STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315042	A. BUILDING _____ B. WING _____	C 06/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK RENAISSANCE REHAB & NURSING	521 PINE BROOK ROAD LINCOLN PARK, NJ 07035

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F 000	INITIAL COMMENTS C # NJ00142334 Survey Date: 6/15/21 CENSUS: 161 SAMPLE SIZE: 32 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 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		7/2/21

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/30/2021

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 656	Continued From page 1 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of medical records, it was determined that the facility failed to develop a person-centered comprehensive care plan to address an EX Order 26 § 4b1 for 1 of 3 residents (Resident #55) from 12/22/20 to 6/12/21. This deficient practice was evidenced by the following: On 6/8/21 at 12:50 PM, the surveyor observed Resident #55 seated in a EX Order 26 § 4b1 in the dining area during lunch. On 6/10/21 at 9:16 AM, the surveyor observed the resident seated in a EX Order 26 § 4b1 in his/her room. The resident stated that his/her has had an EX Order 26 § 4b1 for almost "4-5 months now." The resident showed to the surveyor the EX Order 26 § 4b1	F 656	Lincoln Park Renaissance Rehab & Nursing Plan of Correction for Event ID# OWHU11 Survey Date: 06/15/2021 Completion Date: 7/2/21 F656 Element One Resident #55 is currently still in the facility. A care plan for resident #55 EX Order 26 § 4b1 was immediately implemented. All care plans have been reviewed and updated by the IDC (Interdisciplinary Care Plan) Team for Resident #55. The Interdisciplinary care team will meet weekly on resident #55 to ensure that all care plans are accurate and updated. The MDSC, DON and ADON have met	

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F 656	Continued From page 2 EX Order 26 § 4b on the EX Order 26 § 4b1 . A review of the resident's Face Sheet, an admission summary, indicated that the resident had diagnoses that included EX Order 26 § 4b1 [redacted]. A review of the resident's individualized comprehensive care plans revealed that there was no care plan initiated for the resident's EX Order 26 § 4b1 . A review of the 4/14/21 Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate care management, revealed a Brief Interview for Mental Status (BIMS) score of EX O , which reflected that the resident's cognition was EX Order 26 § 4b1 . The QMDS noted that Resident #55 had an EX Order 26 § 4b1 . Further review of the MDS reflected that on the 12/28/20 assessment, Resident #55 had an EX Order 26 § 4b1 . A review of the June 2021 Order Summary Report reflected an order dated 12/22/20 for EX Order 26 § 4b1 care every shift. The 12/22/20 order was transcribed onto the electronic Treatment Administration Record (eTAR) and signed by nurses every shift daily. On 6/10/21 at 9:21 AM, the Licensed Practical Nurse (LPN) informed the surveyor that Resident #55 was alert with some forgetfulness. The LPN stated that the resident had an EX Order 26 § 4b1 which was changed from an EX Order 26 § 4b1 to a	F 656	and implemented a process for updating Comprehensive Care plans. Supervisors/ADON/DON/MDSC (Minimum Data Set Coordinator) and Administration will receive 24hour report via email each morning prior to clinical report. All changes in plan of care will be updates each morning at clinical report to ensure all Care plans are updated in a timely manner. Element Two All residents in the facility are at risk to be affected by this deficient practice. A comprehensive Care plan meeting was held immediately on each unit and was attended by the DON, ADON and MDSC (Minimum Data Set Coordinator) along with the floor nurse to ensure all care plans are updated with any changes in the plan of care. All Comprehensive care plans have been updated to reflect any changes in the resident's status or plan of care. Element Three All nursing staff has been educated on notifying the MDSC (Minimum Data Set Coordinator), DON or ADON and adding any changes to daily 24hour report when a change is required to the care plan. The DON/ADON/MDSC (Minimum Data Set Coordinator) or designee will be responsible to review 24hour report daily from each unit for 30 days to ensure that all changes are reported and care plans are updated. The IDC (Interdisciplinary Care Plan) team will meet weekly to	

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F 656	Continued From page 3 leg bag in the morning by the nurse. The LPN further stated that "nurses do not do care plans, and care plans were the responsibility of the MDS and the Social Worker to initiate and update care plans." On 6/11/21 at 11:52 AM, the MDS Coordinator (MDS/C) informed the surveyors that it was the responsibility of the nurses and the Assistant Director of Nursing (ADON) to initiate a care plan and the MDS Coordinators to update the care plan when there was a due MDS assessment. The MDS/C stated that the EX Order 26 § 4b1 care plan should have been initiated immediately when it was first ordered according to facility policy and protocol. On 6/11/21 at 12:22 PM, the surveyors met with the Administrator, Director of Nursing (DON), and Administrator in Training (AIT), and discussed the above concerns. On 6/14/21 at 3:27 PM, the DON in the presence of the administrator and the AIT, informed the survey team that Resident #55's EX Order 26 § 4b1 care plan should have been initiated when the EX Order 26 § 4b1 was ordered. A review of the facility's policy for Using the Care Plan with a revised date of 4/23/21 provided by the DON included "The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. Policy Interpretation and Implementation: #3. Changes in the resident's condition must be reported to the DON so that a review of the resident's assessment and care plan can be made."	F 656	review all changes to resident condition and monitor that care plans have been updated. This process will continue weekly for 4 weeks after 30 days of daily audits, then bi-weekly for one month. The DON/ADON/MDSC(Minimum Data Set Coordinator)or designee will conduct random audits weekly for two months to ensure that all changes have been reported to the DON/ADON or MDSC (Minimum Data Set Coordinator)and placed on 24hour reports and care plans have been updated accordingly. Random audits will continue bi-weekly for one month to ensure compliance is maintained. Element Four Results of these audits will be recorded and reported by the Director of Nursing to the Quality Assurance Committee and Administration quarterly. Actions will be implemented as appropriate. Results will be utilized for training purposes and systemic changes.	

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F 656	Continued From page 4 On 6/15/21 at 1:06 PM, there was no further information provided by the facility. NJ 8:39-11.2 (e)	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain professional standards of clinical practice by a.) not following a physician's order; b.) accurately transcribing physician orders (PO) for 3 of 34 residents (Resident #140,Resident #90, and Resident #354); and failed to c.) ensure nurses signed the electronic Medication Administration Record (eMAR) appropriately and followed a physician orders for a supplement for 1 of 8 residents (Resident#149) reviewed for nutrition and d.) follow a physician's order with regards to blood pressure medication with a parameter for 1 of 34 residents (Resident #149) reviewed for medications. The evidence was as follows: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and	F 658	Lincoln Park Renaissance Rehab & Nursing Plan of Correction for Event ID# OWHU11 Survey Date: 06/12/2021 Completion Date: 7/2/21 F658 Element One Residents #149, #90 and #140 are currently still in the facility. Resident #354 has been discharged. The [EX Order 26] dosage for resident #140 was ordered and administered correctly, the pharmacy was contacted to send a [EX Order 26] dose rather than two [EX Order 26 § 4b1]. The order was temporarily changed until the [EX Order 26] tablets were received. Resident #90 was reweighed to confirm an accurate weight, MD was notified of weight change and resident was monitored during weights daily by dietitian and nursing supervisor. The [EX Order 26 ?] order for Resident #354 was discontinued by the physician, the resident	7/2/21

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F 658	Continued From page 5 treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 6/11/21 at 9:50 AM, during the medication observation pass, the surveyor observed a Licensed Practical Nurse (LPN#1) preparing to administer medications for Resident #140. The surveyor observed LPN #1 prepared and administered EX Order 26 § 4b1 tablet for Resident #140. LPN #1 stated that the order for EX Order 2 in the electronic medication administration record (eMAR) was for EX Order 26 § 4b1 give 2 tablets in the morning, but "we" are administering one tablet of EX Order 26 § 4b1 to Resident #140. LPN #1 further stated that the physicians order (PO) and the eMAR and the medication being administered should match. On that same date and time, the surveyor	F 658	was re-evaluated to ensure EX Order 26 § was still needed and a new order was written with the 14-day duration per MD. The orders for resident #149 requiring supplemental documentation was discontinued and rewritten so that proper documentation would appear in the MAR. The nurse for resident #140 was immediately re-educated on medication pass when the error was brought to the attention of the DON. The same nurse is scheduled to receive a full medication pass in-service from the Pharmacy Consultant. The nurse for Resident #90 was immediately re-educated on notifying the physician at the time of identifying a change in resident condition. The physician was contacted immediately upon identifying the lack of physician documentation to inform of the change in resident weight. The nurse for Resident #354 was immediately re-educated on transcription of orders and 14-day regulation for duration of EX Order 26 § 4b1 medications. The nurse for Resident #149 was re-educated on proper documentation in the EMAR. An audit was immediately conducted for all residents receiving fortified foods to ensure that orders were written to require a signature in the EMAR.	

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F 658	Continued From page 6 observed LPN #1 administer two sprays of EX Order 26 § 4b1 nasal spray to each nostril to Resident # 140. The surveyor reviewed the medical record for Resident # 140. Review of the order summary reflected a PO for EX Order 26 § 4b1, give two tablets by mouth in the morning for EX Order 26 § 4b1 dated 4/21/21. Further review of the order summary reflected a PO for EX Order 26 § 4b1 nasal spray dated 2/4/21. The PO indicated to spray one spray in each nostril two times daily for allergies. On 6/11/21 at 11:00 AM, the surveyor interviewed LPN #1 who stated that he should have administered one spray EX Order 26 § 4b1 nasal spray to each nostril. On 6/11/21 at 12:15 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). There was no additional information provided by the facility. 2. On 6/7/21 at 12:15 PM, the surveyor observed Resident #90 seated in a EX Order 26 § 4b1 eating lunch. On 6/14/21 at 1:10 PM, the surveyor reviewed the Admission Record for Resident #90 which indicated that the resident was admitted to the facility on EX Order 26 § 4b with diagnoses which included presence of right EX Order 26 § 4b1, EX Order 26 § 4b1, EX Order 26 § 4b1 and EX Order 26 § 4b1. A review of the order summary reflected a PO dated 5/1/21 for Daily weights with a direction to	F 658	The nurse for Resident #149 was re-educated on ensuring that supplemental documentation is added to the EMAR for all orders with parameters and checking orders for accuracy when transcribing. Element Two All residents in the facility are at risk to be affected by these deficient practices. Education was provided to all nursing staff and audits were immediately conducted to identify deficient practices. All discrepancies identified during the audit process were immediately corrected. Element Three All nurses were educated on medication pass, reading order instructions and cautionaries when administering medications. All nurses were educated on notifying the physician immediately upon identification in change of status or plan of care. All nurses were educated on transcription of medication orders. All nurses were educated on 14-day regulation for PRN psychotropics. Dietary and dietitians were made aware of all residents that require fortified foods on their trays. All nurses were educated on proper	

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F 658	Continued From page 7 notify the Medical Doctor (MD) for weight gain of three pounds or more in 24 hours or five pounds or more in one week every day shift for Ex.Order 26.4(b)(1)). A review of Resident #90's Weights and Vitals Summary revealed that the resident had an EX O-pound weight increase from EX Order pounds on 6/6/21 to Ex Order 2 pounds on 6/7/21. The resident's weights from 6/7/21 to 6/11/21 ranged from EX Order pounds to EX Order pounds. Review of the 6/7/21 electronic Progress Notes (PN) did not indicate that the MD was notified regarding the EX O-pound weight increase on 6/7/21. Further review of the June 2021 electronic PN's indicated that the MD was notified of the EX Order 26 § 4b1 on 6/11/21 (5 days later). On 6/14/21 at 10:45 AM, the surveyor interviewed Resident #90's Certified Nursing Assistant (CNA) who stated that it's her job to weight the resident. She stated that she and another CNA weighed the resident every morning with a Hoyer lift and after obtaining the weight she would enter it in the EMR and then notify the nurse. On 6/14/21 at 11:15 AM, the surveyor interviewed the LPN #2 who stated that she reviewed the weights every day and would notify the physician if the resident had a weight change more than 3 pounds. The surveyor asked LPN #2 why she didn't call the physician when the resident had an Ex.Ord-pound increase on 6/7/21. The LPN #2 stated she didn't know why the physician wasn't notified on 6/7/21. On 6/14/21 at 1:00 PM, the surveyor met the administrator, administrator in training (AIT) and	F 658	documentation in the EMAR. Random audits will continue to ensure that all residents receiving fortified foods have an order in the EMR with directions to document amount consumed in the EMAR. The DON/ADON or designee will perform random audits of 10 residents per week for 1 month to monitor for accuracy in transcribing orders. Random audits will continue after 1 month, for 5 residents weekly for 1 additional month. Lastly, 30 resident records will be randomly audited during month 3 for accuracy in transcribing orders. All CNA□s were re-educated on checking meal tickets prior to distribution of trays to ensure accuracy of items ordered and received. All nurses were educated on ensuring that supplemental documentation is added to the EMAR for all orders with parameters and checking orders for accuracy when transcribing. The Pharmacy consultant will perform a minimum of 5 medication passes per month on staff nurses for 3 months to ensure that nurses are correctly reading orders prior to Administering medication. The DON/ADON or designee will perform daily audits by reading 24-hour report daily to monitor compliance with notification of changes to physician for 3 months.	

