STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. BUILDING _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDBANK CENTER FOR REHABILITATION AND HEALING	**100 CHAPIN AVENUE RED BANK, NJ 07701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Survey Date: 1/11/23 Census: 116 Sample: 24 + 2 + 1 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to implement their abuse policy by ensuring all new employees were screened for potential abuse by conducting reference checks from previous and current	F 600	The facility contacted prior employers of Staff #1, #2, #3, #4 and #5 and requested a reference check form be completed. Proof of reference check contact with date of request and responses was documented on the reference check form	2/28/23

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

Electronically Signed | 02/03/2023

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

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F 600	Continued From page 1 employers. This deficient practice was identified for 4 of 5 staff (Staff #2, #3, #4, and #5) reviewed for newly hired employees and was evidenced by the following: On 1/9/23 at 2:50 PM, the surveyor requested from the[redacted] to provide the survey team with the personnel and health files for five selected newly hired employees (Staff #1, #2, #3, #4, and #5) in the past four months. A review of the facility's "HMNR Abuse Prevention" policy dated 2022, included ....[facility name] will protect the resident/patient right to be free from verbal, sexual, physical, mental abuse, corporal punishment, misappropriation of property and involuntary seclusion...This policy will be accomplished through the seven components of abuse prevention: screening of potential staff...Screening: prospective staff will be screened for any actual or suspected history of resident/patient abuse, neglect, exploitation, misappropriation or mistreatment, or any other criminal felony. a. Prospective staff will sign a release allowing a criminal background check, and a reference check from previous and current employers and checking with appropriate licensing boards and registries... On 1/10/23 at 8:40 AM, the surveyor reviewed the five employee health and personnel files requested and provided by the facility which included: Staff #1, [redacted] hired [redacted]. There was no reference check. Staff #2, [redacted], hired [redacted]. There was no reference check.	F 600	and responses have been placed in the employee personnel files. The facility staffing coordinator was re-educated to check references with an offer of employment and maintain proof in the employee personnel file and to complete the new or rehire checklist to be sure all required steps have been completed. All Residents have the potential to be affected by this practice. The abuse prevention policies were reviewed and staff involved in hiring received re-education. A reference check form was provided to the facility staffing coordinator for use when directly hiring staff. The form is emailed to prior employers and when completed filed in the employee personnel file. A new hire checklist is in place that includes review of reference checks to ensure all documents required are completed timely. The staffing coordinator will audit new employee files weekly for the next four weeks then monthly for the next two months and quarterly thereafter to assure reference checks have been requested for all new or rehire employees. The staffing coordinator will communicate the audit findings weekly with the Administrator for further direction and assistance. Quarterly findings will be reported in aggregate at the QAPI meeting for further direction as appropriate. The Administrator will review new and rehire employee checklists for completion weekly for four weeks and monthly for two	

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F 600	Continued From page 2 Staff #3, U.S. FOIA (b)(6) There was no reference check. Staff #4, U.S. FOIA (b)(6) There was no reference check. Staff #5, U.S. FOIA (b)(6) There was no reference check. On 1/10/23 at 9:11 AM, the surveyor requested the U.S. FOIA (b)(6) to review the employee files provided and locate the reference checks. The U.S. FOIA (b)(6) confirmed the reference checks were not in the files, and stated she had to check with the Human Resource Department for the reference checks. On 1/10/23 at 9:35 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that the facility had a corporate Human Recourse Department and there was no Human Resource Department at the facility. The U.S. FOIA (b)(6) stated that the US FOIA (b)(6) sent her the names of the new hires and she conducted background checks, scheduled these employees for their health examinations and employee identification cards. The U.S. FOIA (b)(6) stated all their paperwork including their application, license verification, and background check went into their file which she kept. The U.S. FOIA (b)(6) stated reference checks came from the corporate Human Resource Department. On 1/10/23 at 9:54 AM, the surveyor attempted to interview the US FOIA (b) via telephone, but there was no answer. On 1/10/23 at 10:50 AM, the U.S. FOIA (b)(6) in the presence of the U.S. FOIA (b)(6) informed the surveyor that she only found a reference check for the	F 600	months. The Administrator will report results at the quarterly QAPI meeting for further discussion and direction as appropriate.	

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F 600	Continued From page 3 U.S. FOIA (b)(6) (Staff #1) and not the other four employees. On 1/10/23 at 10:54 AM, the surveyor interviewed the NJ Exec Orde via telephone who confirmed the facility did not have a U.S. FOIA (b)(6) on-site and he oversaw the NJ Exec Order 26.4b1 for the building. The U.S. FOIA (b)(6) stated that the facility was acquired in 2020 and they were never moved onto their main system which meant the facility was responsible for their own hiring of new employees. The U.S. FOIA (b) verified since the facility was in charge of their own hiring, they were also responsible for conducting their own screening of prospective employees including reference checks. On 1/10/23 at 2:46 PM, the U.S. FOIA (b)(6) in the presence of the U.S. FOIA (b)(6), and survey team stated she was in touch with the U.S. FOIA (b)(6) and the contracted US FOIA (b)(6)] who was responsible for onboarding of new employees, having their reference checks and emailing them to the facility. The U.S. FOIA (b)(6) also stated the facility had no policy for hiring of new employees. On 1/11/23 at 8:43 AM, the surveyor conducted a follow-up interview via telephone with the U.S. FOIA (b) who stated [name redacted] was a contracted U.S. FOIA (b)(6) who completed sourcing requisitions for high level employees such as a director of nursing or administrator. Most of the employees at the facility were hired directly from the facility which went through the U.S. FOIA (b)(6) . The U.S. FOIA (b)(6) was expected to contact these prospective employees and obtain all the necessary documents and screenings including background checks,	F 600		

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F 600	Continued From page 4 reference checks, and license verifications, as well as scheduling health examinations. The U.S. FOIA (b)(6) confirmed for an employee such as a housekeeper or occupational therapist, the contracted U.S. FOIA (b)(6) would not conduct reference checks for them since it was not a high-level position. On 1/11/23 at 10:29 AM, the U.S. FOIA (b)(6), in the presence of the U.S. FOIA (b)(6), and survey team confirmed the facility did not complete reference checks for Staff #2, Staff #3, Staff #4, and Staff #5. The Regional Nurse acknowledged that was part of the screening process to prevent residents from potential abuse. The U.S. FOIA (b)(6) confirmed there were no allegations of abuse made against these employees.	F 600		
F 640 SS=F	NJAC 4.1(a)(5) Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days	F 640		2/28/23

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F 640	Continued From page 5 after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documents, it was determined that the facility failed to complete and submit discharge Minimum Data Set Assessments (MDS), an assessment tool, as required for 17 of 17 residents (Resident #9, #17, #35, #47, #57, #82,	F 640	The required MDS assessment for Resident's #9, #17, #35, #47, #57, #82,#85, #93, #94, #96, #97, #98, #99, #100, #101, #102, and #110 were completed, transmitted and accepted by the CMS system as required.	

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F 640	Continued From page 6 #85, #93, #94, #96, #97, #98, #99, #100, #101, #102, and #110) system selected for MDS over 120 days and was evidenced by the following: On 1/4/23 at 10:32 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated she had been working alone on MDS for about five months, and the facility had been looking for additional help without success. At this time, the surveyor provided the U.S. FOIA (b) with a list of thirty-seven system selected residents identified as having an U.S. FOIA (b) record that was over 120 days overdue. The U.S. FOIA (b) was asked to provide the survey team with the date the last MDS was submitted and the next MDS that was due, as well as if the resident remained in the facility or had been discharged. On 1/5/23 at 9:14 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that she had concentrated on annuals, admissions, and quarterly MDS and had not prioritized discharge MDS's. She further stated she had made administration aware that it was "just too much to keep up with." On 1/5/22 at 11:09 AM, the U.S. FOIA (b)(6) provided the surveyor with the requested system selected MDS information. The U.S. FOIA (b)(6) confirmed that seventeen of thirty-seven selected residents were discharged from the facility and their discharge MDS assessment were not completed. The U.S. FOIA (b)(6) acknowledged the discharge MDS should have been completed at the time of discharge as required. A review of the seventeen residents who were	F 640	The US FOIA (b)(6) was re-educated about requesting assistance when help is needed to complete all MDS assessments timely in compliance with the Resident Assessment Instrument (RAI) manual. All Residents have the potential to be affected by this practice. An audit of all MDS assessment due dates was completed to identify any assessments that were overdue and any found were completed and submitted to the CMS system as required. Additional help has been obtained to assist the MDS Coordinator with completion of MDS assessments timely in accordance with the RAI manual and CMS requirements. A schedule of due assessments is printed weekly to assure all required assessments, including discharge assessments are completed and submitted timely. The schedule is reviewed weekly by the MDS Coordinator, Director of Nursing, and Administrator. The Director of Nursing or designee will review the schedule of due assessments weekly for the next four weeks then monthly for two months to ensure MDS assessments are completed and submitted timely. The Director of Nursing or designee will discuss all findings with the MDS Coordinator and Administrator if needed based on audit findings arrange for assistance for the MDS Coordinator. Findings will be reported at the quarterly QAPI committee meeting for review and further action as appropriate.	

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F 640	Continued From page 7 discharged from the facility with no completed discharge MDS was as follows: 1. Resident #9 had a discharge date of [NJ Exec Order 26.4], a completion due date of [NJ Exec Order 26.4], a submission due date of [NJ Exec Order 26.4b] The MDS was completed on [NJ Exec Order 2] and not yet submitted. 2. Resident #17 had a discharge date of [NJ Exec Order 26.4] a completion due date of [NJ Exec Order 2], and a submission due date of [NJ Exec Order 26.4b]. The MDS was not completed or submitted. 3. Resident #35 had a discharge date of [NJ Exec Order 26.4b], a completion due date of [NJ Exec Order 26], and a submission due date of [NJ Exec Order 26.4b] The MDS was completed on [NJ Exec Order 26] and not yet submitted. 4. Resident #47 had a discharge date of [NJ Exec Order 26.4b] a completion due date of [U.S. FOIA (b)(6)], and a submission due date of [U.S. FOIA (b)(6)]. The MDS was completed on [U.S. FOIA (b)(6)] and submitted on [U.S. FOIA (b)(6)] 5. Resident #57 had a discharge date of [U.S. FOIA (b)(6)], a completion due date of [U.S. FOIA (b)(6)], and a submission due date of [U.S. FOIA (b)(6)]. The MDS was completed on [U.S. FOIA (b)(6)] and not yet submitted. 6. Resident #82 had a discharge date of [NJ Exec Order 26.4], a completion due date [NJ Exec Order 26] and a submission due date of [NJ Exec Order 26.4b]. The MDS was completed on [NJ Exec Order 26] and submitted on [NJ Exec Order 26] 7. Resident #85 had a discharge date of [NJ Exec Order 26.4b] a completion due date of [NJ Exec Order 26], and a submission date of [NJ Exec Order 26.4b]. The MDS was completed on [NJ Exec Order 26] and not yet submitted. 8. Resident #93 had a discharge date of [NJ Exec Order 26.4],	F 640		

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F 640	Continued From page 8 a completion due date of [redacted] and a submission due date of [redacted]. The MDS was completed on [redacted] and not yet submitted. 9. Resident #94 had a discharge date of [redacted] a completion due date of [redacted], and a submission due date of [redacted]. The MDS was not completed or submitted. 10. Resident #96 had a discharge date of [redacted], a completion due date of [redacted], and a submission due date of [redacted]. The MDS was completed on [redacted] and submitted on [redacted] 11. Resident #97 had a discharge date of [redacted] a completion due date of [redacted], and a submission due date of [redacted]. The MDS was not completed or submitted. 12. Resident #98 had a discharge date of [redacted], a completion due date of [redacted] and a submission due date of [redacted]. The MDS was completed on [redacted] and not yet submitted. 13. Resident #99 had a discharge date of [redacted], a completion due date of [redacted], and a submission due date of [redacted]. The MDS was completed on [redacted] and not yet submitted. 14. Resident #100 had a discharge date of [redacted], a completion due date of [redacted], and a submission due date of [redacted]. The MDS was completed on [redacted] and not yet submitted. 15. Resident #101 had a discharge date of [redacted], a completion due date of [redacted], and a submission due date of [redacted]. The MDS was completed on [redacted] and not yet submitted.	F 640		

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F 640	Continued From page 9 16. Resident #102 had a discharge date of [NJ Exec Order 26:4], a completion due date of [NJ Exec Order 26:4b], and a submission due date of [NJ Exec Order 26:4b]. The MDS was completed on [NJ Exec Order 2] and not yet submitted. 17. Resident #110 had a discharge date of [NJ Exec Order 26:4], a completion due date of [NJ Exec Order 26:4], and a submission due date of [NJ Exec Order 2]. The MDS was completed on [NJ Exec Order 26] and not yet submitted. On 1/9/23 at 12:34 PM, the U.S. FOIA (b)(6) informed the surveyor she had fourteen days after discharge to complete the MDS and fourteen days to submit the discharge MDS. The U.S. FOIA (b)(6) acknowledged she had not completed the discharge MDS or submitted them on time as required. On 1/11/23 at 10:30 AM, the U.S. FOIA (b)(6), in the presence of the U.S. FOIA (b)(6) and survey team, acknowledged the identified discharged residents' discharge MDS's were not completed within fourteen days of discharge and submitted within fourteen days in accordance with the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual. A review of the facility provided "MDS/Nursing/Administration" policy dated last reviewed 7/1/2020, included MDS Department: schedules Minimum Data Set (MDS) and Care Plan Meeting in accordance to the existing regulations governing the RAI process... NJAC 8:39-11.1	F 640		

