the EP program. The three facility EP manuals were present for review. When asked about the current facility census of 77 and the two total resident rosters, the LNHA stated the total should be equal because "we need to know who is in the building". The LNHA stated he was unable to explain "why the EP books were not complete or the same". On 03/06/24 at 11:10 AM, the LNHA provided additional EP program information but was unable to provide the staff and resident tracking system to be used in the facility or to explain the discrepency in the current census and the resident rosters.	E 018	related to the disaster telephone tree and staff contact list- names and phone numbers will up updated. And/or as required weekly when information within the facility changes by the Human Resources Director and/or designee. The Administrator and/or designee will audit the Emergency Preparedness manual monthly to assure the disaster telephone tree and staff contact list is up to date. 4. How Will These Actions Be Measured: " The results of the weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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E 018	Continued From page 10 NJAC 8:39-31.6	E 018		
E 025 SS=E	Arrangement with Other Facilities CFR(s): 483.73(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services	E 025		4/16/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 025	Continued From page 11 to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to ensure documentation in the Emergency Preparedness (EP) manual included that arrangements with facilities to receive residents in the event of an emergency were consistent and accurate to maintain the continuity of services for the residents. This deficient practice was identified facility wide and was evidenced by the following: On 03/01/24 at 12:28 PM, the Licensed Nursing Home Administrator (LNHA) provided the survey team the facility, "Mutual Emergency Transfer Agreement" dated 01/01/24. The Agreement listed two accepting facilities in a state other than the state the facility was located in and three accepting facilities in the same state. On 03/06/24 at 8:05 AM, the Registered Nurse Unit Manager (RN UM) on the 100-unit and the surveyor reviewed the EP manual. The section of the EP manual listed five facilities in the same state as the facility with LNHA signatures. The five facilities differed from what the LNHA provided to the survey team. On 03/06/24 at 8:49 AM through 8:57 AM, the	E 025	E025 SS-E 1. Corrective Action: " The mutual emergency transfer agreements with receiving facilities were updated on March 18, 2024, by the Administrator for main EP manual and the 100 and 200 units with the updated names of the Licensed Nursing Home Administrators. The main EP manual and the 100 and 200 units all have been updated to ensure each manual has the same mutual emergency transfer agreements. " On March 18, 2024, the LNHA was educated on the importance of maintaining an up-to-date EP manual. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " The EP main manual and those located on the 100 and 200 units will be reviewed and updated when information related to changes in administrators occur	

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E 025	Continued From page 12 surveyor conducted telephone interviews, in the presence of two other surveyors, and confirmed that all five LNHAs listed in the EP manuals on both resident units, were no longer employed at the listed accepting facilities. On 03/06/24 at 9:00 AM, the Licensed Practical Nurse UM (LPN UM) on the 200-unit provided the unit EP manual. The section of the EP manual listed five facilities in the same state as the facility with LNHA signatures. The five facilities differed from what the LNHA provided to the survey team. On 03/06/24 at 11:00 AM, the facility LNHA in the presence of the survey team, stated all three EP manuals should include the same information. All three facility EP manuals were available for review. The LNHA was unable to explain why the accepting facility information he had provided on 03/01/24, differed from the accepting facility information in all three EP manuals in the facility. The LNHA stated he was unable to explain "why the EP books were not complete or the same". The facility was afforded the opportunity to present additional information but had no additional information to provide. NJAC 8:39-31.6	E 025	for the mutual emergency transfer agreements. And/or as required weekly when information within the facility changes by the Human Resources Director and/or designee. " The EP manual will be audited monthly by the Administrator and/or designee to assure that all sections are up to date. 4. How Will These Actions Be Measured: " The results of the weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	
E 031 SS=E	Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.542(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2).	E 031		4/16/24

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E 031	Continued From page 13 [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on interview, and review of pertinent documentation, it was determined that the facility failed to ensure their Emergency Preparedness (EP) manuals contained the contact information for the Federal, State, Tribal, regional, the local emergency preparedness staff, the state licensing and certification agency, and the state	E 031	E031 SS=E 1. Corrective Action: " On March 18, 2024, the Administrator update the EP main manual and the manuals for the 100 and 200 unit to include contact information for the Federal, State, Tribal, Regional, Local	

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E 031	Continued From page 14 Ombudsman. This deficient practice was identified facility wide and was evidenced by the following: On entrance to the facility on 02/20/24, the survey team requested the facility to provide their EP manual for review. On 03/06/24, the facility provided their EP manual. On 03/06/24 from 8:05 AM through 8:49 AM, the surveyor reviewed the EP manual on the 100-unit, 200-unit, and the facility main EP manual. There was no documentation listing any names or telephone numbers of the Federal, state, tribal, regional, local emergency preparedness staff, the State Licensing or Certification agency, or the Ombudsman the facility would need to contact. On 03/06/24 at 11:00 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team, stated he was responsible for the EP program. He stated the purpose of the EP program was so that all staff know what to do during an emergency. When asked if the EP manuals, all three were in the conference room for review at the time, contained the contact information for the local, regional, and state emergency preparedness agencies, the information was not listed in the book. The LNHA stated it was important to have those contact people and names in case of an emergency. The LNHA stated he was unable to explain "why the EP books were not complete or the same". The facility failed to provide any additional information. NJAC 8:39-31.6	E 031	emergency preparedness staff, the State licensing or certification agency or the Ombudsman that the facility would need to contact. " On March 18,2024 the LNHA was educated on the importance of maintaining an up-to-date EP manual. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " The Administrator and/or designee will audit the facility□s Emergency Preparedness manual monthly to assure the EP main manual and the manuals for the 100 and 200 units include contact information for the Federal, State, Tribal, Regional, Local emergency preparedness staff, the State licensing or certification agency or the Ombudsman that the facility would need to contact. 4. How Will These Actions Be Measured: " The results of the monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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E 036 SS=E	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.	E 036		4/16/24

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E 036	Continued From page 16 *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent documentation, it was determined that the facility failed to ensure the Emergency Preparedness (EP) program training and testing was completed. This deficient practice was identified facility wide and evidenced by the following: On 02/20/24, the survey team requested the facility EP manuals to review. On 03/06/24, the facility provided the main EP manual.	E 036	E036 SS-E 1. Corrective Action: " On March 28, 2024, the Administrator Designee initiated facility wide education on Emergency preparedness to include process to be initiated for facility emergencies and will be completed by April 16, 2024 " On March 18, 2024, the LNHA was educated on the importance of maintaining an up-to-date EP manual	

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E 036	Continued From page 17 On 03/06/24 at 9:56 AM, the unit secretary for both resident units, was asked what the procedure was to follow if there were an emergency. The unit secretary stated that the staff would "close the resident's doors and wait for the front desk" to notify the staff regarding of their responsibilities. She stated she had been educated on fire and evacuation but no "drills or exercises". On 03/06/24 at 11:00 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team, stated the process if there were an emergency was that "we pull together and discuss options". All three facility EP manuals were present for review. When asked about training and testing, the LNHA stated "sure" there were exercises. The LNHA stated he was unable to explain "why the EP books were not complete or the same". The surveyor asked the LNHA to provide that documentation. On 03/06/24 from 8:05 AM through 11:49 AM, the surveyor reviewed the main facility EP manual and the two resident unit EP manuals. The manuals failed to document any facility training and testing of the risk assessment, policies and procedures, and the communication plan. The facility was afforded the opportunity to provide the EP program training and testing but did not have any additional information to provide. NJAC 8:39-31.6	E 036	inclusive of education and drills. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " The Administrator and/or designee will audit to assure that education on emergency preparedness to include the process to be initiated for facility emergencies, is completed monthly and will be placed together with the other mandatory employee education documentation. " 4. How Will These Actions Be Measured: " The results of the monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	
E 037 SS=E	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1),	E 037		4/16/24

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E 037	Continued From page 18 §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures.	E 037		

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(iii) Provide emergency preparedness training at least every 2 years.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under

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arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.

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(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency

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E 037	Continued From page 22 preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent documentation, it was determined that the facility failed to maintain documentation of initial training in Emergency Preparedness (EP) of all new and existing staff and individuals providing services under arrangements. This deficient practice was identified facility wide and evidenced by the following: On 02/20/24 upon the survey team's entrance to the facility, the survey team requested the facility EP program manual to review. On 03/06/24, the facility provided the EP manual. On 03/06/24 at 8:05 AM, in the presence of the surveyor, the resident 100-unit Registered Nurse Unit Manager (RN UM) reviewed the unit's EP manual. The manual was noted as last having been updated on 02/22/23, over a year ago. The Disaster Telephone Tree provided previous not current staff to contact, and the main staff telephone list provided previous and current staff. The RN UM stated that in case of an emergency, the "team would gather, and administration would give assignments". When asked the procedure to contact staff and administration off-hours, the RN UM reviewed the Disaster Telephone Tree and stated, "oh these are the wrong people listed,	E 037	E037 SS-E 1. Corrective Action: " On March 28, 2024, the Administrator Designee initiated facility wide education on Emergency preparedness to include process to be initiated for facility emergencies and will be completed by April 16, 2024. " The disaster telephone tree and staff contact list was updated by the Administrator on March 18, 2024, for the main EP manual and the 100 and 200 units, with the correct employee phone numbers. " The resident rosters were updated on March 18, 2024, by the Administrator for the main EP manual and the 100 and 200 units with the correct resident names commensurate with the facility census. In addition, step by step directions on how to access the most up to date resident rooster was also placed in the binder for staff to access as needed. " The Administrator was educated on March 18, 2024, related to the importance of assuring education is provided facility wide on Emergency Preparedness	

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E 037	Continued From page 23 that's not good". On 03/06/24 at 9:50 AM, the Licensed Practical Nurse UM (LPN UM) on the resident 200-unit, provided the surveyor with the unit's EP manual. When asked, the LPN UM stated the process during an emergency would be to alert the staff and take instructions from the Licensed Nursing Home Administrator (LNHA). When asked, the LPN UM stated there was a resident roster at the nursing desk that would be updated daily. The LPN UM obtained the resident roster which was dated 03/02/24. On 03/06/24 at 9:56 AM, the facility unit secretary stated she works on both resident units. When asked, the unit secretary stated that if there were an emergency, the staff would "close the resident doors and wait for the front desk to notify" her regarding her responsibilities. She stated that there would be a resident roster kept at the nursing desk. The unit secretary was unable to locate the resident roster in the nursing desk and stated she carried her own with her. The unit secretary provided a copy of the 100-unit resident roster dated 03/04/24. The unit secretary stated that she had education on fires and evacuation but had not been part of any drills or exercises regarding EP. On 03/06/24 from 8:05 AM through 11:49 AM, the surveyor reviewed the main EP manual and the two EP manuals kept on the resident care units. All three EP manuals failed to include any documentation of staff or vendor initial EP training. On 03/06/24 at 11:00 AM, the LNHA in the presence of the survey team, had all three facility	E 037	process, disaster phone tree, and resident roster. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " Maintenance Director and/or designee will provide education on emergency preparedness as required by regulation, inclusive of monthly fire drills, to facility employees which will begin 4/1/24. " Monthly audits of emergency preparedness education will be conducted by the Administrator and/or designee to assure education to facility staff is performed. 4. How Will These Actions Be Measured: " The results of the monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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E 037	Continued From page 24 EP manuals present for review. The LNHA was asked about the two resident unit EP manuals not having been updated since 02/22/23. The LNHA stated he was unable to explain why the EP books were not complete, thorough and the same. He stated there were exercises where the staff participated. The surveyor requested the additional information. The facility was afforded the opportunity to provide additional information but were unable to provide documentation of the initial training for staff or vendors, annual EP training, or documentation of training or exercises. NJAC 8:39-31.6	E 037		
E 039 SS=E	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional	E 039		4/16/24

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exercise every 2 years; or

(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.

(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]

(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:

(i) Participate in a full-scale exercise that is community based every 2 years; or

(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or

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(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.

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E 039	Continued From page 27 (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the	E 039		

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following:
(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.

*[For PACE at §460.84(d):]
(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or
(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to

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the following:
(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.

*[For LTC Facilities at §483.73(d):]
(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.
(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility based

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functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.

*[For ICF/IIDs at §483.475(d)]:
(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.
(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency

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scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.

*[For HHAs at §484.102]
(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:
(i) Participate in a full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.

(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem

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statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.

*[For OPOs at §486.360]
(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:
(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.
(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.

*[RNCHIs at §403.748]:
(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:
(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or

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E 039	Continued From page 33 prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent documentation, it was determined that the facility failed to maintain documentation and ensure Emergency Preparedness (EP) testing requirements were met. This deficient practice was identified facility wide and evidenced by the following: On 02/20/24, the survey team entered the facility. The survey team requested the facility EP manual to review. On 03/06/24, the facility provided the main facility EP manual. On 03/06/24 at 8:05 AM, the surveyor reviewed the resident 100-unit EP manual. The Registered Nurse Unit Manager (RN UM) was present. The EP manual was dated as most recent updated 02/22/23. The manual did not include any documented annual emergency exercises; unannounced staff drills utilizing emergency procedures; full-scale exercises community based, individual, or facility based; additional exercises; and no documented analysis of the facility response. On 03/06/24 at 8:21 AM, the surveyor reviewed the resident 200-unit EP manual. The EP manual was dated as most recent updated 02/22/23. The manual did not include any documented annual emergency exercises; unannounced staff drills utilizing emergency procedures; full-scale	E 039	E039 SS-E 1. Corrective Action: " An annual emergency exercise/disaster drill was scheduled with prior notification and acknowledgement to the Office of Emergency Management (on November 28, 2023) and performed on December 15, 2023. " On November 28, 2023, the maintenance director invited community responders to attend the annual emergency exercise. " On November 28, 2023, the maintenance director scheduled an unannounced drill that was completed on December 15, 2023. " The Administrator was educated in March. 18, 2024. related to the importance of maintaining documentation and ensure emergency preparedness testing requirements are met and that a post event analysis needs to be written and reviewed. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place:	

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E 039	Continued From page 34 exercises community based, individual, or facility based; additional exercises; and no documented analysis of the facility response. On 03/06/24 at 8:35 AM, the surveyor reviewed the facility main EP manual. The manual did not include any documented annual emergency exercises; unannounced staff drills utilizing emergency procedures; full-scale exercises community based, individual, or facility based; additional exercises; and no documented analysis of the facility response. On 03/06/24 at 11:00 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team, when asked stated "there are exercises". The three EP manuals were present for review. The LNHA was asked to provide the documentation of the exercises, testing, or any drills. The facility failed to provide any additional information. NJAC 8:39-31.6	E 039	" Monthly audits of emergency preparedness drills will be conducted by the Administrator and/or designee to assure drills are performed as required by regulation. 4. How Will These Actions Be Measured: " The results of the monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	
F 000	INITIAL COMMENTS Complaint #s:NJ 152905, 152911, 152910, 154702, 154763, 159453, 159956, 160660, 161569, 165971, 169440 Survey Date: 02/20/24 - 03/06/24 Census: 77 Sample: 18 + 2 = 20 During a Recertification Survey conducted from	F 000		

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	315282	A. BUILDING _____ B. WING _____	C 03/06/2024

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02/20/24 - 03/06/24, it was determined that the Facility was found to be in Immediate Jeopardy (IJ) for F806.

The Facility failed to ensure that a resident, with a documented food allergy to [redacted] was not served eggs on 02/27/24 during the breakfast meal.

A Recertification Survey was conducted at Excel Care at Manalapan from 02/20/24 - 03/06/24 to determine compliance with 42 CFR Part 483, requirements for Long Term Care Facilities.

During the survey a finding which constituted an IJ was identified under 42 CFR 483.60(d)(4) F806 as the facility failed to ensure that a resident, with a documented food allergy to [redacted] was not served [redacted] on [redacted] during the breakfast meal.

Record review revealed that Resident #32 was admitted to the facility in [redacted]. Additionally, he/she had a diagnosis including, but not limited to, [redacted].

Review of the 01/31/24 Quarterly Minimum Data Set (MDS) Assessment revealed the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] indicating his/her cognition was [redacted]. Additional review of the MDS indicated that the resident required supervision with eating.

Record review of the electronic medical record revealed the resident had an allergy to [redacted] and [redacted] products, amongst other food allergies. The surveyor observed the resident eating a [redacted] on [redacted] at 8:32 AM.

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F 000	Continued From page 36 The Administrator was informed of the IJ and was provided with the IJ template on [redacted] at 12:48 PM. An acceptable removal plan was received on 02/28/24 at 2:20 PM indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: 1) assessment and monitoring of the resident for an allergic reaction; 2) a physician order for [redacted] (a medication that treats [redacted] and [redacted] caused by allergic reactions) to be given if the resident had an allergic reaction; and 3) facility education to the nursing and dietary staff regarding meal tray accuracy and delivery including attention to documented allergies. The survey team verified the removal plan on-site on [redacted] and determined the IJ for F806 was removed as of [redacted] at 9:13 AM. F806 continues at a "D" level for no actual Harm with potential for more than minimal Harm that is not Immediate Jeopardy.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each	F 550		4/16/24

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F 550	Continued From page 37 resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and document review, it was determined that the facility failed to ensure residents were treated with dignity and respect by failing to ensure a) resident requests for water were honored, b) meals were served in a dignified homelike manner without the use of NJ EX Order 264b1) consistently	F 550	F550 SS-E 1. Corrective Action: " Upon identification, the Director of Nursing and Administration began facility wide education to facility staff on March 28, 2024, and will be completed by April 16, 2024. Education included: ensuring	

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F 550	Continued From page 38 communicated with residents by their preferred name and not label residents as [redacted], d) staff did not speak in a foreign language in the presence of the residents, e) staff conducted personal phone calls during resident interactions, and f) all residents were provided with privacy curtains. The deficient practice was identified during a resident council meeting held with six residents, and evidenced during a survey conducted from 02/20/24 through 03/06/24, and affected all residents who resided on 2 of 2 resident units. The deficient practice was evidenced by the following: On 02/23/24 at 11:14 AM, the surveyor held a resident council meeting with six residents. The following concerns were expressed: -6 of 6 Residents stated the Certified Nurse Aides (CNAs) were so loud in the hallway, that the residents were awoken to laughing and giggling in the early morning hours and late at night. -3 of 6 Residents stated they waited anywhere from thirty minutes to one hour for the CNAs to respond to the call bells. Two of six residents stated staffing "is terrible 3:00 PM -11:00 PM and 11:00 PM -7:00 PM." -2 of 6 Residents stated they waited thirty minutes to one hour for assistance and sometime longer, one resident stated, "they leave me wet for hours sometimes and [redacted] me, which I don't ask them to." -1 of 6 Residents stated, "my roommate will use the call bell and the CNAs will come in and turn it off without addressing the concern." -1 of 6 Residents stated, they did not have to call for help because they did everything themselves	F 550	residents were treated with dignity and respect, requests for water were respected, meals are served in a dignified homelike manner without the use of [redacted] (as appropriate), communicating with residents by their preferred name, not speaking alternate languages in front of a resident or speaking on a cell phone during resident interactions, maintaining quiet speaking levels, answering call bells in a timely manner. " Maintenance designee will begin audit of resident rooms on March 28, 2024, to assure each bed had a clean cubical curtain and will be completed by April 16, 2024. " On March 25, 2024, unit managers on the 100 and 200 units reviewed resident shower schedules and re-educated CNA□s on the importance of maintaining the consistency of a residents plan of care schedule. " Maintenance Designee audited par levels for cubicle curtains on March 28, 2024. Additional curtains were secured on March 29, 2024, to assure curtains are available when being changed out. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " The Social Service Director and/or designee will conduct weekly audits of five (5) residents on each unit to validate that	

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F 550	Continued From page 39 and stated, "they need to hire more people though." -5 of 6 Residents stated that shower times were not honored, the staff changed the schedule without notification, and "they by pass my showers sometimes, or the aids will ask me if I want to shower at 11:00 PM and that's just too late." -6 of 6 Residents stated that "staff are always talking in different languages around us" and "sometimes they are talking on the phone while taking care of us, staff are always on their phones while working, either talking or texting." Surveyor #5: 1. During the initial tour on 02/20/24 at 9:30 AM, Surveyor #5 observed Resident #1 sitting in the bed. The resident responded to the surveyor's greetings then asked for a drink of water. The surveyor informed the resident to activate the call light. The resident informed the surveyor that there was no call light. The surveyor did not observe a call light attached to the bed or near the resident. The surveyor exited the room and, observed a CNA in the hallway and informed the CNA that the resident requested water. The CNA, in the presence of the resident, stated "It is a NJ EX Order 264b1, [he/she] always asked for water, [he/she] had NJ EX Order 264b1." The surveyor informed [redacted] again that the resident requested water and the CNA repeated, "it is a NJ EX Order 264b1 behavior, [he/she] had NJ EX Order 264b1." The CNA did not, engage the resident, check the cup on the bedside table to ensure there was water in the cup, or provide the resident with a fresh cup of water. The surveyor then asked the CNA to send the nurse into the room. The Director of Nursing (DON) entered the room and the Resident stated	F 550	resident rights are being honored. " The Activity Director and/or designee will continue to facilitate monthly resident council meetings to validate that resident rights are being honored and be able to continue to proactively address resident concerns. " The Maintenance Director and/or Designee will conduct monthly audits of cubicle curtain par levels to assure curtains are available. 4. How Will These Actions Be Measured: " The results of the weekly Social Service, Maintenance audits and resident council meeting findings will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improv2ment Committee Meeting will be held on April 16, 2024.	

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that he/she would like a drink of water. The cup on the bedside table was empty and Resident #1 did not have a water pitcher in the room. The surveyor informed the DON of the observations and the DON stated that he would address the issue.

2. On 02/23/24 at 8:30 AM, the surveyor observed that Resident #1 received their breakfast meal on [redacted] with [redacted].

On 02/26/24 at 12:15 PM, the surveyor observed Resident #1 on the lunch meal on [redacted] with [redacted].

On 02/27/24 at 8:30 AM, the surveyor observed Resident #1 being served the breakfast meal on a [redacted] with a [redacted] and [redacted].

The surveyor escorted the DON to the room and inquired about the rationale for serving the meal with [redacted]. The DON stated that the resident had a behavior of [redacted].

On 02/27/24 at 10:30 AM, the surveyor reviewed Resident #1's Comprehensive Care Plan and could not locate any documentation regarding that the resident was [redacted] and that all meals should be served on [redacted] with [redacted].

On 03/05/24 at 8:30 AM, the surveyor observed Resident #1 eating the breakfast meal on [redacted] and using [redacted]. The surveyor then interviewed the CNA who delivered the meal confirmed that the resident received all

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meals on NJ EX Order: 264b1, she could not provide the date when the order was written. A review of the meal ticket delivered with the tray confirmed that all meals were to be served on NJ EX Order: 264b1 and [redacted].

A review of the Progress notes from [redacted] to [redacted] did not reflect any behavior of destroying dishware as stated by the DON. The progress notes documented that the resident would refuse medications and care. The [redacted] progress notes dated [redacted] documented the following: "[Resident #1] was currently stable on treatment. On evaluation, was calm and cooperative. Has the tendency to be [redacted] at times, but no recent behaviors were reported by the nursing staff."

On 03/06/24 at 8:45 AM, the surveyor observed that Resident #1 received their breakfast meal on a [redacted] with [redacted].

The facility was unable to provide documentation of any behavior which warranted the use of NJ EX Order: 264b1 for the resident.

Surveyor #1:

2. On 02/20/24 at 12:12 PM, the surveyor toured the [redacted] unit during the meal service. The surveyor observed [redacted] residents eating in the small dining room and [redacted] were eating on [redacted] that were rested on the metal warming pellet. The residents were also using NJ EX Order: 264b1 and [redacted] for beverages. The surveyor asked a CNA why residents were using [redacted] and the CNA stated, "infection control." The surveyor proceeded to tour resident rooms on the [redacted] side

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F 550	Continued From page 42 of the [redacted] unit and observed Resident #61, Resident #45, and Resident #49 also eating off of [redacted], beverages were in [redacted] and were using [redacted]. The surveyor asked Resident #45 if they received [redacted] often, and Resident #45 stated, "yes, they always give me [redacted] also." The surveyor observed Resident #36 was being assisted with the meal in the resident's room by a CNA. The resident's meal was also served on [redacted] and was assisted with [redacted]. The surveyor asked the CNA why [redacted] and [redacted] were used. The CNA stated, "no idea, and this was not the first time." On 02/20/24 at 12:24 PM, the surveyor then proceeded toward the low side of the [redacted] unit and observed the meals served on [redacted] and [redacted] on the resident meal trays. The surveyor asked another CNA why the [redacted] were being used and the CNA stated, "probably not enough plates". The surveyor observed an unsampled resident in Room [redacted] eating the meal off of a paper plate and using [redacted] and a [redacted] for the beverage. On 02/20/24 at 12:42 PM, the surveyor entered the kitchen and interviewed the Food Service Director (FSD) regarding the resident meals served on [redacted] The FSD stated, "we ran out of plates." The surveyor asked how long and the FSD stated "maybe a week". The surveyor asked the FSD if it was acceptable to serve resident meals on [redacted] and he stated, "no, it is not". Surveyor #1 then asked why the residents were eating with [redacted] and the FSD stated, "same thing, short."	F 550		

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On 02/21/24 at 11:57 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and asked if it was dignified to have residents eat from [redacted] and use [redacted]. The LNHA stated it [redacted] plastic utensils. Surveyor #1 asked the LNHA why that was, and he stated "not as homelike."

On 02/22/24 at 8:11 AM, the surveyor observed the breakfast meal cart brought to the [redacted] unit, and staff pulled out a meal tray from the meal cart in front of room [redacted], and began loudly speaking to another staff member in a [foreign language]. The staff member was across the hall by the other resident rooms. The surveyor asked the staff about the observation and the staff stated, "I was talking to her in a [foreign language]", and stated it was the Activity Director (AD). The staff that she was speaking to stated, "we talk often in [a foreign language]." The surveyor interviewed the AD who stated that she needed to speak to the housekeeper in a [foreign language] and was aware they should not speak in another language.

On 02/22/24 at 8:17 AM, during the same observation, the surveyor heard staff referring to a resident while outside of Room [redacted] as a [redacted]", then entered Room [redacted] with another staff. The Licensed Practical Nurse, Unit Manager (LPNUM) was at the meal cart at the time and the surveyor asked her what a '[redacted] was. The LPNUM stated it was "people that needed help" [to eat the meal]. The surveyor asked was [redacted]" a usual term that was used and the LPNUM stated, "yes". The surveyor asked the LPNUM if she was ever trained to not use that term and she stated, "no". The LPNUM then asked the surveyor what the appropriate

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term was that she should use.

On 02/22/24 at 8:39 AM, the surveyor observed a male CNA distribute multiple meal trays on the high side of the [redacted] unit, including to Room [redacted] A female CNA then pointed to meal trays, and identified several residents by saying this one is a "a f[redacted], and that one is a [redacted] to the male CNA. Other residents were in close proximity in the small dining room awaiting the meal distribution.

On 02/22/24 at 9:38 AM, the surveyor interviewed the Registered Nurse Unit Manager Staff Educator (RNUM) and asked about any education provided to staff regarding dignity. The RNUM stated that was completed by social services. The surveyor asked the RNUM if a resident could be called a feeder. The RNUM stated, "we don't use [redacted] it is rude". The RNUM then stated, "that is a big one, that is old, no one is supposed to be using that anywhere, it is a dignity issue."

On 02/22/24 at 9:42 AM, the surveyor asked the RNUM if staff could speak a foreign language in the presence of the residents. The RNUM stated, "no", that is dignity as well." "They [the residents] need to know what is being said in their home."

On 02/22/24 at 10:38 AM, the surveyor interviewed the DON who stated he has worked at the facility for four months. The surveyor asked the DON if the staff could a speak foreign languages around the residents, and identify and point at residents then identify them as [redacted] The DON stated, they are "not supposed to do that, or speaking a foreign language". The DON then stated, [redacted], that is not supposed to be

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used at all, that is a dignity issue." The DON stated, it was "not okay to point, not good."

On 02/23/24 at 11:39 AM, Surveyors #1 and #5 were in the main hallway between the activity room and the dining room and observed a staff in a lab coat pushing Resident #79 in the wheelchair with his right hand, was holding a cellular phone in his left hand and conducted a phone call on speaker while he pushed the resident into the dining room. Surveyor #1 interviewed then the staff who identified himself as Registered Nurse (RN). The surveyor asked him if he typically conducted a phone call on speaker phone while he wheeled a resident with the other hand. The RN stated, "no, that is not normal behavior, I was on my break" and stated Resident #79 needed to be watched.

On 02/26/24 at 10:02 AM, the surveyor interviewed the DON regarding if was acceptable for staff to take a personal phone call while caring for residents. The DON stated," no, it is not acceptable, everyone was trained on that."

On 03/01/24 at 11:06 AM, the surveyor entered the activity room while residents were at the main table, coloring and watching television. At the same table the with the residents, an activity staff (AS) was talking on a cellular phone. The AS hung up the phone and the surveyor asked if she should be on the phone while she is with the residents in an activity. The AS stated, "It was my heart doctor."

Surveyor #3:

On 02/20/24 at 11:09 AM, during environmental rounds of the Uni the surveyor observed

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privacy curtains were missing for both window and door bed (Resident #59 and Resident #335).

On 02/22/24 at 9:41 AM, the surveyor interviewed the Registered Nurse Unit Manager (RN UM) who stated that the purpose of curtains in a resident's room was to provide privacy. She further stated that all residents should have a curtain to provide privacy and for dignity. If a curtain was missing, then the maintenance should be notified, and a new curtain be replaced.

On 02/22/24 at 11:00 AM, the surveyor observed the privacy curtains were still missing from both residents' beds. At that time, the maintenance technician (MT) was observed replacing the curtains on window bed. Resident #59 was not in the bed and Resident #335 was observed lying in his/her bed. The surveyor interviewed the MT who stated that he was not sure how long the privacy curtains had been missing but he was just putting them back up now. The MT further stated that the curtains were sent out to a private company to be cleaned and the facility did not have on site laundry services.

On 02/22/24 at 11:04 AM, the surveyor interviewed the Director of Maintenance (DM) who stated that the privacy curtains were taken down a couple days ago because they were stained and were sent out to a private company to be cleaned. The DM further stated "I did not have any backup curtains to put up when these curtains were sent out to be cleaned. We need to put an order in to get more curtains."

On 02/22/24 at 11;23 AM, the surveyor interviewed the CNA who was assigned to both Resident #59 and #335. He stated that Resident

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#59 needed NJ EX Order. 264b1 with all activities of daily living (ADLs) and transferred to a wheelchair with [redacted] assistance. Resident # 335 needed [redacted] assistance with ADLs and could ambulate to the bathroom with supervision. The CNA stated that "I think the curtains were missing for about 2 days. It is important for residents to have curtains for their privacy."

A review of the electronic medical record (EMR) revealed that Resident #335 was admitted with diagnoses including but not limited to NJ EX Order. 264b1 [redacted] The Quarterly Minimum Data Set (MDS), as assessment tool, dated [redacted] reflected that Resident #335 had NJ EX Order. 264b1 NJ EX Order. 264b1 [redacted] assistance with ADLs and could ambulate 10 feet in the room with supervision.

A review of the electronic medical record (EMR) revealed that Resident #59 was admitted with diagnoses including but not limited to [redacted] The Annual Minimum Data Set (MDS), as assessment tool, dated [redacted] reflected that Resident #59 had NJ EX Order. 264b1 [redacted], [redacted] assistance with ADLs and [redacted] assistance for transfers.

A review of the facility policy titled, "Dignity", Revised February 2021 revealed a Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feeling of self-worth and self-esteem.
1. Residents are treated with dignity and respect at all times.
2. The facility culture supports dignity and respect

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F 550	Continued From page 48 for residents by honoring resident goals, choices, preferences, values, and beliefs. This begins with the initial admission and continues throughout the resident's facility stay. 5. When assisting with care, residents are supported in exercising their rights. For example, residents are c. provided with a dignified dining experience. 6. Speak respectfully to residents at all times, including addressing the by his or her name of choice and not "labeling" or referring to the resident by his or her room number, diagnosis, or care needs. 12. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents. 13. Staff are expected to treat cognitively impaired residents with dignity and sensitivity. A review of the policy titled, "Resident Rights"last revised February 2011, indicated the following: Employees shall treat all residents with kindness, respect and dignity. The resident shall exercise his or her rights as a resident of the facility and as a citizen of the Unites States. Be supported by the facility in exercising his or her rights. When assisting with care, residents are supported in exercising their rights. For example, residents are provided with a dignified dining experience. NJAC 8:39-4.1(a) 12	F 550		
F 565 SS=F	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize	F 565		4/16/24

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F 565	Continued From page 49 and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Complaint #s NJ 152910, 152911, 159956 Based on observation, interview and document review, it was determined that the facility failed to	F 565	F565 SS-F (cross walked to 567F and 568F) 1. Corrective Action: " Upon identification, the Director of	

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F 565	Continued From page 50 ensure that all residents were treated with respect and dignity by ensuring the facility acted promptly to respond to ongoing residents grievances affecting quality of life by failing to consistently and uniformly address grievances regarding: a) ensuring residents had consistent access to their personal needs account funds (PNA), b) food complaints identified on 02/28/2022 when the resident council was alerted to the menu being changed to "kosher style", and c) the menu not being posted, not having access to menus to select meal choices and the repetitiveness of the menu. This deficient practice was identified by 6 of 6 residents who attended a resident council meeting and affected all residents who resided on 2 of 2 units. The deficient practice was evidenced by the following: Refer to: 567F and 568F On 02/20/24 at 9:41 AM, during the initial tour of the kitchen with the Food Service Director (FSD), the surveyor asked if the kitchen was a kosher kitchen and the FSD stated it was "kosher style". On 02/20/24 at 12:07 PM, during the tour of the facility, the surveyor observed a large bulletin board affixed to the wall and labeled, "Daily Menu", with five empty slots. The board was in the central area of the [redacted] unit. The surveyor observed a Licensed Practical Nurse (LPN) and asked where the menu would be posted. The LPN stated the menu was not posted. On 02/20/24 at 1:30 PM, the surveyor received the 81-page facility "Admission Agreement" provided by the Licensed Nursing Home	F 565	Social Service began facility wide education to facility staff on March 28, 2024. Education included: the importance of responding to resident grievance quickly, the facility policy and process on PNA access and meal preferences of residents. " On March 26, 2024, the Administrator facilitated a food committee meeting with the residents to address meal preferences, kosher style dining, access to menus and where they are posted. " On March 26, 2024, the dietary director was educated on the importance of assuring the daily menus are posted timely. " On March 25, 2024, the Administrator and Human Resources Director reviewed the PNA process and policy to assure that it promotes resident access to PNA as directed by regulation. " On March 27, 2024, the dietitian re-reviewed the 4-week menu cycle to re-confirm that the menu met the regulatory requirements. " The Administrator was educated on March 18, 2024, related to the importance of resident rights, and timely follow up to the residents. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " The Social Service Director and/or designee will conduct weekly audits of five	

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F 565	Continued From page 51 Administrator (LNHA) as part of the entrance documents. A review of the document revealed 3. Services Provided: a. Services Included in the Daily Basic Rate. The facility agrees to provide the following basic services, all of which are included in the daily basic rate: (i) Board, including food and drink that is palatable, attractive, and at a safe and appetizing temperature, drinks consistent with Resident needs and preferences and in quantities sufficient to maintain Resident hydration, therapeutic or modified diets, as prescribed by a physician or other licensed health professional, and menus meeting the nutritional needs of Residents in accordance with established national guidelines, taking into account religious, cultural, and ethnic needs of the Resident groups, that accommodates Resident allergies, intolerance's, and preferences. Food shall be stored, prepared, distributed, and served in accordance with professional standards for food service safety. (The "kosher style" menu was not included as part of the Admission Agreement) On 02/21/24 at 11:17 AM, the LNHA provided the surveyor with a copy of the current four-week menu cycle. Upon review, the surveyor observed that the breakfast meals listed only "Vegetarian Sausage Links" as a breakfast item three times per week, no pork products were listed on the menu and chicken was listed as a lunch entrée on 21 of 28 days and fish as a dinner entree 23 out of 28 days. On 02/23/24 at 6:36 AM, the surveyor again toured the kitchen, and the breakfast meal was in progress. The surveyor interviewed the Cook regarding what the "kosher style" menu was. The cook stated, "we don't have pork, meat and dairy	F 565	(5) residents on each unit to validate that resident rights are being honored. " The Activity Director and/or designee will continue to facilitate monthly resident council meetings to validate that resident rights are being honored and be able to continue to proactively address resident concerns with timely feedback to the residents post resident council. 4. How Will These Actions Be Measured: " The results of the monthly Social Service audits and resident council meetings will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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together and no meat for breakfast." The Cook stated the kosher style menu started about 1-1/2 years ago and it changed with the new owners that wanted that kind of menu. The cook stated, "we used to have bacon and sausage all of the time and now we don't have it." The surveyor asked about the chicken that was observed in the walk-in refrigerator. The cook stated, there is "quite a lot of chicken on the menu".

On 02/23/24 at 6:43 AM, the FSD entered the kitchen, and at 6:48 AM, the surveyor asked the FSD if he created the menus and he stated that they came from a company. The surveyor asked the FSD to explain what a "kosher style" menu was. The FSD stated, "it is kosher style, and he was not sure why it was changed". The surveyor asked the FSD if he met with the residents regarding the menu. The FSD stated he attended a "Food Forum" meeting at the resident council. The surveyor asked the FSD to provide any meeting minutes or documentation regarding what was discussed at the meeting. The FSD stated he had none to provide. The surveyor asked the FSD if he was provided with anything in writing, including meeting minutes that he had to respond to or change regarding resident menu concerns. He stated, "I'm not handed anything" regarding meeting minutes.

On 02/23/24 at 11:14 AM, a surveyor conducted a resident council meeting with 6 residents. All 6 of 6 residents stated that they were made aware that the meals are from a kosher style kitchen, and they do not have any pork products. The resident's confirmed that they used to get pork products but only get vegetable sausage now. All six residents confirmed that they have asked for pork products before, and the facility told them it

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is a "kosher style" kitchen, and they only serve chicken and fish mostly. One resident stated they would only get chicken and they don't ask for pork products because they won't get them, and all 6 of 6 residents confirmed that menus have not been provided to review or make selections.

The surveyor asked the residents about their PNA account and 6 of 6 residents stated they were not able to access their PNA when they want. All six residents confirmed they were only allowed to remove $ 25.00 at a time. Resident #10 stated "they always say they have to go to the bank for it, and the money goes to fast." The resident also stated that you "can't get it when you want it or need it, they say they have to get someone to go to the bank to get the cash, and the person responsible doesn't drive." Resident #25 stated, "I can't get my money right away, I also have to wait like everyone else". Resident #18 stated, "when I say I need money, they say we don't have it or some lame [exploitive redacted] excuse that they can't. Main excuse they use is that they are too busy". Resident #30 stated, "they still owe me $ 25.00; I've been to [Human Resources Director's] office seven times and she told me yesterday she would bring it to me and still haven't seen it. I will be going to her office today." Resident #17 stated, "I never receive my money on time either and they only give $25 at a time." Resident #49 stated, "when I first came here in [date redacted] I asked for money, and they told me no. I used to have it in [Facility Name Redacted] and they would give me $50.00 every month. When I went, they said I don't have an account. I have not received any money since I've been here". An unidentified resident stated, there was no receipt provided when getting any money and only $25.00 increments allowed at a time.

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The LNHA provided the surveyor with the following Resident Council Meeting Minutes which revealed:

-02/28/22; 20 Residents in attendance. Dietary: New Business: "[Staff name redacted] met with residents to explain the new kosher style menu and to give them copies of the week's rotation. Residents voiced their concerns with the new diet and many of the substitutes. [Resident name redacted] stated that most residents don't want kosher and that [redacted] is speaking for them [redacted] The other residents present did not confirm this. "[Staff name redacted] said she would ask about the possibilities of substitutes and get back to them. They came back and said she was told she may give milk at the evening meals but that she could not do anything about pork or bacon. The residents voiced having the option of switching lunch to meat and dinner to dairy." Administrator: "Our new Administrator introduced himself and took questions mostly concerning the new menu. He left to inquire to the owners about their concerns. He came back shortly after to tell the council that they will make any allowances they require such as milk in the evenings and cheese for hamburgers. The Administrator confirmed that if the general consensus of the residents was to switch the menu, we most definitely can. We agreed to convene next meeting to go over any concerns."

-There were no Resident Council minutes provided for a [redacted] meeting, and no follow- up regarding reconvening with the Administrator to review concerns regarding the menu.

-[redacted]; 17 Residents in attendance.

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F 565	Continued From page 55 Dietary: Past Issues: Residents are happy with meat served at the midday meal (No response included regarding the concerns about the menu change to a kosher style menu). [redacted] 19 Residents in attendance. Past Issues: Residents would still like a menu posted somewhere. Response: [New Food Service Director] will post them on the wall to the right as everyone enters the dining room ...Residents are reminded that if they would prefer they can order from the always menu: chicken, hot dogs, burgers and grilled cheese. (No response included regarding the concerns about the menu change to a kosher style menu, or posting the menu). [redacted];19 Residents in attendance. Dietary: New Business: Food Committee meeting to review the menu just prior to this meeting. Residents state they love the new spring/summer menu that just started on June 19th. (No Food committee meeting minutes attached, and no response included regarding the concerns about the menu change to a kosher style menu or posting the menu). -There were no Resident Council minutes provided for a [redacted] meeting, (No response included regarding the concerns about the menu change to a kosher style menu or posting the menu). -[redacted]; 20 Residents in attendance. Dietary: Past Issues: No past issues mentioned. (No response included regarding the concerns about the menu change to a kosher style menu or	F 565		

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posting the menu.)
New Business: Food committee meeting prior to this meeting. Resident stated too much chicken is on the menu and the Food Service Director agreed and will make changes.