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F 658	Continued From page 8 the Director of Nursing (DON). The DON provided the surveyor with a progress note dated 6/15/21 timed at 9:19 which indicated "late entry" for 6/7/21 indicating that nursing notified the physician on 6/7/21. A review of the facility's policy for Transcribing Physician Orders dated 4/23/21 and the policy for Weight Assessment and Intervention dated 4/23/21, provided by the DON did not addressed the above concerns. 3. On 6/07/21 at 12:31 PM, the surveyor observed the resident in bed awake, but did not respond to the surveyor's questions. A review of the resident's Face Sheet (an admission summary) and the Diagnosis Sheet, reflected that Resident #354 was admitted on EX Order 26 § 4b1 with diagnoses that included but not limited to EX Order 26 § 4b1 EX Order 26 § 4b1 and EX Order 26 § 4b1 following a EX Order 26 § 4b1 A review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, indicated a Brief Interview for Mental Status (BIMS) score of [redacted], which reflected that the resident's cognition was EX Order 26 § 4b1. A review of the Psychiatric Follow-Up Form dated 4/15/21, revealed the resident had a diagnosis of	F 658	The DON/ADON or designee will perform random audits of 10 residents per week for 1 month to monitor for accuracy in transcribing orders. Random audits will continue after 1 month, for 5 residents weekly for 1 additional month. Lastly, 30 resident records will be randomly audited during month 3 for accuracy in transcribing orders. The Dietitian/DON or designee will perform audits to ensure fortified foods are provided on trays, listed on meal ticket and documented in the EMAR with amount consumed. 10 resident audits will be performed each week for one month. Random audits will continue after 1 month, for 5 residents weekly for 1 additional month. Lastly, 15 resident records will be randomly audited during month 3 for accuracy. The DON/ADON or designee will perform random audits of 20 physician orders per week for 1 month to monitor for accuracy in transcribing orders with supplemental documentation. Random audits will continue after 1 month, for 10 resident charts weekly for 1 additional month. Lastly, 30 resident records will be randomly audited during month 3 for supplemental documentation being correctly added to physician orders. Element Four Results of these audits will be recorded and reported by DON to the Quality Assurance Committee and Administration	

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F 658	Continued From page 9 EX Order 26 § 4b1 . Review of the recommendation/plan indicated to start EX Order 26 § 4b1 by mouth every six hours as needed for 14 days and then re-evaluate. A review of the June 2021 Order Summary Report revealed an order dated 4/15/21 for EX Order 26 § Tablet 0.5 mg, give 1 tablet by mouth every six hours as needed for anxiety. The above corresponding physician orders were transcribed into the April, May and June 2021 electronic Medication Administration records (eMARs). A review of the comprehensive care plan revealed a care plan for the use of anti-anxiety medications related to anxiety disorder, dated 4/15/21. On 6/14/21 at 10:05 AM, the surveyor, in the presence of another surveyor interviewed LPN #1. The surveyors and LPN #1 reviewed the Psychiatric Follow-Up Form dated 4/15/21. LPN #1 acknowledged that the EX Order 26 § recommendation was written for 14 days. At that same time, the surveyors and LPN #1 reviewed the 4/15/21 PO. LPN #1 acknowledged she did not transcribe the EX Order 26 § order to reflect 14 days. She stated that the EX Order 26 § order should have been reassessed after 14 days. On 6/15/21 at 9:36 AM, the surveyor, in the presence of the survey team interviewed LPN #2 who stated that the 11-7 shift nurses were responsible for chart checks and review of orders from the day before up until and through their shift. LPN #2 further stated that the EX Order 26 § order	F 658	quarterly. Actions will be implemented as appropriate. Results will be utilized for training and systemic changes.	

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should have been transcribed for 14 days which was a standard of practice. She also stated that the transcription error should have been identified. She further stated that after the 14 days, the physician should have reassessed the need and effectiveness of the medication.

A review of the facility policy "Transcribing Physician Orders", with a review date of 4/23/21, reflected that orders for medications must include "Quantity or specific duration of therapy." It also reflected that the nurse shall ensure that the timing and scheduling of the order is correct and scheduled to be started and administered as ordered as well as to notify the physician immediately during the order confirmation process if any questions arise.

4. On 6/7/21 at 10:46 AM, the surveyor observed Resident #149 awake and laying on the bed. The resident informed the surveyor that his/her appetite varied, and the dietician had spoken to him/her about his/her food preferences. The resident stated, "I feel nauseous" when taking EX Order 26 § 4b1. The resident further stated that the facility provided EX Order 26 § 4b1 and "I can't take it."

A review of the resident's Face Sheet (an admission summary), reflected that the resident was admitted to the facility with diagnoses that included Ex.Order 26.4(b)(1) nspecified, and Ex.Order 26.4(b)(1).

A review of the 5/4/21 Quarterly Minimum Data Set (QMDS), an assessment tool used to

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facilitate the management of care, indicated a Brief Interview for Mental Status (BIMS) score of [redacted], which reflected that the resident's cognition was Ex.Order 26.4(b)(1).

A review of the June 2021 Order Summary Report with an order date of 5/26/21, revealed an order to provide fortified cereal at breakfast in the morning and an order to provide fortified pudding at lunch daily.

The above corresponding physician orders were transcribed into the June 2021 eMAR. Further review of the June 2021 eMAR's revealed checkmarks which indicated that the nurses signed the eMAR for the fortified cereal and pudding were provided to the resident.

A review of the EMR indicated the resident weighed [redacted] pounds on 5/25/21 and weighted [redacted] pounds on 6/9/21.

On 6/8/21 at 12:45 PM, the surveyor observed the resident seated on the bed, lunch served. There was no fortified pudding on the lunch tray. In addition, the resident's meal/diet ticket did not indicate fortified pudding.

On 6/9/21 at 8:41 AM, the surveyor observed the resident seated on the bed, able to feed self and consumed 50% of grits cereal. There was no fortified cereal on the breakfast tray and the meal/diet ticket did not indicate that the resident should get a fortified cereal.

On 6/9/21 at 10:12 AM, CNA #1 informed the surveyors that Resident #149 was alert with some forgetfulness, could verbalize his/her needs and wants, and had a variable appetite. CNA #1

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stated that the resident's weight "today" was EX Order 2 pounds. CNA #1 further stated that the "pudding was served at lunch but not every day." CNA #1 stated that the resident did not receive fortified cereals for breakfast "today." CNA #1 informed the surveyor that it was the CNAs responsibility to distribute and check the residents' meal trays during meals.

On 6/9/21 at 10:28 AM, the surveyor, in the presence of the survey team interviewed LPN #1 who confirmed that he was the assigned nurse who cared for Resident # 149. The LPN #1 stated that Resident # 149 was alert with some forgetfulness, able to make his/her needs known, had no weight loss and had a varied appetite.

On 6/10/21 at 8:39 AM, during the breakfast meal, CNA #2 and the surveyor observed the resident's breakfast tray which had farina cereal on it. There was no fortified cereal on the resident's breakfast tray. Review of the meal/diet ticket indicated 4 oz [ounces] of Farina cereal.

On 6/10/21 at 9:24 AM, the surveyor interviewed LPN #1 who stated it was the CNAs responsibility to distribute, pass the meal trays to the resident, and check the trays for accuracy.

On that same date and time, LPN #1 stated, "I didn't know that the resident wasn't receiving the pudding and the fortified cereal." The surveyor then asked LPN #1 why the eMAR was being signed that the resident was receiving the pudding and fortified cereal. LPN #1 could not speak to why the eMAR was signed and further stated, that moving forward, "I will have to check the resident's meal tray to make sure the resident will receive the pudding and the fortified cereal."

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On 6/11/21 at 12:22 PM, the survey team met with the administrator, DON, and AIT, and discussed the above observations and concerns. The DON stated that it was the CNAs responsibility to distribute and check the meal trays for accuracy.

On 6/15/21 at 9:35 AM, the DON informed the survey team that LPN #1 should have checked and ensured that the resident received and consumed the fortified pudding and cereals before documenting a checkmark in the eMAR.

A review of the facility Dietary Supplements Policy provided by the DON with a revised date of 4/23/21 included "Residents will be offered nourishments routinely and in accordance with physician orders. Nourishments are planned, prepared, and delivered by Dietary and served by nursing staff. Supplements are charted as to time and amount consumed."

5. A review of the May and June 2021 Order Summary Report with an order date of 5/28/21, revealed an order for EX Order 26 § 4b1 [redacted]

The above corresponding physician order was transcribed into the May and June 2021 eMAR. Further review of the May and June 2021 eMAR's revealed that nurses signed as administered from 5/28/21 through 6/9/21 with no documentation of the resident's SBP. The May and June 2021 eMAR reflected that the order was not followed.

On 6/9/21 at 11:52 AM, LPN #1 informed the

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survey team that nurses should check the blood pressure (bp) at the time the bp medication would be administered to get the accurate bp to compare it with the with parameters as ordered. LPN #1 stated that a checkmark in the eMAR meant that the medication was administered and "I'm not sure what would be the code to put if the medication was held or not given."

On that same date and time, LPN #1 acknowledged that he was the nurse that signed the eMAR on 5/28/21, 5/31, 6/1, 6/2, 6/7, and 6/7/21 for Norvasc with no supplemental documentation of bp. LPN #1 stated, "I know I did not give the medication today because I have to follow the order for parameters." He further stated, "I don't know why" it was a checkmark today which means it was administered even though I know I didn't give the medication because of the parameters."

LPN #1 showed the surveyor a piece of paper with the handwritten name of Resident # 149 and the handwritten bp which indicated 111/60. LPN #1 stated, that the resident's bp was obtained "around 8:30 AM."

A review of the Order Details for Norvasc showed that it was a Registered Nurse#1 (RN#1) who confirmed the order of the Nurse Practitioner (NP) for Norvasc that was created on 5/27/21.

On 6/9/21 at 12:37 PM, the surveyor, in the presence of the survey team interviewed RN #1 who stated, "I confirmed the order but I don't need to check it for accuracy."

On 6/11/21 at 12:22 PM, the survey team met with the administrator, DON, and the AIT, and

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F 658	Continued From page 15 discussed the above concerns. On 6/15/21 at 9:35 AM, the DON informed the survey team that LPN #1 should have documented the bp when administering the Norvasc according to the physician's order and clarified the physician's order if there was a concern. The DON further stated that RN #1 should have checked the physician's order for accuracy when confirming an order. She further stated that there was no negative effect on the resident. A review of the Transcribing Physician Orders Policy provided by the Regional Director with a revised date of 4/23/21 included "Policy Interpretation and Implementation: #10. Orders shall be verified with the Physician and verified and confirmed into the EMR. #11. During the process of confirmation, the nurse shall ensure that the timing and scheduling of the order is correct and scheduled to be started/administered as ordered. #12. Nursing staff shall notify the physician immediately during the order confirmation process if any questions arise."	F 658		
F 686 SS=D	NJAC: 8-39-27.1 (a) Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 686		7/2/21

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F 686	Continued From page 16 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with EX Order 26 § 4b1 receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new EX Order 26 § from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) ensure a Registered Professional Nurse assessed and documented the development of a stage II facility acquired EX Order 26 § 4b1 on 5/21/21; b.) track and document the correct extremity until surveyor inquiry; c.) obtain a physician's order for the continuum of care for the EX Order 26 § 4 from 5/28/21 through 6/3/21; d.) ensure accountability for EX Order 26 § 4b1 in accordance with the EX Order 26 § 4b1 Recommendations; and e.) develop and implement a comprehensive care plan for the development of a facility acquired Ex.Order 26.4(b)(1) to the Ex.Order 26.4(b)(1. This deficient practice was identified for 1 of 1 resident reviewed for facility acquired EX Order 26 § 4b, Resident # 52. The evidence was as follows: On 6/7/21 at 12:15 PM, the surveyor interviewed the Assistant Director of Nursing/Licensed Practical Nurse (ADON/LPN #1) who stated she was the charge nurse for units 2 A and 2 B. She further told the surveyor that there were no residents with a facility acquired EX Order 26 § on those units. On 6/7/21 at 8:17 AM, the Director of Nursing (DON) provided a typed paper list which revealed	F 686	Lincoln Park Renaissance Rehab & Nursing Plan of Correction for Event ID# OWHU11 Survey Date: 06/15/2021 Completion Date: 7/2/21 F686 Element One Resident #52 is currently residing in the facility. Resident #52 EX Order 26 § was immediately assessed by an RN and the EX Order 26 § physician once the deficient practice was identified. The correct EX Order was assessed and documentation was corrected. The treatment order was reassessed and a proper ordered was written placed into the TAR for proper documentation. Immediate education was given to the nurse that initially assessed the EX Order 26 § on ensuring that an RN performs the assessment. Counseling was performed with the MD and the ADON that incorrectly documented the incorrect extremity. Immediate education was performed with the MD and the nurse on duty when the	

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F 686	Continued From page 17 there was one resident in the facility with a facility acquired [redacted]. Resident # 52. On 6/8/21 at 9:08 AM, the surveyor observed Resident # 52 laying in bed. The resident's [redacted] dated 6/8/21. The surveyor did not observe an air mattress in use. At that same time, the surveyor interviewed the residents Certified Nursing Assistant (CNA) who stated that the resident refused to eat breakfast. On 6/9/21 at 12:15 PM, the surveyor observed the resident awake, dressed, and seated in a [redacted] inside his/her room eating lunch. The resident's appetite was poor. The resident stated the broccoli and the meat was "tough to chew. I don't enjoy it." The resident was observed wearing a black special shoe on the left foot. The bed was stripped of bed linens and there was no air mattress observed in use. On 6/10/21 at 9:53 AM, the surveyor observed a Licensed Practical Nurse (LPN) perform the [redacted]. The surveyor observed the [redacted]. There was no odor. There was slight amount of [redacted] on the [redacted]. The [redacted] The resident [redacted] when the LPN assessed the resident for [redacted]. The surveyor did not observe an air mattress in use. The surveyor reviewed the medical record for Resident # 52. A review of the Quarterly Minimum Data Set	F 686	[redacted] care order expired to ensure no lapse in treatment orders. An audit was immediately conducted to ensure that all orders that require accountability are plotted correctly in EMR. A comprehensive care plan was immediately developed for resident #52. An audit was performed to ensure that all residents with Ex.Order 26.4(b)(1) have comprehensive care plans. Element Two All residents in the facility are at risk to be affected by this deficient practice. Education was provided to all nursing staff and audits were immediately conducted to identify deficient practices. All discrepancies identified during the audit process were immediately corrected. Element Three All nurses were educated on ensuring that an RN performs all assessments. The DON/ADON or designee will review all daily reports/chart assessments to ensure that assessments have been performed by or in conjunction with an RN daily for 30 days. Random audits will continue after 1 month, for 10 resident charts weekly for 1 additional month. Lastly, 30 resident records will be randomly audited during month 3 to ensure that assessments have been completed by an RN.	