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F 692	Continued From page 10	F 692		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to obtain [redacted] as ordered for newly admitted residents with significant [redacted]. This deficient practiced was identified for 2 of 2 residents (Resident #19 and #59) reviewed for [redacted] and was evidenced by the following: On 1/3/23 at 11:19 AM, the surveyor observed Resident #59 lying in bed asleep with an [redacted] (a	F 692	The [redacted] and the Unit Manager reviewed the [redacted] for Resident #59 and confirmed the [redacted] occurred during the hospitalization at which time a [redacted] and [redacted] were started. On readmission the [redacted] obtained was accurate and the [redacted] obtained during the survey also was accurate and showed a [redacted] gain. The Registered Dietician instructed the nursing staff to obtain weekly [redacted] for four weeks. The Registered Dietician is reviewing the weekly [redacted] to ensure	2/28/23

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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 692	Continued From page 11 NJ Exec Order 26.4b1) hanging on a NJ Exec Order 26.4b1 not being administered. The resident appeared to be NJ Exec Order 26.4b1 On 1/3/23 at 11:30 AM, the surveyor interviewed the NJ Exec Order 26.4b1) who stated the NJ Exec Order 26.4b1 nursing unit did not have a NJ Exec Order 2 book for the residents' NJ Exec Order 26.4b she kept all the residents' NJ Exec Order 26.4 on a spreadsheet on her personal computer. The U.S. FOIA (b)(6) stated she reviewed the NJ Exec Order 26.4 and gave a copy of the NJ Exec Order 26.4 to the U.S. FOIA (b)(6) The U.S. FOIA (b)(6) stated NJ Exec Order 26.4 were generally obtained in the beginning of each month. At this time, the surveyor requested a copy of all the residents' NJ Exec Order 26.4 for the past six months. A review of Resident #59's NJ Exec Order 26.4 reflected the resident NJ Exec Order 26.4b NJ Exec Order NJ Exec Order 26 (#) in NJ Exec Order 26.4b .1# in NJ Exec Order 26.4b1 # in NJ Exec Order 26.4b1 There was no evidence of a NJ Exec Order 26.4b1 for the NJ Exec Order 26.4b1 NJ Exec Order 26 which would have been a NJ Exec Orde NJ Exec Order 26.4b1 or a NJ Exec Order 26.4 significan NJ Exec Order 26.4b1 in NJ Exec Order 26.4b1 . On 1/5/23 at 9:01 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated Resident #59 was re-admitted to the facility on NJ Exec Order 26.4b1 after a NJ Exec Order 26.4b1 in the hospital. The NJ Exec Order 26.4b stated since the resident was out of the facility for more than NJ Exec Order 26.4b1 , this was considered a new admission for the resident. The surveyor reviewed the medical record for Resident #59. A review of the Resident's Face Sheet (an	F 692	Resident #59 continues to NJ Exec Order 26.4b1 . The U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6) reviewed the NJ Exec Order 26.4 for Resident #19 and confirmed after readmission from the hospital there was one NJ Exec Order 2 missing. The U.S. FOIA (b)(6) was aware the Resident had a NJ Exec Order 26.4b1 which was addressed. The U.S. FOIA (b)(6) instructed the nursing staff to obtain weekly NJ Exec Order 26.4 for four weeks to determine if the NJ Exec Order 2 NJ Exec O continues. The NJ Exec Order 26.4b1 is reviewing the weekly NJ Exec Order 26.4 and will recommend modification of the NJ Exec Order 26.4b plan as needed to promote NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 if possible. All Residents who are new or readmissions who have had significant weight loss have the potential to be affected by this practice. A weight spreadsheet is in place on all units and is completed by the Unit Manager monthly and updated with weekly weights as ordered. Information is kept in a readily accessible location for review by the Registered Dietician. The Unit Manager informs the Registered Dietician of any weight changes to ensure timely intervention to stabilize weight. The US FOIA (b)(6) received re-education regarding obtaining weekly weights for all new or readmissions and communicating results timely The Unit Manager will review all weight spreadsheets weekly on an ongoing basis to assure all weights have been obtained per facility policy including weekly weights of new or readmissions and any Resident	

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	315286	A. BUILDING _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 692	Continued From page 12 admission summary) reflected the resident was admitted to the facility in NJ Exec Order 26.4b1 with diagnoses which included U.S. FOIA (b)(6) [redacted]. A review of the Minimum Data Set (MDS), an assessment tool, reflected the admission assessment was in progress. A review of the New Jersey Universal Transfer form dated NJ Exec Order 26.4b1 reflected the resident was transferred to the facility from the hospital with a primary diagnosis of a NJ Exec Order 26.4b1. The resident was on a nothing by mouth (NPO) [redacted]. A review of the NJ Exec Order 26.4b1 and Vital Signs Record for year NJ Exec Order, reflected the weight on NJ Exec Order 26.4b1 A review of the NJ Exec Order 26.4b1 Protocol dated NJ Exec Order 26.4b1 indicated the resident was to receive NJ Exec via a NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 with a total volume of NJ Exec Order NJ Exec Order 26 and NJ Exec Order NJ Exec Order 26.4b1 A review of the NJ Exec Order 26.4b1 Assessment completed by the NJ Exec Order 26.4b1 reflected the resident had a NJ Exec Order NJ Exec Order 26.4b1 during a NJ Exec Order 26.4b1 hospitalization. The resident had a NJ Exec Order 26. until they put in a NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1. Recommendation was NJ Exec Order 26.4b1	F 692	with significant weight changes. Findings will be discussed as appropriate at morning clinical meetings and the Registered Dietician notified immediately of any unplanned weight changes. The Registered Dietician will review the weight records of all Residents with weekly weights on a weekly basis to ensure proper nutritional interventions are in place to promote weight stabilization. The Registered Dietician will intervene when appropriate and make nutritional recommendations. Findings will be reviewed by the Registered Dietician and presented in aggregate at weight meetings when appropriate and quarterly at the QAPI committee meeting.	

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F 692	Continued From page 13	F 692		

A review of the resident's individualized person-centered care plan included a focus area of nutrition - NJ Exec Order 26.4b1 support with risk for NJ Exec Order 26.4b1 initiated NJ Exec Order 26.4b1, with interventions that included to administer NJ Exec Order 26.4b1 with required water as prescribed by physician; notify physician if NJ Exec Order 26 is not NJ Exec Order 26.4b1 or not NJ Exec Order 26 as per orders; and monitor NJ Exec Order 26.4 as physician ordered.

On 1/5/23 at 12:20 PM, the surveyor interviewed the U.S. FOIA (b) who stated that every unit obtained monthly NJ Exec Order 26.4 for each resident which were taken by the U.S. FOIA (b)(6) and given to the medication nurse who gave the NJ Exec Order 26.4 to the U.S. FOIA (b)(6). The NJ Exec Order 26.4 were usually written on the census sheet for the day and given to the U.S. FOIA (b)(6). If a weight had to be re-done, the nurse completed the NJ Exec Order 26.4b1

On 1/5/23 at 12:22 PM, the surveyor re-interviewed the NJ Exec Order 26.4b who confirmed the unit did not have a NJ Exec Order 2 book for the residents. The U.S. FOIA (b)(6) stated that the NJ Exec Order 26.4 were taken at the beginning of each month by the assigned U.S. FOIA (b, and if there was a discrepancy of NJ Exec O or more from the previous month's NJ Exec Order 26 a NJ Exec Order 26.4b1 was taken the same day and observed by the nurse to ensure accuracy. The U.S. FOIA (b)(6) confirmed both NJ Exec Order 26.4 were not recorded on her spreadsheet so there was no evidence a NJ Exec Order 26.4b was completed. The U.S. FOIA (b)(6) stated that sometimes the US FOIA ordered NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 were done upon admission or re-admission to the facility and documented on the Medication Administration Record (MAR). The U.S. FOIA (b)(6) stated the

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F 692	Continued From page 14	F 692		

physician did not need to write an individual order for weekly [redacted] for four weeks for a new or re-admission because it was a standing order. At this time, the surveyor reviewed the [redacted] and [redacted] MARs with the [redacted] who confirmed Resident #59's [redacted] was not obtained weekly; the only [redacted] for the resident was upon admission. The [redacted] acknowledged they "did drop the ball" for that resident.

On 1/5/23 at 12:43 PM, the surveyor observed the resident laying in bed with [redacted] running at a rate of [redacted] hour with a total [redacted] of [redacted]

On 1/6/23 at 9:40 AM, the surveyor asked the [redacted] if they obtained a [redacted] for the resident yet. The [redacted] stated no, she planned on asking a [redacted] to take today. At this time, the surveyor requested the resident's [redacted] to be taken in their presence.

On 1/6/23 at 10:18 AM, the surveyor observed CNA #1, CNA #2, and the [redacted] obtain Resident #59's [redacted] via a [redacted]. The weight was [redacted] which was a [redacted] since admission.

On 1/10/23 at 12:48 PM, the surveyor interviewed the [redacted] via telephone who stated that standard practices for resident [redacted] included monthly [redacted] weekly [redacted] for two or four weeks for residents with significant [redacted] and weekly [redacted] for four weeks for new or re-admitted residents. The [redacted] stated Resident #59 was [redacted] in the hospital and [redacted] that they were [redacted] them weekly. The [redacted] stated she generally verified they were taking

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F 692	Continued From page 15 NJ Exec Order 26.2 weekly and usually documented it. The U.S. FO stated that she had unfortunately been out of the building recently and had not been monitoring the resident's NJ Exec Order 26 On 1/10/23 at 1:21 PM, the surveyor and U.S. FOIA (b)(6) reviewed Resident #59's chart. The U.S. FOIA (b)(6) confirmed there was no further documentation from the U.S. FO after NJ Exec Order 26.4b1. On 1/11/23 at 10:20 AM, the NJ Exec Order 26.4b1 in the presence of the U.S. FOIA (b)(6) nd survey team, acknowledged Resident #59's NJ Exec Order 26.2 were not obtained weekly as ordered. 2. On 1/3/23 at 10:57 AM, the surveyor observed Resident #19 in bed. The resident NJ Exec Order 26.4b1 On 1/3/23 at 11:30 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated the NJ Exec Order 26.4b1 nursing unit did not have a NJ Exec Order 2 book for the residents' NJ Exec Order 26.4 she kept all the residents' NJ Exec Order 26.2 on a spreadsheet on her computer. The U.S. FOIA (b)(6) stated she reviewed the NJ Exec Order 26.2 and gave a copy of the NJ Exec Order 26.2 to the U.S. FO. The U.S. FOIA (b)(6) stated NJ Exec Order 26.2 were generally obtained in the beginning of each month. At this time, the surveyor requested a copy of all the residents' NJ Exec Order 26.2 for the past six months. A review of Resident #19's NJ Exec Order 26.4 for the past six months were: NJ Exec Order 26.4b1 #	F 692		

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F 692	Continued From page 16	F 692		

NJ Exec Order 26.4b1 [redacted]

This was a NJ Exec Order NJ Exec Order 26.4b1 of NJ Exec Order 26.4b NJ Exec Order 26.4b1 .

The surveyor reviewed the medical record for Resident #19.

A review of the Resident Face Sheet reflected the resident was admitted to the facility in NJ Exec Order 26.4b1 [redacted] with diagnoses which included NJ Exec Order 26.4b1 [redacted].

A review of the most recent quarterly MDS dated NJ Exec Order 26.4b1 reflected the resident had a brief interview for mental status (BIMS) score of NJ Exec Order [redacted], which indicated a NJ Exec Order 26.4b1 [redacted]. The assessment further indicated the resident did not have a NJ Exec Order 26.4b1 or NJ Exec O in NJ Exec Order 26.4b1 .