- [redacted] 13 Residents in attendance.
Past Issues: Residents are requesting a daily menu so they can choose what they would like to eat. (This is a repeat concern, there was no follow-up to the Food Service Director confirming there was too much chicken on the menu and no response included regarding the concerns about the menu change to a kosher style menu or posting the menu.)

[redacted] 12 Residents in attendance.
Dietary: Past Issues: Resolved (No responses provided regarding the menu changed to kosher style, too much chicken on the menu, and not being provided with a menu.)
New Business: Dietary Director has left, will have Food Forum when a new director is hired
...Residents are requesting daily menus (Repeat concern without resolution). Residents would like to be aware of other alternatives they may choose from.

- [redacted]; 7 Residents in attendance.
Dietary: Past Issues: Residents would like weekly menus delivered to them. (No responses provided regarding the menu changed to kosher style, too much chicken on the menu, and not being provided with a menu.)
New Business: New Dining Director was introduced. Residents asked about a breakfast meat and Dining Director told them they can do turkey bacon or sausage. Residents would like to be aware of other alternatives they may choose

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from (Repeat concern without resolution).

[redacted]; 6 Residents in attendance.
Dietary: Past Issues: Residents requesting winter menu. (No responses provided regarding the menu changed to kosher style, too much chicken on the menu, and not being provided with a menu.)
New Business: New Dining Director was introduced. Residents asked about a breakfast meat and Dining Director told them they can do turkey bacon or sausage. Residents would like to be aware of other alternatives they may choose from. (Repeat concern without resolution).

[redacted]; 11 Residents in attendance.
Dietary: [left blank]
Past Issues: Winter menu still not finalized. (No responses provided regarding the menu changed to kosher style, too much chicken on the menu, and not being provided with a menu or the winter menu).
[redacted]; 9 Residents in attendance.
Dietary: They are waiting too long for missing items.

[redacted]; 13 Residents in attendance.
Concerns:
Dietary: better. (No specific follow up and no responses provided regarding the menu changed to kosher style, too much chicken on the menu, and not being provided with a menu or winter menu).
Administration: There is a need for PNA (personal needs account) money to be available on weekends.

[redacted]; 10 Residents in attendance.
Dietary: Resident would like sausage and bacon

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added to the menu for breakfast. (No specific follow up and no responses provided regarding the menu changed to kosher style, too much chicken on the menu, and not being provided with a menu or winter menu).

Administration: Not listed and there was no follow-up regarding the concern regarding PNA money not being available on the weekends.

[redacted] 6 Residents in attendance.
Activities: Resident requesting trip to a restaurant. Also want to make sure they receive money before going.

Dietary: Coffee is sometimes not hot enough. Patient requesting for variety other than fish or chicken (no resolution-repeat complaint nine months prior). Residents are requesting turkey burgers, meatloaf, stuffed peppers, corn beef, pepper steak, turkey legs and bologna. (No specific follow up and no responses provided regarding the menu changed to kosher style, too much chicken on the menu, and not being provided with a menu or winter menu)

[redacted]; 8 Residents in attendance.

Dietary: No Concerns:
(No follow up for cold coffee. No follow up for requests for variety other than fish or chicken and other requested items that included turkey burgers, meatloaf, stuffed peppers, corn beef, pepper steak, turkey legs and bologna. There was no follow up and no responses provided regarding the menu changed to kosher style, too much chicken on the menu, [Repeat Complaint] and not being provided with a menu or winter menu).

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F 565	Continued From page 59 Administration: No follow-up regarding the concern regarding PNA money not being available on the weekends. Residents were informed that we are in the process of switching to a new company with the goal of improving our service. [redacted]; 6 Residents in attendance. Dietary: Notes of Resident preferences were recorded by Dietary Director. Residents liked the summer menu. (No follow up for cold coffee. No follow up for requests for variety other than fish or chicken and other requested items that included turkey burgers, meatloaf, stuffed peppers, corn beef, pepper steak, turkey legs and bologna. There was no follow up and no responses provided regarding the menu changed to kosher style, too much chicken on the menu, [Repeat Complaint] and not being provided with a menu or winter menu). No follow-up regarding the concern regarding PNA money not being available on the weekends. [redacted]; 10 residents in attendance. Dietary: Food is cold sometimes. Food forum was held, and resident's preferences will be honored. (No follow up for cold coffee. No follow up for requests for variety other than fish or chicken and other requested items that included turkey burgers, meatloaf, stuffed peppers, corn beef, pepper steak, turkey legs and bologna. There was no follow up and no responses provided regarding the menu changed to kosher style, too much chicken on the menu, [Repeat Complaint] and not being provided with a menu or winter menu).	F 565		

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No follow-up regarding the concern regarding PNA money not being available on the weekends.

[redacted] 11 Residents listed in attendance.
Dietary:
Concerns:
No concerns, Food forum was held and resident's preferences will be honored.
(No follow up for cold coffee and food. No follow up for requests for variety other than fish or chicken and other requested items that included turkey burgers, meatloaf, stuffed peppers, corn beef, pepper steak, turkey legs and bologna. There was no follow up and no responses provided regarding the menu changed to kosher style, too much chicken on the menu, [Repeat Complaint] and not being provided with a menu or winter menu).

No follow-up regarding the concern regarding PNA money not being available on the weekends.

-[redacted]; 20 Residents listed in attendance.
Dietary:
Concerns: Food forum was held and resident preferences made, new food company has been contracted to improved food quality. Response: Residents are looking forward to new recipes and new culinary experiences. (No follow up for cold coffee and food. No follow up for requests for variety other than fish or chicken (and other requested items that included turkey burgers, meatloaf, stuffed peppers, corn beef, pepper steak, turkey legs and bologna. There was no follow up and no responses provided regarding the menu changed to kosher style, too much chicken on the menu, [Repeat Complaint] and not being provided with a menu or winter

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F 565	Continued From page 61 menu). (No follow up for cold coffee and food. No follow up for requests for variety other than fish or chicken and other requested items that included turkey burgers, meatloaf, stuffed peppers, corn beef, pepper steak, turkey legs and bologna. There was no follow up and no responses provided regarding the menu changed to kosher style, too much chicken on the menu, [Repeat Complaint] and not being provided with a menu or winter menu). [redacted]; 16 Residents listed in attendance. Dietary: Resident chose the menu for the holidays, went over new items in the menu and requested their preferences. (No follow up for cold coffee and food. No follow up for requests for variety other than fish or chicken and other requested items that included turkey burgers, meatloaf, stuffed peppers, corn beef, pepper steak, turkey legs and bologna. There was no follow up and no responses provided regarding the menu changed to kosher style, too much chicken on the menu and not being provided with a menu or winter menu). No follow-up regarding the concern regarding PNA money not being available on the weekends. [redacted] 15 Residents listed in attendance. Dietary: No issues, food has improved, residents shared their preferences, and there are no complaints. (No follow up for cold coffee and food. No follow up for requests for variety other	F 565		

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than fish or chicken and other requested items that included turkey burgers, meatloaf, stuffed peppers, corn beef, pepper steak, turkey legs and bologna. There was no follow up and no responses provided regarding the menu changed to kosher style, too much chicken [identified 16 months prior] on the menu, and not receiving a menu.)

No follow-up regarding the concern regarding PNA money not being available on the weekends.

[redacted]; 14 Residents listed in attendance.

Dietary:
...occasionally food is not warm enough ...(No follow up for cold coffee and food [repeat complaint] No follow up for requests for variety other than fish or chicken and other requested items that included turkey burgers, meatloaf, stuffed peppers, corn beef, pepper steak, turkey legs and bologna. There was no follow up and no responses provided regarding the menu changed to kosher style, too much chicken on the menu, and not receiving a menu.)

No follow-up regarding the concern regarding PNA money not being available on the weekends.

On 02/26/24 at 1:09 PM, interviewed the Food Service Director (FSD) regarding the facility menu development. The FSD stated he is not responsible with the menu development; a company provides the menu. I asked the FSD who signs off on the menu to ensure it meets the residents needs and is nutritionally adequate and he stated, "I am not sure". I asked the FSD to elaborate on the kosher style menu, and he stated it started about two years ago, "I am not

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sure, and I don't know why". The FSD stated, "it wasn't always kosher".

On 02/26/24 at 1:26 PM, the surveyor interviewed the LNHA about facility policies and procedures. The LNHA stated they are reviewed on an annual basis. The surveyor asked the administrator when the menu was changed to kosher style and he stated, " I believe it was changed a few months ago, I don't know exactly when it was changed". The surveyor asked the LNHA regarding the company who was responsible for the menu development per the FSD. The LNHA stated he was not sure if the contract for the menu company was still in effect.

On 02/29/24 at 9:51 AM, the surveyor interviewed, in the presence of the surveyor team, the Registered Dietitian Vice President (VPRD) Of Clinical Services for the Consultant Dietitian Company. The VPRD stated she was responsible for the clinical nutrition for the residents. The surveyor asked what her menu functions were and she stated we don't create the menu, and we don't do menu development, but we review it. She stated, "I look to make sure there is a variety" and to make sure there is different fruits and vegetables and entrees. Asked the VPRD to provide information regarding if chicken should be served 7 days per week. The surveyor asked if she attended resident council and she said the FSD will attend and and if there are concerns that are brought up in resident council we can make adjustments to the menu. The surveyor asked about the menu and she stated it was a kosher style menu. The surveyor asked about the kosher style menu and the VPRD stated it does not have meat served with dairy and they don't serve pork or shellfish. The

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surveyor asked if the residents were notified if the menu was changed to kosher style. The VPRD stated, "I believe normally, they do notify the residents if they implement a kosher style menu". The surveyor asked if the menus should be posted for the residents and the VPRD stated, "yes, for the residents".

On 02/29/24 at 10:29 AM, the surveyor conducted an interview with Resident #18, who served in the role as the Resident Council President (RCP). The surveyor asked the RCP how the meals were, and the RCP stated the "quality went down". The surveyor asked about receiving pork breakfast meats. The RCP stated, "we don't get it anymore, we don't get any bacon". The RCP stated we get vegetable sausage and it [exploitive redacted]. The RCP stated that grits used to be on the menu also, and they no longer provide them. The surveyor asked the RCP if the facility provided anything in writing when the menu was changed to no longer include pork products, and the RCP stated, "no". The surveyor asked the RCP if the council decided to not allow any residents to take out $25.00 at a time from their PNA. The RCP stated, "no, we never decided on only $25.00, no, that was not our decision, not ever!". The RCP stated even when he/she was not the RCP, that he/she still attended the Resident Council and stated, "we want all our money." Asked if all the money was available, "no, we cannot get it, maybe $15.00 or $25.00 at a time". The surveyor asked if a receipt was provided when a transaction was made. The RCP stated, "no, never, we barely get the money, and if you don't get the money and the Human Resources Director (HRD) goes home, you are [exploitive redacted] out of luck!" The RCP stated, "they don't have money on the weekends, they

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used to have money". The RCP stated, "there is no money on the weekends, none, nada, zilch ever". The RCP stated that the HRD sometimes doesn't have money during the week either. The surveyor asked if the LNHA ever conducted a meeting with the residents regarding the changes to the menus. The RCP stated, "he comes, stands there for like five minutes and leaves" and stated, "no" we never had a meeting. The surveyor asked the RCP if a menu was provided to make selections and the RCP stated, "we would have to ask for it", it is not distributed and "it should be left at the nurses station".

On 02/29/24 at 1:27 PM, the surveyor conducted a follow up interview with the VPRD. The VPRD stated there is no "kosher policy" and stated residents could request anything. The surveyor asked is that including pork and bacon, and she stated she cannot speak to that. The VPRD did not provide any information regarding why there is chicken often 7 days per week on the menu.

On 02/29/24 at 1:41 PM, the surveyor interviewed the LNHA and DON, in the presence of the survey team. The surveyor asked if bacon was provided to the residents, and the LNHA stated "only if a resident asks they can provide bacon". The surveyor asked about the "admission agreement", not specifying a kosher style menu. The LNHA stated, a resident can ask and there are "no, non-kosher items on the menu." The surveyor asked, are there any pork products in the kitchen and the LNHA stated, "no".

On 03/01/24 10:00 AM, the LNHA, in the presence of the survey team, provided the surveyor with the Resident Council minutes from [redacted] and stated that in the minutes it was

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documented that if the general consensus was to switch the menu, we most definitely can. The LNHA also provided five random food receipts for unidentified bacon and stated that the bacon was for people who requested it. The LNHA did not provide any documented evidence that the concerns were addressed with the resident council.

On 03/01/24 10:52 AM, the surveyor observed an "Always Available Menu" posted on a bulleting board on the 200's unit. The Menu "Please notify our dietary food service department if you prefer and of the alternate options below. Included for Breakfast- French Toast, Scrambled Eggs, Hard Boiled Egg, Assorted Cold Cereal, Hot Cereal of the Day; Bacon, sausage, or any alternate breakfast meats were not listed, and were not listed for Lunch or Dinner.

On 03/01/24 at 10:56 AM, the surveyor interviewed the Social Worker (SW) regarding the grievance process. The SW stated if she received the grievance, she would fill out a grievance form and then provide it to the department head and notify the staff. The surveyor asked about grievances at resident council. The SW stated she would sit in on "Food Forum", it would be when the residents in attendance would discuss their food preferences, and the Activity Director handled that process.

On 03/01/24 at 11:30 AM, the surveyor interviewed the AD about the "Food Forum". The AD stated that would be held right before resident council and conducted by the FSD. The surveyor asked if she would receive a copy of the minutes from the "Food Forum". The AD stated, "no" it was a "note thing" and the FSD would review the

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always available menu. The surveyor asked the AD if the residents brought up that they wanted pork breakfast meats. The AD stated the FSD told the residents they could have turkey sausage. The surveyor asked the AD if the FSD had ever informed the residents that they could select pork bacon and the AD stated, "no" the FSD would tell the residents that they could request turkey bacon. The AD confirmed that there were no documented minutes for the "Food Forum".

On 03/05/24 at 11:10 AM, the surveyor interviewed the LNHA in the presence of the survey team. The surveyor asked if the LNHA documented responses regarding resident grievances. The LNHA stated he did not document responses to resident grievances and that would be the social worker's responsibility.

On 03/05/24 at 1:35 PM, the survey team conducted a pre-exit conference with the Director of Nursing (DON) and LNHA. The surveyor reviewed the above concerns.

On 03/06/24 at 11:55 AM, the LNHA, provided the surveyor with a Resident Council Concern Form dated [redacted]. "Concern" was crossed out and listed was proposing plant-based sausage, cheese blend souffle, residents expressed personal preferences, introducing turkey pastrami, kielbasa, turkey burgers and soup will be added, brisket, tortellini Alfredo. Another form was dated [redacted] and was for a specific resident for coffee all meals and another resident would like bacon (type not indicated), Resolution: Resident would receive coffee all meals and other resident would start receiving (unidentified) bacon for breakfast. The LNHA did not provide any

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F 565	Continued From page 68 information regarding responding to the documented resident council concerns. There LNHA provided eight pages of a handwritten documents titled "Daily PNA Disbursements" with handwritten resident names and 16 highlighted names/dates that the LHNA stated were weekends. The highlighted amounts revealed, $1.00- $25.00 amounts and 1 of 16 named had a documented $50.00 amount. No additional information was provided. Review of the "Resident Rights" policy Revised February 2021, revealed Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: u. voice grievances to the facility ... v. have the facility respond to his or her grievances ... NJAC 8:39-4.1(a)(8)(9)(10)(33)	F 565		
F 567 SS=F	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section.	F 567		4/16/24

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F 567	Continued From page 69 (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on interview and document review it was determined that the facility failed to ensure that a system was in place for residents to receive their Personal Need Account (PNA) funds without restrictions, ensure that the residents had access to at least $50.00 which would be provided the same day it was requested, and ensure a system was in place which included receipts provided to residents to confirm disbursement. The deficient practice effected all residents who maintained PNA funds who resided in the facility. The deficient practice was evidenced by the following:	F 567	F567 SS-F (Cross walk to F565F) 1. Corrective Action: " On March 28, 2024, a review of the current PNA balance for both current and expired residents was performed to assess their current balances by the human resources designee. " On March 28, 2024, the Facility Administrator and Human Resources Director a reviewed the current PNA policy, process and procedure and updated the system to assure that residents have access to their requested	

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F 567	Continued From page 70 Refer to 565F On 02/21/24 at 8:50 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with the requested list of current PNA balances and stated that the Human Resources Director (HRD) was responsible for the PNA accounts. The list included 94 accounts and listed 6 residents with a "Current Balance" more than $50.00 who were listed as "Expired [deceased]" under Status. On 02/22/24 at 1:22 PM, the surveyor interviewed the HRD who confirmed that she handled the PNA money for the resident's accounts "during the week". She clarified and stated, during the week, the residents will come find her and on the weekends the residents would obtain money from the activity staff. She stated that if the resident's requested large amounts that the resident's would give her notice. The surveyor asked why there were expired residents with PNA balances which included Resident #237 who expired [redacted] and had a balance of [redacted] and Resident # 236 who expired on [redacted] and had a balance of $[redacted]. The HRD stated she did not know about the people who were expired, and she did not close the account. The HRD stated a remote business office handled the accounts and they were in [another state]. The surveyor asked the HRD if statements were provided to the residents for their PNA accounts. The HRS stated that she printed and mailed out statements. The surveyor asked if she had a type of form, or document that she sent to the residents. She stated no, and could not provide proof that statements were sent to the residents and she did not document when statements were mailed out. The surveyor asked the HRD if she opened PNA	F 567	PNA funds 7 days per week and that PNA funds of residents that are expired have their PNA funds refunded by regulatory requirements. " On February 26, 2024, the process was begun to refund expired resident□s PNA funds based on regulatory requirements. Refunds will be completed upon receiving a response from Medicaid as to the financial breakdown to be returned. " On March 25, 2024, The Activity Director, Activity Staff, Human Resources Director was educated on the facility PNA process and policy. " On March 26, 2024, a resident council meeting was held to inform residents of the facility PNA policy and process for requesting funds on the weekdays and weekends and re-enforced that, with proper notification (for larger amounts of money) the facility does not have a limit to the amount of funds that can be withdrawn. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents who maintain PNA funds at the facility have the potential to be affected by this deficient practice. 3. Measures Put into Place: " Weekly audits of the PNA request log will be completed by the Human Resources Director and/or designee for one month and monthly thereafter to assure residents have timely access to their PNA funds.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT MANALAPAN	104 PENSION ROAD MANALAPAN, NJ 07726

(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 567	Continued From page 71 accounts and she stated, she did not open, or close accounts and she would reach out to the remote business office about the closed accounts. On 02/23/24 at 11:14 AM, a resident council meeting was held with 6 residents (Resident #10, #17, #18, #25, #30, #49) who all confirmed that they are not able to access their PNA money when they want it. The surveyor asked the residents about their PNA account and 6 of 6 residents stated they were not able to access their PNA when they want. All six residents confirmed they were only allowed to remove $ 25.00 at a time. A resident stated, "they only allow you to pull out $ 25.00 at a time and they always say they have to go to the bank for it, and the money goes to fast", the resident also stated that you "can't get it when you want it or need it, they say they have to get someone to go to the bank to get the cash, and the person responsible doesn't drive." Another resident stated, "I can't get my money right away, I also have to wait like everyone else". Another resident stated, "when I say I need money, they say we don't have it or some lame [exploitive redacted] excuse that they can't. Main excuse they use is that they are too busy". Another resident stated, "they still owe me $ 25.00; I've been to [Human Resources Director's] office seven times and she told me yesterday she would bring it to me and still haven't seen it. I will be going to her office today." Another resident stated, "I never receive my money on time either and they only give $25 at a time." The resident continued and stated, "when I first came here in [date redacted] I asked for money, and they told me no. I used to have it in [Facility Name Redacted] and they would give	F 567	" Monthly audits of the PNA fund report will be facilitated by the Administrator and/or designee to assure expired resident PNA funds are refunded according to regulatory requirements. " The Activity Director and/or designee will continue to facilitate monthly resident council meetings to follow up on any resident feedback related to PNA access and be able to continue to proactively address resident concerns. 4. How Will These Actions Be Measured: " The results of the weekly and monthly Human Resource, Administrator audits and resident council meetings will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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me $50.00 every month. When I went, they said I don't have an account. I have not received any money since I've been here". Another resident stated, there was no receipt provided when getting any money and again confirmed only $25.00 increments were allowed at a time.

A review of Resident Council minutes provided by the Licensed Nursing Home Administrator revealed on [redacted]; 13 Residents were in attendance, and the concerns included, "There is a need for PNA money to be available on weekends." The Resident Council minutes were reviewed through 01/30/24 and there was no documented resolution to the residents' concern with PNA availability on the weekends.

On 02/29/24 at 10:29 AM, the surveyor conducted an interview with the Resident Council President (RCP). The surveyor asked the RCP if the council decided as a group to not permit any of the residents to take out more than $25.00 at a time from their PNA account. The RCP stated, "no, we never decided on only $25.00, no, that was not our decision, not ever!". The RCP stated even when he/she was not the RCP, that he/she still attended the Resident Council and stated, "we want all our money." The surveyor then asked if all the money was available upon request, "no, we cannot get it, maybe $15.00 or $25.00 at a time". The surveyor asked if a receipt was provided when a transaction was made. The RCP stated, "no, never, we barely get the money, and if you don't get the money and the Human Resources Director (HRD) goes home, you are [exploitive redacted] out of luck!" The RCP stated, "they don't have money on the weekends, they used to have money". The RCP stated, "there is no money on the weekends, none, nada, zilch

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ever". The RCP stated that the HRD sometimes doesn't have money during the week either.

On 02/28/24 at 1:17 PM, the surveyor conducted a follow-up interview with the HRD. The surveyor asked exactly how the process of the PNA funds was managed on the weekends, how much money was maintained and was there a log system to log the disbursements and provide receipts. The HRD stated it was the same process as during the week and the activity staff had cash on hand and they used a sheet to keep track. The HRD stated the amount varied. The surveyor asked the HRD if residents ever told her that there was no money available on the weekends and the HRD stated the residents are told to ask the activity staff on the weekends for PNA money. The surveyor reiterated and asked if there was a policy for the PNA and how much money is kept on site to ensure there is weekend availability. The HRD stated a lot of the residents would come to her on [redacted] and stated, "we don't have a policy". She did not elaborate on any amount available for the residents, and stated residents are told they can ask activity staff. The surveyor asked how the resident would ask for money and the HRD stated, "there is a very specific and actual process". The surveyor asked if there were regulations regarding handling the residents PNA and the HRD stated "I wouldn't say I have a regulation." The surveyor asked the HRD how long she was responsible for the PNA and she stated she doesn't know when she took it over. The surveyor asked what the purpose of the PNA was and the HRD stated, "at any given point in time, to make sure there is enough money". The HRD stated that when the old activity director was there, the resident council decided on $25.00 as being the amount that any resident was

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allowed to withdraw on the weekends so there would be enough money at the facility to be distributed to all of the residents. She further stated, "to her recollection it was discussed at resident council" and the surveyor asked if something was provided in writing to the residents regarding the PNA rules and the HRD stated stated that everything regarding the PNA process "was relayed to the residents verbally." The HRD stated if resident requested a log sheet was used and she showed the surveyor a couple of documents. The surveyor requested the log sheets for the past six including the weekends. The HRD stated it was a running list and she would have to "look through all of the sheets."

On 02/28/24 at 1:29 PM, the surveyor reviewed the list of the PNA balances in the presence of the HRD. The surveyor reviewed the PNA balances and asked the HRD if the Resident #10, who was listed with a PNA balance, could retrieve money from their PNA account on the weekends. The HRD stated it was not very frequent that residents ask for money on the weekends, and stated Resident #10 would come during the week and ask for money. The HRD showed the surveyor log sheets and stated "they generally give me this back [log sheets]." The HRD stated that the residents decided what a "reasonable request of what they can take out" from their PNA accounts would be, to make sure there was enough money for all. The surveyor specifically asked for the weekend PNA logs and the HRD stated, I don't know if I have six months of logs, but that is the thing, we are not processing withdrawals on the weekend".

On 02/29/24 at 10:51 AM, the surveyor interviewed the Activity Director (AD). The AD

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stated she has been there for 6 months. The surveyor asked if the activity staff provided PNA funds on the weekends. The AD stated the HRD usually gives it on Friday, and her staff would provide it on the weekends. The AD stated in the past there was a restriction that residents could only take out $15.00 at a time from their PNA.

On 02/29/24 at 11:10 AM, the surveyor interviewed an Activity Staff (AS #1) regarding the PNA. The AS #1 stated she hands out PNA funds on the weekends. AS #1 stated that the HRD provided $40.00- $50.00 total for weekend distribution, but the HRD stated that she would distribute the money on Friday for the residents who wanted money for the weekend. The AS #1 stated that the HRD instructed her the she "can give out $20.00 maximum" and usually we have them sign a PNA sheet, and it would be with the HRD. The PNA sheet would have the amount that was given. The surveyor asked if there was a book or receipt that was provided to the residents when they withdrew money. The AS #1 stated, "no, we don't have a booklet or a receipt book, no we don't have that". The surveyor asked if residents ever said that they needed more money on the weekends and she stated, "once in a blue moon". When asked if she ever ran out of money to provide to the residents, she stated, "usually we don't", and the surveyor asked if she was provided with a policy or something in writing regarding the PNA process. The AS #1 stated nothing in writing was provided to her.

On 02/29/24 at 12:35 PM, in the presence of the survey team, the HRD provided the surveyor with three "Daily PNA Disbursement" sheets with highlighted dates that were identified as weekends. The surveyor informed the HRD that

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staff stated they were instructed to disperse $20.00 on the weekends to the residents. The HRD stated that sometimes it would be more than that. The HRD stated there is no set amount of money to leave with the staff for the weekends. I don't have any proof of the amount of money that is available at any given moment. I hand the staff a bag with money in it, but it is not a set amount. The HRD stated there was no policy in writing regarding how the PNA was handle on the weekends. The surveyor asked about the expired residents who had PNA money. The HRD stated the remote business office informed her that they must contact a family member or Medicaid, otherwise it can be distributed to the next of kin. The surveyor asked the HRD to provide additional information on the resident who were expired, some over one year, and still had PNA funds held by the facility.

The "Daily PNA Disbursements" handwritten sheets that were provided from the HRD were dated [redacted] through [redacted] and six months were not provided as requested. The sheets revealed: [redacted] one resident name with an amount of $25.00 was listed, and the Resident Signature section was left blank; [redacted] three residents names were listed, with $25.00, $15.00 and $10.00 as amount listed and no individual signatures next to each name was documented. There was one disbursement on [redacted] for $10, with a scribble under name and no resident signature. On [redacted] and [redacted] there was one resident with $15 and another with $25.00 with a signature/initials next to the amount, and one disbursement on [redacted] for $15.00 with a notation in the signature column. There was no disbursement greater than $25.00 on the highlighted weekends, and the remaining

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amounts ranged mostly from $2.00 to $25.00.

On 02/29/24 at 2:01 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) and Director of Nursing, in the presence of the team, of the findings related to the PNA, including the resident council concerns. The surveyor asked the LNHA how resident's get their money. The LNHA stated they go to the HRD. The surveyor asked the LNHA how much money the residents can request and the LNHA stated, "whatever they need, we try to give them, and $50.00 is what they get". The surveyor asked for a policy and the LNHA stated, "I don't have a policy". The surveyor asked the LNHA if he was aware of a limit of money that the residents could withdraw, and he stated, "I've never heard of it". The surveyor asked if the resident should receive quarterly PNA statements, and he stated they should be provided with quarterly statements.

On 03/06/24 at 11:48 AM, the survey team conducted an exit conference with the LNHA, Director of Nursing, and Vice President of Operations (VPO) and Nursing (VPON) from a management company. The LNHA provided eight "Daily PNA Disbursements" handwritten sheets which now included sheets from [redacted] through [redacted] and stated that the areas highlighted proved that money was available and the VPO added the regulation did not state that they needed to cover all the residents money in the facility. No further information was provided regarding a documented process or policy for PNA disbursements, what is done when resident's expire and PNA money is left, or in response to the resident's documented concerns.

Review of the "Resident Rights" policy Revised

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F 567	Continued From page 78 February 2021, revealed Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: r. manage his or her personal funds (if he wishes). NJAC 8:39-4.1(a)(9)(10)	F 567		
F 568 SS=F	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have a system in place to ensure all residents who had the facility manage Personal Needs Account (PNA) funds were provided with a quarterly statement. The deficient practice effected all resident who had PNA funds and was evidenced by the following: Refer to 565F and 567F. On 02/21/24 at 8:50 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with the requested list of current PNA	F 568	F568 SS-F (Cross Walk to F565F and F567F) 1. Corrective Action: • On March 28, 2024, the facility Administrator performed a review of the current PNA balance for both current and expired residents was performed to assess their current balances. • On April 1, 2024, quarterly statements will be sent to residents that maintain a PNA balance at the facility. • On February 26, 2024, process was begun to refund expired resident's PNA	4/16/24

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F 568	Continued From page 79 balances and stated that the Human Resources Director (HRD) was responsible for the PNA accounts. The list included 94 accounts and listed 6 residents with a "Current Balance" more than $50.00 who were listed as "Expired [deceased]" under Status. On 02/22/24 at 1:22 PM, the surveyor interviewed the HRD who confirmed that she handled the PNA money for the resident's accounts "during the week". She clarified and stated, during the week, the residents will come find her and on the weekends the residents would obtain money from the activity staff. She stated that if the resident's requested large amounts that the resident's would give her notice. The surveyor asked why there were expired residents with PNA balances which included Resident #237 who expired [redacted] and had a balance of [redacted] and Resident # 236 who expired on [redacted] and had a balance of $1[redacted]. The HRD stated she did not know about the people who were expired, and she did not close the account. The HRD stated a remote business office handled the accounts and they were in [another state]. The surveyor asked the HRD if statements were provided to the residents for their PNA accounts. The HRS stated that she printed and mailed out statements. The surveyor asked if she had a type of form, or document that she sent to the residents. She stated no, and could not provide proof that statements were sent to the residents and she did not document when statements were mailed out. The surveyor asked the HRD if she opened PNA accounts and she stated, she did not open, or close accounts and she would reach out to the remote business office about the closed accounts.	F 568	funds based on regulatory requirements. Refunds will be completed upon receiving a response from Medicaid as to the financial breakdown to be returned. • On March 25, 2024, The Activity Director, Activity Staff, Human Resources Director was educated on the revised facility PNA process and policy. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: • All residents who maintain PNA funds at the facility have the potential to be affected by this deficient practice. 3. Measures Put into Place: • Monthly audits of the PNA fund report will be facilitated by the Administrator and/or designee to assure expired resident PNA funds are refunded according to regulatory requirements. • Quarterly audits to assure Quarterly PNA statements are distributed to residents that maintain PNA balances within the facility will be completed by the Administrator and/or designee. • The Activity Director and/or designee will continue to facilitate monthly resident council meetings to follow up on any resident feedback related to PNA access and be able to continue to proactively address resident concerns. 4. How Will These Actions Be Measured: • The results of the monthly and quarterly Administrator audits and resident council meetings will be submitted to the	

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F 568	Continued From page 80 On 02/29/24 at 2:01 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) and Director of Nursing, in the presence of the team, of the findings related to the PNA, including the resident council concerns. The surveyor asked the LNHA about the PNA process which included if there was a policy and the LNHA stated, "I don't have a policy". The surveyor asked if the resident should receive quarterly PNA statements, and he stated they should be provided with quarterly statements. On 03/06/24 at 11:48 AM, the survey team conducted an exit conference with the LNHA, Director of Nursing, and Vice President of Operations (VPO) and Nursing (VPON) from a management company. No further information was provided regarding PNA statements. Review of the "Resident Rights" policy Revised February 2021, revealed Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: r. manage his or her personal funds (if he wishes). NJAC 8:39-4.1(a)(9)(10)	F 568	Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	
F 569 SS=F	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition	F 569		4/16/24

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F 569	Continued From page 81 to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on interview and document review it was determined that the facility failed to have a process in place to ensure that within 30 days of a resident's death the facility conveyed, the resident's funds, and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate. This deficient practice occurred for 6 of 6 expired residents identified with a current Personal Needs Account balance (Resident #236, #237, #238 and 3 unsampled residents) and was evidenced by the following: On 02/21/24 at 8:50 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with the requested list of current PNA balances and stated that the Human Resources Director (HRD) was responsible for the PNA accounts. The list included 94 accounts and listed 6 residents with a "Current Balance" who were listed as "Expired" [deceased] under "Status". The Expired residents included: 1. Unsampled Resident (UR #1); Expired	F 569	F569 SS-F 1. Corrective Action: " On March 28, 2024, the facility Administrator performed a review of the current PNA balances for expired residents was performed to assess their current balances. " On February 26, 2024, process was begun to refund expired resident□s PNA funds for UR #1, UR #2, UR #3, Resident #236, Resident #237, and Resident #238, based on regulatory requirements. Refunds will be completed upon receiving a response from Medicaid as to the financial breakdown to be returned. " On March 25, 2024, The Activity Director, Activity Staff, Human Resources Director was educated on the revised facility PNA refund process and policy. 2. Identification of other residents or areas having the potential to be affected	

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F 569	Continued From page 82 [redacted] with a "Current Balance" $[redacted]. 2. UR #2; Expired [redacted] with a "Current Balance" [redacted] 3. UR #3; Expired [redacted] with a "Current Balance" [redacted] 4. Resident #236; Expired [redacted] with a "Current Balance" [redacted] 5. Resident #237; Expired [redacted] with a "Current Balance" [redacted] 6. Resident #238; Expired [redacted] with a "Current Balance" [redacted] On 02/22/24 at 1:22 PM, the surveyor interviewed the HRD regarding the PNA funds and she confirmed that she handled the PNA money for the resident's accounts. The surveyor asked why there were expired residents with PNA balances which included Resident #237 who expired [redacted] and had a balance of [redacted] and Resident # 236 who expired on [redacted] and had a balance of [redacted] The HRD stated she did not know about the people who were expired, and she did not close the accounts. The HRD stated a remote business office (RBO) handled the accounts and they were located in [another state]. The surveyor asked the HRD if she opened PNA accounts and she stated, she did not open, or close accounts and she would reach out to the RBO about the closed accounts. On 02/23/24 at 8:46 AM, the LNHA provided the surveyor with a copy of an email that the LNHA stated was from the HRD regarding the surveyor questions. The email dated [redacted] revealed "I am writing to respond to your request for specific information regarding how interest is calculated for your resident accounts". "When an individual	F 569	due to the nature of the deficiency: " All residents who maintain PNA funds at the facility have the potential to be affected by this deficient practice. 3. Measures Put into Place: " Monthly audits of the PNA fund report will be facilitated by the Administrator and/or designee to assure expired resident PNA funds are refunded according to regulatory requirements. 4. How Will These Actions Be Measured: " The results of the monthly Administrator audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315282	A. BUILDING _____ B. WING _____	C 03/06/2024

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EXCEL CARE AT MANALAPAN	**104 PENSION ROAD MANALAPAN, NJ 07726**

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F 569	Continued From page 83	F 569		

account is closed mid-period, the interest accrued through that date is calculated and posted on the same day the account is closed".

On 02/26/24 at 8:56 AM, the surveyor interviewed the HRD in the presence of the survey team, regarding the copy of the email that was provided and the surveyor had not received any information about how the expired resident's PNA was managed. The HRD stated that she contacted the RBO and asked about the PNA for the expired residents. The HRD stated she was told that paperwork from family was needed and that was what she was told. The HRD stated, "I didn't push them for specific information" and was unable to confirm if the RBO was handling the process or if she was responsible for any part of it.

On 02/29/24 at 12:38 PM, the surveyor conducted a follow up interview with the HRD regarding expired resident PNA accounts. The HRD stated that the RBO had to contact the next of kin to be able to disperse the money. The surveyor asked what happened and what was done and requested a policy for management of PNA.

On 02/29/24 at 2:01 PM, the survey team conducted a pre-exit interview with the LHNA and Director of Nursing (DON). The surveyor discussed the above findings with the LNHA and when asked about a PNA policy he stated, "I don't have a policy".

On 03/06/24 at 1:57 PM, the survey team conducted the exit convergence with the LHNA, DON, Vice President of Operations and Nursing from a management company. No information regarding the expired resident PNA accounts was

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F 569	Continued From page 84 provided. NJAC 8:39-4.1(7)(9)	F 569		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph	F 580		4/16/24

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F 580	Continued From page 85 (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Complaint #s NJ 154702, NJ 154763 Based on interviews, review of medical records and other facility documentation, it was determined that the facility failed to notify a resident representative and/or physician for 2 of 3 residents reviewed for change in condition. This deficient practice was identified for Resident #19 and Resident #45 reviewed for a change in condition and was evidenced by the following: 1) Review of Resident #19's Medication Administration Record (MAR) revealed that Resident #19 did not receive [redacted] milligrams (mg) as ordered by the physician for three consecutive days 03/18/22, 03/19/22, and 03/20/22. The resident did not receive the same medication on an additional three consecutive days 03/29/22, 3/30/22 and 3/31/22. There was no documented evidence that the resident's physician was notified of the resident not being administered the medication as ordered.	F 580	F580 SS-E 1. Corrective Action: " Resident #19□s representative, and physician were notified of the change in status that occurred in [redacted]. " Resident #45□s representative and physician were notified of the resident not taking their medication in [redacted]. " All licensed professionals were in-serviced on March 24, 2024, by the Director of Nursing on the expectation that the resident□s responsible party and physician must be notified when a resident experiences a change in condition or does not take their medication. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice.	

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F 580	Continued From page 86 Review of Resident #19's Electronic Medical Record (EMR) revealed a Progress Note dated [redacted] at 9:43 PM, by the Registered Nurse (RN) which revealed, "Received resident by front of [his/her] doorway sitting on the wheelchair with [redacted] behaviors, [redacted] noted. Observed resident [redacted] [him/herself], states that staff and [his/her] roommate are "[redacted]" [him/her] and also stated [his/her] [redacted] took [his/her] house from [him/her] that [he/she] inherited from [his/her] dead parents. Saying [he/she] is going to call [his/her] lawyer to jail [his/her] [redacted]r, however attempts was made to redirect, and reassured resident also encouraged [him/her] to watch TV/play [his/her] music [he/she] refused, [redacted] to[redacted]t [him/her]. Snack and fluids offered not effective. [redacted] mg [redacted]-tab po PRN (as needed) given as ordered for [redacted] with mild effect noted. After a short period of time resident started to [redacted] [him/herself] again continue to have [redacted]. Refused meal, at dinner time said [he/she] is not hungry, resident was encouraged and educated to eat for nutritional purpose [he/she] still refused, refused bedtime snack, accepted all due medication and po fluids well tolerated." There was no documented evidence that the resident's representative was notified of the change in the resident's condition. 2) Review of Resident #45's MAR reveal that the resident did not receive [redacted] mg as ordered by the physician on two consecutive days 03/11/22 and 03/12/22. The resident did not receive the same medication on three consecutive days 03/18/22, 03/19/22 and 03/20/22. There was no documented evidenced	F 580	3. Measures Put into Place: " Unit Managers and/or designee for wings 100 and 200 will audit weekly residents who exhibit a change in condition and missed medications to assure responsible party and physician have been notified. 4. How Will These Actions Be Measured: " The results of the weekly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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F 580	Continued From page 87	F 580		

that the resident's physician was notified of the resident not being administered the medication as ordered.

Review of Resident #45's EMR revealed a Progress Note dated [redacted] at 3:04 PM, documented by the Licensed Practical Nurse (LPN) which indicated, "7:04 AM resident refused q (every) 2[redacted]) for [redacted] refill. The resident was aggressive and yelled at this author and the lab technician to get out of [his/her] room and to leave [him/her] alone. Doctor made aware of resident's behaviors. No new orders given at this time. Lab re-draw scheduled for this [redacted] Pharmacy in need of updated labs for [redacted] refill." There was no documented evidence that the resident's representative was notified of the change in the resident's condition.

On 3/1/24 at 10:21 AM, the surveyor interviewed the LPN on unit [redacted]. The LPN stated if a resident refused a medication or it was held, it needs to be documented and the family representative and physician need to be notified.

On 3/1/24 at 12:41 PM, the surveyor interviewed the [redacted] Nurse Practitioner [redacted]. The [redacted] stated that the nurse was to notify the [redacted] of any missed doses that have been either held or refused by a resident. The [redacted] stated, furthermore the nurse and staff needed to document in the EMR the behavior to ensure that the symptoms were not worsening.

A review of the facility's Change in Condition or Status Policy, revised on February 2021, which included but were not limited to:

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F 580	Continued From page 88 POLICY STATEMENT "our facility promptly notifies the resident, his or her attending physician, and resident representative of changes in the resident's medical/mental condition and/or status" 1.) The nurse will notify the resident's attending physician or physician on call when there has been a (an): -significant change in the resident's physical/emotional/mental condition. -refusal of treatment or medication two (2) or more consecutive times. NJAC 8:39-13.1(C)	F 580		
F 584 SS=F	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance	F 584		4/16/24

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F 584	Continued From page 89 services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Complaint # NJ 169440 Based on observation and interview it was determined that the facility failed to have a system in place to ensure all resident rooms and common areas were maintained in a clean, sanitary and homelike manner, and resident equipment was maintained in good condition. The deficient practice was observed throughout the [redacted] unit and was observed by the following: On 02/20/24 at 10:26 AM through 11:15 AM, surveyor #1 observed the following on the [redacted] Unit: -Room [redacted] Resident in bed, a gray chair next to the bed was visibly stained on the seat cushion, the bed and bed frame appeared rusted, the	F 584	F584 SS-F 1. Corrective Action: " The chair in Resident room [redacted] was cleaned. The bed and bed frame were painted to remove any visibly rusted areas. The bedside table was repaired/replaced, and the privacy curtain was cleaned. " The bedside curtain in Resident room [redacted] was cleaned. " The wall by the air conditioner in Resident room [redacted] was repaired. The [redacted]-Bed nightstand was repaired/replaced and the ceiling over the bed was painted. " The wall area that appeared cracked above the air conditioner in Resident room [redacted] was repaired. The bedside table by the door bed was repaired/replaced.	