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F 686	Continued From page 18 (MDS), an assessment tool used to facilitate the management of care, dated 4/13/21 reflected that the resident was admitted to the facility on Ex.Order 26.4(b)(1) with diagnoses which included but not limited to EX Order 26 § 4b1 The MDS assessment further revealed that the resident had a Brief Interview for Mental Status EX Order 26 § 4b1 which indicated that the resident's EX Order 26 § 4b1 . The resident was assessed to have no behaviors that EX Order 26 § 4b1 . The MDS further included that the resident was always EX Order 26 § 4b1 A review of the resident's individual comprehensive Care Plan initiated 1/22/20 and revised 1/13/21 reflected that the resident had the potential for EX Order 26 § 4b1 related to EX Order 26 § 4b1 . A review of the goals reflected that the resident would maintain clean and EX Order 26 § 4b1 by the next review date of 7/22/21. The interventions included were to encourage EX Order 26 § 4b1 in order to promote EX Order 26 § 4b1 , keep both EX Order 26 § 4 EX Order 26 § 4b1 assessment by a licensed nurse. There was no comprehensive care plan developed with interventions implemented to address the development of the 5/21/21 facility	F 686	The DON/ADON or designee will review all EX Order 26 § 4 consults for the EX Order 26 § 4 doctor weekly and assess resident EX Order 26 § location after receiving consult note to ensure correct extremity is documented weekly for 30 days. Random audits will continue for one month after initial 30 days for a minimum of 5 resident charts with EX Order 26 § 4b . Lastly, All resident EX Order 26 § 4 consults will be audited randomly while assessing resident EX Order 26 § 4 location for during month 3 to ensure correct location is documented by EX Order 26 § 4 MD and weekly EX Order 26 § tracking assessment. All nurses were educated on ensuring that expiring orders are reordered at the time of expiration after calling MD to verify if warranted. The DON/ADON/MDSC (Minimum data set coordinator) or designee will monitor all EX Order 26 § 4 orders weekly for one month to ensure that physician orders continue while a EX Order 26 § 4 is still present. Random audits will continue for an additional 30 days for a minimum of 5 resident charts to ensure EX Order 26 § orders continue while appropriate. Lastly, random audits will be performed for month 3 on a minimum of 15 EX Order 26 § 4 orders for the month to ensure orders are present for continuum of care. All nurses were in-serviced on plotting orders in EMR that requires accountability. The DON/ADON or designee will perform random audits of 10 residents per week	

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F 686	Continued From page 19 acquired EX Order 26 § 4b1 . A review of the quarterly Braden Scale for Predicting Pressure Sore Risk, an assessment tool used to determine risk of developing a pressure ulcer, dated 4/13/21 indicated a score of 15 which indicated the resident was at risk for developing a pressure ulcer. A review of the May 2021 electronic Treatment Administration Record (eTAR) reflected that a nurse signed that Resident # 52 had a weekly skin assessment on the evening shift on 5/17/21, four days before the EX Order 26 § 4 was identified. There was no documented evidence for the findings of the complete skin assessment signed as conducted on 5/17/21 in the eTAR or in the electronic and paper medical records. A review of the electronic order summary report reflected a physician's order (PO) dated 11/1/20 for pressure reducing device to bed and EX Order 26 § 4b1 every shift. In addition, there was a PO dated 6/7/21 to provide EX Order 26 § 4b1 two times a day for risk of EX Order 26 § 4b1 4 oz [ounces] at lunch and dinner. A review of the eTAR for May and June 2021 reflected the above corresponding PO for the pressure reducing device to bed and EX Order 26 § 4b1 every shift. A review of the eMAR for June 2021 reflected the above corresponding PO to provide Health Shake two times a day. A review of the electronic Progress Notes dated 5/21/21 timed at 13:43 and written by a Licensed Practical Nurse (LPN) reflected that the resident	F 686	for 1 month to monitor for accountability in the EMR for orders written. Random audits will continue after 1 month, for 5 residents weekly for 1 additional month. Lastly, 30 resident records will be randomly audited during month 3 for accuracy in plotting orders on EMR to ensure signatures and accountability is required. All nursing staff has been educated on notifying the MDSC (Minimum data set coordinator), DON or ADON and adding any changes to daily 24hour report when a change is required to the care plan. The DON/ADON/MDSC (Minimum data set coordinator) or designee will be responsible to review 24hour report daily from each unit for 30 days to ensure that all changes are reported and care plans are updated. The IDC (Interdisciplinary care) team will meet weekly to review all changes to resident condition and monitor that care plans have been updated. This process will continue weekly for 4 weeks after 30 days of daily audits, then bi-weekly for one month. Element Four Results of these audits will be recorded and reported by the Director of Nursing to the Quality Assurance Committee and Administration quarterly. Actions will be implemented as appropriate. Results will be utilized for training purposes and systemic changes.	

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was received in bed in a supine position with the head of the bed elevated ..."resident has [redacted] and called to NP [nurse practitioner] but did not received call back from them waiting for treatment for resident, safety in place will be monitoring."

A review of the electronic Progress Notes dated 5/21/21 timed at 14:42 and written by an LPN reflected that the LPN received an order for the resident's [redacted] from the doctor.

Further review of the electronic Progress Notes dated 5/21/21 timed at 16:27 and written by a physiatrist [physical medicine and rehabilitation doctor] physician assistant reflected that the resident was seen and examined in the "morning secondary to nursing request ... Nursing advised stage 2 left heel [redacted] was noted this morning. Patient is sitting in [redacted] and in NAD [no apparent distress] ...denies [redacted]. [redacted] is stable with [redacted]." The note further included "[redacted]." The Progress Note did not indicate evidence of [redacted]

A review of the electronic Progress Notes for the Initial [redacted] Consult written by the [redacted] doctor dated 5/27/21, six days after the [redacted] was identified on 5/21/21, reflected "Pt [patient] presents with [redacted]

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described as EX Order 26 § 4b1 . Context of EX Order 26 § 4b1 is that pt [patient] is EX Order 26 § 4b1 EX Order 26 § 4b1 . Pt [patient] complains of EX Order 26 § 4b1

Further review of the progress notes under assessment indicated "EX Order 26 § 4b1 "

There was no assessment of the facility acquired EX Order 26 § 4b1 from a Registered Professional Nurse. There was no documented evidence of a complete and through assessment of the facility acquired EX Order 26 § 4b1 by a Registered Professional Nurse or a physician from 5/21/21 through 5/27/21 (7 days). Furthermore, the documented assessment by the EX Order 26 § 4b1 indicated he documented the EX Order 26 § 4b1 .

A review of the electronic order summary report reflected a PO dated 5/21/21 for EX Order 26 § 4b1 Further review of the order summary reflected an end date for 5/28/21.

A review of the May 2021 eTAR reflected the above corresponding PO. Further review of the eTAR revealed that the EX Order 26 § 4b1 on

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 22 5/23/21 was not signed. Further review of the electronic progress notes and the order summary did not reflect that a PO was obtained for the EX Order 26 § 4b1 after the 7 days ended on 5/28/21. Further review of the electronic medical record revealed that from 5/28/21 through 6/3/21 (7 days) there was no PO obtained and no accountability that the resident received treatment to his/her EX Order 26 § 4b1 . Review of the order summary reflected a PO dated 6/4/21 for EX Order 26 § 4b1 Review of the June 2021 eTAR reflected the above corresponding PO. Further review of the order summary reflected a PO for Ex.Order 26.4(b)(1)] when in bed dated 5/21/21 and a PO for EX Order 26 § 4b1 dated 5/21/21. Review of the May and June 2021 eTAR did not reflect the above corresponding PO's. There was no accountability for the EX Order 26 § 4b1 when in bed from 5/21/21 through 6/13/21 and no accountability for the EX Order 26 § 4b1 from 5/21/21 through 6/14/21. A review of the electronic EX Order 26 § 4b1 -V 2 form created by the Assistant Director of Nursing/Licensed Practical Nurse (ADON #1) reflected that an EX Order 26 § 4b1	F 686		

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	315042	A. BUILDING _____ B. WING _____	C 06/15/2021

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turning and repositioning were preventative measures in place. She documented that the location of the Ex.Order 26.4(b)(1) was the "EX Order 26 § 4b1 " and that the date acquired was documented as "05/25/21." The area to describe the extent of the EX Order 26 § 4 was left blank.

The surveyor could not locate the electronic 6/3/21 EX Order 26 § 4b1 -V 2 in the electronic medical records (EMR). The ADON/LPN #1 provided the surveyor with a printed copy of the form on 6/10/21 at 12:10 PM. At that same time, the ADON/LPN #1 stated "it was on my desk."

On 6/10/21 at 10:50 AM, the surveyor interviewed the ADON/LPN #1 who stated that she documented "EX Order 26 § 4b1 " on the 5/27/21 EX Order 26 § 4 V 2 form "because I read what the doctor wrote and documented what he wrote. He wrote right heel." The surveyor asked the ADON/LPN #1 if she looked at the

. She stated, "no, I didn't see the EX Order 26 § 4." She further stated that the purpose of the EX Order 26 § 4 - V 2 form was to track the EX Order 26 § 4 but "I don't fill it out until after the resident is seen by the EX Order 26 § 4b1 ." She further stated that "Licensed Practical Nurses are allowed to take measurements of a EX Order 26 § 4 and document the EX Order 26 § 4b1 . They are not allowed to EX Order 26 § 4b1 ." The ADON/LPN #1 further stated that the facility's process when a EX Order 26 § 4 is found is to call the doctor, get an order based on the appearance of the EX Order 26 § 4 then refer for a EX Order 26 § 4b1 . She further stated, "the care plan should have been initiated by me or the MDS coordinator. I just didn't get that far yet. We usually have meetings weekly. Today we are having a meeting, usually on Thursdays."

On that same date at 11:30 AM, the surveyor

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interviewed the physiatrist physician assistant who stated, "I was asked by nursing to see the resident due to the EX Order 26 § 4b1, but I don't assess the EX Order 26 § 4. The EX Order 26 § 4b1 doctor would do that. I examined [him/her] so that therapy would not hinder the EX Order 26 § 4. The EX Order 26 § 4b1 doctor would do the measurements and assess the EX Order 26 § 4. I did not do that. No, I would not assess the EX Order 26 § 4 or order a treatment for the EX Order 26 § 4b I examined [him/her] on 5/21/21 so that the EX Order 26 § 4 wouldn't get hindered by therapy."

On that same date at 11:45 AM, the surveyor interviewed the Registered Nurse (RN) assigned to care for Resident # 52. The RN stated and confirmed that he was the assigned nurse who worked on 5/21/21 but he did not remember if he reported the EX Order 26 § to the nursing supervisor. He stated that the facility process when a EX Order 26 § is found "is you would call the doctor, get an order for the EX Order 26 § after you have assessed the EX Order 26 § 4. If I found the EX Order 26 § myself, I would have obtained an order. I would have assessed the EX Order 26 § 4 and documented the EX Order 26 § 4 and documented my interventions." He further stated that usually the care plans are updated or revised by the supervisor or managers.

Later, on that same date at 12:00 PM, the surveyor interviewed the EX Order 26 § 4 doctor who stated and provided an addendum to his 5/27/21 progress note. He confirmed and acknowledged that he erroneously documented the 'EX Order 26 § 4b1' when he should have documented 'EX Order 26 § 4b1.'

Review of the 6/9/21 EX Order 26 § 4 doctor's Progress Note addendum reflected "note discrepancy correction: note from 5/27/21 erroneously lists EX Order 26 § 4 as being on EX Order 26 § 4b1 when it is

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actually on EX Order 26 § 4b1 [redacted] of this visit. Treatment has however been ordered correctly to EX Order 26 § [redacted] "

On 6/10/21 at 12:34 PM, the surveyor conducted a telephone interview with the LPN who identified the facility acquired EX Order 26 § 4b1 on 5/21/21. The LPN stated that he worked on 5/21/21 with an RN who was orientating him to that unit. He stated that "the RN was the one who found the EX Order 26 § [redacted] and showed him the EX Order 26 § [redacted] " and the both of them called the doctor to obtain a EX Order 26 § 4 [redacted] treatment order but he was the one who documented the EX Order 26 § [redacted] in the progress notes.