A review of the NJ Exec Order 26 Progress Note dated NJ Exec Order 26 , reflected the resident was re-admitted from the hospital and the U.S. FO was awaiting a NJ Exec Order 26

A review of the U.S. FOIA (b)(6) Progress Note dated NJ Exec Order 26.4b reflected the resident's NJ Exec Order 2 was NJ Exec Order 26 with was a NJ Exec Order 26.4b1 of NJ Exec O . The U.S. FO noted this was a NJ Exec Order 26.4b1 and to follow with weekly NJ Exec Order 26.4b

A review of an incomplete History and Physical Examination, reflected the resident was re-admitted to the facility from the hospital on

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F 692	Continued From page 17 NJ Exec Order 26.4b On 1/5/23 at 12:20 PM, the surveyor interviewed the U.S. FOIA who stated that every unit obtained monthly NJ Exec Order 26.4 for each resident which were taken by the U.S. FOIA (b and given to the medication cart nurse who gave the NJ Exec Order 26.4 to the U.S. FOIA (b)(6). The NJ Exec Order 26.4 were usually written on the census sheet for the day and given to the U.S. FOIA (b)(6) If a NJ Exec Order 2 had to be re-done, the nurse completed the NJ Exec Order 26.4b1 On 1/5/23 at 12:22 PM, the surveyor re-interviewed the U.S. FOIA (b)(6) who confirmed the unit did not have a NJ Exec Order 2 book for the residents. She explained that the NJ Exec Order 26.4 were taken at the beginning of each month by the assigned U.S. FOIA (b, and if there was a discrepancy o NJ Exec Order 26.4b1 or more from the previous month's NJ Exec Order 26 a NJ Exec Order 26.4b1 was taken the same day and observed by the nurse to ensure accuracy. The U.S. FOIA (b)(6) confirmed both weights were not recorded on her spreadsheet so there was no evidence a NJ Exec Order 26.4b1 was completed. The NJ Exec Order 26.4b stated that sometimes the US FOIA ordered weekly NJ Exec Order 26.4 or weekly NJ Exec Order 26.4 were done upon admission or re-admission to the facility and documented on the MAR. The NJ Exec Order 26.4b1 stated the physician did not need to write an individual order for weekly NJ Exec Order 26.4 times four weeks for a new or re-admission because it was a standing order. The surveyor reviewed the NJ Exec Order 26.4b1 MAR for the resident which did not include weekly NJ Exec Order 26.4b On 1/10/23 at 12:48 PM, the surveyor interviewed the U.S. FO via telephone who stated that standard practices for resident NJ Exec Order 26.4 included monthly	F 692		

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F 692	Continued From page 18 NJ Exec Order 26.4b weekly NJ Exec Order 26.4 for two or four weeks for residents with NJ Exec Order 26.4b1, and weekly NJ Exec Order 26.4 for four weeks for new or re-admitted residents. The U.S. FOIA stated she generally documented weekly for any resident on weekly NJ Exec Order 26.4b. The U.S. FOIA stated Resident #19 has had a NJ Exec Order 26.4b1 and she thought the NJ Exec Order 26.4b1 had been in touch with the family. On 1/10/23 at 1:21 PM, the surveyor and the NJ Exec Order 26.4b reviewed the resident's chart. The NJ Exec Order 26.4b1 stated there were no documented weekly NJ Exec Order 26.4 on the MAR as should be, but the US FOIA documented in her notes the resident's NJ Exec Order 2 on NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 and NJ Exec Order 26.4 the weight was NJ Exec Order 26 on NJ Exec Order 26.4b1 The NJ Exec Order 26.4b confirmed there were no documented NJ Exec Order 26.4 for the week of NJ Exec Order 26.4b1 . The U.S. FOIA (b)(6) stated she must have just given the U.S. FO the NJ Exec Order 26.4 instead of documenting the NJ Exec Order 26.4 on the MAR. On 1/11/23 at 10:29 AM, the U.S. FOIA (b)(6) in the presence of the U.S. FOIA (b)(6) and survey team acknowledged weekly NJ Exec Order 26.4 were not completed for Resident #19 as ordered. A review of the facility's "HMNR Resident/Patient Weights" policy dated revised 7/2022, included residents/patient weights are taken upon admission or readmission (to establish a baseline weight), weekly for the first four weeks after admission and at least monthly to help identify and document trends such as slow progressive weight changes...resident/patients with a recent history of weight loss and or risk for weight loss may be weighed weekly as determined by the dietitian and or physician. Weekly weights will be completed on the same day each week and may	F 692		

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F 692	Continued From page 19 be initiated by nursing, the dietitian or physician. NJAC 8:39-27.1(a); 27.2(a)	F 692		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents conducted face-to-face visits and wrote progress notes at least every thirty days. This deficient practice was identified for 1 of 24 residents (Resident #19) reviewed for physician visits and evidenced by the following:	F 712	Resident #19 was immediately seen by the attending physician who documented the visit. The attending physician completed the admitting history and physical. The Medical Director discussed the medical visit requirements with the attending physician of Resident #19 to ensure timely visits within 48 hours for all new and readmissions and then ongoing	2/28/23

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F 712	Continued From page 20 On 1/3/23 at 10:57 AM, the surveyor observed Resident #19 lying in bed asleep. The resident NJ Exec Order 26.4b1 The surveyor reviewed the medical record for Resident #19. A review of the Resident Face Sheet (an admission summary) reflected the resident was admitted to the facility in NJ Exec Order 26.4b1 with diagnoses which included NJ Exec Order 26.4b1 [redacted] A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], reflected the resident had a brief interview for mental status (BIMS) score of [redacted], which indicated a NJ Exec Order 26.4b1 [redacted]. A review of the Physician's Progress Notes reflected the resident was seen by the physician on NJ Exec Order 26.4b1 . There was an incomplete History and Physical Examination dated [redacted] for a re-admission from the hospital. There was no evidence the resident was seen by the physician in NJ Exec Order 26.4b1. On 1/9/23 at 11:34 AM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated the resident was sent to the hospital for NJ Exec Order 26.4b1) and returned to the facility in NJ Exec Order 26.4b1 on an [redacted]. On 1/9/23 at 1:37 PM, the surveyor interviewed	F 712	visits every 30 days. All Residents have the potential to be affected by this practice. The Medical Director notified all physicians via letter who provide medical services for facility Residents of their responsibility to conduct face to face visits within 48 hours of admission or readmission and then once every thirty days thereafter. The unit manager or designee will audit the charts of all new and readmissions weekly for two weeks then monthly for two months to ensure compliance with physician visits. The unit manager or designee will then review a sample of 5 charts every month to review to ensure compliance with visits every thirty days. Findings will be reported by the unit manager or designee to the Director of Nursing and Administration monthly. The unit manager or designee will provide findings in aggregate at the quarterly QAPI meeting for action as appropriate.	

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F 712	Continued From page 21	F 712		

the NJ Exec Order 26.4b1 who stated the facility currently did not use U.S. FOIA (b)(6) and that the physicians saw their residents. The NJ Exec Order 26.4b stated when a resident was admitted or re-admitted to the facility, the physician needed to see the resident, but she was unsure within how many days. The NJ Exec Order 26.4b1 stated that the resident's Physician visited the facility at least every sixty days. At this time, the surveyor and the NJ Exec Order 26.4b reviewed the resident's medical chart. The NJ Exec Order 26.4b confirmed that the resident was briefly sent out to the hospital in NJ Exec Order 26.4b, and returned to the facility on NJ Exec Order 26.4b. The U.S. FOIA (b)(6) confirmed that the Physician did not see Resident #19 upon re-admission from the hospital or for the month of NJ Exec Order 26.4b1. The U.S. FOIA (b)(6) confirmed the resident was not seen until U.S. FOIA (b)(6). The U.S. FOIA (b)(6) stated that she flagged the resident's chart for the Physician to see them, but confirmed the resident was not seen.

On 1/9/23 at 1:57 PM, the surveyor interviewed the NJ Exec Order 26.4b1 who stated physicians needed to see their residents monthly. The NJ Exec Order 26.4b1 also stated that upon admission or re-admission to the facility, the physician had forty-eight hours to see the resident. At this time, the surveyor reviewed with the NJ Exec Order 26.4b1 Resident #19's chart, and the NJ Exec Order 26.4b1 confirmed the resident should have been seen by the physician upon re-admission on U.S. FOIA (b)(6).

On 1/9/23 at 2:10 PM, the surveyor called the U.S. FOIA (b)(6) office and spoke to the U.S. FOIA (b)(6) who stated the U.S. FOIA (b)(6) would return the surveyor's phone call.

On 1/11/23 at 10:29 AM, the NJ Exec Order 26.4b1 in

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F 712	Continued From page 22 the presence of the NJ Exec Order 26.4b1 [redacted] and survey team confirmed the U.S. FOIA (b)(6) did not visit Resident #19 in NJ Exec Order 26.4b1 that the visit was flagged but not done. The U.S. FOIA (b)(6) never returned the surveyor's phone call. A review of the facility's "HMNR Physician Services" policy last revised 12/2022, included each provider will comply with applicable federal laws, rules and regulations, as well as facility policies and standards of medical and nurse professional practice...the physician will review the resident's/patient's total program of care, including medications and treatments, at each required visit...for the initial comprehensive visit, a resident/patient must be seen by a physician in a person (face-to-face) within 48 hours of admission...the physician will visit the resident/patient at least every 30 days for the first 90 days and at least once every 60 days thereafter.	F 712		
F 730 SS=F	NJAC 8:39-23.2(d) Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 730		2/28/23

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F 730	Continued From page 23 Based on interview and review of pertinent facility documents, it was determined that the facility failed to conduct yearly performance reviews of Certified Nursing Aides (CNA) in order to provide specific education based on the outcomes of the reviews. This deficient practice was identified for 4 of 4 CNAs whose personnel records were reviewed and was evidenced by the following: 1. According to the data provided by the facility, CNA #1 was hired on [redacted]. Review of CNA #1's personnel file reflected there was no current performance evaluations completed for CNA #1. 2. According to the data provided by the facility, CNA #2 was hired on [redacted]. Review of CNA #2's personnel file reflected there was no current performance evaluations completed for CNA #2. 3. According to the data provided by the facility, CNA #3 was hired on [redacted]. Review of CNA #3's personnel file reflected there was no current performance evaluations completed for CNA #3. 4. According to the data provided by the facility, CNA #4 was hired on [redacted]. Review of CNA #4's personnel file reflected there were no current performance evaluations completed for CNA #4. On 1/10/23 at 9:13 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that the [redacted] would evaluate the CNAs performance annually. She further stated that performance evaluations were done annually in order to identify the CNA's strengths and weaknesses to determine what education they needed. The U.S. FOIA (b)(6) could not explain why there had been no annual performance	F 730	Performance evaluations of CNA□s #1, #2, #3, and #4 were immediately completed and any required education provided based on the reviews. The US FOIA (b)(6) [redacted] were re-educated about the requirement to complete annual performance evaluations from the date of hire for each CNA and to utilize a spreadsheet implemented to track CNA's annual performance review due dates and then address needed education based on reviews. All Residents have the potential to be affected by this practice. An audit of performance evaluations of facility CNAs was completed to identify those in need of an annual review. An annual performance review spreadsheet was implemented to ensure compliance with all educational requirements for CNAs. The spreadsheet will be maintained by the facility educator and information used to ensure timely completion of annual reviews and corresponding education. Annual performance evaluations of facility CNAs were completed, and education as required provided. The policy for performance evaluations was reviewed and updated and management staff re-educated regarding requirements. The Director of Nursing or designee will review the schedule of CNA annual performance evaluations weekly for the next four weeks then monthly for two months to ensure evaluations are completed timely and required education	

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F 730	Continued From page 24 evaluations completed for CNA #1, #2, #3 and #4. The U.S. FOIA (b)(6) further stated she was unable to locate performance evaluations from previous years. On 1/11/23 at 11:45 AM, the NJ Exec Order 26.4b1 in the presence of th NJ Exec Order 26.4b1 , and survey team stated the facility was not disputing anything and that she was unable to provide performance evaluations for any of the CNAs. The U.S. FOIA (b)(6) further stated since she could not find any performance evaluations it meant that they were not done. A review of an undated facility policy "HMNR Employee Evaluations" included all employees will be evaluated within 90 days of hire and annually or as needed to evaluate work performance thereafter, with the purpose to establish skills, dependability, personal relationships, emotional stability, personal appearance and to be used as a basis for disciplinary action...	F 730	provided. The Director of Nursing or designee will discuss all findings with the Staff educator and Administrator. The staff educator will then review the spreadsheet monthly on an ongoing basis. Findings will be reported at the quarterly QAPI committee meeting for review and further action as appropriate.	
F 755 SS=E	NJAC 8:39-43.17(b) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		2/28/23

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F 755	Continued From page 25 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined the facility failed to a.) ensure an accurate ordering and receiving of narcotic medications on the required Federal narcotic acquisition forms (DEA 222 forms) were completed with sufficient detail to enable accurate reconciliation for 1 of 1 forms provided; b.) ensure the DEA 222 forms were dated and signed as of the day it was submitted for filling for 4 of 7 forms provided; and c.) to accurately document the administration of controlled medication for 2 sampled residents (Resident #52 and Resident #61) identified upon inspection of 1 of 3 medication carts. The evidence was as follows:	F 755	The pre-signed DEA 222 forms were immediately voided in the presence of two witnesses. A binder was implemented to include all DEA222 narcotic forms properly completed according to form requirements and with corresponding proof of receipt of any replacement narcotics for the automated dispensing system. The Director of Nursing and Medical Director were re-educated about the proper completion and storage of the forms under double lock. The [US FOIA ID] who administered medication to Resident #52 was immediately	

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F 755	Continued From page 26 1. On 1/6/23 at 9:43 AM, the surveyor reviewed the facility provided DEA 222 forms which revealed four of the seven provided forms had been pre-signed by the facility's US FOIA (b)(6) prior to submission to the provider pharmacy for filling. The forms were as follows: Order form number: 220240368; 220240367; 220317342; and 220317341. On 1/6/23 at 1:56 PM, the surveyor interviewed the U.S. FOIA (b)(6) in the presence of the survey team. The U.S. FOIA (b) acknowledged there were seven blank DEA 222 forms in the facility provided binder. Upon inspection, the U.S. FOIA (b) acknowledged there were four out of seven forms pre-signed by the U.S. FOIA (b)(6)) for convenience. The U.S. FOIA (b) stated that the U.S. FOIA pre-signed the forms because he was not always at the facility; that he only came to the facility once a week. The U.S. FOIA (b) acknowledged there should be no pre-signed forms; forms were signed by the U.S. FOIA after they were completed, and the narcotic medications were ready to be ordered. On 1/10/23 at 2:49 PM, the surveyor conducted an interview via the phone with the facility U.S. FOIA who stated he was available to the facility twenty-four hours a day seven days a week, even when he was away. The U.S. FOIA further stated the facility used his DEA number to order narcotics; that the DEA 222 form was filled out by the U.S. FOIA (b), and he would sign the form to be sent to the provider pharmacy for filling. The surveyor then asked the U.S. FOIA why there were four pre-signed forms found in the facility binder? He stated he was not aware until recently that he should not	F 755	re-educated regarding the proper process for documenting administration of narcotics on the declining inventory sheet upon removal of the medication and then on the Resident Medication Administration sheet (MAR) at the time of administration. All Residents have the potential to be affected by this practice. The process for completion of DEA 222 forms when ordering narcotics for the automated dispensing system was immediately reviewed and revised and nursing management re-educated to assure proper use in compliance with all regulations. Licensed nurses received re-education regarding the proper process to document administration of narcotics on the declining inventory sheet and on the resident MAR. The consultant pharmacist will review the DEA 222 forms for proper completion during monthly visits for three months. Findings will be discussed with the Director of Nursing and Administrator. The consultant pharmacist will report findings in aggregate at the quarterly QAPI committee meeting for further action as appropriate. The Unit Manager will audit 5 declining inventory sheets and MARs during med pass weekly for four weeks then monthly for two months to ensure nurses are properly documenting administration of narcotics per facility policy. Findings are reported monthly to the Director of Nursing and quarterly to the QAPI committee for further action as needed.	

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F 755	Continued From page 27 pre-sign the DEA 222 forms. He had only recently learned from another facility that he should not pre-sign. The [U.S. FOIA] could not recall when he had signed the identified forms, but it was definitely not within the last six months. The [U.S. FOIA] further stated he was not sure why he should not have pre-signed; he could only guess it was because the forms could be misdirected or misused. On 1/11/23 at 10:29 AM, the [U.S. FOIA (b)(6)] in the presence of the [U.S. FOIA (b)(6)], and survey team confirmed the MD should not have pre-signed the DEA 222 forms. A review of the Instructions for DEA Form 222, under Part 1. Purchaser Information, 6. The order form must be signed and dated by the purchaser on the day it is submitted for filling. 2. On 1/6/23 at 9:43 AM, the surveyor reviewed the facility provided DEA 222 forms. There were no forms completed for 2022. There was only a packing slip from the Provider Pharmacy and an inventory receipt from the facility's automated medication dispensing system. On 1/6/23 at 10:57 AM, the surveyor requested from the [U.S. FOIA (b)(6)] any completed DEA 222 forms for 2022. The [U.S. FOIA (b)] stated her automated medication dispensing system was in bad shape and she did not request any controlled substances all year. The [U.S. FOIA (b)] stated she did not have or keep a copy of the DEA 222 forms submitted to the Provider Pharmacy for filling. The [NJ Exec Order] stated she would contact the Provider	F 755		

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F 755	Continued From page 28	F 755		

Pharmacy for a copy of the form. The [U.S. FOIA (b)] acknowledged that since she did not have a copy of the submitted DEA 222 form, she was unable to complete the form as directed once the controlled medications were received.

On 1/11/23 at 10:29 AM, the U.S. FOIA (b)(6) in the presence of the U.S. FOIA (b)(6), and survey team confirmed the facility was not completing and maintaining the DEA 222 forms in accordance with the form's instructions.

3. On 1/6/23 at 12:40 PM, the surveyor in the presence of the NJ Exec Order 26.4b1) inspected the U.S. FOIA (b)(6) nursing unit Cart-A medication cart. A review of the narcotics located in the secured and locked narcotic box and reconciled to the declining inventory sheet revealed Resident #52's NJ Exec Order 26.4b1 a medication used for [NJ Exec Order 26.4] did not match. The blister pack contained [NJ Exe] tablets and the declining inventory sheet indicated there should be [NJ Exe] tablets remaining. Upon further cart inspection, it was revealed that Resident #61's NJ Exec Order 26.4b1 tablets also did not match. The blister pack contained [NJ] tablet and the declining inventory sheet indicated there should be [NJ Ex] tablets remaining. The [U.S. FOIA] stated he had just administered the medications and he had forgotten to sign the declining inventory sheet for the doses he had administered. He further stated he should have recorded on the declining inventory sheet as well as the medication administration record (MAR) after he had administered the medication.

On 1/6/23 at 2:04 PM, the surveyor interviewed the [U.S. FOIA (b)] in the presence of the survey team. The

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F 755	Continued From page 29 U.S. FOIA (b) stated when administering a controlled medication, you would first check the medication matches the medication order, then punch out the medication from the blister pack, once the medication was administered you would come back and sign the declining inventory sheet and the MAR. The U.S. FOIA (b) acknowledged the purpose of the declining inventory sheet was for each shift to reconcile and ensure there was accountability for the inventory of the controlled medication. At that time, the surveyor reviewed with the U.S. FOIA (b) the facility provided "Medication Administration" policy dated last approved 3/22, which included...P. When a controlled medication is administered, the declining inventory form is signed by the nurse at the time the medication is removed from the container. The MAR is signed after the resident takes the medication... The US FOIA (b) acknowledged she must have "misspoken" and that the nurse should always be following the medication administration policy. On 1/11/23 at 10:29 AM, the U.S. FOIA (b)(6) in the presence of the U.S. FOIA (b)(6), and survey team confirmed the declining inventory was signed at the time the medication was removed from inventory.	F 755		
F 801 SS=F	NJAC 8:39- 29.2(d), 29.7 Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments,	F 801		2/28/23

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F 801	Continued From page 30 individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other	F 801		

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F 801	Continued From page 31 clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to employee staff with the appropriate competencies and skills sets to carry	F 801	The facility has hired a food service U.S. FOIA (b)(6)) with proper certification in compliance with regulations. The Registered Dietitian (RD) conducts a	

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F 801	Continued From page 32 out the functions of the food and nutrition service in the role of the [NJ Exec Order 26.4b1]) in the absence of a full-time [U.S. FOIA (b)(6)]. This deficient practice would affect all residents and was evidenced by the following: On 1/3/23 at 9:24 AM, the surveyor entered the kitchen and asked to tour with the [U.S. FOIA]. The [U.S. FOIA (b)(6)]) stated he was "temporarily filling in for the [U.S. FOIA] who has been out on leave since May." The [U.S. FOIA] stated he had no certifications in dietary management, food service management and safety or have a degree in food service management. The [U.S. FOIA] stated he was employed at the facility for [NJ Exec Order 26.4b1] and was just helping while the [U.S. FOIA] was out. The [U.S. FOIA] stated that a sister facility's [U.S. FOIA] could help out and was certified. The surveyor asked if any of the other employees in the kitchen had food safety certification, and the [U.S. FOIA] stated no. The surveyor requested copies of food safety certifications from kitchen staff. On 1/6/23 at 12:01 PM, the surveyor interviewed the [NJ Exec Order 26.4b1] who confirmed that the kitchen had no management and no one in the kitchen was certified in food safety or dietary management. The [U.S. FOIA (b)(6)] stated the previous [U.S. FOIA] was out of the facility on leave and for legal reasons, he was unable to hire a new [U.S. FOIA]. The [U.S. FOIA (b)(6)] acknowledged the facility could have provided the [US FOIA] with food safety management training. On 1/6/23 at 1:53 PM, the [U.S. FOIA (b)(6)] informed the surveyor that the [U.S. FOIA (b)(6)] would now be overseeing the kitchen who is certified in food service management and safety.	F 801	kitchen inspection with the food service director a minimum of monthly to ensure compliance with sanitary codes and provides staff education as appropriate. All Residents have the potential to be affected by this practice. Kitchen sanitation and safe food handling education has been provided as appropriate to dietary staff by the Registered Dietician and food service director to ensure compliance with kitchen sanitation and safe food handling practices. The facility food service director will conduct weekly sanitation and food handling inspections in the kitchen for four weeks then monthly for two months. Findings will be reported to the Administrator monthly and in aggregate quarterly to the QAPI committee by the food service director for action as appropriate. The Registered Dietician will conduct monthly inspections with the food service director on an ongoing basis to ensure compliance with kitchen sanitation codes and safe food handling. Inspection findings will be discussed and acted upon and serve as the basis for staff education as appropriate.	

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F 801	Continued From page 33 On 1/9/23 at 10:41 AM, the U.S. FOIA (b)(6) informed the surveyor that the previous U.S. FOIA (b)(6) last day of work was NJ Exec Order 26.4b On 1/10/23 at 12:48 PM, the surveyor interviewed the U.S. FOIA (b)(6)) via telephone who stated she was a part-time US FOIA (b)(6) at the facility and was contracted for twenty-four hours a week. The U.S. FOIA stated that besides clinical assessments for the residents, the U.S. FO provided education to the kitchen staff including ensuring meal tray accuracy and gluten-free diets. On 1/10/23 at 2:53 PM, the in the presence of the U.S. FOIA (b)(6) , and survey team confirmed that the U.S. FO was a part-time employee. The U.S. FOIA (b)(6) stated the U.S. FOIA on occasion would attend their morning meetings, but the U.S. FO did not attend morning meetings. The U.S. FOIA (b)(6) confirmed that all department heads attended the morning meetings, which did include the previous U.S. FOIA , but not the NJ Exec who was acting as the U.S. FOIA since U.S. FOIA (b)(6). On 1/11/23 at 8:54 AM, the U.S. FOIA (b)(6) confirmed the facility only had one U.S. FOIA (b)(6) and the U.S. FO was contracted part-time. At this time the surveyor requested a copy of the U.S. FOIA (b) contract, U.S. FOIA (b) resume, the NJ Exec 's resume or job application, and the job responsibilities for the U.S. FOIA (b)(6). On 1/11/23 at 11:48 AM, the U.S. FOIA (b)(6) informed the survey team that the U.S. FOIA was hired at the facility in U.S. FOIA (b) , and she did not have his application, nor did he have a resume. A review of the U.S. FOIA (b) contract dated NJ Exec Order 26.4b1 indicated the U.S. FO was hired as NJ Exec Order 26.4b1 for	F 801		

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F 801	Continued From page 34 U.S. FOIA (b)(6) hours a week. A review of the facility's "Job Description" Director of Dietary dated revised 10/1/21, included Knowledge, Education and Skills Required: Knowledge of food safety, sanitation, regulatory compliance, and guidelines governing dietary services in long-term care facility...Prior supervisory experience, preferably in long term care setting. Knowledge, Education and Skills Preferred: Bachelor's degree; Preferred Certification/Licensing: 1. Serv Safe Certification; 2. CDM (Certified Dietary Manager) or RD (Registered Dietitian) from an accredited entity. If neither is currently active, the Director must enroll in a program within six months of obtaining the position and pass the exam within six months of course completion. Refer F806 and F812 NJAC 8:39-17.1(a); 17.2(g)	F 801		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §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, and review of	F 806	The nutritional needs and meal tickets of	2/28/23

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F 806	Continued From page 35 pertinent facility documents, it was determined that the facility failed to follow a physician's order for no cheese by ensuring a resident did not receive cheese tortellini which was listed on their meal ticket preference as no cheese. This deficient practice was identified for 1 of 2 residents (Resident #23) reviewed for food choices, and was evidenced by the following: On 1/3/23 at 11:22 AM, the surveyor observed Resident #23 awake lying in bed. The resident informed the surveyor he/she was NJ Exec Order 26.4b with the kitchen because they sent inappropriate foods to them. The resident continued they had a recent diagnosis of NJ Exec Order 26.4b1 and was supposed to receive NJ Exec Order 26.4b1. The resident stated the facility sent them dishes with cheese last week which included chicken cordon blue and pizza. The resident stated he/she informed the kitchen and as an alternative was given a burger with no bun because the kitchen did not have any buns. The resident stated his/her meal ticket also indicated no corned beef and he/she received corned beef. The resident stated that they felt the kitchen was "missing management." The surveyor reviewed the medical record for Resident #23. A review of the Resident Face Sheet (an admission summary) reflected the resident was re-admitted to the facility in NJ Exec Order 26.4b1 with diagnoses which included U.S. FOIA (b)(6) [redacted] A review of the most recent quarterly Minimum	F 806	Resident #23 were immediately re-evaluated and clearly marked to designate food preferences and dietary restrictions and allergies as appropriate. The U.S. FOIA (b)(6) [redacted] will meet with Resident #23 periodically to ensure his food preferences are met. U.S. FOIA (b)(6) staff were re-educated by the U.S. FOIA (b)(6) [redacted]) about reading the meal ticket for all residents at each meal to ensure resident food preferences and allergies are properly noted. All Residents have the potential to be affected by this practice. The Registered Dietician reviewed the charts of residents with food allergies and food intolerances to assure this information is properly noted on the kitchen tray line meal tickets. Nursing staff were re-educated about checking meal tickets when passing trays to ensure the meals are consistent with food intolerances and allergies. Weekly for four weeks and then monthly thereafter the Registered Dietician or designee will review 5 meal tickets of Residents to ensure tray accuracy. Audit findings will be provided by the Registered Dietician designee to the Administrator and Director of Nursing and will be discussed at the quarterly QAPI committee meeting.	

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F 806	Continued From page 36 Data Set (MDS), an assessment tool dated [redacted], reflected the resident had a brief interview for mental status (BIMS) score of a [redacted] which indicated a fully [redacted]. A review of the [redacted] Physician's Order Sheet reflected a physician's order (PO) dated [redacted] A review of Weekly Menu Cycle 3 menu for [redacted], reflected on [redacted], lunch was a [redacted]. On 1/5/23 at 12:47 PM, the surveyor observed Resident #23 receive their lunch tray. The surveyor observed on the tray [redacted] with [redacted]. The resident informed the surveyor he/she should not have the [redacted] because it had [redacted] in it. At this time, the surveyor observed the resident's meal ticket which indicated [redacted]. On 1/5/23 at 12:49 PM, the surveyor accompanied by the [redacted]) went into Resident #23's room and observed their meal tray. The [redacted] stated the [redacted] should have [redacted] in it and the resident should not be receiving cheese. The [redacted] asked the resident if they completed a menu request and they responded no. The [redacted] stated sometimes the resident ordered foods that contained [redacted] and the nurse administered them [redacted] medication. The resident confirmed they did not request [redacted] for lunch. The resident also informed the [redacted] that last Friday they received [redacted] and informed the kitchen. The [redacted] stated after the resident's recent	F 806		

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F 806	Continued From page 37	F 806		

hospitalization, they came back to the facility self-reporting they were NJ Exec Order 26.4b1 and would take NJ Exec Order 26 medication if he/she wanted NJ Exec Order 26.4b The U.S. FOIA (b)(6) acknowledged the resident should not receive any foods with NJ Exec Order 26 unless they requested it.