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F 584	Continued From page 90 bedside table had chips, and the privacy curtain was visibly soiled. -Room [redacted] There was no handle on the middle drawer of the door side bedside table. Bed frame appeared rusty, and a male Certified Nurse Aide (CNA) entered room with a [redacted] recliner chair that had a ripped arm rest and was for resident use. -Room [redacted], The resident was in bed and the bedside curtain and wall by the bed was visibly soiled and stained. -Room [redacted] The wall by the air conditioner was cracked, the [redacted] bed nightstand was chipped, and ceiling over the bed was stained with brown splatter. -Room [redacted] The wall area above the air conditioner was cracked, rusted in appearance bedside table base (door bed), the privacy curtain was visibly soiled, the dresser and walls were also visibly chipped. -Room [redacted], Both privacy curtains were stained and an Unsampled resident was in [redacted] bed. The resident stated the privacy curtains were not cleaned and also observed dust above the bed headboard. -Room [redacted], An Unsampled resident was in a low bed which was visibly chipped on the wood frame. There were splatters on the wall and on the privacy curtain, and there was a hole in the wall behind the bed. -Room [redacted] Resident #42 on top of the bed and there was a ripped/broken area on the wall by the	F 584	The privacy curtain was cleaned. The dresser and the walls that appeared cracked were repaired. " Both privacy curtains in Resident room [redacted] were cleaned. The resident□s headboard ([redacted] was dusted to remove any dust that was present at the time of cleaning. " The wood frame on the bed of the resident in Resident room [redacted] was repaired. The wall in Resident room [redacted] was cleaned to remove any visible splatters. The nightstand dresser edge was repaired. The privacy curtain was cleaned. The hole in the wall behind the resident□s bed was repaired. " The ripped or broken area in Resident room [redacted](Resident #42) was repaired. " The ceiling tile in Resident room [redacted] that was stained and appeared to be buckling was repaired. " The privacy curtains in Resident room [redacted] were cleaned. The wood bed board was repaired. Chipped or rough furniture in the room were repaired. " The exposed screw under the tv in Resident room [redacted] was removed. The splatter on the wall closet was cleaned. " The walls in Resident room [redacted] were repaired. The privacy curtains were cleaned. " The walls that appeared scuffed in Resident room [redacted] were painted. " The bedside table that appeared rusted in Resident room [redacted] was replaced. The privacy curtains were cleaned and replaced. The hole above the dresser was repaired. The door frame that appeared rusted was repaired.	

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F 584	Continued From page 91 television. On 02/21/24 at 11:25 AM, two surveyors (Surveyor #1 and #2) conducted a tour with the Licensed Nursing Home Administrator (LNHA) and observed the following: -Room [redacted], The ceiling tile was stained and appeared to be buckling. The surveyors asked the LNHA if he had completed environmental rounds in the building. The LNHA stated he made rounds daily and would look at the fire extinguishers and look if call lights were going off. The surveyors asked the LNHA if the rounds were documented and he responded, "no." -Room [redacted], Both privacy curtains were visibly stained, and the LNHA acknowledged "needs to be cleaned." The wood bed board was visibly chipped and rough. The surveyor pointed to the chipped/ rough areas on the furniture, and the stained curtains and asked the LNHA if that was okay, and the LNHA stated "it's not okay." -Room [redacted], The wall had an exposed screw under the television, and the wall closest to the resident had visible splatter on it. -Room [redacted], The gray chair in the room remained stained, the curtains remained soiled, and the furniture was in the same condition as observed on 02/20/24. -Room [redacted] The walls were chipped in several areas, the furniture had chipped areas and the privacy curtains were soiled. -Room [redacted], As observed on 02/20/24, the bed frame remained visibly rusted and there was a	F 584	" The loose piece on the bed of Resident room [redacted] was fastened and repaired. The privacy curtains were cleaned. " The loose piece from the bed of Resident room [redacted] was fastened and repaired. The foot board and dresser handle were replaced. " The missing paint and scrapes on the wall were repainted in Resident room [redacted]. The privacy curtain was cleaned. " The missing blind in Resident room [redacted] was replaced. Privacy curtains were replaced in the room. " The film on the window of the [redacted]-unit dining area was removed. The floor was cleaned and the walls where scuffs appeared were painted. The hole in the closet like door was repaired. " The stains on the ceiling by the hallway outside of the 200-unit dining area was cleaned. " The resident wheelchairs for rooms [redacted] and [redacted] were cleaned and repaired. " The mechanical lift in the hallway was cleaned and repaired and the padding replaced. " Education was provided to the maintenance and Environmental Service Departments by the Administrator on March 28, 2024, regarding the importance of maintaining resident rooms and common areas in a clean homelike fashion as well as resident equipment being maintained in good condition. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency:	

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F 584	Continued From page 92 now a ripped sheet on the bed. This was pointed out to the LNHA who stated, "moving forward we will fix broken furniture." -Room [redacted] The wall area on both sides of the room were visibly scuffed. -Room [redacted] The resident was in bed. There was an edge hanging off the bedside table, the air conditioner remained cracked above the unit and the curtain remained soiled as observed on 02/20/24. -Room [redacted], The dresser was worn, walls remained scratched, dust remained above the furniture and the privacy curtains remained stained in the same manner that was observed on 02/20/24. -Room [redacted], The resident was in bed, the ceiling had splatter type stains above the resident along with the curtain. The nightstand dresser edge was hanging off and in the direction toward the resident. -Room [redacted] The bedside table was visibly rusted in appearance, the privacy curtains were soiled, there was a hole in the wall above the dresser, the door frame was rusted. -Room [redacted] The bed frame had a loose piece on the frame and a visibly soiled privacy curtain. -Room [redacted], There was a large loose piece from the bed frame, the foot board and dresser handle were missing. On 02/20/24 from 11:05 AM through 11:15 AM, surveyor #4 observed the following on the [redacted]	F 584	" All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " A weekly rounding tool was implemented for the environmental and maintenance departments to assure cleanliness and equipment are cleaned, repaired, and maintained timely. " Staff re-education by the Maintenance Designee on the use of maintenance logs was initiated on March 28, 2024, and will be completed by April 16, 2024 4. How Will These Actions Be Measured: " The results of the weekly audits completed by the Environmental and Maintenance departments will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on APRIL 16, 2024.	

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F 584	Continued From page 93 Unit: - Room [redacted], Missing paint and scrapes on the wall by the door bed, and a black stain on the privacy curtain between the two beds. -Room [redacted] A blind missing form one pane (2 window pane), no privacy curtain for door and window bed. On 02/21/24 at 11:57 AM, the surveyor asked the LNHA what the expectations were for the privacy curtains and rooms. The LNHA stated, "It should have a curtain in every room and be clean, the expectation was "it should be perfect." On 02/21/24 at 12:13 PM, the surveyor asked about the observed conditions and asked the LNHA were there any pending environmental projects. The LNHA stated, "the new company took over in [redacted] The LNHA stated "it was a work in progress, and we do our best" and did not provide any specific information regarding the observed conditions or pending projects. On 02/22/24 at 12:37 PM the LNHA informed the surveyor that 4-5 rooms had been painted on the [redacted] Unit. The surveyor asked the LNHA if there was any reason the rooms were not painted prior to the tour conducted with two surveyors the previous day. The LNHA stated, "no real reason" we were focusing on the 100 unit. On 02/26/24 at 8:37 AM, Surveyor #1 toured the 200-unit day room/dining room and observed three residents were eating breakfast at that time. There was a film over the window to the outside which was ripped and partially obstructed the view. The floor was very soiled in the area where	F 584		

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the wall met the floor and had various debris and crumbs. There were marks throughout on the walls and there was a hole in a closet type door behind a resident table. The surveyor interviewed an activity staff (AS) member who was in the room and asked if the area looked clean. The AS stated "no", that is housekeeping.

On 02/26/24 at 8:42 AM, the ceiling in the hallway outside of the same day room/dining room was visibly stained with multiple splatters.

On 02/26/24 at 10:50 AM, Surveyor #1, interviewed the LNHA regarding the continued observations. The LNHA stated, "he's getting to it" [maintenance] and no further explanation was provided.

On 02/27/24 at 8:14 AM, two wheelchairs outside the area between Room [redacted] One was blue and had a black seat cushion, which was heavily soiled and stained, along with the black cushion leg support. The second was black leather like chair with a ripped back and seat, and was visibly soiled. Both were labeled with resident's names.

On 02/27/24 at 8:23 AM, the mechanical lift in the hallway was visibly soiled, rusted and the padding was ripped.

On 03/05/24 at 1:35 the survey team conducted a meeting with the LNHA and the Director of Nursing and presented the above concerns.

On 03/06/24 at 11:48 AM, the LNHA, Director of Nursing, Vice President of Operations and Nursing from a Management company did not offer any additional information and the LNHA

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F 584	Continued From page 95 stated, we share the same goal and strive to do our best and we have to work better on it. "Next survey we will do better." NJAC 8:39-4.1(a)11; 31.2(e)	F 584		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: The facility failed to ensure the required Minimum Data Set (MDS) assessments were submitted timely as evidenced by 1 of 1 resident reviewed (Resident #66) for a system selected MDS Record over [redacted] days old. The deficient practice was evidenced by the following: On 02/22/24 at 11:33 AM, the surveyor reviewed the MDS for Resident #66 and interviewed the Licensed Practical Nurse MDS coordinator (MDSC) regarding submission of the MDS. The MDSC stated she was not at the facility at that time and an old medical record system was utilized. The MDSC then viewed an MDS report on the old system and stated the quarterly MDS and discharge MDS did not appear to be submitted and she would research further. On 02/23/24 at 10:00 AM, the Licensed Nursing Home Administrator (LNHA) provided a report for Resident #66's Discharge Assessment scheduled as due no later than [redacted] which was "Accepted." The Quarterly Assessment stated	F 638	F638 SS-D 1. Corrective Action: " Resident # 66 MDS assessments were reviewed to assure they are up to date. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " An MDS audit of assessments for all current residents were completed to assure all assessments were up to date based on their ARD date. " MDS Coordinator and/or designee will do a random audit MDS assessments of 5 residents per week to assure their assessments are up to date and completed.	4/16/24

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F 638	Continued From page 96 was "Submitted", not accepted per the document, and Transmission date no later than [redacted]3. On 03/05/24 at 1:35 PM, the surveyor informed the LNHA and Director of Nursing (DON) of the MDS concerns. On 03/06/24 at 12:04 PM, the DON provided the surveyor with a Final Validation Report which indicated the record was now "Accepted", and "Record Submitted Late: The submission date is more than 14 days after [redacted] on this new [redacted] equals 1 assessment). NJAC 8:39-11.1	F 638	4. How Will These Actions Be Measured: " The results of the weekly MDS audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		4/16/24

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F 656	Continued From page 97 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to develop and implement an individualized resident-centered comprehensive care plans with measurable goals: a) to integrate approaches for a resident with a history of [redacted] and exhibited behaviors, b) for a resident with a history of [redacted] including f[redacted] with injury, c) and interventions for a resident who had a history of [redacted], and d) for a resident with allergies. This deficient practice was identified for 4 of 18 residents (Resident #1, #5, #76, and #32) reviewed for	F 656	F656 SS-E 1. Corrective Action: " The care plan for Resident #1 was reviewed and updated on 3/1/24 to address aggressive behavior. " The care plan for Resident #5 was reviewed on 3/24/24, by the interdisciplinary team for residents history of falls and to assure interventions were up to date. " The care plan for Resident #76 was updated to address the resident s mood and cognitive status inclusive of	

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F 656	Continued From page 98 Care Plans (CP) and was evidenced by the following: a. On 02/20/24 at 12:34 PM, Surveyor #1 observed Resident #1 in bed with the lunch tray on the bedside table. The lunch tray was covered with a plastic wrap and the resident was eating off of disposable dinnerware and with disposable cutlery. The surveyor left the room and observed the Director of Nursing (DON) in the hallway. Surveyor #1 inquired regarding the resident being served on disposable dinnerware and cutlery. The DON informed the surveyor that the resident had behavior of being aggressive and destroyed dishware and had a CP for the behavior. A review of Resident #1's medical record revealed: The Physician Orders sheet (POS) for [redacted] reflected that the resident was admitted to the facility with diagnoses which included but were not limited to: [redacted] disease and [redacted]. The POS reflected that the resident was receiving [redacted] an [redacted] for [redacted]. A review of the resident's comprehensive care plan did not include that the resident had behavior of being [redacted] and was to have all meals served on [redacted] and [redacted]. The Care plan dated [redacted] indicated that the resident had behaviors of [redacted], and had not exhibited the behavior since last revised on [redacted] A gradual dose reduction of [redacted] was done on [redacted] in the absence of the Target Behavior [redacted]).	F 656	measurable goals, interventions, and targeted behaviors, related to the diagnosis of psychosis. " The care plan for Resident #32 was updated to include interventions and measurable goals and side effects for allergies related to erythromycin and penicillin. " An audit was started on March 25, 2024, by the Unit managers to assure that resident care plans are commensurate with the residents required plan of care and that interventions, and goals are measurable and will be completed by COMPLETION DATE. " Education was provided to the interdisciplinary team members, by the regional nurse, on the facilities care plan policy on March 25, 2024. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " Weekly random audits of 10 resident care plans (5 on each unit) will be initiated by each Unit Manager and/or designee to assure that resident care plans are commensurate with the residents required plan of care and that interventions, and goals are measurable. 4. How Will These Actions Be Measured: " The results of the weekly care plan audits will be submitted to the Quality	

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F 656	Continued From page 99 Review of the NJ EX Order 264b1 Medication Administration Record (MAR) behavior monitoring and interventions sheet provided by the facility, indicated that the resident was receiving these medications for the target behaviors of NJ EX Order 264b1 and NJ EX Order 264b1 s. Behavior monitoring reports were provided for NJ EX Order 264b1, and there were no behavior monitoring sheets provided for being NJ EX Order 264b1 or NJ EX Order 264b1. During the survey from 02/20/24 to 03/05/24, Surveyor #1 observed the resident during four separate observations being served on NJ EX Order 264b1 with NJ EX Order 264b1. On 02/23/24 at 9:23 AM, the surveyor interviewed the Certified Nursing Aide (CNA) who stated that Resident #1 preferred to stay in bed. The resident would refuse care at times but did not exhibit any NJ EX Order 264b1 towards staff. At that time the, CNA stated that the resident had always been served on NJ EX Order 264b1 and NJ EX Order 264b1 On 02/26/24 at 9:08 AM, the surveyor observed the resident being served again on NJ EX Order 264b1 NJ EX Order 264b1 and NJ EX Order 264b1. The surveyor accompanied the DON to the room and inquired about the rationale for the resident being served all meals on NJ EX Order 264b1 and NJ EX Order 264b1 The DON stated that the resident had a behavior of NJ EX Order 264b1 and the concern had been addressed on the CP. On 02/26/24 at 11:30 AM, the surveyor interviewed the Licensed Practical Nurse /Unit Manager (LPN/UM) who stated she has worked at the facility for a while. She confirmed that the resident had been served on NJ EX Order 264b1 NJ EX Order 264b1 e and NJ EX Order 264b1 and was cared plan for	F 656	Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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the behavior. At that time, the LPN/UM and Surveyor #1 looked at the resident's [redacted] Progress Notes and noted that the Target Behaviors mentioned were [redacted] and [redacted] s. Review of the Monthly [redacted] Review reflected that the Target Behaviors being monitored were [redacted] and [redacted] (not [redacted]). The resident did not have a care plan in place which addressed a [redacted] and being [redacted]. The LPN/UM was unable to speak to the resident being [redacted] or if the resident had a care plan for being served on [redacted] and [redacted]. The LPN/UM was unable to provide documented evidence of a care plan for the behavior.

On 03/05/24 at 11:43 AM, the surveyor conducted a second interview with the DON regarding Resident #1 being served on [redacted] during the survey. The DON confirmed that the behavior was addressed on the CP. The surveyor reviewed the care plan with the DON and noted that the behavior of [redacted] and [redacted] was added on [redacted] (after the surveyor's inquiry). When inquired of the purpose for the care plan, the DON stated that there should have been a CP to reflect the resident's current status with measurable goals and interventions.

b. On 02/28/24 at 8:35 AM, the surveyor observed Resident #5 in the room and observed a [redacted] and [redacted] that [redacted] from the [redacted] to the [redacted] area and had [redacted] to [redacted]. A visitor was in the room and informed the surveyor that the resident [redacted] on [redacted] and had been transferred to the hospital and returned to the

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facility last night [redacted]

A review of Resident #5's Face Sheet (admission summary) reflected that Resident # 5 was readmitted to the facility from another long term care facility, with diagnoses which included but were not limited to: [redacted] and [redacted] of [redacted] of [redacted] subsequent encounters for [redacted] with [redacted] and need for assistance with personal care. The Quarterly Minimum Data Set (MDS) dated [redacted] reflected that Resident #5 had [redacted] t. Resident #5 received a score of [redacted] on the Brief Interview for Mental Status (BIMS.)

Surveyor #1 reviewed the history and physical dated [redacted], which revealed the resident had a history [redacted] The resident [redacted] at home and sustained a [redacted]. The resident underwent surgery to repair the [redacted] and was admitted for rehabilitation.

The surveyor reviewed the care plan which did not address a focus related to or any interventions to prevent further [redacted]

The comprehensive care plan dated [redacted], reflected that the resident [redacted] risks were not addressed for the current admission dated [redacted] Resident #5 was discharged home on [redacted] and readmitted to the facility on [redacted] following an '[redacted]) surgical intervention to repair a [redacted].

Resident #5 sustained a [redacted] out of bed on [redacted] at 2:12 PM. The Certified Nursing Assistant documented: "Heard somebody

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screaming, upon entering the room, observed the resident lying on the floor. I called the nurse.
The nurse documented: I asked the resident what happened. The resident stated, "I wanted to walk". I assessed the resident. The resident had a [redacted] to the [redacted], the resident complained of [redacted].

Following the [redacted], Resident #5 was referred to Physical Therapy who made the following recommendations:
Continue with physical and occupational therapy. Patient will need: [redacted] for safety. Patient education to call for assistance as needed.

There was no documented evidence that the interventions were implemented, on the Care Plan, per the recommendations made by Physical Therapy (PT). There was no Care Plan developed after, on [redacted], the resident reported [redacted] in the [redacted] and [redacted]. The physician ordered an [redacted] of the [redacted]. Resident #5 was diagnosed with a [redacted] of [redacted] of the [redacted].

On 02/26/24 at 10:00 AM, the Assistant Director of Nursing (ADON) indicated that the resident had a care plan in the current Electronic Medical Record (EMR) system. The ADON could not provide a Care Plan for the prior f[redacted]
The surveyor reviewed a care plan provided by the ADON, dated [redacted] for falls identified as" Risk for [redacted]
The goal was Resident #5 will be free from injury through the target date of [redacted]
Interventions included:
Anticipate and meets my needs.

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Be sure my call light is within reach and encourage me to use it for assistance a needed. [redacted] when in bed. initiated [redacted] Line of site when out of bed. initiated [redacted]

On 02/26/24 at 10:30 AM, Surveyor #1 reviewed with the DON the recommendations made after the [redacted] regarding the Physical Therapy recommendations. The DON stated that he could not comment on the interventions not being implemented as he was not working at the facility at that time.

On 03/05/24 at 1:04 PM, the surveyor reviewed the falls incidents and the care plan with the Licensed Nursing Home Administrator (LNHA) and he could not comment on the omission of the interventions from the care plan. The LNHA stated that the nursing department was to implement the recommendations.

c) On 02/20/24 at 10:01 AM, during a tour of the [redacted] unit of the facility, Resident #76 was observed awake and alert in bed watching television. Surveyor #2 attempted to speak to the resident, but English was not [his/her] primary language. The resident was able to convey that [he/she] had been at the facility for a few months.

A review of the Admission Record revealed that Resident #76 had diagnoses which included but were not limited to; [redacted]

A review of the Admission MDS dated [redacted], included but was not limited to; Section [redacted] which indicated the resident "[redacted]" by others and [redacted]" which

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indicated the resident '[redacted]. Resident #76 had a BIMS of [redacted] which indicated[redacted]. Section [redacted] Signs and Symptoms [redacted] documented "2" behavior present, fluctuates for inattention. Section [redacted] should [redacted] interview be conducted? indicated [redacted]" No - resident rarely/never [redacted]. Medications documented that [redacted] resident received [redacted] on a routine basis; "[redacted]" Gradual Dose Reduction (GDR) had been attempted; and "no" GDR has not been documented by a physician as clinically contraindicated.

A review of the Physicians "Order Summary Report", active orders as of [redacted] included but was not limited to; a physician's order dated [redacted] for [redacted] (an [redacted] milligrams (mg) give 1 tablet by mouth in the evening for [redacted]. The Order Summary Report did not include any target behaviors for the resident.

A review of the consulting pharmacy, "Nursing Summary Report" dated [redacted], included but was not limited to; a pharmacy recommendation to identify and monitor the behavior being exhibited for the use of [redacted] regarding Resident #76. There was no documented evidenced that the recommendation was followed with the physician or dated to indicate it had been completed by the facility.

A review of the [redacted] evaluation Progress Note (PN) dated [redacted] included but was not limited to; Medication: [redacted] mg [redacted]). Plan: 1. Always consider supportive interventions ..... redirection, support, reassurance, comfort measures, reduced

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stimulation, expression of feelings, family involvement. Treat medical issues.

On 03/05/24 at 9:07 AM, Surveyor #2 interviewed the DON and the Registered Nurse Unit Manager (RN UM) of the [redacted] unit. The RN UM accessed Resident #76's on-going comprehensive Care Plan and acknowledged [redacted] was not listed nor were there any measurable goals or interventions. The DON stated that the purpose of a comprehensive Care Plan was so that the entire staff would know how to "treat the resident". When asked what would be expected to monitor for a resident with [redacted]s, the DON stated [redacted]. When asked where the staff would know where to find the target behaviors for the resident, the DON did not reply. The RN UM stated "I guess it should be in the Care Plan. I don't know."

A review of the resident-centered on-going Care Plan had no documented evidence of a focus area of [redacted] medication for [redacted] or target behaviors; no measurable goals; no interventions; and did not list [redacted] as a diagnosis.

The facility had no additional information to provide.

d) On 02/27/24 at 8:15 AM, Surveyor #2 observed the breakfast meal ticket for Resident #32. The meal ticket showed Allergies: [redacted]

A review of the Admission Record revealed Resident #32 had "Allergies [redacted]".

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A review of the Physician's Order Summary Report dated [redacted], documented Allergies [redacted] products, [redacted], [redacted].

A review of Task record (a Certified Nursing Assistant guide to care for the residents) included Allergies [redacted] products, [redacted]), [redacted].

A review of the Physician's Assistant Progress Note dated [redacted], documented Allergies [redacted] products, [redacted], [redacted]

A review of the Registered Dietitian's Progress Note dated [redacted] revealed Allergies [redacted] products, [redacted], [redacted]

A review of the resident-centered on-going comprehensive Care Plan for Resident #32 listed Allergies [redacted] products, [redacted]. The Care Plan had no documented evidence to include a focus area for the medication allergies of [redacted] and Penicillins to include measurable goals, possible side effects, and interventions. The Care Plan had no documented evidence to include a focus area for the food allergies of [redacted] products, [redacted] to include measurable goals, possible side effects, and interventions.

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A review of the facility provided, "Director of Nursing Services" job description undated, included but was not limited to; Care Plan and Assessment Functions: assist in the development of preliminary and comprehensive assessments; develop a written care plan (preliminary and comprehensive) that identifies the resident's problems/needs, indicates the care to be give, goals to be accomplished, and which professional service is responsible for each element of care; review nurses' notes to determine if the care plan is being followed; and review and revise care plans and assessments as necessary.

A review of the facility provided, "Nurse Supervisor" job description undated, included but was not limited to; Purpose: ..... to ensure that the highest degree of quality care is maintained at all times. Care Plan and Assessment Functions: participate in the development of written preliminary and comprehensive assessments of the needs of each resident; participate in the development of a written care plan that identifies the problems and needs of the residents, indicates the care to be given, goals to be accomplished, and which professional service is responsible for each element of care; and review the resident care plans for appropriate goals, problems, approaches, and revisions based on needs.

A review of the facility provided, "Care Plan-Baseline" policy revised 3/2022, included but was not limited to; Policy Statement: to meet the resident's immediate health and safety needs, developed for each resident within forty-eight hours of admission. Interpretation and Implementation: 1. To include instructions needed

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to provide effective, person-centered care that meets professional standards of quality care and must include the minimum healthcare information needed to properly care for the resident including but not limited to; a. initial goals; b. physician orders; c. dietary orders. 2. The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan. The baseline care plan is updated as needed to meet the resident's needs.

A review of the facility provided, "Care Plan, Comprehensive Person-Centered" policy revised 3/2022, included but was not limited to; Statement: ... ... includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Interpretation and Implementation: 3. The care plan interventions are derived from a thorough analysis of the information gathered in the comprehensive assessment. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes services to be furnished to attain or maintain the highest practicable physical, mental, and psychosocial well-being. c. stated goals upon admission and desired outcomes; d. builds on resident's strength; and e. reflects recognized standards of practice for problem areas and conditions. 10. When possible, interventions address the underlying source of the problem areas, not just symptoms or triggers.

The facility failed to follow their policies.

NJAC 8:39-11.2; 27.1

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F 677 SS=F	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Complaints NJ #s: 159956, 161569, 165971, 169440 Based on observation, interview, record review, and review of pertinent documents, it was determined that the facility failed to ensure that Activities of Daily Living Care (ADLs) was consistently provided to residents by failing to a.) provide appropriate incontinent care to dependent residents (Resident #6, #18, #22, #23, #31, #32, #38 #50, #51 #53 #55); and b.) provide residents with scheduled showers (Resident #233 and #80). This deficient practice occurred for 12 of 12 residents, 1 of 1 closed record (Resident #80) reviewed for ADLs, and 1 of 6 residents who attended a resident council meeting. The deficient practice was evidenced by the following: On 02/23/24 at 11:14 AM, a resident council meeting was held with 6 residents which revealed that 1 of 6 stated "they leave me wet for hours sometimes, and [redacted] me, which I don't ask them to". On 02/20/24 at 9:16 AM, upon entrance to the facility, the survey team observed a strong odor of urine that permeated into the facility's lobby.	F 677	F677 SS-F 1. Corrective Action: " Resident #□s 6, #18, #22, #23, #31, #32, #38, #50, #51, #53 and #55 no longer use the [redacted] (referred to in 2567 as incontinence brief). " All remaining Prevail liners remining in the facility were discarded and the ability to order them was removed from the ordering list. " Resident #233 was offered a bath, and a bed bath was provided, per her preference. " Resident #80 does not appear on the resident sample list provided. " Resident #233 placed on a bathing schedule that she agreed to. " On March 26, 2024, [redacted] care education was provided to all clinical staff by the Unit Manager. " On March 26, 2024, education was provided to CNA□s, by the unit manager, on documenting the importance of completing Point of Care documentation upon completing resident care. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be	4/16/24

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F 677	Continued From page 110 a) On 02/23/24 at 6:15 AM, Resident #51 was observed in bed was NJ EX Order. 264b1 and was observed NJ EX Order. 264b1. Two CNAs assisted in the presence of the Licensed Practical Nurse (LPN) and confirmed that some of the residents wore NJ EX Order. 264b1. When inquired if all the residents consented to have two briefs on, the CNA stated that the residents that could not consent to the [redacted] inside the NJ EX Order. 264b1, the staff would "just put them on." The CNA stated that residents who were labeled as "NJ EX Order. 264b1", the facility provided the [redacted] to be used. A review of the Admission Summary revealed that Resident #51 was admitted to the facility with diagnoses which included but were not limited to, NJ EX Order. 264b1. The Annual Minimum Data Set (MDS) dated [redacted] an assessment tool used by the facility to prioritize care reflected that Resident #51 was NJ EX Order. 264b1. Resident #51 scored [redacted] on the Brief Interview for Mental Status (BIMS). [redacted] of the MDS which addressed personal hygiene reflected that Resident #51 required maximum assistance from staff with ADLs. The Comprehensive Care Plan initiated [redacted] had a focus for limited physical mobility related to NJ EX Order. 264b1 in performing ADLs, NJ EX Order. 264b1 and [redacted]. The resident's care plan did not have a focus for ADLs [redacted] performance deficit, or any care plan related to wearing two NJ EX Order. 264b1. b) On 02/23/24 at 6:22 AM, Surveyor #2 was on the [redacted] unit [redacted] hall. CNA #2 was present and stated that the rooms in that area were on her assignment and that the [redacted] care had	F 677	affected by this deficient practice. 3. Measures Put into Place: " The unit manger and/or designee will do random audits of 5 residents per week to assure that only one [redacted] product is used on a resident at a time. " The unit manager and/or designee will do random audits on Point of Care documentation of 5 resident to assure incontinence documentation is completed commensurate with care provided. " The unit manager and/or designee will do random audits of 5 residents per week to assure that they received their bath and/or shower as scheduled. 4. How Will These Actions Be Measured: " The results of the weekly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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been completed.

On 02/23/24 at 6:31 AM, the LPN stated the staff would use NJ EX Order. 264b1 s for residents during the night. She stated the resident would either request two or if they can not request them, the staff would use [redacted] "anyway".

On 02/23/24 at 6:39 AM, Surveyor #2 was standing outside of Resident #32's room door and there was a NJ EX Order. 264b1. CNA #2 was in the hall and confirmed the odor was present. CNA #2 and Surveyor #2 entered the room and pulled the privacy curtain. CNA #2 began to perform [redacted] care. At that time, it was observed that the resident had on NJ EX Order. 264b1 NJ EX Order. 264b1.

On 02/23/24 at 8:23 AM, Surveyor #2 interviewed Resident #32 about wearing NJ EX Order. 264b1 [redacted]. Resident #32 stated that the staff "never" asked [him/her] about using NJ EX Order. 264b1 and that he/she "never" asked to use [redacted] NJ EX Order. 264b1

A review of the Admission Record revealed Resident #32 had diagnoses which included but were not limited to: NJ EX Order. 264b1 [redacted] A review of the quarterly MDS dated [redacted] included a BIMS of [redacted] which indicated NJ EX Order. 264b1 cognition. The MDS indicated the resident required substantial/maximal assistance for toileting hygiene. The resident-centered comprehensive on-going care plan included but was not limited to; a focus area of functional ability performance deficit with ADL tasks.

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c) On 02/23/24 at 6:30 AM, the surveyor observed Resident #23 in bed. When asked the CNA to check the resident, the CNA replied, "I just provided incontinence care to the resident". The CNA and surveyor then observed the resident was wearing NJ EX Order: 264b1, and NJ EX Order: 264b1 were NJ EX Order: 264b1. The CNA declined to comment on the last time the resident was cared for.

On 02/23/24 at 7:00 AM, the surveyor interviewed another CNA who worked the 11:00 PM-7:00 AM shift regarding the term, NJ EX Order: 264b1". The CNA stated that all the residents who were NJ EX Order: 264b1 " wore NJ EX Order: 264b1, and the facility provided the NJ EX Order: 264b1 that were applied inside the NJ EX Order: 264b1. When inquired about who instructed them on applying the NJ EX Order: 264b1 on the residents, the CNA stated that the resident was care planned to have the NJ EX Order: 264b1 on and declined to comment further.

Review of medical record revealed: The Admission Summary revealed Resident #23 was admitted to the facility with diagnoses which included but were not limited to; NJ EX Order: 264b1. The Quarterly Minimum Data Set (MDS) dated NJ EX Order: 264b1 an assessment tool used by the facility to prioritize care, reflected that Resident #23 had NJ EX Order: 264b1 (BIMS NJ EX Order: 264b1 and required extensive assistance from staff with Activities of Daily Living (ADLs).

The Care Plan (CP) initiated on NJ EX Order: 264b1 revealed that the Resident had a focus for NJ EX Order: 264b1

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NJ EX Order 264b1 Intervention included but was not limited to provide pericare after each NJ EX Order 264b1 episode. Wearing NJ EX Order 264b1 was not listed as a documented intervention on the CP as stated by the CNA.

The form "Task Schedule (TS) for NJ EX Order 264b1" under Personal Hygiene, showed no documentation to indicate that Resident #23 was provided with Personal Hygiene care for 15 days out of the 29 days. The facility could not provide documentation for the discrepancy. On 02/26/24 at 11:30 AM the Task schedule reflected that Resident #23 received NJ EX Order 264b1 care at 10:38 PM on 02/23/24.

d) On 02/23/24 at 6:40 AM, the CNA checked Resident #50 for NJ EX Order 264b1 care. The surveyor observed that Resident #50 was wearing NJ EX Order 264b1 which were NJ EX Order 264b1 NJ EX Order 264b1. The CNA stated, the resident was a NJ EX Order 264b1, "and all NJ EX Order 264b1 wore NJ EX Order 264b1 It is on the care plan."

Review of the medical record revealed: The Admission Face Sheet (an admission summary), Resident #50 was admitted to the facility with diagnoses which included but were not limited to: NJ EX Order 264b1. The Quarterly Minimum Data Set (MDS), an assessment tool, dated NJ EX Order 264b1 reflected that Resident #50 had NJ EX Order 264b1 (BIMS NJ EX Order 264b1 and was NJ EX Order 264b1 on staff with Activities of Daily Living (ADLs). The Care Plan (CP) initiated on NJ EX Order 264b1, revealed the Resident had a focus for Functional Ability Performance Deficit related to NJ EX Order 264b1. Interventions included but were not limited to: Encourage the resident to participate to the fullest extent

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possible with each interaction. There was nothing documented regarding placing NJ EX Order 264b1 on the resident per the CNA.

e) On 02/23/24 at 6:49 AM, the surveyor observed Resident #55 wearing NJ EX Order 264b1 which were NJ EX Order. 264b1. The CNA stated that the resident was a NJ EX Order 264b1 and wore NJ EX Order 264b1. The CNA further added that the facility provided the NJ EX Order 264b1 which the facility referred to as NJ EX Order 264b1"

Review of the medical record revealed: Resident #55 had diagnoses which included but were not limited to: NJ EX Order. 264b1. The Annual Minimum Data Set (MDS) dated NJ EX Order 264b1 reflected that Resident #55 was NJ EX Order. 264b1 (BIMS NJ EX Order 264b1) and was NJ EX Order 264b1 on staff for ADLs. The Comprehensive Care Plan reflected a "Focus" for communication problem related to NJ EX Order 264b1 and NJ EX Order 264b1. The goal was for the staff to anticipate all needs. The care plan did not address how the resident personal care will be met.

The Task form provided by the Assistant Director of the Nursing (ADON) where the CNA documented the time NJ EX Order 264b1 care was provided, was left blank for 15 days during the February month. On 02/23/24, the day of the tour, incontinence care was documented as provided, at 2:16 AM, then 2:37 PM (12 hours later), and 9:24 PM (9 hours later).

On 02/23/24 at 11:15 AM, during an interview with the Unit Manager she stated that the CNA would provide NJ EX Order 264b1 care to dependent residents at the beginning of the shift and prior to exit the

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shift.

f) On 02/23/24 at 7:54 AM, during a random care tour with the CNA, Resident #31 was observed wearing NJ EX Order. 264b1 which were NJ EX Order. 264b1. The CNA informed the surveyor that the resident was a NJ EX Order. 264b1 and needed NJ EX Order. 264b1 to be worn.

Review of the medical record revealed: Resident #31 was admitted to the facility with diagnoses which included but were not limited to: NJ EX Order. 264b1. According to the Quarterly Minimum Data Set (MDS), an assessment tool, dated NJ EX Order. 264b1, Resident # 31 was NJ EX Order. 264b1 paired. Resident #31 scored NJ EX Order. 264b1 on the Brief Interview for Mental Status (BIMS) and was dependent on staff with Activities of Daily Living (ADLs). The Care Plan (CP) initiated on NJ EX Order. 264b1, showed that the Resident had Functional Ability Performance deficit related to NJ EX Order. 264b1 due to NJ EX Order. 264b1 Intervention included but was not limited to encourage the resident to participate to the fullest extent possible with each interaction. There was no documented intervention to utilize NJ EX Order. 264b1.

g) On 02/23/24 at 10:17 AM, during the care tour, Surveyor #1 observed Resident #53 was saturated with urine and was observed wearing NJ EX Order. 264b1. The CNA again stated that the resident was a NJ EX Order. 264b1

Review of the medical record revealed: Resident #53 was admitted to the facility with diagnoses which included but were not limited to; NJ EX Order. 264b1

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care. According to the Quarterly MDS dated [redacted], Resident #53 had [redacted] (BIMS [redacted] and required [redacted] staff assistance with ADLs. The Care Plan (CP) created on [redacted], revealed that the Resident had [redacted] and required [redacted] ADL assistance. Interventions included but were not limited to: Anticipate and meet the resident's needs. There was no documented intervention to [redacted].

The form "Task" under Personal Hygiene, showed no documentation to indicate that Resident #53 was assisted with Personal Hygiene for 18 out of 29 days for February.On 02/23/24 at 12:01 PM, the surveyor performed a care tour with the assigned CNA. Resident #22 was sitting at the edge of the bed, and the sheet [redacted] The resident's [redacted] and the [redacted] were [redacted]. The CNA stated that he provided care to the resident in the morning, the time was not provided. The CNA did not mention that the resident refused or was combative with care.

h) On 02/26/24, during a subsequent observation at 8:38 AM, the surveyor observed the resident in the room attempted to get dressed and the breakfast tray was noted on the bedside table. An [redacted] permeated the room. Resident #22 then attempted to put their [redacted] on, and the [redacted] was [redacted] and [redacted] in the front preventing the resident from pulling on their [redacted] The surveyor asked the resident to activate the call light. The resident stated "that they would not come." The surveyor went to the hallway and asked a random CNA to assist. The CNA confirmed that she served the breakfast tray and did not realize that

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the resident needed to be [redacted]. At the surveyor request, the resident was checked for [redacted]. The resident was soiled with urine and feces and was wearing [redacted]. The CNA stated that she did not provide care yet to the resident. The CNA stated that the [redacted] were from the night shift.

Review of the medical record revealed: Resident #22 was admitted to the facility with diagnoses which included, but were not limited to; [redacted]

According to the Quarterly Minimum Data Set (MDS) dated [redacted], Resident #22 had severe [redacted] Resident #22 scored [redacted] out of [redacted] on the Brief Interview for Mental Status) BIMS. Resident #22 required [redacted] staff assistance with ADLs. The Care Plan (CP) created on [redacted] failed to address the resident ADLs needs. The care plan revealed that the resident had a behavior of [redacted]. There was no documented intervention to utilize [redacted].

i) On 02/26/24 at 9:30 AM, the surveyor observed Resident #38 sitting at the edge of the bed and attempted to stand up. The LPN had the medication cart next to the resident's door. A [redacted] was permeated at the door entrance. The LPN acknowledged that the resident was a [redacted] risk and needed to be [redacted] The LPN informed the surveyor that the CNA was not available to [redacted] the resident yet, she was at the door to ensure that the resident did not [redacted] The LPN did not make any attempt to change the resident. The surveyor left the room and informed the Unit Manager of the observations. The Unit Manager and another

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CNA provided incontinence care to the resident. During [redacted] care, the surveyor observed that Resident #38 was NJ EX Order: 264b1 and their clothing was also [redacted] and needed to be [redacted].

Review of the medical record revealed: Resident #38 was admitted to the facility with diagnoses which included but were not limited to: [redacted].

According to the Quarterly MDS dated [redacted], Resident #38 had NJ EX Order: 264b1 and required [redacted] staff assistance with ADLs. The Care Plan (CP) had a focus for [redacted] related to NJ EX Order: 264b1s. One of the interventions was for staff to anticipate all needs.

j) On 02/26/24 at 9:17 AM, Surveyor #1 and #3 met with Resident #18 regarding care concerns that Resident #18 stated were addressed with the Director of Nursing. Resident #18 stated that [redacted] care was not provided in a timely manner and [redacted] care was to be provided every 2 hours but was not being done. The resident could not provide the specific date and time but stated that on one occasion she requested to be [redacted] at 2:00 PM and did not get [redacted] until 7:00 PM. The resident confirmed the use of the [redacted] and stated that some times it was allowed because it was known that the staff would not provide [redacted] care every two hours. Resident #18 further stated that this issue had been discussed with the DON. The surveyor then asked the resident if they would be able to recount the same story in the presence of the DON. The resident agreed to discuss the concerns with the DON in

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the room. The surveyor then accompanied the DON to the room and the resident recounted the same story and stated, "he told me he was going to take care of it". The DON confirmed that the concern had been brought to his attention and was addressed. Surveyor #1 asked Resident #18 how that made him/her feel to have to wait and the resident stated, "I don't like it".

A review of Resident #18's medical record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; NJ EX Order. 264b1 s. The surveyor reviewed the resident clinical record. The Quarterly Minimum Data Set dated NJ EX Order. 264b1 reflected that Resident #18 had NJ EX Order. 264b1. Resident #18 was NJ EX Order. 264b1 NJ EX Order. 264b1 Resident #18 scored NJ EX Order. 264b1 on the Brief Interview for Mental Status (BIMS). The Comprehensive Care Plan initiated NJ EX Order. 264b1 reflected a focus for NJ EX Order. 264b1 related to NJ EX Order. 264b1. One of the interventions was to provide NJ EX Order. 264b1 care after each episode. There was no documented intervention to utilize NJ EX Order. 264b1.