On 6/10/21 at 12:55 PM, the surveyor interviewed the ADON/LPN #1 who confirmed that there was no PO obtained from 5/28/21 through 6/3/21 (7 days). She further stated that there should have been a PO obtained and she did not know why is wasn't. She stated that even though there wasn't a PO the 11-7 nurse continued to do the EX Order 26 § 4 [redacted] treatment.

On 6/11/21 at 11:00 AM, the ADON/LPN #1 provided the surveyor a handwritten statement from the 11-7 nurse, an LPN indicating he continued to do the treatment to the EX Order 26 § 4b [redacted] without a PO.

Review of the 11-7 nurses' handwritten statement reflected "this is to inform your good office that in good conscience, I continued to do [name redacted] EX Order 26 § 4b1 [redacted] daily EX Order 26 § 4b1 [redacted] [treatment] after the EX Order 26 § 4b1 order from May 27, 2021 onward. Seeing the EX Order 26 § 4 [redacted] not yet fully healed but did not get worse, I continued to do the same kind of EX Order 26 § 4b1 [redacted] [treatment] as

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previously ordered plus applied [his/her] [EX Order redacted]. It's my daily routine [EX Order 26 § 4b1 redacted] since May 27, 2021."

On 6/14/21 at 11:25 AM, the surveyor again interviewed the RN who had stated he did work on 5/21/21. He stated that he was not told about the [EX Order 26 § 4 redacted] on 5/21/21 and that he had no knowledge of the [EX Order 26 § 4 redacted] "so that is why I did not assess or document the [EX Order 26 § 4 redacted] in the progress notes."

On 6/14/21 at 11:30 AM, the surveyor observed Resident # 52 lying in bed. There was no air mattress in use and there were no [EX Order 26 § 4b1 redacted] in use. The surveyor observed the [EX Order 26 § 4b1 redacted] on the [EX Order 26 § 4b1 redacted] seat. At that same time, the surveyor asked the RN assigned to care for the resident to show the surveyor the resident's feet. The RN applied gloves and lifted the blanket. The resident was observed without any [EX Order 26 § 4b1 redacted] in use and the [EX Orde redacted][EX Order redacted][EX Order 26 § 4b redacted][EX Order 26 § 4b1 redacted] was off and the [EX Order 26 § 4 redacted] was exposed and touching the bed linen. The RN stated, "the [EX Order 26 § 4b1 redacted] should be on." The surveyor asked the RN who was responsible for applying the [EX Order 26 § 4b1 redacted]. The RN stated, "the CNA." The surveyor asked who signs for or ensures that the [EX Order 26 § 4b1 redacted] are in use. The RN stated, "I do."

On 6/14/21 at 11:51 AM, the surveyor interviewed the CNA assigned to care for Resident # 52. The CNA stated "I am responsible for applying his/her [EX Order 26 § 4b1 redacted] but because he was resisting this morning, I couldn't put them on. I told the male CNA an hour ago. No, I did not tell the nurse."

On that same date at 12:00 PM, the surveyor

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interviewed the male CNA who stated "yes, the other CNA came and got me because she didn't know what do to. The resident was resisting to wear the [redacted]. I told the RN."

On 6/14/21 at 1:33 PM, the surveyor attempted but was unable to conduct a telephone interview with the 11-7 LPN who continued to do the [redacted] treatment to the [redacted] without a PO.

Later, on that same day at 2:50 PM, the surveyor observed Resident # 52 lying in bed with [redacted] in use.

On 6/14/21 at 5:55 PM, the surveyor conducted a telephone interview with the 11-7 LPN who stated "I continued to do the treatment to the [redacted] without an order because the treatment needed to be continued. In all honesty and in good consciousness I had to continue the treatment. The 7-3 nurse rounds with the [redacted] doctor who should have obtained an order to continue the treatment."

On 6/14/21 at 3:26 PM, the surveyor interviewed the DON who stated "there should have been an RN assessment of the [redacted] which should have been documented but the PA [physiatrist physician assistant] assessed [him/her] the [redacted]" The DON further stated that there should have been a care plan developed and implemented for the [redacted] and did not know why there wasn't one. She also acknowledged that there should have been a PO obtained after the 5/21/21 PO ended. The DON confirmed that the 11-7 LPN continued to do the [redacted] treatment without a PO and that he should not have done so without an order. The DON could not speak to why there was no PO obtained from 5/28/21

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through 6/3/21. She also could not speak to why an air mattress wasn't ordered until 6/14/21.

On 6/15/21 at 10:32 AM, the surveyor observed Resident # 52 awake out of bed seated in a EX Order 26 § 4b1 inside his/her room. The resident was observed wearing the EX Order 26 § 4b1 on the EX Order 26 § 4b and the surveyor observed an air mattress in use.

On 6/15/21 at 1:06 PM, the surveyor interviewed the DON who stated that the PA put the order for EX Order 26 § 4b1 into the electronic medical records incorrectly and that was why there was no accountability for it. The DON acknowledged there should have been accountability for the offloading of the resident's EX Order 26 prior to 6/13/21. The surveyor asked the DON why there was no air mattress in use until 6/15/21. The DON stated that the resident's mattress was a Lumex standard care foam mattress and that the mattress was effective in the prevention of a EX Order 26 § 4b1. She provided the surveyor with the specifications for the Lumex standard Care Foam Mattress. She further stated that "we met yesterday with the PA [physiatrist physician assistant] as to what more we could have done to prevent his/her pressure ulcer, so he/she is having a EX Order 26 § 4b1 done today to see if there is any EX Order 26 § 4b1 going on."

Review of the specifications for the Lumex Standard Care Foam Mattress 316 and 319 series provided by the DON indicated that the mattress is effective in the prevention or treatment of a EX Order 26 § 4b1. The resident was assessed by the EX Order 26 § 4 care doctor on 5/27/21 with a EX Order 26 § 4b1 on the EX Order 26 § 4b. The Lumex Standard Care Foam

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Mattress was not an appropriate intervention to facilitate the healing of a EX Order 26 § 4b1 .

A review of the EX Order 26 § 4b1 Investigation Worksheet dated 5/25/21 provided by the ADON/LPN #1 indicated that Resident # 52's facility acquired EX Order 26 § 4b1 was identified on 5/21/21 on the EX Order 26 § 4b. The investigation also indicated the resident did not have a history of EX Order 26 § 4b1 and that the following preventative measures were implemented prior to the development of the EX Order 26 § 4b1 to the EX Order 26 § 4b: EX Order 26 § 4b1 The risk factors identified were EX Order 26 § 4b1 consult dated 5/21/21. The investigation conclusion indicated the EX Order 26 § 4b1 was secondary to EX Order 26 § 4b1 .

A review of the facility's policy for Identifying a EX Order 26 § 4b1 dated 4/29/21 included that a "nurse should evaluate the Ex.Order 26.4(b)(1) and gather information to relay to the physician to obtain an appropriate plan of care ...the physician should be notified to come assess the area and give orders ...if physician is not present in the facility the nurse should notify the physician via telephone, describe the EX Order 26 § 4 with the most accurate information, and obtain orders to ensure proper delivery of care ...treatment orders should be obtained ...pressure relieving intervention orders should be obtained .. EX Order 26 § 4 will be tracked and added to the quarterly QAPI meeting for review."

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F 686	Continued From page 30 A review of the facility's policy for Acute Condition Changes-Clinical Protocol dated 4/23/21 included that "an LPN may assess under the supervisor of an RN, NP, PA or physician and report all findings to the physician for the purpose of obtaining proper orders to treat. A review of the facility's policy for Pressure EX Order 26 § 4b1 -Clinical Protocol dated 4/23/21 included that "the nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing EX Order 26 § 4b1 ." A review of the facility's policy for Using the Care Plan dated 4/23/21 included that "Facility staff noting a change in the resident's condition must also report these changes to the Nurse Supervisor and/or the ADON. Changes in the resident's condition must be reported to the ADON so that a review of the resident's assessment and care plan can be made." According to the New Jersey Board of Nursing, Chapter 37 with a revision date of 10/19/20 indicated "A registered professional nurse shall not delegate the physical, psychological, and social assessment of the patient, which requires professional nursing judgement, intervention, referral, or modification of care." NJAC 8:39-27.1 (e)	F 686		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes,	F 692		7/2/21

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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 observation, interview, record review, and review of facility documents, it was determined that the facility failed to prevent a severe weight loss of [redacted] pounds (lbs) which was [redacted]% in 50 days from 3/2/21 through 4/21/21, a 7.7 lbs loss which was [redacted]% in 14 days from 4/21/21 through 5/5/21, and an additiona[redacted] lb loss from 5/5/21 through 6/2/21. The facility failed to a.) identify significant weight losses and obtain reweights in a timely manner, b.) implement and monitor weekly weights, c.) ensure prescribed fortified foods were provided, d.) evaluate and adjust nutritional interventions, e.) comprehensively assess the resident after a significant weight change and f.) revise the nutritional care plan. This was identified for 1 of 9 residents (Resident #30) reviewed for nutrition.

Lincoln Park Renaissance Rehab & Nursing
Plan of Correction for Event ID# OWHU11
Survey Date: 06/15/2021

Completion Date: 7/2/21
F692
Element One
Resident #30 is currently residing in the facility. Resident #30 was immediately placed on weekly weights, the medical record was reviewed by the interdisciplinary care team including the physician to ensure that proper interventions were put into place.
Resident #30 was scheduled for a [redacted]
A significant change MDS

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The evidence was as follows:

On 6/8/21 at 1:10 PM, two surveyors observed Resident #30 in his/her room in a reclined chair with eyes closed. The lunch tray was on an overbed table. Review of the lunch tray meal ticket listed pureed Philly cheese steak on a bun, pureed peppers & onions, mashed potatoes (not identified on the meal ticket as fortified), pureed cauliflower, pudding (not identified on the meal ticket or labeled as fortified), four-ounce whole milk, coffee, salt, pepper and sugar.

On 6/9/21 at 9:15 AM, the surveyor observed the residents breakfast tray on an overbed table. Review of the breakfast tray meal ticket listed grits (not identified on the meal ticket or labeled as fortified cereal), one slice of puree French toast, puree breakfast sausage, four-ounce orange juice, eight-ounce whole milk, coffee, margarine, salt, pepper, sugar packets and maple syrup.

On 6/10/21 at 8:40 AM, two surveyors observed the residents breakfast tray on an overbed table. Review of the breakfast tray meal ticket listed farina cereal (not identified on the meal ticket or labeled as fortified), pureed scrambled eggs, four-ounce orange juice, eight-ounce whole milk, coffee, margarine, salt, pepper, sugar packet and jelly. The resident's assigned Certified Nurse Aide (CNA) #1 was present. She stated that the resident needed to be fed and had a varied consumption of the pureed meals but consumed 100% of fluids, the supplement Two Cal HN and typically preferred fluids and sweets.

On 6/11/21 at 9:25 AM, the surveyor observed the residents breakfast tray on an overbed table.

was completed and care plan was updated according to changes in the residents plan of care.

Reweigh policy was reviewed with administration and dietitian in regards to obtaining weights for significant weight changes.

Dietitian was immediately educated on obtaining weights and reweights in a timely manner.

Policy for implementing and monitoring weekly weights was reviewed and revised by administration and dietitian.

Dietitian and nurses were immediately in-serviced on implementing weekly weights on any resident with a significant change.

Dietitian, FSD (Food Service Director) and nursing staff were immediately educated on checking trays to ensure ordered fortified foods are present on tray prior to administering tray to resident.

An audit was immediately performed by FSD (Food Service Director) and dietitian on all residents being provided fortified foods to check trays prior to leaving kitchen and prior to being given to residents to ensure all ordered items are present on the tray.

An in-service was performed with the MDSC (Minimum Data Set Coordinator) and dietitian on comprehensive

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F 692	Continued From page 33 Review of the breakfast tray meal ticket listed Maypo cereal (not identified on the meal ticket or labeled as fortified), pureed Western omelet, puree wheat toast, four-ounce orange juice, eight-ounce whole milk, coffee, margarine, salt, black pepper, sugar, and jelly. CNA #1 was present and stated the resident consumed 25% of meal, mainly hot cereal, and drank 100% of the liquids. The surveyor reviewed the medical record for Resident # 30. The resident's Face Sheet (an admission record) reflected the resident was admitted on Ex.Order 26.4(b)(with diagnoses that include Ex.Order 26.4(b)(1). A further review of the resident's medical diagnoses included unspecified protein-calorie EX Order 26 § 4b1 dated 12/8/20. A review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 3/27/21 reflected a Brief Interview for Mental Status (BIMS) score of EX O which indicated the resident cognition was Ex.Order 26.4(b)(1). A review of the Order Summary Report reflected a physician's order (PO) dated 8/21/20 for a puree diet with "Fortified foods (cereal/mashed/pudding);" a PO dated 8/20/20 for EX Order 26 § 4b1 (a nutrient dense supplement) eight ounces two times a day with med pass at 9 AM and 6 PM. Further review of the order summary reflected a PO dated 10/15/20 to "Monitor behavior every shift (crying/screaming/physically aggressive with staff during am care) every shift."	F 692	assessments after a significant weight change. The dietitian was immediately in-serviced on properly and immediately updating the nutritional care plan when a change in status or intervention is identified. Element Two All residents in the facility are at risk to be affected by this deficient practice. Education was provided to all nursing staff, FSD (Food Service Director and dietitian and audits were immediately conducted to identify deficient practices. All discrepancies identified during the audit process were immediately corrected. Element Three All nurses and dietitians were immediately educated on obtaining reweights for significant weight losses, reweights and notifying IDCP (Interdisciplinary Care Plan) team. Weekly weight meetings will be held with the dietitian and IDCP (Interdisciplinary Care Plan) team. The Dietitian/DON/ADON or designee will review the weight book on each unit daily and ensure that all weights for that day have been recorded. Results of audit will be brought to daily clinical morning meeting and issues related to unobtained weights will be addressed immediately. This process will continue for 60 days. For the third month, random audits of a minimum of 25 resident weights and the time taken to obtain weight will be audited.	