On 1/5/23 at 12:57 PM, the surveyor interviewed the Dietary Aide (DA #1) who was acting as the facility's U.S. FOIA (b)(6) while their U.S. FOIA was out on leave. The surveyor asked DA#1 what the NJ Exec Order 26.4 was filled with? DA #1 asked the Cook who stated the NJ Exec Order 26.4b1 filled. DA #1 explained the food service tray line had three people to serve the food; the US FOIA (b)(6) plated and the last person on the line (DA #2) checked the meal ticket to ensure it matched the meal tray. At this time, DA #2 confirmed she checked the meal tickets and if a resident could not have a food, she let the US FOIA (b)(6) know. The surveyor reviewed Resident #23's meal ticket with DA #1 and DA #2 which indicated NJ Exec Order 26.4b1. When asked why the resident received NJ Exec Order 26 today, DA #2 stated maybe the NJ Exec Order 26.4b The US FOIA (b)(6) again confirmed the NJ Exec Order 26.4b1 contained NJ Exec Order 26.4b DA #1 and the US FOIA (b)(6) confirmed the resident should not have received NJ Exec Order 26.4b

On 1/5/23 at 1:36 PM, the surveyor observed the resident who confirmed they received an egg salad sandwich on whole wheat bread.

On 1/5/23 at 1:42 PM, the U.S. FOIA (b)(6) confirmed the NJ Exec Order 26.2 was tri-colored; beige, green, and red. The U.S. FOIA (b)(6) stated the nurse did check meal tickets with meal trays to ensure accuracy, but sometimes the resident requested NJ Exec Order 26 and it

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F 806	Continued From page 38 was their choice. On 1/10/23 at 12:48 PM, the surveyor interviewed the NJ Exec Order 26.4b1) via telephone who stated that she worked at the facility part-time twenty-four hours a week. The U.S. FOIA stated that she audited the diet orders in the kitchen to ensure they were correct and had in-serviced the kitchen staff on tray accuracy. When asked if the kitchen had an issue with tray accuracy, the U.S. FOIA responded that the kitchen staff "are human but do try." The surveyor informed the U.S. FOIA Resident #23 received U.S. FOIA (b)(6) for lunch on NJ Exec Order 26.4 and the U.S. FOIA responded that was something she would need to address with the kitchen. The U.S. FOIA stated Resident #23 did not have a NJ Exec Order 26.4b1; the resident had NJ Exec Order 26.4b1 and could request NJ Exec Order 2 medication if they wanted NJ Exec Orde products. The U.S. FOIA acknowledged unless the resident requested , the kitchen should not serve the resident NJ Exec Orde products. On 1/11/23 at 10:29 AM, the U.S. FOIA (b)(6) in the presence of the U.S. FOIA (b)(6)), and survey team acknowledged Resident #23 should not have been served NJ Exec Order 26.4b1. A review of the facility's "Tray Identification" policy dated 9/13/19, included...to assist in setting up and serving the correct food trays/diets to residents, the Food Service Department will use appropriate identification (e.g. color coded or computer generated diet cards) to identify the various diets. The Food Services Manager or supervisor will check trays for correct diets before the food carts are transported to their designated areas. Nursing staff shall check each food tray	F 806		

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F 806	Continued From page 39 for correct diet before serving the residents...	F 806		
F 812 SS=F	NJAC 8:39-17.4(a)(1) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) ensure the dish machine in use maintained the appropriate temperature according to the manufacturer's specifications; b.) maintain multiuse food-contact surface cutting board in a manner to prevent microbial growth; c.) store, label, and date potentially hazardous foods to prevent food-borne illness; d.) discard potentially hazardous foods past their date of expiration; and e.) maintain	F 812	The following items in the walk-in refrigerator were immediately discarded: o The outdated coleslaw o The Italian dressing o The turkey breast and o The tilapia The vinyl strip curtains on the entrance to the walk-in freezer were ordered to be replaced. All the cutting boards on the storage rack were replaced and the pitted boards	2/28/23

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F 812	Continued From page 40 storage areas in a sanitary manner. This deficient practice was evidenced by the following: On 1/3/23 at 9:24 AM, the surveyor entered the kitchen and asked to tour with the U.S. FOIA (b)(6) [redacted]. The U.S. FOIA (b)(6) stated he was "temporarily filling in for the [redacted] who has been out on leave since [redacted]. The [redacted] stated he had no certifications in food service management and safety, dietary management, or have a degree in food service management. The [redacted] stated he was employed at the facility for many [redacted] and was just helping while the [redacted] was out. The [redacted] stated that a sister facility's [redacted] could help out who was certified. The surveyor asked if any of the other employees in the kitchen had food safety certification, and the [redacted] stated no. At this time, the surveyor and the [redacted] toured the kitchen and observed the following: 1. In the walk-in refrigerator, one 3.18 kilogram (kg) carton of coleslaw with a use by date of 12/23/22. 2. In the walk-in refrigerator, a one-gallon opened container of fat free Italian dressing. The container was not labeled when opened and had a labeled use by date of 12/15/22. 3. In the walk-in refrigerator, one opened box of mesquite turkey breast which contained one unopened three-pound turkey breast. The box indicated use or freeze by date of 1/2/23. 4. In the walk-in refrigerator, one opened box that contained one package of breaded tilapia. The box indicated to keep frozen. The [redacted] confirmed	F 812	discarded. The lemon juice on the shelf by the prep area was discarded. The floor in the dry storage room was immediately cleaned. The dish washing machine was repaired and converted to a low temperature rinse cycle with use of chemicals. Dietary staff were re-educated about how to monitor and log dish washer temps and if outside the required range to report immediately to the food service director. All Residents have the potential to be affected by this practice. Dietary staff received re-education regarding kitchen sanitation, safe food handling and storage and labeling and dating of food. The process for monitoring and documenting temperatures of the dish washer were reviewed with dietary staff and instructions posted by the dishwasher for easy reference. The food service director will monitor the dish washer temperature log daily for four weeks, then weekly for one month, and then monthly on an ongoing basis to ensure proper functioning. Findings will be discussed with the Administrator monthly and presented in aggregate at the quarterly QAPI committee meeting by the food service director. Monthly the Registered Dietitian (RD) will inspect the kitchen and food storage areas with the food service director to ensure all sanitation, foods storage and labeling, and the dish washer temperatures meet regulations and standards of practice. Findings will be	

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F 812	Continued From page 41 the breaded tilapia was thawed. There was no indication of when the breaded tilapia was pulled from the freezer or when to use by. 5. In the walk-in freezer, the vinyl strip curtains located in the entrance to the freezer were all missing except three strip curtains on the outer sides of the doorway. These curtains protect the inside of the freezer from outside dust particles as well as keep the cold air from escaping the freezer when the door was opened. 6. On a storage rack, the surveyor observed two small white, two large tan, two large red, two light blue, one large green, one large yellow, and one large white cutting boards. The cutting boards were all deeply pitted and discolored. The [redacted] stated the cutting boards were changed a couple of months ago and should be changed when discolored. The [redacted] acknowledged the pitting and discoloration could lead to bacterial growth and the cutting boards should not be in use. 7. On a shelf by the kitchen preparation area, one opened container of lemon juice. The lemon juice packaging indicated to refrigerate when opened. 8. In the Dietary Dry Storage Room, a large brown dried spillage on the floor. The [redacted] stated someone must have spilled the prune juice that was opened and did not clean-up. On 1/6/23 at 12:01 PM, the surveyor addressed the above concerns with the U.S. FOIA (b)(6) [redacted]) who acknowledged he was aware. The [redacted] confirmed the kitchen had no management; that no one was certified in food safety management. The [redacted] stated the	F 812	presented by the Registered Dietician to the Administrator monthly and quarterly at the QAPI committee meeting.	

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F 812	Continued From page 42 U.S. FOIA was out on leave, and the U.S. FOIA was acting in his place because the U.S. FOIA (b)(6) was unable to hire a new U.S. FOIA for legal reasons. On 1/6/23 at 1:53 PM, the U.S. FOIA (b)(6) informed the surveyor that a U.S. FOIA (b)(6) would now be overseeing the kitchen who was certified in food safety management. On 1/9/23 at 10:41 AM, the surveyor requested the U.S. FOIA (b)(6) to provide the survey team with all in-service education the kitchen staff had received for the past year. On 1/10/23 at 10:10 AM, the surveyor did a follow-up kitchen inspection to inspect the facility's dish machine. The surveyor observed the U.S. FOIA pushing a drying rack that contained 79 food insulator tops that had visible water beads. The dish machine was turned on, but was not observed in use. The U.S. FOIA (b)(6) stated that the dish machine was a high temperature dish machine meaning the wash temperature needed to be 150 degrees Fahrenheit (F) or higher and the final rinse temperature had to be 180 F or higher to sanitize. The NJ Exec Order 26.4b1 ran several empty dish racks through the machine, and the final rinse temperature did not reach higher than 150 F. At this time, the surveyor reviewed the "Dish Machine Temperature Record" for January 2023 which was not completed for that day's breakfast shift. On 1/10/23 at 10:15 AM, the surveyor interviewed the US FOIA (b)(6) who informed them that they were assigned to wash the morning dishes. The US FOIA (b)(6) stated the temperature log was not completed for	F 812		

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REDBANK CENTER FOR REHABILITATION AND HEALING	**100 CHAPIN AVENUE RED BANK, NJ 07701**

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F 812	Continued From page 43 that morning because the facility had not yet washed dishes. The surveyor questioned the observed insulator tops with the water beads, and the [NJ Exec Ord] confirmed they were just washed, but could not speak to why the log was not completed prior to washing the insulator tops. The [US FOIA (b)(6)] stated that the final rinse temperature varied, that it reached 180 F but did not stay there consistently. The [US FOIA (b)(6)] began running empty dish racks and the surveyor observed with one rack, the final rinse reached 180 F. The next tray sent through the machine; the final rinse reached 150 F. The [US FOIA (b)(6)] continued to run empty racks through the dish machine, but the final rinse temperature did not reach 180 F. On 1/10/23 at 10:20 AM, the U.S. FOIA (b)(6) stated the facility did not have heat test strips to determine if the dish machine temperature was hot enough. The U.S. FOIA (b)(6) stated he would test the final rinse temperature by collecting a sample of the water in the machine at the end. The U.S. FOIA (b)(6) calibrated a digital thermometer to 32.9 F using an ice bath method. On 1/10/23 at 10:23 AM, the U.S. FOIA (b)(6) sent a food insulator top in the dish machine to collect the dish water. The surveyor observed the final rinse temperature on the gauge was 154 F and the U.S. FOIA (b)(6) measured the temperature of the water collected in the insulator lid which was 155 F. The U.S. FOIA (b)(6) sent an empty mug through the dish machine to collect the dish water during the final rinse. The surveyor observed the final rinse temperature gauge was 162 F and the U.S. FOIA (b)(6) measured the temperature of the water collected in the mug was 161 F. The U.S. FOIA (b)(6) confirmed the temperature gauge for the final rinse was accurate. The [U.S. FOIA (b)(6)]	F 812		

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F 812	Continued From page 44 U.S. FOIA stated the dish machine could not be used until the Dish Machine Repair Company [name redacted] came to fix the machine. The Regional U.S. FOIA acknowledged the insulator tops were washed that morning and had to be rewashed and sanitized by hand. A review of the "Dish Machine Temperature Record" for January 2023, revealed that the final rinse temperature was below 180 F on 1/3/23 breakfast; 1/6/23 breakfast, lunch, and dinner; 1/7/23 breakfast, lunch, and dinner; 1/8/23 breakfast and lunch; and 1/9/23 lunch. On 1/10/23 at 11:33 AM, the U.S. FOIA (b)(6) informed the surveyor the U.S. FOIA (b)(6) Employee [name redacted] was at the facility and left; they were going to convert the dish machine to a low temperature dish machine that sanitized with a chemical solution. At this time, the surveyor reviewed the "Dish Machine Temperature Record" for January 2023 with the U.S. FOIA (b)(6) which revealed that for ten shifts for the month the dish machine's final rinse temperature was not 180 F. The U.S. FOIA (b)(6) confirmed the machine should not have been used if the final rinse was not at 180 F; staff should have washed dishes by hand. On 1/10/23 at 11:39 AM, the surveyor interviewed the U.S. FO who stated last week the dish machine was not maintaining temperature, so he called the NJ Exec Order 26.4b1 [name redacted] who serviced the machine. The U.S. FO was unsure what day the NJ Exec Order 26.4b1 [name redacted] was there, but confirmed the kitchen used the dish machine all last week. On 1/10/23 at 12:38 PM, the surveyor interviewed	F 812		

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F 812	Continued From page 45 the NJ Exec Order 26.4b1 [name redacted] who stated he was at the facility last Tuesday (1/4/23) to service the dish machine since the dish temperature was not reaching 180 F. The NJ Exec Order 26.4b1 [name redacted] stated there was an issue with the dish machine's booster system which increased the water temperature for the final rinse. He continued that he had to order a part for the machine so in the meantime, he increased the water temperature to 185 F and the temperature was maintaining when he left. The NJ Exec Order 26.4b1 stated since the final rinse temperature was not reaching 180 F, he was converting the dish machine to a low temperature machine which he had to set the water temperature lower since sanitizing was done with a chemical solution. The NJ Exec Order 26.4b1 confirmed the facility should not have used the dish machine if the final temperature was not 180 F because that was the temperature needed to kill and sanitize and the facility should have called them. On 1/10/23 at 12:42 PM, the surveyor re-interviewed the U.S. FOI regarding the dish machine being used when the temperature for the final rinse was below 180 F. The U.S. FOI stated it was not brought to his attention the dish machine was below 180 F or he would have called the NJ Exec Old to come back to the facility. The U.S. FOI stated the kitchen did receive in-service education from the U.S. FOIA (b)(6) A review of the facility provided in-services for kitchen staff did not include in-service education	F 812		

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F 812	Continued From page 46 on high temperature dish machine usage. On 1/10/23 at 2:53 PM, the U.S. FOIA (b)(6) in the presence of the U.S. FOIA (b)(6), informed the survey team that he had been at the facility for eight weeks now. The U.S. FOIA (b)(6) stated he was aware there was no food service management, and he expected the kitchen to bring any concerns to his attention. The U.S. FOIA (b)(6) stated he does rounds of the kitchen and was aware of the missing strip curtains in the walk-in freezer, but since the facility did not have a vendor, the Corporate company would not allow the U.S. FOIA (b)(6) to order. The [redacted] stated he was unaware the dish machine was not working properly and would have expected the kitchen staff to let him know. The NJ Exec Order stated the kitchen staff should be aware to bring all issues to his attention, and acknowledged all the above findings. A review of the NJ Exec Order 26.4b1 [name redacted] service report dated NJ Exec Order 2[redacted], revealed that the repair company was at the facility on NJ Exec Order 2[redacted] for a service call that the dish machine rinse temperature was low. The company turned the machine's booster heater temperature up and the temperature reached 184 F. Resolved. A review of the facility's "HMNR Dishwashing" policy dated effective 12/22, included...turn on dish-washing machine and check wash and rinse temperatures. Wash temperature must be 160 F or higher. Rinse temperature must be 180 F or higher; all temperatures must be documented on the Dish-machine Temperature Log; If temperatures are not in proper range corrective actions must be taken and documented. Dish-washing machine will only be used if	F 812		

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F 812	Continued From page 47 machine is running at proper temperatures... A review of the facility's "HMNR Refrigerated Storage" policy dated effective 10/21, included all items in the refrigerator must be labeled properly. They must follow the Food Labeling Policy... A review of the facility's undated "Food Labeling" policy included all food must be labeled properly upon delivery and after preparation. If food is not properly labeled it will be discarded...any items that are not labeled correctly must be discarded; any items that have past the date and time of expiration must be discarded.	F 812		
F 814 SS=E	NJAC 8:39-17.2(g) Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to properly dispose and maintain waste in garbage dumpster areas. This deficient practice was identified for 5 of 6 garbage dumpsters in 1 of 2 garbage disposal areas and was evidenced by the following: On 1/4/23 at 8:15 AM, the surveyor observed the garbage dumpster area which contained five garbage dumpsters. Out of the five garbage dumpsters, one of the garbage dumpster's lids was opened exposing its contents. The surveyor observed high levels of debris surrounding all five	F 814	The debris by all the garbage dumpsters was immediately cleaned and the dumpster lids properly closed. Dietary and housekeeping staff were re-educated about keeping lids closed after placing trash in a dumpster and always maintaining the area around dumpster clean and free of debris. All Residents have the potential to be affected by this practice. A daily cleaning schedule was implemented to ensure daily inspection and cleaning of the areas around the five dumpsters. Dietary and housekeeping	2/28/23

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F 814	Continued From page 48 garbage dumpsters on all four sides. The debris included but was not limited to disposable gloves, boxes, paper, bottles, and other debris. On 1/5/23 at 8:11 AM, the surveyor observed the garbage dumpster area which contained five garbage dumpsters. Out of the five garbage dumpsters, one of the garbage dumpster's lids was opened exposing its contents. The surveyor observed high levels of debris surrounding all five garbage dumpsters on all four sides. The debris included but was not limited to disposable gloves, boxes, paper, bottles, and other debris. On 1/6/23 at 7:51 AM, the surveyor observed the garbage dumpster area which contained five garbage dumpsters. Out of the five garbage dumpsters, one of the garbage dumpster's lids was opened exposing its contents. The surveyor observed high levels of debris surrounding all five garbage dumpsters on all four sides. The debris included but was not limited to disposable gloves, boxes, paper, bottles, and other debris. On 1/6/23 at 11:15 AM, the surveyor accompanied by the U.S. FOIA (b)(6)) who was acting as the U.S. FOIA (b)(6) for the U.S. FOIA who was out on leave observed the dumpster garbage area which contained five garbage dumpsters. They observed one of the five garbage dumpster's lid was opened and the U.S. FOIA confirmed the lids should be closed at all times unless disposing of garbage. They also observed surrounding all five garbage dumpsters on all four sides high levels of debris including bags containing garbage, coffee cup lids, coffee cups, water bottles, used gloves, plastic bags, milk containers, cups, boxes, and paper. The U.S. FOIA acknowledged the debris around the garbage	F 814	staff received re-education abut the cleaning schedule and assigned responsibilities. The Housekeeping Director or designee will monitor the dumpster area daily for the next four weeks then weekly thereafter to ensure the area is free of debris and all dumpster lids kept closed. Audit findings will be discussed with the food service director and Administrator and provided in aggregate quarterly at the QAPI committee meeting.	

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F 814	Continued From page 49 dumpsters was unacceptable. The [U.S. FC] stated that these dumpsters were used by both dietary and housekeeping staff, and both departments were responsible for maintaining the area. The [U.S. FC] stated there was no formal cleaning schedule for the area, and staff were expected to clean the area when they were disposing of garbage. On 1/6/23 at 11:19 AM, the survey interviewed the [U.S. FOIA (b)(6)]) who stated that housekeeping staff utilized the garbage compactor in a second garbage area to dispose of their waste. The [U.S. FOIA (b)] stated that the dumpster area containing five garbage dumpsters were utilized by the dietary staff who were expected to maintain the area. At this time, the [U.S. FOIA (b)] accompanied the surveyor to the garbage dumpster area and observed the condition of the area. The [U.S. FOIA (b)] confirmed that the garbage dumpster area should be maintained free of waste and the conditions were not acceptable (unsanitary) and could promote pests and needed to be cleaned immediately. On 1/6/23 at 12:01 PM, the [U.S. FOIA (b)(6)] provided the surveyor with the facility's "Food-Related Garbage and Refuse Disposal" policy. The [U.S. FOIA (b)(6)] stated he was aware of the conditions of the garbage dumpster area and acknowledged it was not acceptable. A review of the facility's "food-Related Garbage and Refuse Disposal" policy dated revised October 2017, included all food waste shall be kept in containers; all garbage and refuse containers are provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use...garbage and refuse	F 814		

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F 814	Continued From page 50 containing food wastes will be stored in a manner that is inaccessible to pests; storage areas will be kept clean at all times, and shall not constitute a nuisance; outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter. NJAC 8:39-19.3(a); 19.7(a)(b)	F 814		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		2/28/23

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F 880	Continued From page 51 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct 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, and review of	F 880	The [US FOIA (b)] who provided the [NJ Exec Order 26]	

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F 880	Continued From page 52 pertinent facility documents, it was determined that the facility failed to maintain infection control standards of practice and procedures to prevent the risk of infection and promote healing. This deficient practice was identified for 1 of 1 residents (Resident #33) observed during NJ Exec Order 2 treatments and was evidenced by the following: On 1/4/23 at 10:14 AM, the surveyor observed Resident #33 in bed with his/her eyes open. The resident did not respond to the surveyor. The surveyor reviewed the medical record for Resident #33. A review of the Resident Face Sheet (an admission summary) reflected that the resident was admitted to the facility in NJ Exec Order 26.4b1 with diagnoses that included NJ Exec Order 26.4b1 [redacted] A review of the annual Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4, reflected the resident had a brief interview for mental status (BIMS) score of NJ Exec Order 26.4b1, which indicated a NJ Exec Order 26.4b1. The MDS further indicated that Resident #33 was admitted with a NJ Exec Order 26.4b1 [redacted]. A review of the Advance Practice Nurse's NJ Exec Order 26.4 Assessment Progress Note dated NJ Exec Order 2, reflected an NJ Exec Order 26.4b1 [redacted] was present which per the unit	F 880	treatment to Resident #33 was immediately corrected and re-educated and a wound competency completed with a return demonstration. Resident #33□s NJ Exec Order 26.4 bed was immediately recleaned and properly dressed per the physician order. All Residents who require wound care have the potential to be affected by this practice. Nursing staff received re-education regarding the proper cleansing of a wound. A wound competency evaluation with a return demonstration is completed on hire and annually for licensed nurses with documentation included in their education file. The required 3 modules are being completed. The staff educator is conducting audits of 3 nurses wound care weekly for four weeks and monthly for two months to ensure licensed nurses followed proper protocol when doing wound care. Audit results were discussed with the Director of Nursing and Administrator and provided in aggregate to the QAPI committee for further action as appropriate.	

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F 880	Continued From page 53 manager has been present for years. [redacted] NJ Exec Order 26.4b1 [redacted]; was seen by a surgeon and the area will remain chronic for the patient. He/she had a functioning NJ Ex Order 26.4b1 to the area. Will use NJ Exec Order 26.4b1 to keep the area [redacted] and [redacted] Plan: clean the area with NJ Exec Order 26.4b1 [redacted] apply a NJ Exec Order 26.4b1 daily/change prn (as needed). A review of the NJ Exec Order 26.4b1 Physician Order Summary which was transcribed onto the Treatment Administration Record (TAR) included a physician's order dated [redacted], to cleanse the [redacted] with [redacted] and apply a NJ Exec Order 26.4b1 once a day for [redacted] care. On 1/4/23 at 10:33 AM, the surveyor observed the US FOIA (b)(6) perform a treatment to Resident #33's [redacted]. The surveyor observed the following: The [redacted] disinfected the over-bed table (OBT) with sanitizing wipes and then applied a clean barrier. The [redacted] then assembled the needed supplies from the treatment cart and placed them on the OBT in the resident's room. Among the supplies were a bottle of [redacted] a NJ Exec Order 26.4b1, [redacted] sponges, and a marker. The LPN provided the treatment for Resident #33's [redacted]. During the treatment, the [redacted] removed the NJ Exec Order 26.4b1, washed his hands using soap and water, donned a new pair of gloves, moistened the [redacted] with [redacted] and told the surveyor, " I will clean from the inside of	F 880		

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F 880	Continued From page 54	F 880		

the [NJ Exec Order 2] to the outside." The [NJ Exec O] cleaned the center of the [NJ Exec Order 2] to the outer edges using a circular motion. The [NJ Exec O] and surveyor observed a NJ Exec Order 26.4b1 on the [NJ Exec Order 26.4b1] The [NJ Exec O] discarded the [NJ Exec Order 2] moistened a new [NJ Exec Order 26.4b1] with [NJ Exec Or], cleansed the [NJ Exec Order 26.4b1] (NJ Exec Order 26.4b1) in a circular motion, and discarded the [NJ Exec Order 2] The [U.S. FOIA] used a NJ Exec Order 26.4b1 with [NJ Exec O] to cleanse the [NJ Exec Order 26.4b1] again and then with the same NJ Exec Order 26.4b1 cleansed the center of the [NJ Exec Order 2] The [U.S. FOIA] used this technique two times, each time NJ Exec Order 26.4b1 . At that time, the surveyor asked the [U.S. FOIA] to stop the treatment so they could step away and talk privately. The [NJ Exec O] acknowledged he had contaminated the [NJ Exec Order 2] by using the same [NJ Exec Order 2] he used to cleanse the [NJ Exec Order 26.4b1]. He stated he needed to clean the [NJ Exec Order 2] using appropriate infection control techniques. The [U.S. FOIA (b)] proceeded to wash his hands with soap and water, donned gloves, and cleaned the [NJ Exec Order 2] using acceptable technique. The [NJ Exec O] applied the NJ Exec Order 26.4b1 to the [NJ Exec Order 2] and then dated and initialed the [NJ Exec Order 26.4b] on the resident.

On 1/4/23 at 11:00 AM, the surveyor discussed the breaks in technique with the [U.S. FOIA (b)]. The [NJ Exec Or] acknowledged that he had contaminated the [NJ Exec Order 2] by cleaning around the [NJ Exec Order 2] and then using the same [NJ Exec Order 2] to clean the [NJ Exec Order 2]. The [NJ Exec O] further stated that he should have initialed and dated the NJ Exec Order 26.4b1 prior to its application to the resident.

On 1/11/23 at 10:05 AM, the surveyor met with the NJ Exec Order 26.4b1 and discussed the concerns observed during the [NJ Exec Order 26] treatment. The NJ Exec Order 26.4b1

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	315286	A. BUILDING _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDBANK CENTER FOR REHABILITATION AND HEALING	100 CHAPIN AVENUE RED BANK, NJ 07701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 55 stated that the [U.S. FOIA] had acknowledged he had contaminated the [NJ Exec Order 26] and that he was very nervous. The U.S. FOIA (b)(6) acknowledged that the [NJ Exec Order 26] should be cleansed from inner aspect to the outer, and that the [U.S. FOIA (b)] should have initialed and dated the foam dressing before applying it to the resident's [NJ Exec Order 26]. She further stated that staff should not be writing on residents. A review of the "Wound Dressing Change Competency Checklist" dated 3/15/2019, included the following instructions: clean wound from the least to most contaminated area; apply treatment then dressing as ordered; secure dressing labeled with initials and date.... NJAC 8:39-27.1(a)	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: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure the systemic implementation of their [NJ Exec Order 26.4b] stewardship program. This deficient practice was identified while reviewing Resident #29 for use of [NJ Exec Order 26.4b]	F 881	A review of the medical record and lab results of Resident #29 was completed by the facility U.S. FOIA (b)(6) Attending physician of resident #29 was notified The facility infection preventionist	2/28/23

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F 881	Continued From page 56 for a NJ Exec Order 26.4b1 and has the potential to affect all residents. The evidence was as follows: On 1/3/23 at 12:02 PM, the surveyor observed Resident #29 lying in bed. The resident had a U.S. FOIA (b)(6) in a NJ Exec Order 26.4b1 that was positioned below the NJ Exec Order 26.4b1. The surveyor reviewed the medical record for Resident #29. A review of the Resident Face Sheet (an admission summary) reflected the resident was readmitted to the U.S. FOIA (b)(6) with diagnoses which included NJ Exec Order 26.4b1 [redacted]. A review of the Physician Order Sheet (POS) revealed on NJ Exec Order 26.4b1 at 2:00 PM, there was a telephone order for a U.S. FOIA (b)(6) and a NJ Exec Order 26.4b1) that were used to determine the presence and type of NJ Exec Order 26.4b1. The results of the [redacted] determine which type of NJ Exec Order 26.4b1 should be used to treat the NJ Exec Order 26.4b1 Further review of the POS revealed an order dated NJ Exec Order 26.4b1, for NJ Exec Order 26.4b1 [redacted]. A review of the NJ Exec Order 26.4b1	F 881	modified the antibiotic communication form to be used by nursing staff and re-educated the licensed nurses regarding use of the form as a communication tool when contacting the doctor to ensure proper use of antibiotics. All Residents have the potential to be affected by this practice. The facility antibiotic stewardship program was reviewed and modified to include antibiotic specific tools following McGeer criteria. The antibiotic stewardship program was updated to reflect the use of these tools. Licensed nurses received re-education concerning use of these tools. Licensed nurses receive education regarding the antibiotic stewardship program and proper use of antibiotic specific tools on hire during clinical orientation and annually. The facility infection preventionist will conduct chart audits of 3 residents with infections who have ordered antibiotics weekly for the next four weeks and monthly thereafter to ensure proper use of antibiotics in compliance with the facility ABT stewardship program criteria. Audit findings are discussed with the Director of Nursing and presented by the facility IP at the facility Infection Control meetings and quarterly at the QAPI committee meeting.	

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F 881	Continued From page 57	F 881		

Administration Record (MAR) revealed that the [redacted] was administered as ordered for the five days.

A review of Resident #29's laboratory results dated [redacted] reflected that on [redacted] they were signed and faxed to the [redacted]. The [redacted] indicated many [redacted] which was an abnormal result. The C/S result of the [redacted] revealed [redacted] consistent with [redacted] indicating probable contamination. There was no evidence of further work up.

A review of the Nurses Note (NN) dated [redacted], 3-11 PM shift indicated that the [redacted] were obtained. The [redacted] results were received and faxed to the [redacted] and on [redacted]. The nurse received a call from the Physician who ordered [redacted] to be administered twice a day for five days for the diagnosis of [redacted]

On 1/6/23 at 11:45 AM, the surveyor interviewed the [redacted] on the [redacted] nursing unit who stated depending on what the physician's ordered, whether a [redacted], the nurse would inform the [redacted] of the results, and the [redacted] determined what [redacted] to order. The [redacted] further stated that she could not answer how the [redacted] determined the exact [redacted] to treat tha[redacted] with the results of the [redacted] and no results from the [redacted] since the [redacted] indicated what [redacted] should be used to treat.

On 1/6/23 at 11:52 AM, the surveyor interviewed the [redacted]

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REDBANK CENTER FOR REHABILITATION AND HEALING	**100 CHAPIN AVENUE RED BANK, NJ 07701**

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F 881	Continued From page 58	F 881		

(IP/RN) who stated that the facility did have an [NJ Exec Order 26.4b1] Stewardship Program. The nurses on the unit would use a Resident Infection Record form and a form for the pharmacy and they would be reviewed when a [U.S. FOIA (b)(6)] ordered an [U.S. FOIA (b)(6)] for a resident. This process was used to try to reduce the overuse of [U.S. FOIA (b)(6)] and that was their goal.

On 1/6/23 at 1:00 PM, the surveyor interviewed the Third-Floor nursing unit [NJ Exec Order 26.4b] who stated that she had not received any formal training for the [NJ Exec Order 26.4b1] Stewardship Program, but she used the SBAR (Situation, Background, Assessment, Recommendation) form which was a technique that provided a framework of communication between members of health care team about a resident's condition that the nurses followed.

On 1/6/23 at 1:10 PM, the surveyor interviewed the [NJ Exec Order 26] who stated that he had been working in the facility for [NJ Exec Order 26.4b1] and did not use the SBAR form because it was not consistently used by the nurses, and that he wanted to start using another form. The [U.S. FOIA (b)(6)] continued that the facility must "refocus" on what forms to use for the program. He stated it would make more sense to have a [NJ Exec Order] before an [NJ Exec Order 26.4b1] would be ordered because the [NJ Exec Order] indicated which [NJ Exec Order 26.4b1] should be used for treatment. The [NJ Exec Order] further stated that the facility completely "dropped the ball" as it had not developed an [U.S. FOIA (b)(6)] Stewardship Program; there was no formal process in place, and he had not provided staff with education.

On 1/6/23 at 2:18 PM, the surveyor interviewed the [U.S. FOIA (b)(6)]) who stated her responsibility with the [U.S. FOIA (b)(6)] Stewardship

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F 881	Continued From page 59 Program was to submit the clinical outcomes to the regional staff monthly. The [U.S. FOIA (b)] stated that the [U.S. FOIA (b)(6)] oversaw the program and every month the [U.S. FOIA (b)(6)] shared his folder with her, and she performed an audit to determine how many antibiotics were used and discussed the information during daily clinical meetings. The [U.S. FOIA (b)] further stated the staff were educated by the U.S. FOIA (b)(6)) who was the staff educator and that there was no formal meeting for the [U.S. FOIA (b)(6)] Stewardship Program. On 1/10/23 at 2:25 PM, the U.S. FOIA (b)(6) in the presence of the NJ Exec Order 26.4b1 , and the survey team stated the [NJ Exec Order 26.4b1] Stewardship Program was not completed and not as "robust" as she would like it to be; there was no discussion or leadership. She acknowledged there was a policy and a plan, but the facility was not implementing their policy and plan. She stated the facility focused on infection control and Covid-19, but did not talk about the [U.S. FOIA (b)(6)] Stewardship Program. The U.S. FOIA (b)(6) also confirmed the facility was not implementing the SBAR. At this time, the [U.S. FOIA (b)(6)] stated he was unaware that the facility had no formal [U.S. FOIA (b)(6)] Stewardship Program. On 1/11/23 at 10:31 AM, no further information including but not limited to staff [U.S. FOIA (b)(6)] education or audits provided. A review of the facility's "Antibiotic Stewardship Policy" with an effective date of 3/22, included the purpose of an antibiotic stewardship program was to optimize clinical outcomes in adults, to ensure the optimal selection, dose, and duration of	F 881		

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F 881	Continued From page 60 antibiotics that leads to the best clinical outcomes for the treatment or prevention of infection, while producing the fewest possible side effects and the lowest risk for subsequent resistance... A review of the facility's "Antibiotic Stewardship Program" dated reviewed 3/8/22, included the program components should consist of leadership, accountability of a team, antibiotic expertise, antibiotic stewardship actions, measuring actions (tracking), reporting, and education which should be provided by the facility to the staff, prescribing providers, residents, and families... A review of the facility's "Infection Control Coordinator (ICC)" job description included that they are responsible for the implementation and administration of an organization-wide system for the prevention and control of infection, coordination of infection control within the confines of established policies and procedures, including surveillance, identification, and analysis of problem areas...Essential generic job function: the IP actively participates and assists in presentation of reports including but not limited to the antibiotic stewardship program... NJAC 8:39-19.4(d)	F 881		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061325	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDBANK CENTER FOR REHABILITATION AN	100 CHAPIN AVENUE RED BANK, NJ 07701

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 11 out of 42 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) 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	S 560	Daily staffing is reviewed by the staffing coordinator and the Director of Nursing or designee and additional hours are offered to facility staff to fill vacant slots due to callouts. The staffing coordinator overstaffs to meet the required ratios. Agency staff are used when facility staff cannot fill open shift slots. The facility maintains multiple contracts with staffing agencies. The staffing coordinator and Director of Nursing review the CNA schedule monthly and make adjustments to assure difficult to staff weekends meet minimum ratios.	2/28/23

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

Electronically Signed | 02/03/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 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. During entrance conference on 1/3/23 at 10:08 AM, the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA) and Regional Nurse, informed the surveyor that the facility staffing was moderate. The DON stated the facility used Agency staff to cover shifts. As per the "Nurse Staffing Report" completed by the facility for the weeks of 12/18/22 to 12/24/22 and 12/25/22 to 12/31/22, which revealed the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift, total staff for residents of 1 to 14 on the evening shift, and CNA to total staff on the evening shifts as documented below: 12/18/22 had 9 CNAs for 119 residents on the day shift, required 15 CNAs. 12/20/22 had 13 CNAs for 116 residents on the	S 560	Incentives are provided to staff willing to work additional shifts. All Residents have the potential to be affected by this practice. Administration has formed a staffing committee and has conducted salary analyses and implemented creative strategies for attracting new employees to minimize the use of agency personnel. Bonuses and incentive programs have been implemented to attract and to retain current staff. An employee recognition committee comprised of front line workers was implemented to plan events to improve the morale of staff and recognize the exemplary services provided by staff. Improvements in the environment and working conditions has helped attract new staff. Daily staffing levels are reported to the core team and management company and additional incentives are provided for working an extra shift if needed. The success of bonuses and incentives is analyzed by the facility Administrator and Director of Nursing who make recommendations weekly to the QAPI compliance committee at the weekly meetings and to the management company regarding what incentives or bonuses are working. Staffing is discussed at daily morning operations meetings and recommendations solicited from the management team about ways to attract new hires to fill vacant positions. Staffing levels of direct care staff and recruitment efforts are discussed daily by nursing management and the	

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S 560	Continued From page 2 day shift, required 14 CNAs. 12/21/22 had 13 CNAs for 116 residents on the day shift, required 14 CNAs. 12/22/22 had 12 CNAs for 116 residents on the day shift, required 14 CNAs. 12/23/22 had 10 CNAs for 120 residents on the day shift, required 15 CNAs. 12/24/22 had 9 CNAs for 120 residents on the day shift, required 15 CNAs. 12/25/22 had 8 CNAs for 120 residents on the day shift, required 15 CNAs. 12/25/22 had 10 total staff for 120 residents on the evening shift, required 12 total staff. 12/25/22 had 4 CNAs to 10 total staff on the evening shift, required 5 CNAs. 12/26/22 had 11 CNAs for 118 residents on the day shift, required 15 CNAs. 12/27/22 had 13 CNAs for 115 residents on the day shift, required 14 CNAs. 12/28/22 had 13 CNAs for 115 residents on the day shift, required 14 CNAs. 12/29/22 had 12 CNAs for 115 residents on the day shift, required 14 CNAs. 12/30/22 had 9 CNAs for 115 residents on the day shift, required 14 CNAs. On 1/10/23 at 9:35 AM, the surveyor interviewed the Staffing Coordinator who stated she was responsible for doing the scheduling for the nursing department. The Staffing Coordinator stated that she followed the staffing ratio that was provided to her to staff CNAs, but she did also staff additional CNAs than required if needed. The Staffing Coordinator stated she had a fair amount of callouts from nursing staff and she would replace any staff that called out with their staff based on availability or Agency staff. The Staffing Coordinator stated it was more difficult on the weekend to to replace callouts staff.	S 560	administrator, are reported daily to the management company, and are reviewed at the quarterly QAPI committee meetings. Vacancy rates are reviewed weekly by the Director of Nursing and discussed with the Administrator. The effectiveness of strategies to attract and retain staff are discussed and strategies modified as needed. Findings are also discussed weekly with the management company that provides direct assistance with recruitment efforts.	

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S 560	Continued From page 3 On 1/10/23 at 9:53 AM, the Staffing Coordinator informed the surveyor that the staffing ratio was one CNA to eight residents on the day shift; one CNA to ten residents on the evening shift; and one CNA to fourteen residents on the night shift. NJAC 8:39-5.1(a)	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315286 Y1	A. Building B. Wing Y2	2/28/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
REDBANK CENTER FOR REHABILITATION AND HEALING	100 CHAPIN AVENUE RED BANK, NJ 07701

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 F0600	Correction	ID Prefix F0640	Correction	ID Prefix F0692	Correction
Reg. # 483.12(a)(1)	Completed	Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.25(g)(1)-(3)	Completed
LSC	02/28/2023	LSC	02/28/2023	LSC	02/28/2023
ID Prefix F0712	Correction	ID Prefix F0730	Correction	ID Prefix F0755	Correction
Reg. # 483.30(c)(1)-(4)	Completed	Reg. # 483.35(d)(7)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	02/28/2023	LSC	02/28/2023	LSC	02/28/2023
ID Prefix F0801	Correction	ID Prefix F0806	Correction	ID Prefix F0812	Correction
Reg. # 483.60(a)(1)(2)	Completed	Reg. # 483.60(d)(4)(5)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	02/28/2023	LSC	02/28/2023	LSC	02/28/2023
ID Prefix F0814	Correction	ID Prefix F0880	Correction	ID Prefix F0881	Correction
Reg. # 483.60(i)(4)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80(a)(3)	Completed
LSC	02/28/2023	LSC	02/28/2023	LSC	02/28/2023
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?
1/11/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061325 Y1	A. Building B. Wing Y2	2/28/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
REDBANK CENTER FOR REHABILITATION AND HEALING	100 CHAPIN AVENUE RED BANK, NJ 07701

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	02/28/2023	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	
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Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/11/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. BUILDING **01** B. WING _____	**01/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDBANK CENTER FOR REHABILITATION AND HEALING	**100 CHAPIN AVENUE** **RED BANK, NJ 07701**

(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 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		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/10/2023 and Hackensack Meridian Health Nursing and Rehab was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Hackensack Meridian Health Nursing and Rehab is a four-story Type II Protected building that was built in 1975. The facility is divided into 12 smoke zones.	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and facility	K 211	All the furniture blocking the means of	2/28/23

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

Electronically Signed | 02/03/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. BUILDING 01 B. WING _____	01/11/2023

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REDBANK CENTER FOR REHABILITATION AND HEALING	100 CHAPIN AVENUE RED BANK, NJ 07701

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K 211	Continued From page 1 policy review, it was determined that the facility failed to maintain the means of egress to be continuously free of obstructions to allow for prompt egress in case of emergency on [NJ Exec Order 26.4b1] of [NJ Exec Order 26.4b1] facility exits. This deficient practice had the potential to affect [NJ Exec Order 26.4b1] residents who resided on the second floor and [NJ Exec Order 26.4b1] residents who resided on the third floor. Findings included: An observation on 01/10/2023 at 11:56 AM, on the [NJ Exec Order 26.4b1], revealed the corridor by Rooms [NJ Exec Order 26.4b1] was being used to store two wheelchairs and one reclining [NJ Exec Order 26.4b1] chair. A concurrent observation and interview on 01/10/2023 at 12:14: PM, on the third floor-A Wing, revealed the corridor by Room [NJ Exec Order 26.4b1] was being used to store one [NJ Exec Order 26.4b1]-chair. Unit Manager (UM) #1 revealed the chair was stored there because the resident in Room [NJ Exec Order 26.4b1] had not gotten out of bed that day. During an interview on 01/10/2023 at 1:03 PM, the [U.S. FOIA (b)(6)] acknowledged the findings and stated he had instructed staff not to store items in the corridors. He stated the local Fire Marshall on the last inspection had noted stored items in the corridor, and the corridors could not be obstructed. He stated he expected the egress to be maintained unobstructed. During an interview on 01/10/2023 at 1:41 PM, the [NJ Exec Order 26.4b1] acknowledged the findings and stated he knew storage of items in the corridor was not allowed. He stated all staff were trained	K 211	egress on the [NJ Exec Order 26.4b1] by rooms [NJ Exec Order 26.4b1] were immediately removed and staff on the unit immediately re-educated about proper storage of furniture and equipment always keeping the emergency means of egress free of obstructions. All the furniture blocking the means of egress on the [NJ Exec Order 26.4b1] by room [NJ Exec Order 26.4b1] was immediately removed and staff on the unit immediately re-educated about proper storage of furniture and equipment always keeping the emergency means of egress free of obstructions. All Residents have the potential to be affected by this practice. Fire safety education is provided by the staff educator on hire and annually to all facility staff and includes keeping all emergency means of egress free from equipment and furniture that may impede exiting in case of a fire in compliance with life safety regulations. The maintenance director has added monitoring of hallways for clear passage free of furniture or equipment to his weekly environment rounds checklist. The administrator will conduct random rounds weekly to check the hallways and all means of egress for safe passage. Monitoring of all areas of emergency means of egress is part of the maintenance department walking rounds checklist. The Maintenance Director or designee will make daily rounds for two weeks and weekly rounds thereafter specifically monitoring all emergency means of egress to ensure no furniture or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. BUILDING **01** B. WING _____	**01/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDBANK CENTER FOR REHABILITATION AND HEALING	**100 CHAPIN AVENUE** **RED BANK, NJ 07701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 2 not to obstruct the corridors and expected the corridors to be maintained per the life safety code. Review of an undated facility policy titled, "Exits or Means of Egress," revealed, "Our facility has designated exits for each area of the building to allow for rapid evacuation." The policy also indicated, "3. All personnel shall keep exits clear at all times. Exit doors should never be blocked, even briefly." New Jersey Administrative Code §8:39-31.1(c), 31.2(e)	K 211	equipment blocks any area. The maintenance director will review the audit findings of the rounds with the Administrator weekly. The QAPI committee will review audit findings presented by the Maintenance Director at the quarterly QAPI meeting for further direction and guidance.	
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interviews, document review, and facility policy review, it was determined that the facility failed to ensure 2 of 16 heat detectors for the fire alarm system were maintained in accordance with National Fire Protection Association (NFPA) 72. This deficient practice had the potential to affect [redacted] residents who resided on the [redacted] of the facility. Findings included:	K 345	The fire alarm heat detector in the [redacted] electrical room was immediately repaired. The fire alarm heat detector in the second [redacted] soiled utility room was immediately repaired. All Residents have the potential to be affected by this practice. The Maintenance Director and Administrator conducted walking rounds	2/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. BUILDING 01 B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 345	Continued From page 3 A review of the facility's quarterly fire alarm inspection dated 10/03/2022, revealed 16 heat detectors in the facility. On 01/10/2023 at 11:50 AM, an observation of the NJ Exec Order 26.4b1 electrical room revealed a heat detector hanging down approximately two inches by the wiring. On 01/10/2023 at 12:06 PM, an observation of the NJ Exec Order 26.4b1 soiled utility room revealed a heat detector hanging down approximately three inches by the wiring. During an interview on 01/10/2023 at 1:01 PM, the U.S. FOIA (b)(6)) acknowledged the findings and stated he was not aware the detectors were hanging down and would get them fixed. He indicated he made rounds daily but had not observed the detectors hanging down from the wiring. He stated he expected the fire alarm system components to be maintained per the life safety code. During an interview on 01/10/2023 at 1:45 PM, the U.S. FOIA (b)(6) acknowledged the findings and stated he was unaware the detectors were hanging by the wiring. He indicated the U.S. FO was responsible for life safety code issues. He also stated he expected the fire alarm system components to be maintained per the life safety code. Review of a facility policy titled, "Fire Alarm System Testing and Inspection," revised April 2022, revealed, "Purpose: To ensure that all fire warnings and safety systems are operating properly. The Environment of Care Committee,	K 345	and checked all the heat detectors to ensure they were all maintained per life safety codes. The maintenance director has added monitoring of heat detectors on his weekly rounds. The Maintenance Director and Administrator contacted the fire safety vendor and notified them of the issues and directed them to check all heat detectors during each inspection period. The Maintenance Director or designee makes daily walking rounds and checks all heat detectors for proper placement and immediately repairs any detectors found in need of repair. The QAPI committee will review audit findings presented by the maintenance director at the quarterly QAPI meetings for further direction and guidance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. BUILDING **01** B. WING _____	**01/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDBANK CENTER FOR REHABILITATION AND HEALING	**100 CHAPIN AVENUE** **RED BANK, NJ 07701**

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K 345	Continued From page 4 through the [redacted], shall ensure that all fire warnings and safety systems are tested and inspected as mandated by NFPA." New Jersey Administrative Code §8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on interviews, document review, and facility policy review, it was determined that the facility failed to ensure an internal obstruction investigation was conducted on the automatic sprinkler system every five years in accordance with National Fire Protection Association (NFPA) 25. This deficient practice had the potential to	K 353	The sprinkler company that conducts all required internal inspections was immediately contacted to complete the required five year inspection and provided documentation that it had been completed on March 19, 2021. All Residents have the potential to be	2/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. BUILDING **01** B. WING _____	**01/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDBANK CENTER FOR REHABILITATION AND HEALING	**100 CHAPIN AVENUE** **RED BANK, NJ 07701**

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K 353	Continued From page 5 affect all 116 residents. Findings included: A review of the "Report of Internal Condition of Sprinkler Piping," dated 02/18/2015, revealed "Results of initial examination: 1. The interior of the sprinkler piping appears in satisfactory condition." A review of the "Agreement Type: Sprinkler - 5 Year Internal Piping," dated 02/01/2022, revealed, "We are pleased to provide you with this inspection, service and repair agreement. We hope you find our proposal both complete and competitive. Please note that this is in addition to the annual inspection and is required to be completed at five year intervals." A review of the "Report of Sprinkler System Tests and Inspections," dated 03/23/2022, 06/30/2022, 09/21/2022, and 12/30/2022, revealed no five-year internal inspection was performed. During an interview on 01/10/2023 at 10:30 AM, the U.S. FOIA (b)(6)) acknowledged the findings and stated that once the service quote for the five-year internal inspection was received, he thought he sent it to be fulfilled, but it was not done as required. He indicated he was responsible for ensuring the five-year internal inspection was completed and expected the sprinkler system to be maintained per the life safety code. During an interview on 01/10/2023 at 1:40 PM, the U.S. FOIA (b)(6) stated he had only worked at the facility for [redacted]. He was aware of this code requirement but was not aware the five-year	K 353	affected by this practice. The Maintenance Director added the five year internal inspection requirement on the spreadsheet developed for use to track all life safety inspections to ensure timely completion. The Maintenance Director will review the maintenance inspection binder spreadsheet monthly to ensure all required inspections are completed and reports received timely. Findings will be discussed with the administrator if any inspections have not been completed or issues were identified and will be acted upon accordingly to assure compliance with life safety codes. The QAPI committee will review findings reported by the maintenance director at the quarterly QAPI meeting for further direction and guidance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. BUILDING **01** B. WING _____	**01/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDBANK CENTER FOR REHABILITATION AND HEALING	**100 CHAPIN AVENUE** **RED BANK, NJ 07701**

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K 353	Continued From page 6 internal inspection was not completed. He indicated he expected the sprinkler system to be maintained per the life safety code. A review of an undated facility policy titled, "Testing of Sprinkler System," revealed, "The facility's sprinkler system shall be tested on a regularly scheduled basis." The policy also indicated, "4. An annual certification of the sprinkler system shall be conducted by the agency who installed the system, or its authorized agent, to ensure all component of the system are operable and in good working order." New Jersey Administrative Code §8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353		
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and	K 531		2/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315286	A. BUILDING **01** B. WING _____	**01/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDBANK CENTER FOR REHABILITATION AND HEALING	**100 CHAPIN AVENUE** **RED BANK, NJ 07701**

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K 531	Continued From page 7 elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation, interviews, document review, and facility policy review, it was determined that the facility failed to maintain testing of 2 of 2 elevators provided with firefighter recall in accordance with 9.4.6, Elevator Testing. Life Safety Code (LSC) 9.4.6.2, which states that all elevators with firefighters' emergency operation in accordance with 9.4.3 shall be subject to monthly operation with a written record of findings made and kept on the premises as required by American Society of Mechanical Engineers (ASME) A17.1, Safety Code for Elevators and Escalators. This deficient practice had the potential to affect all 116 residents. Findings included: On 01/10/2023 at 10:03 AM, a review of the facility's life safety code preventative maintenance documentation revealed no monthly elevator inspection documentation was available for review. On 01/10/2023 at 11:27 AM, an observation revealed two elevators located in the facility, which were equipped with firefighter recall. During an interview on 01/10/2023 at 10:50 AM, the U.S. FOIA (b)(6) acknowledged the findings and stated he was not aware the elevators required monthly inspections. He acknowledged the elevators had firefighters' recall. He indicated he received a few weeks of training from the previous U.S. FO, which did not include monthly inspections of the elevators. He	K 531	The elevator inspection company that conducts all required elevator inspections was immediately contacted to complete the required annual elevator testing of the two elevators with firefighter recall. They informed us the elevator was inspected on 1/31/23 All Residents have the potential to be affected by this practice. The Maintenance Director added the monthly elevator testing requirement on the spreadsheet developed for use to track all life safety inspections to ensure timely completion. The Maintenance Director will review the maintenance inspection binder spreadsheet monthly to ensure all required inspections monthly elevator testing is completed and reports received timely. Findings will be discussed with the administrator if any inspections have not been completed or issues were identified and will be acted upon accordingly to assure compliance with life safety codes. The QAPI committee will review audit findings presented by the maintenance director at the quarterly QAPI meeting for further direction and guidance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 531	Continued From page 8 stated he expected the elevators to be maintained per the life safety code. During an interview on 01/10/2023 at 1:40 PM, the U.S. FOIA (b)(6) stated he only worked at the facility for eight weeks and had not reviewed the life safety code inspections and preventative maintenance. He acknowledged the elevators had firefighters' recall but indicated he was not aware that elevators with the firefighters' recall must be inspected monthly. He stated he expected the elevators to be maintained per the life safety code. A review of a facility policy titled, "Elevator Repairs," revised in September 2022, revealed, "Monthly and annual preventative maintenance is performed by the elevator service company. Phase 1 and 2 fire recall is tested monthly by maintenance staff." New Jersey Administrative Code §8:39-31.1(c), 31.2(e)	K 531		

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
315286 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/28/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
REDBANK CENTER FOR REHABILITATION AND HEALING	100 CHAPIN AVENUE RED BANK, NJ 07701

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).

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Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0211	02/28/2023	LSC K0345	02/28/2023	LSC K0353	02/28/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0531	02/28/2023	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	
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Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
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FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/11/2023	☐ YES ☐ NO