On 02/26/24 at 9:28 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) and inquired if wearing NJ EX Order. 264b1 was on the CNA instructions care card. The LPNUM stated, "no" that residents should be NJ EX Order. 264b1 every two hours.

On 02/26/24 at 9:41 AM, in the presence of the survey team. The surveyor asked the DON what are the expectations regarding providing NJ EX Order. 264b1 care to the residents? The DON stated the moment I was made aware of the

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double diapers, I suspended employees, however the DON did not respond to why the surveyor observed the ongoing use of NJ EX Order 264b1 [redacted]. The surveyor asked about using an NJ Ex Order 264b1 and inserting a separate [redacted] NJ EX Order 264b1. The DON stated he was aware about the [redacted] being put inside an NJ EX Order 264b1. The DON then stated, if a lady is requesting a liner inside the [redacted], it was okay.

On 02/26/24 at 9:45 AM, during an interview with the DON, he revealed that the concern with Resident #38 was brought to his attention and the LPN was in-serviced. The DON further stated that all licensed staff can provide NJ EX Order 264b1

02/26/24 at 9:47 AM the surveyor asked if Resident #18's complaints were followed up and the DON, stated "everyone knows that [redacted] should be done every two hours", and "everyone knows their jobs". The surveyor asked if the supervisor was addressed regarding the resident complaints. The DON stated the supervisor checked on staff, by making rounds and talking to nurses.

On 02/26/24 at 11:20 AM, the surveyor interviewed Resident #31 regarding NJ Ex Order 264b1 care received at the facility. The resident stated that NJ Ex Order 264b1 care was not provided in a timely manner. The surveyor asked the resident if she requested to have NJ Ex Order 264b1 on, the resident stated that she did not request to have NJ EX Order. 264b1 on.

On 02/26/24 at 12:30 PM, the surveyor interviewed a CNA on the [redacted] side of the [redacted] Unit. The CNA confirmed that incontinent care was provided at the beginning and at the end of

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the shift. Resident who were considered as [redacted] wore [redacted] to prevent their clothing from being [redacted] when they attended activities.

On 02/27/23 at 11:15 AM the surveyor interviewed the Social Worker (SW) regarding the resident's concerns. The SW informed the surveyor that she was aware and assisted Resident #18 with filing a grievance. The SW also stated that she had discussed the issue with the DON and the team in morning meeting. The surveyor reviewed the grievance book and verified that the concern with [redacted] care was addressed.

k) On 02/26/24 at 10:30 AM, Resident #6 informed the surveyors that he/she also had some concerns that he/she would like to address. Resident #6 expressed their frustration over not receiving [redacted] care in a timely manner. When he/she asked to be changed if the roommate did not ask to be [redacted], he/she would not be [redacted]. Resident #6 stated, for example, on [redacted] he/she asked to be [redacted] and the CNA kept walking back and forth in the hallway and ignored their request. The resident stated, "It took a lot from me to open my mouth" I was really in bad shape, I let her have it. That was not right that I have to sit in my excrements for hours. By the time I was provided with [redacted] care I was [redacted] I had to open my mouth. I felt neglected".

Review of the medical record revealed: Resident # 6 was admitted to the facility with diagnoses which included but were not limited to: [redacted].

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F 677	Continued From page 122 The Admission Minimum Data Set (MDS) an assessment tool used by the facility to prioritize care, reflected that the resident cognition was [redacted] Resident #6 scored [redacted] on the Brief Interview for Mental Status (BIMS). The Comprehensive Care Plan dated [redacted] had a focus for Functional Ability Performance Deficit. The intervention was to observe for possible reversible cause such as reconditioning. The care plan did not include how the resident would be assisted with ADLs care. While in the room, Resident #6 informed the surveyors that she also had some concerns that she would like to address. Resident #6 expressed their frustration over not receiving [redacted] care in a timely manner. When he/she asked to be changed if the roommate did not ask to be changed she would not be changed. The form "Task Schedule (TS) for [redacted] under Personal Hygiene, showed missing documentation to indicate that Resident #6 was assisted with Personal Hygiene for 11 days during the month. On 02/25/24 the Task was not signed to indicate when [redacted] care was provided as indicated by Resident #6 2: a) On 02/21/24, Surveyor #1 reviewed the closed medical record for Resident #80. Resident #80 was noted as not receiving their scheduled showers or a bed bath specifically on [redacted] and [redacted] The record also noted not receiving their scheduled shower on [redacted] and [redacted] On 02/21/24 at 8:15 AM, Surveyor #1 requested the shower log for review. The LPN/UM indicated that there was no shower log for the designated	F 677		

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time. The UM/LPN revealed that the shower time aligned with the skin assessment. All residents were scheduled for shower and skin assessment x 2 weekly.

On 02/21/24 at 10:59 AM, the Director of Nursing (DON) stated that he implemented the shower log book in [redacted]. Prior to [redacted], the CNAs were documenting showers in the computer. The surveyor requested the entries from the computer to verify that residents received their shower as scheduled, none were provided.

The surveyor reviewed the Treatment Administration Record (TAR) for [redacted] The TAR revealed that skin assessments were scheduled to be performed weekly and was checked as being done, on [redacted] and [redacted]. The TAR did not reflect that Resident #80 received a shower on [redacted]

A review of the [redacted] TAR reflected that Resident #80's skin check was ordered weekly and was done on the following dates: [redacted] and [redacted]. The skin assessment was not signed for [redacted], [redacted] and [redacted] to reflect that Resident #80 received a shower on those days.

On 02/29/24 at 10:35 AM, Surveyor #1 interviewed the LPN/UM regarding Resident #80. The LPN/UM stated Resident #80 was very difficult to care for on shower days. The resident had [redacted] and had to be transferred on a [redacted] After showers, Resident #80 requested staff to spend time drying their [redacted] The process was long and the staff had other patients to care for. The Interdisciplinary Team decided that the Resident would have one shower

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on the 7:00 AM-3:00 PM shift and one shower on the 3:00 PM-11:00 PM shift. The LPN/UM did not provide the Interdisciplinary Notes for review. There was no documented evidence in the clinical record which reflected that Resident #80 received a shower on the 3:00 PM-11:00 PM shift.

On 02/27/24 at 8:50 AM, Surveyor #1 conducted an interview and a care tour with a CNA who had been at the facility for over 4 months. During the care tour, the resident was observed wearing NJ EX Order 264b1. When inquired regarding who instructed her to use NJ EX Order 264b1 on the residents, the CNA replied clearly, "I was instructed to apply the NJ EX Order 264b1 during orientation."

On 02/27/24 at 10:30 AM, the surveyor conducted an interview with the Registered Nurse (RN) assigned to the N/A side of the NJ EX Order Unit. The RN stated that ADLs provided to the residents were documented in the computer by the CNAs every shift.

On 02/27/24 at 11:25 AM, the surveyor asked the CNA to show the surveyor the ADL documentation on the computer. The CNA was unable to show the documentation.

On 02/29/24 at 11:05 AM, the surveyor interviewed the DON in the presence of the team. The DON revealed again that the facility did not have a process in place to ensure showers were given on assigned days prior to NJ EX Order 264b1. The DON went on to state, for example, the resident's family would complain about their loved ones not receiving showers and there was no documentation to verify that the residents received their showers on their scheduled days.

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He implemented the shower log in [redacted].

On 02/26/24 at 10:06 AM, an interview with the Unit Secretary in charge of Central supply, revealed that the facility asked her to order the [redacted] that the CNAs referred to as a "[redacted]". On 02/26/24 at 11:00 AM, Surveyor #1 and Surveyor #2 accompanied the Unit Secretary to the storage room and verified that the facility stored multiple boxes of the [redacted] at the lower level of the facility.

b) On 03/05/24, Surveyor #2 reviewed the Admission Record for Resident #233 which had diagnoses which included but were not limited to; [redacted]. A review of the "Order Summary Report" failed to include an order for showers or bathing. A review of the quarterly MDS dated [redacted], included but was not limited to; the resident required [redacted] assistance for shower/bathe.

A review of the CNA tasks documentation dated [redacted]", included but was not limited to; ADL-Bathing= assist of one person indication that on [redacted] and [redacted], the staff documented "8,8". The code description for 8,8 indicated that bathing either self-performance or support provided "did not occur". The resident had been out of the facility [redacted] This indicated that 12 of the 19 days Resident #233 was in the facility, [he/she] was not provided with bathing/shower.

The facility provided three shower review sheets dated [redacted], and [redacted], which indicated the resident had a bed bath. This resulted in Resident

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#233 not being provided a bath or shower for 9 of the 19 days [he/she] was in the facility in [redacted]y [redacted].

A review of the facility provided, "Certified Nursing Assistant" Job Description undated, included but was not limited to; Purpose: .... to provide each of your assigned residents with routine daily nursing care and services in accordance with the resident's assessment and care plan. Personal Nursing Care Functions: Assist residents with daily dental and mouth care. Assist residents with bath functions (bed bath, tub, or shower). Keep residents dry. Assist residents with bowel and bladder functions. Keep incontinent residents clean and dry. Check each resident routinely to ensure personal care needs are being met.

A review of the facility's policy titled, "Activities of Daily Living (ADL), Supporting last revised 03/2018 provided by the facility on 02/26/24 timed 02:00 PM, indicated the following:
Policy statement
Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs)
Residents who are unable to carry out activities of daily living independently, will receive the services necessary to maintain good nutrition, grooming, personal and oral hygiene.
Under policy interpretation and implementation #6 it is stated, " Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice.

On 03/05/24 at 1:30 PM, the above concerns

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F 677	Continued From page 127 were discussed with the administrative staff and were asked to provide any additional information on the exit day. On 03/06/24 at 8:38 AM, Surveyor #1 interviewed the Assistant Director/Nurse Educator, (ADON) responsible for orientation and in-services at the facility. The ADON stated that she was not aware that the CNAs were still using NJ EX Order 264b1 briefs on the residents. The ADON stated that 2 months ago the issue was brought to their attention and the staff was in-serviced. Some staff were suspended. When inquired if any follow up was done to verify compliance she stated, "No". The policy was not being followed. NJAC 8:39-4.1 (12) NJAC 8:39-27.2(g) (h) NJAC 8:39-4.1 (12) NJAC 8:39-27.2(g) (h)	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by:	F 679		4/16/24

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F 679	Continued From page 128 Based on interview, record review and document review, it was determined that the facility failed to ensure that an ongoing activity program was designed to meet the needs of all residents, specifically those who enjoyed outside of the facility trips. The deficient practice was identified for 1 of 2 residents reviewed for activities (Resident #18) and was evidenced by the following: On 02/29/24 at 9:00 AM, the surveyor reviewed the Electronic Medical Record for Resident #18, and reviewed the current Care Plan which did not include a care plan for activity preferences. The annual minimum data set (MDS) dated [redacted] revealed Resident #18 scored a [redacted] on the Brief Interview for Mental Status, and was cognitively intact. The Interview for Activity Preferences revealed it was very important to go outside for fresh air when the weather was good. On 02/29/24 at 10:29 AM, the surveyor conducted an interview with Resident #18 who also served as the resident council president. The surveyor asked Resident #18 if the Licesnsed Nursing Home Administator (LNHA) ever conducted a meeting with the residents regarding the changes to the menus. Resident #18 stated "he comes, stands there for like five minutes and leaves" and stated, "no" we never had a meeting. Resident #18 then stated, that we used to go on trips, twice per month. Resident #18 stated that he/she informed the LNHA that residents wanted to go on trips and Resident #18 stated that the LNHA informed him/her that the bus was too expensive and it was too expensive for a trip every month. Resident #18 stated that the last trip was in December and that was three months ago, and prior to that the last trip was to the shopping mall.	F 679	F679 SS-D 1. Corrective Action: " The care plan for Resident #18 was updated to activity preferences on 3/29/24. " The LNHA reviewed the current activity calendar and added a trip on March 27, 2024. Resident #18 was made aware of this addition to the calendar. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " The Administrator and Activity Director will review the Activity calendar prior to the start of each month to plan resident trips that will be able to be followed through. " Monthly audits will be facilitated by the Administrator and/or designee to assure that facility trips were able to occur every other month. 4. How Will These Actions Be Measured: " The results of the monthly Activity Trip audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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The surveyor reviewed the NJ EX Order 20401 activity calendar posted by activity room. The calendar revealed on 02/13/24 at "11:00 Trip to [restaurant name redacted] - TBD".

On 02/29/24 at 10:51 AM, the surveyor interviewed the Activity Director (AD) who stated she had been at the facility for about six months. The surveyor asked the AD if the resident are ever scheduled for trips outside of the facility. The AD stated, the facility would have to hire a company and "bills are pending". The AD stated she cannot schedule trips and she was not sure why. The surveyor asked if trips were important to the residents and the AD stated, "yes" they were important and she spoke with the LNHA and it was at corporate. The AD stated she put a trip on the calendar last month and the transportation company would not come to the facility. The AD showed the surveyor an invoice dated, 08/01/23 for $375.00 for a Recreational Trip. The AD stated she submitted the invoice to corporate on 08/11/23 and 11/21/23 for payment and it has not been paid. The AD stated she is unable to schedule trips and the LNHA did not inform her why the invoice is not getting paid. The AD showed the surveyor the February 2024 where the restaurant trip is "TBD" [To Be Determined].

On 03/05/24 at 1:35 PM, the surveyor informed the LNHA and Director of Nursing, the presence of the survey team, regarding the concerns about the inability to schedule trips due to the transportation invoice not being paid. The LNHA stated, he paid the bill and trips run on the calendar as "TBD". No additional information was provided.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT MANALAPAN	104 PENSION ROAD MANALAPAN, NJ 07726

(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 679	Continued From page 130 NJAC 8:39-7.3(a)(1)(7)	F 679		
F 687 SS=E	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Complaint # NJ 159956 Based on observations, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to obtain a physician's order from the attending physician as recommended by the consulting podiatrist for a resident with a diabetic foot ulcer for 1 of 1 resident (Resident #51) reviewed for foot care. A review of the Electronic medical Record (EMR) revealed that Resident #51 was admitted to the facility with diagnosis including but not limited to: NJ EX Order. 264b1 [redacted]).	F 687	F687 SS-E 1. Corrective Action: " On March 29, 2024, the director of nursing reviewed all current recommendations by consultant physicians to assure the attending physician agreed with them. " Education was provided by the regional nurse to licensed nursing staff on March 26, 2024, that all consultant physician recommendations must be provided to the attending physician and documentation of whether the physician agrees or disagrees with the orders should be documented in the resident□s chart. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency:	4/16/24

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F 687	Continued From page 131 The Annual Minimum Data Set (MDS), as assessment tool, dated [redacted], revealed that Resident # 51 had NJ EX Order: 264b1, an active diagnosis of NJ EX Order: 264b1, acquired absence of the [redacted], transfers with [redacted] assistance and is [redacted]. A review of the comprehensive care plan, initiated [redacted] revealed Resident #51 had [redacted] to [redacted] with an intervention to1. follow facility protocols for treatment of injury and 2. monitor/document NJ EX Order: 264b1 injury. Report abnormalities, failure to heal, signs and symptoms of infection, macerations, etc. to MD. The facility transferred to a new Electronic Medical Record program NJ EX Order: 264b1. The surveyor had limited access to the previous EMR. The facility needed to print all requested medical records. The surveyor reviewed what medical records were provided by the facility. 0n 02/22/24 at 12:40 PM, the surveyor requested all records for Resident #51 from [redacted] through [redacted]. On 02/23/24 at 11:04 PM, the surveyor requested all wounds assessments, incident reports related to the [redacted], [redacted] consults, transfer records from the acute hospital and a timeline for the NJ EX Order: 264b1. On 02/26/24 at 9:00AM, the Director of Nursing (DON) provided a timeline titled "[redacted]. A review of all the printed medical records provided by the facility, skin assessments and the	F 687	" All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " The Unit Manager will do a random weekly audit of 5 residents on the 100 unit and 5 residents on the 200 unit to confirm that the consultant physician orders are reviewed with the attending physician to see if they are in agreement. 4. How Will These Actions Be Measured: " The results of the weekly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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F 687	Continued From page 132	F 687		

timeline of NJ EX Order. 264b1 revealed the following:

NJ EX Order. 264b1 - Resident admitted to the facility as a transfer from [name redacted]. No breakdown of NJ EX Order. 264b1 noted by Registered Nurse (RN) assessment.

NJ EX Order. 264b1 Incident report indicates NJ EX Order. 264b1 (a NJ EX Order. 264b1, NJ EX Order. 264b1 or NJ EX Order. 264b1 tissue) to NJ EX Order. 264b1.

NJ EX Order. 264b1 - Incident report dated NJ EX Order. 264b1 at 8:30 PM- a NJ EX Order. 264b1 was found on the NJ EX Order. 264b1. This patient is NJ EX Order. 264b1. There is a NJ EX Order. 264b1 NJ EX Order. 264b1 Left message for daughter, Director of Nursing signed the report.

NJ EX Order. 264b1 at 5:13 PM- NJ EX Order. 264b1 consult pt [patient] seen at bedside. Complaint: evaluation NJ EX Order. 264b1 NJ EX Order. 264b1. Seen with NJ EX Order. 264b1 r present- NJ EX Order. 264b1 but palpable, NJ EX Order. 264b1 NJ EX Order. 264b1. NJ EX Order. 264b1 is not infected, covered by NJ EX Order. 264b1 no NJ EX Order. 264b1. NJ EX Order. 264b1 cleaned. NJ EX Order. 264b1 (topical NJ EX Order. 264b1 ointment) and dry sterile dressing (DSD) applied.

NJ EX Order. 264b1 at 7:31 PM Nurses note: Resident was seen by NJ EX Order. 264b1, new order received to apply NJ EX Order. 264b1 ointment to NJ EX Order. 264b1 cover with dressing. Order carried out.

NJ EX Order. 264b1 2 at 8:36 PM Podiatry note - Pt has NJ EX Order. 264b1 to NJ EX Order. 264b1 noted in the area, no signs of NJ EX Order. 264b1, and no NJ EX Order. 264b1. NJ EX Order. 264b1 cleaned and flushed, NJ EX Order. 264b1 and DSD applied. Continue daily use of topica NJ EX Order. 264b1 to the NJ EX Order. 264b1.

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NJ EX Order 264b1 note- complaint at the time is related to evaluation of NJ EX Order 264b1. Pts NJ EX Order 264b1 present. NJ EX Order 264b1 is not infected, covered by NJ EX Order 264b1 no NJ EX Order 264b1. NJ EX Order 264b1 to touch noted, no NJ EX Order 264b1. Recommendations to continue topical cream uses QOD every other day. Follow as needed.

NJ EX Order 264b1 at 5:24 PM NJ EX Order 264b1 note- apply NJ EX Order 264b1 (used to treat certain NJ EX Order 264b1 (such as NJ EX Order 264b1. It is an NJ EX Order 264b1. It works by stopping the growth of certain NJ EX Order 264b1) NJ EX Order 264b1 NJ EX Order 264b1 every other day (QOD).

NJ EX Order 264b1 note- NJ EX Order 264b1 is not infected, covered by eschar, no NJ EX Order 264b1 or NJ EX Order 264b1. NJ EX Order 264b1 to touch noted, no NJ EX Order 264b1. Today, no dressing on noted in the area. NJ EX Order 264b1 NJ EX Order 264b1 cleaned, NJ EX Order 264b1 applied, and DSD applied. Covered by small dressing. Recommendations to continue topical cream uses QOD. Follow as needed.

NJ EX Order 264b1 NJ EX Order 264b1 is not infected, covered by NJ EX Order 264b1 No r NJ EX Order 264b1 or NJ EX Order 264b1 to touch. today, no dressing is noted in the area. NJ EX Order 264b1 cleaned, NJ EX Order 264b1 and DSD applied. Covered with small dressing. improving and is NJ EX Order 264b1. Recommendations to continue topical cream uses QOD. Follow as needed.

NJ EX Order 264b1 y note: NJ EX Order 264b1 is not infected, covered by NJ EX Order 264b1 NJ EX Order 264b1. Some of the NJ EX Order 264b1 tissue NJ EX Order 264b1. No dressing noted in the area. NJ EX Order 264b1 to NJ EX Order 264b1 cleaned NJ EX Order 264b1 applied and DSD. Covered by small dressing. Recommendations to continue topical cream uses QOD. Follow as needed.

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F 687		F 687		

Continued From page 134

NJ EX Order. 264b1 NJ EX Order. 264b1 is not infected, covered by NJ EX Order. 264b1, no NJ EX Order. 264b1. NJ EX Order. 264b1 is improving and NJ EX Order. 264b1 NJ EX Order. 264b1 cleaned some of the NJ EX Order. 264b1 tissue NJ EX Order. 264b1 applied and DSD applied. Recommendations to continue topical cream uses QOD. Follow as needed.

On NJ EX Order. 264b1 at 2:24 PM, Resietn#51 was transferred to an NJ EX Order. 264b1, was admitted with a NJ EX Order. 264b1 and subsequently had a an [name redacted] NJ EX Order. 264 NJ EX Order. 264b1 and was treated for NJ EX Order. 264b1

A review of the handwritten Nursing Skin Assessments (NSA) revealed weekly skin assessments were completed by the nursing staff from dates NJ EX Order. 264b1 through NJ EX Order. 264b1 did not reveal any recommended treatments that were ordered for the NJ EX Order. 264b1 .

A review of the NJ EX Order. 264b1 through NJ EX Order. 264b1 Medication Administration Records (MARs)and Treatment Administration Records (TARS) revealed only a Physician Order (PO) with a start date of NJ EX Order. 264b1 for NJ EX Order. 264b1 wipes, 1 application daily, apply to NJ EX Order. 264b1 cover with dressing.

A review of Resident #51's NJ EX Order. 264b1 through NJ EX Order. 264b1 MARs and TARs revealed no physicians order for NJ EX Order. 264b1 as recommended by the consulting NJ EX Order. 264b1.

A review of the attending physicians' progress notes dated NJ EX Order. 264b1 revealed that the Resident #51 was NJ EX Order. 264b1 and NJ EX Order. 264b1 and did not have any NJ EX Order. 264b1 issues. The facility did not provide any physicians

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F 687	Continued From page 135 progress noted from [redacted] through [redacted]. A review of the handwritten physician order sheets dated [redacted] through [redacted], provided by the facility, did not include any PO for NJ EX Order. 264b1 as recommended by the consulting podiatrist. The facility did not provide the EMR physician orders for Resident #51 from [redacted] through [redacted]. On 02/27/24 at 10:09AM, the LPN Unit Manager (LPN UM) for the [redacted] unit stated that the [redacted] that was treating Resident #51 in [redacted] does not work at the facility at that time and the resident was being treated by a different [redacted] now. On 02/27/24 at 11:31 AM, the surveyor interviewed the LPN UM who stated that if a [redacted] was on the [redacted] then a [redacted] would be following the resident, if the [redacted] was a NJ EX Order. 264b1, then a [redacted] consult would be ordered. The LPN UM also stated that the attending physician from [redacted] does not work at the facility at this time. On 02/29/24 at 02:02 PM, the surveyor interviewed the Director of Nursing who state that when a podiatrist or an outside consulting doctor makes a recommendation, then the attending doctor [redacted] need to write an order. A review of the facility's policy titled "Medication Administration," dated April 2019, reflected that medications are administered in a safe and timely manner and as prescribed.	F 687		

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F 687	Continued From page 136 NJAC 8:39-27.1(a)	F 687		
F 689 SS=H	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other pertinent documents, it was determined that the facility failed to a) ensure adequate supervision to prevent [redacted], b) ensure current documented fall prevention interventions were consistently implemented, and c) ensure the [redacted] Policy was consistently followed to complete an assessment of the causal factor and identify and implement pertinent [redacted] prevention interventions to prevent further [redacted], . This deficient practice was identified for 1 of 5 residents (Resident #5), reviewed for accidents. Resident #5 was identified as a [redacted] risk for [redacted]. Sustained [redacted] falls from [redacted] through [redacted] including [redacted] with major injuries on [redacted] (72 hours after admission) sustained a [redacted] to the [redacted] and [redacted] to the [redacted]. On 0[redacted] sustained a NJ EX Order. 264b1 of the NJ EX Order. 264b1 NJ EX Order. 264b1 of NJ EX Order. 264b1 On [redacted], Resident #5 had an unwitnessed [redacted] required emergent 911 transfer and resulted in a [redacted].	F 689	F689 SS-H 1. Corrective Action: " Upon identification, a rehab/therapy evaluation was initiated on 3/25/24 for Resident #5. " On 3/24/24, Resident #5□s care plan was updated to include frequent checks to assure that all safety precautions are in place per care plan interventions and to proactively anticipate resident□s needs, assure frequently used items are within reach, ask resident if she has to us the bathroom during frequent checks. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " Fall prevention education will be provided to clinical and interdisciplinary staff by therapy and will be completed by April 4, 2024.	4/16/24

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F 689	Continued From page 137 The deficient practice was evidenced by the following: On 02/20/24 at 9:57 AM, the surveyor observed Resident #5 being transferred to the room in a wheelchair by a Certified Nursing Assistant (CNA). On 02/21/24 at 10:30 AM, during an interview with the CNA, she stated that Resident #5's dominant language was a [foreign language redacted] but was able to understand and follow commands and required assistance with transfers. On 02/28/24 at 8:35 AM, the surveyor observed Resident #5 in the room and observed a [redacted] NJ EX Order: 264b1 that [redacted] from the NJ EX Order: 264b1 to the [redacted] and with NJ EX Order: 264b1. A visitor was in the room and informed the surveyor that the resident had a [redacted] on [redacted], and was transferred to the hospital, then returned to the facility "last night" ([redacted]). On 02/28/24 at 10:00 AM, the surveyor conducted an initial review of the electronic medical record (EMR) for Resident #5. The EMR did not contain any medical records prior to [redacted]. The surveyor requested all medical records from [redacted] from the Licensed Nursing Home Administrator (LNHA). According to the current Admission Record (an admission summary), Resident #5 was re-admitted to the facility on [redacted], with diagnoses which included NJ EX Order: 264b1 [redacted].	F 689	" The DON and/or designees will audit fall incident reports weekly to assure that appropriate interventions and rehab screens were added and completed post fall. " The DON and/or designee will audit weekly all NJ EX Order: 264b1 and [redacted] used a [redacted] precaution measure to sure they are in place and functioning. 4. How Will These Actions Be Measured: " The results of the weekly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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F 689	Continued From page 138 Other diagnoses included but were not limited to; need for assistance with personal care, NJ EX Order. 264b1 . Review of the Admission/Re-Admission Nursing Assessment dated [redacted] timed 10:45 PM, indicated that Resident #5 was admitted to the facility from another Long Term Care facility, was NJ EX Order. 264b1 with intermittent [redacted] Admitting diagnosis: NJ EX Order. 264b1 [redacted] related to [redacted] from home prior to admission. The assessment indicated that Resident #5 required NJ EX Order. 264b1 with transfer, bed mobility and toileting, supervision with meals, NJ EX Order. 264b1 . Review of the most recent Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], reflected the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted], indicating that the resident had [redacted] NJ EX Order. 264b1 . Review of the Incident /Accident Report dated 09/11/22 timed 2:12 PM, indicated that the CNA called the nurse to the room. Resident #5 noted to be lying on the floor next to the bed. Resident confused but stated that [he/she] needed to get out of the bed. Resident noted with [redacted] and [redacted] area above NJ EX Order. 264b1 , reported NJ EX Order. 264b1 . MD [Medical Doctor] aware, and NJ EX Order. 264b1 ordered. [redacted] check in progress. Kept at nursing station for close supervision. Resident has new bed with side rails at this time. Family called and updated on plan of care. Call bell in place. [redacted] done at 10:00 PM.	F 689		

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On 02/28/2024 at 11:00 AM, the surveyor requested all [redacted] medical records for Resident #5 from the Director of Nursing (DON). Review of the facility provided care plan revealed a Care Plan (CP) for [redacted] Established [redacted] 2. The CP Problem indicated the following:

[redacted] r/t [related to] history [redacted], [redacted], [redacted] and [redacted] med use [[redacted] and [redacted] medication use], NJ EX Order. 264b1, [diagnosis] NJ EX Order. 264b1

Goals: "I will have no incidents and will remain free of injury [related to] [redacted]". Started [redacted] with a Target Date of [redacted] The DON provided a CP for [redacted] CP that was from a prior admission to the facility and was "Discontinued" on [redacted]

A Care Plan for [redacted] -Site 1, Established [redacted] and Discontinued [redacted] revealed Problem NJ EX Order. 264b1 system [status post] NJ EX Order. 264b1 with interventions that included [redacted] "Medicate for [redacted] prior to activities, i.e. [example] physical therapy, ADL [Activities of Daily Living] care, transfers."

Review of the Physician Progress Notes dated [redacted] revealed Impaired mobility, and self care due to NJ EX Order. 264b1 was transferred to the facility on [redacted]. Admission course complicated by NJ EX Order. 264b1 out of the bed [redacted] NJ EX Order. 264b1 and [redacted] at [redacted] at best NJ EX Order. 264b1 aggravated with NJ EX Order. 264b1. The physician progress notes continued: Repeated [redacted] probably due to [redacted], decreased [redacted], NJ EX Order. 264b1 and [redacted]

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Review of the History and Physical (H&P) dated , completed by the physician, indicated that Resident #5 had a past medical history of NJ EX Order. 264b1 NJ EX Order. 264b1 New probably/ no additional work-up: likely due to recent fall, seen by who recommended Patient can resume NJ EX Order. 264b1 to the NJ EX Order. 264b1. Continue Physical therapy (PT) and Occupational therapy (OT) to focus on strategies to and during functional and ADLs.

The surveyor was unable to locate evidence in the resident's medical record that reflected Resident #5 was assessed as a upon readmission on 2, or that a CP for was developed upon readmission to include interventions to prevent further The focus for falls that was provided was from the with the prior admission. Resident #5 was discharged home on and readmitted to the facility on . No care plan for fall with interventions was initiated on

The surveyor reviewed the facility form titled, "Incident/Accident Report" dated timed 2:12 PM, which reflected that Resident #5 had an unwitnessed fall at 2:12 PM. According to the report, the assigned CNA heard Resident #5 calling out for help and observed the resident was on the floor. The nurse then interviewed Resident #5 and the resident stated that [he/she] wanted to get out of the bed. A assessment which indicated that the resident was a .

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Resident #5 received a score of [redacted]. According to the [redacted] risk assessment a score of [redacted] or higher was considered a [redacted]

Review of the Post Incident Review dated [redacted], reflected that Resident #5 was referred to Physical Therapy (PT) on [redacted]. The Therapy Screen dated [redacted] made the following recommendations: "Patient (referring to Resident #5) will need: [redacted] and [redacted] for [redacted]. Patient education to call for assistance as needed. The Screening Form dated [redacted] indicated, "Cognition: [redacted] NJ EX Order. 264b1, history [redacted], long history of NJ EX Order. 264b1." Recommendations: Continue with skilled therapy to increase [redacted] and [redacted]. Patient requires NJ EX Order. 264b1 The surveyor could not locate where these recommendations /interventions were added on the care plan.

Review of the nurse's notes dated [redacted] timed 12:17 (12:17 PM), revealed the following: "... S/P [status post], NJ EX Order. 264b1 and [redacted] noted to NJ EX Order. 264b1, NJ EX Order. 264b1 [redacted] noted to [redacted] NJ EX Order. 264b1 ... [redacted] y pending result.

Review of the Nurse's notes dated [redacted] timed 5:45 PM, revealed: Right eyebrow still noted with NJ EX Order. 264b1. [redacted] precaution maintained. Resident encouraged to use safety whenever help is needed. Bed placed to lowest position, call bell with personal items within reach. [redacted] done result still pending.

Review of the nurses notes dated [redacted] indicated that Resident #5 was moved to Room 216-2 to be closer to the nursing station. [redacted]

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result negative.

The facility was unable to provide the report of the ordered on . An report of the dated was attached to the Incident Report dated

Review of the nurses notes dated revealed the following documentation: MD ordered the due to to site. Resident reported to the . of the was for a NJ EX Order. 264b1 of the of .

Further review of the medical records revealed that on , the resident was referred to the t who ordered that an be applied to mobilize the .

Review of the Nurse's Progress notes dated at 2:40 PM, indicated documentation of an unwitnessed Resident noted to be sliding out of the bed, onto the floor next to the bed. The resident did not have a or a to alert the staff. According to Incident /Accident statement, Resident #5 was trying to reach for the phone. The phone was not within reach. The post incident review indicated in the post incident interventions that the phone should be on the over bed table, as well as other items frequently used. Continue with PT and OT. The facility determined on , after reviewing the incident /accident report that the call bell and personal items would be within reach.

Review of the Incident /Accident Report dated at 11:25 AM, indicated resident was

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found sitting on the floor inside the bathroom. Resident went to the bathroom unassisted, the wheelchair was not locked. There was no documented evidence that the [redacted] sounded and alerted the staff, or that the alarm was present. The staff was unaware that the resident was in the bathroom and could not determine how long the resident had been on the floor.

Review of the CNA statement dated 1[redacted] timed 11:25 AM, indicated that she assisted the resident with care and placed the resident in the wheelchair. The CNA did not indicate that she offered or assisted the resident to the bathroom prior to or after breakfast. The post interventions were to reeducate to lock the wheelchair prior to transfer. Reminded the resident to call for assistance to the bathroom. Therapy referral, Reeducate to call for assistance.

Review of the Incident /Accident Report dated [redacted] at 10:30 AM, indicated Resident #5 had another unwitnessed fall. Resident #5 was found on the floor. The resident reported [redacted] in the [redacted]. On the fall investigation tool, for the question if a safety monitor was in place and was activated, the [redacted] was checked "No".

Review of the Incident /Accident Report dated [redacted] timed 12:50 PM, revealed that Resident #5 had another unwitnessed [redacted] Resident #5 was observed sitting on the floor next to the bed on the right side. Resident later reported [redacted]. Bruises noted to [redacted] measuring [redacted] NJ EX Order. 264b1. NJ EX Order. 264b1, NJ EX Order. 264b1.

Review of the Incident /Accident Report dated [redacted] timed 9:45 AM, revealed Resident #5

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noted sitting on the floor. There was no documented evidence that the [redacted] sounded and alerted the staff. Interventions: Educate on using call bell. Frequent rounding by staff, keep bed at the lowest position, Physical therapy referral.

Review of the Incident /Accident Report dated [redacted] 9:40 AM, indicated Resident # 5 was observed sitting on the floor next to the bed. Resident stated [he/she] was going to the bathroom. Upon assessment, Resident #5 was noted to be NJ EX Order 264b1. Post incident interventions: [redacted] care, offer to take resident to the bathroom frequently. Remind resident to use call bell for assistance. Continue with PT/ OT.

Review of the Incident /Accident Report dated [redacted] at 6:30 PM, indicated resident lost balance while ambulating from bathroom, hit the wall, and landed on the left side. The incident/accident supervisor's statement form indicated that the roommate reported that the resident went to the bathroom unassisted. No [redacted] sounded to alert the staff that the resident was in the bathroom. The [redacted] assessment revealed [redacted] the [redacted] t, and [redacted]. [redacted] eve[redacted]. Resident remained on the floor until paramedics arrived. Resident #5 was transferred to the Emergency Department for evaluation and treatment. Resident #5 was diagnosed with NJ EX Order 264b1 and NJ EX Order 264b1). After the [redacted] of [redacted] the Interdisciplinary met and decided to add a [redacted] and a [redacted].

The recommendations from a "Nursing Communication to Therapy Form" and dated and

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signed by a Physical Therapist on [redacted] revealed, "Patient will need [redacted] for [redacted]" The Care Plan revealed an intervention, initiated on [redacted] 3, "Resident uses [redacted] while in bed". This intervention was added to the care plan 14 months after the initial [redacted] on [redacted]

Review of the Incident /Accident Report dated [redacted] timed 7:40 AM, indicated Resident # 5 unplugged [redacted] and tried to get out of the bed, resident slide down to the floor on the right side. There was no statement attached to the [redacted] incident report. The facility could not explain how the resident was able to pull the pad and disconnect the [redacted]

Review of the Incident /Accident Report dated [redacted], revealed that during a transfer the resident slid to [redacted] on the floor. Scratch marks observed to [redacted]. [redacted] observed to [redacted] of the [redacted]

Review of the Incident /Accident Report dated [redacted], indicated an unwitnessed [redacted] out of bed. The nurse documented: "Heard [redacted] sounded off, upon checking the room, observed resident sitting leaning on the right side. Observed a [redacted] on the [redacted], unable to explain what happened, probably hit the [redacted] on the side of the bed." No statement attached to the incident/ Accident report. Resident #5 was transferred to the Emergency Room for evaluation and treatment. The resident was admitted for observation and [redacted] ([redacted]) diagnostic imaging of the [redacted]. The resident returned to the facility on [redacted] with [redacted] which [redacted] from the [redacted], and

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on .

Review of the Nurse's Notes dated timed 21:01 (9:01 PM), indicated that the resident was , denied any and able to move NJ EX Order. 264b1 , ice applied on site. There was no documented evidence for new interventions listed for fall prevention or injury reduction based on the causal factor after each

On 02/26/24 at 10:30 AM, the facility provided a care plan from the new EMR which was initiated on with a target date of . The care plan had a Focus for: "I am at related to history of NJ EX Order. 264b1, ..." The goal was for Resident #5 to be free from injury through the review date. The Interventions initiated on included: Anticipate and meet my needs; Be sure the call light is within reach and encourage to use call light for assistance as needed. Additional interventions initiated on , included [Resident #5] uses while in bed; Ensure the device is in place and functional; [Resident #5] has NJ EX Order. 264b1 s and to NJ EX Order. 264b1 . "I need frequent cues and reminders." Additional interventions initiated on , included Line of site when out of bed.

On 02/28/24 at 9:30 AM, the surveyor reviewed the incident dated and with the Licensed Practical Nurse/Unit Manager (LPN/UM) and requested the care plan for The LPN/UM stated that she did not remember any details of the incident and was not able to speak any further. She informed the surveyor that she would print the care plan.

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F 689	Continued From page 147 On 02/28/24 at 10:30 AM, the surveyor requested a timeline of all the [redacted] and explained to the DON that the timeline should include, date, time, location, causal factor and interventions implemented after each [redacted]. On 02/28/24 at 1:15 PM, the surveyor met with the Assistant Director of Nursing (ADON) and inquired regarding the care plan for the readmission of [redacted] and requested a timeline for all of the [redacted]. The ADON provided a Comprehensive Care Plan with a focus for [redacted] that was initiated on [redacted]. The surveyor in the presence of the ADON reviewed the care plan for [redacted] initiated on [redacted] which indicated that the care plan for falls was not initiated when the resident was re-admitted on [redacted], after the fall with the hip fracture. The ADON did not have any additional information to provide. On 03/05/24 at 8:47 AM, the DON provided the fall timeline with no interventions. The causal factor was not identified. The DON confirmed that he was unable to locate a [redacted] care plan for [redacted]. The DON further stated, that he started working for the facility on [redacted] and could not account for the missing documents. On 03/05/24 at 11:04 AM, during a pre-exit meeting held with the survey team and current facility Licensed Nursing Home Administrator (LNHA), the DON and Executive Nursing Management, the surveyor discussed the concerns regarding Resident #5's [redacted], including [redacted] with [redacted] and the Comprehensive Care Plan not updated after the [redacted]. The administrator added that the nursing department was responsible to review the	F 689		

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recommendations and implemented them.

On 03/06/24 at 1:30 PM, there was no additional information provided.

Review of the facility policy titled: "Accidents and Incidents-Investigating and Reporting" last revised July 2017, revealed under Policy Statement that all accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator.

Policy interpretation: The nurse supervisor/charge nurse and /or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. Incident/accident reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities.

[redacted] - Clinical Protocol", Revised March 2018, revealed under Cause Identification 1. For an individual who has [redacted] the staff and practitioner will begin to try to identify possible causes within 24 hours of the [redacted]. a. Often, multiple factors contribute to a [redacted] problem. 3. The staff and physician will continue to collect and evaluate information until either the cause of the [redacted] is identified, or it is determined that the cause cannot be found or is not correctable.

Under Treatment/Management; 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to to to prevent subsequent falls and to address the risks of clinically significant consequences of [redacted].

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F 689	Continued From page 149 Under Monitoring and Follow-Up, 1a. Delayed complications such as late fractures and major bruising may occur hours or days after a fall while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall. 2. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. 3. If interventions have been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with the physician whether these measures are still needed ... NJAC 8:39-27.1(a)	F 689		
F 690 SS=H	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 690		4/16/24

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F 690	Continued From page 150 demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Complaint #159956 Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to develop and implement interventions to prevent [redacted] for a resident with a history of [redacted] (from [redacted] through [redacted]) which required oral and intravenous (IV) antibiotic therapy, and required hospitalization. This deficient practice was identified for 1 of 2 Residents (Resident #51) reviewed for NJ EX Order: 264b1 and was evidenced by the following: On 02/23/24 at 6:15 AM, Surveyor #5 completed an incontinence care tour on the [redacted] Unit, a [redacted] permeated in the hallway of the [redacted] side of the [redacted] Unit. Surveyor #5, in the presence of a Certified Nurse Aide (CNA #1), observed Resident # 51 was wearing two [redacted] that was [redacted].	F 690	F690 SS-H 1. Corrective Action: " On 3/21/24, Resident #51□s care plan for [redacted] I□s was reviewed and updated with additional interventions. " On 3/22/24 the DON spoke and discussed case with Resident #51□s primary physician who stated and documented that resident has been treated multiple times for [redacted] and the organisms have been [redacted] and difficult to eradicate. In his opinion, Resident #51 is [redacted] and will experience recurrent infections in the future due to [redacted] and not due to her incontinence or products used to manage the same. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice.	