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F 692	Continued From page 34 A review of the March 2021 electronic Medication Administration Record (eMAR) did not reflect the above corresponding PO for fortified foods. There was no documented evidence of monitoring for prescribed fortified foods. Further review of the eMAR revealed that the resident consumed EX Order 26 § of the EX Order 26 § 4b1 . Review of the March 2021 behavior monitoring in the eMAR record reflected the resident did not exhibit any behaviors. Review of the April 2021 eMAR did not reflect the above corresponding PO for fortified foods. There was no documented evidence of monitoring for prescribed fortified foods. Further review of the eMAR revealed that the resident consumed EX Order 26 § Review of the April 2021 behavior monitoring indicated the resident exhibited behaviors on 4/1/21, during the 11-7 shift. The behavior exhibited was not documented. There was no other documented evidence of the resident exhibiting behaviors until the 23 rd of the month for the 7-3 and the 3-11 shift. Review of the May 2021 eMAR did not reflect the above corresponding PO for fortified foods. There was no documented evidence of monitoring for prescribed fortified foods. Further review of the eMAR revealed that the resident consumed EX Order 26 § Review of the May 2021 behavior monitoring	F 692	The Dietitian/DON/ADON or designee will review 24-hour report 3 times per week to identify any weight changes. Additionally, the dietitian will round on each unit daily and speak to staff to identify any weight changes. Once a weight change is identified the morning clinical team will discuss to identify the appropriate weight orders to be put in place. This process will take place daily for 60 days. For the third month, random audits of all weights for a minimum of 25 residents will be reviewed, frequency of weight orders will be reviewed and audited at that time. All Food service employees that fill tray tickets were educated on process to check trays twice for fortified foods prior to tray leaving kitchen. All nursing staff was educated to check tray to ensure fortified foods is present on tray prior to giving to resident. The Dietitian/DON/ADON or designee will audit trays to ensure ordered fortified foods are present on tray. For the first 30 days, the Dietitian/ADON/DON or designee will audit 5 trays three times a week for both breakfast and lunch to ensure fortified foods are present on trays. For the following 30-day period, 5 random trays will be audited daily. Lastly, for the final 30 days, random audits will be performed over the 30-day period on a minimum of 25 trays to ensure ordered fortified foods are present on the tray.	

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indicated the resident exhibited behaviors on 5/7/21, during the 7-3 shift, 5/14/21, during the 3-11 shift, and on 5/16/21, during the 7-3 shift. There was no other documented evidence of behaviors exhibited by the resident for the month of May 2021.

Review of the June 2021 eMAR did not reflect the above corresponding PO for fortified foods. There was no documented evidence of monitoring for prescribed fortified foods. Further review of the eMAR revealed that the resident consumed [redacted]

Review of the June 2021 behavior monitoring indicated the resident exhibited behaviors on 6/3/21 during the 3-11 shift, and 6/9/21 through 6/11/21 during the 7-3 shift.

The surveyor reviewed the weight record in the electronic medical record (EMR). Weights documented were as follows:

3/2/21 [redacted]
4/21/21 [redacted]
5/5/21 [redacted]
5/24/21 [redacted]
6/2/21 [redacted]

Review of the Registered Dietitian's (RD) Quarterly Nutrition Note dated 3/25/21, reflected the resident was on a puree diet with "fortified foods (cereal, mashed and pudding) at meals" and eight-ounces of [redacted] The RD's note reflected that the resident's meal intake was between [redacted] and supplement intake was [redacted]. She further

The dietitian will audit identified residents with a weight change for appropriate nutritional interventions via audit and review at clinical report with IDCP (Interdisciplinary Care Plan) team. All residents with an identified weight change will be placed on the audit sheet and reviewed three times per week at morning report with the IDCP (Interdisciplinary Care Plan) team for 30 days. For the following 30 days, the dietitian will identify 5 residents per day three times per week to audit for appropriate interventions. Lastly, for the final 30 days, random audits will be performed over the 30-day period on a minimum of 25 residents with a weight change to have nutritional interventions reviewed.

The MDS department was educated on bringing to the attention of the IDCP (Interdisciplinary Care Plan) team daily during clinical meeting if any significant weight changes are noted and a comprehensive significant change is warranted.

THE MDSC/DON/ADON or designee will audit 5 charts per week with a significant weight change to identify if a comprehensive significant change is warranted and discuss findings with the IDCP team daily for 60 days. For the final 30 days a random audit of 10 resident charts with weight changes will be audited to determine if a comprehensive significant change is warranted.

The Dietitian/DON/ADON or designee will

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F 692	Continued From page 36 indicated that the resident was receiving an appetite stimulant [redacted], had a history of significant weight loss and had not gained weight over the last six months. The RD questioned the effectiveness of the [redacted] and indicated that the resident may benefit from the discontinuation of [redacted]. The RD made no nutritional recommendations. Review of the RD's Weight Change Note dated 4/21/21, indicated she had witnessed the resident's weight obtained on 4/21/21. The resident weighed [redacted] lbs. The RD documented "It suggests significant weight loss of [redacted]. [redacted] is not desired and seems to be due to suboptimal PO [by mouth] intake. Resident was taken off [redacted] (3/25/21) in lieu of no [redacted], however, [redacted] may have been keeping resident [redacted] stable. [Resident] is fed regular [redacted] diet at meals with noted decrease in po intake- now consuming [redacted] Fortified foods (cereal/mashed and pudding) provided as well as [redacted]. No recent labs and [redacted] currently intact. Recommend to restart [redacted] bid to stimulate [redacted]." The RD made no nutritional recommendations. Further review of the EMR and paper chart, revealed no documented evidence that the facility addressed the 5/5/21 Ex.Order 26.4(b)(1) of [redacted] lbs (5.6%) since 4/21/21 (15 days). The resident weighed [redacted] lbs on 4/21/21 and weighed [redacted] lbs on 5/5/21. The RD did not address the residents Ex.Order 26.4(b)(1) until 5/24/21 (19 days later).	F 692	audit 5 resident charts, three times per week to ensure that the nutritional care plan has been updated for all residents with an identified weight change. For the following 30 days, a random audit of 5 charts per week for residents with a weight change to ensure that the nutritional care plan has been updated. For the final 30 days, a total of 10 random charts will be audited to ensure that nutritional care plans have been updated with the appropriate interventions. Element Four Results of these audits will be recorded and reported by the Director of Nursing to the Quality Assurance Committee and Administration quarterly. Actions will be implemented as appropriate. Results will be utilized for training purposes and systemic changes.	

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Review of the EMR and paper chart did not reveal that the physician was notified on 5/5/21 of the resident's Ex.Order 26.4(b)(1) of [redacted] within 15 days.

Review of the RD's Weight Change Note dated 5/24/21, indicated EX Order 26 § 4b1 [redacted] not desired and is due to suboptimal po intake. Resident is fed regular EX Order 26 § 4b1 diet at meals. Appetite EX Order 26 § 4b1 with anywhere from EX Order 26 § 4b consumed. EX Order 26 § 4b1 provided-currently on EX Order 26 § 4b1, as well as EX Order 26 § 4b1 to tx [treat] dx [diagnosis] depression with possible s/e [side effects]of increasing EX Order 26 § 4b1. Nursing staff reports that his/her refusal of po is 'behavioral.' In order to meet estimated EX Order 26 § 4b1 needs, EX Order [redacted] provided BID [twice a day] (also accepted with fluctuation) and po fluids encouraged ...Reviewed resident status with ADON [Assistant Director of Nursing.] Family will be informed, and plan of care options discussed. Recommend d/c [discontinue] EX Order 26 § 4b at this time due to ineffective." The RD made no nutritional recommendations.

Review of the RD's Weight Change Note dated 6/9/21, indicated EX Order 26 § 4b1 [redacted] EX Order 26 § 4b1 not desired and is due to suboptimal EX Order 26 § 4b1. Resident has been on EX Order 26 § 4b1 EX Order 26 § 4b1 EX Order 26 § 4b1 and EX Order 26 § 4b1 with no effect. He/she remains on EX Order 26 § 4b1 for EX Order 26 § 4b1 with possible s/e [side effect] of EX Order 26 § 4b1. Resident

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is fed regular puree thin liquid diet at meals. Despite encouragement, [redacted] fluctuates with anywhere from [redacted] consumed. No noted difficulty EX Order 26 § 4b1. Fortified foods (cereal at breakfast, mashed and pudding at lunch/dinner) provided. In addition [redacted] provided bid to better meet estimated nutritional needs. Resident also accepts this with fluctuation. Po fluids encouraged. No new labs and skin intact. MD aware of resident decline. Resident family has been informed of Ex.Order 26.4(b)(1) Awaiting family to return calls to make decision of plan of care." The RD made no nutritional recommendations.

Review of the Physicians note dated 4/6/21, indicated [redacted] not yet recorded this month." It also reflected that the residents baseline weight was 120 lbs and the resident's order for [redacted] was recently discontinued. It further reflected "dietitian following."

Review of the Physicians note dated 5/4/21, indicated "Weight not yet recorded this month." It also reflected that the residents baseline weight was 120 lbs and the resident's order for [redacted] was increased. It further reflected "dietitian following."

Review of the Physicians note dated 6/1/21, indicated that the residents baseline weight was [redacted] lbs and was [redacted] to [redacted] lbs. It also reflected that the recent increase of [redacted] showed no improvement. It further reflected "dietitian following" and "patient's family discussing hospice care."

Review of the Physicians note dated 6/13/21,

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indicated that the Physician's Assistant (PA) and the ADON discussed the options of Hospice verse the risks and benefits of "EX Order 26 § 4b1 "Ex.Order 26.4(b)(1) directly to the EX Order 26 § 4b1) with the family post surveyor inquiry. Documentation reflected the family decided to proceed with the EX Order 26 § 4b1 placement.

A review of the resident's individual nutritional comprehensive Care Plan initiated on 12/26/19 and revised 3/25/21, reflected the resident had a history of EX Order 26 § 4b1 and significant EX Order 26 § 4b1, but did not address the residents recent EX Order 26 § 4b1 for April and May of 2021. The Care Plan "Goal" area had not been revised since 3/25/21 and reflected that the resident would EX Order 26 § 4b1 The Care Plan "Interventions" area reflected to monitor for EX Order 26 § 4b1 which included a EX Order 26 § 4b EX Order 26 § loss in one week. This parameter could not be used since weekly weights were not implemented for monitoring.

On 6/11/21 at 10:25 AM, the surveyor, in the presence of another surveyor interviewed the residents Licensed Practical Nurse (LPN) #1. She stated that the resident had EX Order 26 § 4b1 and had a varied meal intake and "takes the supplement EX Order 26 § 4b1 well." The LPN also stated that the resident drinks better than eating the puree food and preferred sweet items. She further stated that she thought the resident received fortified foods and confirmed there was an order in the electronic medical Record (EMR), but it was not on the eMAR and acknowledged there was no documented evidence to ensure the resident

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received and consumed the items. The LPN stated that the resident had Ex.Order 26.4(b)(1) and that the supervisor, the family, the physician, and the RD were typically notified. She also stated that the RD would usually recommend a three-day calorie count, weekly weights and a change in supplementation, however she acknowledged that the RD did not do this for Resident #30.

On 6/11/21 at 10:45 AM, the surveyor, in the presence of another surveyor interviewed the Food Service Director (FSD), the Food Service Supervisor (FSS), and the Dietary Secretary (DS). The FSD stated that they received diet change information which included the addition of fortified foods via email notification as well as in writing on a designated form which they kept on file over the last two years. The DS looked through these files and stated that there were "no communication forms" for Resident #30. The DS then gave the surveyor a copy of an email from the RD dated 6/9/21 which indicated "Please update Prime to reflect the following:" [Prime was the FS software program which was used to print the residents tray tickets]. Resident #30 was listed as should have been receiving "fortified cereal at breakfast, mashed and pudding at lunch/dinner." The DS stated, "this was the first time we got this." The FSD provided the surveyor with the fortified food recipes which reflected that oatmeal was the hot cereal specifically used to make the fortified cereal.

On 6/11/21 at 11:23 AM, the surveyor interviewed the (Licensed Practical Nurse/Assistant Director of Nursing) (LPN/ADON #2) and LPN #3 in the presence of the survey team. They both stated that they would have notified the FS department

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about an order for fortified foods in writing via a designated communication form. LPN #3 had signed for Resident #30's fortified food order in the EMR on 8/21/20. The LPN and the surveyor reviewed the EMR together. LPN #3 acknowledged she had signed for the fortified food order but could not remember if she communicated the order to the FS department. LPN/ADON #2 and LPN #3 stated that the fortified foods would not have been reflected on the eMAR and could not speak to how there would have been accountability to ensure the resident had received the fortified food items.