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F 690	Continued From page 151 On that same date and time, a nurse was also present, who stated that some of the residents wore [redacted] At that same time, Surveyor #5 interviewed the CNA who stated that if a resident was a [redacted], a [redacted] would be placed inside the [redacted] A review of the current Electronic Medical Record (EMR) revealed that Resident #51 was admitted to the facility with diagnoses including but not limited to; NJ EX Order. 264b1 [redacted]). The Annual Minimum Data Set (MDS), as assessment tool used to facilitate the management of care dated [redacted] reflected the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating that the resident had NJ EX Order. 264b1. Further review of the MDS indicated the resident required [redacted] assistance for toileting, hygiene, was always NJ EX Order. 264b1, had a [redacted] in the last 30 days and was [redacted]. A review of Resident #51's comprehensive care plan and interventions, initiated on [redacted], with a target date of [redacted] revealed the resident had a UTI with a goal of the resident's [redacted] will resolve without complications by the review date. The care plan interventions included to encourage adequate [redacted]; give [redacted] therapy as ordered. Monitor/document for side	F 690	3. Measures Put into Place: " The Regional nurse began education on March 4, 2024, to licensed nurses and will complete the education by April 16, 2024 on clinical causes of [redacted] " The unit manager and/or designee will do random weekly checks for 8 [redacted] t residents to assure that proper [redacted] care is being provided. 4. How Will These Actions Be Measured: " The results of the weekly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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effects and effectiveness; give [redacted], [redacted] and [redacted] as ordered/PRN [as needed]; monitor/document for side effects and effectiveness; monitor/document/report to MD [medical doctor] PRN for signs and symptoms of [redacted] Frequency, [redacted], [redacted] and [redacted], [redacted] Behavioral -initiated [redacted]

The care plan did not include any updated interventions after each [redacted] or to prevent further [redacted] There was no focus for activities of daily living self care performance deficit (ADLs) related to [redacted] care.

A review of the current EMR revealed the following physician's orders (PO) and corresponding progress notes:

[redacted] a PO for [redacted] used to treat [redacted] milligram (mg) 1 capsule orally three times a day for [redacted] produced by some [redacted] that may make them [redacted]) for [redacted] days. A nurses noted dated [redacted] at 11:44 PM, reflected that the resident was started on an [redacted] treatment.

On [redacted] a PO for [redacted] used to treat [redacted] mg give [redacted] capsule by mouth. A review of [redacted] Nurse Practitioner's (NP) note revealed that Resident #51 had a [redacted] that was [redacted] for [redacted] and was currently being managed with [redacted]

Review of the medical record revealed a nurses

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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note dated [redacted], that Resident #51 had an intermittent reproductive [redacted], the doctor was notified and an order for [redacted] medicine and a [redacted] was obtained. On [redacted] a PO for [redacted] mg tablet, 1 tablet by mouth once daily for [redacted] days; and a NP note, dated [redacted] at 1:20 PM, revealed that the resident had M[redacted] an infection caused by a type of [redacted] that's become [redacted] used) in the [redacted], was on [redacted] and was currently being managed with [redacted], and was previously on [redacted]

On 02/28/24 at 9:29 AM, the Director of Nursing/Infection Preventionist (DON/IP) provided a timeline of Resident #51's [redacted]s from [redacted] through [redacted] which revealed the following:

[redacted]- MD ordered [redacted] mg twice a day for [redacted] days (an [redacted] commonly used for [redacted].

[redacted]- Resident admitted to the hospital with a [redacted]

1[redacted]- [redacted]) elevated, order to collect [redacted] and [redacted] then start [redacted] mg twice a day for [redacted] days.

[redacted] [redacted] and infection disease consult ordered.

[redacted] was discontinued and [redacted] [redacted] (an [redacted] used to treat a wide variety of [redacted]) [redacted] every [redacted] hours times [redacted] days was ordered for [redacted] found in some [redacted] in the [redacted] of the [redacted] admitted to the hospital with [redacted] (an

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infection in the).
Readmitted to the facility on
mg a day for days for a
NJ EX Order. 264b1, resident received
NJ EX Order. 264b1 used to treat many
NJ EX Order. 264b1 gm times one dose.
- resident was admitted to the hospital
after a f and admitted with a
resident readmitted to facility with a
and an order gm ( ) times dose.
NJ EX Order. 264b1 L,
mg t a day times days
ordered.
- NJ EX Order. 264b1 mg
a day for days ordered.
NJ EX Order. 264b1 mg times a day for
days for
NJ EX Order. 264b1 discontinued and
started.

A review of hospital records, dated
revealed Resident #51 presented with a and
was ordered NJ EX Order. 264b1.

On 02/28/24 at 10:29 AM, the surveyor interviewed CNA#2 who stated that if a resident was left in a for long periods of time, they can get a .

On 02/28/24 at 10:44 AM, the surveyor interviewed a Licensed Practical Nurse (LPN) who stated that ways to prevent a resident from getting a I would include checking and g the resident every 2 hours, monitor for any changes in NJ EX Order. 264b1 dry. "If a resident is left wet in a diaper for long periods of time, it can

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cause a [redacted]. It is important to provide [redacted] care every 2 hours or as needed in order to prevent [redacted].

On 02/28/24 at 10:31 AM, the surveyor interviewed the DON/IP who stated that it was important to change a resident's [redacted] every two hours, if not changed, and if the resident was heavily soiled with [redacted], it could lead to an [redacted]n. The DON/IP further stated, "If urine is sitting there it can cause [redacted]s for the ladies. If residents are not changed in a timely manner, it can be serious."

On 02/29/24 at 1:49 PM, the Licensed Nursing Home Administrator (LNHA) and the DON/IP were made aware of the above concerns.

On 03/06/24 at 1:35 PM, the LNHA, DON/IP, Vice President of Nursing (VPN) and Vice President of Operations for the management company met with the survey team. The VPN stated that the resident had [redacted] and the facility did not offer any additional information regarding interventions to prevent [redacted].

A review of the facility's policy titled "[redacted] Infections/[redacted]-Cimical Protocol," revised April 2018, revealed that when a resident has a persistent or recurring [redacted] after treatment with [redacted]s, the physician will review the situation with the nursing staff and consider other or additional issues (such as [redacted]) before prescribing additional courses of [redacted].

A review of the facility's policy titled "[redacted] [redacted]-Assessment and Management," revised September 2010, revealed

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F 690	Continued From page 156 that the physician and staff will provide appropriate services and treatment to help resident restore or improve NJ EX Order 264b1 and prevent NJ EX Order 264b1 to the extent possible. The staff and physician will identify the presence of any [redacted] that may be related to NJ EX Order 264b1. A review of the facility's policy titled, "Activities of Daily Living (ADL), Supporting," revision date of 03/2018, indicated the following: Policy statement: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs.) Residents who are unable to carry out activities of daily living independently, will receive the services necessary to maintain good nutrition, grooming, personal and oral hygiene. A review of the facility provided, "Certified Nursing Assistant" Job Description undated, included but was not limited to; Purpose: .... to provide each of your assigned residents with routine daily nursing care and services in accordance with the resident's assessment and care plan. Personal Nursing Care Functions: Assist residents with bowel and bladder functions. Keep incontinent residents clean and dry. Check each resident routinely to ensure personal care needs are being met. NJAC 8:39-19.4(a), 27.2(d)	F 690		
F 697 SS=D	Pain Management CFR(s): 483.25(k)	F 697		4/16/24

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F 697	Continued From page 157 §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records, and review of other pertinent documentation, it was determined that the facility failed to ensure residents received pain management consistent with professional standards of practice and physician's orders. This deficient practice was identified for 2 of 2 residents (Resident #75 and #286) reviewed for [redacted] and was evidenced by the following: 1.) On 02/20/24 at 9:31 AM, the surveyor observed Resident #75 lying in bed [redacted]. Resident #75 stated that his/her [redacted] had been hurting. He/she stated that [redacted] (medication used to relieve [redacted]) helps "some". He/she further stated that he/she used to get a [redacted] on their [redacted] but "not for a while". A review of the Admission Record revealed that Resident #75 had diagnoses which included but were not limited to; [redacted] A review of the Order Summary Report included but was not limited to; a physician's order dated [redacted] to observe for [redacted] signs and symptoms of [redacted] every shift and take action as appropriate. A physician's order dated [redacted], [redacted] (medication to relieve [redacted] mg (milligrams) give [redacted] tablets by mouth every [redacted]	F 697	F697 SS-D 1. Corrective Action: " On 2/26/24 the lidocaine patch for Resident #75 was obtained and applied to resident. " On 2/21/24, Percocet 7.5/325 MG was administered to Resident #286 for [redacted] " The nurses who were identified to not provide the ordered pain mediation was provided education on 3/27/24 by the Director of Nursing regarding if an ordered pain medication is not available, that the nurse should notify the physician and get an alternate order for a [redacted] medication to treat the pain until the ordered medication arrives. " On 2/22/24, the director of nursing did an audit to assure that all ordered pain medications were available. All medications were available. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " The DON/designee began education on March 26, 2024, and will be completed	

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F 697	Continued From page 158 hours as needed for [redacted]. A physician's order dated NJ EX Order. 264b1 (a topical [redacted] to relieve [redacted] apply to [redacted] daily. Apply in the morning and remove at bedtime. A review of the Minimum Data Set (MDS) an assessment tool to facilitate resident care, dated [redacted], included but was not limited to; a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated intact cognition. A review of the resident-centered comprehensive on-going Care Plan (CP) revealed a focus area at [redacted] with a goal that the resident will not have an interruption in normal activities due to [redacted] through the review date, and interventions that included but were not limited to; administer NJ EX Order. 264b1 as per orders, anticipate the need for [redacted] and respond immediately, monitor/record/report any signs and symptoms of [redacted] A review of the Medication Administration Record (MAR) [redacted] included but was not limited to; the order for the NJ EX Order. 264b1 apply to [redacted]. Apply in the [redacted], remove at [redacted]. In the morning for [redacted] management and remove per schedule. Remove NJ EX Order. 264b1. The MAR documented the following: [redacted]: apply was documented as administered. [redacted]: was documented as applied and removed. [redacted] was documented as apply code [redacted] which indicated hold/see progress note and remove was documented as completed. The progress note (PN) dated [redacted] and timed 12:31 PM, by the Registered Nurse (RN) documented "NJ EX Order. 264b1 apply to [redacted]	F 697	by COMPLETION DATE regarding if an ordered pain medication is not available, that the nurse should notify the physician and get an alternate order for a [redacted] medication to treat the [redacted] until the ordered medication arrives. " The unit manager and/or designee will do a random weekly audit of 8 residents who receive ordered [redacted] medications to assure that the pain medications are available, will be completed. 4. How Will These Actions Be Measured: " The results of the weekly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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[redacted]. Apply in am, remove at bedtime in the morning for [redacted] management and remove per schedule.
[redacted]: apply was documented as code [redacted] which indicated other/see progress notes and remove was documented as code [redacted] drug refused. The PN dated 02/16/24 at 14:57 (2:57 PM), revealed OOF (out of facility) not given. There was no documentation that the physician was notified.
[redacted] and [redacted]4: both indicated both applied and removed.
[redacted] and [redacted]: both indicated code [redacted] for NJ EX Order. 264b1 d. The PN dated [redacted] at 11:02 indicated not give, no patch on pt (patient). The PN dated [redacted] at 13:22 (1:22 PM), indicated patch oof not given. There was no documentation that the physician was notified.
[redacted]: documented apply and remove as code "[redacted]". The PN for [redacted] at 8:14 was the only note and documented the order of [redacted] apply to [redacted] daily. Apply in the NJ EX Order. 264b1 in the morning for [redacted] management and remove per schedule. There was no documentation that the physician was notified.
[redacted]: documented apply as code [redacted] and removed as administered. The PN dated [redacted] that at 16:39 (4:39 PM) the resident complained of [redacted] rated [redacted] and that NJ EX Order. 264b1 mg [redacted] tablets was administered. There was no documentation indicating why the NJ EX Order. 264b1 had not been applied. There was no documentation that the physician was notified.
[redacted] documented apply as code [redacted]" which indicated absent from home with meds (medications) and removed as administered. There was no PN dated [redacted] to document

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the reason why the resident had not been administered the [redacted] patch. There was no documentation that the physician was notified. [redacted]: documented apply and remove code as [redacted]". The PN dated 02/24/24 at 8:10 AM, indicated "Patch OOF (out of facility), not given". There was no documentation that the physician was notified. [redacted]: documented apply and remove as code '[redacted]". The PN dated 02/25/24 at 8:29 AM, indicated Patch OOF, not given. There was no documentation that the physician was notified.

On 02/23/24 at 7:42 AM, the surveyor and the resident's direct care Registered Nurse (RN) were in Resident #75's room. The resident asked about [redacted] and stated it was a '[redacted] scale up to [redacted] as the worst) in his/her [redacted] Stated he/she was supposed to be getting a "patch" for his/her back. The RN and surveyor exited the room. The RN stated the patches were house stock and asked another staff member to get the house stock [redacted] patches.

On 02/23/24 at 11:37 AM, the surveyor went to the residents room and was informed the [redacted] patch had not yet been applied to the residents [redacted]

On 02/26/24 at 8:30 AM, the surveyor observed the resident sitting up in bed. The resident stated he/she was still not having his/her [redacted] patch applied every morning and that the staff keep telling him/her they were "trying to get it and meanwhile I am in agony here".

On 02/26/24 at 8:32 AM, RN #2 who was caring for the resident stated he had been borrowing [redacted] patches from the other unit. RN #2 and the surveyor looked through the medication cart

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F 697	Continued From page 161 and confirmed there were no [redacted] patches. On 02/26/24 at 9:24 AM, the RN Unit Manager (RN UM) was questioned about the inconsistency of the application of the [redacted] patch for Resident #75. The RN UM asked about [redacted] patch not consistently being applied. The RN UM stated the facility should be "getting a delivery of patches today I know. I don't know why he/she has not been getting the [redacted] patch". She further stated that the staff should have been calling the physician about missing medication, but the resident's [redacted] patch was house stock. On 02/26/24 at 9:36 AM, the Director of Nursing (DON) in the presence of the survey team, confirmed that if house stock medications were missing and the resident was not being administered the ordered medication, the staff should call the physician and obtain a onetime order for something similar. The DON stated he was not sure if there was a policy and procedure. He further stated that the [redacted] patch should be in the facility house stock but if not, the physician should be called, and that call should be documented in the resident's medical record. The DON stated it was important to call the physician, so a resident does not miss their prescribed medication. On 02/26/24 at 12:15 PM, during a telephone interview in the presence of the survey team, the ordering physician stated she was never made aware by anyone at the facility that the resident was not getting the [redacted] patch consistently. "I am absolutely positive nobody let me know about that. I could have addressed it."	F 697		

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A review of a PN by the Nurse Practitioner dated [redacted] at 13:38 (1:38 PM), included but was not limited to; the resident was seen "due to pt's (patients) complain of [redacted] with [redacted]". The PN documented to "cw" (continue with) the [redacted] patch and [redacted] PRN (as needed).

On 02/27/24 at 8:24 AM, the surveyor observed Resident #75 awake sitting up in bed and smiling. When asked how he/she was feeling, Resident #75 stated, "thank you so much. I got my patch yesterday and today already. The nurse promised I would get it as ordered every day. It takes the edge off and helps me to do my exercises to get strong. I'm so happy about it."

b.) On 02/20/24 10:15 AM, the surveyor observed Resident #286 lying in bed [redacted] with an [redacted] the [redacted] Resident #286 stated he/she [redacted] his/her [redacted] and [redacted]). Resident #286 stated he/she had told the staff he/she was previously on P[redacted] medication) [redacted] milligram (mg) for [redacted] not the [redacted]. He/she stated the staff informed him/her that the [redacted] mg had been ordered last [redacted], he/she "waited all week but it never came". Resident #286 stated that staff told him/her "the order was never put in".

A review of the Admission Record revealed that Resident #286 had diagnoses which included but were not limited to; [redacted]. A review of the Admission MDS dated [redacted], included but was not limited to; a BIMS of [redacted] 15 which

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indicated the resident was NJ EX Order. 264b1. NJ EX Order. 264b1 Health Conditions documented the resident had frequent [redacted]. A review of the comprehensive resident-centered on-going CP included but was not limited to; a focus area of has NJ EX Order. 264b1 related to [redacted] cture with one goal that the resident will verbalize adequate relief of [redacted] to cope with NJ EX Order. 264b1 [redacted] through the review date, and interventions which included but were not limited to; administer [redacted] as ordered, anticipate need for [redacted] relief and respond immediately, and evaluate the effectiveness of [redacted] interventions, alleviating of symptoms, and resident satisfaction with results.

A review of the Order Summary Report revealed a physician's order dated [redacted] Percocet (NJ EX Order. 264b1 medication) [redacted] mg give [redacted] tablet by mouth every [redacted] hours as needed for [redacted] [redacted] discontinue once [redacted] dose arrives. A review of the resident's paper medical chart revealed a prescription by the physician dated [redacted] for NJ EX Order. 264b1 mg give [redacted] tablet every [redacted] hours PRN (as needed) for [redacted]

A review of the Treatment Administration Record (TAR) dated NJ EX Order. 264b1, revealed pain monitoring which began [redacted] when the NJ EX Order. 264b1 mg was ordered. The TAR revealed the following elevated resident [redacted] n ratings from 0 (no pain) to [redacted] (worst pain): NJ EX Order. 264b1 [redacted] The TAR documented the previous physician's order NJ EX Order. 264b1 mg give [redacted] tablet every [redacted] hours as needed for NJ EX Order. 264b1 [redacted] The medication was requested and administered as follows: [redacted]: with a pain rating of [redacted] and the recheck indicated [redacted] ineffective, a second dose with a [redacted] rating of [redacted]

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: twice with a rating of three times once with a rating of and the additional two with a rating of : four times twice with a rating of , one with a rating of and with a rating of three times, two with a rating of : four times, three with a rating of and one with a rating of /24: twice with a rating of and 24: once with a rating of 8. The facility provided TAR dated through , failed to document the physician's order dated for the 7 mg.

A review of the facility provided Progress Notes (PN) dated through included but was not limited to; date at 16:36 (4:36 PM) NJ EX Order: 264b1) mg administered for level Date at 20:52 (8:52 PM) NJ EX Order: 264b1 mg administered for level . Date at 1:10 AM Percocet mg administered for level Date at 11:41 mg pain scale not noted. Date 4 at 16:10 (4:10 PM) Percocet mg for scale

A review of the PNs ranging from through when the resident received the first dose of NJ EX Order: 264b1 mg, failed to document any contact with the physician or the facility pharmacy to determine why the medication ordered on had not arrived or to inform the physician the resident was not getting the prescribed higher dose of medication.

On 02/22/24 at 8:49 AM, the Registered Nurse Unit Manager (RN UM) stated the process when a prescription was received was to "write the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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order, put it in the computer and it goes to the pharmacy". She further stated, "We don't know when pharmacy gets the order. If it is in the morning or if they get in in afternoon." The RN UM stated that medications were delivered within 24 hours and that the staff would sign for the delivered medications. When asked about the [redacted] mg order from [redacted], she stated "the [redacted] was ordered for the [redacted] mg, but the pharmacy never sent it. We would check every day but actually got it days later." The RN Um stated the communication with the pharmacy would be documented in the electronic medical record. The RN UM stated she had contacted the pharmacy, but the surveyor was unable to find documentation in the electronic medical record.

On 02/22/24 at 9:20 AM, the Director of Nursing (DON) stated the process for a written prescription would be "to fax it to the pharmacy, a confirmation page of the may or may not be kept but the staff would write a note in [the electronic medical record] that the script (prescription) was faxed. We may get the medication overnight or the next day". When asked about how the facility would track medications sent to the pharmacy to ensure they were received and delivered, the DON stated if the medication was not delivered, he would be notified. He further stated that if the medication does not arrive, the staff would call the pharmacy. The DON stated that communication would be documented in the electronic medical record and the staff should call the physician. The DON stated that within 24 hours the medication should be delivered to the facility.

On 02/22/24 at 9:44 AM, the RN UM provided a PN dated [redacted] at 9:07 AM, created on [redacted]

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at 8:58 AM, regarding call to pharmacy. The PN documented she had spoken to the pharmacy x3 (three times). The PN documented the pharmacy stated the [redacted] mg had not been sent because the resident had an order for [redacted] mg. "This RN explained that the 5/325 is to remain until the [redacted] arrives so patient continues to have [redacted] coverage. Pharmacist stated understanding and said that the order would go out on the next run."

On 02/22/24 at 9:50 AM, during a telephone interview in the presence of two surveyors, the facility pharmacist stated the [redacted] mg was initially sent to the pharmacy [redacted] and was sent out to the facility on [redacted]. The pharmacist stated the resident was on [redacted] mg and the pharmacy was trying to confirm which order the physician wanted because the [redacted] mg was also written on [redacted] The pharmacist stated it should not typically take that long. Because we received both scripts [redacted], but we did not get a call from the facility until the [redacted] from [name redacted RN UM] asking why the [redacted] mg had not been sent. The pharmacist stated that at that time, she confirmed which medication was to be provided, and sent out the [redacted] mg on the [redacted]. The Pharmacist stated, "there were no other phone calls from anyone at the facility regarding the clarification".

A review of the Packing Slip confirmed that Resident #286's [redacted] mg tablets were delivered on [redacted]

On 02/22/24 at 10:10 AM, Resident #286 stated, "I finally got the correct [redacted] and it doesn't alleviate all the [redacted] but it takes it down at least a

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notch from the other medication ( )".

On 02/22/24 at 10:12 AM, the residents direct care RN stated she was familiar with the resident. The RN stated, "the resident tells her he/she has pain and the resident asked for a higher dose of so the doctor wrote it. If the medication wasn't delivered, we would call pharmacy". She stated she worked and she faxed the prescription for the NJ EX Order: 26461 mg. The RN stated she called the pharm to tell them to use the NJ EX Order: 26461 mg. She stated, "I work part time, so I wasn't here for a while" to know that the medication did not arrive. She stated the resident was complaining he/she was in and that was why I got the doctor to see him/her. She stated she did not document that she called the pharmacy to clarify the order that day.

On 02/23/24 at 10:23 AM, during a telephone interview in the presence of the surveyors, Resident #286's physician was asked if he was aware that the NJ EX Order: 26461 mg that was ordered on , had not been delivered until . The physician stated that on he was made aware and that the clarified order was just put in at that time. The physician confirmed that no staff attempted to clarify the order with him prior to regarding the order.

A review of the facility provided, Assessment and Management" policy and procedure dated revised 3/20, included but was not limited to; Purpose: to help staff identify in the resident, and to develop interventions that are consistent with the resident's goals and need that address the underlying causes of pain. Guidelines: 1. .... Commitment to appropriate assessment and treatment of pain, based on

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professional standards of practice, the comprehensive care plan, and the resident's choices related to [redacted] management. 2. "Pain management" defined as the process of alleviating the resident's [redacted] based on his/her clinical condition and established treatment goals. 3. [redacted] management is a multidisciplinary care process that includes: a. assessing the potential for pain; b. recognizing the presence of [redacted]; 3. Developing and implementing approaches to [redacted] management; f. identifying and using specific strategies for different levels and sources of [redacted]; and h. modifying approaches as necessary. Assessing Pain: 1.a. history of [redacted] and its treatment. 3. Discuss with the resident or representative his/her goals for pain management and satisfaction with the current level of [redacted] control. Implementing [redacted] Management Strategies: 2. Pharmacological interventions may be prescribed ..... 3. The physician and staff will establish a treatment regimen based on: c. current medication regimen. Documentation: 1. Document the reported level of [redacted] with adequate detail (ex: enough information to gauge the status of [redacted] and effectiveness of interventions) as needed and in accordance with the pain management program.

A review of the facility provided, "Administering Medications" policy and procedure revised 4/19, included but was not limited to; 4. Medications are administered in accordance with prescriber orders.

A review of the facility provided, "Unavailable Medication" dated 1/1/23, included but was not limited to; Policy: it is the facility policy to administer medications as ordered by a physician/NP (Nurse Practitioner). Procedure: 3.

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F 697	Continued From page 169 The nurse will notify the physician/NP that the ordered medication is not available for administration as ordered. 5. The physician/NP will provide orders to address the unavailability of the ordered medication ..... 6. The nurse will communicate with the pharmacy to ensure that the physician ordered medications have been appropriately ordered from the pharmacy. A review of the facility provided, "Medication Orders and Receipt Recor" revised 04/07, included but was not limited to; Policy: ... document all medications that are ordered and received. Interpretation: 1. the charge nurse will maintain medication order ... records. 2. the medication order ... record shall contain d. order dae; e. name and title of person placing the order; g. the date and quantity received. 3. The DON will designate individuals to be responsible ...	F 697		
F 725 SS=F	NJAC 8:39-27.1(a)(c)3 Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services	F 725		4/16/24

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F 725	Continued From page 170 by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Complaint #s NJ 152905, 152910, 152911, 159956, 161569, 165971, 160660, 169440 Based on observation, interview and review of pertinent documents it was determined that the facility failed to ensure sufficient and competent staff were available to a) provide appropriate incontinence care to dependent residents (Resident #6, #18, #22, #23, #31, #32, #38, #50, # 51, #53 and #55), b) provide residents with scheduled showers (Resident #80 and #233), and c) ensure all residents were treated in a dignified manner. This deficient practice was identified for 12 of 12 residents, 1 of 1 closed record (Resident #80) reviewed for ADLs, expressed by 6 of 6 Residents who attended a Resident Council meeting, and affected all residents on 2 of 2 units. This deficient practice was evidenced by the following: Refer to 677F, 690H On 02/23/24 at 11:14 AM, the surveyor held a resident council meeting with six residents. The	F 725	F725 SS-F (Cross walked to 677F and 690H) 1. Corrective Action: " Staffing coordinator was educated on New Jersey state staffing ratio requirements on March 25, 2024, by the regional nurse. " Efforts to hire facility staff will continue until there is adequate staff to meet the minimum staff to resident ratios. Until that time, the facility will use staffing agencies and offer additional shifts to current staff with bonuses as required. " Facility Administrator worked with Human resources to secure additional staffing agency contracts. " Interdisciplinary team met on March 26, 2024, to discuss recruitment and retention interventions which included scheduling a job fair to be held on April 10, 2024. " Resident #□s 6, #18, #22, #23, #31, #32, #38, #50, #51, #53 and #55 no	

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F 725	Continued From page 171 resident's expressed the following concerns: -3 of 6 Residents stated they waited anywhere from 30 minutes to one hour for the Certified Nurse Aides (CNAs) to respond to the call bells. Two of six residents stated, staffing "is terrible 3:00 PM -11:00 PM and 11:00 PM -7:00 PM." -2 of 6 Residents stated they waited 30 minutes to 1 hour for assistance and sometime longer, one resident stated, "they leave me wet for hours sometimes, and NJ EX Order: 264b1 me, which I don't ask them to". -1 of 6 Residents stated, "my roommate will use the call bell and the CNAs will come in and turn it off without addressing the concern". -5 of 6 Residents stated that shower times were not honored, the staff changed the schedule without notification, and "they by pass my showers sometimes, or the aids will ask me if I want to shower at 11:00 PM and that's just too late". -6 of 6 Residents stated that "Staff were always talking in different languages around us" and "sometimes they are talking on the phone taking care of us, staff are always on their phones while working, either talking or texting." a) On 2/22/23 at 10:20 AM, Surveyor #1 observed Resident #53 with an incontinence brief balled up in front of him/her. Surveyor #1 observed Resident #53 was wearing NJ EX Order: 264b1 that were NJ EX Order: 264b1. CNA #1 stated resident was a "NJ EX Order: 264b1" and required NJ EX Order: 264b1. On 2/23/23 at 6:00 AM, the survey team entered the facility and aided by CNA #2, performed a random care tour on the [redacted] Unit. The following was observed:	F 725	longer use the NJ EX Order: 264b1 (referred to in 2567 as NJ EX Order: 264b1). " Resident #233 was offered a bath, and a bed bath was provided, per [redacted] preference. " Resident #80 does not appear on the resident sample list provided. " Resident #233 placed on a bathing schedule that [redacted] agreed to. " Upon identification, the Director of nursing and Administration began facility wide education to facility staff on March 28, 2024. Education included: ensuring residents were treated with dignity and respect, requests for water were respected, meals are served in a dignified homelike manner without the use of NJ EX Order: 264b1 (as appropriate), communicating with residents by their preferred name, not speaking alternate languages in front of a resident or speaking on a cell phone during resident interactions, maintaining quiet speaking levels, answering call bells in a timely manner. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " Weekly recruitment, retention and employee appreciation meeting was initiated and will be led by the Director of Human Resources and/or designee. " Hiring and recruitment efforts including pay for experience, online job	

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F 725	Continued From page 172 Surveyor #1 observations: On 2/23/23 at 6:15 AM, the surveyor observed Resident #51 was wearing NJ EX Order. 264b1 NJ EX Order. 264b1 . On 2/23/24 at 6:30 AM, the surveyor observed Resident #23 was wearing NJ EX Order. 264b1 that were NJ EX Order. 264b1 with NJ EX Order. 264b1 . On 2/23/24 at 6:40 AM, the surveyor observed Resident #50 was wearing NJ EX Order. 264b1 NJ EX Order. 264b1 On 2/23/24 at 6:49 AM, the surveyor observed Resident #55 was wearing NJ EX Order. 264b1 NJ EX Order. 264b1 On 2/23/24 at 7:54 AM, the surveyor observed Resident #31 was wearing NJ EX Order. 264b1 NJ EX Order. 264b1 On 2/26/24 at 11:20 AM, the surveyor interviewed Resident #31 regarding NJ EX Order. 264b1 care. The resident stated that NJ EX Order. 264b1 care was not provided in a timely manner. On 2/22/23 at 10:20 AM and on 2/23/24 at 10:17 AM, the surveyor observed Resident #53 was wearing NJ EX Order. 264b1 NJ EX Order. 264b1 with NJ EX Order. 264b1 On 2/23/24 at 6:39 AM, Surveyor #2 was standing outside of Resident # 32's room and there was a NJ EX Order. 264b1 e. CNA #2 was in the presence of Surveyor #2 and confirmed the NJ EX Order. 264b1 At that time, CNA #2 performed care in the presence of the surveyor who observed Resident #32 was	F 725	listings, job fairs, shift differentials and referral bonuses are being utilized to continue to be competitive in the marketplace. " Focus on retention efforts include, but are not limited to incentive programs, career growth and educational training opportunities and employee morale incentives. " The facility administrator/designee will continue to track and document all recruitment and retention efforts weekly. " The administrator/designee will review staffing schedules weekly to ensure adequate staffing for all shifts. " The unit manager and/or designee will do random audits of 5 residents per week to assure that they received their bath and/or shower as scheduled. " The unit manager and/or designee will do random weekly checks for 8 NJ EX Order 264b1 residents to assure that proper NJ EX Order 264b1 care is being provide. " The Social Service Director and/or designee will conduct weekly audits of five (5) residents on each unit to validate that resident rights are being honored. " The Activity Director and/or designee will continue to facilitate monthly resident council meetings to validate that resident rights are being honored and be able to continue to proactively address resident concerns. 4. How Will These Actions Be Measured: " The results of the weekly audits will be submitted to the Quality Assurance and	

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F 725	Continued From page 173 wearing NJ EX Order. 264b1. On 2/23/24 at 12:01 PM, the surveyor observed Resident #22 sitting at the edge of the bed, and the NJ EX Order. 264b1. The resident's NJ EX Order. 264b1 and the NJ EX Order. 264b1 were NJ EX Order. 264b1 with NJ EX Order. 264b1. The CNA stated he/she provided care to the resident in the morning, the time was not provided. The same resident was observed on 2/26/24 at 8:36 AM and was wearing NJ EX Order. 264b1 that were NJ EX Order. 264b1 with NJ EX Order. 264b1 NJ EX Order. 264b1 The CNA informed the surveyor that the NJ EX Order. 264b1 were from the night shift, and that she had not yet provided NJ EX Order. 264b1 care to the resident. On 2/26/24 at 9:17 AM, Surveyors #1 and #3 interviewed Resident #18 regarding care concerns. Resident #18 stated that NJ EX Order. 264b1 care was not provided in timely manner and NJ EX Order. 264b1 care was to be provided every two hours, but was not being done. The resident stated that on one occasion she requested to be changed at 2:00 PM and did not get changed until 7:00 PM. The resident confirmed the use of NJ EX Order. 264b1 and stated that sometimes it was allowed because it was known that the staff would not provide NJ EX Order. 264b1 care every two hours. Resident # 18 further stated that this issue had been discussed with the Director of Nursing (DON). Surveyor # 1 asked Resident # 18 how that made him/her feel to have to wait for NJ EX Order. 264b1 care to be provided, and resident stated, "I don't like it." On 2/26/24 at 9:28 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) and confirmed the residents should not be wearing NJ EX Order. 264b1 and should be changed	F 725	Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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every 2 hours

On 2/26/24 at 9:30 AM, the surveyor observed Resident #38's [redacted] and person were NJ EX Order: 26401. A Licensed Practical Nurse positioned at the resident's door informed the surveyor that the CNA was not available to change the resident yet, and she was at the door to ensure that the resident did not [redacted]

On 2/26/24 at 10:30 AM, Resident # 6 informed the surveyors that he/she also had some concerns. Resident #6 expressed their frustration over not receiving in [redacted] care in a timely manner. Resident #6 stated on NJ EX Order: 26401 he/she requested to be [redacted] and the CNA ignored his/her request. The resident stated, "It took a lot from me to open my mouth. I was really in bad shape, I let her have it. That was not right that I have to sit in my [redacted] for hours. By the time I was provided with [redacted] care I was sore. I had to open my mouth. I felt neglected."

b) On 2/21/24 the surveyor reviewed closed medical record for Resident # 80. Resident #80 was not provided with a shower or bed bath on [redacted] and [redacted] Resident #80 was not provided with a scheduled shower on [redacted] and [redacted], and did not receive a shower on [redacted] NJ EX Order: 26401 [redacted].

On 2/29/24 at 10:35 AM, the surveyor interviewed the LPN/UM regarding Resident #80. The LPN/UM stated that Resident #80 was very difficult to care for due to NJ EX Order: 26401 and had to be transferred on a [redacted]. The LPN/UM recalled the resident and stated, the resident requested staff to spend time drying their

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F 725	Continued From page 175 [redacted] which was a long process, and staff had other patients to care for. On 3/5/24, the surveyor reviewed the CNA task documentation dated "[redacted] ", which revealed that Resident #233 was not provided with bathing/shower for 12 of 19 days. c. On 02/22/24 at 8:11 AM, the surveyor observed the breakfast meal cart brought to the [redacted] unit, and staff pulled out a meal tray from the meal cart in front of room [redacted] and began loudly speaking to another staff member in a [foreign language]. The staff member was across the hall by the other resident rooms. The surveyor asked the staff about the observation and the staff stated, "I was talking to her in a [foreign language]", and stated it was the Activity Director (AD). The staff that she was speaking to stated, "we talk often in [a foreign language]". The AD stated that she needed to speak to the housekeeper in a [foreign language] and knew they should not speak in another language. On 02/22/24 at 8:17 AM, during the continued observation, the surveyor heard staff referring to a resident while outside of Room [redacted] as a [redacted], regarding the meal tray, then went with another staff into Room [redacted]. The Licensed Practical Nurse, Unit Manager (LPNUM) was at the meal cart and the surveyor asked her what a "[redacted]" was and the LPNUM stated it was "people that needed help". The surveyor asked was that a usual term that was used and the LPNUM stated, "yes". The surveyor asked the LPNUM if she was ever trained to not use that term and she stated "no". The LPNUM then asked the surveyor what the appropriate term was to use.	F 725		

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F 725	Continued From page 176 On 02/22/24 at 8:39 AM, the surveyor observed a male CNA distribute multiple meal trays on the high side of the [redacted] unit, including to Room #231. A female CNA then pointed to meal trays, and identified several resident meal trays by saying this one is a "a[redacted]", and that one is a "[redacted] to the male CNA. Residents were in close proximity in the small dining room at tables awaiting the meal distribution. On 02/22/24 at 9:38 AM, the surveyor interviewed the Registered Nurse Unit Manager Staff Educator (RNUM) and asked about any education provided to staff regarding dignity. The RNUM stated that was completed by social services. The surveyor asked the RNUM if a resident could be called a feeder. The RNUM stated, "we don't use[redacted] it is rude". The RNUM then stated, "that is a big one, that is old, no one is supposed to be using that anywhere, it is a dignity issue." On 02/22/24 at 9:42 AM, the surveyor asked the RNUM if staff could speak a foreign language in the presence of the residents. The RNUM stated, "no", that is dignity as well." "They [the residents] need to know what is being said in their home". On 02/22/24 at 10:38 AM, the surveyor interviewed the DON who stated he has been at the facility for four months. The surveyor asked the DON if the staff could a speak foreign languages around the residents, and identify and point at residents identified as [redacted]". The DON stated, they are "not supposed to do that or speaking a foreign language". The DON then stated,[redacted] that is not supposed to be used at all, that is a dignity issue." The DON stated, "not	F 725		

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okay to point, not good."

On 02/23/24 at 11:39 AM, Surveyors #1 and #5 were in the main hallway between the activity room and the dining room and observed a staff in a lab coat pushing Resident #79 in the wheelchair with his right, and was holding his cellular phone in his left hand and conducted a phone call on speaker while he pushed the resident into the dining room. Surveyor #1 interviewed the staff who identified himself as Registered Nurse (RN). The surveyor asked him if he typically took a phone call on speaker and wheeled a resident with the other hand. The RN stated, "no, that is not normal behavior, I was on my break" and Resident #79 needed to be watched.

On 02/26/24 at 10:02 AM, the surveyor interviewed the DON regarding if it is ever acceptable for staff to take a personal phone call while caring for residents. The DON stated," no, it is not acceptable" and "everyone was trained on that."

On 03/01/24 at 11:06 AM, the surveyor entered the activity room while residents were at the main table, coloring and watching television. At the same table the residents were at, an activity staff (AS) was talking on a cellular phone. The AS hung up the phone and the surveyor asked if she should be on the phone with the residents and the AS stated it was her "heart doctor".

It was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This was evident in Certified Nursing Assistant (CNA) staffing for 14 of 14-day shifts reviewed.

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Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:

One Certified Nurse Aide (CNA) to every eight residents for the day shift.

One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and

One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.

1. For the 2 weeks of Complaint staffing from 02/20/2022 to 03/05/2022, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows:

-02/20/22 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs.
-02/24/22 had 6 CNAs for 58 residents on the day shift, required at least 7 CNAs.
-02/25/22 had 6 CNAs for 58 residents on the day shift, required at least 7 CNAs.

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-02/28/22 had 6 CNAs for 59 residents on the day shift, required at least 7 CNAs.
-03/04/22 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs.

2. For the 2 weeks of Complaint staffing from 09/04/2022 to 09/17/2022, the facility was deficient in CNA staffing for residents on 9 of 14 day shifts as follows:

-09/05/22 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs.
-09/06/22 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs.

-09/11/22 had 6 CNAs for 55 residents on the day shift, required at least 7 CNAs.
-09/12/22 had 6 CNAs for 55 residents on the day shift, required at least 7 CNAs.
-09/13/22 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs.
-09/14/22 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs.
-09/15/22 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs.
-09/16/22 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs.
-09/17/22 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs.

3. For the 2 weeks of Complaint staffing from 10/16/2022 to 10/29/2022, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows:

-10/16/22 had 6 CNAs for 59 residents on the day shift, required at least 7 CNAs
-10/20/22 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs.

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F 725	Continued From page 180 -10/21/22 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs. -10/22/22 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs -10/23/22 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs. -10/25/22 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs. -10/26/22 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs. -10/27/22 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs. -10/28/22 had 6 CNAs for 59 residents on the day shift, required at least 7 CNAs. -10/29/22 had 6 CNAs for 58 residents on the day shift, required at least 7 CNAs. 4. For the 2 weeks of Complaint staffing from 11/06/2022 to 11/19/2022, the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows: -11/11/22 had 7 CNAs for 61 residents on the day shift, required at least 8 CNAs. 5. For the week of Complaint staffing from 11/27/2022 to 12/03/2022, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -12/01/22 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs. 6. For the 2 weeks of Complaint staffing from 12/18/2022 to 12/31/2022, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows:	F 725		

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-12/18/22 had 6 CNAs for 56 residents on the day shift, required at least 7 CNAs.
-12/21/22 had 5 CNAs for 55 residents on the day shift, required at least 7 CNAs.
-12/22/22 had 5 CNAs for 55 residents on the day shift, required at least 7 CNAs.

-12/27/22 had 6 CNAs for 58 residents on the day shift, required at least 7 CNAs.

7. For the week of Complaint staffing from 01/22/2023 to 01/27/2023, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows:

-01/22/23 had 6 CNAs for 56 residents on the day shift, required at least 7 CNAs.
-01/24/23 had 6 CNAs for 56 residents on the day shift, required at least 7 CNAs.
-01/27/23 had 6 CNAs for 56 residents on the day shift, required at least 7 CNAs.

8. For the 4 weeks of Complaint staffing from 02/05/2023 to 03/04/2023, the facility was deficient in CNA staffing for residents on 25 of 28 day shifts as follows:

-02/05/23 had 7 CNAs for 63 residents on the day shift, required at least 8 CNAs.
-02/06/23 had 7 CNAs for 63 residents on the day shift, required at least 8 CNAs.
-02/09/23 had 6 CNAs for 63 residents on the day shift, required at least 8 CNAs.
-02/10/23 had 7 CNAs for 66 residents on the day shift, required at least 8 CNAs.
-02/11/23 had 6 CNAs for 65 residents on the day shift, required at least 8 CNAs.

-02/12/23 had 7 CNAs for 64 residents on the

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F 725	Continued From page 182	F 725		

day shift, required at least 8 CNAs.
-02/14/23 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs.
-02/15/23 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs.
-02/16/23 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs.
-02/17/23 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs.
-02/18/23 had 6 CNAs for 64 residents on the day shift, required at least 8 CNAs.

-02/19/23 had 6 CNAs for 62 residents on the day shift, required at least 8 CNAs.
-02/20/23 had 7 CNAs for 62 residents on the day shift, required at least 8 CNAs.
-02/21/23 had 7 CNAs for 61 residents on the day shift, required at least 8 CNAs.
-02/22/23 had 6 CNAs for 61 residents on the day shift, required at least 8 CNAs.
-02/23/23 had 7 CNAs for 61 residents on the day shift, required at least 8 CNAs.
-02/24/23 had 6 CNAs for 61 residents on the day shift, required at least 8 CNAs.
-02/25/23 had 6 CNAs for 61 residents on the day shift, required at least 8 CNAs.

-02/26/23 had 6 CNAs for 61 residents on the day shift, required at least 8 CNAs.
-02/27/23 had 7 CNAs for 62 residents on the day shift, required at least 8 CNAs.
-02/28/23 had 5 CNAs for 62 residents on the day shift, required at least 8 CNAs.
-03/01/23 had 7 CNAs for 62 residents on the day shift, required at least 8 CNAs.
-03/02/23 had 7 CNAs for 62 residents on the day shift, required at least 8 CNAs.
-03/03/23 had 6 CNAs for 63 residents on the day shift, required at least 8 CNAs.

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F 725	Continued From page 183 -03/04/23 had 6 CNAs for 63 residents on the day shift, required at least 8 CNAs. 9. For the 2 weeks of Complaint staffing from 03/19/2023 to 04/01/2023, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows: -03/19/23 had 6 CNAs for 62 residents on the day shift, required at least 8 CNAs. -03/20/23 had 7 CNAs for 62 residents on the day shift, required at least 8 CNAs. -03/21/23 had 6 CNAs for 62 residents on the day shift, required at least 8 CNAs. -03/22/23 had 7 CNAs for 62 residents on the day shift, required at least 8 CNAs. -03/23/23 had 7 CNAs for 61 residents on the day shift, required at least 8 CNAs. -03/24/23 had 6 CNAs for 59 residents on the day shift, required at least 7 CNAs. -03/25/23 had 6 CNAs for 59 residents on the day shift, required at least 7 CNAs. -03/26/23 had 6 CNAs for 58 residents on the day shift, required at least 7 CNAs. -03/28/23 had 6 CNAs for 58 residents on the day shift, required at least 7 CNAs. -03/29/23 had 5 CNAs for 58 residents on the day shift, required at least 7 CNAs. -03/30/23 had 6 CNAs for 59 residents on the day shift, required at least 7 CNAs. 10. For the 2 weeks of Complaint staffing from 07/23/2023 to 08/05/2023, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows: -07/23/23 had 8 CNAs for 71 residents on the day shift, required at least 9 CNAs.	F 725		

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-07/24/23 had 7 CNAs for 71 residents on the day shift, required at least 9 CNAs.
-07/25/23 had 8 CNAs for 71 residents on the day shift, required at least 9 CNAs.
-07/26/23 had 7 CNAs for 71 residents on the day shift, required at least 9 CNAs.
-07/29/23 had 8 CNAs for 71 residents on the day shift, required at least 9 CNAs.

-07/30/23 had 8 CNAs for 71 residents on the day shift, required at least 9 CNAs.

11. For the week of Complaint staffing from 09/10/2023 to 09/16/2023, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows:

-09/11/23 had 8 CNAs for 83 residents on the day shift, required at least 10 CNAs.
-09/12/23 had 9 CNAs for 82 residents on the day shift, required at least 10 CNAs.
-09/13/23 had 9 CNAs for 81 residents on the day shift, required at least 10 CNAs.
-09/14/23 had 9 CNAs for 81 residents on the day shift, required at least 10 CNAs.
-09/16/23 had 9 CNAs for 80 residents on the day shift, required at least 10 CNAs.

12. For the 2 weeks prior to survey from 02/04/2024 to 02/17/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:

-02/04/24 had 7 CNAs for 72 residents on the day shift, required at least 9 CNAs.
-02/05/24 had 6 CNAs for 72 residents on the day shift, required at least 9 CNAs.

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-02/06/24 had 4 CNAs for 72 residents on the day shift, required at least 9 CNAs. On this day, the facility provided only half of the minimum allowed CNA staff to provide resident care.
-02/07/24 had 5 CNAs for 72 residents on the day shift, required at least 9 CNAs.
-02/08/24 had 5 CNAs for 72 residents on the day shift, required at least 9 CNAs.
-02/09/24 had 6 CNAs for 73 residents on the day shift, required at least 9 CNAs.
-02/10/24 had 6 CNAs for 73 residents on the day shift, required at least 9 CNAs.

-02/11/24 had 6 CNAs for 72 residents on the day shift, required at least 9 CNAs.
-02/12/24 had 5 CNAs for 72 residents on the day shift, required at least 9 CNAs.
-02/13/24 had 4 CNAs for 74 residents on the day shift, required at least 9 CNAs. On this day, the facility provided only half of the minimum allowed CNA staff to provide resident care.
-02/14/24 had 5 CNAs for 72 residents on the day shift, required at least 9 CNAs.
-02/15/24 had 4 CNAs for 72 residents on the day shift, required at least 9 CNAs. On this day, the facility provided only half of the minimum allowed CNA staff to provide resident care.
-02/16/24 had 7 CNAs for 75 residents on the day shift, required at least 9 CNAs.
-02/17/24 had 7 CNAs for 75 residents on the day shift, required at least 9 CNAs.

On 02/27/24 at 12:32 PM, the surveyor interviewed the Staffing Coordinator (SC) who stated that she was aware of the mandaory staffing requirements of 8 residents to 1 CNA on day shift, 10 residents to1 direct care staff on evening shift and 14 residents to 1 direct care staff on night shift. When asked if she was able to

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F 725	Continued From page 186 meet these requirments, the SC stated "No, we fall short." NJAC 8:39-27.1(a)	F 725		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent documentation, it was determined that the facility failed to ensure the designated licensed Director of Nursing (DON) worked on a full-time basis as DON to oversee the care of all residents in the facility. This deficient practice was evidenced by the following: On 02/21/24 at 11:34 AM, the DON stated that the previous facility Infection Preventionist (IP) was a corporate nurse who was covering "multiple facilities". He stated that the facility had been interviewing candidates for the IP position, but they did not have enough experience or wanted a lot of money so he had been also	F 727	F727 SS-F 1. Corrective Action: " On March 25, 2024, the facility Administrator was educated by the Regional Administrator on the job descriptions and regulatory requirements of the Director of Nursing and the Infection Prevention roles and responsibilities. " A FT IP was hired as the IP on March 20, 2024, and was approved by the Department of Health, based on the Directed Plan of Correction on March 22, 2024. 2. Identification of other residents or	4/16/24

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F 727	Continued From page 187 performing the job as IP. On 02/22/24 at 11:02 AM, the DON in the presence of the survey team, confirmed his job was to be the full-time DON, but he was also working as the facility IP. On 03/05/24 at 10:44 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team, stated that the DON "assumed the responsibilities" of the Infection Preventionist (IP) for the facility "a few months ago in the fall." The LNHA stated he was responsible to oversee the DON as the DON and as the facility IP. He further stated that he would discuss with the DON IP what was going on in the facility but none of the discussions were documented. The LNHA confirmed that the DON was hired to work a scheduled 40-hour week. A review of the facility provided, "Director of Nursing Services" job description undated, included but was not limited to; Purpose: primary purpose is to plan, organize, develop, and direct the overall operation of the Nursing Service Department ..... to ensure that the highest degree of quality care is maintained at all times. Delegation of Authority: delegated the administrative authority, responsibility, and accountability for carrying out your assigned duties. Functions: Assist the Infection Control Coordinator .... Acknowledgment: ... agree to perform the tasks outlined in the job description .... The facility failed to ensure the full-time, 40-hour work schedule for the DON was dedicated to the responsibilities of the DON and not the IP to ensure the highest degree of quality of care is	F 727	areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " Facility Administrator will continue to assure that the Director of Nursing role and the Infection Preventionist role remain separate 40 hour/week positions. 4. How Will These Actions Be Measured: " The results of the monthly review will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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F 727	Continued From page 188 maintained at all times. NJAC 8:39-25.1(a)	F 727		
F 742 SS=H	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Complaint NJ #s 154702, #154763 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure a) antipsychotic medications were administered daily per physician orders for two residents, Resident #19 who missed 8 daily doses, and Resident #45 who missed 9 daily doses. This resulted in increased NJ EX Order. 264b1 behaviors that necessitated transfer to [redacted] via 911 (emergency) for both residents, and b) behaviors were monitored and documented and appropriate interventions were developed and implemented for Resident #76 who required [redacted] medication. This deficient practice was identified for 2 of 3 residents (Resident #19 and #45) reviewed for change in condition and for 1 of 4 resident (Resident #76) reviewed for use of	F 742	F742 SS-H 1. Corrective Action: " Resident #45 is no longer on [redacted]. " Resident #19 is no longer on [redacted]. " Resident #76 had his care plan reviewed and non-pharmacological interventions were added. " On 3/15/24 [redacted] was discontinued, therefor alleviating the need for Resident #76 to have behavior monitoring documentation. " The regional nurse educated all licensed clinical professionals on the proper management of [redacted] on [redacted]. " The regional nurse educated all licensed clinical professionals on the	4/16/24

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F 742	Continued From page 189 NJ EX Order 2540I medications. The deficient practice was evidenced by the following. 1.) On 02/20/24 at 11:50 AM, the surveyor reviewed Resident #45's Electronic Medical Record (EMR) which revealed diagnoses which included but were not limited to; NJ EX Order 2540I [redacted] On 02/22/24 at 10:05 AM, the surveyor reviewed Resident #45's EMR which revealed the following documention: Review of the March 2022 Medication Administration Record (MAR) revealed a physicians order for a NJ EX Order 2540I medication for NJ EX Order 2540I mg (milligrams) at bedtime (9:00 PM) for the diagnosis of NJ EX Order 2540I. Review of the NJ EX Order 2540I MAR revealed the resident did not receive the NJ EX Order 2540I mg as ordered by the physician on 03/11/22, 03/12/22, 3/14/22, 3/17/22, 3/18/22, 3/19/22, 3/20/22, 3/22/22 and 3/23/22 (9 days). There was no documented evidence why the NJ EX Order 2540I milligrams (mg) was omitted for 9 days. A review of Resident #45's comprehensive resident-centered care plan included but was not limited to; a focus area on NJ EX Order 2540I drug use for management of NJ EX Order 2540I dated NJ EX Order 2540I; goal "will continue to benefit from medication use	F 742	importance of initiating behavior monitoring, Gradual Dose Reductions (GDR) and the use of non-pharmacological interventions for residents who utilize NJ EX Order 2540I medications. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " The unit manager and/or designee will do weekly audits for all residents on NJ EX Order 2540I to assure proper management of the medication. " The unit manager and/or designee will do weekly audits of 8 residents on anti-psychotic medications to assure GDR, Behavior monitoring have been implemented as required and that non-pharmacological interventions have been implemented as appropriate on resident plans of care. 4. How Will These Actions Be Measured: " The results of the weekly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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without complication through next review. [redacted]d and [redacted] will remain stable within baseline through next review. Will exhibit decreased episodes of anxiety"; interventions "administer [redacted] medication as ordered. Observe for side effects of medication. Educate staff to report any concerns. Notify Medical Doctor (MD) of abnormalities."

Review of the Licensed Practical Nurse (LPN) Progress Note (PN) dated [redacted] at 10:09 PM, indicated, The resident refused all medication and [redacted], stating "unhappy with room".

Review of the LPN's PN dated [redacted] at 11:11 PM, indicated the following documention: Resident refused his/her [redacted] and medication despite multiple attempts by this writer. When asked why, he/she kept saying "Leave me alone, I don't want it."

Review of the LPN's PN dated [redacted] at 3:04 PM, indicated, "7:04 AM Resident refused Q (every) [redacted] week NJ EX Order: 264b1 for [redacted] refill. The resident was [redacted] and [redacted]d at this author and the lab technician to get out of his/her room and leave him/her alone. Doctor made aware of resident's behaviors. No new orders given at this time. Lab re-draw scheduled for this [redacted]. Pharmacy in need of updated labs for [redacted] refill."

Review of the LPN's PN dated [redacted] at 3:59 PM, indicated, "Resident is observed talking to self, episode of NJ EX Order: 264b1 [redacted] at the staff, redirected [redacted] numerous times unsuccessful, MD was made aware left voicemail to office to be sent out to [redacted]

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Review of the Registered Nurse (RN) PN dated [redacted] at 10:10 PM, indicated, "The resident started NJ EX Order. 264b1 his/her [redacted] at staff, 911 called due to the resident being a danger to self and others. When the EMS (Emergency Medical Services) arrived, the resident continued with NJ EX Order. 264b1 his/her [redacted] and after verbal redirection, the resident did not resist."

2.) On 02/27/24 at 8:29 AM, the surveyor interviewed Resident #19. He/she was observed seated upright eating breakfast in bed. The resident stated he will be leaving "today", the resident was [redacted] his/her [redacted] with NJ EX Order. 264b1 stating he/she cannot discuss where he/she will be going, and said "that is all I have to say" and the surveyor exited the residents room.

The surveyor reviewed Resident #19's EMR which revealed the following documentation:

Review of the Admission Summary, revealed diagnoses which included but were not limited to; [redacted] other specified [redacted], NJ EX Order. 264b1 [redacted] without [redacted].

Review of the March 2022 MAR revealed the physicians order for [redacted] c medication for [redacted] mg at bedtime (9:00 PM) for the diagnosis of [redacted] phrenia (a mental disorder commonly characterized by [redacted] and [redacted]

Review of the [redacted] MAR revealed the resident did not receive the [redacted] mg as ordered by the physician on 03/16/22, 03/18/22, 03/19/22, 03/20/22, 03/22/22, 03/29/22, 03/30/22,

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and 03/31/22 (8 out of 31 days). There was no documented evidence why the [redacted] mg was omitted for 8 days.

Review of Resident #19's comprehensive resident-centered care plan included but was not limited to; a focus area on [redacted] drug use for management of [redacted] dated [redacted], managed with use of [redacted]-target behaviors: [redacted]; goal will exhibit no [redacted]s and or [redacted]; interventions administer [redacted] medication as ordered. Observe for side effects of medication. Educate staff to report any concerns. Notify MD of abnormalities. Monitor for and document changes in [redacted] ior noting any precipitating factors, interventions attempted, and effectiveness of interventions. Keep MD informed of concerns.

Review of the LPN PN dated [redacted] at 11:09 AM, indicated the following documention:
The resident continued with his/her paranoid behaviors and speech. Stated that staff and his roommate are "out to get him/her". He/she was observed placing a chair in front of the doorway to block entry into the room. Resident was experiencing visual and [redacted]. He/she was observed [redacted] and [redacted] towards staff. The LPN's PN further indicated, "By the afternoon the resident was [redacted] and [redacted] towards redirection. Attempted music therapy but the resident continues to [redacted] him/herself. Spoke with pharmacy, states the resident needs to be enrolled into the [redacted] gy) program for [redacted] refill. Attempted to reach [redacted] Doctor several times. Unable to leave message online. Spoke with MD [medical doctor], states he is not

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enrolled in the [redacted] program and cannot enroll the patient. New order given for [redacted] mg po (by mouth) [redacted] a day) x [redacted] days PRN (as needed) for [redacted] and NJ EX Order. 264b1 until able to reach [redacted] for patient enrollment. Order carried out. Resident sitting in his/her room with music, no issues observed at this time. Will continue to monitor."

Review of the RN PN dated [redacted] at 9:43 PM, indicated the resident was received in his/her wheelchair by the front door with [redacted] behaviors, NJ EX Order. 264b1. He/she was observed [redacted] and stated that the NJ EX Order. 264b1 are "[redacted]" and that his/her family member took the house that was inherited by him/her from the dead parents. He/she stated the lawyer will be called to place [redacted] family member in jail. Several attempts made to redirect the resident were unsuccessful. The physician was contacted and the resident received [redacted] mg po PRN for [redacted] disorder, the medication had mild effect. The resident continued to talk to self and have NJ EX Order. 264b1. The resident accepted all scheduled medication.

Review of the RN's PN dated [redacted] at 10:34 PM, indicated, "Resident remains [redacted] and [redacted] with periods of [redacted] noted. No complaint of [redacted] noted. Resident refused dinner after several attempts and educating resident and the importance of eating his/her meals for nutritional benefits, he/she stated that he/she understands but does not want to eat, bedtime snack also was offered and he/she refused. The resident accepted all PM medication, medication well tolerated."

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Review of the RN's PN dated 4/1/22 at 7:13 AM indicated, "The resident was awake most of the night playing music in bed. At 4:00 AM the resident left his/her room to walk around, after redirected to go back to his/her room the resident said no. The resident walked to the [redacted] unit and refused to come back to his/her unit to the [redacted] unit. The staff attempted to redirect the resident and was noted to have NJ EX Order: 264b1 behaviors, fighting staff and refused to get up off the floor. The resident threatened to [redacted] the staff if they assisted him/her to get up. Resident continued with his/her [redacted] behaviors, becoming a NJ EX Order: 264b1. The resident was offered [redacted] at 5:30AM, but refused and 911 was called to send the resident to [redacted] for evaluation. The emergency transport arrived and resident departed at 6:40 AM. The family and medical doctor were notified."

On 02/27/24 at 2:13 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA). The surveyor requested any investigations for Resident #19 and #45 for [redacted] and [redacted]

On 02/28/24 at 9:32 AM, the Director of Nursing (DON) confirmed that the surveyor was provided with everything that was available for Resident #19 and #45. There was no additional information provided.

On 02/28/24 at 1:03 PM, the surveyor interviewed the DON in the presence of the survey team regarding both Resident #19 and #45 not receiving physician ordered [redacted] medication. The DON stated, "It was a big mess", regarding the residents not receiving their medications. The DON further stated, "I am sure

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the medical doctor could have overridden it [ordering the NJ EX Order 2640 medication] but he is not familiar with NJ EX Order 2 meds NJ EX Order 2640 medications]".

On 3/1/24 at 10:21 AM, the surveyor interviewed the LPN #1 on the NJ EX Order s Unit. The LPN stated she does not have any resident on NJ EX Order 2640, but she does have other residents on NJ EX Order 2640 medication. The LPN stated that if patient refused a medication, it should be documented in the EMR, the rationale for refusal and interventions that were attempted to encourage the patient to take the medication. The LPN stated if a medication was held, it could be for numerous reasons. One reason could be the criteria to administer the medication was not met, for example parameter to follow to administer blood pressure medications. Another reason could be the medication not available. Regardless of the rationale for a prescribed medication not to be administered, the physician must be notified and the nurse must have an order to hold the medication.

On 3/1/24 at 10:35 AM, the surveyor interviewed the LPN #2 on the NJ EX Order Unit. The LPN stated if a patient refused the medication, the nurse would assess the patient, identify the rationale for refusing the medication, and notify the physician and the resident's representative. The LPN further stated, "If a medication was held, the physician must be notified, and the nurse should document the rationale for not administering the medication."

On 3/1/24 at 12:41 PM, the surveyor interviewed the NJ EX Order 2640 Nurse Practitioner NJ EX Order 2640 The NJ EX Order 2640 stated that NJ EX Order 2640 is

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classified as an [redacted] and is used in patients that have [redacted]. The PMHNP confirmed that [redacted] should not be [redacted] or [redacted] d. The [redacted] stated, if you [redacted], it can have a reverse reaction and the patient will have a [redacted] and more [redacted] symptoms of [redacted] will occur which will lead the patient to [redacted] e [a decline in [redacted] often with increased [redacted]]. The PMHNP confirmed that the nurse was to notify the PMHNP of any missed doses that have not been administered or refused. She further stated that the nurse and staff need to document in the EMR the behavior exhibited to ensure that symptoms were not worsening.

On 03/06/24 at 11:03 AM, the Vice President of Operations and Nursing for the management company, the DON and LNHA met with the survey team. There was no additional information provided regarding the above concerns.

Review of the facility provided Behavioral Assessment, Intervention and Monitoring policy, revised [redacted], which included but were not limited to:
"The facility will provide and residents will receive behavioral health service as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care."

"The facility will comply with regulatory requirements related to the use of medications to manage behavioral changes."

Review of the facility provided Change in a Resident's Condition or Status policy, revised

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February 2021, which included but were not limited to:
the nurse will notify the resident's attending physician or physician on call when there has been a(an): d.) significant change in the residents.

3.) On 02/20/24 at 10:01 AM, during tour of the facility [redacted]-unit, Resident #76 was observed in bed, awake and alert. Resident #76 was continually observed during the day staying in [his/her]bed.

A review of the Admission Record revealed that Resident #76 had diagnoses which included but were not limited to; NJ EX Order. 264b1 [redacted]

A review of the Admission Minimum Data Set (MDS) an assessment tool dated [redacted]4, included but was not limited to; the resident was assessed as "NJ EX Order. 264b1 [redacted]" NJ EX Order. 264b1. The resident had a BIMS score of [redacted], indicating the resident had NJ EX Order. 264b1. Review of Section [redacted] revealed NJ EX Order. 264b1: Use and Indication indicated the resident was on an NJ EX Order. 264b1 [redacted]t medications. Review of the [redacted] Medication section indicated [redacted] were received on a routine basis; a gradual dose reduction (GDR) had not been attempted; and no GDR was documented as clinically contraindicated.

A review of the [redacted] Order Summary Report, revealed a physician's order dated [redacted], for NJ EX Order. 264b1) [redacted]

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milligram (mg) give [redacted] tablet by mouth one time a day related to NJ EX Order. 264b1, NJ EX Order. 264b1. A physician's order dated [redacted] for [redacted] (medication used to treat behaviors such as NJ EX Order. 264b1, episodes of mania) [redacted] give [redacted] tablet by mouth in the evening for [redacted].

A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated [redacted] through [redacted], reflected [redacted] mg give [redacted] tablet by mouth in the evening for [redacted] "monitor for [redacted] and NJ EX Order. 264b1". The MAR and TAR further documented [redacted] give [redacted] tablet one time a day related to [redacted]. The MAR and TAR had no documented evidence that monitored the presence and/or absence of specific target behaviors or possible side effects associated with the use of NJ EX Order. 264b1 medications to determine the efficacy and adverse consequences.

A review of the MAR and TAR dated [redacted] through [redacted] documented the Seroquel 25 mg give [redacted] tablet by mouth in the evening for [redacted] "monitor for [redacted] and [redacted] r". The MAR and TAR further documented [redacted] mg give [redacted] tablet one time a day related to NJ EX Order. 264b1. The MAR and TAR had no documented evidence that monitored and document the presence and/or absence of specific target behaviors or possible side effects associated with the use of NJ EX Order. 264b1 medications to determine the efficacy and adverse consequences.

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A review of the comprehensive resident-centered care plan included but was not limited to; a focus area on [redacted] medication for management of depression date initiated [redacted]. The goal indicated, "will have minimal side effects from [redacted] medications." Interventions included but limited to: administer medications as ordered by MD (medical doctor), assess, and monitor for side effects, counseling as ordered and PRN (as needed), and [redacted]) consult as ordered. All interventions were initiated on [redacted]. The care plan did not address any evidence of an individualized, [redacted] approaches to care that are provided as part of a [redacted] and [redacted] environment, directed toward preventing, relieving, and/or accommodating a resident's [redacted] as well as maintaining or improving a resident's [redacted] or [redacted] well-being regarding the [redacted] medication used for the diagnosis of [redacted]

A review of the Pharmacy consultant recommendation, dated [redacted], included but was not limited to; "identify and monitor the behavior being exhibited for [redacted]". This was not dated as having been completed. There was no documented evidence in the Progress Notes (PN) that this was addressed with the doctor.

A review of the Nurse Practioners (NP) PN dated [redacted], included but was not limited to; Signs/symptoms: [redacted], [redacted]. Plan: 1. Always consider supportive interventions, including redirection, support/reassurance, comfort measures, reduced stimulation, expression of feelings, family involvement.

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A review of the PNs dated [redacted] through [redacted], revealed no consistent documented evidence of behaviors or lack of behaviors to summarize and monitor the residents.

On 03/05/24 at 9:07 AM, the Director of Nursing (DON) and Registered Nurse Unit Manager (RN/UM) were interviewed on the [redacted]-unit. The DON stated that Resident #76 "doesn't get behavior monitoring because [he/she] does not have behaviors".

On 03/05/24 at 10:30 AM, the DON in the presence of four surveyors, stated that the consultant pharmacy review would be completed on admission and then monthly. The DON was provided the pharmacy consultant recommendation dated [redacted], to identify and monitor the behaviors for the use of Seroquel. The DON was unable to explain why it was not initiated.

On 03/05/24 at 11:08 AM, the DON was again interviewed and shown the RN/UM note dated [redacted], "[redacted] NP in to evaluate use of [redacted]. Stated pt (patient) was on in the hospital for [redacted] and [redacted]. When pt [patient] shows continuous lack of behaviors, GDR can be started." The DON stated that a "GDR wouldn't be considered except for every 3 months". The surveyor requested a policy to address this, but the facility was unable to provide any policy or additional information.

On 03/05/24 at 12:43 PM, the surveyor conducted a telephone interview with the [redacted] Nurse Practitioner (NP) in the presence of the survey team. The NP stated it would be her expectation

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that the staff would "document behaviors" so that she "would be able to review the documentation and examine the resident to determine GDR". She further stated, "I read the documentation and base any symptoms on my assessment." The NP further stated she had not been back to the facility yet to evaluate Resident #76.

On 03/06/24 at 12:01 PM, after surveyor inquiry, the facility prvided a note from the NP dated [redacted] which included but was not limited to; "I will plan to GDR [redacted] at the next visit on [redacted], and eventually discontinue [redacted] if patient continues to be without symptoms. [redacted] are indicated for use in the management of [redacted] disorders, and other brief [redacted] episodes such as [redacted], or other [redacted] related triggers such as [redacted]

The surveyor requested the facility policy on [redacted] Medication use and the Director of Nursing (DON) provided the policy "Identifying Involuntary Seclusion and Unauthorized Restraint" policy dated 4/21, which included but was not limited to; "If [redacted] medication is used to treat a medical symptom, the use of the medication is supported by a documented rationale for its use, administered at the correct dose and duration, and with adequate monitoring."

Review of the facility provided "Behavioral Assessment, Intervention and Monitoring" policy, revised [redacted], included but were not limited to:

"The facility will provide and residents will receive behavioral health service as needed to attain or

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maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care."

"The facility will comply with regulatory requirements related to the use of medications to manage behavioral changes"

"Behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment." Guidelines: 1. Behavior is the response of an individual to a variety of factors which may include medical, physical, functional, psychosocial, emotional, psychiatric, or environmental causes. 1.a. behavior is regulated by the brain and influenced by past experiences, personality traits, environment, and interactions with others. b. behavior may be a way for an individual in distress to communicate unmet needs, discomfort, or express thoughts that cannot be articulated. 2. As part of the comprehensive assessment, the staff will evaluate ..... a. the resident's patters of cognition, mood, and behavior. c. typical or past responses to stress, fatigue, fear, anxiety, frustration, and other triggers. d. previous patterns of coping with stress, anxiety, and depression. 3. "The nursing staff will identify, document, and inform the physician about specific detains regarding changes in an individual's mental status, behavior, and cognition, including: a. onset, duration, intensity, and frequency of behavior symptoms; b. any recent precipitating or relevant factors or environmental triggers .... c. appearance and alertness of the resident and related observations. Monitoring: 4. If antipsychotic medications are used to treat

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F 742	Continued From page 203 behavioral symptoms, the IDT (Interdisciplinary Team) will monitor the indication ..... a. the IDT will monitor for side effects and complications related to psychoactive medications example: lethargy, abnormal involuntary movements, anorexia, recurring falls. Review of the facility provided Change in a Resident's Condition or Status policy, revised February 2021, included but were not limited to, "the nurse will notify the resident's attending physician or physician on call when there has been a(an): d.) significant change in the residents physical/emotional/mental condition f.) refusal of treatment or medications two (2) or more consecutive times. NJAC 8:39-27.1 (a); 28.1(c)	F 742		
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Complaint # NJ # 160660 Based on observation, interview and document review it was determined that the facility failed to serve hot and cold foods at an appetizing temperature for 4 of 4 hot food items, 2 of 2 cold	F 804	F804 SS-F 1. Corrective Action: " On March 26, 2024, the Food Service Director and the Dietary Department were educated about serving hot and cold food at appetizing temperatures by the Facility	4/16/24

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F 804	Continued From page 204 food items and for 6 of 6 residents who attended a resident council meeting. The deficient practice was evidenced by the following: On 02/22/24 at 8:44 AM, the last meal tray was tested for temperature by two surveyors utilizing a calibrated thermometer and the Food Service Director (FSD). The resident meal was labeled a "Chopped Diet". Hot food items: -Chopped French Toast; FSD- 90 degrees Farenheight (F), Surveyor-88 F. -Sausage; FSD- 89 F, Surveyor -90 F. -Hot Cereal; FSD-132 F, Surveyor-129 F. -Coffee; FSD- 124 F. The surveyor asked the FSD what the hot food temperature should be, and he stated 140 F or above. Cold food items: -4 ounces skim milk; both 51 F -4 ounces orange juice; FSD-54 F The surveyor asked the FSD what the cold food temperatures should be, and he stated cold should be 35 F or below. The surveyor asked if the food temperatures were in appropriate range and he stated, "unfortunately not." On 02/23/24 at 11:14 AM, a surveyor conducted a resident council meeting with six residents and 6 out of 6 residents stated the food was "cold" and the food sat too long in the hallway before the staffed passed out the trays. The Food Temperatures and Holding Policy, undated revealed: Hot food should arrive at the resident above 135 F. It is recommended to leave the kitchen at a much higher temperature. Cold food should arrive at the resident below 41 F. It is	F 804	Administrator. " On March 26, 2024, the Dietary director and Administrator reviewed the process for passing trays and updated the process where necessary to assure that food is served at appetizing temperatures. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " Dietary and clinical staff will be re-educated by the Food Service Director and/or Dietitian and/or designee on the updated process for passing trays. Education will be completed by COMPLETION DATE. " The dietitian and/or designee will perform weekly random food temperature tray audits of 5 trays per unit to assure that food is being served at appetizing temperatures. 4. How Will These Actions Be Measured: " The results of the weekly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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F 804	Continued From page 205 recommended to leave the kitchen at a much lower temperature. Soup and Hot Beverages. A minimum of 150 F is preferred while not exceeding a too high and dangerous temperature. 8:39-17.4(a)2	F 804		
F 806 SS=J	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to provide food that accommodated a resident's known food allergy to [redacted] and [redacted] products. This deficient practice was identified for 1 of 18 residents (Resident #32) reviewed for meal observations. On 02/27/24 at 8:32 AM, Resident #32 was observed eating a [redacted]. The meal ticket on their breakfast tray had documented allergies to e[redacted]s and [redacted] products. This posed the likelihood of serious harm to the health and wellbeing of Resident #32. This resulted in an Immediate Jeopardy (IJ).	F 806	F806 SS-J 1. Corrective Action: " On 2/27/24, the family and physician of Resident #32 was notified of the notated event. " On 2/27/24, Resident #32 was immediately assessed with no reaction noted. " On 2/27/24 Resident #32□s physician evaluated the resident and subsequently discontinued the [redacted] allergy order. The resident□s chart and the dietary department was notified of the update. " An order was received on 2/27/24 to monitor the resident and administer Benadryl PO Q6 hours PRN for allergic	4/16/24

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F 806	Continued From page 206 The IJ was identified and began on [redacted] and the IJ template was given to the Licensed Nursing Home Administrator (LNHA) on [redacted] at 12:48pm. An acceptable removal plan was received on [redacted] at 2:20 PM and was verified on-site on [redacted] at 9:13 AM. The evidence was as follows: A review of the facility policy for "Food Allergies and Intolerance's", revised August 2017, included but was not limited to: "Residents with food allergies .... Are identified upon admission ..... Steps are taken to prevent resident exposure to the allergen(s). Assessment and Interventions: 1. Residents are assessed for a history of food allergies .... upon admission and as part of the comprehensive assessment. 2. Resident food allergies ... are documented in the assessment notes and incorporated into the resident's care plan." The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted] reflected the resident had a brief interview for mental status (BIMS) of [redacted], indicating that the resident had NJ EX Order. 264b1 . Section [redacted] was coded as [redacted] which indicated that the resident required supervision for eating. On 02/23/24, the surveyor reviewed Resident #32's electronic medical record. A review of the Admission Record dated [redacted], documented that Resident #32 had "Allergies: NJ EX Order. 264b1 or [redacted] products, NJ EX Order. 264b1),	F 806	reaction. No allergic reaction was noted so no Benadryl was needed. " Re-education was provided to nursing staff on 2/27/24 to check meal tickets prior to giving a resident their tray. " Re-education was provided to Dietary staff on 2/27/24 to check each resident□s tray for accuracy according to the meal ticket at the end of the tray line prior to placing the tray on the cart. " A dietary aide will be assigned the responsibility to check each tray for accuracy. The administrator also checked trays with the dietary aide on 2/27/24 to verify accuracy at lunch and dinner. " On 2/27/24, an Ad Hoc quality assurance and performance improvement meeting was held to discuss the process of assuring the allergies on the meal tickets are accurate and match what is being served on the tray. " A list of residents with food allergies was completed and reviewed to verify actual allergies with notification of the dietary department of any changes as needed was completed on 2/27/24. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " Audits for residents with food allergies will be conducted 2x/week by the Administrator and/or designee to assure tray accuracy. This audit will be done for 4 weeks and then 2x monthly for 6	

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F 806	Continued From page 207 NJ EX Order. 264b1". The Admission Record revealed diagnoses which included but were not limited to NJ EX Order. 264b1 and need for assistance with personal care. The Physician's "Order Summary Report" dated NJ EX Order. 264b1, indicated Allergies: NJ EX Order. 264b1 products NJ EX Order. 264b1, NJ EX Order. . A review of the resident's current Comprehensive Care Plans documented the resident's diagnosis, date of birth, physician's name, admission date, room location and allergies which included NJ EX Order. 264b1 A review of the NJ EX Order. 264b1 Certified Nursing Aide (CNA) Task record (a guide to care NJ EX Order. 264b1 products, NJ EX Order. 264b1 A review of the Physician's Assistant Progress Notes (PN) dated NJ EX Order. 264b1, included but was not limited to: Allergies NJ EX Order. 264b1 NJ EX Order. 264b1, NJ EX Order. . A review of the Dietitian's PN dated NJ EX Order. 264b1, included but was not limited to: Allergies NJ EX Order. 264b1 products, NJ EX Order. 264b1 . A review of the NJ EX Order. 264b1 consult dated NJ EX Order. 264b1 revealed Resident #32's documented allergy list as NJ EX Order. 264b1 products, NJ EX Order. 264b1	F 806	months. " Random weekly Tray accuracy audit of 5 trays will be completed by the Food Service Director and /or designee. 4. How Will These Actions Be Measured: " The results of the weekly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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F 806	Continued From page 208 On 02/27/24 at 8:15 AM, the surveyor observed Resident #32's meal ticket which indicated allergies: [redacted] On 02/27/24 at 8:32 AM, the surveyor observed Resident #32 sitting up in bed with the meal in front of the resident. The surveyor observed the meal ticket next to the resident's plate. Resident #32 stated [he/she] wanted pancakes. The resident then raised their right hand, which had a half-eaten [redacted], and ate the rest of the [redacted] in the presence of the surveyor. The surveyor did not observe an allergic reaction. The surveyor then went into the hallway outside of Resident # 32's room and interviewed the MDS/LPN nurse and Licensed Practical Nurse (LPN). The MDS/LPN stated she had delivered the meal tray to Resident #32. The surveyor inquired what the process was regarding meal tray delivery. The MDS/LPN stated she would check for the correct diet. She also stated she does not normally pass out meal trays and that she does not "look down at the allergies" on the meal ticket. The MDS/LPN confirmed that there were two [redacted] on the resident's meal tray. On 02/27/24 at 8:33 AM, the surveyor interviewed the LPN Unit Manager (LPN/UM) who verified that Resident # 32 had food allergies to [redacted] via the electronic medical record (EMR). On 02/27/24 at 8:54 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the MDS/LPN should have looked for allergies on the meal ticket. The DON acknowledged that Resident #32's EMR and meal ticket documented an [redacted] allergy.	F 806		

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F 806	Continued From page 209 On 02/27/24 at 8:57 AM, the surveyor interviewed the Food Service Director (FSD) and a Dietary Aide (DA). The FSD stated the facility used a meal tracker system to print out the resident's food order and a list of allergies. The DA preparing the tray was responsible to review the allergies to ensure the resident was not receiving those foods. On that same date and time, the DA stated that she would always read the meal tickets and be "mindful" about food allergies. The DA acknowledged the resident's meal ticket indicated pancakes and that she should have provided pancakes. The DA stated, "It is my fault." On 02/27/24 at 10:03 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that Resident #32 should not have been served [redacted] given that [redacted] were listed as a food allergy on the resident's meal ticket. On 02/27/24 at 10:46 AM, the surveyor, in the presence of two other surveyors, conducted a telephone interview with Resident #32's Medical Doctor (MD). The MD confirmed he had been the resident's MD since [redacted]. He stated "I would expect [he/she] did not get any [redacted]" if there was an egg allergy noted on Resident #32's meal ticket. He further stated he had never clarified what Resident #32's reaction was to any of the allergies documented in the medical record. On 02/29/24 at 8:27 AM, the surveyor interviewed the DA again regarding why [redacted] were placed on Resident #32's meal tray. The DA stated she	F 806		

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F 806	Continued From page 210 thought she could give it to her so she did eventhough the meal ticket documented an [redacted] allergy. An acceptable removal plan was received on [redacted] at 2:20 PM indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: 1) assessment and monitoring of the resident for an allergic reaction; 2) a physician order for [redacted] a medication that treats [redacted] caused by allergic reactions) to be given if the resident had an allergic reaction; and 3) facility education to the nursing and dietary staff regarding meal tray accuracy and delivery including attention to documented allergies. The survey team verified the removal plan on-site on [redacted] and determined the IJ for F806 was removed as of [redacted] at 9:13 AM.	F 806		
F 812 SS=F	NJAC 8:39-17.4; 27.1 (a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		4/16/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 211 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review it was determined that the facility failed to ensure a) foods were stored properly and labeled with a use by date, b) equipment was maintained in a clean and sanitary manner, and c) hair restraints were appropriately worn to prevent the spread of potential infection or food borne illness. The deficient practice was evidenced by the following: On 02/20/24 from 9:41 AM through 10:15 AM, the surveyor conducted an initial tour with the Food Service Director (FSD) and observed the following: The walk-in refrigerator contained: -A package of undated meat was in a plastic -type wrap, stored in a metal pan, on a shelf and was covered with aluminum foil. The FSD stated, "sometimes they throw on a use by date" and stated it was pulled from the freezer on 02/17/24 and "it's beef stew for tomorrow". -A large metal pan of chicken thighs was next to the container of meat, had a plastic covering on it with a handwritten label "Chicken Pulled 2-17-24" and did not contain a "use by date". -A yellow carton labeled "Frozen Egg Product", "Keep Frozen", was on a shelf with 5 other	F 812	F812 SS-F 1. Corrective Action: " On the package of undated meat was discarded. " On 2/17/24, a use by date was added to the chicken thighs that was placed in a metal pan. " Upon identification, on 2/17/24 the yellow carton labeled frozen egg product was discarded. " On 2/17/24 the carton of whole raw eggs was relocated to the bottom shelf of the refrigerator. " On 2/17/ the 10- pound carton of potato salad was discarded. " Upon identification, the 5-pound container of cottage cheese was discarded on 2/17/24. " On 2/26/24 the food service director was educated on the policy of use-by dates and wet nesting of trays by the Administrator. " Upon identification, the dirty can opener affixed to the table was immediately removed and cleaned with the surveyor present. " On 2/26/24 all dietary staff was in-serviced on the need to wear hair and beard coverings while in the kitchen	

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F 812	Continued From page 212 cartons of the same product. The opened carton had a manufacturer "Sell by date" stamped 11/20/2024. There was no open date or "use by date" on the item. The surveyor asked the FSD about the expiration of the product and he stated 14 days. The surveyor then asked how you would know that, and he stated, "we are supposed to put an open and label the use by date". The surveyor observed that the carton was stamped in red, "Thawed product stored at 40 degrees or below should be used within 5 days" (Not 14 days as per the FSD). The FSD stated "we are going to toss it, we don't know when it was opened, the carton is clearly labeled should be used within 5 days". -There was a box that contained whole raw eggs that was stored on a middle shelf. The FSD stated the eggs were supposed to be on bottom shelf because they were raw eggs. -There was a large, ten-pound container of potato salad with a manufacture label, "packed on 01/04/24" there was "no use by date" on the product or expiration date. At that time the surveyor asked the FSD if there is a special type of menu used by the facility and he stated, the menu was "Kosher style". - A 5-pound container of cottage cheese had a manufactures stamp on the container "Sell by Jan 19 24" and a sticker from the vendor dated 1/10/24. The surveyor requested the use by date from the FSD and he stated, "it doesn't have a use by date." -A rack containing burgundy resident meal trays was observed stacked up to 6 in a slot, and there were ten large slots and multiple rows. The	F 812	and/or handling food by the Food Service Director. " Upon identification, the pantry refrigerator that was repaired. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " The cooks workflow was revised, that the can opener will be cleaned after each meal is prepared " The food service director and/or designee will do a weekly audit to ensure that the can opener is cleaned after each meal is prepared. " The food service director and/or designee will do a weekly audit of use by dates in the kitchen.	

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surveyor asked the FSD to remove several of the trays which were visibly wet and dripping.

-The can opener affixed to the table was visible soiled by the blade and the base. The FSD stated, "it needs to be washed."