On 6/11/21 at 11:30 AM, the surveyor, in the presence of the survey team interviewed LPN/ADON #2 who stated that Resident # 30 had a significant EX Order 26 § 4b1 last year and the physician contributed the significant EX Order 26 § 4b1 to Covid-19. However, the resident had further significant EX Order 26 § 4b1 since. LPN/ADON #2 stated that she worked with the RD for all the interventions for Resident #30 but could not speak to nutritional interventions. She stated there were medication changes as well as psychiatric interventions related to behaviors which were now managed. She further stated that since the resident continued to Ex.Order 26.4(b)(1) despite interventions, she contacted the family regarding EX Order 26 § 4b1 versus a EX Order 26 § 4b1. This occurred post surveyor inquiry. She added that the family called back "today" and had decided "they" wanted the facility to proceed with a EX Order 26 § 4b1. She could not speak to whether a significant change MDS was completed.

On 6/11/21 at 1:15 PM, the surveyor, in the presence of the survey team interviewed the RD who stated that monthly weights should be

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completed by the 10th of the month and that reweights were taken when there was a significant change from the previous weight. She further stated that reweights were not always documented in the weight section; at times it was documented in her progress notes. The RD could not speak to why the resident's monthly weight for April 2021 was not documented in the EMR until 4/21/21. She stated, "I don't know why it took so long to get a weight." She also stated, "I have to chase them to get weights and the resident has behavior issues." She could not speak to whether the behavior issues were in relation to obtaining weights. The RD stated that she did not recommend weekly weights for the resident because the April 2021 weight obtained was so close to May 2021. She further stated she couldn't "get" a reweight of the resident for May 2021 until 5/24/21 and by then it was so close to June 2021 that she again did not recommend weekly weights. The RD stated that weekly weights were typically implemented when a resident has a significant EX Order 26 § 4b1 and could not speak to whether she notified anyone from nursing or administration regarding her inability to ascertain the resident weights in a timely manner. She stated that she asked LPN/ADON #2 to speak with the residents family about the Ex.Order 26.4(b Ex.Order 26 and that "we did everything we could on this end so the options are EX Order 26 § 4b or a EX Order 26 § 4b1 because" he/she "was still declining despite everything we were doing." The RD stated that she had not reassessed or adjusted the resident's nutritional needs after the significant Ex.Order 26.4(b Ex.Order 26.4(b) or the continued EX Order 26 § 4b1 "this" month since she assessed the resident's nutritional needs in the December 2020 annual assessment. She further stated that the resident's nutritional needs would not have changed since she based

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this on the resident's desirable body weight. The RD further stated that she had not seen the need to change the resident's nutritional interventions because "I didn't think the Ex.Order 26.4(b)(1) was related to calories; I do not reassess specifically." She stated that she felt the resident's April Ex.Order 26.4(b)(1) was due to the discontinuation of the [redacted] in March 2021 and her April 2021 intervention was to restart the [redacted]. The RD acknowledged that the resident had an additional significant Ex.Order 26.4(b [redacted] in May 2021 despite the restart of [redacted] and stated that was the reason the resident needed [redacted] or a [redacted]. The RD acknowledged that the resident was consuming the [redacted] well but did not recommend increasing it because "I didn't think calories was the problem." The RD stated that she was responsible to update the nutritional care plan when there were changes and acknowledged she had not updated the residents care plan since 3/25/21. She stated, "I did not update that." She acknowledged the care plan did not reflect the significant change Ex.Order 26.4(b)(1), that the goals were not met and were not measurable as there was no target weight range. The RD further acknowledged that she was unable to implement the monitoring intervention of a three lb weight loss within a week parameter, since she had not implemented weekly weights for Resident #30. She also stated that she did not inform the MDS Coordinator about the resident's Ex.Order 26.4(b)(1) [redacted] because the resident only had one decline in activities of daily living (ADLs), and two or more were required to proceed with a significant change MDS. She stated, "I don't know when I would tell the MDS Coordinator about a Ex.Order 26.4(b)(1)." The RD stated that the resident received a puree diet and fortified foods which consisted of hot cereal at breakfast and

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mashed potatoes and pudding at lunch and dinner. She stated that she notified the FS department via an email about the addition of fortified foods but could not speak to why the surveyors had not observed fortified foods on the resident's breakfast and lunch meal trays. She stated that each fortified item provided approximately 250-400 calories each. The RD stated that she did meal rounds but "I did not ask the residents regular CNAs what the resident likes to eat or drink." She stated that she did not see the need for further nutritional interventions prior to proceeding with a feeding tube and could not speak to why a feeding tube was not discussed with the resident family earlier.

On 6/11/21 at 1:50 PM, the surveyor, in the presence of the survey team interviewed the MDS Coordinator #1. She stated that a significant change MDS would not have been done for Ex.Order 26.4(b)(1) alone and that more than one decline in ADLs was required to qualify. She further stated that the Resident Assessment Instrument (RAI) manual guided the process for a significant change MDS which included an assessment step and a team meeting.

On 6/11/21 at 2:15 PM, the surveyor, in the presence of the survey team interviewed the residents PA. She stated that along with the Physician, they see the resident monthly. The PA stated that the resident had Covid-19 "last year and had end stage Ex.Order 26.4(b)(1) and was pretty healthy otherwise." She stated that the resident lost weight again after the new year and "had a Ex.Order 26.4(b)(1) this month." She stated that appetite stimulants were tried, and psychiatry was involved for a while. The PA acknowledged that the facility just recently spoke with the resident's

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family about a EX Order 26 § 4b1. She stated that when she documented in the progress notes "dietitian following" that it was both her and the physician's expectation that the RD was reassessing the resident's nutritional needs and implementing and adjusting nutrition interventions. She stated that "we rely on and defer to the RD." She further stated that the "expectation was that other nutritional interventions should have been tried before opting for a Ex.Order 26.4(b)(1)."

On 6/14/21 at 9:50 AM, the surveyor, in the presence of another surveyor interviewed CNA #2 assigned to care for Resident # 30.
The CNA stated that they usually finish taking monthly weights by the third of the month and give the weights to LPN #1. She stated she would be given a list if a resident needed to be reweighed or weighed weekly. CNA #2 stated that Resident #30 was combative during weighing at times; however, she weighed the resident on a Hoyer lift (an assistive device) with another CNA and they were always able to get a weight for the resident.

On 6/14/21 at 10:05 AM, the surveyor, in the presence of another surveyor interviewed LPN #1 who stated that monthly weights were done by the fifth of the month, and that weights were taken on the 7 -3 and 3-11 shifts. She also stated that the monthly weights were reviewed by the RD who informed her of which resident's required reweights or weekly weights. LPN #1 could not remember if the RD requested a reweight for Resident #30. She acknowledged that the resident was not on weekly weights and could not speak to why the April 2021 weight was not entered into the EMR until 4/21/21. When asked about nutritional interventions for this resident,

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LPN #1 stated that "the RD was on top of it."

On 6/14/21 at 11:10 AM, the surveyor, in the presence of the survey team interviewed the MDS Coordinator #1. She stated she had spoken to the Long-Term Care (LTC) MDS Coordinator #2 who stated that she had not been informed of Resident #30's Ex.Order 26.4(b)(1).

On 6/14/21 at 12:56 PM, the surveyor, in the presence of the survey team interviewed the MDS Coordinator #1 who stated that she spoke with the LTC MDS Coordinator #2 again who sent her copies of the form she used to meet with the team on 4/22/21 and 5/5/21 which indicated a decision not to proceed with a significant change MDS for Ex.Order 26.4(b)(1) for Resident # 30.

Review of the 4/22/21, IDT (interdisciplinary team) determination on whether significant change in status assessment will occur or not indicated "sig [significant] change will not occur secondary to inability to facilitate useful strategy to improve Ex.Order 26.4(b)(1). Pt [patient] remains a feeder. No decline noted in any other areas. Collective decision has made not to proceed with sig change assessment." Further review of the IDT document indicated that K0300 Emergence of unplanned EX Order 26 § 4b1 [redacted] was marked as checked.

Review of the 5/5/21, IDT determination on whether significant change in status assessment will occur or not indicated "Sig [significant] change will not occur as PT [patient] remains a feeder. No decline noted in any other areas. Decision was made by IDT team not to proceed with sig change assessment." Further review of the IDT document indicated that K 0300

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Emergence of EX Order 26 § 4b1 (EX Order 26 § 4b1 [redacted]) was marked as checked.

The MDS Coordinator #1 could not speak to the meaning of the verbiage on the form and could not speak to why the form was not part of either the EMR or the paper chart.

On 6/14/21 at 2:05 PM, the surveyor attempted to conduct a telephone interview with the LTC MDS Coordinator #2 but was unable to complete the interview.

On 6/14/21 at 2:34 PM, the surveyor, in the presence of the survey team interviewed the RD who stated that she sent a list of resident's who were on fortified foods via an email to FS on 6/9/21 to confirm they had the correct information. The surveyor asked the RD if she conducted tray audits for fortified foods to ensure residents received the items. The RD stated she did not conduct any tray audits. The RD provided the surveyor with the nutritional information for the fortified foods which revealed the following:

EX Order 26 § 4b1 [redacted]

On that same date and time, the RD further stated that she did not conduct weight audits or weight meetings. She then stated that she had notified MDS Coordinator #2 regarding the resident's Ex.Order 26.4(b)(1) on 4/21/21 and 5/5/21.

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She stated that "I don't recall why I told you I didn't tell the MDS Coordinator about the Ex.Order 26.4(b Ex.Order 26.4(b last week." The RD further stated that they met to decide if they were going to proceed with a significant change MDS or not and did not because there was only one decline in ADLs. The surveyor and the RD together reviewed the "IDT determination on whether significant change in status assessment will occur," dated 4/22/21 and 5/5/21. She stated that she could not speak to or explain the rationale that was written on IDT documentation forms and did not remember the content discussed. She acknowledged that she signed the forms and stated, "my lesson is to read what I sign before I sign it, now I've learned." The RD could not speak to what tools she used to monitor the resident. She again stated that "weeks went by quickly and I couldn't get reweights." She stated that she couldn't speak to if she or anyone documented that a weight could not be obtained due to the residents behaviors; but stated that it should have been documented, "you know what, from now on I will." The RD again acknowledged that she had not revised the resident's nutritional care plan and stated, "I should have updated it." She also stated, "I would have approached the family a lot quicker if I knew the appetite stimulants didn't work again." When asked about why nutritional interventions were not adjusted the RD stated, "I didn't think anything else should have been done."

On 6/14/21 at 3:27 PM, the surveyor, in the presence of the survey team interviewed the Director of Nursing (DON), the Licensed Nursing Home Administrator (LNHA) and the Administrator in Training (AIT). The DON stated that she was not involved with the MDS and

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would have to talk to the MDS coordinator regarding significant changes.

On 6/14/21 at 4:01 PM, the surveyor, in the presence of the survey team interviewed the DON, the LNHA and the AIT. The DON stated that she could not speak to why the April 2021 monthly weight was not documented until 4/21/21. She also stated that she could not speak to what if any nutritional interventions were implemented and how the resident was being monitored related to the Ex.Order 26.4(b)(1). The DON stated that the resident was consuming the supplements, "well I think 75%." She acknowledged she did not see documented evidence of the RD monitoring the resident, how the resident was responding to the order for [redacted] or staff unable to weigh the resident due to combative behavior. She further stated that once a Ex.Order 26.4(b)(1) was identified on 4/21/21 and 5/5/21, nutritional interventions should have been implemented even without a reweight. The DON stated that she assumed the RD would have implemented nutritional interventions, increased the supplements and recommended weekly weights. She stated that they rely on the RD. The DON stated she could not speak to why the resident had Ex.Order 26.4(b)(1) and could not recall team conversations about the same. She stated that the RD was responsible to update and revise the nutritional care plan and should have done so since the resident had a decline. The DON also acknowledged that the intervention for monitoring for a three lb Ex.Order 26.4(b) Ex.Order 26 in a week as significant was not possible since weekly weights were not implemented.

On 6/15/21 at 9:36 AM, the surveyor, in the presence of the survey team interviewed the

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DON who stated that the order for fortified foods should have been on the eMAR for accountability.

On 6/15/21 at 1:13 PM, the surveyor, in the presence of the survey team interviewed the DON, LNHA and AIT. The DON stated that the RD was unable to provide documentation that her method of estimating nutritional needs using desirable body weight were based on an accredited source.

Review of the facility policy for "Weight Assessment and Intervention" with a revised date of 4/23/21, reflected that the policy statement was that the multidisciplinary team would strive to prevent, monitor, and intervene for undesirable [redacted]. It also reflected that there was a weight change of [redacted]% or more since the last weight a reweight should be taken and if confirmed the RD would be notified immediately and would respond within 72 hours. The policy reflected that the RD would review the weight records by the 15th of the month and that a 5% loss would be considered significant and greater than 5% would be considered severe. It further reflected that the team would meet and implement a care plan for weight loss and nutrition, including time frames and parameters for monitoring and reassessment. In addition, it reflected that interventions for undesirable weight loss should be based on careful consideration of the residents preferences, nutrition needs and the use of supplements.

Review of the facility policy for "MDS 3.0 Completion" dated 1/1/21, reflected that residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care

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plan.

Review of the facility policy "MDS Completion and Submission Timeframes" with a revised date of 4/23/21, reflected that the facility would conduct and submit resident assessments in accordance with current federal and state submission guidelines. It further reflected that the "Assessment Coordinator or designee" were responsible for ensuring that resident assessments were submitted, and Significant Change in Status (SCSA) assessments were to be completed by the 14th calendar day after determination of a significant change in status.

Review of the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual, updated October 1, 2019. Indicated that the Guidelines for Determining a Significant Change in a Resident's Status: Note: this is not an exhaustive list. Some Guidelines to Assist in Deciding If a Change Is Significant or Not:

"In this example, a resident with a [redacted]% weight loss in 30 days would not generally require an SCSA unless a second area of decline accompanies it. Note that this assumes that the care plan has already been modified to actively treat the [redacted] as opposed to continuing with the original problem, "EX Order 26 § 4b1." This situation should be documented in the resident's clinical record along with the plan for subsequent monitoring and, if the problem persists or worsens, an SCSA may be warranted. If there is only one change, staff may still decide that the resident would benefit from an SCSA. It is important to remember that each resident's situation is unique, and the IDT [Interdisciplinary Team] must make the decision as to whether or

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not the resident will benefit from an SCSA. Nursing homes must document a rationale, in the resident's medical record, for completing an SCSA that does not meet the criteria for completion. An SCSA is also appropriate if there is a consistent pattern of changes."

Review of the facility policy for "Nutritional Assessment" with a revised date of 4/23/21, indicated that the RD, in conjunction with the nursing staff and healthcare practitioners should conduct a nutritional assessment as indicated by a change in condition that places the resident at risk for impaired nutrition. It also reflected that the nutritional assessment process included gathering and interpreting data to help define meaningful interventions for the resident at risk for or with impaired nutrition. In addition, the policy reflected that the RD estimates calorie, protein, nutrient and fluids needs, determines whether the resident's current intake was adequate to meet his/her nutritional needs and may implement special food formulations. It further reflected that once conditions and risk factors for impaired nutrition were assessed and analyzed, individual care plans would be developed to address or minimize to the extent possible the resident's risks for nutrition complications and interventions would be developed taking into account the residents preferences.

Review of the facility policy for "Care Plans-Comprehensive" with a review date of 4/23/21, indicated that assessments of residents were ongoing and care plans were revised as information about the resident and the resident's condition change. It further reflected that the care planning/interdisciplinary team was responsible

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F 692	Continued From page 53 for the review and updating of care plans when there was a significant change in the resident's condition and when the desired outcome was not met. Review of the facility policy for "Using the Care Plan" with a revised date of 4/23/21, reflected that changes in the resident's condition must be reported to the ADON so that review of the resident's assessment and care plan can be made. It also reflected that documentation must be consistent with the resident's care plan.	F 692		
F 761 SS=E	NJAC 8:39-11.2(e)(i), 17.1(c), 17.4(a)(1), 27.1(a) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		6/30/21

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F 761	Continued From page 54 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) secure 1 of 7 medication rooms and b.) properly label, store and dispose of medications in 6 of 9 medication carts inspected. This deficient practice was evidenced by the following: On 6/14/21 at 11:00 AM, the surveyor observed the Villa 1 medication room door that was wide opened, and the room contained supplements and expired medications. The door was observed opened for less than 5 minutes. The surveyor observed no staff or residents in the vicinity of the medication room. The surveyor interviewed a Licensed Practical Nurse (LPN #1) who stated that the medication room should always be locked and was unable to tell the surveyor why the medication room door was left opened. On 6/14/21 at 11:10 AM, the surveyor inspected the Villa 1 medication cart in the presence of LPN #1. The surveyor observed an unopened Humalog insulin pen and an unopened Lantus insulin pen that were stored in the medication cart. The surveyor interviewed the LPN #1 who stated that all unopened insulin pens and vials should be stored inside a refrigerator. On 6/14/21 at 11:20 AM, the surveyor inspected the Villa 2 medication cart in the presence of LPN #2. The surveyor observed an unopened Lantus	F 761	Lincoln Park Renaissance Rehab & Nursing Plan of Correction for Event ID# OWHU11 Survey Date: 06/15/2021 Completion Date: 6/30/21 F761 Element One A specific resident was not identified in this deficiency. A new pharmacy consultant provided was hired to provide services to the facility in reference to the storage, labeling and discarding of medications. In-servicing has started for all nursing staff through out the facility. All medication and treatment carts were immediately reviewed by nursing administration and pharmacy consultant, all errors were immediately addressed to ensure all medications were stored, labeled and discarded of properly. The nurse that failed to close the Villa 1 medication room was immediately counseled. Self-closing door devices were installed on all medication room floors in the Villa. Element Two All residents in the facility are at risk to be affected by this deficient practice. The	

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F 761	Continued From page 55 insulin pen that was stored in the medication cart. The surveyor interviewed the LPN #2 who stated that an unopened Lantus insulin pen should have been stored in the medication refrigerator. On 6/14/21 at 11:25 AM, the surveyor inspected the Villa 4 medication cart in the presence of a Registered Nurse (RN #1). The surveyor observed an opened Anoro Ellipta inhaler that was not dated. The surveyor interviewed RN #1 who stated that an opened Anoro Ellipta inhaler should have been dated. On 6/14/21 at 11:35 AM, the surveyor inspected the unit B medication cart #1 in the presence of LPN #3. The surveyor observed an opened Travatan eye drop that had an opened date of 2/7/21 and an opened Pazeo eye drop that had an opened date of 3/3/21 which were both expired. The surveyor also observed a Tobradex eye drop that was discontinued and an opened Travatan eye drop that was not dated. The surveyor interviewed the LPN #3 who stated that all expired and discontinued eye drops should have been removed from the active inventory medication cart. LPN #3 also stated that all eye drops should have been dated when opened. On 6/14/21 at 11:40 AM, the surveyor inspected the unit B medication cart #2 in the presence of LPN #4. The surveyor observed an opened and undated Breo inhaler. The surveyor interviewed LPN #4 who stated that the opened Breo inhaler should have been dated. On 6/14/21 at 12:10 AM, the surveyor inspected the unit A medication cart #2 in the presence of LPN #5. The surveyor observed an opened Novolog insulin vial that had an expiration date of	F 761	pharmacy consultant conducted a facility-wide inspection of all units and medication and treatment carts to identify and correct any deficient practices. Element Three All nursing staff received education from the Pharmacy Consultant on medication storage, labeling and discarding. The DON/ADON or designee will perform medication storage, labeling and discarding rounds on one medication cart per day, five days per week for 30 days. For the following 30 days 5 random medication cart audits will be conducted per week. For the final 30 days, a random audit of all carts will consist of auditing a minimum of 20 carts for the month. Element Four Results of these audits will be recorded and reported by the Director of Nursing to the Quality Assurance Committee and Administration quarterly. Actions will be implemented as appropriate. Results will be utilized for training purposes and systemic changes.	

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6/12/21 in the active inventory medication cart. The surveyor interviewed LPN #5 who stated that the Novolog vial was expired and should have been removed from the medication cart.

A review of the Manufacturer's Specifications for the above medications indicated the following:

1. Unopened Lantus insulin pen should be stored inside a refrigerator.
2. Unopened Humalog Insulin pen should be stored inside a refrigerator.
3. Anoro inhaler once opened had an expiration date of 42-days.
4. Pazeo eye drops once opened had an expiration date of 90-days.
5. Travatan eye drops once opened had an expiration date of 28-days.
6. Breo inhaler once opened had an expiration date of 42-days.
7. Novolog insulin vial once opened had an expiration date of 28-days.

On 6/14/21 at 3:15 PM, the surveyor met with the Licensed Nursing Home Administrator and the Director of Nursing (DON). No further information was provided by the facility.

A review of the facility's policy for Storage of Medications dated 4/23/21 that was provided by the DON indicated the following: "The facility shall not use discontinued, outdated or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.", "Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall

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	315042	A. BUILDING _____ B. WING _____	C 06/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK RENAISSANCE REHAB & NURSING	521 PINE BROOK ROAD LINCOLN PARK, NJ 07035

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 57 not be left unattended if open or otherwise potentially available to others." and "Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location." A review of the facility's policy for Labeling of Medication Containers dated 4/23/21 that was provided by the DON indicated the following: "Labels for individual containers shall include all necessary information such as: (h), The expiration date when applicable." NJAC: 8:39-29.4 (a) (h) (d)	F 761		
F 880 SS=E	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	F 880		7/15/21

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F 880	Continued From page 58	F 880		

conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct 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

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F 880	Continued From page 59 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 facility documents, it was determined that the facility failed to a.) practice appropriate disposal of PPE for 2 of 5 staff members b.) practice appropriate hand hygiene for 2 of 12 staff members, and c.) practice appropriate use of personal protective equipment (PPE) for 2 of 5 staff members, observed in accordance with the Centers for Disease Control and Prevention guidelines for infection control to mitigate the spread of COVID-19. This deficient practice was evidenced by the following: According to the U.S. CDC guidelines Interim Infection Control Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, updated 3/29/21, included "Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room." According to the U.S. CDC guidelines Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated February 23, 2021, included "2. Recommended infection prevention and control (IPC) practices when	F 880	Lincoln Park Renaissance Rehab & Nursing Plan of Correction for Event ID# OWHU11 Survey Date: 06/15/2021 Completion Date: 7/15/21 F880 Element One Residents #144 and #355 are no longer residing in the facility. At the time of the deficient practice, staff caring for the individual residents were re-educated. Waste bins in the resident rooms were placed in a more noticeable area. All staff members who did not follow proper infection control policies and protocols were immediately educated and will receive continuing education. Element Two All residents in the facility are at risk to be affected by this deficient practice. Immediate education was done with all employees on following proper infection control policies and protocols. Two employees that neglected to dispose of PPE in the proper disposal bin failed to do so due to lack of education as they were floated to this unit and did not take note of where bins were located. These staff members were educated on location of bins on all units.	

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F 880	Continued From page 60 caring for a patient with suspected or confirmed SARS-CoV-2: Personal Protective Equipment-HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection." In addition, the document indicated that "Hand Hygiene - Health Care Personnel should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on or after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process. Health Care Personnel should perform hand hygiene by using Alcohol Based Hand Sanitizer with 65-95% alcohol or washing hands with soap and water for at least 20 seconds." 1. On 6/08/21 at 12:32 PM, two surveyors observed a Licensed Practical Nurse (LPN) #1 and a Certified Nurses Aide (CNA) #1 enter Resident #144's room who was on Droplet Precautions due to the resident's new admission and unvaccinated status. Both staff members were observed with appropriate PPE inside the room. However, before exiting the room, the surveyors observed both staff members remove their PPE and discard it into an open trash bin located under the sink in the middle of the resident's room. The surveyors observed a black dedicated PPE trash bin located inside the room near the door. The surveyors observed CNA #1 perform hand washing in the resident's room with a friction time	F 880	The staff member that did not wash her hands properly for 20 seconds failed to do so due to lack of comprehension of education during training due to a language barrier that was not identified during training. Employee was educated in her language and was able to perform an appropriate return demonstration. The two employees that entered the room of an isolation room without proper PPE believed that answering an alarm should took precedence over protecting themselves and the resident while on isolation. It was determined that the employees lacked proper educations and understanding on the risk they impose when not using PPE to protect themselves and the resident. One on one education was provided for both employees. The employee that defied handwashing protocols was terminated due to poor attitude and lack of interest in following IPC standards and protocols. Element Three All staff has been educated on all Infection Control policy and procedures. The DON/ADON, ICP Staff Educator or designee will conduct weekly inspection on each shift for four weeks to monitor that staff entering isolated resident rooms have donned appropriate PPE, have practiced proper hand hygiene and have used only equipment designated for isolated residents. This inspection will continue every other week for an additional four weeks, then randomly for	

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F 880	Continued From page 61 of five seconds. There was a large secondhand clock directly above the sink which the surveyors used to measure the five seconds. The surveyor interviewed CNA #1 who stated that she thought she applied friction for 20 seconds and further stated that she had not been in-serviced on handwashing. The surveyor asked CNA #1 why she didn't use the dedicated black PPE trash bin to dispose her PPE before exiting the room. The CNA #1 stated that she did not typically work on that unit and that she "didn't pay attention" and "did not see it." LPN #1 also acknowledged that they should have used the black dedicated black PPE bin for soiled PPE and should have removed her PPE closer to the exit. She stated, "I forgot." On 6/11/21 at 12:22 PM, the survey team met with Director of Nursing (DON), the Licensed Nursing Home Administrator (LNHA), and the Administrator in Training (AIT) who were made aware of the above observations and concerns. The DON stated that LPN #1 and CNA #1 should have removed their PPE and discarded it into the designated black covered PPE bin by the door and not into the open trash bin in the middle of the room. In addition, the DON acknowledged that CNA #1 had not performed appropriate hand hygiene. 2. On 6/14/21 at 11:22 AM, the surveyors observed CNA #2 and CNA #3 in the room of Resident #355 who was on Droplet Precautions due to the resident's new admission and unvaccinated status. Both staff members were observed wearing an N95 mask. CNA # 2 was wearing gloves but no gown or eye protection and CNA # 3 was only wearing an N95 mask. The resident was observed seated on the side of the bed with legs hanging over. The resident was not	F 880	one month. The DON/ADON, ICP or Staff Educator or designee will conduct weekly audits on all residents on isolation to ensure that staff is discarding of used PPE in appropriate bin. This audit will continue every other week for an additional four weeks, then randomly for one month. The DON/ADON, ICP or Staff Educator or designee will conduct hand hygiene competencies on a minimum of 5 employees per day for 30 days. Competencies will continue every other week for an additional four weeks for a minimum of 30 employees per week, finally randomly for one month a minimum of 50 employees will complete hand washing competencies. The following education was performed and completed: Nursing Home Infection and Preventionist Training Course (Train.org)- Topline Staff and Infection Preventionist CDC COVID-19 Prevention Messages for the Front Line Ling Term Care Staff, Keep COVID 19 Out- Frontline Staff CDC COVID 19 Prevention Messages for the Front Line Ling Term Care Staff, Use PPE Correctly for COVID 19- Frontline Staff Nursing Home Infection Preventionist Training Course (Train.org)- All staff including topline Staff and Infection Preventionist Element Four	

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F 880	Continued From page 62 wearing a mask. CNA #2 was observed touching the resident's hair, and the resident's EX Order 26 § 4b1 next to the bed. She was observed assisting the resident back to bed. CNA #3 was observed at the head of the resident's bed. She was touching the residents side rail and top of the blanket. Both staff members were observed inside Resident #355's room for five minutes. On 6/14/21 at 11:27 AM, the surveyors observed CNA #2 wash her hands appropriately before she exited the room and observed CNA #3 exit the room without performing hand hygiene. She proceeded down the hallway and passed two opportunities to use Alcohol Based Hand Sanitizer [ABHS] (one was wall mounted to her left and one was on the medication cart to her right). The surveyor interviewed CNA #2 who stated that she heard the resident's bed alarm and she entered the room without applying PPE because the resident was a fall risk. CNA #3 stated that when she got to the room, CNA #2 and the resident were in the bathroom; however, she continued to enter the room without PPE because she was assigned to this resident and the resident was a fall risk. LPN #2 was present during the interviews and stated that both CNA's should have applied PPE which should have included a gown, gloves, eye protection and a surgical mask over their N95 masks. On that same date at 11:31 AM, the surveyor asked CNA #3 why she didn't perform hand hygiene before or immediately after exiting the resident's room. CNA #3 stated that she did not perform hand hygiene because the surveyors interrupted her. CNA #3 then proceeded to walk	F 880	Results of these audits/inspections will be recorded and reported by the DON to the Quality Assurance Committee and Administration quarterly. Actions will be implemented as appropriate. Results will be utilized for training and systemic changes.	