On 02/22/24 at 8:25 AM, during a subsequent kitchen observation, and during the tray line, which was in progress for the breakfast meal, the surveyor observed a female staff in the kitchen who was actively working in the kitchen and was throwing out spice containers, then removed buckets of sanitizer. The unidentified staff was not wearing a hair covering containing all her hair and the front portion was out. The surveyor went to the FSD who was prepping trays and observed that the cook was plating food, and the beard restraining did not cover all of his facial hair. The surveyor asked the FSD at that time if he had noticed the cook's exposed facial hair and he stated, "he did not."

On 02/23/24 at 7:18 AM, during a tour of the 1st floor with the Registered Nurse, the pantry refrigerator was observed as non-functioning.

On 03/05/24 at 1:35 PM, the surveyor informed the Administrator of the findings, and no additional information was provided.

A review of the following policies revealed: Food Preparation and Service Policy, Last Update: February 2021 revealed 7. Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food; The Policy for Hairnets and Beard Snoods, Last Update: March 2023 revealed How to wear a hairnet properly, 1. Hair net should cover the hair

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F 812	Continued From page 214 and the ears. 2. All hair should be restrained within the net. 3. Hair restraints must be worn by every worker entering any of the kitchen areas, even those workers with shaved heads. Procedure for beard snoods, 1. Fit the beard snood over the nose with the elastic over the ears, 2. Secure the hairnet with the closure at the front, 3. Once the hairnet is secured, no hair should be exposed. Food Receiving and Storage Policy, Last Update: February 2021 revealed: 8. All foods stored in the refrigerator or freezer will be covered, labeled, and dated ("use by" date)., 11. Food shall be discarded as per any labeling instructions and policy upon supervisor inspection to prevent spoilage. 16. Uncooked and raw animal products and fish will be stored separately in drip-proof containers and below fruits, vegetables and other ready to eat foods. NJAC 8:39-17.2(g)	F 812		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review it was determined that the facility administration failed to ensure policies, procedures and effective systems were implemented to maintain each resident's highest practicable physical, mental, and psychosocial well-being by failing to ensure a) a resident with	F 835	F835 (Refer to EP□s 1,7,18,25,31,36,37,39, F550E, F565F, F567F, 568F, F584F, F677F, F679D, F689G, F690H, F725F, F742H, F806J, F865F, F880F) 1. Corrective Action: " On March 25, 2024, the Administrator	4/16/24

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F 835	Continued From page 215 documented food allergies were provided with appropriate food items, b) that appropriate and timely incontinence care was provided to dependent residents, c) residents were treated with dignity and respect, d) residents were consistently provided with physician ordered medications, e) interventions were implemented to prevent falls for a resident with frequent [redacted] with history of [redacted], residents received appropriate [redacted] care to limit [redacted], f) resident council grievances were addressed, e) residents resided in a homelike environment, g) resident's had unrestricted access to their Personal Needs Accounts, h) transportation was available to ensure outside trips were scheduled, i) the facility maintained a comprehensive emergency preparedness program, j) infection control program contained the required antibiotic stewardship and infection surveillance components to prevent the spread of infection, k) administration self identified areas for improvement and developed quality assurance plans, and l) staffing levels were adequate to meet resident needs. The deficient practice affected 2 of 2 resident units and was evidenced by the following: Refer to: EP #s 1, 7, 18, 25, 31, 36, 37, 39; F550E, F565F, F567F, F568F, F584F, F677F, F679D, F689G, F690H, F725F, F742H, 806J, 865F, 880F On 02/20/24 at 11:19 AM, the surveyor conducted an entrance conference with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) and the Vice President of Nursing (VPON) from a management company. The surveyor was informed that the VPON was from the company that was looking to purchase	F 835	was educated on his job description, roles, and responsibilities to ensure that policies and procedures and effective systems were implemented to assure residents maintain their highest physical, mental, and psychosocial well-being, Regional Administrator. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " The LNHA corporate supervisor will conduct weekly audits on random facility policies and procedures to ensure the administrator's adherence to and compliance of facility policies and procedures. 4. How Will These Actions Be Measured: " The results of the weekly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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the facility. The surveyor asked if any renovations were in progress and the LNHA stated, just cosmetic on the [redacted] unit. When asked who was the Infection Preventionist, the DON stated, he "took over doing that" and has been at the facility for four months.

On 02/27/24 at 10:51 AM, the surveyor conducted a telephone interview, in the presence of the survey team, with the Medical Director regarding the identified concerns with Resident #32 who had a documented [redacted] allergy who received and consumed [redacted]. The surveyor informed the Medical Director that the LNHA was made aware regarding the Immediate Jeopardy situation regarding the kitchen serving the [redacted] although the meal ticket for Resident #32 identified the [redacted] allergy, then the nurse who failed to read the ticket for the documented allergies and then served the meal to Resident #32. The Medical Director confirmed that should not have happened, and he had not been made aware of specifics. The surveyor informed the MD regarding the survey teams finding regarding multiple resident who were NJ EX Order 264b1, were wearing NJ EX Order 264b1 and the survey team's findings regarding substandard quality of care. The MD stated the facility did not make him aware of the NJ EX Order 264b1 care concerns, he would want the DON involved with that, and the "Certified Nurse Aide's involved should be disciplined."

On 03/05/24 at 10:39 AM, the surveyor conducted an interview with the LNHA in the presence of three surveyors. The surveyor showed the LNHA a copy of his Job Description and he confirmed his date of hire was [redacted].

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The surveyor asked the LNHA who the governing board of the facility was and the LNHA stated the management company operated the facility. The surveyor asked when that changed and the LNHA stated, "I don't know exactly", but he reported to the management company. The LNHA said he was hired by the former owner and doesn't remember when it changed. The surveyor asked if he communicated with the management company [i.e.. governing board]. The LNHA stated he reported to the Chief Operating Officer for the management company. The surveyor asked the LNHA what was his role in the infection control program. The LNHA stated that the Infection Preventionist was now the DON's responsibility. The surveyor asked the LNHA if he had been aware that antibiotic stewardship was not being completed and he stated, "he was not aware." The surveyor asked the LNHA if antibiotic stewardship was important and the LNHA stated, "it was important, because it keeps track of residents with infections." The surveyor asked when the Infection Preventionsist role transferred to the DON and he stated, "I do not recall exactly." The surveyor asked how the LNHA ensured that the DON fulfilled the antibiotic stewardship functions and the LNHA stated, "we discussed it from time to time." The surveyor asked the LNHA were the discussions documented and the LNHA stated, "no", he could not recall the last time he had that discussion. The surveyor asked the LNHA if he should have been aware that antibiotic stewardship was not being completed and he stated, "yes, he should have know he was not doing it."

The surveyor asked the LNHA about the environmental concerns observed on 02/21/24 with two surveyors on the [redacted] unit which

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included, but was not limited to; holes in walls in resident rooms, broken furniture with jagged edges and multiple soiled privacy curtains. On 02/21/24 at 11:25 AM, the surveyor asked the LNHA about completion of daily rounds to which the LNHA stated he had not documented environmental rounds. The surveyor asked the LNHA what was his role to identify the concerns that were pointed out during the environmental tour. The LNHA stated, the big picture of the room looked like it should and "I will pay closer attention to those small items, if I missed things, I miss things." The surveyor asked should the areas have been identified and he stated, "yes". The LNHA stated we did a lot of painting on the 100 side, "we are moving slowly."

On 03/05/24 at 10:54 AM, the surveyor asked the LNHA if he interacted with the MD. The surveyor reviewed the concerns identified during the survey, which included, lack of appropriate incontinence care provided to residents and asked the LNHA if he had reviewed concerns with the medical director. The LHNA stated, we discuss various issues. When asked if documented, he stated, "no documentation".

On 03/05/24 at 10:55 AM, the surveyor asked the LNHA how often did he meet with different departments. The LNHA stated he attended morning meeting every day, regarding anything of significance that day. The surveyor asked the LNHA if staffing was reviewed and did the LNHA think staffing was adequate. The LNHA stated "most of the time". The surveyor asked the LNHA if staffing was adequate, should the survey team have identified multiple residents wearing double briefs and did you investigate the concerns. The LNHA stated, "I personally didn't document"

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[regarding being aware of staff using double incontinence briefs on residents.] The surveyor asked the LNHA if you identified the concern, should it have happened again, "no, we took are hard stance on it, we discussed it". The surveyor asked, if it was the same staff using double briefs on residents and the LNHA stated, "I don't believe so, I don't recall." The surveyor asked the LNHA if the facility utilized a risk management program for investigations, and the LNHA stated, "I believe we have one, I am not sure of the details". The surveyor asked the LNHA if he reviewed accident and incident reports and the LNHA stated, "yes" to make sure all steps are followed for an investigation, and what and why something happened. The surveyor asked does the LNHA ensure that any specific interventions are appropriate and implemented and he stated that would be determined with nursing. The surveyor asked how would know if fall interventions are effective, and the LNHA stated, "if the person doesn't fall again". The surveyor asked if interventions were documented, and the LNHA stated, "yes it should be".

On 03/05/24 at 11:10 AM, the surveyor showed the LNHA a signed job description and he confirmed it was his, and his start date was 06/13/22. The surveyor asked the LNHA how does the facility ensure that the resident funds are managed properly. The LNHA stated, to make sure that enough funds are available as necessary, "I am not sure it is a policy". The surveyor asked the LNHA do you oversee that process and the LNHA stated, "yes". The surveyor asked if he communicated with the Human Resources Director (HRD) regarding if funds were available and it is documented. The LNHA stated, "no". The surveyor asked do they

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discuss how much money is available at the facility, and without any specifics offered, he stated, "enough to meet the residents needs". Reviewed concerns brought up in resident council, including receipts to residents when money was removed. The LNHA stated, "if they [resident] request a receipt than they can get that as well."

On 03/05/24 at 1:35 PM, the survey team conducted a meeting with the LNHA and DON to again, review concerns identified during the survey conducted from 02/20/24 through 03/06/24 which included, but was not limited to, the following concerns:

-The lack of a comprehensive, accurate emergency preparedness program.
- Resident #5's multiple [redacted] with [redacted] and lack of interventions to prevent further [redacted]
- On 02/23/24 at 6:15 AM, two surveyors observed multiple residents with [redacted] were NJ EX Order 264b1.
- Failure to treat residents with dignity and respect on multiple observations for multiple days, serving residents meals on [redacted] and NJ EX Order 264b1 for meal service, labeling residents, speaking a foreign language in the presence of residents, and taking personal phone calls while caring for residents.
- Failure to perform hand hygiene during meals, no antibiotic stewardship or infection surveillance.
-Failure to follow up on resident council concerns for over one year regarding changing the menu to "kosher style", and repetitive menus, failure to provide menus.
-Lack of outside trips due to not paying the transportation bill, re
-Resident Personal Needs Funds limited, no

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process, no policy, no oversight.
-Resident rooms with damaged furniture, walls, equipment, and soiled areas including privacy curtains.

On 03/06/24 at 11:03 AM, the LNHA, in the presence of the Vice President of Nursing and Vice President of Operations from the management company, along with the survey team, stated to the survey team: It has been a challenging two weeks, and we know we share the same goal to strive to do our best and we have to work better on it. Next survey we will do better.

The signed LNHA Job Description, dated 06/13/22 revealed:

The primary purpose of your job position is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards,, guidelines, and regulations that governs nursing facilities to assure that the highest degree of quality of care can be provided to our residents at all times. Administrative functions: Plan, develop, organized, implement, evaluate, and direct the facility's programs and activities in accordance with guidelines issued by the governing board. Develop and maintain written policies and procedures and professional standards of practice that govern the operation of the facility. Make written and oral reports/recommendations to the governing board concerning operation of the facility. Make routine inspections of the facility to assure that established policies and procedures are being implemented and followed. Safety and Sanitation: Ensure that the building and grounds are maintained in good repair. Review

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F 835	Continued From page 222 accident/incident reports (e.g., falls, injuries of an unknown source, abuse, etc.). Monitor to determine the effectiveness of the facility's risk management program. Resident Rights: Ensure that the resident's rights to fair and equitable treatment, self determination, individuality, privacy, property and civil rights, including the right to wage complaints are well established and maintained at all times. Review resident complaints and grievances and make written reports of action taken. Discuss such actions with resident and family as appropriate. Ensure that resident funds maintained by the facility are managed in accordance with current federal and stated regulations and that appropriate accounting records are maintained. NJAC 8:39- 5.1(a); 9.2(a)	F 835		
F 842 SS=F	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 842		4/16/24

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EXCEL CARE AT MANALAPAN	104 PENSION ROAD MANALAPAN, NJ 07726

(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 842	Continued From page 223 (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services	F 842		

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F 842	Continued From page 224 provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that medical record access was provided in a timely manner during an on-site survey conducted from 02/20/24 through 03/06/24. The deficient practice was evidenced the following: On 02/20/24 11:19 AM, the surveyor conducted an entrance conference with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) and the Vice President of Nursing (VPON) from a management company. The VPON stated the management company was the company that was purchasing the facility. The surveyor asked about the electronic medical record (EMR) system the facility utilized and the LNHA stated they have a new EMR since NJ Ex Order 26401. The surveyor asked if the facility still had access to records prior to the NJ Ex Order 26401 and he stated, the facility "still has access and the information was imported into the new system." On 02/21/24 at 11:21 AM, the facility provided the survey team with a tablet and was informed that the EMR access for medical records prior to NJ Ex Order 26401 would need to be accessed using the tablet to access the prior EMR.	F 842	F842 SS-F 1. Corrective Action: " On 2/20/24, survey team was immediately provided computer and access to all emergency health record platforms, by the Administrator, that maintained historical and current resident documentation. " On 2/20/24 and throughout the duration of the survey, the unit manager supported the survey team in timely retrieval of resident information (through printing out documentation and assisting with looking up information) requested due to survey teams unfamiliarity with the Visual platform. " The facility transitioned to PCC in 4th quarter of 2023 and no longer utilizes the Visual platform. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " The facility transitioned to PCC in 4th quarter of 2023 and no longer utilizes the	

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F 842	Continued From page 225 On 02/22/24 at 11:10 AM, the surveyor asked the LHNA, in the presence of the survey team regarding why the facility did not have immediate access to the medical records prior to 1[redacted]. The LHNA stated he was unsure why the facility did not have access to the records and stated, he was unaware that was needed, "no one looked for it." The LHNA stated, there was one person in the facility that is familiar with the old EMR system and if she cannot assist the survey team and provide the requested information, the LHNA will have to contact the former EMR company. On 02/23/24 9:59 AM, which was day four of the survey, the survey team met with the LNHA and DON regarding the following medical records that have been requested and not yet provided: Resident #45's medication and treatment administration records for [redacted] and [redacted]. All accidents and incidents from [redacted] and all physician orders from [redacted]; Resident #19's physician orders, care plan and medication and treatment administration records from [redacted]; Resident #54's physician orders from [redacted] and Resident #51's [redacted] complete medical record. NJAC 8:39-35.2(k)	F 842	Visual platform and will continue to assure timely surveyor access to the PCC platform. 4. How Will These Actions Be Measured: " Upon any DOH survey exit, administrator and/or designee will advise the QAPI committee should there be a concern raised by the surveyor about access to the EHR system. Based on the feedback by the administrator after a survey exit, a decision will be made regarding the need for continued submission and reporting to the QAPI committee. " The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must:	F 865		4/16/24

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F 865	Continued From page 226 §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life,	F 865		

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and resident choice;

§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.

§483.75(f) Governance and leadership.
The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.

§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;
§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;

§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.

§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and

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F 865	Continued From page 228 §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, it was determined that the facility's Quality Assessment and Assurance Committee (QAPI) failed to ensure the facility self- identified areas for improvement including environmental concerns, resident care related concerns, the Antibiotic Stewardship Program and adverse events. This deficient practice had the potential to affect all residents that resided in the facility and was evidenced by the following: Refer to F550F, F565F, F567F, F584F, F677E, F689G, F690H, F742H, F806J, F890G 1.) During a tour of the [redacted] unit on 02/20/24 and 02/21/24, the surveyors observed several rooms with broken furniture, soiled privacy curtains, missing privacy curtains, dust in rooms and air conditioners cracked. On 02/21/24 at 11:25 AM, two surveyors (Surveyor #1 and #2) conducted a tour with the	F 865	F865 SS-F (Cross walked to F550F, 565F, 567F, 584F, 677E, 689G, 690H, 742H, 806J, 890G) 1. Corrective Action: " Upon identification, an ad-hoc QAPI meeting was scheduled on March 28, 2024, to review the thoroughness of the QAPI program and process. " QAPI plans were implemented for the following areas: Environmental Concerns, Resident Care Related Concerns and Antibiotic Stewardship Program and Adverse Events. " Education was provided to the QAPI team members on the QAPI program, policy, and process on March 28, 2024. " The current QAPI policy was reviewed by the Administrator and was revised on March 28, 2024, to include a QAPI policy/procedure QAPI/QAA Improvement Activities. " QAPI meetings were increased from	

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F 865	Continued From page 229 Licensed Nursing Home Administrator (LNHA) and observed the broken furniture, soiled privacy curtains, missing privacy curtains, cracked air conditioners. The LNHA stated that he made environmental rounds daily but did not document the rounds. On 02/21/24 at 12:13 PM, the surveyor asked about the observed conditions. The LNHA stated, "the new company took over in [redacted]. The LNHA stated "it was a work in progress, and we do our best" and did not provide any specific information regarding the observed conditions. 2.) On 02/23/24 at 11:14 AM, a surveyor conducted a resident council meeting with 6 residents. All 6 of 6 residents stated that they were made aware that the meals are from a kosher style kitchen, and they do not have any pork products. The residents confirmed that they have asked for pork products before, and the facility told them it is a kosher style kitchen, and they only serve chicken and fish mostly. The residents also had concerns about the menus being posted and the variety of foods on the menu. On 02/26/24 at 1:09 PM, a surveyor interviewed the Food Service Director (FSD) who stated he was not responsible with the menu development; a company provides the menu. When asked who signs off on the menu to ensure it meets the residents needs and is nutritionally adequate, the FSD stated, "I am not sure". The FSD stated the "kosher style food" started about two years ago, "I am not sure, and I don't know why". The FSD stated, "it wasn't always kosher". On 02/26/24 at 1:26 PM, the surveyor interviewed	F 865	quarterly meeting to monthly meeting with the next meeting scheduled for April 16, 2024. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " Weekly and monthly audits have been implemented to address the following areas: Environmental Concerns, Resident Care Related Concerns and Antibiotic Stewardship Program and Adverse Events. (Please refer to F550F, 565F, 567F, 584F, 677E, 689G, 690H, 742H, 806J, 890G) for specific audits and who will be initiating them) 4. How Will These Actions Be Measured: " The results of the weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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the LNHA who stated he was not sure if the contract for the menu company was still in effect. When asked about the Kosher style food, the LNHA stated, "I believe it was changed a few months ago, I don't know exactly when it was changed".

The surveyor interviewed the Resident Council President (RCP) who stated the facility never conducted a meeting with the residents regarding the changes in the menus. The RCP further stated that menus were not provided to the residents.

The LNHA provided the survey team with the following Resident Council Meeting Minutes from [redacted] through [redacted]. Each month the residents voiced concerns about kosher style food, no pork products, the variety of food items or menus changes with no follow up noted from the facility.

3.) During Resident Council meeting, 6 of 6 residents stated they were not able to access their Personal Need Account (PNA) when they want. The residents expressed concerns that only a limited amount of money was accessible on the weekends.

On 02/29/24 at 2:01 PM, the surveyor informed the LNHA and Director of Nursing (DON), in the presence of the team, of the findings related to the PNA, including the resident council concerns. The surveyor asked the LNHA how resident's get their money. The LNHA stated the residents go to the Human Resource Director (HRD) for their PNA money. The LNHA stated that he was not aware of a limited amount of money the residents could withdraw and he does not have a policy.

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The LNHA provided the survey team with the following Resident Council Meeting Minutes from [redacted] through [redacted] On 03/28/23, the residents expressed concerns about the need for PNA money to be available on weekends. The following monthly resident council meeting minutes did not address the PNA money.

4.) On 02/22/23 at 8:15 AM, Surveyor #1 observed Resident #53 wearing [redacted] that were [redacted] NJ EX Order. 264b1.

On 02/23/24 at 6:15 AM, Surveyor #5 completed an [redacted] care tour with a Certified Nursing Assistant (CNA) and 8 residents did not receive appropriate [redacted] care, personal care hygiene and observed wearing [redacted]. Resident #51 who was observed wearing [redacted] NJ EX Order. 264b1 and had a history of NJ EX Order. 264b1.

On 02/26/24 at 9:30 AM, the surveyor observed Resident #38 during [redacted] care who was [redacted] and their clothing was also [redacted] and needed to be changed.

On 03/06/24 at 8:38 AM, the surveyor interviewed the Assistant Director/Nurse Educator, (ADON) responsible for orientation and in-serviced at the facility. The ADON stated that she was not aware that the CNA were still using [redacted] on the residents. The ADON stated that 2 months ago the issue was brought to their attention and the staff was in-serviced. Some staff were suspended. When inquired if any follow up was done to verify compliance she stated, " No".

5.) On 02/29/24 at 10:11 AM, the Director of

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Nursing Infection Preventionist (DON IP) provided the Antibiotic Stewardship Program (ASP) policy and procedure and provided July 2023 ABP and August 2023 ABP. A review of the Antibiotic Stewardship Program revealed that the facility was not using a system for routine feedback reports and tracking measures of outcome surveillance related to antibiotics as per facility policy and national standards.

On 03/05/24 at 10:44 AM, the LNHA in the presence of the survey team, stated he was unaware that the ASP was not being completed by the DON IP. The LNHA stated that he should have been aware, and that the ASP was important for the facility to be able to track infections and how the residents respond. The LNHA stated there was no documentation of any conversations between him and the DON IP, but that he should have known the ASP was not being conducted.

6.) A review of Resident #5's medical records revealed the resident sustained [redacted] from [redacted] through [redacted], including [redacted] with injuries on [redacted] and the comprehensive care plan was not updated after the [redacted]

On 03/05/24 at 8:47 AM, the DON provided the fall timeline with no interventions, the causal factor was not identified and the care plan for [redacted] could not be located. The DON further stated that he started working for the facility on [redacted] and could not account for the missing documents.

On 03/05/24 at 11:04 AM, during a pre-exit meeting held with the survey team and current facility Licensed Nursing Home Administrator

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(LNHA), the DON and Executive Nursing Management, the surveyor reviewed the concerns regarding Resident #5's multiple [redacted] including [redacted] with [redacted] and the Comprehensive Care Plan not updated after the falls. The administrator added that the nursing department was responsible to review the recommendations and implemented them.

On 03/06/24 at 1:30 PM the facility did not provide any additional information regarding Resident #5.

7.) A review of the medical records for Resident #19 and Resident #76 revealed that the residents were not administered [redacted] medications in [redacted] as ordered by the physician which resulted in a [redacted]s emergency transfer for both residents. There was no documentation of the reason the medications were held or that the attending physician was notified. The surveyor interviewed a Licensed Practical nurse (LPN) and the [redacted] Nurse Practitioner [redacted] who both stated that the physician should have been notified of any missed doses of medication and the reason should be documented in the medical records.

On 03/05/24 at 1:35 PM, the surveyor presented the above concerns to the DON and LNHA in the presence of the survey team.

On 03/06/24 at 11:03 AM, the Vice President of Operations and Nursing for the management company, the DON and LNHA met with the survey team and no additional information was provided regarding the above concerns.

On 03/06/24 at 10;24 AM, the surveyor

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interviewed the LNHA who confirmed the QAA/QAPI policy dated 02/01/22 that was given to the survey team was the only policy used at present. The LNHA stated quarterly QAA meetings included all department heads, the DON, Medical Director, Infection Preventionist (IP), pharmacy consultant and lab consultants. The LNHA said that prior to a quarterly QAA meeting, there would be a meeting and each department was requested to bring an issue they would like to work on, and each department had a QAPI tool/form to fill out. These issues also included any family or residents' concerns, and we would address them. The LNHA stated that the facility knows if the corrective actions that were implemented were effective and improvement occurred when each department would bring their results to the QAA meeting, and the group would discuss if ongoing investigation was needed.

The surveyor asked the LNHA if the QAA committee was aware of any of the concerns presented to the facility by the survey team. The LNHA stated only the issue with double briefs.

The LNHA provided the surveyor with the QAPI binder and confirmed the current QAPI's were as follows:
1. Staffing- the activities department staffing
2. Dietary- kitchen sanitation, temperature logs of the dishwasher and preventing food born illnesses.
3. Rehabilitation- certification documents should be signed timely.
4. MDS (Minimum Data Set) working on timely MDS.
5. Advance Directives (AD)- making sure all residents have an AD on file.

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6. Weight loss-residents who had weight loss in the last few months.

On 03/06/24 at 11:01 AM, the LNHA provided the surveyor three QAPI's he had "found" in his computer from the prior LNHA of the facility. The QAPIs included the following:

12/29/22- hand hygiene not being performed while passing trays.
05/15/23- Holes in the MAR's and TARS's (Medication and Treatment Administration Records)
07/21/23-Medications not being obtained timely form the pharmacy.

A review of the above QAPI's did not have any ongoing tracking/reporting or resolution. When asked if the QAA was currently working on these QAPI's, the LNHA stated "No."

A review of the QAA/QAPI binder, dated 2022 through 2023 provided by the LNHA, revealed no reporting from the Infection Preventionist on the ASP or infection tracking and trends. When asked if the QAA Committee reviewed adverse events and reportable events, the LNHA said "yes they should be reviewed in the meeting."

A review of the following policies revealed: Quality Assurance and Performance Improvement (QAPI), dated 02/01/22, polices were intended to ensure the facility develops a plan that described the process for conducting QAPI/QAA activities, such as identifying and correcting the quality deficiencies as well as opportunities for improvement, which will lead to improvement in the lives of nursing home residents through continuous attention to quality

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EXCEL CARE AT MANALAPAN	**104 PENSION ROAD MANALAPAN, NJ 07726**

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of care, quality of life and resident safety. The policy will include;

1. QAPI Program/Plan
2. QAPI/ QAA Improvement Activities
3. QAA Committee

QAA Committee, dated 02/01/22, revealed that the QAA will develop and implement plans of action to correct identified quality deficiencies: regularly review and analyze data, including data collected under the QAPI program and act on available data to make improvements.

The QAPI policy, dated 02/01/22, reflected that the facility will develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes and care and quality of life. The facility will maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirement of this section. This may include but is not limited to systems and reports demonstration systematic identification, reporting, investigation, analysis, prevention of adverse events; and documentation demonstrating the development, implementation and evaluation of corrective actions or performance improvement activities. It must address all systems of care and management practices, include clinical care, quality of life, and resident choice, an utilize the best available evidence to define the measure indicators of quality and facility goals that reflect processes of care and facility operations.

The QAPI policy did not include a Policy/Procedure for
2. QAPI/QAA Improvement Activities.

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F 865	Continued From page 237 NJAC 8:39-33.1(a)(b)(c)(e); 33.2 (a)(b)(c)(d)	F 865		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality	F 868		4/16/24

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F 868	Continued From page 238 assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and the review of pertinent facility documentation, it was determined that the facility failed to have the a.) the Medical Director (MD) and the Infection Preventionist (IP) present for one (1) of four (4) quarterly Quality Assurance Performance Improvement (QAPI) meetings and b.) Infection Preventionist (IP) report on the Infection Prevention and Control Program (IPCP) for four (4) out of four (4) QAPI meetings reviewed. The deficient practice had the potential to affect all residents who resided in the facility and was evidenced by the following: a.) On 03/06/24 at 9:17 AM, the surveyor reviewed the last four (4) quarterly sign in sheets for the QAPI meetings. The sign in sheet dated 04/18/23 did not include the signature of the IP and the sign sheet dated 07/08/23 did not include a signature that the MD was in attendance. The 10/17/23 and the 01/17/24 sign in sheets were missing the IP's signature. On 03/06/24 at 10:24 AM, the Licensed Nursing Home Administrator (LNHA) acknowledged that the IP signature was missing on 04/18/23 and the MD's signature was missing on 07/08/23. On the 10/17/23 and 01/17/24 QAPI sign in sheets, the LNHA stated that the Director of Nursing (DON) was the acting IP at that time. On 02/27/24 at 10:51 AM, during a telephone interview with the MD in the presence of the surveyors, the MD stated that he had just become MD in January 2024 and only attended one QAPI meeting.	F 868	F868 SS-F 1. Corrective Action: " Upon identification, an ad-hoc QAPI meeting was scheduled on March 28, 2024, to review the thoroughness of the QAPI program and process. " Education was provided to the QAPI team members on the QAPI program, policy, and process on March 28, 2024. " The current QAPI policy was reviewed by the Administrator and was revised on March 25, 2024, to include that the IP (Infection Preventionist) must attend quarterly meetings. " A full time IP (Infection Preventionist) was hired on March 20, 2024, and was approved by the Department of Health, based on the Directed Plan of Correction on March 19, 2024. " The Administrator spoke with the Medical Director on March 28, 2024, and educated him on the importance of attending the quarterly QAPI meetings. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " The facility Administrator will review the job description during their orientation program, to include attendance/participation in QAPI	

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F 868	Continued From page 239 b.) On 03/06/24 the LNHA provided the surveyor with the QAPI book dated 2022-2023 for the last four quarters. The surveyor reviewed each quarterly minutes and notes and there was no documentation from the IP reporting on the Infection Prevention and Control Program (IPCP) including infection surveillance, tracking of infections and antibiotic stewardship. On 03/06/24 at 11:01 AM, the surveyor reviewed the QAPI binder dated 2022-2023 with the LNHA. The LNHA confirmed that that the QAPI quarterly meetings did not contain any documentation from the IP regarding, including antibiotic stewardship and infection trends. A review of the facility provided, "Infection Control, Prevention and Surveillance Plan" dated 03/01/23, included but was not limited to; Policy: The Infection Prevention and Control Plan (IPCP) consists of the IPCP policy and procedures and the Antibiotic Stewardship program. 2. Oversight - meets quarterly and report to QAPI (Quality Assurance and Performance Improvement) committee. A review of the facility's policy and procedure titled "QAA (Quality Assessment and Assurance) Committee," dated 02/01/22, revealed that the facility must maintain a QAA committee consisting at a minimum of a. the DON, b. the Medical Director of his/her designee, and c. at least three other members of the facility's staff at least one of who must be the administrator, owner, a board member or other individual in a leadership role. The policy did not include the IP must attend the quarterly meetings. On 03/06/24 at 10:24 AM, the LNHA confirmed	F 868	meetings. " The Administrator and/or DON will review monthly the tracking and trending of patient outcomes, incident reports and quality metric reports and refer to the QAPI committee to identify and correct concerns related to identified concerns. 4. How Will These Actions Be Measured: " The results of the monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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F 868	Continued From page 240 this was the only QAA policy at that time. NJAC 8:39-19.4(d)(g); 23.1(3); 33.1(b)	F 868		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880		4/16/24

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F 880	Continued From page 241 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 pertinent facility documents, it was determined that the facility failed to follow infection control practices to prevent the spread of potential infection by a) storing dirty meal trays apart from clean, not yet served, resident meals	F 880	F880 SS-F 1. Corrective Action: " Upon identification, on 2/22/24, the dirty tray was removed from the clean tray delivery cart and placed on the dirty tray delivery cart, by the activity director.	

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F 880	Continued From page 242 trays on 1 of 2 units; b) adhering to accepted standards of infection control practices for the proper storage of [redacted] and [redacted] after use for 1 of 1 residents reviewed (Resident #31); c.) ensuring the ice scoop and ice scoop container were clean for 1 of 2 units; and d.) ensuring staff performed appropriate hand hygiene (HH). The deficient practice was identified on 2 of 2 units and evidenced by the following: 1. On 02/22/24 at 8:35 AM, Surveyor #1 went to the 200 Unit to observe the breakfast meal. The surveyor observed a facility's staff exited a room with an uncovered dirty tray with the remaining of the food not eaten and placed the tray on the food cart with the other breakfast trays that had not yet been served. The surveyor remained in the hallway and observed a Certified Nursing Aide (CNA) removed the dirty tray from the food cart at 8:40 AM. On 02/22/24 at 8:47 AM, the surveyor followed the CNA who disposed of the dirty tray at the nursing station. During an interview with the CNA, the CNA stated, "the tray is contaminated and should be separated from the other trays." On 02/22/24 at 8:58 AM, the staff was identified as the Activity Director (AD). The surveyor interviewed the AD who stated that she had been working at the facility for 7 months. She usually assisted with the breakfast meal in the morning. She confirmed that she removed the dirty tray from Resident #1's room and placed the tray on the food cart. The surveyor then asked the AD what is the process when you removed a dirty tray from a resident room. The AD stated after you removed the tray you have to dispose of the	F 880	" The DON provided education to the AD on 2/22/24 with regards to only placing dirty trays on the dirty delivery cart as that is the proper process for infection control. " • The [redacted] for the resident in question were disposed and a [redacted] were obtained and placed in a [redacted] at residents bedside. • An audit of all pts that use [redacted] will be done to assure that [redacted] are [redacted] if they are not, they will be replaced and bagged " Education was provided to CNA #2 on March 25, 2024, by the Unit Manager to wash their hands before and after delivering resident trays to their room. " Upon identification, house wide education on hand hygiene and was provided by the ADON starting on 3/12/24 and was completed on April 16, 2024 " Upon identification the plastic ice scoop holder was cleaned. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " Weekly random audits on one unit per week by the DON and/or designee to assure that proper handwashing occurs during care and meal delivery. " Weekly random audits of 5 patients by the DON and/or designees that use nebulizers to assure that equipment is	

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F 880	Continued From page 243 tray properly and washed your hands. The dirty tray should not be placed with other trays that had not been served. The AD further stated, "for infection control, you have to avoid spreading infection to other residents and the environment." The AD stated she received in-service education on infection control during orientation. 2. During the care tour on 02/23/24 at 6:43 AM, the surveyor entered Resident #31's room and observed Resident #31 lying in bed. Surveyor #1 observed the NJ EX Order. 264b1 directly placed on the bedside table touching the NJ EX Order. 264b1 surface on top of the night stand. The CNA provided incontinence care to the resident and left the room. On 02/23/24 at 7:15 AM, Surveyor #1 returned to the room and observed the NJ EX Order. 264b1 (used for NJ EX Order. 264b1 treatments) still on the bedside table, not contained and exposed to the environment. The surveyor accompanied the Licensed Practical Nurse (LPN) who worked the 11:00 PM -7:00 AM shift to the room. Upon inquiry the LPN informed the surveyor that the 3:00 PM -11:00 PM left the NJ EX Order. 264b1 on the table. The LPN added that she did not realize that the NJ EX Order. 264b1 was on the the bedside table during the night. The LPN added that the NJ EX Order. 264b1 should have been placed inside a NJ EX Order. 264b1 when not in use to prevent infection. On 02/23/24 at 11:15 AM, review of the medical record reflected that Resident #31 was admitted to the facility with diagnoses which included, but were not limited to NJ EX Order. 264b1 A review of the Physician's Order Sheet (POS) for	F 880	bagged and dated. " Weekly audit of the ice scoop holders to assure cleanliness will be completed by the Maintenance Director and or designee. " The Administrator and/or designees will perform random visual audits weekly to assure that dirty meal trays are not placed on clean delivery carts. 4. How Will These Actions Be Measured: " The results of the weekly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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F 880	Continued From page 244 NJ EX Order 264b1 revealed the following orders for Resident #31: NJ EX Order. 264b1 every [redacted] hours as needed for [redacted] 3. On 02/23/24 at 6:30 AM, the surveyor performed a random care tour with a Certified Nursing Assistant (CNA) #1. The CNA donned (put on) gloves, draw the curtain, checked the resident's NJ EX Order 264b1 and observed that the resident had NJ EX Order 264b1 on which were NJ EX Order 264b1 with NJ EX Order 264b1 The CNA provided NJ EX Order 264b1 care to the resident, removed the gloves, went to the bathroom and performed hand hygiene under running water for 13.6 seconds. The surveyor asked the CNA if she received in-service education on hand hygiene, she stated,"yes". A review of the CNA's file confirmed receipt of in-service education on hand hygiene on 01/31/23. 4. On 02/20/24 at 10:46 AM, Surveyor #2 toured the facility and observed the ice machine located by the nursing station on the [redacted]-unit. The surveyor observed the plastic ice scoop holder on the side of the ice machine was visibly soiled with a black substance on the bottom corner and the bottom of the holder with the ice scoop in direct contact. At that time, the unit secretary was at the nurse's desk. The unit secretary confirmed the ice scoop holder with the ice scoop resting in it was visibly soiled with the black substance. The unit secretary stated she would clean the ice scoop and ice scoop holder at night but that she would try to clean it at least twice a day. The unit secretary stated, "oh no that has to be washed. It's dirty and the residents could get something" from the scoop in direct contact with the soiled	F 880		

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F 880	Continued From page 245	F 880		

holder.

The facility was made aware of the concern and provided a policy.

5. On 02/20/24 at 11:50 AM to 11:59 AM, Surveyor #2 observed the lunch meal being served on the [redacted]-unit. The Certified Nursing Assistant (CNA) #2 was observed not performing HH before and after delivering meal trays to rooms [redacted], [redacted] Door, [redacted] Window and assisted opening juice, [redacted], and 1[redacted]

On 02/20/24 at 12:01 PM, CNA #2 stated the process for meal delivery was to verify the right resident, right diet, and to clean the residents hands. When asked about staff HH, CNA #2 stated she was not required to perform HH during meal delivery unless she touches "something like a call bell in the room".

On 02/23/24 at 6:39 AM, on the 200-unit, Surveyor #2 observed CNA #1 perform hand washing. CNA #1 applied soap and washed her hands entirely under running water for 12 seconds. CNA #1 administered incontinent care to a resident while wearing gloves. Next CNA #1 disposed of the [redacted] and used the same gloved hands to pick up a pillowcase to put on the residents pillow that was under the residents head. Surveyor #2 asked about the process and CNA #1 stated she should not have been using dirty gloves to put a clean pillowcase on the residents pillow. CNA #1 removed her gloves, entered the bathroom, applied soap, and washed her hands entirely under the running water for 13 seconds. CNA #1 put the new pillowcase on the pillow. Next CNA

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F 880	Continued From page 246 #1 went into the bathroom to wash her hands again. She applied soap and washed her hands entirely under the running water for 11 seconds. On 02/23/24 at 7:54 AM, on the [redacted] unit, Surveyor #2 observed the medication administration task. The Registered Nurse (RN) completed administering medication to a resident and entered the bathroom to wash her hands. The RN applied water and soap and next washed her hands entirely under the running water for 13 seconds. When asked about the process for handwashing, the RN stated to apply soap, and apply friction for 20-30 seconds, and rinse your hands. When made aware of her handwashing only for 13 seconds, the RN did not offer an explanation. The Director of Nursing (DON) was made aware of the hand hygiene observations and was asked to provide any staff education regarding hand hygiene. On 02/23/24 at 11:37 AM, the DON provided the following Handwashing Observations which included: water temperature checked before beginning; hands wet applying a good amount of soap; front and back of hands properly scrubbed for at least 20 seconds; hands rinsed without touching any surface; hands properly dried with paper towel; faucet turned off with new paper towel; and paper towel properly discarded. The Handwashing Observations revealed the following: CNA #2 had a Handwashing Observation dated 01/31/23, which documented "yes" for all procedure steps.	F 880		

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CNA #1 had a Handwashing Observation dated 02/06/23, which documented "yes" for all procedure steps.

RN had a Handwashing Observation dated 07/05/23, which documented "yes" for all procedure steps.

A review of the facility provided Nutritional Services policy and procedure dated 09/12/22, included but was not limited to; Policy: maintain the ice machine, scoop, and storage container in a sanitary manner to minimize the risk of food hazards. The scoop and storage container will be cleaned once each day. Procedure: 7. Wash and sanitize the ice scoop at least once a day in the dishwasher and air dry. 8. Store the ice scoop in a clean .... container.

A review of the facility provided, "Handwashing/Hand Hygiene" policy and procedure revised 08/19, included but was not limited to; Statement: the facility considers hand hygiene the primary means to prevent the spread of infection. Interpretation and Implementation: 2. All personnel shall follow the handwashing/hand hygiene procedures to prevent the spread of infections to other personnel, residents, and visitors. 7. use an alcohol-based hand rub or alternatively soap and water for: B. before and after direct resident contact. I. after contact with a resident's intact skin. am. after removing gloves. p. before and after assisting a resident with meals. 9. The use of gloves does not replace hand washing or hand hygiene.

This facility considers hand hygiene the primary means to prevent the spread of infection. All personnel shall be trained and regularly

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F 880	Continued From page 248 in-serviced on the importance of hand hygiene in preventing the transmission of healthcare -associated infections. " Washing Hands" 1. Wet hands first with water, then apply an amount of product recommended by the manufacture to hands. 2. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. 3. Rinse hands with water and dry thoroughly with a disposable towel. 4. Use towel to turn off faucet. 5. Avoid using hot water, because repeated exposure to hot water may increase the risk of dermatitis. The facility failed to follow their policies. NJAC 8:39-19.4(a)(l)	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Complaint NJ #159556 Based on observation, interview and review of	F 881	F881 SS-F 1. Corrective Action: " On 3/22/24 the DON spoke and	4/16/24

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pertinent facility documentation, it was determined that the facility failed to ensure a.) 1 of 1 resident (Resident # 51) was reviewed for NJ EX Order. 264b1 and b.) a facility-wide implementation of the Antibiotic Stewardship program, which included a system for routine feedback reports and tracking measures of outcome surveillance related to antibiotic use was followed, as per facility policy and national standards.

This deficient practice was evidenced by the following:

1.) On 02/21/24 at 11:01 AM, the surveyor observed Resident #51 awake and alert sitting in his /her wheelchair in dining room eating lunch.

A review of the Electronic medical record (EMR) revealed the following physician's orders (PO) and corresponding progress notes:
On [redacted] a PO for NJ EX Order. 264b1 c used to treat [redacted] infections) [redacted] (milligram) 1 capsule orally three times a day for [redacted]) for [redacted] days. A nurses note dated [redacted] at 11:44 PM, reflected that the resident was started on an [redacted] for [redacted] treatment.
On [redacted] a PO for [redacted] (an [redacted] used to treat [redacted] mg give 1 capsule by mouth. A review of 12/26/23 Nurse Practitioner's (NP) note revealed that Resident #51 had a [redacted] that was NJ EX Order. 264b1 and was currently being managed with [redacted]

On [redacted], a PO for NJ EX Order. 264b1 [redacted] mg tablet, [redacted] tablet by mouth once daily for [redacted]

discussed case with Resident #51□s primary physician who stated and documented that resident has been treated multiple times for [redacted] and the organisms have been NJ EX Order. 264b1 In his opinion, Resident #51 is colonized and will experience NJ EX Order. 264b1 in the future due to [redacted] and not due to NJ EX Order. 264b1 or products used to manage the same.
" A FT IP was hired on March 19, 2024, and was approved by the Department of Health, based on the Directed Plan of Correction on March 22, 2024, and will be responsible for establishing an antibiotic stewardship program which was put in place on March 24, 2024.
" On March 22, 2024, the IP was educated by the DON and Administrator on her role and responsibilities (via her job description) related to the antibiotic stewardship program and infection control.

2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency:
" All residents have the potential to be affected by this deficient practice.

3. Measures Put into Place:
" The DON and/or designee will do monthly audits of the Antibiotic Stewardship Program to assure that specific elements of [redacted] use protocols and systems are in place.

4. How Will These Actions Be

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F 881	Continued From page 250 days. A nurses note dated [redacted] revealed that Resident #51 had an NJ EX Order. 264b1 [redacted], the doctor was notified and an order for [redacted], NJ EX Order. 264b1 and a [redacted] was obtained. A NP note, dated [redacted] 1:20 PM, revealed that the resident had NJ EX Order. 264b1 [redacted] caused by a NJ EX Order. 264b1 that's become [redacted] to many of the NJ EX Order. 264b1) in the [redacted] was on [redacted] precaution and was currently being managed with [redacted], and was previously on [redacted] On 02/28/24 at 9:29 AM, the Director of Nursing/Infection Preventionist (DON/IP) provided a timeline of Resident #51's [redacted] from [redacted] which revealed the following: [redacted]-MD ordered NJ EX Order. 264b1 mg [redacted] a day for [redacted] days (an antibiotic commonly used for [redacted] [redacted]-Resident admitted to the hospital with a [redacted] NJ EX Order. 264b1 elevated, order to collect NJ EX Order. 264b1 [redacted] then start [redacted] mg twice a day for [redacted] days. NJ EX Order. 264b1 and infection disease consult ordered. NJ EX Order. 264b1 was discontinued and [redacted] (an [redacted] used to treat a wide variety of [redacted] infections [redacted] gram every [redacted] hours times [redacted] days was ordered for [redacted] in the NJ EX Order. 264b1 of the [redacted]. [redacted] admitted to the hospital with [redacted] (an infection in the [redacted] [redacted]-Readmitted to the facility on [redacted] mg [redacted] a day for [redacted] days for a [redacted] NJ EX Order. 264b1, resident received	F 881	Measured: " The results of the monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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NJ EX Order. 264b1 used to treat many NJ EX Order. 264b1 infections) NJ EX Order. 264b1 gm times one dose. NJ EX Order. 264b1 resident was admitted to the hospital after a NJ EX Order. 264b1 and admitted with a NJ EX Order. 264b1 resident readmitted to facility with a NJ EX Order. 264b1 and an order for NJ EX Order. 264b1) times one dose.

NJ EX Order. 264b1 , NJ EX Order. 264b1 mg NJ EX Order. 264b1 a day times NJ EX Order. 264b1 days ordered.

NJ EX Order. 264b1 mg NJ EX Order. 264b1 a day for NJ EX Order. 264b1 days ordered.

NJ EX Order. 264b1 mg NJ EX Order. 264b1 times a day for NJ EX Order. 264b1 days for NJ EX Order. 264b1 NJ EX Order. 264b1 discontinued and NJ EX Order. 264b1 started.

A review of the Electronic medical Record (EMR) revealed that Resident #51 was admitted to the facility with diagnosis including but not limited to: NJ EX Order. 264b1).

The Annual Minimum Data Set (MDS), as assessment tool, dated NJ EX Order. 264b1 , revealed that Resident # 51 had NJ EX Order. 264b1 needed NJ EX Order. 264b1 assistance for toileting hygiene, always NJ EX Order. 264b1 had a NJ EX Order. 264b1 in the last NJ EX Order. 264b1 days and NJ EX Order. 264b1

On 02/29/24 at 12:31 PM, the DON/IP provided the Antibiotic Stewardship binder dated January 2022-September 2023. The Antibiotic Stewardship binder revealed a [name redacted]

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Infection Surveillance Checklist completed for Resident # 51 [redacted] for the following: [redacted] 3 reflected that the [redacted] criteria was met, 06/11/23 did not indicate the [redacted] criteria was met or not met and [redacted] reflected that the [redacted] criteria was NOT met. There were no [name redacted] Infection Surveillance Checklist completed for Resident #51 [redacted] that were documented in the [redacted] timeline or EMR as referenced above.

The DON/IP provided the surveyor with an untitled print out of residents who were ordered antibiotics for the follow months: December [redacted] January [redacted] and February [redacted] The untitled print out revealed Resident #51 was started on the antibiotic [redacted] on [redacted] and completed [redacted] on [redacted] or [redacted] in the [redacted]. Resident #51 was ordered [redacted] mg on [redacted] and completed on [redacted] for a [redacted]. There was no [name redacted] Infection Surveillance Checklist completed or reviewed for Resident #51.

The untitled print out of residents who were ordered antibiotics for [redacted] revealed Resident #51 started [redacted] on [redacted] and completed on [redacted] for an [redacted] There was no [name redacted] Infection Surveillance Checklist completed or reviewed for Resident #51.

2.) On 02/21/24 at 8:24 AM, the DON stated that he had been working as the Infection Preventionist (IP) also for "about [redacted] months".

On 02/21/24 at 11:34 AM, the surveyor was in the DON's office. The DON stated one of his responsibilities included the Antibiotic Stewardship Program (ASP) and that it "depends

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on the day to determine how much time would be spend on IP or on being DON". He stated that he would review the electronic medical records (EMR) daily to see if a resident was ordered an antibiotic. He would review how long the order was for, if it was affective, and the staff would document daily during the antibiotic use and three days after the antibiotic was discontinued. The DON stated that he followed the facility policy and the Centers for Disease Control and Prevention (CDC) guidelines. The facility used a [name redacted] Criteria for Infection Surveillance Checklist.

On 02/29/24 at 10:11 AM, the DON IP provided the ABP policy and procedure and provided July 2023 ABP and August 2023 ABP which was documented by the previous IP nurse. The information was as follows:

July [redacted] listing included [redacted] residents. The column to document "onset-end date" was incomplete for all [redacted] residents. The column to document "[redacted]y" failed to document on four of the [redacted] residents. The column to document "meets criteria" failed to document on all 1[redacted] of the residents. The column to document "outcome" failed to document on [redacted] residents. The facility failed to implement the [name redacted] Criteria for Infection Surveillance Checklist for [redacted] of the [redacted] residents, failed to complete the checklist for two of the nine residents, and failed to document that [redacted] were reviewed. The facility provided a "Point Prevalence of Antibiotic Use ([redacted]), printed on [redacted] which included but was not limited to; 30 residents listed with end dates in [redacted] drug class with percentage of the use of that drug class; the residents name; status in or out of "house";

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medication name; the directions for use; diagnosis; and start and end date. The report failed to include a diagnosis for [redacted] of the 30 residents.

[redacted] listing included six residents. The column to document "onset-end date" was incomplete for all [redacted] residents. The column to document "symptoms/infection" was left blank for one resident. The column to document "meets criteria" was left blank for all [redacted] residents. The column to document "outcome" was left blank for five of the [redacted] residents. The [name redacted] Criteria for Surveillance Checklist was not provided for one of the [redacted] residents. The [name redacted] Criteria for Surveillance Checklist for [redacted] residents documented "criteria not met" and the [redacted] residents were ordered antibiotics, and five of the checklists were not reviewed. There was no "Point Prevalence of Antibiotic Use" for the month.

[redacted] was an untitled print out of [redacted] resident names, date started (no end dates), the medication name, a site of infection with two of the [redacted] left blank, symptoms with [redacted] of [redacted] residents left blanks, pathogen with one of [redacted] left blank, community/health care associated with eight of [redacted] left blank, and comments with all [redacted] residents left blank. There was no "Point Prevalence of Antibiotic Use" for the month, no [name redacted] Criteria for Surveillance Checklist completed or reviewed for any of the [redacted] residents, and no outcome results for any of the [redacted] residents.

[redacted] was an untitled print out of 10 residents, date started (no end dates), the medication name, site of infection for [redacted] of the

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[redacted] symptoms were blank for all [redacted] residents, pathogen was blank for [redacted] of the [redacted] residents, community/health care associated was blank for [redacted] of the [redacted] residents, and the comments were blank for all [redacted] residents. There was no "Point Prevalence of Antibiotic Use" for the month, no [name redacted] Criteria for Surveillance Checklist completed or reviewed for any of the [redacted] residents, and no outcome results for any of the [redacted] residents.

[redacted] was an untitled print out of [redacted] residents, date started (no end dates), the medication name, site of infection for [redacted] of the [redacted] residents, symptoms were blank for [redacted] of the [redacted] residents, pathogen was blank for [redacted] of the [redacted] residents, community/health care associated was blank for [redacted] of the [redacted] residents, and comments was blank for nine of the [redacted] residents. There was no "Point Prevalence of Antibiotic Use" for the month, no [name redacted] Criteria for Surveillance Checklist completed or reviewed for any of the [redacted] residents, and no outcome results for any of the [redacted] residents.

The DON/IP was responsible for the following ABT stewardship tracking which included but was not limited to the following;

[redacted] was an untitled print out of 19 names, date started (no end dates), the medication name, site of infection was blank for [redacted] of the [redacted] residents, symptoms were blank for [redacted] of the [redacted] residents, pathogen was blank for [redacted] of the [redacted] residents, and comments were blank for [redacted] of the [redacted] residents. There was no "Point Prevalence of Antibiotic Use" for the month, no [name redacted] Criteria for Surveillance Checklist completed or reviewed for any of the [redacted]

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residents, and no outcome results for any of the [redacted] residents.

[redacted] was an untitled print out of [redacted] residents, date started, date completed, medication name, site of infection, symptoms with blanks for [redacted] of the [redacted]t residents, pathogen with blanks for [redacted] of the [redacted] residents, and comments were blank for [redacted] of the [redacted]t residents. There was no "Point Prevalence of Antibiotic Use" for the month, no [name redacted] Criteria for Surveillance Checklist completed or reviewed for any of the [redacted] residents, and no outcome results for any of the [redacted] residents.

[redacted] was an untitled print out of five residents, date and end date, medication name, site of infection, symptoms were left blank for four of the [redacted] residents, pathogen, community/health care associated was blank for [redacted] of the [redacted] residents and comments was left blank for [redacted] of the [redacted] residents. There was no "Point Prevalence of Antibiotic Use" for the month, no [name redacted] Criteria for Surveillance Checklist completed or reviewed for any of the [redacted] residents, and no outcome results for any of the five residents.

On 02/29/24 at 11:22 AM, the DON stated that it was his responsibility to "track down any antibiotics", to determine if they were affective, and to discuss the antibiotics with the physicians. He stated that excessive use of an antibiotic could "lead to other things". The DON stated the process was to use the [name redacted] Criteria checklist with the algorithm and that ideally the corresponding test results would be included. The DON stated that it was his responsibility to ensure the algorithm and checklist were correct. The

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DON stated the checklist would be reviewed at morning meeting. He further stated that "I haven't been able to check on them [Antibiotic Stewardship] for a while."

On 03/05/24 at 10:44 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team, stated he was unaware that the ASP was not being completed by the DON IP. The LNHA stated that he should have been aware and that the ASP was important for the facility to be able to track infections and how the residents respond. The LNHA stated there was no documentation of any conversations between him and the DON IP, but that he should have known the ASP was not being conducted.

On 03/06/24 at 8:03 AM, the Registered Nurse Unit Manager (RN UM) stated that the process for tracking infections was that if there were orders for antibiotics, they would be in the resident's Medication Administration Record (MAR). She stated that there were no other tracking methods for any other infections.

A review of the facility provided, "Infection Control Nurse" job description undated, included but was not limited to; Purpose: ..... to ensure that an effective infection control program is maintained at all times. Responsibilities: plan, develop, organize, implement, evaluate, coordinate, and direct the infection control program in accordance with current rules, regulation, and guidelines that govern in nursing care facilities. Functions: ensure that laboratory support is available, including microbiological and serological services. Prepare monthly summaries of resident and personnel infections, the corrective actions taken, and the results of the corrective actions.

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A review of the facility provided, "Infection Control-Antibiotic Stewardship" dated 03/01/23, included but was not limited to; Intent: to support the judicious use of antibiotics in accordance with State and Federal regulations and national guidelines. Procedure: 1. Establish protocols for prescribing antibiotics in accordance with national guidelines and treatment protocols. 2. Establish algorithms for appropriate diagnostic testing (example obtaining cultures) for specific infections. 3. Summarize antibiotic use on a quarterly basis and use the data to evaluate adherence to antibiotic prescribing protocols and appropriate diagnostic testing protocols. 4. Provide an antibiogram annually to medical staff to support prescribing practices. 5. Document dose, duration, and indication for all antibiotics prescribed.

A review of the facility provided, "Infection Control, Prevention and Surveillance Plan" dated 03/01/23, included but was not limited to; Policy: The Infection Prevention and Control Plan (IPCP) consists of the IPCP policy and procedures and the Antibiotic Stewardship program. Mission and Goals: focus on both employee health and resident care practices; the prevention of adverse outcomes such as healthcare associated infections, optimizing antibiotic use and fostering evidenced-based decision making. 2. a. proactively preventing, identifying, reporting, investigating, and controlling infections and communicable diseases. b. initiating proper measures to limit exposure to pathogens or their spread from identified sources of contagion... c. collecting, analyzing, and trending data and instituting corrective actions. 4. optimize the use of antibiotics to meet resident specific needs per

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the Antibiotic Stewardship Program. Scope: based on the latest recommendations from the CDC. Components include. 6. Antibiotic Stewardship: specific elements as defined by the CDC. Committee Oversight: 2. a. meets quarterly and report to QAPI (Quality Assurance and Performance Improvement) committee. 3. a. provides oversight for improvement and sustainability of infection prevention and control and the antibiotic stewardship practices and outcomes. Authority: 1. d. generate and review data such as infection rates and antibiotic resistance rates. e. monitors and reports the antibiotic use to meet resident needs. IP responsibilities: culture surveillance; route surveillance; antibiotic drug resistant management; and antibiotic stewardship oversight. Antibiotic Use Protocols and Systems: elements of antibiotic stewardship including: d. monitoring and tracking, e. reporting. f. documenting. Evaluating: regularly review and analyze antibiotic use data, including data from drug regimen reviews. Antibiotic Stewardship measurement is critical to identify opportunities for improvement and assess the impact of improvement efforts.

Reference: CDC "Core Elements of Antibiotic Stewardship of Nursing Homes", dated 09/07/23. https://www.cdc.gov/antibiotic-use/core-elements/nursing-homes.html

A review of the CDC "Core Elements of Antibiotic Stewardship of Nursing Homes", dated 09/07/23, included but was not limited to; 4. Does the facility have policies to improve antibiotic prescribing/use? Developed facility specific algorithm for diagnostic testing for specific infections; reviews antibiotic agents listed on the

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F 881	Continued From page 260 medication formulary. 5. Developed reports summarizing the antibiotic susceptibility patterns; implemented an antibiotic review process or "time out". 9. Does the facility provide specific reports on antibiotic use and outcomes with clinical providers and nursing staff? Measures of outcomes related to antibiotic use; report of facility antibiotic susceptibility patterns with the last 18 months; personalized feedback on antibiotic prescribing practices to clinical providers. The above information was presented to the facility on 03/05/24. The facility had no additional information to provide the survey team. NJAC 8:39-19.4(d)(g); 27.1	F 881		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Complaint NJ 161569, NJ 169440 Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to ensure that the resident call bells were accessible. This deficient practice was identified for 3 of 18	F 919	F919 SS-E 1. Corrective Action: " On March 7, 2024, the Administrator audited all resident rooms to assure the resident call bell were accessible and within reach. 2. Identification of other residents or	4/16/24

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F 919	Continued From page 261 residents (Residents #1, #78 and #288) reviewed for the call bells and was evidenced by the following: 1) During the tour of the facility on 02/20/24 at 10:04 AM, Surveyor #1 observed Resident #1 sitting in the bed. The resident responded to the surveyor's greetings then asked for a drink of water. The surveyor informed the resident that she was just a visitor and not staff and instructed the resident to activate the call light. The resident informed Surveyor #1 that [he/she] did not have a call light. The surveyor looked on the bed and on the floor and did not observe a call light. The surveyor left the room and observed a Certified Nursing Assistant (CNA) #1 in the hallway. The surveyor asked CNA #1 to activate the call light. The CNA was unable to locate the call light. The surveyor asked the CNA to send the nurse to the room. The Director of Nursing (DON) entered the room with another CNA. The surveyor asked the DON to activate the call light. The DON looked on the bed and on the floor and could not locate the call light. After searching the room, the call light was noted on the other bedside table blocked by the privacy curtain and out of the resident's reach when the resident was in bed. The DON retrieved the call light and placed it on the resident's blanket. Upon inquiry the DON stated, "the call light should be accessible to all residents." Review of the care plan for Resident #1 dated [redacted] included a problem area of being at risk for f[redacted] due to NJ EX Order: 264b1, behaviors and use of [redacted] medications. Two of the listed approaches included for staff to keep the call bell within reach and encourage the resident	F 919	areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: 4. Education was Started to all staff on March 25, 2024, and will be completed by April 16, 2024, related to assuring the resident call bells were assessable and within reach. " Weekly random audits of ten (10) residents per unit will be performed by the unit manager and/or designee to assure that the resident call bell is within reach and accessible. 5. How Will These Actions Be Measured: " The results of the weekly call bell audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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to use the call bell for assistance as needed.

On 03/05/24 at 8:29 AM, Surveyor #1 entered the room and observed Resident #1 in bed. The breakfast tray was on the bedside table and emptied. Resident #1 asked the surveyor if [he/she] could have more food. The surveyor asked the resident to activate the call light. The resident stated, "I do not have a call light." The surveyor left the room and observed the DON in the hallway. Surveyor #1 accompanied the DON to the room where we both observed that Resident #1's call light was not accessible. The call light was observed behind the night stand and out of the resident's reach.

On 03/05/24 at 8:45 AM, the surveyor asked the DON who was responsible to ensure that the call light was accessible to the residents. The DON stated,"everyone, the nurses and the CNAs."

2) On 03/05/24 at 8:34 AM, Surveyor #2 walked onto the 100 unit of the facility. Surveyor #2 observed Resident #78 awake sitting up in bed with [his/her] call light down the side of the bed, and on the floor out of reach of the resident.

At that time, CNA #2 was in the hall. CNA #2 acknowledged Resident #78's call bell was inaccessible and stated that the call bell should be within reach of the resident in case the resident needed help.

A review of the Admission Record revealed that Resident #78 had diagnoses which included but were not limited to; NJ EX Order. 264b1 [redacted]

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dated [redacted] Safety General with interventions which included safety measures to reduce the risk of [redacted] A focus area dated [redacted], at risk for NJ EX Order. 264b1 [redacted] with interventions which included "be sure my call light is within reach and encourage me to use it for assistance as needed."

3) On 03/05/24 at 8:38 AM, Surveyor #2 observed, on the [redacted] unit of the facility, that Resident #288 was awake, alert and sitting up in bed. Surveyor #2 knocked and entered the room and observed the call bell handing off the side of the bed and on the floor out of reach of the resident. At that time, Surveyor #2 asked Resident #288 if [he/she] had a call bell if [he/she] needed to call for the staff for help. Resident #288 replied, "I don't know. Where would it be?". Resident #288 was moving both hands over the covers on [his/her] bed.

On 03/05/24 at 8:35 AM, CNA #3 was in the hallway and Surveyor #2 asked for her assistance in the resident's room. CNA #3 entered the room and acknowledged the call bell out of the resident's reach. CNA #3 stated, "I'm sorry I did not see your call bell on the floor." CNA #3 stated that all residents need to be able to reach their call bells in case of an emergency.

A review of the Admission Record revealed that Resident #288 had diagnoses which included but were not limited to; NJ EX Order. 264b1 [redacted] A review of the resident centered on-going Care Plan included but was not limited to; a focus area dated [redacted] to receive physical and occupational therapy services for ADL

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(activities of daily living) tasks, NJ EX Order. 264b1 and NJ EX Order. 264b1. Intervention included balance, gait training, ADL re-training, and therapeutic exercises. A review of the [redacted] 4, Minimum Data Set (MDS) an assessment tool to facilitate resident care, included but was not limited to; a Brief Interview for Mental Status (BIMS) of [redacted] indicating Resident #32 was NJ EX Order. 264b1 [redacted]. NJ EX Order. 264b1 documented that Resident #288 was either [redacted] or required NJ EX Order. 264b1 assistance from staff for picking up objects; hygiene, toileting, bathing, dressing, rolling left and right; sit to lying; lying to sitting on the side of the bed; sit to stand; chair/bed transfer; toilet transfer; and walking.

On 03/05/24 at 8:55 AM, the Director of Nursing (DON) was made aware of the inaccessible call bells. The DON stated that the CNAs should ensure call bells were in place and within reach for the residents.

A review of the facility provided, "Certified Nursing Assistant" job description, undated, included but was not limited to; Purpose: provide residents with daily nursing care and services in accordance with the resident's assessment and care plan. Functions: perform all tasks in accordance with established policies and procedures. Answer resident calls as promptly as feasible. Ensure residents who are unable to call for help are checked frequently. Check residents routinely to ensure that personal care needs are being met in accordance with their wishes.

A review of the facility provided, "LPN (Licensed Practical Nurse)" job description, undated,

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included but was not limited to; Purpose: to supervise the day-to-day nursing activities performed by CNAs and other personnel and to provide direct nursing care to the residents. Functions: make rounds on your unit/shift to ensure that assigned CNAs and other personnel are performing their work assignments. Ensure residents who are unable to call for help are checked frequently.

A review of the facility's policy titled, "Answering the Call Light" dated 2001, last revised 03/2023 indicated the following:
Purpose
The purpose of this procedure is to ensure timely response to resident's requests and needs.
General Guidelines
Upon admission and periodically as needed, explain and demonstrate use of call light to the resident.
Ask the resident to return the demonstration.
Be sure that the call light is plugged in and functioning at all times.
When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.
Steps 3 of the procedure revealed the following: "
If assistance is needed when you enter the room, summon help by using the call signal. The policy was not being followed.

NJAC 8:39-31.8 (c)9

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #s NJ 152905, NJ 152910, NJ 152911, NJ 159956, NJ 161569, NJ 165971, NJ 160660, NJ 169440 Based on interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This was evident in Certified Nursing Assistant (CNA) staffing for 14 of 14-day shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	S 560	S560 1. Corrective Action: " Staffing coordinator was educated on New Jersey state staffing ratio requirements on March 25, 2024. " Efforts to hire facility staff will continue until there is adequate staff to meet the minimum staff to resident ratios. Until that time, the facility will use staffing agencies and offer additional shifts to current staff with bonuses as required. " Facility Administrator worked with Human resources to secure additional staffing agency contracts. " Interdisciplinary team met on March 26, 2024, to discuss recruitment and retention interventions which included	4/16/24

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

Electronically Signed | 03/31/24

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S 560	Continued From page 1 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the 2 weeks of Complaint staffing from 02/20/2022 to 03/05/2022, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -02/20/22 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs. -02/24/22 had 6 CNAs for 58 residents on the day shift, required at least 7 CNAs. -02/25/22 had 6 CNAs for 58 residents on the day shift, required at least 7 CNAs. -02/28/22 had 6 CNAs for 59 residents on the day shift, required at least 7 CNAs. -03/04/22 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs.	S 560	scheduling a job fair to be held on April 10, 2024. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " Weekly recruitment, retention and employee appreciation meeting was initiated and will be led by the Director of Human Resources and/or designee. " Hiring and recruitment efforts including pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to continue to be competitive in the marketplace. " Focus on retention efforts include, but are not limited to incentive programs, career growth and educational training opportunities and employee morale incentives. " The facility administrator/designee will continue to track and document all recruitment and retention efforts weekly. " The administrator/designee will review staffing schedules weekly to ensure adequate staffing for all shifts. 4. How Will These Actions Be Measured: " The results of the weekly recruitment and retention audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued	

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S 560	Continued From page 2 2. For the 2 weeks of Complaint staffing from 09/04/2022 to 09/17/2022, the facility was deficient in CNA staffing for residents on 9 of 14 day shifts as follows: -09/05/22 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs. -09/06/22 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs. -09/11/22 had 6 CNAs for 55 residents on the day shift, required at least 7 CNAs. -09/12/22 had 6 CNAs for 55 residents on the day shift, required at least 7 CNAs. -09/13/22 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs. -09/14/22 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs. -09/15/22 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs. -09/16/22 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs. -09/17/22 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs. 3. For the 2 weeks of Complaint staffing from 10/16/2022 to 10/29/2022, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows: -10/16/22 had 6 CNAs for 59 residents on the day shift, required at least 7 CNAs -10/20/22 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs. -10/21/22 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs. -10/22/22 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs -10/23/22 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs.	S 560	submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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S 560	Continued From page 3 -10/25/22 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs. -10/26/22 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs. -10/27/22 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs. -10/28/22 had 6 CNAs for 59 residents on the day shift, required at least 7 CNAs. -10/29/22 had 6 CNAs for 58 residents on the day shift, required at least 7 CNAs. 4. For the 2 weeks of Complaint staffing from 11/06/2022 to 11/19/2022, the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows: -11/11/22 had 7 CNAs for 61 residents on the day shift, required at least 8 CNAs. 5. For the week of Complaint staffing from 11/27/2022 to 12/03/2022, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -12/01/22 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs. 6. For the 2 weeks of Complaint staffing from 12/18/2022 to 12/31/2022, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows: -12/18/22 had 6 CNAs for 56 residents on the day shift, required at least 7 CNAs. -12/21/22 had 5 CNAs for 55 residents on the day shift, required at least 7 CNAs. -12/22/22 had 5 CNAs for 55 residents on the day shift, required at least 7 CNAs.	S 560		

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S 560	Continued From page 4 -12/27/22 had 6 CNAs for 58 residents on the day shift, required at least 7 CNAs. 7. For the week of Complaint staffing from 01/22/2023 to 01/27/2023, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows: -01/22/23 had 6 CNAs for 56 residents on the day shift, required at least 7 CNAs. -01/24/23 had 6 CNAs for 56 residents on the day shift, required at least 7 CNAs. -01/27/23 had 6 CNAs for 56 residents on the day shift, required at least 7 CNAs. 8. For the 4 weeks of Complaint staffing from 02/05/2023 to 03/04/2023, the facility was deficient in CNA staffing for residents on 25 of 28 day shifts as follows: -02/05/23 had 7 CNAs for 63 residents on the day shift, required at least 8 CNAs. -02/06/23 had 7 CNAs for 63 residents on the day shift, required at least 8 CNAs. -02/09/23 had 6 CNAs for 63 residents on the day shift, required at least 8 CNAs. -02/10/23 had 7 CNAs for 66 residents on the day shift, required at least 8 CNAs. -02/11/23 had 6 CNAs for 65 residents on the day shift, required at least 8 CNAs. -02/12/23 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs. -02/14/23 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs. -02/15/23 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs. -02/16/23 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs. -02/17/23 had 7 CNAs for 64 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
	061323	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT MANALAPAN	104 PENSION ROAD MANALAPAN, NJ 07726

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 5	S 560		

day shift, required at least 8 CNAs.
-02/18/23 had 6 CNAs for 64 residents on the day shift, required at least 8 CNAs.

-02/19/23 had 6 CNAs for 62 residents on the day shift, required at least 8 CNAs.
-02/20/23 had 7 CNAs for 62 residents on the day shift, required at least 8 CNAs.
-02/21/23 had 7 CNAs for 61 residents on the day shift, required at least 8 CNAs.
-02/22/23 had 6 CNAs for 61 residents on the day shift, required at least 8 CNAs.
-02/23/23 had 7 CNAs for 61 residents on the day shift, required at least 8 CNAs.
-02/24/23 had 6 CNAs for 61 residents on the day shift, required at least 8 CNAs.
-02/25/23 had 6 CNAs for 61 residents on the day shift, required at least 8 CNAs.

-02/26/23 had 6 CNAs for 61 residents on the day shift, required at least 8 CNAs.
-02/27/23 had 7 CNAs for 62 residents on the day shift, required at least 8 CNAs.
-02/28/23 had 5 CNAs for 62 residents on the day shift, required at least 8 CNAs.
-03/01/23 had 7 CNAs for 62 residents on the day shift, required at least 8 CNAs.
-03/02/23 had 7 CNAs for 62 residents on the day shift, required at least 8 CNAs.
-03/03/23 had 6 CNAs for 63 residents on the day shift, required at least 8 CNAs.
-03/04/23 had 6 CNAs for 63 residents on the day shift, required at least 8 CNAs.

9. For the 2 weeks of Complaint staffing from 03/19/2023 to 04/01/2023, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows:

-03/19/23 had 6 CNAs for 62 residents on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061323	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT MANALAPAN	104 PENSION ROAD MANALAPAN, NJ 07726

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 6	S 560		

day shift, required at least 8 CNAs.
-03/20/23 had 7 CNAs for 62 residents on the day shift, required at least 8 CNAs.
-03/21/23 had 6 CNAs for 62 residents on the day shift, required at least 8 CNAs.
-03/22/23 had 7 CNAs for 62 residents on the day shift, required at least 8 CNAs.
-03/23/23 had 7 CNAs for 61 residents on the day shift, required at least 8 CNAs.
-03/24/23 had 6 CNAs for 59 residents on the day shift, required at least 7 CNAs.
-03/25/23 had 6 CNAs for 59 residents on the day shift, required at least 7 CNAs.

-03/26/23 had 6 CNAs for 58 residents on the day shift, required at least 7 CNAs.
-03/28/23 had 6 CNAs for 58 residents on the day shift, required at least 7 CNAs.
-03/29/23 had 5 CNAs for 58 residents on the day shift, required at least 7 CNAs.
-03/30/23 had 6 CNAs for 59 residents on the day shift, required at least 7 CNAs.

10. For the 2 weeks of Complaint staffing from 07/23/2023 to 08/05/2023, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows:

-07/23/23 had 8 CNAs for 71 residents on the day shift, required at least 9 CNAs.
-07/24/23 had 7 CNAs for 71 residents on the day shift, required at least 9 CNAs.
-07/25/23 had 8 CNAs for 71 residents on the day shift, required at least 9 CNAs.
-07/26/23 had 7 CNAs for 71 residents on the day shift, required at least 9 CNAs.
-07/29/23 had 8 CNAs for 71 residents on the day shift, required at least 9 CNAs.

-07/30/23 had 8 CNAs for 71 residents on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061323	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT MANALAPAN	104 PENSION ROAD MANALAPAN, NJ 07726

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 7 day shift, required at least 9 CNAs. 11. For the week of Complaint staffing from 09/10/2023 to 09/16/2023, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -09/11/23 had 8 CNAs for 83 residents on the day shift, required at least 10 CNAs. -09/12/23 had 9 CNAs for 82 residents on the day shift, required at least 10 CNAs. -09/13/23 had 9 CNAs for 81 residents on the day shift, required at least 10 CNAs. -09/14/23 had 9 CNAs for 81 residents on the day shift, required at least 10 CNAs. -09/16/23 had 9 CNAs for 80 residents on the day shift, required at least 10 CNAs. 12. For the 2 weeks prior to survey from 02/04/2024 to 02/17/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -02/04/24 had 7 CNAs for 72 residents on the day shift, required at least 9 CNAs. -02/05/24 had 6 CNAs for 72 residents on the day shift, required at least 9 CNAs. -02/06/24 had 4 CNAs for 72 residents on the day shift, required at least 9 CNAs. On this day, the facility provided only half of the minimum allowed CNA staff to provide resident care. -02/07/24 had 5 CNAs for 72 residents on the day shift, required at least 9 CNAs. -02/08/24 had 5 CNAs for 72 residents on the day shift, required at least 9 CNAs. -02/09/24 had 6 CNAs for 73 residents on the day shift, required at least 9 CNAs. -02/10/24 had 6 CNAs for 73 residents on the day shift, required at least 9 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061323	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT MANALAPAN	104 PENSION ROAD MANALAPAN, NJ 07726

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 8 -02/11/24 had 6 CNAs for 72 residents on the day shift, required at least 9 CNAs. -02/12/24 had 5 CNAs for 72 residents on the day shift, required at least 9 CNAs. -02/13/24 had 4 CNAs for 74 residents on the day shift, required at least 9 CNAs. On this day, the facility provided only half of the minimum allowed CNA staff to provide resident care. -02/14/24 had 5 CNAs for 72 residents on the day shift, required at least 9 CNAs. -02/15/24 had 4 CNAs for 72 residents on the day shift, required at least 9 CNAs. On this day, the facility provided only half of the minimum allowed CNA staff to provide resident care. -02/16/24 had 7 CNAs for 75 residents on the day shift, required at least 9 CNAs. -02/17/24 had 7 CNAs for 75 residents on the day shift, required at least 9 CNAs. On 02/27/24 at 12:32 PM, the surveyor interviewed the Staffing Coordinator (SC)who stated that she was aware of the mandaory staffing requirements of 8 residents to 1 CNA on day shift, 10 residents to1 direct care staff on eve shift and 14 residents to 1 direct care staff on day shift. When asked if she was able to meet these requirments, the SC stated "No, we fall short."	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061323 Y1	A. Building B. Wing Y2	5/1/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT MANALAPAN	104 PENSION ROAD MANALAPAN, NJ 07726

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/16/2024	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	
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?
3/6/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061323 Y1	A. Building B. Wing Y2	5/1/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT MANALAPAN	104 PENSION ROAD MANALAPAN, NJ 07726

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/16/2024	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	
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?
3/6/2024	☐ 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
315282 Y1	A. Building B. Wing Y2	5/1/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT MANALAPAN	104 PENSION ROAD MANALAPAN, NJ 07726

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0565	Correction	ID Prefix F0567	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(f)(5)(i)-(iv)(6)(7)	Completed	Reg. # 483.10(f)(10(i)(ii)	Completed
LSC	04/16/2024	LSC	04/16/2024	LSC	04/16/2024
ID Prefix F0568	Correction	ID Prefix F0569	Correction	ID Prefix F0580	Correction
Reg. # 483.10(f)(10)(iii)	Completed	Reg. # 483.10(f)(10)(iv)(v)	Completed	Reg. # 483.10(g)(14)(i)-(iv)(15)	Completed
LSC	04/16/2024	LSC	04/16/2024	LSC	04/16/2024
ID Prefix F0584	Correction	ID Prefix F0638	Correction	ID Prefix F0656	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.20(c)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	04/16/2024	LSC	04/16/2024	LSC	04/16/2024
ID Prefix F0677	Correction	ID Prefix F0679	Correction	ID Prefix F0687	Correction
Reg. # 483.24(a)(2)	Completed	Reg. # 483.24(c)(1)	Completed	Reg. # 483.25(b)(2)(i)(ii)	Completed
LSC	04/16/2024	LSC	04/16/2024	LSC	04/16/2024
ID Prefix F0689	Correction	ID Prefix F0690	Correction	ID Prefix F0697	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.25(k)	Completed
LSC	04/16/2024	LSC	04/16/2024	LSC	04/16/2024

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315282 Y1	A. Building B. Wing Y2	5/1/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT MANALAPAN	104 PENSION ROAD MANALAPAN, NJ 07726

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0725	Correction	ID Prefix F0727	Correction	ID Prefix F0742	Correction
Reg. # 483.35(a)(1)(2)	Completed	Reg. # 483.35(b)(1)-(3)	Completed	Reg. # 483.40(b)(1)	Completed
LSC	04/16/2024	LSC	04/16/2024	LSC	04/16/2024
ID Prefix F0804	Correction	ID Prefix F0806	Correction	ID Prefix F0812	Correction
Reg. # 483.60(d)(1)(2)	Completed	Reg. # 483.60(d)(4)(5)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	04/16/2024	LSC	04/16/2024	LSC	04/16/2024
ID Prefix F0835	Correction	ID Prefix F0842	Correction	ID Prefix F0865	Correction
Reg. # 483.70	Completed	Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. # 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i)	Completed
LSC	04/16/2024	LSC	04/16/2024	LSC	04/16/2024
ID Prefix F0868	Correction	ID Prefix F0880	Correction	ID Prefix F0881	Correction
Reg. # 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80(a)(3)	Completed
LSC	04/16/2024	LSC	04/16/2024	LSC	04/16/2024
ID Prefix F0919	Correction				
Reg. # 483.90(g)(1)(2)	Completed				
LSC	04/16/2024				

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?
3/6/2024	☐ 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
315282 Y1	A. Building B. Wing Y2	5/1/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT MANALAPAN	104 PENSION ROAD MANALAPAN, NJ 07726

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0565	Correction	ID Prefix F0567	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(f)(5)(i)-(iv)(6)(7)	Completed	Reg. # 483.10(f)(10(i)(ii)	Completed
LSC	04/16/2024	LSC	04/16/2024	LSC	04/16/2024
ID Prefix F0580	Correction	ID Prefix F0584	Correction	ID Prefix F0677	Correction
Reg. # 483.10(g)(14)(i)-(iv)(15)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.24(a)(2)	Completed
LSC	04/16/2024	LSC	04/16/2024	LSC	04/16/2024
ID Prefix F0687	Correction	ID Prefix F0690	Correction	ID Prefix F0725	Correction
Reg. # 483.25(b)(2)(i)(ii)	Completed	Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.35(a)(1)(2)	Completed
LSC	04/16/2024	LSC	04/16/2024	LSC	04/16/2024
ID Prefix F0742	Correction	ID Prefix F0804	Correction	ID Prefix F0919	Correction
Reg. # 483.40(b)(1)	Completed	Reg. # 483.60(d)(1)(2)	Completed	Reg. # 483.90(g)(1)(2)	Completed
LSC	04/16/2024	LSC	04/16/2024	LSC	04/16/2024
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?
3/6/2024	☐ 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
315282 Y1	A. Building B. Wing Y2	10/23/2001 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT MANALAPAN	104 PENSION ROAD MANALAPAN, NJ 07726

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 F0226	Correction	ID Prefix F0241	Correction	ID Prefix F0246	Correction
Reg. # 483.13(C)(1)(i)	Completed	Reg. # 483.15(a)	Completed	Reg. # 483.15(e)(1)	Completed
LSC	10/23/2001	LSC	10/23/2001	LSC	10/23/2001
ID Prefix F0253	Correction	ID Prefix F0272	Correction	ID Prefix F0279	Correction
Reg. # 483.15(h)(2)	Completed	Reg. # 483.20(b)	Completed	Reg. # 483.20(k)	Completed
LSC	10/23/2001	LSC	10/23/2001	LSC	10/23/2001
ID Prefix F0281	Correction	ID Prefix F0314	Correction	ID Prefix F0323	Correction
Reg. # 483.20(k)(3)(i)	Completed	Reg. # 483.25(c)	Completed	Reg. # 483.25(h)(1)	Completed
LSC	10/23/2001	LSC	10/23/2001	LSC	10/23/2001
ID Prefix F0324	Correction	ID Prefix F0325	Correction	ID Prefix F0332	Correction
Reg. # 483.25(h)(2)	Completed	Reg. # 483.25(i)(1)	Completed	Reg. # 483.25(m)(1)	Completed
LSC	10/23/2001	LSC	10/23/2001	LSC	10/23/2001
ID Prefix F0364	Correction	ID Prefix F0368	Correction	ID Prefix F0371	Correction
Reg. # 483.35(d)(1)&(2)	Completed	Reg. # 483.35(f)(1)-(3)	Completed	Reg. # 483.35(h)(2)	Completed
LSC	10/23/2001	LSC	10/23/2001	LSC	10/23/2001

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315282 Y1	A. Building B. Wing Y2	10/23/2001 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT MANALAPAN	104 PENSION ROAD MANALAPAN, NJ 07726

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 F0372	Correction	ID Prefix F0441	Correction	ID Prefix F0456	Correction
Reg. # 483.35(h)(3)	Completed	Reg. # 483.65(a)(1)-(3)	Completed	Reg. # 483.70(c)(2)	Completed
LSC	08/27/2001	LSC	08/27/2001	LSC	10/23/2001
ID Prefix F0460	Correction	ID Prefix F0463	Correction	ID Prefix F0468	Correction
Reg. # 483.70(c)(1)(iv&v)	Completed	Reg. # 483.70(f)	Completed	Reg. # 483.70(h)(3)	Completed
LSC	10/23/2001	LSC	10/23/2001	LSC	10/23/2001
ID Prefix F0469	Correction	ID Prefix F0490	Correction	ID Prefix F0521	Correction
Reg. # 483.70(h)(4)	Completed	Reg. # 483.75	Completed	Reg. # 483.75(o)(2)&(3)	Completed
LSC	10/23/2001	LSC	10/23/2001	LSC	10/23/2001

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?
8/24/2001	☐ YES ☐ NO