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F 880	Continued From page 63	F 880		

down the hallway toward the unit exit doors without performing hand hygiene. CNA #3 passed three opportunities to apply ABHS (two ABHS mounted to the wall on the left and one ABHS on the medication cart to the right) before exiting the unit double doors.

On 6/14/21 at 12:20 PM, the surveyors interviewed LPN #2 who stated that Resident #355 was a new admission and not fully vaccinated. She again stated that the resident was placed in a private room on Droplet Precautions and that the staff should have worn a surgical mask over their N95 mask, a gown, gloves, eye protection and should have either washed their hands prior to leaving the room or should have applied ABHS after exiting the room.

On 6/14/21 at 3:59 PM, the survey team met with the DON, LHNA and the AIT. The DON acknowledged that the CNA's should have worn full PPE and should have performed hand hygiene by washing hands or applying ABHS prior to leaving the unit.

On 6/15/21 at 9:40 AM, the surveyor interviewed the Infection Control Preventionist (ICP)/LPN #3 in the presence of the survey team. She stated that when staff enter a Droplet Precaution room, they should wear a gown, gloves, eye protection (face shield or goggles) and a surgical mask over an N95 mask. She further stated that the staff should have washed their hands before they exited the rooms or should have used the antibacterial hand rub. In addition, the ICP/LPN #3 stated that the facility followed infection control guidance from the executive orders, the CDC, the Local Health Department and their facility policies.

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F 880	Continued From page 64 A review of the facility policy "Policies and Practices - Infection Control", with a revised date of 4/23/21, reflected that that these policies and practices were intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. The objectives are to establish guidelines for implementing Isolation Precautions, including Standard and Transmission Based Precautions. It further reflected that the policies were set forth by current CDC guidelines and recommendations. A review of the facility policy "Isolation when admitting and readmitting", with a revised date of 5/13/21, reflected that an unvaccinated residents required isolation for 14 days after admission/readmission. A review of the facility policy "Handwashing/Hand Hygiene", with a revised date of 4/23/21, reflected that employees must wash their hands or use ABHS after direct contact with a resident or with objects in their immediate vicinity. It also reflected that hand hygiene is always the final step after removing and disposing of PPE. NJAC 8:39-19.4 (a) (1) (n)	F 880		

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
315042 Y1	A. Building B. Wing Y2	8/10/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK RENAISSANCE REHAB & NURSING	521 PINE BROOK ROAD LINCOLN PARK, NJ 07035

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 F0656	Correction	ID Prefix F0658	Correction	ID Prefix F0686	Correction
Reg. # 483.21(b)(1)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed
LSC	07/02/2021	LSC	07/02/2021	LSC	07/02/2021
ID Prefix F0692	Correction	ID Prefix F0761	Correction	ID Prefix F0880	Correction
Reg. # 483.25(g)(1)-(3)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	07/02/2021	LSC	06/30/2021	LSC	07/15/2021
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
6/15/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315042	A. BUILDING **01, 02** B. WING _____	**06/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK RENAISSANCE REHAB & NURSING	**521 PINE BROOK ROAD** **LINCOLN PARK, NJ 07035**

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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 06/14,15/21 and Lincoln Park Renaissance Rehab & Nursing 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. Lincoln Park Renaissance Rehab & Nursing is a 2-story building that was built in the 70's. It is composed of Type II construction. The facility is divided into 11 smoke zones.	K 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 06/14,15/21 and Lincoln Park Renaissance Rehab & Nursing (JDT Pavillion) 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. Lincoln Park Renaissance Rehab & Nursing (JDT Pavillion) is a 4-story building that was built in 2012 It is composed of Type II construction. The facility is divided into 9 smoke zones.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101	K 222		7/2/21

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/30/2021

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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K 222	Continued From page 1 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected	K 222		

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	315042	A. BUILDING **01, 02** B. WING _____	**06/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK RENAISSANCE REHAB & NURSING	**521 PINE BROOK ROAD** **LINCOLN PARK, NJ 07035**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 2 throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 06/15/21, it was determined that the facility failed to ensure that exit doors locked with a delayed egress device were provided with instructional signage in accordance with the requirements of NFPA 101:2012 - Chapter 7.2.1.6.1.1(4). This deficient practice was evidenced by the following: A tour of the Renaissance Building's 2nd floor in the presence of the facility's Maintenance Director from 10:00 AM to 12:30 PM revealed that 6 of 7 exit doors did not have a sign indicating clear instructions for opening during an emergency. The doors were equipped with a push-bar an alarm which opened within the 30-seconds when tested by the surveyor. However, the doors were	K 222	Lincoln Park Renaissance Rehab & Nursing Plan of Correction for Event ID# OWHU21 Survey Date: 06/15/2021 Completion Date: 7/2/2021 K222 Egress doors to have visible signage with clear instructions for opening during an emergency. 1. All Egress doors noted during the annual survey, have had the proper signage installed. 2. Maintenance staff will be educated on inspecting and maintaining Emergency doors with the proper signage. 3. A facility wide inspection of the Egress	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315042	A. BUILDING **01, 02** B. WING _____	**06/15/2021**

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LINCOLN PARK RENAISSANCE REHAB & NURSING	**521 PINE BROOK ROAD** **LINCOLN PARK, NJ 07035**

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K 222	Continued From page 3 not provided with a readily visible sign with 1-inch letters indicating "Push Until Alarm Sounds, Door Can Be Opened in 30 Seconds". This finding was verified by the Maintenance Director during the observation and testing of doors. The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference at 1:00 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.2.1.6.1(4)	K 222	doors was conducted. All doors found to have the proper signage. 4. Audits will be conducted weekly X4, monthly X1 by maintenance director/ designee. Findings of the audits will be submitted to QAPI for review and recommendations. Results of these audits will be recorded and reported by DON to the Quality Assurance Committee and Administration quarterly. Actions will be implemented as appropriate. Results will be utilized for training and systemic changes.	
K 281 SS=D	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 06/15/21, it was determined that the facility failed to ensure that all means of egress was provided with continuous lighting. This deficient practice was evidenced by the following: At 11:15 AM, the surveyor observed in the presence of the facility's Maintenance Director, 1 of 2 exit discharge areas was equipped with only a single bulb light fixture. There was no	K 281	Lincoln Park Renaissance Rehab & Nursing Plan of Correction for Event ID# OWHU21 Survey Date: 06/15/2021 Completion Date: 7/2/2021 K281 Means of egress shall have continuous lighting.	7/2/21

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	315042	A. BUILDING **01, 02** B. WING _____	**06/15/2021**

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LINCOLN PARK RENAISSANCE REHAB & NURSING	**521 PINE BROOK ROAD** **LINCOLN PARK, NJ 07035**

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K 281	Continued From page 4 supplemental light to ensure area is illuminated should the single bulb or single bulb light fixture failed. This finding was acknowledge by the facility's Maintenance Director in an interview during the tour. The facility's Administrator was informed of this finding during the Life Safety Code survey exit conference at at 1:00 PM NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.8	K 281	1. An electrician was contracted to install an additional light fixture by the exit door noted during survey, light fixture corrected. 2. Maintenance staff was educated on inspecting and maintaining means of egress with continuous lighting. 3. A facility wide inspection of the means of egress Emergency doors was conducted. All doors found to have continuous lighting. 4. Audits will be conducted weekly X4, monthly X1 by maintenance director/ designee. Results of these audits will be recorded and reported by Administrator to the Quality Assurance Committee and Administration quarterly. Actions will be implemented as appropriate. Results will be utilized for training and systemic changes.	
K 311 SS=E	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced	K 311		7/2/21

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	315042	A. BUILDING **01, 02** B. WING _____	**06/15/2021**

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LINCOLN PARK RENAISSANCE REHAB & NURSING	**521 PINE BROOK ROAD** **LINCOLN PARK, NJ 07035**

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K 311	Continued From page 5 by: Based on observation and interview on 06/14/21, it was determined that the facility failed to ensure that vertical openings were sealed with a material that's provides a 1-hour fire rating and capable of limiting the transfer of smoke, fumes and fire. This deficient practice was evidenced by the following: A tour of the Villa section of the building from 11:00 AM to 12:00 PM with the facility's Maintenance Director revealed that 4 of 5 electrical closets had a section of ceiling that was breached by multiple electrical cables and wires. These penetrations created openings in the ceiling tiles which were sealed with an orange foam product with no known fire rating or a Through Penetration System (TPS). This finding was verified by the facility's Maintenance Director in an interview during the tour. The facility's Administrator was informed of this finding during the Life Safety Code survey exit interview on 06/15/21 at 1:00 PM. NJAC 8:39.31.2 (e) NFPA 101:2012 - 19.3.1.6	K 311	Lincoln Park Renaissance Rehab & Nursing Plan of Correction for Event ID# OWHU21 Survey Date: 06/15/2021 Completion Date: 7/2/2021 K311 Vertical openings sealed with 1 hour fire rated material. 1. The areas of penetration in the electrical closets noted during survey were resolved using appropriate sealant. 2. Maintenance staff will be educated on inspecting and maintaining Vertical openings sealed with 1 hour fire rated material. 3. A facility wide inspection of all electrical closets has been examined for penetration. All electrical closets found to be free of any penetration. 4. Audits will be conducted weekly X4, monthly X1 by maintenance director/ designee. Results of these audits will be recorded and reported by DON to the Quality Assurance Committee and Administration quarterly. Actions will be implemented as appropriate. Results will be utilized for training and systemic changes.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure	K 321		7/2/21

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	315042	A. BUILDING **01, 02** B. WING _____	**06/15/2021**

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LINCOLN PARK RENAISSANCE REHAB & NURSING	**521 PINE BROOK ROAD** **LINCOLN PARK, NJ 07035**

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K 321	Continued From page 6 Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 06/15/21, it was determined that the facility failed to ensure that combustible storage rooms exceeding 50 square feet were equipped with self-closing doors. This deficient practice was evidenced by the following:	K 321	Lincoln Park Renaissance Rehab & Nursing Plan of Correction for Event ID# OWHU21 Survey Date: 06/15/2021 Completion Date: 7/2/2021 K321 Combustible storage rooms	

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K 321	Continued From page 7 At 11:45 AM, the surveyor observed in the presence of the facility's Maintenance Director, the Dietary storage room located on the 1st floor was not equipped with door that was capable of automatically self-closing. The room contained supplies stored in multiple cardboard boxes and measured 136.89 square feet (8.1-ft.x16.9-ft). This finding was confirmed by Maintenance Director in an interview during the observation. The facility's Administrator was informed of this finding during the Life Safety Code survey exit conference at 1:00 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 8.4	K 321	exceeding square feet are equipped with self-closing doors. 1. A self closing mechanism was installed on the dietary storage door. 2. Maintenance staff will be educated on inspecting and maintaining combustible storage rooms exceeding square feet are equipped with self closing doors. 3. A facility wide inspection of the Combustible storage rooms was conducted. All doors found to have the proper closer. 4. Audits will be conducted weekly X4, monthly X1 by maintenance director/ designee. Findings of the audits will be submitted to QAPI for review and recommendations. Results of these audits will be recorded and reported by DON to the Quality Assurance Committee and Administration quarterly. Actions will be implemented as appropriate. Results will be utilized for training and systemic changes.	

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
315042 Y1	A. Building 02 - JDT PAVILLION B. Wing Y2	8/10/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN PARK RENAISSANCE REHAB & NURSING	521 PINE BROOK ROAD LINCOLN PARK, NJ 07035

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0281	Correction Completed 07/02/2021	ID Prefix Reg. # NFPA 101 LSC K0311	Correction Completed 07/02/2021	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
6/15/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO