

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

PRINTED: 11/22/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315383</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/06/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHESHIRE HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9 RIDGEDALE AVE FLORHAM PARK, NJ 07932</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  Survey Date: 9/06/24  Census: 31  Sample: 12 + 1 closed record  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 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)  §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to ensure that the resident's call light was readily accessible within reach. The deficient practice was identified for one (1) of one (1) resident, Resident #1, reviewed for accommodation of needs.  This deficient practice was evidenced by the following:  On 9/03/2024 at 9:20 AM, the surveyor observed Resident #1 sitting in their wheelchair (w/c) beside the bed in their room. The resident was [redacted] and [redacted] with [redacted]. The surveyor observed the resident's call	F 558	The call light was immediately placed by the [redacted] where Resident #1 could reach it. All residents have the potential to be affected. All other residents were checked to ensure call lights were within reach. To ensure that all residents have access to their call bells at all times the staff (nurses and CNAs) was re-trained. The staff will place the call bell in reach on the bed once it is made. The Director of Nursing reviewed the facility procedure titled Making an Open Bed and found it to be adequate and meets the needs of the facility. The protocol Making an Open Bed was reinforced with nursing staff.	10/2/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/20/2024

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

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F 558	<p>Continued From page 1</p> <p>light was resting on the opposite side of the bed against the wall and the resident was unable to reach it.</p> <p>On 9/04/2024 at 9:41 AM, the surveyor observed the resident sitting in their w/c beside the bed in their room. The resident was [redacted] and [redacted] with [redacted]. The resident's call light was resting on the opposite side of the bed against the wall away from the resident. The resident was not able to reach their call light.</p> <p>A review of the medical record for Resident #1 revealed the following information: The Admission Record (an admission summary) indicated Resident #1 had diagnoses that included, but were not limited to, [redacted] and [redacted].</p> <p>The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, indicated the resident had a Brief Interview for Mental Status (BIMS). Resident #1 scored a [redacted] out of 15 which showed that the resident was [redacted]. Section [redacted], revealed that the resident had [redacted] and [redacted] in both [redacted] and [redacted].</p> <p>A care plan (CP) with a focus that read, "[Resident #1] is at risk for [redacted] r/t [related to] [redacted] ...Hx [history] of [redacted] ...has [redacted] ...is [redacted] and has [redacted] r/t [related to] [redacted] are not steady requires [redacted] ..." was last revised on [redacted]</p>	F 558	<p>The Inservice Coordinator inserviced all nurses and CNAs on making the call bells available at all times. It will be done annually and upon hire.</p> <p>To ensure prevention of further deficient practices, a log was created by the Director of Nursing (DON) to ensure call bells are placed within the reach of residents. Audits of every resident will be completed by the Assistant Director of Nursing (ADON) or designated staff member weekly for one month, then monthly the next 3 months. The DON will monitor this process and review the results of the log at the Quality Assurance and Performance Improvement meetings quarterly. The Quality Assurance Committee will determine the effectiveness of the room checks to determine if further monitoring and evaluations is required.</p>		

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F 558	<p>Continued From page 2</p> <p><sup>NJ Exec Order 26.451</sup> . An intervention for the CP indicated to be sure that the resident's call light was within reach and the resident was encouraged to use it.</p> <p>On 9/04/24 at 11:13 AM, the surveyor interviewed the <sup>US FOIA (b)(6)</sup> ) who was assigned to care for Resident #1. The <sup>US FOIA</sup> stated that the resident required assistance with activities of daily living and used the call light to call for staff assistance when needed. The <sup>US FOIA</sup> confirmed that the call light should be within reach of the resident.</p> <p>The surveyor accompanied the <sup>US FOIA</sup> into the resident's room to observe the call light. Resident #1 was observed sitting in a w/c in their room. The <sup>US FOIA</sup> observed the call light resting on the bed against the wall, away from the resident. The <sup>US FOIA</sup> placed the call light within the resident's reach.</p> <p>On 9/05/2024 at 11:45 AM, the survey team met with the <sup>US FOIA (b)(6)</sup> and the <sup>US FOIA (b)(6)</sup> . The surveyor informed the facility of the above findings and observations regarding the call light not being within Resident #1's reach. The facility management acknowledged that all residents should have their call lights within reach. The surveyor requested any policy related to call lights.</p> <p>On 9/06/24 at 8:53 AM, the <sup>US FOIA (b)(6)</sup> provided the surveyor with the facility's policy titled, "Making an Open Bed." The surveyor reviewed the undated policy, which indicated under Procedure to " ...16. Make sure the call bell is within the resident's reach ..."</p>	F 558			

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F 558	Continued From page 3	F 558			
F 607 SS=D	<p>NJAC 8:39-27.1 (a)</p> <p>Develop/Implement Abuse/Neglect Policies</p> <p>CFR(s): 483.12(b)(1)-(5)(ii)(iii)</p> <p>§483.12(b) The facility must develop and implement written policies and procedures that:</p> <p>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,</p> <p>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and</p> <p>§483.12(b)(3) Include training as required at paragraph §483.95,</p> <p>§483.12(b)(4) Establish coordination with the QAPI program required under §483.75.</p> <p>§483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.</p> <p>§483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d) (3) of the Act.</p> <p>§483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and review of pertinent documentation provided by the facility, it was determined that the facility failed to ensure</p>	F 607		10/2/24	
			Reference check requests were immediately sent out for employees S#1 and S#2. Reference checks were		

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F 607	<p>Continued From page 4</p> <p>reference checks were completed for two (2) out of six (6) newly hired staff (Staff #1 and #2) prior to their start date of employment.</p> <p>This deficient practice was evidenced by the following:</p> <p>The surveyor reviewed six randomly selected new employee files.</p> <p>The review for reference checks for two of the six new employees revealed the following:</p> <p>-Staff #1's (S#1's) file, a <b>US FOIA (b)(6)</b> <b>US FOIA (b)(6)</b> who was hired on <b>US FOIA (b)(6)</b> showed there were no reference checks in their file.</p> <p>-S#2, a <b>US FOIA (b)(6)</b> who was hired on <b>US FOIA (b)(6)</b> showed there were no reference checks in their file.</p> <p>On 9/06/24 at 11:00 AM, the surveyor notified the <b>US FOIA (b)(6)</b> and the <b>US FOIA (b)(6)</b> about the concern that there were no references in the employee files of S#1 and S#2. The <b>US FOIA (b)(6)</b> stated she would follow up with the <b>US FOIA (b)(6)</b> who was not in the facility today. The <b>US FOIA (b)(6)</b> acknowledged it would be expected for there to be references documented in the employee files upon hire.</p> <p>On 9/06/24 at 11:09 AM, the surveyor interviewed the <b>US FOIA (b)(6)</b> over the phone. The <b>US FOIA (b)(6)</b> stated the previous <b>US FOIA (b)(6)</b> left in <b>US FOIA (b)(6)</b> and that was when she began covering the position. The <b>US FOIA (b)(6)</b> stated that two references from new employees were requested. There was a facility inquiry form that was emailed or faxed to previous</p>	F 607	<p>received for both S#1 and S#2 on 9/30/2024.</p> <p>All residents have the potential to be affected. All other new employee files since the last annual survey were inspected to ensure that reference checks had been sent.</p> <p>A New Hire Requirements Log was created to ensure all necessary items are received for each employee prior to the first day of work. (See Attachment 14). One item on the log is the request for at least two reference checks for each employee. The Director of Human Resources or Acting Human Resource Representative (AHRR) will initial and date the log on the date the reference checks are requested and the date the reference requests are returned and reviewed.</p> <p>The AHRR reviewed the Personnel Management Reference Checks policy and is reviewed annually as well. In addition, the AHRR updated the Personnel Management Staffing policy to include the initiation and completion of a New Hire Requirements Log for each new employee. The Director of Human Resources reviews all Human Resources policies annually. The Director of Human Resources inservices all Human Resources staff on the Personnel Management Staffing policy, and inservices staff annually and upon hire. The Director of Human Resources keeps a log of all reviews and inservices and will</p>	

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F 607	<p>Continued From page 5</p> <p>employers. Additionally, personal references were called and there was a form to be filled out by the facility representative when conducting the interview. The [US FOIA (b)(6)] further explained that sometimes you may not get a response back and they tried to get at least one reference. The [US FOIA (b)(6)] stated that she had not experienced issue with getting two references. The surveyor discussed the concern with S#1 and S#2 not having any references checks documented in their file. The [US FOIA (b)(6)] could not speak to those staff files as they were prior to when she started the position. The surveyor asked the [US FOIA (b)(6)] about the expectation for the reference checks of newly hired staff. The [US FOIA (b)(6)] replied that it would be expected for there to be an attempt to get a reference for the employee.</p> <p>On 9/06/24 at 12:20 PM, the surveyor informed the [US FOIA (b)(6)] and the [US FOIA (b)(6)] of the concern that for two of the six new employee files reviewed, there were no reference checks found.</p> <p>On 9/06/24 at 12:47 PM, the [US FC] provided a copy of an inquiry form that was faxed on [NJ Ex Order 26.7] to a previous employer of S#2. The form was dated [NJ Ex Order 26.7] and was not completed. The [US FC] acknowledged there was no response received from this previous employer and no other references found for S#2.</p> <p>There was no additional information provided by the facility.</p> <p>The surveyor reviewed the facility's policy titled "Personnel Management Reference Checks" with a last revised date of 8/96. Under Procedure it read, " ...2. [facility name] will seek the maximum</p>	F 607	<p>submit to the Quality Assurance Committee quarterly.</p> <p>The Director of Human Resources or AHRH presents the New Hire Requirements Logs for each new employee to the Quality Assurance Committee quarterly.</p>		

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F 607	Continued From page 6 number of references possible on a new applicant, in order to obtain a solid work ethic and character background ..."	F 607		
F 686 SS=D	N.J.A.C. 8:39-9.3 (a), (b) 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 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers 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 provide care and services consistent with professional standards of practice for a resident with <b>NJ Exec Order 26.4b1</b> . This deficient practice was identified in two (2) of two (2) residents (Resident #8 and #9), reviewed for <b>NJ Exec Order 26.4b1</b> care and prevention.  The deficient practice was evidenced by the following:  Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse	F 686	The <b>NJ Exec Order 26.4b1</b> were immediately measured for Resident #8 and Resident #9. Documentation related to current <b>NJ Exec Order 26.4b1</b> status and <b>NJ Exec Order 26.4b1</b> risk assessments were completed for Resident #8 and Resident #9 and documented in the nursing progress notes. The Assistant Director of Nursing/MDS Coordinator (ADON/MDSN) updated the care plans for Resident #8 and Resident #9 to reflect the current <b>NJ Exec Order 26.4b1</b>  All residents with a neurological deficit	10/2/24

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F 686	<p>Continued From page 7</p> <p>Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist."</p> <p>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."</p> <p>Reference: National Pressure Injury Advisory Panel's Pressure Injury Prevention Points include the following: Risk Assessment Consider bedfast and chairfast individuals to be at risk for development of pressure injury. Use a structured risk assessment, such as the Braden Scale, to identify individuals at risk for pressure injury as soon as possible (but within 8 hours after admission). Refine the assessment by including these additional risk factors. Fragile skin Existing pressure injury of any stage, including</p>	F 686	<p>have the potential of being affected. (This includes but is not limited to quadriplegia, paraplegia, neuropathy, Multiple Sclerosis, Guillain Barre Syndrome, etc.) The care plans for all other residents with wounds were updated as necessary by the ADON/MDSN. Residents with wounds were audited for care plan updating, missing weekly wound assessments with measurements and progress notes, and addressed as needed.</p> <p>A meeting was held immediately upon exit of survey with the Director of Nursing, Assistant Director of Nursing/MDS Coordinator, and nursing supervisors to discuss the need for implementation of a pressure wound predicting tool. The policies for "Wound Management Program Staging," and "Standard Operating Procedure Prevention, Assessment and Containment of Pressure Areas were reviewed and revised as needed to include weekly wound measurements and tools for pressure ulcer risk assessment.</p> <p>The Braden Scale is used on all current residents with wounds. It is also used for all new admissions and re-admissions. (See Attachment 16). All nurses were inserviced on the use and interpretation of the Braden Scale by the Inservice Coordinator. It is completed annually and upon hire. The Braden Scale has been entered into the Electronic Medical Record (EMR) for each resident.</p> <p>All residents with wounds are assessed</p>		

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F 686	<p>Continued From page 8</p> <p>those ulcers that have healed or are closed Impairments in blood flow to the extremities from vascular disease, diabetes or tobacco use Pain in areas of the body exposed to pressure Repeat the risk assessment at regular intervals and with any change in condition. Base the frequency of regular assessments on acuity levels: Acute care ... Every shift Long term care ... Weekly for 4 weeks, then quarterly Develop a plan of care based on the areas of risk, rather than on the total risk assessment score. For example, if the risk stems from immobility, address turning, repositioning, and the support surface. If the risk is from malnutrition, address those problems.</p> <p>1. On 9/04/24 at 12:25 PM, the surveyor observed Resident #8 sitting in a [redacted] wheelchair in their room. Resident #8 was [redacted] NJ Exec Order 26.4b1, and greeted the surveyor. The resident stated they had [redacted] and had no concerns with their care.</p> <p>The surveyor reviewed the hybrid (paper and electronic) medical records of Resident #8.</p> <p>The Admission Record (AR; a summary of important information about the resident) documented that the resident had diagnoses that included but were not limited to [redacted] and [redacted] NJ Exec Order 26.4b1.</p> <p>A comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] NJ Exec Order 26.4b1, indicated the facility assessed the resident's [redacted] using [redacted] NJ Exec Order 26.4b1.</p>	F 686	<p>and measured weekly by the Advanced Practice Nurse or the nursing supervisor and the information is documented in the EMR in the progress notes. Audits for all residents with wounds will be completed by Assistant Director of Nursing (ADON) weekly for one month, then monthly the next 3 months, and logs will be maintained. The DON will monitor this process and review the results at the Quality Assurance and Performance Improvement meetings quarterly. The committee will determine the effectiveness of the EMR and care plan checks to determine if further monitoring and evaluation is required. All nurses were inserviced on the updated wound management policy by the Inservice Coordinator. It is completed annually and upon hire. The Inservice Coordinator maintains inservice logs to be presented to the Quality Assurance Committee quarterly. This updated policy will be discussed at the next quarterly meeting. In addition, the facility has contracted with the electronic medical record system provider to implement a Skin &amp; Wound management tool by 2025. (See Attachment 17).</p>	

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F 686	<p>Continued From page 9</p> <p>a Brief Interview Mental Status (BIMS) test. Resident #8 scored a [redacted] out of 15, which indicated the resident was [redacted] NJ Exec Order 26.4b1. Under Section [redacted] NJ Exec Order 26.4b1 of the MDS assessment, it was documented that determination of [redacted] NJ Exec Order 26.4b1 for the resident was determined by clinical assessment. Additionally, it was documented that Resident #8 had a [redacted] NJ Exec Order 26.4b1 and was receiving treatment (tx).</p> <p>A review of physician's orders (PO) included the following:</p> <p>-A PO dated [redacted] NJ Exec Order 26.4b1 that read, 'Complete [redacted] NJ Exec Order 26.4b1 "Check" Tool in Assessments every day shift every Tue [Tuesday] for [redacted] NJ Exec Order 26.4b1.'</p> <p>-A PO dated [redacted] NJ Exec Order 26.4b1 read [redacted] NJ Exec Order 26.4b1 Cleanse with [redacted] NJ Exec Order 26.4b1. Pat dry. Apply [redacted] NJ Exec Order 26.4b1 Cover with [redacted] NJ Exec Order 26.4b1 Secure with [redacted] NJ Exec Order 26.4b1 as needed for [redacted] NJ Exec Order 26.4b1 for [redacted] NJ Exec Order 26.4b1</p> <p>-A PO dated [redacted] NJ Exec Order 26.4b1 read [redacted] NJ Exec Order 26.4b1 Cleanse with [redacted] NJ Exec Order 26.4b1 Pat dry. Apply [redacted] NJ Exec Order 26.4b1 Cover with [redacted] NJ Exec Order 26.4b1 Secure with [redacted] NJ Exec Order 26.4b1 every day shift for [redacted] NJ Exec Order 26.4b1 for [redacted] NJ Exec Order 26.4b1 Days"</p> <p>-A PO dated [redacted] NJ Exec Order 26.4b1 read [redacted] NJ Exec Order 26.4b1 -cleanse [redacted] NJ Exec Order 26.4b1, Pat dry, [redacted] NJ Exec Order 26.4b1 with [redacted] NJ Exec Order 26.4b1, cover with [redacted] NJ Exec Order 26.4b1 as needed for [redacted] NJ Exec Order 26.4b1/shower for [redacted] NJ Exec Order 26.4b1</p> <p>-A PO dated [redacted] NJ Exec Order 26.4b1 read [redacted] NJ Exec Order 26.4b1 Pat dry, [redacted] NJ Exec Order 26.4b1 with [redacted] NJ Exec Order 26.4b1, cover with [redacted] NJ Exec Order 26.4b1 every day shift every other day for [redacted] NJ Exec Order 26.4b1 for [redacted] NJ Exec Order 26.4b1</p>	F 686		

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F 686	<p>Continued From page 10</p> <p>-A PO dated [redacted] read "NJ Exec Order 26.4b1 [redacted], Pat dry, [redacted] with [redacted], cover with [redacted] every evening shift every other day for [redacted] for [redacted] Days"</p> <p>-A PO dated [redacted] read [redacted] - Cleanse area with [redacted] pat dry, cover with [redacted] for [redacted] as needed for [redacted]"</p> <p>-A PO dated [redacted] read [redacted] - Cleanse area with [redacted] pat dry, cover with [redacted] for [redacted] every day shift every Tue for [redacted]</p> <p>-A PO dated [redacted] read [redacted] - Cleanse area with [redacted] pat dry, cover with [redacted] for [redacted] every evening shift every other day for [redacted]</p> <p>The resident had a care plan with a focus that read, "[Resident #8] has [redacted] Actual [redacted] to [redacted] &amp; [redacted] ..." The care plan was last revised on [redacted].</p> <p>Interventions of the care plan (CP) included: -Weekly tx documentation to include measurement of each area of [redacted] width, length, depth, type of [redacted] and [redacted] and any other notable changes or observations. Date Initiated: [redacted];</p> <p>-Weekly [redacted] assessment done by nursing (includes measurements, description of [redacted] interventions and behavior e.g non-compliance). [Resident #8] was followed by [redacted] specialist in the facility see <b>US FOIA (b)(6)</b> [redacted]).</p>	F 686	

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F 686	<p>Continued From page 11</p> <p>US FOIA (b) notes. Resident's NJ Exec Order 26.4b1 and overall status is discussed by IDT (Interdisciplinary team) e.g improvement or worsening of NJ Exec Order 26.4b1 weekly and PRN (as needed). Date Initiated: NJ Exec Order 26.4b1</p> <p>-Monitor/document location, size and tx of NJ Exec Order 26.4b1. Report NJ Exec Order 26.4b1 NJ Exec Order 26.4b1, s/sx (signs/symptoms) of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 etc. to US FOIA (b)(6). Date Initiated NJ Exec Order 26.4b1;</p> <p>NJ Exec Order 26.4b1 : cleanse with NJ Exec Order 26.4b1 NJ Exec Order 26.4b1, pat dry, NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 cover with NJ Exec Order 26.4b1 Secure with [name] NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 care. Date Initiated: NJ Exec Order 26.4b1</p> <p>NJ Exec Order 26.4b1 - Cleanse area with NJ Exec Order 26.4b1 pat dry, NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1, cover with NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 daily and as needed x NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 care Date Initiated: NJ Exec Order 26.4b1</p> <p>A review of Resident #8's medical records indicated the interventions for the NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 did not reflect the current NJ Exec Order 26.4b1 of Resident #8. Additionally, the CP did not include the resident's NJ Exec Order 26.4b1 NJ Exec Order 26.4b1</p> <p>A review of Assessments in the EHR (electronic health record) revealed NJ Exec Order 26.4b1 documented. There were no NJ Exec Order 26.4b1 assessments completed weekly which included NJ Exec Order 26.4b1 measurements, NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 description.</p> <p>A review of nurse progress notes (PN) and the US FOIA (b)(6) PN revealed, there was no weekly documentation of the resident's NJ Exec Order 26.4b1 assessment including measurements and NJ Exec Order 26.4b1</p>	F 686		

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F 686	<p>Continued From page 12 description.</p> <p>On 9/05/24 at 9:25 AM, the surveyor interviewed the [US FOIA (b)(6)] about residents with [US FOIA (b)(6)]. The [US FOIA (b)(6)] stated there were no formal investigation reports for new [NJ Exec Order 26] acquired by residents. The [US FOIA (b)(6)] further explained the protocol was for the [NJ Exec Order 26] to be assessed by the [US FOIA (b)(6)] supervisor/charge nurse, the physician was made aware and tx orders were obtained. The [US FOIA (b)(6)] stated the nurses who assessed the [NJ Exec Order 26] would document a PN and [NJ Exec Order 26.4b1] were conducted.</p> <p>The surveyor asked the [US FOIA (b)(6)] how the cause of a [NJ Exec Order 26] was determined and if it was discussed by the IDT. The [US FOIA (b)(6)] stated that the cause was determined by discussion with the residents. She further explained that residents sometimes were non-compliant with [NJ Exec Order 26.4b1] interventions which contributed to [NJ Exec Order 26.4b1].</p> <p>The [US FOIA (b)(6)] stated that the tx RNs and RN supervisors assess [NJ Exec Order 26] there were CP for the residents, and [NJ Exec Order 26] notes would be documented in the nurses' notes. The [US FOIA (b)(6)] stated the [NJ Exec Order 26] note should be an extensive note, that included [NJ Exec Order 26] description, discussion with the resident and education provided.</p> <p>The surveyor asked the [US FOIA (b)(6)] for new [NJ Exec Order 26] if a summary and conclusion about the [NJ Exec Order 26] was found in the nurse PN. The [US FOIA (b)(6)] replied, "It should be." The [US FOIA (b)(6)] stated that all residents were considered at risk for developing [NJ Exec Order 26] due to medical conditions and there was no formal assessment completed to assess a resident's risks for [NJ Exec Order 26]. The surveyor</p>	F 686		

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F 686	<p>Continued From page 13</p> <p>requested any facility policies related to [redacted]</p> <p>On 9/05/24 at 10:08 AM, the surveyor interviewed the [redacted] who provided resident [redacted] treatments. The [redacted] stated [redacted] were performed twice a week after a resident showered and [redacted] were documented in the nurses PN. The [redacted] supervisor would perform [redacted] assessments. When a new [redacted] was found, the [redacted] would assess the [redacted] the physician would be notified, a tx would be ordered and nurse PN would document what was found. Nurse documentation for [redacted] were the [redacted] and nurse PN. All residents were considered at risk for [redacted] and there was no formal risk assessment tool. The [redacted] stated interventions to help [redacted] included [redacted] residents every two hours and if a resident refused it would be documented.</p> <p>On 9/05/24 at 10:39 AM, the surveyor interviewed the [redacted] who performed wound treatments and assessments. The [redacted] stated [redacted] assessments were performed on residents and that [redacted] assessments with the [redacted] would be done periodically. The [redacted] detailed that there was no routine schedule for when the [redacted] would assess [redacted] with the [redacted] and it would depend on the [redacted]. The [redacted] stated that when [redacted] were assessed, it would be measured and findings would be documented in a wound PN. Additionally, there was a weekly log/tracking binder which would document the [redacted] assessment and progression. The [redacted]</p>	F 686		

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F 686	<p>Continued From page 14</p> <p>surveyor asked if the weekly log/tracking binder was documented in the resident's hybrid medical records. The [US FOIA (b)(6)] stated it was not.</p> <p>On 9/05/24 at 11:45 AM, the survey team met with the [US FOIA (b)(6)] the [US FOIA (b)(6)] ( [US FOIA (b)(6)] ), and the acting [US FOIA (b)(6)]. The surveyor informed the facility of the concern related to documentation of Resident #8's [NJ Exec Order] assessments and follow up on newly acquired [NJ Exec Order 261]. The [US FOIA (b)(6)] stated that [NJ Exec Order] assessment documentation would be found in the PN and would provide to the surveyor.</p> <p>On that same date and time, the surveyor asked the [US FOIA (b)(6)] if the [NJ Exec Order] assessments including the measurements that were documented in the binder were found in the resident's medical records. The [US FOIA (b)(6)] replied that she was not sure and that the [US FOIA (b)(6)] may have documented [NJ Exec Order] measurements in her notes in the EMR.</p> <p>On 9/06/24 9:22 AM, the surveyor interviewed the [US FOIA (b)(6)] about weekly [NJ Exec Order] rounds and documentation. The [US FOIA (b)(6)] stated there were the [NJ Exec Order] log binders in which [NJ Exec Order] assessments would be documented by the nurse. The [US FOIA (b)(6)] stated she would review the [NJ Exec Order] binders to complete residents' MDS assessments.</p> <p>On that same date and time, the [US FOIA (b)(6)] provided weekly [NJ Exec Order] logs from the binder for Resident #8. The weekly logs were noted with blank entries. The surveyor reviewed with the [US FOIA (b)(6)]. The [US FOIA (b)(6)] replied that it may be that a resident refused, was out on an appointed or something</p>	F 686			

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F 686	<p>Continued From page 15</p> <p>else may have occurred for the assessment not to be completed. The [REDACTED] acknowledged it would have been expected for the nurses to document if an assessment could not have been performed.</p> <p>At that time, the [REDACTED] stated that daily update for residents were performed by the IDT and there was an internal worksheet that was signed. The [REDACTED] added that it was facility documentation and not part of the medical record.</p> <p>The surveyor reviewed with the [REDACTED] about the concerns with Resident #8's CP. The [REDACTED] stated she would review to provide further information.</p> <p>On 9/06/24 at 9:56 AM, the [REDACTED] met with the surveyor. The [REDACTED] stated "I have to update CP." She acknowledged the CP did not reflect the resident's current [REDACTED] status. The [REDACTED] explained that the resident did have a history of a [REDACTED] and [REDACTED] which has since [REDACTED]. The resident was currently being treated for a [REDACTED] and a [REDACTED].</p> <p>On 9/06/24 at 10:05 AM, the [REDACTED] informed the surveyor that it is expected for there to be a weekly [REDACTED] note documented. The surveyor asked the [REDACTED] about [REDACTED] documentation as there was not a weekly note by the [REDACTED] found. The [REDACTED] stated some residents had chronic [REDACTED] and that the [REDACTED] did not see every resident weekly for their [REDACTED].</p> <p>2. On 9/03/24 at 8:26 AM, the surveyor observed Resident #9 seated upright in bed on an [REDACTED]. Resident #9 stated that they had a [REDACTED] <b>NJ Exec Order 26.4b1</b> that [REDACTED] over [REDACTED].</p>	F 686			

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F 686	<p>Continued From page 16</p> <p><b>NJ Exec Ord</b> from a previous <b>NJ Exec</b></p> <p>The surveyor reviewed the hybrid medical records of Resident #9.</p> <p>A review of the AR documented that the resident had diagnoses that included but were not limited to <b>NJ Exec Order 26.4b1</b></p> <p>[REDACTED]</p> <p>A review of Resident #9's most recent quarterly MDS, reflected that the resident had a BIMS score of [REDACTED] out of 15, which indicated that Resident #9 was <b>NJ Exec Order 26.4b1</b>. Under Section <b>NJ Exec Order 26.4b1</b>, it was documented that determination of <b>NJ Exec Order 26.4b1</b> for the resident was determined by clinical assessment. Additionally, it was documented that Resident #9 had a <b>NJ Exec Order 26.4b1</b> that was not present upon admission/entry or reentry.</p> <p>A review of Resident #9's EHR revealed that Resident #9 did not have any formal assessment instrument/tool like a <b>NJ Exec Order 26.4b1</b></p> <p>[REDACTED] to determine the resident's risk for <b>NJ Exec</b> development. There was no documented evidence that a <b>NJ Exec Order 26.4b1</b> or other formal assessment instrument or tool was done quarterly to assess the risk for <b>NJ Exec</b> development. Further review of Resident #9's hybrid medical record revealed that there was no documentation of a clinical</p>	F 686		

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F 686	<p>Continued From page 17</p> <p>assessment related to determination of the resident's risk for developing a [REDACTED]</p> <p>A review of Resident #9's individualized CP indicated a focus area of resident was at risk for <b>NJ Exec Order 26.4b1</b></p> <p>[REDACTED], has h/o (history of) of <b>NJ Exec Order 26.4b1</b> and has <b>NJ Exec Order 26.4b1</b>.</p> <p>The CP included the following intervention: Assess/record/monitor [REDACTED] (weekly) Measure length, width and depth where possible. Assess and document status of <b>NJ Exec Order 26.4b1</b>, [REDACTED] and [REDACTED] progress. Report improvements and declines to the <b>US FOIA (b)(6)</b> [REDACTED] with an initiated date of [REDACTED]</p> <p>Further review of Resident #9's Assessments in the EHR revealed "<b>NJ Exec Order 26.4b1</b>" documented. The "<b>NJ Exec Order 26.4b1</b>" did not include consistent weekly documentation of the [REDACTED] with measurements. There was occasional documentation of the description of the [REDACTED]</p> <p>A review of Resident #9's nurse PN and the <b>US FOIA (b)(6)</b> PN revealed, there was no consistent weekly documentation of the resident's [REDACTED] assessment which included measurements and description.</p> <p>On 9/05/24 at 9:28 AM, the surveyor interviewed the <b>US FOIA (b)(6)</b> regarding risk assessment for [REDACTED] development. The <b>US FOIA (b)(6)</b> stated that the facility did not do a <b>NJ Exec Order 26.4b1</b> because "everyone is at risk for <b>NJ Exec Order 26.4b1</b>" and "most [residents] come with <b>NJ Exec Order 26.4b1</b>"</p> <p>On 9/05/24 at 10:03 AM, the surveyor interviewed the <b>US FOIA (b)(6)</b> regarding the process for MDS and [REDACTED] The</p>	F 686		

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F 686	<p>Continued From page 18</p> <p><b>US FOIA (b)(6)</b> stated that for section <b>NJ Exec Order 2</b> she would use the documentation that was in the medical record and refer to the binder that has the information of when the last time the <b>NJ Exec Order</b> was looked at. The surveyor asked where she obtained the information for determination of risk for <b>NJ Exec</b> from. The <b>US FOIA (b)(6)</b> stated that she did not check that a formal tool was used and that she checked that a clinical assessment was done because the nurse did an assessment like a <b>NJ Exec Order 26,451</b>. She added that everyone that came to the facility was at risk. She added that there was no formal tool used at the facility.</p> <p>On 9/05/24 at 11:45 AM, in the presence of the survey team, the surveyor notified the <b>US FOIA (b)(6)</b> the <b>US FOIA (b)(6)</b> and the acting <b>US FOIA (b)(6)</b> the concern that Resident #9 did not have a quarterly formal risk assessment or any documentation of a clinical assessment for risk of developing a <b>NJ Exec</b>.</p> <p>On 9/06/24 at 12:15 PM, in the presence of another surveyor, the surveyor notified the <b>US FOIA (b)(6)</b> and <b>US FOIA (b)(6)</b> the concern that Resident #9's weekly <b>NJ Exec</b> measurements were not in the resident's medical record.</p> <p>The facility did not provide any additional information.</p> <p>On 9/06/24 at 12:40 PM, the survey team met with <b>US FOIA (b)(6)</b> and <b>US FOIA (b)(6)</b>. There was no additional response by the facility.</p> <p>The surveyor reviewed the facility's policy titled, "Wound Management Program Staging," with a revised date of August 2018. Under Procedure, C. Ongoing Wound Assessment, it read: " ...</p>	F 686		

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F 686	<p>Continued From page 19</p> <ol style="list-style-type: none"> <li>1. A system for weekly (or more frequent) wound assessment has been established.</li> <li>2. An assessment tool in [EMR] is used.</li> <li>3. Comprehensive wound assessment should include at least the following parameters:               <ol style="list-style-type: none"> <li>a. Location of wound ...</li> <li>b. Length, width, and depth measurements ...</li> <li>c. Direction and length of tunneling and undermining</li> <li>d. Appearance of the wound base</li> <li>e. Type and percentage of tissue in wound ...</li> <li>f. Drainage amount and characteristics including color, consistency, and odor ...</li> <li>g. Appearance of wound edges ...</li> <li>h. Description of the peri-wound condition or evaluation of the skin adjacent to the wound ...</li> </ol> </li> <li>7. Progress toward healing is monitored ...               <ol style="list-style-type: none"> <li>a. If the wound shows no sign of healing within two to four weeks, the plan of care is reevaluated, and it is determined whether to continue or modify the plan of care. This discussed with the Medical Director and the wound care Nurse Practitioner ..."</li> </ol> </li> </ol> <p>Policy [Facility name redacted] is committed to providing a comprehensive wound management program to promote the resident's highest level of functioning and well-being and to minimize the development of in-house acquired pressure ulcers, unless the individual's clinical condition demonstrates they are unavoidable ... A commitment to the wound management program is demonstrated by implementation of processes founded on accepted standards of practice, research-driven clinical guidelines, and interdisciplinary involvement. Objectives The wound management program incorporates</p>	F 686			

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F 686	<p>Continued From page 20</p> <p>currently accepted standards of practice and guidelines, including ongoing assessment of the stage of development of decubitus ulcers. The policy did not include any information about risk assessment for PU development.</p> <p>Under F. Documentation and Care Planning, it read: " ...</p> <p>1. The wound management program documentation requirements include:</p> <ol style="list-style-type: none"> <li>a. Identification of the location and frequency of wound documentation</li> <li>b. Required comprehensive description of pressure ulcer weekly, at a minimum</li> <li>c. Goals of the wound CP collaboratively with the resident, family, and IDT</li> <li>d. Assigned responsibility/accountability for the initial CP and for subsequent updating</li> <li>e. Determined facility time frames for CP updating ..." <p>A review of the facility provided undated policy titled, "Standard Operating Procedure Prevention, Assessment and Containment of Pressure Areas," included the following:</p> <p>Policy</p> <p>The [facility name redacted] population is primarily spinal cord injury and other neurologically impaired residents. Diagnosis involves paralysis, diminished peripheral circulation and spasms. Therefore, careful attention is given to maintaining intact skin.</p> <p>The residents at [facility name redacted] are mostly traumatic spinal cord injuries. All of the residents are neurologically impaired. This diagnosis can lead to the development of pressure injuries. Once a resident develops a wound it becomes a secondary diagnosis.</p> <p>Contributing Factors</p> </li></ol>	F 686			

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F 686	Continued From page 21 Immobility Poor fitting clothing, shoes Poor nutrition Noncompliance with repositioning, turns and splints History of smoking Incontinence Procedure Staff is to follow all standard operating procedures upon admission involving but not limited to the following: 10. Skin checks are done weekly and PRN on resident designated in TAR (Treatment Administration Record) after their shower. A skin assessment must then be filled out by the nurse in EHR. The policy did not include any information about risk assessment for PU development or PU measurements.	F 686			
F 690 SS=D	NJAC 8:39-27.1 (a)(e) Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)  §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.  §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the	F 690		10/2/24	

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F 690	<p>Continued From page 22</p> <p>resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to provide care and services in a manner consistent with standards of practice for appropriate storage of <b>NJ Exec Order 26.4b1</b> for one (1) of one (1) resident reviewed for <b>NJ Exec Order 26.4b1</b> care (Resident #15).</p> <p>The deficient practice was evidenced by the following:</p> <p>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</p>	F 690	<p>Resident #15 was immediately instructed on the management of a <b>NJ Exec Order 26.4b1</b>, how to empty it, rinse it, cap it, and store it. <b>NJ Ex</b> was also instructed on notifying <b>NJ Ex</b> nurse on how much <b>NJ Exec O</b> was in the <b>NJ Exec O</b>. The care plan was updated. The existing <b>NJ Exec Order 26.4b1</b> was replaced and a cap was provided.</p> <p>Residents who are able to empty their own urinary drainage bags have the potential to be affected. A facility wide audit was conducted by the Director of Nursing (DON) to identify any other residents who are able to empty their own night urinary drainage bags and none</p>		

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F 690	<p>Continued From page 23</p> <p>treating human responses to actual or 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 regimes as prescribed by a licensed or otherwise legally authorized physician or dentist."</p> <p>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."</p> <p>On 9/03/24 at 9:10 AM, the surveyor observed Resident #15 lying in bed, [redacted] and [redacted]. Resident #15 stated they used an [redacted] NJ Exec Order 26.4b1 during the night and removed in the morning. The surveyor observed a [redacted] NJ Exec Order 26.4b1 hanging at the bedside with [redacted] NJ Exec Order 26.4b1 and the [redacted] of the [redacted] NJ Exec Order 26.4b1 was uncovered. The resident stated that the [redacted] NJ Exec Order 26.4b1 was changed weekly by the nursing staff.</p> <p>On 9/04/24 at 9:51 AM, the surveyor observed a [redacted] US FOIA (b)(6) at the resident's bedside preparing to assist Resident #15 out of bed to their [redacted] NJ Exec Order 26.4b1 wheelchair (w/c). The surveyor observed the resident's [redacted] NJ Exec Order 26.4b1</p>	F 690	<p>were identified. All CNAs and nurses were re-instructed on the proper care of night urinary drainage bags. The appropriate care plan was updated by the Inservice Coordinator.</p> <p>The Director of Nursing updated the following:</p> <ol style="list-style-type: none"> <li>1. The procedure for changing night urinary drainage bags monthly and as needed.</li> <li>2. The Urinary Tract Infection Policy and the care of night urinary drainage bag protocol was updated to include the use of a urosheath.</li> </ol> <p>All staff (CNAs, nurses and new hires) was inserviced on the proper emptying and storing of night bags by the Inservice Coordinator and all staff is inserviced annually and upon hire. Inservice logs are maintained by the Inservice Coordinator. The Inservice Coordinator will inservice residents who are able to empty their own night urinary drainage bags on the proper procedure annually, upon admission, and as needed. Notation of such counseling is documented in the residents electronic medical records by the MDS Coordinator and is also care planned.</p> <p>Audits are completed by Assistant Director of Nursing (ADON) or designated staff member on all residents using night urinary drainage bags weekly for one month, then monthly the next 3 months. A log is kept by the Director of Nursing and it is submitted to the Quality Assurance committee at each quarterly meeting. The</p>	

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F 690	<p>Continued From page 24</p> <p>█ hanging at bedside with █ NJ Exec Order 26.4b1 and the █ of █ was not covered.</p> <p>On 9/04/24 at 10:13 AM, the surveyor interviewed Resident #15 who was sitting upright in their w/c about the storage of their █ NJ Exec Order 26.4b1. The █ NJ Exec Order 26.4b1 remained hanging at the bedside with █ NJ Exec Order 26.4b1 and the █ NJ Exec Order 26.4b1 remained uncovered. The █ NJ Exec Order 26.4b1 was dated █ NJ Exec Order 26.4b1. Resident #15 stated they preferred to care for the █ NJ Exec Order 26.4b1 on their own.</p> <p>At that time, the surveyor asked if the █ NJ Exec Order 26.4b1 always remained at the bedside and if there was any cap/cover for the █ NJ Exec Order 26.4b1 of the █ NJ Exec Order 26.4b1. The resident replied that they emptied the █ NJ Exec Order 26.4b1 washed the █ with water in the bathroom sink, and hung it in the bathroom to store for later use in the night. Resident #15 showed the surveyor where in the bathroom the █ NJ Exec Order 26.4b1 would be hung. The surveyor asked the resident if there was a cap or cover for their █ NJ Exec Order 26.4b1. Resident #15 replied, they did not have one and was careful when handling their █ NJ Exec Order 26.4b1.</p> <p>On 9/04/24 at 10:21 AM, the surveyor interviewed the █ US FOIA (b) who was assigned to care for Resident #15 about █ NJ Exec Order 26.4b1 care and storage. The █ US FOIA (b) stated the █ NJ Exec Order 26.4b1 would be emptied, rinsed with warm water, the █ NJ Exec Order 26.4b1 of the █ NJ Exec Order 26.4b1 sanitized with an alcohol pad, covered with cap, and stored in the bathroom in plastic bag. The surveyor asked the █ US FOIA (b) about the care for Resident #15's █ NJ Exec Order 26.4b1. The █ US FOIA (b) stated that Resident #15 preferred to care for their █ NJ Exec Order 26.4b1 and the resident was able to remove their █ NJ Exec Order 26.4b1, wash and store their █ NJ Exec Order 26.4b1 in the bathroom.</p>	F 690	Quality Assurance Committee will determine the effectiveness of the drainage bag checks to determine if further monitoring and evaluation is required. Inservice logs are submitted to the Quality Assurance Committee by the Inservice Coordinator quarterly.		

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F 690	<p>Continued From page 25</p> <p>On that same date and time, the surveyor discussed with the [redacted] about the observation of the resident's [redacted] that was uncovered. The [redacted] stated that the resident would not have a cap for their [redacted] because the resident did not have a [redacted] which was where the cap came from. The [redacted] stated that it was not okay for the [redacted] to remain uncovered.</p> <p>On 9/04/24 at 11:15 AM, the surveyor interviewed Licensed Practical Nurse#1 (LPN#1) who had cared for Resident # 15. LPN #1 stated that [redacted] were stored by CNAs in the resident's bathroom in a specified area. LPN #1 could not explain the process of storing a [redacted], she was not sure and stated another staff could explain the process. LPN #1 stated she was not aware Resident #15 cared and stored their [redacted].</p> <p>On 9/04/24 at 11:18 AM, the surveyor interviewed LPN #2 who had cared for Resident #15. LPN #2 stated [redacted] were usually throw away [redacted] and a new [redacted] placed. LPN #2 stated [redacted] when not in use should be capped. For residents using an [redacted], it should be taken off, the [redacted], and the [redacted] thrown away. LPN #2 clarified that a large [redacted] was saved, capped and placed in a plastic bag for storage for residents using [redacted] who switched to [redacted] during the day,</p> <p>At that time, the surveyor discussed with LPN #2 the observation of Resident #15's [redacted] that was uncovered. LPN #2 stated the uncapped [redacted] was an [redacted] concern. She further explained it should be sanitized with</p>	F 690			

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F 690	<p>Continued From page 26</p> <p>an alcohol swab and stored appropriately. LPN #2 was not aware of the resident caring for their own [redacted] and storing.</p> <p>The surveyor reviewed the hybrid (paper and electronic) medical record of Resident #15.</p> <p>The Admission Record (a summary of important information about the resident) documented that the resident had diagnoses that included but were not limited to, [redacted] and [redacted].</p> <p>A quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] indicated the facility assessed the resident's [redacted] using a Brief Interview Mental Status (BIMS) test. Resident #15 scored a [redacted] out of 15, which indicated the resident was [redacted].</p> <p>A physician's order (PO) dated [redacted] that read, "[redacted] Log every shift for [redacted]"</p> <p>A PO dated [redacted] read "[redacted] per preference"</p> <p>A care plan (CP) with an initiation date of [redacted] for Resident #15 had a focus that read, "[Resident #15] was [redacted] for [redacted] related to ..., has [redacted] and [redacted] ... [Resident #15] uses [redacted] to manage [redacted] ..." The CP was last revised on [redacted].</p> <p>Further review of the CP interventions showed it did not address the resident's use of an [redacted] and [redacted] care. There</p>	F 690		

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F 690	<p>Continued From page 27</p> <p>was no documentation of the resident receiving education or caring for their own <sup>NJ Exec Order 26.4b1</sup> [REDACTED]</p> <p>On 9/05/24 at 9:25 AM, the surveyor requested from the <sup>US FOIA (b)(6)</sup> [REDACTED] facility policies related to storage of <sup>NJ Exec Order 26.4b1</sup> [REDACTED] and <sup>NJ Exec Order 26.4b1</sup> [REDACTED].</p> <p>On 9/05/24 11:08 AM, the <sup>US FOIA (d)</sup> [REDACTED] provided the facility document titled "How To Take Care of <sup>NJ Exec Order 26.4b1</sup> [REDACTED] and <sup>NJ Exec Order 26.4b1</sup> [REDACTED] policy that referenced <sup>NJ Exec Order 26.4b1</sup> [REDACTED].</p> <p>On 9/05/24 at 11:45 AM, the survey team met with the with <sup>US FOIA (b)(6)</sup> [REDACTED]. The surveyor informed the facility of the above concerns. The <sup>US FOIA (d)</sup> [REDACTED] stated it would be expected for a <sup>NJ Exec Order 26.4b1</sup> [REDACTED] stored to be capped. The surveyor asked the <sup>US FOIA (d)</sup> [REDACTED] if the resident was educated on the care and storage of their <sup>NJ Exec Order 26.4b1</sup> [REDACTED]. The <sup>US FOIA (d)</sup> [REDACTED] stated the staff probably spoke to the resident about it and stated that she believed the resident's education was not documented.</p> <p>At that time, the surveyor requested any additional policies related to <sup>NJ Exec Order 26.4b1</sup> [REDACTED] and <sup>NJ Exec Order 26.4b1</sup> [REDACTED]. The facility would follow up to provide additional information.</p> <p>On 9/06/24 at 8:53 AM, the <sup>US FOIA (d)</sup> [REDACTED] provided a progress notes which indicated the resident was provided caps for their <sup>NJ Exec Order 26.4b1</sup> [REDACTED] and educated about its care. There was no additional information provided by the facility.</p>	F 690			

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F 690	<p>Continued From page 28</p> <p>Further review of the [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] electronic Medication Administration Record (eMAR) included the documentation of the resident's [NJ Exec Order 26.4b1] every shift.</p> <p>There were entries 17 entries that did not document an exact total amount and were written as [NJ Exec Order 26.4b1]</p> <p>On 9/06/24 at 12:20 PM, the surveyor informed the [US FOIA (b)] and [US FOIA (b)] about the concern with nurses' documentation of the [NJ Exec Order 26.4b1]. The surveyor reviewed the eMAR with the [US FOIA (b)]. The [US FOIA (b)] stated that it was okay for the nurses to add the [NJ Ex] sign to the [NJ Exec Order 26.4b1] of an exact number as the resident emptied their [NJ Exec Order 26.4b1] on their own. The [US FOIA (b)] acknowledged it was expected for the nurses to document a note when the resident emptied on their own and she could not say if the resident was ever asked by staff to monitor their [NJ Exec Order 26.4b1]. There was no additional information provided by the facility.</p> <p>The surveyor reviewed the undated facility policy titled, "How To Take Care of Drainage Bags." Under Caring for your night drainage bag it read, "...3. Rinse the bag with cool water. Hang it up to dry ..." The document did not further address storage of a urinary drainage bag.</p> <p>The surveyor reviewed the facility policy titled "Urinary Tract Infection" related to indwelling catheters. The policy did not address external catheters and it did not address urinary drainage bag storage and care.</p> <p>N.J.A.C. 8:39-27.1 (a)</p>	F 690		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695 SS=D	<p>Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)</p> <p>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to: a.) ensure [redacted] setup and [redacted] were changed as per physician orders. b.) change [redacted] for the [redacted] resident. This deficient practice was identified for one (1) of two (2) residents (Residents #11) reviewed for [redacted] care according to the standard of clinical practice, and the facility's policy and procedure.</p> <p>This deficient practice was evidenced by the following:</p> <p>Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized</p>	F 695	<p>The [redacted] setup, [redacted] and [redacted] set up for Resident # 11 were immediately changed by the [redacted] present. Disciplinary action was provided to the [redacted] who signed but did not change the [redacted]. The [redacted] present and the [redacted] who signed but did not change the [redacted] were immediately serviced by the Infection Preventionist/Registered Nurses.</p> <p>All residents who need oral or tracheal suctioning have the potential to be affected, as well as residents requiring nebulizer treatment. The nebulizer setup, mask and suction setup for all residents who need oral or tracheal suctioning as well as residents requiring nebulizer treatments were checked. No issues were found.</p> <p>All nurses including new hires were instructed by the Inservice Coordinator on the proper way to change the nebulizer set up, mask and suction set up and will be done annually and upon hire. All nurses including new hires were instructed by the Director of Nursing on</p>	10/2/24

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F 695	<p>Continued From page 30 physician or dentist."</p> <p>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."</p> <p>During initial tour on 9/03/2024 at 9:01 AM, the surveyor observed Resident #11 resting in their room. The surveyor observed the resident's <b>NJ Exec Order 26.4b1</b> [REDACTED] which had a <b>NJ Exec Order 26.4b1</b> [REDACTED] The resident stated that they received <b>NJ Exec Order 26.4b1</b> [REDACTED] treatment (tx) every day. The surveyor observed the <b>NJ Exec Order 26.4b1</b> [REDACTED] labeled with a small piece of tape dated <b>NJ Exec O</b> [REDACTED] and initials were written with a black pen.</p> <p>According to the Admission Record (an admission summary), Resident #11 was admitted to the facility with <b>NJ Exec Order 26.4b1</b> [REDACTED]</p> <p>The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the</p>	F 695	<p>the importance of proper documentation. The Inservice Coordinator inservices all nurses on the importance of proper documentation annually and upon hire.</p> <p>The Director of Nursing and the Inservice Coordinator keeps logs concerning teachings. The Infection Preventionist/Registered Nurse or designated staff member audits the nebulizer setup, mask and suction setup for all residents who need oral or tracheal suctioning as well as residents requiring nebulizer treatments and keeps a log on a weekly basis for one month, and monthly for 3 months. All reports are presented to the Quality Assurance committee quarterly. The Quality Assurance committee will determine the effectiveness of the nebulizer setup, mask, and suction setup checks to determine if further monitoring and evaluation is required.</p>		

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F 695	<p>Continued From page 31</p> <p>management of care, dated [redacted] reflected a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that the resident was [redacted].</p> <p>A review of the active Physician's Orders (PO) revealed the following orders:  <b>NJ Exec Order 26.4b1</b>  [redacted] every 6 hours (hrs) as needed (PRN) for <b>NJ Exec Order 26.4b1</b> separate from PRN by 4 hrs. And <b>NJ Exec Order 26.4b1</b> every night shift for [redacted] maintenance (via [redacted] with a start date of [redacted].</p> <p>-Change [redacted] setup every day shift starting on the [redacted] and ending on the [redacted] every month and PRN with a start date of [redacted].</p> <p>-Change [redacted] &amp; [redacted] every day shift starting on the [redacted] and ending on the [redacted] every month and PRN with a start date of [redacted].</p> <p>The above PO was transcribed to the [redacted] electronic Medication Administration Record (eMAR) to change [redacted] setup every day shift starting on the [redacted] and ending on the [redacted] every month and to change [redacted] and [redacted] every day shift starting on the [redacted] and ending on the [redacted] every month. The PO was signed off for [redacted] reflecting it was completed.</p> <p>Further review of the [redacted] and [redacted] eMAR for <b>NJ Exec Order 26.4b1</b> [redacted] every night shift for [redacted] maintenance (via [redacted] was signed by nurses as administered from [redacted] until [redacted].</p>	F 695	

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F 695	<p>Continued From page 32</p> <p>A review of the [redacted] NJ Exec Order 26.4b1 nursing progress notes (PN) reflected that Resident #11 received [redacted] NJ Exec Order 26.4b1 tx via [redacted] NJ Exec Order 26.4b1. Further review of the [redacted] NJ Exec Order 26.4b1 and [redacted] NJ Exec Order 26.4b1 PN did not reflect any notes pertaining to changing of [redacted] NJ Exec Order 26.4b1 equipment such as [redacted] NJ Exec Order 26.4b1 setup and [redacted] NJ Exec Order 26.4b1.</p> <p>During an interview with the surveyor on 9/05/24 at 10:23 AM, the [redacted] US FOIA (b)(6) stated that the [redacted] NJ Exec Order 26.4b1 setup and [redacted] NJ Exec Order 26.4b1 setup gets changed on the [redacted] NJ Exec Order 26.4b1 every month. She further stated, "If I see the expired date on [redacted] NJ Exec Order 26.4b1 setup then I would change it." The [redacted] US FOIA stated the tx nurse was accountable to make sure the [redacted] NJ Exec Order 26.4b1 setup was changed as per protocol. She acknowledged that it was not an acceptable practice and if the resident was on [redacted] NJ Exec Order 26.4b1 treatments, you would make sure the [redacted] NJ Exec Order 26.4b1 was clean due to [redacted] NJ Exec Order 26.4b1.</p> <p>On 9/05/24 at 10:36 AM, the Infection Preventionist/Registered Nurse#1 (IP/RN #1) stated that it was important to change the [redacted] NJ Exec Order 26.4b1 as per PO to prevent the resident who were on [redacted] NJ Exec Order 26.4b1 tx and the staff providing care to the resident to be exposed to any [redacted] NJ Exec Order 26.4b1.</p> <p>On that same date at 10:41 AM, in the presence of the surveyor, the [redacted] US FOIA walked into Resident #11's room to check the [redacted] NJ Exec Order 26.4b1 setup, [redacted] NJ Exec Order 26.4b1 and the [redacted] NJ Exec Order 26.4b1 setup. The [redacted] US FOIA checked the dates on the [redacted] NJ Exec Order 26.4b1, and she took the [redacted] NJ Exec Order 26.4b1 out of the black bag. The [redacted] NJ Exec Order 26.4b1 had a small piece of tape marked with [redacted] NJ Exec Order 26.4b1 and initials were written with a black pen. The nurse then checked the [redacted] NJ Exec Order 26.4b1 setup and observed a piece of tape marked with [redacted] NJ Exec Order 26.4b1 and initials were written with a black pen. The [redacted] US FOIA acknowledged that it was</p>	F 695			

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F 695	<p>Continued From page 33</p> <p>not an acceptable practice, and she would call the physician to get orders.</p> <p>On 9/05/24 at 11:39 AM, the survey team met with <b>US FOIA (b)(6)</b>. The surveyor discussed the above findings with the facility management.</p> <p>During an interview with the surveyor on 9/06/24 at 10:03 AM, the IP/RN #2 stated the <b>NJ Exec Order 26-48</b> setup should be changed on time as scheduled, due to the <b>NJ Exec Order 26-48</b> inside the <b>NJ Exec Order</b> IP/RN #2 acknowledged that the above observations and findings were not an acceptable practice.</p> <p>A review of the facility provided "Respiratory Equipment Set-up checklist" that was provided by <b>US FOIA (b)(6)</b> included: Under Neb set up - Change Neb set up once a week. Label and Date. Under Suction Machine Set up: Change suction machine set up (canister, tubing &amp; antibacterial filter) once a month. Label and date.</p> <p>On 9/06/24 at 12:31 PM, the survey team met with <b>US FOIA (b)(6)</b> for an Exit Conference and there was no additional information provided by the facility management.</p>	F 695			
F 732 SS=D	<p>NJAC 8:39-11.2(b); 25.2(c)4; 27.1(a)</p> <p>Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)</p> <p>§483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:</p>	F 732		9/16/24	

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F 732	<p>Continued From page 34</p> <p>(i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.</p> <p>§483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.</p> <p>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation it was determined that the facility failed to ensure the daily report of licensed nurses, certified nursing assistant staffing, and the resident census was posted at</p>	F 732	<p>The nurse staffing information was immediately updated and changed to the proper date and shift by the nursing secretary. This was corrected at the front desk. The unit secretaries and charge</p>		

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F 732	<p>Continued From page 35</p> <p>the beginning of the current shift for two (2) of four (4) days during the survey.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 9/03/24 at 7:40 AM, upon entry to the facility, the surveyor observed a Nursing Home Resident Care Staffing Report (NHRCSR) posted at the front desk by the main entrance. The NHRCSR posted was dated 9/02/24, for the [8 AM to 4 PM] day shift. There was no NHRCSR for 9/03/24 posted.</p> <p>On 9/05/24 at 8:35 AM, the surveyor observed a NHRCSR posted at the front desk by the main entrance. The NHRCSR posted was dated 9/04/24 for the day shift. There was no NHRCSR for 9/05/24 posted.</p> <p>On 9/05/24 at 11:45 AM, the survey team met with the <b>US FOIA (b)(6)</b> [REDACTED]. The surveyor informed the facility of the concerns observed on two days with the NHRCSR not posted for the current shift. The <b>US FOIA (b)(6)</b> [REDACTED] stated that the <b>US FOIA (b)(6)</b> [REDACTED] was responsible for posting the NHRCSR for the day and evening shift. A nurse would post the NHRCSR for the night shift.</p> <p>There was no further verbal response from the facility at this time. The surveyor requested any policy related to the posting of the NHRCSR.</p> <p>On 9/05/24 02:01 PM, the <b>US FOIA (b)(6)</b> [REDACTED] provided the policy titled "Staffing Nursing Staffing Information."</p>	F 732	<p>nurses were immediately inserviced on the protocol by the Inservice Coordinator.</p> <p>No residents were immediately affected by this deficiency. All residents have the potential to be affected. All nurses and nursing secretaries were inserviced on this protocol. The protocol is to change the Nurse Staffing Information Sheet at the front desk and outside the nursing station each shift by the charge nurse or designated staff member.</p> <p>The Inservice Coordinator inservices all nurses and nursing secretaries annually and upon hire. The logs of these inservices are presented to the Quality Assurance committee quarterly.</p> <p>The Assistant Director of Nursing or designated staff member checks the nurse staffing data once a week for 1 month, and then once a month for 3 months. The Assistant Director of Nursing reports findings to the Quality Assurance Committee quarterly. The Quality Assurance committee will determine if further monitoring and evaluation is required.</p>	

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F 732	Continued From page 36  On 9/06/24 at 8:58 AM, the surveyor interviewed the day shift [REDACTED] who was responsible for posting the NHRCSR for the 8-4 shift on weekdays. The [REDACTED] stated each shift was responsible for ensuring the NHRCSR was posted. The [REDACTED] acknowledged that the NHRCSR may be posted late. The [REDACTED] could not speak to the other shifts and stated that ultimately the charge nurse was responsible for ensuring that the NHRCSR was posted for each shift. The [REDACTED] further explained that it was discussed by staff that it was important to ensure that the NHRCSR was posted and accurate.  On 9/06/24 at 12:45 PM, the survey team met with the [REDACTED] and the [REDACTED]. There was no additional information provided.  The surveyor reviewed the facility's policy titled, "Staffing Nursing Staffing Information" dated 12/21. Under Procedure it read: "... A. The facility will post the following information on a daily basis: a. Facility name b. The current date c. The total number and the actual hours worked by following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: i. Registered nurses ii. Licensed practical nurses ... iii. Certified nurse aides ... B. The facility will post the nurse staffing data on a daily basis at the beginning of each shift ..."  NJAC 8:39-41.2	F 732			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		10/9/24	

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F 756	<p>Continued From page 37</p> <p>§483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>§483.45(c)(2) This review must include a review of the resident's medical chart.</p> <p>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p> <p>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.</p>	F 756			

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F 756	<p>Continued From page 38</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interviews, record review, and a review of pertinent facility documents, it was determined that the facility failed to identify the irregularity with regard to the physician's order for as needed pain medications for one (1) of five (5) residents, (Resident #21) reviewed for unnecessary medications in accordance with facility's practice and policy.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 9/03/24 at 10:42 AM, the surveyor observed Resident #21 with [redacted] to the [redacted] and could use the [redacted] wheelchair with no problem. The resident had a [redacted] on their [redacted].</p> <p>On that same date and time, the resident stated that he/she was currently on [redacted] management and included in their [redacted] medications (meds) were as needed (PRN) [redacted] to be given with PRN [redacted] for [redacted] NJ Exec Order 26.4b1. The resident further stated that at times their PRN [redacted] was not given when PRN [redacted] was administered. Resident #21 was unable to state why the nurse at times did not include the PRN [redacted] when PRN [redacted] was administered. The resident also stated that they were aware that the physician order (PO) for PRN [redacted] and PRN [redacted] should be given together.</p> <p>The surveyor reviewed Resident #21's hybrid (a combination of paper-based and electronic medical records that primarily involves tracking and storing a patient's health records in several formats and places) medical records.</p>	F 756	<p>An immediate meeting was held with the Director of Nursing and the pharmacy consultant. The [redacted] involved and all other nurses who did not sign for both medications were inserviced immediately on signing out for all PRN medication by the Director of Nursing (DON). Disciplinary action took place for all nurses who did not sign for both medications. It was confirmed by the DON that the next dose of PRN [redacted] and PRN [redacted] given to Resident #21 were both administered together and signed off appropriately by the administering nurse.</p> <p>The Electronic Medication Administration Records(eMARs) of all other residents who receive multiple PRN medications that are to be administered together were reviewed. No issues were found.</p> <p>All residents requiring PRN medications have the potential of being affected. All nurses including new hires were educated on proper pain medication administration and documentation by the Inservice Coordinator and will be done annually and upon hire. The Inservice Coordinator maintains inservice logs. The inservice logs are presented to the Quality Assurance committee at each quarterly meeting by the Inservice Coordinator.</p> <p>The monthly report given by the pharmacy consultant is audited by the Nursing Supervisors within one week and kept in a</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>CHESHIRE HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>9 RIDGEDALE AVE FLORHAM PARK, NJ 07932</b>		
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F 756	<p>Continued From page 39</p> <p>According to the Admission Record (an admission summary), the resident was admitted to the facility with diagnoses that included but were not limited to <b>NJ Exec Order 26.4b1</b></p> <p>[REDACTED]</p> <p>A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of <b>NJ Exec Order 26.4b1</b> revealed a brief interview for mental status (BIMS) score of <b>NJ Exec Order 26.4b1</b> out of 15 which indicated that resident was <b>NJ Exec Order 26.4b1</b>.</p> <p>A review of the <b>NJ Exec Order 26.4b1</b> Order Summary Report (OSR) showed a PO dated <b>NJ Exec Order 26.4b1</b> for <b>NJ Exec Order 26.4b1</b> Tablet (tab) <b>NJ Exec Order 26.4b1</b> Give 2 tablets (tabs) by mouth every 6 hours (hrs) PRN for <b>NJ Exec Order 26.4b1</b>; <b>NJ Exec Order 26.4b1</b>; give along with <b>NJ Exec Order 26.4b1</b>; max (maximum) of <b>NJ Exec Order 26.4b1</b> for all sources.</p> <p>Further review of the <b>NJ Exec Order 26.4b1</b> OSR revealed a PO dated <b>NJ Exec Order 26.4b1</b> for <b>NJ Exec Order 26.4b1</b> give 1 tab by mouth every 6 hrs PRN for <b>NJ Exec Order 26.4b1</b> give along with <b>NJ Exec Order 26.4b1</b>.</p>	F 756	<p>binder for review. A summary of the pharmacy consultant reports are presented to the Quality Assurance committee quarterly by the Nursing Supervisors.</p> <p>To ensure prevention of further deficient practices, an audit tool was created by the DON to ensure proper pain medication administration and documentation. Audits will be completed by Assistant Director of Nursing (ADON) or designated staff member for all residents receiving multiple PRN medications at the same time weekly for one month, then monthly the next 3 months. The monthly report given by the pharmacy consultant will also be audited by the Nursing Supervisors and compared with the facility audit reports to ensure compliance and accuracy. The DON monitors this process and reviews the results at the Quality Assurance and Performance Improvement meetings quarterly. The Quality Assurance committee will determine if further monitoring and evaluation is required.</p>	

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F 756	<p>Continued From page 40</p> <p>The above PO for PRN [redacted] and PRN [redacted] were transcribed to the electronic Medication Administration Record (eMAR) and signed by nurses as administered for [redacted] and [redacted] and revealed: [redacted] eMAR: PRN [redacted] was signed by nurses as administered 32x (32 times) while the PRN [redacted] was signed by nurses as administered 77x. [redacted] eMAR: PRN [redacted] was signed by nurses as administered 47x while the PRN [redacted] was signed by nurses as administered 67x. [redacted] eMAR: PRN [redacted] was signed by nurses as administered 2x while the PRN [redacted] was signed by nurses as administered 9x.</p> <p>Further review of the above [redacted] and [redacted] eMAR showed that the PRN [redacted] along with PRN [redacted] PO were not followed: [redacted] eMAR: PRN [redacted] was not administered 45x when it should have been a total of 77x. [redacted] eMAR: PRN [redacted] was not administered 20x when it should have been a total of 67x. [redacted] eMAR: PRN [redacted] was not administered 7x when it should have been a total of 9x.</p> <p>A review of the [redacted] and [redacted] Progress Notes (PN) revealed that there was no documented evidence that the [redacted] identified the above irregularity for PRN [redacted] and PRN [redacted]</p> <p>A review of the CP Monthly Report (also known</p>	F 756		

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F 756	<p>Continued From page 41</p> <p>as Medication Regimen Review or MRR) showed that there was no documented evidence that the <sup>US FOIA</sup> identified the irregularity for PRN <sup>NJ Exec Order 26.4b1</sup> and PRN <sup>NJ Exec Order 26.4b1</sup></p> <p>On 9/04/24 at 8:44 AM, the surveyor interviewed Registered Nurse Supervisor/Infection Preventionist #1 (RNS/IP#1) and RNS/IP#2. RNS/IP#1 stated that Resident # 21 was <sup>NJ Exec Order 26.4b1</sup>. RNS/IP#2 stated that Resident # 21 has <sup>NJ Exec Order 26.4b1</sup> in the <sup>NJ Exec Order 26.4b1</sup> and <sup>NJ Exec Order 26.4b1</sup> being followed up by a <sup>NJ Exec Order 26.4b1</sup> management Doctor who adjusts the resident's <sup>NJ Exec Order 26.4b1</sup> medication (med).</p> <p>On that same date and time, the surveyor asked both RNS/IPs to check the eMAR of the resident for <sup>NJ Exec Order 26.4b1</sup> for PRN <sup>NJ Exec Order 26.4b1</sup> along with PRN <sup>NJ Exec Order 26.4b1</sup>. The surveyor asked should the nurse administer both meds together and what the order meant. The RNS/IP#1 and #2 stated that the nurse should follow the PO to administer both PRN <sup>NJ Exec Order 26.4b1</sup> and PRN <sup>NJ Exec Order 26.4b1</sup> together. The surveyor then asked why there were more signatures of nurses for PRN <sup>NJ Exec Order 26.4b1</sup> than PRN <sup>NJ Exec Order 26.4b1</sup> if they should be administered together. RNS/IP#1 and #2 both stated that they were not sure why, but they would talk to the nurses about it to make sure to follow the PO to administer both PRN <sup>NJ Exec Order 26.4b1</sup> and PRN <sup>NJ Exec Order 26.4b1</sup>. The surveyor then notified RNS/IP#1 and #2 of the above findings and concerns.</p> <p>On 9/05/24 at 9:34 AM, the surveyor interviewed the <sup>US FOIA (b)(6)</sup> <sup>US FOIA</sup>. The surveyor notified the <sup>US FOIA</sup> of the above findings and concerns. The <sup>US FOIA</sup> stated that the Nursing Supervisors made her aware of the concern yesterday. She further stated that she should</p>	F 756			

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

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F 756	<p>Continued From page 42</p> <p>have signed both the PRN [redacted] and PRN [redacted] at the same time when administering the meds according to the PO. The [redacted] stated that she administered the PRN [redacted] at that time but failed to sign it in the eMAR, and now she was aware, and she will make sure that they were signed both. The [redacted] acknowledged that she was one of the nurses who administered the PRN [redacted] and did not follow the PO to sign the PRN [redacted] when both PRN [redacted] meds were administered.</p> <p>On 9/05/24 at 10:30 AM, the surveyor interviewed the [redacted] via phone conference. The [redacted] informed the surveyor that she was responsible for the facility's monthly MRR and unit inspections. The [redacted] stated that reports from the monthly MRR and unit inspections were submitted via email to the [redacted] <b>US FOIA (b)(6)</b></p> <p>On that same date and time, the surveyor notified the [redacted] of the above findings and concerns regarding PRN [redacted] and PRN [redacted]. The surveyor asked should the [redacted] had identified the irregularities that the nurses were not signing the PRN [redacted] when administered along with PRN [redacted]. The [redacted] stated that she would have to check the record first and would get back to the surveyor.</p> <p>On 9/05/24 at 11:39 AM, the survey team met with the [redacted] <b>US FOIA (b)(6)</b>. The surveyor notified the facility management of the findings and concerns.</p> <p>On 9/05/24 at 12:36 PM, the [redacted] informed the surveyor that after checking the record of</p>	F 756		

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F 756	<p>Continued From page 43</p> <p>Resident # 21, she <sup>US FOIA</sup> [REDACTED] should put something in writing to address the irregularity for not signing the PRN <sup>NJ Exec Order 26.4b1</sup> [REDACTED] when the PRN <sup>NJ Exec Order 26.4b1</sup> [REDACTED] was administered. The <sup>US FOIA</sup> [REDACTED] acknowledged that the <sup>US FOIA</sup> [REDACTED] did not address the irregularity of signing both PRN <sup>NJ Exec Order 26.4b1</sup> [REDACTED] and <sup>NJ Exec Order 26.4b1</sup> [REDACTED] when administered for a <sup>NJ Exec Order 26.4b1</sup> [REDACTED] as ordered in their monthly MRR.</p> <p>On 9/06/24 at 12:31 PM, the survey team met with <sup>US FOIA (b)(6)</sup> [REDACTED]. The facility management did not provide additional information for the above findings and concerns.</p> <p>A review of the facility's Medication System Drug Regimen Review &amp; Unit Inspections Policy with date of 10/18 that was provided by the <sup>US FOIA (b)(6)</sup> [REDACTED] revealed: Policy: It is the policy of the facility that a licensed pharmacist will review the resident drug regime including the resident's chart at least once a month. The CP may need to conduct med regimen review more frequently depending on the resident's condition, review of short stay residents, and risk of adverse consequences. The licensed pharmacist will report in writing, any irregularities to the attending physician, the facility's medical director and the DON to be acted upon.</p> <p>On 9/06/24 at 12:52 PM, the survey team met with the <sup>US FOIA (b)(6)</sup> [REDACTED] for an Exit Conference. The facility management did not provide additional information.</p> <p>NJAC 8:39-29.3 (a)(1)</p>	F 756			
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i)	F 770		9/16/24	

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F 770	<p>Continued From page 44</p> <p>§483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure a.) [redacted] recommendations from [redacted] for laboratory (lab(s)) and b.) routine lab orders for [redacted] and [redacted] were followed and obtained in a timely manner. The deficient practice was identified for one (1) of five (5) residents reviewed for unnecessary medications (Resident #21), and was evidenced by the following:</p> <p>On 9/03/24 at 9:12 AM, the surveyor observed Resident # 21's room was closed. The Staff stated that the resident was about to [redacted], and the surveyor had to return at a later time.</p> <p>The surveyor reviewed Resident #21's hybrid (a combination of paper-based and electronic medical records that primarily involves tracking and storing a patient's health records in several formats and places) medical records.</p> <p>According to the Admission Record (an admission summary), the resident was admitted to the facility with diagnoses that included but were not limited to [redacted]</p>	F 770	<p>An immediate meeting was held between the Director of Nursing, Assistant Director of Nursing, and the 2 nursing supervisors. The physician was contacted for an order to complete a [redacted] and [redacted] on Resident # 21 immediately. The Physicians Order was obtained and the tests were completed and reviewed on [redacted]</p> <p>All residents requiring labs have the potential to be affected. The Electronic Medication Administration Records (eMARs) for all residents with Physicians Orders for standing labs were checked. All standing labs were up to date.</p> <p>The Director of Nursing reinforced to the Infection Prevention Supervisor RN about performing labs as ordered by the doctor and maintain logs. These logs are presented to the Quality Assurance committee at the next quarterly meeting. All labs are completed as the doctors order specifies and according to standing orders.</p>	

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F 770	<p>Continued From page 45</p> <p><b>NJ Exec Order 26.4b1</b></p> <p>[REDACTED]</p> <p>A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of [REDACTED] revealed a brief interview for mental status (BIMS) score of [REDACTED] out of 15 which indicated that resident was [REDACTED]. Section [REDACTED] Medications (meds) showed that the resident received [REDACTED] meds.</p> <p>A review of the [REDACTED] Order Summary Report (OSR) showed a physician's order (PO): -order date [REDACTED] for labs: [REDACTED] and [REDACTED] every [REDACTED] r/t (related to) [REDACTED]</p> <p><b>NJ Exec Order 26.4b1</b></p> <p>[REDACTED]</p> <p>-order date [REDACTED] for [REDACTED] Evaluation with [name] [REDACTED]</p> <p>-order date [REDACTED] for [REDACTED]</p>	F 770	<p>The nursing supervisors have audited all residents' medical records for standing lab orders and ensured the lab has the correct dates. This audit is done weekly for 1 month and then monthly for 3 months. The nursing supervisors maintain a log of these reviews and present the logs to the Quality Assurance committee at each quarterly meeting. The Quality Assurance Committee will determine the effectiveness of the medical record audits to determine if further monitoring and evaluation is required.</p>

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F 770	<p>Continued From page 46</p> <p>NJ Exec Order 26.4b1) give one tab by mouth four times a day for NJ Exec Order 26.4b1.</p> <p>-order date NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1</p> <p>give three capsules (caps) by mouth one time a day for NJ Exec Order 26.4b1 (total dose: NJ Exec Order 26.4b1</p> <p>-order date NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1</p> <p>give one tab by mouth one time a day for NJ Exec Order 26.4b1</p> <p>The above PO for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 were transcribed to the electronic Medication Administration Record (eMAR) and signed by nurses as administered from NJ Exec Order 26.4b1</p> <p>A review of the electronic medical records (eMR) showed that there was a NJ Exec Order 26.4b1 Consult note dated NJ Exec Order 26.4b1 with a diagnosis and a plan to continue with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1. Also, continue to monitor labs for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 every 3-6 months.</p> <p>Further review of the eMR showed there was no PO to monitor labs for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 every NJ Exec Order 26.4b1. There was no documented evidence that the recommendations of the US FOIA (b)(6) were followed and/or why it was not followed.</p> <p>Further review of the hybrid medical records showed that there was no documented evidence that the order for routine labs for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 every NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 were followed and/or why it was not followed.</p>	F 770	

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F 770	<p>Continued From page 47</p> <p>On 9/06/24 at 11:50 AM, the surveyor interviewed the <b>US FOIA (b)(6)</b> regarding the facility's practice with regard to standing orders for labs. The <b>US FOIA (b)(6)</b> stated that as the facility's practices all standing orders for labs, will be electronically entered into the eMR and should be done according to the POs.</p> <p>On that same date and time, the surveyor asked the <b>US FOIA (b)(6)</b> should the requisition for the labs to be done also comes out electronically or need to order the requisition manually (or handwritten). The <b>US FOIA (b)(6)</b> stated and responded that it depends on the nurse, if it will be the <b>US FOIA (b)(6)</b> assigned on that date, the requisition will come out electronically but if it will be another nurse they do it manually the requisition form for the kind of labs to be drawn. The surveyor then asked why some electronically and others manually, and then the <b>US FOIA (b)(6)</b> responded, that it should be electronically printed.</p> <p>At that time, the surveyor notified the <b>US FOIA (b)(6)</b> of the above findings and concerns regarding routine labs ordered on <b>NJ Exec Order 26-46</b> for <b>NJ Exec O</b> and <b>NJ Exec O</b> for <b>NJ Exec O</b> and <b>NJ Exec O</b> and recommendations of the <b>US FOIA (b)(6)</b> for <b>NJ Exec O</b> and <b>NJ Exec O</b> on <b>NJ Exec Order 26-46</b> every 3-6 months were not followed. The <b>US FOIA (b)(6)</b> stated that she would get back to the surveyor.</p> <p>On 9/06/24 at 12:09 PM, the <b>US FOIA (b)(6)</b> stated that there were labs done on <b>NJ Exec Order 26-46</b> that were recommended by the <b>US FOIA (b)(6)</b> and the result for <b>NJ Exec Order 26-46</b> was <b>NJ Exec O</b>. The surveyor asked the <b>US FOIA (b)(6)</b> should the standing order for labs had been followed for <b>NJ Exec O</b> and <b>NJ Exec O</b>. The <b>US FOIA (b)(6)</b> stated that she would get back to the surveyor.</p>	F 770			

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NAME OF PROVIDER OR SUPPLIER  <b>CHESHIRE HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9 RIDGEDALE AVE FLORHAM PARK, NJ 07932</b>		
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F 770	Continued From page 48 On 9/06/24 at 12:31 PM, the survey team met with the <b>US FOIA (b)(6)</b> The surveyor notified the facility management of the above findings and concerns. The <b>US FOIA (b)(6)</b> did not provide additional information.  On 9/06/24 at 12:52 PM, the survey team met with the <b>US FOIA (b)(6)</b> for an Exit Conference. The facility management did not provide additional information.	F 770			
F 880 SS=D	NJAC 8:39-27.1(a) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.  §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F 880		10/2/24	

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F 880	Continued From page 49  §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 infection.	F 880			

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F 880	<p>Continued From page 50</p> <p>§483.80(f) Annual review.</p> <p>The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to a.) follow appropriate hand hygiene, use of personal protective equipment (PPE), and disinfect equipment practices for one (1) of four (4) staff (US FOIA (b)(6), Dietary Staff, and two nurses) and b.) follow appropriate infection control practices prevent the potential spread of infection for two (2) of two (2) rooms observed during laundry area tour in accordance with the Center for Disease Control and Prevention (CDC) guidelines and facility's policy.</p> <p>This deficient practice was evidenced by the following:</p> <p>According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 02/27/24 revealed:</p> <p>Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications:</p> <p>Immediately before touching a patient ...</p> <p>Before moving from work on a soiled body site to a clean body site on the same patient ...</p> <p>After touching a patient or the patient's immediate environment</p> <p>After contact with blood, body fluids, or contaminated surfaces</p> <p>Immediately after glove removal.</p> <p>According to CDC Recommendations for</p>	F 880	<p>Hand hygiene was immediately reinforced by the Inservice Coordinator to the NJ Exec Order 26.4b1. The US FOIA (b)(6) was re-educated on not using gloves in the hallways, hand hygiene, and changing gloves between each wheelchair cushion check by the Inservice Coordinator. He was observed by the Inservice Coordinator performing hand hygiene as per protocol.</p> <p>All residents have the potential of being affected. The Inservice Coordinator reinforced and educated all staff, all departments, and new hires on the importance of hand hygiene and not using gloves in hallways. It is completed annually and upon hire. In addition, the Inservice Coordinator inserviced all Rehabilitation Department staff on hand hygiene, not wearing gloves in the hallway, and changing gloves between each wheelchair cushion check. The Inservice Coordinator maintains logs of inservices to present to the Quality Assurance committee quarterly.</p> <p>The Inservice Coordinator checks 30 staff members including the Rehabilitation Department a month for three months for hand hygiene and gloves in the hall. All nursing staff (nurses and CNAs) complete an annual competency. Logs are kept by</p>	

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F 880	<p>Continued From page 51</p> <p>Disinfection and Sterilization in Healthcare Facilities, dated 12/07/23, revealed:</p> <p>5. Cleaning and Disinfecting Environmental Surfaces in Healthcare Facilities: ...</p> <p>5.g. Use a one-step process and an EPA-registered hospital disinfectant designed for housekeeping purposes in patient care areas where uncertainty exists about the nature of the soil on the surfaces (e.g., blood or body fluid contamination versus routine dust or dirt); or uncertainty exists about the presence of multidrug-resistant organisms on such surfaces ...</p> <p>1. On 9/03/24 at 9:15 AM, the surveyor observed the <b>US FOIA (b)(6)</b> in the hallway with a pair of gloves. The surveyor also observed the checked residents' <b>NJ Exec Order</b> wheelchair (w/c) cushions with the use of handheld equipment. The handheld equipment was not disinfected after each use. The <b>US FC</b> passed the resident rooms that included from <b>NJ Ex</b> through <b>NJ Ex</b>.</p> <p>Afterward, the surveyor observed the <b>US FC</b> on the other side of the hallway with the same pair of gloves and checked the other w/c that were in front of rooms <b>NJ Ex</b> through <b>NJ Ex</b> between rooms <b>NJ Ex</b> and <b>NJ Ex</b> and rooms <b>NJ Ex</b> and <b>NJ Ex</b>. The <b>US FC</b> did not change gloves, did not perform hand hygiene, and did not disinfect the handheld equipment.</p> <p>At that time, the surveyor interviewed the <b>US FC</b>. The surveyor asked the <b>US FC</b> if it was appropriate to wear gloves in the hallway, and the <b>US FC</b> responded that he had to wear gloves because he checked the w/c cushion weekly. The surveyor then asked how about changing the gloves in each w/c, and the <b>US FC</b> stated, "This is how I was told." The surveyor also asked who the facility staff</p>	F 880	<p>the Inservice Coordinator and all logs are presented to the Quality Assurance committee at each quarterly meeting. The Quality Assurance committee will determine the effectiveness of the education of hand hygiene, not using gloves in the hallway, and changing gloves between each cushion check, and determine if further monitoring and evaluation is required.</p> <p>The Director of Nursing met with the Director of Rehabilitation and a safer, more efficient wheelchair cushion check policy was developed. An updated policy for wheelchair cushion checks in relation to infection control has been completed by the Director of Rehabilitation. The Inservice Coordinator inserviced all members of the Rehabilitation Department on the updated policy for wheelchair cushion checks and does so annually and upon hire. Inservice logs are kept by the Inservice Coordinator and presented to the Quality Assurance committee quarterly.</p> <p>The Director of Rehabilitation monitors the Physical Therapist Assistant or designated Rehabilitation Department staff member on the performance of the wheelchair cushion checks for the 10 residents that do not transfer during their therapy session. They are checked for hand hygiene and the changing of gloves between wheelchairs weekly for 1 month, and monthly for 3 months. The remaining 25 chairs are checked on a weekly basis during one of the residents therapy</p>		

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F 880	<p>Continued From page 52</p> <p>instructed him to wear the same gloves and he said his director.</p> <p>On 9/03/24 at 10:34 AM, the surveyor notified the <b>US FOIA (b)(6)</b> of the above findings and observations about the <b>US FC</b> regarding gloves use in the hallway, not changing gloves in between residents' w/c, and not disinfecting the equipment to check the cushion of w/c. The <b>US FOIA (b)(6)</b> stated that the <b>US FC</b> should have cleaned and changed gloves in each check of residents' w/c.</p> <p>On 9/04/24 at 8:59 AM, the surveyor interviewed Registered Nurse Supervisor/Infection Preventionist #1 (RNS/IP#1) and RNS/IP#2. The surveyor notified RNS/IP#1 and #2 of the above observations and findings with the <b>US FC</b> on <b>NJ Exec Order 2</b>.</p> <p>On that same date and time, RNS/IP#1 informed the surveyor that she was made aware by the <b>US FOIA (b)(6)</b> of what had happened yesterday about the gloves in the hallway by the <b>US FC</b> RNS/IP#2 informed the surveyor that the <b>US FOIA (b)(6)</b> provided education to <b>US FC</b> yesterday about appropriate hand hygiene. RNS/IP#2 further stated that the <b>US FC</b> educated the <b>US FC</b> that the use of gloves in the hallway was not appropriate. Both the <b>US FOIA (b)(6)</b> stated that it was not appropriate that staff wear gloves in the hallway, <b>US FC</b> should have changed gloves, performed hand hygiene in between w/c, and disinfecting the pump used for checking the cushion in the w/c for infection control.</p> <p>A review of the facility's Infection Prevention &amp; Control Hand Hygiene Policy with a revision date of 8/21 that was provided by the <b>US FOIA (b)(6)</b> showed: Policy: The objective is to ensure all</p>	F 880	<p>appointments. Logs are maintained by the Director of Rehabilitation or designated staff member. This is to ensure all residents' cushions are checked at least once during this time frame. The Director of Rehabilitation or designated staff member reports findings to the Quality Assurance committee at the next quarterly meeting. The Quality Assurance committee will determine the effectiveness of the plan and if further monitoring and evaluation is required.</p> <p>The fan was removed from the clean linen storage area Laundry Area #1 (LA#1) immediately. Clean linens were re-washed and placed on the proper covered shelf immediately.</p> <p>All residents have the potential to be affected by the deficient practice. The Director of Environmental Services will make documented rounds twice a day to ensure that all clean linen and incontinence pads are stored away properly after being folded and covered. These logs will be presented to the Quality Assurance Committee quarterly.</p> <p>The Director of Environmental Services will provide a documented in-service to the Environmental Services staff on infection control in-regards to the proper storage of clean linen. The Director of Environmental Services will purchase a cover for the clean linen to ensure a clean area for that is free from foreign materials including dust. The Director of</p>		

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F 880	<p>Continued From page 53</p> <p>residents/patients are cared for by staff following hand hygiene protocols.</p> <p>2. On 9/05/24 at 9:28 AM, the surveyor toured laundry area #1 (LA#1) with the <b>US FOIA (b)(6)</b> from the contracted company for the facility's laundry services. During the tour, the <b>US FOIA</b> stated that LA#1 was for linens, blankets, and fitted sheets. The 1st door upon entry of LA#1 washer and dryers were being used at that time, next door, the folding room where there was an electric fan hung on the wall. The electric fan was in use and there was an accumulation of grayish and whitish substances around the fan while blowing air, next to it were two metal racks with folded blankets uncovered. The folding table had the folded incontinence pad uncovered.</p> <p>On that same date and time, the surveyor asked the <b>US FOIA</b> if those folded incontinence pads and blankets were considered clean, and the <b>US FOIA</b> responded "Yes." The surveyor asked the <b>US FOIA</b> what the accumulation of grayish and white substances in the electric fan was. The <b>US FOIA</b> stated and claimed it was dust and should have been cleaned. The <b>US FOIA</b> further stated that he would ask someone to remove the fan.</p> <p>Later on, the surveyor and the <b>US FOIA</b> went to LA#2 which was in the nursing area in front of rooms <b>NJ EXC</b> and <b>NJ EXC</b>. LA#2 was an open area with two washers and two dryers actively being used, and unattended. There were multiple empty laundry bins near the dryers. The folded incontinence pads, folded socks, and other personal clothing on top of the 1st washer not bagged, uncovered, and exposed to the environment. The <b>US FOIA</b> stated that LA#2 was for washing residents' clothing. He further stated that the residents' clothing and</p>	F 880	<p>Environmental services will conduct documented rounds of the clean linen storage area to ensure that clean linen is covered properly twice a day. These logs will be presented to the Quality Assurance committee quarterly.</p> <p>The results of the rounds and in-service will be discussed during the Quality Assurance meeting to ensure compliance.</p> <p>The clothing was removed from on top of the washing machines in Laundry Area #2 (LA#2). The machine interiors and exteriors were sanitized and the clothing was re-washed. A sign was put up to not use the machines until further notice until a plan was put in place. The machines were unplugged and locks were installed by a licensed electrician. (See Attachment 8).</p> <p>All residents have the potential to be affected.</p> <p>All residents that do their own laundry will undergo an evaluation by the Therapy department to assess their ability to independently and safely use the machines, with a focus on infection control and hand hygiene. (See Attachment 9).</p> <p>The Director of Rehabilitation will present a summary of these evaluations to the Quality Assurance Committee quarterly. Based on this assessment, residents will either be cleared to use the machines independently or will require supervision from a caregiver (family or staff).</p>		

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F 880	<p>Continued From page 54</p> <p>incontinence pad on top of the 1st washer were considered soiled.</p> <p>At that time, the surveyor asked the [US FOIA] why the soiled residents' clothing was left on top of the washer not properly stored and unattended. The [US FOIA] stated, "Maybe someone had put it there." He further stated that it would be washed next. The surveyor asked the [US FOIA] if it was appropriate for the soiled residents' clothing left exposed to the environment, and the [US FOIA] had no response.</p> <p>Furthermore, the surveyor asked the [US FOIA] what he should do with the blankets in LA#1 that were exposed to dust. The [US FOIA] stated that he would ask someone to remove the fan from the room. The surveyor then asked how the blanket and linen should be stored. The [US FOIA] stated that he would ask if the facility could order a cover for the clean blankets.</p> <p>On 9/05/24 at 10:23 AM, the surveyor asked the [US FOIA] what happened to LA#2 soiled residents' clothing, the [US FOIA] stated it was washed immediately and that should have been in a bag with the resident's name. The [US FOIA] stated that he did not know who put the soiled residents' clothing on top of the washer.</p> <p>On 9/05/24 at 11:39 AM, the survey team met with the [US FOIA (b)(6)]</p> <p>The surveyor notified the facility management of the above findings and concerns with the [US FOIA] and the laundry tour.</p> <p>On that same date and time, the [US FOIA] stated that LA#2 was being used by residents to wash their clothes and no staff was assigned to LA#2 to</p>	F 880	<p>After evaluation, the Inservice Coordinator will provide instruction on infection control procedures, including sanitizing hands and wiping down the machines with facility-approved cleaners before and after use. These will be logged and presented to the next Quarterly Assurance committee meeting.</p> <p>Laundry cannot be left on top of the machines, and residents must sign out the machines for use between 10 am and 4 pm. Laundry bags labeled with the resident names are provided upon request.</p> <p>Residents who participated in the assessment and demonstrate understanding of infection control will receive a key for machine access. For those needing caregiver assistance, family members will receive a pamphlet detailing washer/dryer instructions and infection control procedures prior to resident receiving a key and will sign an acknowledgement upon receipt.</p> <p>A sign-up sheet, directions, and rules will be posted near the machines. Residents found loaning keys to others will have their access suspended.</p> <p>Environmental services staff will also sanitize the machines twice a day in the morning and afternoon. These sanitizations will be logged and presented to the Quality Assurance committee quarterly.</p> <p>Resident use of machines will be randomly monitored and logged by the Inservice Coordinator to ensure compliance with infection control</p>		

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F 880	<p>Continued From page 55</p> <p>monitor that area. The surveyor asked the [US FOIA (b)(6)] if they have a list of residents who does their own laundry and if they were educated about proper use of laundry and specifically infection control. The [US FOIA (b)(6)] stated residents were not provided with education about infection control regarding washing their own clothes. The [US FOIA (b)(6)] further stated that LA#2 was not being cleaned after each wash or being cleaned at all. The [US FOIA (b)(6)] also stated that they did not have a list of residents who use the laundry area and that was a busy area all day, and no one monitors them.</p> <p>On 9/06/24 at 9:47 AM, the survey team met with the [US FOIA (b)(6)] and the [US FOIA (b)(6)] from the contracted agency for laundry services. The [US FOIA (b)(6)] informed the surveyor that LA#1 was where the soiled blankets, linens, and residents' clothing were being washed. The [US FOIA (b)(6)] stated that soiled meant "anything" with body fluids and vomit. She further stated that LA#2 was where the dirty residents' clothing was being washed, dirty meant anything that was not soiled.</p> <p>At that same time, the [US FOIA (b)(6)] stated that after the residents washed their clothes, the residents themselves were not wiping or disinfecting LA#2 environment (top and areas in the washers and dryers). The [US FOIA (b)(6)] stated, "We know now we have a gap, and we are working on the gap now."</p> <p>On 9/06/24 at 12:31 PM, the survey team met with [US FOIA (b)(6)]. The facility management stated that they were no additional information for the surveyor's concerns and findings.</p> <p>A review of the facility's undated Soiled Laundry Collection Policy that was provided by the [US FOIA (b)(6)]</p>	F 880	practices. The Inservice Coordinator will present these logs at the Quality Assurance Committee quarterly.		

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F 880	Continued From page 56 showed: Procedure:... 4. Once the fabric is collected, it should be put in a hamper, laundry bag, or other device to facilitate the transport to the laundry apartment without the risk of having the laundry contaminate other surfaces...  On 9/06/24 at 12:52 PM, the survey team met with the <b>US FOIA (b)(6)</b> for an Exit Conference. The facility management did not provide additional information.  NJAC 8:39-19.4(a)(1),l,n	F 880			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>061421</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/06/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CHESHIRE HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>9 RIDGEDALE AVE FLORHAM PARK, NJ 07932</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments  The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation  (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows:  1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later.	S1410		9/7/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

09/20/24

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>061421</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/06/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CHESHIRE HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>9 RIDGEDALE AVE FLORHAM PARK, NJ 07932</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S1410	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation it was determined that the facility failed to ensure newly hired employees completed the required <b>NJ Exec Order 26.4b1</b> upon hire. The deficient practice was identified for one (1) of six (6) randomly selected new employees (Staff #1) and was evidenced by the following:</p> <p>The surveyor reviewed six randomly selected newly hired employee files.</p> <p>The review for <b>NJ Exec</b> screening upon hire for one of the six new employees revealed the following:</p> <p>Staff #1, a Certified Nursing Aide (CNA), hired on <b>NJ Exec Order 26.4b1</b>, had completed the first step of a <b>NJ Exec Order 26.4b1</b> as required on <b>NJ Exec Order 26.4b1</b>. The result of the first step <b>NJ Exec C</b> was <b>NJ Exec Order 26.4b1</b> on <b>NJ Exec Order 26.4b1</b>. There was no additional documentation in the file for the second step of the <b>NJ Exec C</b> or <b>NJ Exec Order 26.4b1</b> being completed.</p> <p>On 9/06/24 at 11:09 AM, the surveyor interviewed the Acting Human Resource Representative (AHRR). The AHRR stated the previous HR representative left in <b>NJ Exec Order 26.4b1</b> and that was when she began covering the position. The AHRR stated newly hired staff must have a physical and <b>NJ Exec C</b> results upon hire. The AHRR further explained newly hired staff were asked to bring <b>NJ Exec C</b> results and if not, the facility would perform <b>NJ Exec C</b> testing. The In-service coordinator was responsible for administering <b>NJ Exec Ord</b> to</p>	S1410	<p>Staff #1 was immediately removed from the schedule and will not be put back on the schedule until a <b>NJ Exec Order 26.4b1</b> is presented to the Acting Human Resource Representative (AHRR), and read and confirmed by the Inservice Coordinator/Licensed Practical Nurse (ISC/LPN).</p> <p>All residents have the potential to be affected. All other new employee files since the last annual survey were inspected to ensure that Purified Protein Derivative(PPD) results were received.</p> <p>A New Hire Requirements Log was created to ensure all necessary items are received for each employee prior to the first day of work. The New Hire Requirements Log is placed in front of each new employees Personnel File. One item on the log is the verification of negative PPD results prior to the first day of work. In the event a second PPD is not administered, the staff has up to 21 days after the first PPD to show proof of a chest X-Ray or Quantiferon blood test. The Director of Human Resources or AHRR will initial and date the log upon receipt of the negative PPD results.</p> <p>The AHRR reviewed the Personnel Management Employee Health Surveillance policy and will review annually. In addition, the AHRR updated</p>	
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>061421</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/06/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CHESHIRE HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>9 RIDGEDALE AVE FLORHAM PARK, NJ 07932</b>
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S1410	<p>Continued From page 2</p> <p>employees. Newly hired could also provide alternative <sup>NJ Exec Order 26.4b1</sup> results if <sup>NJ Exec C</sup> was contraindicated and the facility could send the newly hired staff for a <sup>NJ Exec Order 26.4b1</sup> if needed.</p> <p>On that same date and time, the surveyor discussed the concern with Staff #1 <sup>NJ Exec C</sup> results found in the file. The AHRR replied that Staff #1 refused the second step of the <sup>NJ Exec C</sup> and wanted to do a <sup>NJ Exec C</sup> instead. The AHRR further stated that the Staff #1 wanted to schedule her own <sup>NJ Exec Ord</sup>. The AHRR was not sure which day Staff #1 refused the <sup>NJ Exec C</sup> and stated that she followed up with the employee this week. The AHRR could not speak to if there was any follow up with Staff #1 prior to this week and stated Staff #1 was to bring in the <sup>NJ Exec C</sup> results later today.</p> <p>On 9/06/24 at 11:41 AM, the surveyor interviewed the in-service coordinator/Licensed Practical Nurse (ISC/LPN). The ISC/LPN stated that she administered <sup>NJ Exec Order 26.4b1</sup> to newly hired staff if needed. The ISC/LPN stated that Staff #1 received the <sup>NJ Exec Order 26.4b1</sup> <sup>NJ Exec Order 26.4b1</sup> as documented in the employee's file. The ISC/LPN explained Staff #1 was to receive the <sup>NJ Exec Order 26.4b1</sup> <sup>NJ Exec Order 26.4b1</sup> on <sup>NJ Exec Order 26.4b1</sup> and Staff #1 refused the <sup>NJ Exec C</sup> at the time. The ISC/LPN continued to state that Staff #1 wanted to do a <sup>NJ Exec Ord</sup> declined to go to the facility's vendor and was to schedule her own <sup>NJ Exec Ord</sup>. The ISC/LPN said the <sup>NJ Exec C</sup> were expected to be received immediately or as soon as possible.</p> <p>At that time, the surveyor asked if it would be documented that the staff refused a <sup>NJ Exec C</sup> and if there was any follow up with Staff #1 after that day. The ISC/LPN stated it was not documented if staff refused a <sup>NJ Exec Ord</sup> it was just "word of mouth"</p>	S1410	<p>the Personnel Management Staffing policy to include the initiation and completion of a New Hire Requirements Log for each new employee. The Director of Human Resources reviews all Human Resources policies annually. The Director of Human Resources inserviced all Human Resources staff on the Personnel Management Staffing policy and will do so annually and upon hire. The Director of Human Resources keeps a log of all reviews and inservices and submits them to the Quality Assurance Committee quarterly. The ISC/LPN will confirm receipt of the negative PPD results prior to the first day of work for each new employee and will initial the New Hire Requirements Log for that employee. The Director of Human Resources will present the New Hire Requirements Logs for each new employee to the Quality Assurance Committee quarterly.</p>	
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>061421</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/06/2024</b>
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S1410	<p>Continued From page 3</p> <p>and the <b>NJ Exec Order 26.4b1</b> such as a <b>NJ Exec O</b> would be received. The ISC/LPN stated the AHRR followed up with Staff #1 yesterday and was not sure of any previous follow up and stated Staff #1 had not been on the schedule since <b>NJ Exec Order 26.4b1</b>. The ISC/LPN showed the surveyor an email that she had just received which indicated that Staff #1 had to provide <b>NJ Exec O</b> results prior to being able to return to the schedule and further indicated that Staff #1 set up an appointment to have a <b>NJ Exec O</b> done on <b>NJ Exec Order 26.4b1</b>.</p> <p>On 9/06/24 at 12:35 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and Administrative Assistant. The surveyor notified the facility management of the concern for the screening. The DON stated that Staff #1 will not be allowed to work until the <b>NJ Exec O</b> results were received and acknowledged that they should have followed up sooner with the employee for the <b>NJ Exec O</b> to be completed. There was no additional information provided by the facility.</p> <p>The surveyor reviewed the facility's policy titled, "Personnel Management Employee Health Surveillance" last revised on 6/23. Under Procedure it read, " ...2.) All new staff members are required to have a two-step Tuberculin Test ...The Only Exceptions are as followed: Positive result of initial step ...Employee presents proof of previous positive PPD or Chest X-Ray ...A negative two step PPD within year of hire date, only one repeat test will be performed ...Employee with documented negative PPD of greater than six months will require a two-step PPD ..."</p>	S1410		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>061421</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/06/2024</b>
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S2345  S2345	Continued From page 4  8:39-31.6(o) Mandatory Physical Environment  (o) The facility shall conduct at least one evacuation drill each year, either simulated or using selected residents. State, county, and municipal emergency management officials shall be invited to attend the drill at least 10 working days in advance.  This REQUIREMENT is not met as evidenced by: Based on documentation review and interviews on 9/04/2024 in the presence of the Administrator and the Administrative Assistant, it was determined that the facility failed to invite state, county, and municipal emergency management officials to at least one evacuation drill at least 10 working days in advance.  The Administrative Assistant did provide documentation of drills conducted on 01/16/2023 and 12/07/2023 but was unable to provide documentation regarding invitation to emergency management officials for either drill.  The Administrative Assistant provided an email from the police department dated 3/06/2023 regarding an active shooter drill, availability for when it could be conducted and a request from the police department for a response on how the facility would like to proceed.  There was no documentation provided with a response from the facility, that a drill was conducted, or that emergency management officials were invited to the drill.	S2345  S2345	An evacuation drill has been scheduled for 10/02/2024. State, county, and local emergency management officials were invited on 9/17/2024 via Email. (See Attachment 15).  All residents have the potential to be affected. Prior to the start of the new calendar year, a schedule of planned emergency drills will be established for the following year by the Administrative Assistant. The schedule will include planning steps that need to be completed. One of the steps will be to invite state, county, and local emergency management officials at least 10 working days in advance of the drill date.  The Administrative Assistant will review and update the schedule quarterly to assure all steps are completed. The Administrative Assistant will submit the schedule to the QA Committee quarterly.	10/2/24

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>061421</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/06/2024</b>
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S2345	Continued From page 5  The facility's Administrator was notified of the deficient practice at the Life Safety Code exit conference on 09/04/2024.	S2345		

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315383	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 10/10/2024	Y3
NAME OF FACILITY CHESHIRE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 9 RIDGEDALE AVE FLORHAM PARK, NJ 07932		

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 F0558	Correction	ID Prefix F0607	Correction	ID Prefix F0686	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.12(b)(1)-(5)(ii)(iii)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed
LSC	10/02/2024	LSC	10/02/2024	LSC	10/02/2024
ID Prefix F0690	Correction	ID Prefix F0695	Correction	ID Prefix F0732	Correction
Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.35(g)(1)-(4)	Completed
LSC	10/02/2024	LSC	10/02/2024	LSC	09/16/2024
ID Prefix F0756	Correction	ID Prefix F0770	Correction	ID Prefix F0880	Correction
Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.50(a)(1)(i)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	10/09/2024	LSC	09/16/2024	LSC	10/02/2024
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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/6/2024		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>		

**STATE FORM: REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 061421	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 10/10/2024
NAME OF FACILITY CHESHIRE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 9 RIDGEDALE AVE FLORHAM PARK, NJ 07932	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S1410	Correction	ID Prefix S2345	Correction	ID Prefix _____	Correction
Reg. # 8:39-19.5(b)(1)	Completed	Reg. # 8:39-31.6(o)	Completed	Reg. # _____	Completed
LSC _____	09/07/2024	LSC _____	10/02/2024	LSC _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	_____	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	_____	LSC _____	_____	LSC _____	_____
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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 9/6/2024

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?  YES  NO

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

PRINTED: 11/22/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315383</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/06/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CHESHIRE HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>9 RIDGEDALE AVE FLORHAM PARK, NJ 07932</b>
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E 000	Initial Comments	E 000		
K 000	INITIAL COMMENTS  A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/03/2024 and 09/04/2024. Cheshire Home was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.  Cheshire Home is a one-story building that was built in 1981 with an addition that was built in the late 1990's. It is composed of Type II unprotected construction as per the evacuation plan. They have an outdoor, diesel powered generator that supplies 100% of the facility as per Director of Plant Operations. There is a finished basement that is used for storage.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101  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	K 222		10/2/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>09/20/2024</b>
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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.

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

PRINTED: 11/22/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315383</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/06/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHESHIRE HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9 RIDGEDALE AVE FLORHAM PARK, NJ 07932</b>		
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K 222	<p>Continued From page 1</p> <p>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.</p> <p>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 <b>SPECIAL NEEDS LOCKING ARRANGEMENTS</b></p> <p>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.</p> <p>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 <b>DELAYED-EGRESS LOCKING ARRANGEMENTS</b></p> <p>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 throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4 <b>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS</b></p> <p>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be</p>	K 222			

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K 222	<p>Continued From page 2 permitted. 18.2.2.2.4, 19.2.2.2.4 <b>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS</b> 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 09/03/2024 in the presence of the <b>US FOIA (b)(6)</b>, it was determined that the facility failed to ensure that doors in a required means of egress were not equipped with a latch or lock in accordance with NFPA 101: 2012 Edition, Section 19.2.2.2.5. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>An observation at 12:30 PM, revealed that both sets of automatic sliding exit doors at the front entrance were equipped with a thumb turn latch.</p> <p>An observation at 12:50 PM, revealed that both sets of automatic sliding exit doors near the administration offices were equipped with a thumb turn latch.</p> <p>In interviews at the time of the observations, the <b>US FOIA (b)(6)</b> confirmed the observations.</p> <p>The facility's <b>US FOIA (b)(6)</b> was notified of the deficient practice at the Life Safety Code exit conference on 09/04/24.</p>	K 222	<p>To ensure the safety of all residents and staff, the thumb-turn latches at both the front entrance and exit doors near the administration offices were removed on Monday, September 9th, 2024. Dummy cylinders were installed by a certified locksmith to replace the open holes left by the thumb turn latches. (See attachments 1 and 2).</p> <p>All residents and staff have the potential to be affected.</p> <p>The Director of Plant Operations (DOPO) reviewed NFPA 101. The DOPO inspected the rest of the facility and confirmed that no other doors in a required means of egress were equipped with a latch or lock that requires the use of a tool or key.</p> <p>The DOPO will monitor any future work done on the automatic sliding exit doors to ensure that doors in a required means of egress are not equipped with a latch or lock in accordance with NFPA101: 2012 Edition, Section 19.2.2.2.5. Any work done on the automatic sliding doors will be logged by the DOPO and submitted to</p>		

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

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K 222	Continued From page 3 N.J.A.C 8:39-31.2(e)	K 222	the Quality Assurance Committee quarterly. The DOPO explained to each security guard, residents, and staff about the removal of the thumb turn latches. The DOPO will speak with each resident upon admission, annually, and as needed and will maintain written logs of acknowledgement. The DOPO will speak with security guards and staff annually and upon hire and will maintain written logs of acknowledgement. These logs will be documented and submitted to the Quality Assurance Committee quarterly.		
K 223 SS=F	Doors with Self-Closing Devices CFR(s): NFPA 101  Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 09/03/2024 in the presence of the <span style="background-color: black; color: white;">US FOIA (b)(6)</span> , it was determined that the facility failed to ensure that doors permitted to	K 223	To ensure the safety of all residents and staff, the table and chair were immediately removed from the resident kitchen to prevent them from blocking the fire door	10/2/24	

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K 223	<p>Continued From page 4</p> <p>be held open would self-close upon loss of power to the hold open in accordance with NFPA 101:2012 Edition, Sections 7.2.1.8.2 and 19.2.2.7. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>An observation at 1:20 PM revealed that the resident's kitchen door had a chair placed in front of it, preventing the door from closing and latching when tested by the [US FOIA (b)(6)]. Upon removal of the chair, the door did close and latch.</p> <p>In an interview at the time, the [US FOIA (b)(6)] confirmed the observation.</p> <p>The facility's [US FOIA (b)(6)] was notified of the deficient practice at the Life Safety Code exit conference on 09/04/24.</p> <p>N.J.A.C 8:39-31.2(e)</p>	K 223	<p>from closing. The Director of Plant Operations (DOPO) purchased a door sign to be placed on the door of the resident kitchen that reads DO NOT BLOCK DOOR. (See Attachment 3).</p> <p>All residents and staff have the potential to be affected. The DOPO is responsible for ensuring fire doors are not blocked. The DOPO inspected all other fire doors to ensure that no others were blocked from closing. The DO NOT BLOCK DOOR signs were placed on each fire door in the building.</p> <p>The DOPO will inspect each fire door weekly for one month, then monthly for 3 months to ensure that there is nothing blocking them from closing. Logs of inspections will be kept by the DOPO and submitted to the Quality Assurance Committee quarterly. The Quality Assurance Committee will determine the effectiveness of the fire door inspections to determine if further monitoring is required.</p> <p>The Inservice Coordinator inservice all staff on fire safety and in particular to not block fire doors from closing. The Inservice Coordinator will inservice all staff on fire safety upon hire, annually, and as needed. The Inservice Coordinator will maintain inservice logs. The Inservice Coordinator will present inservice logs to the Quality Assurance Committee at each quarterly meeting.</p> <p>The DOPO spoke to each resident about fire safety. The DOPO will speak with</p>		

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K 223	Continued From page 5	K 223			
K 293 SS=F	<p>Exit Signage CFR(s): NFPA 101</p> <p>Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 09/03/2024 in the presence of the <span style="background-color: black; color: white;">US FOIA (b)(6)</span> it was determined that the facility failed to ensure that access to exits were marked by readily visible signs in all cases where the exit or way to reach the exit was not readily apparent and that the size and location of directional indicators was in accordance with NFPA 101: 2012 Edition, Sections 7.10.1.5, 7.10.1.8, 7.10.2 and 7.10.6.2. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>An observation at 12:21 PM, revealed that the view of the directional exit sign outside of room 35 was blocked by a full dome safety mirror. Additionally, the directional indicators were not located at the end of the sign for the directions of</p>	K 293	<p>each resident about fire safety upon admission, annually, and as needed and will maintain written receipts of acknowledgement. These will be documented and submitted to the Quality Assurance Committee quarterly.</p> <p>The exit sign outside of room 35 was moved by a licensed electrician on 9/18/2024 so as not to be blocked by the full dome safety mirror. (See Attachment 10). In addition, the sign was changed to include upgraded directional indicators at the end of the sign for the directions of travel to an exit at the time it was moved. (See Attachment 11).</p> <p>All residents have the potential to be affected. The Director of Plant Operations (DOPO) engaged a licensed electrician to change all other exit signs to include updated directional indicators at the end of the sign for the directions of travel to an exit and the DOPO inspected all other exit signs to ensure full visibility. The signs</p>	9/18/24	

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K 293	Continued From page 6 travel to an exit.  In an interview at the time of the observation, the [REDACTED] confirmed the observations.  The facility's [REDACTED] was notified of the deficient practice at the Life Safety Code exit conference on 09/04/24.  N.J.A.C 8:39-31.2(e)	K 293	found to be obstructed were relocated for better visibility by the licensed electrician. To ensure that the solutions are sustained, any new exit sign that is installed in the building will be inspected and documented by the DOPO and local fire inspector during his annual inspection and as needed to ensure full visibility and the presence of upgraded directional indicators.  The DOPO will submit the documentation of work from the licensed electrician and any documentation related to newly installed exit signs to the Quality Assurance Committee at the next quarterly meeting.		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101  Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as	K 324		9/9/24	

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K 324	<p>Continued From page 7</p> <p>hazardous areas, but shall not be open to the corridor.</p> <p>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview on 09/04/2024 in the presence of the <b>US FOIA (b)(6)</b> ( ), it was determined that the facility failed to ensure that the cooking equipment was protected and maintained in accordance with NFPA 101: 2012 Edition, Sections 19.3.2.5.1, NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, and NFPA 17 A, Chapter 4. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>An observation at 10:03 AM revealed that the kitchen hood suppression system contained 4 spray nozzles that were not provided with protective blow off caps. There was grease build up on all the spray nozzles with the heaviest buildup on the 2 spray nozzles above and closest to the deep fryer.</p> <p>In an interview at the time of the observation, the <b>US FOIA (b)(6)</b> confirmed the observation.</p> <p>The facility's <b>US FOIA (b)(6)</b> was notified of the deficient practice at the Life Safety Code exit conference on 09/04/24.</p> <p>N.J.A.C 8:39-31.2(e) NFPA 96, 17 A</p>	K 324	<p>All residents and staff have the potential to be affected.</p> <p>To ensure the safety of all residents and staff, the observed grease build-up on the 4 spray nozzles was immediately cleaned. The grease from within the inside of the nozzles was removed, the 4 spray nozzles were then covered with protective blow off caps. (See attachment 4). The Director of Dietary will add this cleaning to his weekly cleaning schedule.</p> <p>The Director of Dietary inserviced the cooks and chefs on the importance of proper grease removal and proper placement of blow off caps. The Director of Dietary will inservice them annually and upon hire, and a log will be maintained and presented to the Quality Assurance Committee at each quarterly meeting. On a bi-annual basis, the nozzles will be inspected, cleaned, and protective blow off caps will be inspected by our Licensed Fire Suppression System Technician. In between those visits the Director of Dietary will inspect the nozzles weekly to make sure they are free of grease build-up and the protective blow off caps are in place.</p> <p>The Director of Dietary will maintain logs</p>	

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K 324	Continued From page 8	K 324			
K 345 SS=F	<p><b>Fire Alarm System - Testing and Maintenance</b> CFR(s): NFPA 101</p> <p>Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on documentation review and interviews on 09/03/2024 in the presence of the <span style="background-color: black; color: white;">US FOIA (b)(6)</span>, it was determined that the facility failed to ensure that semi-annual fire alarm system inspections, testing and maintenance (ITM) were conducted in accordance with NFPA 101: 2012 Edition, Sections 9.6.1.3, 9.6.1.5, NFPA 70, and NFPA 72. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>In an interview during the Life Safety Code entrance conference, the surveyor requested ITM documentation for the fire alarm system from the <span style="background-color: black; color: white;">US FOIA (b)(6)</span></p> <p>A documentation review at 10:00 AM, revealed that semi-annual fire alarm inspections were last</p>	K 345	<p>of his weekly cleaning schedule as well as logs kept by our Licensed Fire Suppression System Technician. The Director of Dietary will present these logs to the Quality Assurance Committee at each quarterly meeting.</p> <p>A fire alarm inspection was completed on 9/12/2024. (See Attachment 12).</p> <p>All residents have the potential to be affected. The Director of Plant Operations (DOPO) contracted with a new fire alarm inspection company. This company automatically schedules the inspections in advance for a year, and email reminders will be sent from the company to the DOPO before each inspection. (See Attachment 13). The DOPO reviewed NFPA 70, 72. In addition, the DOPO reviewed fire alarm inspection frequency with by the consultant fire safety contractor. Documentation of the review was acknowledged by the consultant fire</p>	9/17/24	

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K 345	Continued From page 9 conducted on 01/29/2024, more than 7 months earlier.  In an interview at 11:00 AM, the [US FOIA (b)(6)] stated that the service provider was running a little behind on inspections and that it would be completed shortly.  No further documentation was provided regarding the semi-annual inspections of the fire alarm system.  The facility's [US FOIA (b)(6)] was notified of the deficient practice at the Life Safety Code exit conference on 09/04/24.  N.J.A.C 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	safety contractor. (See Attachment 19) This documentation will be presented to the Quality Assurance Committee by the DOPO at the next quarterly meeting. The DOPO reviewed the schedule received from the fire alarm inspection company to ensure it meets requirements. The DOPO is responsible for ensuring the semi-annual fire alarm inspections are done, so reminders were added to the DOPO's calendar as to the dates the next inspections are to be completed. The fire alarm company will provide inspection reports to the DOPO upon completion of each inspection.  The DOPO will submit the schedule for the next year from the fire alarm company to the Quarterly Assurance committee at each quarterly meeting. In addition, for the upcoming year, calendar reminders of the dates the fire alarm inspections are due were added to the Administrative Assistant's calendar. The Administrative Assistant will confirm with the DOPO when fire alarm inspections are completed by initialing the inspection reports. Once inspections are completed, the initialed inspection reports will be presented by the DOPO to the Quality Assurance Committee quarterly. The Quality Assurance Committee will determine the effectiveness of the Executive Assistant initialing the inspection reports to determine if further monitoring is required.		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		9/20/24	

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K 353	<p>Continued From page 10</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on documentation review and interviews on 09/03/2024 in the presence of the <span style="background-color: black; color: white;">US FOIA (b)(6)</span>, it was determined that the facility failed to ensure that quarterly fire sprinkler system inspection, testing and maintenance (ITM) was conducted in accordance with NFPA 101: 2012 Edition, Sections 9.7.5, 9.7.7 and NFPA 25. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>In an interview during the Life Safety Code entrance conference, the surveyor requested ITM documentation for the fire sprinkler system from the <span style="background-color: black; color: white;">US FOIA (b)(6)</span></p> <p>Documentation review at 10:00 AM, revealed that quarterly fire sprinkler inspections since the last</p>	K 353	<p>The Director of Plant Operations (DOPO) contacted the sprinkler system maintenance and testing service provider. The service provider provided inspection, testing and maintenance (ITM) documentation of a fire sprinkler inspection on February 29, 2024 and June 11, 2024. (See Attachment 5).</p> <p>DOPO confirmed with the provider that the next quarterly fire sprinkler inspections are scheduled for September and December 2024. (See Attachment 6). All residents and staff have the potential to be affected.</p> <p>The DOPO will re-review NFPA 101:2012 Edition, Sections 9.7.5, 9.7.7 and NFPA 25. In addition, the DOPO reviewed fire</p>		

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K 353	<p>Continued From page 11</p> <p>recertification survey on 08/18/2023 were conducted on 10/17/2023, 03/06/2024, and 07/05/2024.</p> <p>In an interview at 11:00 AM, the <span style="background-color: black; color: white;">US FOIA (b)(6)</span> stated that the service provider was usually good at keeping up with the inspections and that they would contact them to figure out what happened.</p> <p>No further documentation was provided regarding the quarterly fire sprinkler ITM.</p> <p>The facility's <span style="background-color: black; color: white;">US FOIA (b)(6)</span> was notified of the deficient practice at the Life Safety Code exit conference on 09/04/24.</p> <p>N.J.A.C 8:39-31.2(e) NFPA 25</p>	K 353	<p>sprinkler inspection frequency with by the consultant fire safety contractor. Documentation of the review was acknowledged by the consultant fire safety contractor. (See Attachment 20) This documentation will be presented to the Quality Assurance Committee by the DOPO at the next quarterly meeting. Following each fire sprinkler inspection, since the DOPO is responsible for ensuring the quarterly fire sprinkler inspections are done, a monthly reminder will be added to the DOPO electronic calendar as to the date the next inspection must be completed. The service provider provides inspection documentation to the DOPO at the completion of each inspection.</p> <p>To ensure the safety of all residents and staff, the service provider will maintain logs of inspection and submit a copy of each inspection to the DOPO. In addition, for the upcoming year, calendar reminders of the dates the sprinkler inspections are due will be added to the Administrative Assistant's calendar. The Administrative Assistant will confirm with the DOPO when sprinkler inspections are completed by initialing the inspection reports. Once inspections are completed, the initialed inspection reports will be presented by the DOPO to the Quality Assurance Committee quarterly. The Quality Assurance Committee will determine the effectiveness of the Executive Assistant initialing the inspection reports to determine if further monitoring is required.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315383</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/06/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHESHIRE HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9 RIDGEDALE AVE FLORHAM PARK, NJ 07932</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 371 SS=F	<p>Subdivision of Building Spaces - Smoke Compar CFR(s): NFPA 101</p> <p>Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING</p> <p>Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2</p> <p>Detail in REMARKS zone dimensions including length of zones and dead-end corridors. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview on 09/03/2024 in the presence of the <span style="background-color: black; color: white;">US FOIA (b)(6)</span>, it was determined that the facility failed to ensure that smoke barriers were continuous through all concealed spaces in accordance with NFPA 101: 2012 Edition, Sections 19.3.7.3, 8.6.7 and 8.5.2. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>An observation at 12:25 PM, revealed that the smoke barrier wall near the exit door from the TV room to the lobby had an unprotected penetration approximately 5-inches wide and 38-inches high.</p> <p>In an Interview at the time of the observation, the <span style="background-color: black; color: white;">US FOIA (b)(6)</span> confirmed the observation.</p> <p>The facility's <span style="background-color: black; color: white;">US FOIA (b)(6)</span> was notified of the deficient practice at the Life Safety Code exit conference on 09/04/24.</p> <p>N.J.A.C 8:39-31.2(e)</p>	K 371	<p>To ensure the safety of all residents and staff, the Director of Plant Operations (DOPO) immediately closed and reinforced the unprotected penetration in the smoke barrier wall near the exit door from the TV room to the lobby (See Attachment 18). The DOPO is responsible for ensuring there are no penetrations in the smoke barrier. The DOPO conducted an inspection of the building to ensure that there were no other unprotected penetrations in the smoke barrier walls.</p> <p>All residents and staff have the potential to be affected. In addition to re-reviewing NFPA 101: 2012 Edition, Sections 19.3.7.3, 8.6.7 and 8.5.2, the DOPO reviewed the purpose and structure of smoke barriers and compartments with the consultant fire safety contractor. Documentation of the review was acknowledged by the consultant fire safety contractor. (See Attachment 22)</p>	9/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315383</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/06/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHESHIRE HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9 RIDGEDALE AVE FLORHAM PARK, NJ 07932</b>		
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K 371	Continued From page 13	K 371	This documentation will be presented to the Quality Assurance Committee by the DOPO at the next quarterly meeting. It was found that the penetration in the smoke barrier wall was caused by electrical work done recently by a contractor. Any future work done that could impact the smoke barriers will be inspected by the DOPO to ensure there are no openings or penetrations. All such work will be logged on the Smoke Barrier Log by the DOPO and submitted to the Quality Assurance committee quarterly. The smoke barrier compartments will be inspected quarterly by the DOPO to ensure there are no penetrations. A log of each inspection will be maintained by the DOPO and submitted to the Quality Assurance committee quarterly.		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101  Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced	K 761		10/23/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315383</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/06/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHESHIRE HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9 RIDGEDALE AVE FLORHAM PARK, NJ 07932</b>	
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K 761	<p>Continued From page 14</p> <p>by: Based on observation and interview on 09/03/2024 in the presence of the [US FOIA (b)(6)], it was determined that the facility failed to ensure that fire door assemblies were inspected and tested annually in accordance with NFPA 80 Standard for Fire Door and Other Opening Protectives. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>In an interview during the Life Safety Code entrance conference, the surveyor made a requested for fire door assemblies inspection, testing and maintenance (ITM) to the [US FOIA (b)(6)].</p> <p>An observation at 1:00 PM revealed, the stairway enclosure that leads to the basement was equipped with a fire rated door assembly.</p> <p>In an interview at 2:00 PM a request was made to the [US FOIA (b)(6)] for fire door assemblies ITM for review the following morning.</p> <p>No further documentation was provided regarding fire door assemblies ITM.</p> <p>The facility's [US FOIA (b)(6)] was notified of the deficient practice at the Life Safety Code exit conference on 09/04/24.</p> <p>N.J.A.C 8:39-31.2(e)</p>	K 761	<p>To ensure the safety of all residents and staff, the Director of Plant Operations (DOPO) identified all fire doors in the building and contracted the services of a certified Fire Door Inspection Company to conduct an annual Fire Door inspection, testing and maintenance (ITM) on the door assemblies, including the door assembly that leads to the basement. The ITM was completed on 10/23/2024. (See Attachment 23) Moving forward, the DOPO will ensure these inspections will be done annually. In addition, calendar reminders were added to the DOPOs and Administrative Assistants calendars. The Administrative Assistant will confirm with the DOPO when door inspections are completed by initialing the inspection reports.</p> <p>All residents and staff have the potential to be affected. The DOPO reviewed NFPA 80 and reviewed the need for Fire Door inspections with by the consultant fire safety contractor. Documentation of the review was acknowledged by the consultant fire safety contractor. (See Attachment 21) This documentation will be presented to the Quality Assurance Committee by the DOPO at the next quarterly meeting.</p> <p>The DOPO will maintain the Fire Door Inspection logs and submit to the Quality Assurance committee quarterly.</p>	

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315383	Y1	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	DATE OF REVISIT 10/24/2024	Y3
NAME OF FACILITY CHESHIRE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 9 RIDGEDALE AVE FLORHAM PARK, NJ 07932		

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 K0222	Correction Completed 10/02/2024	ID Prefix _____ Reg. # NFPA 101 LSC K0223	Correction Completed 10/02/2024	ID Prefix _____ Reg. # NFPA 101 LSC K0293	Correction Completed 09/18/2024
ID Prefix _____ Reg. # NFPA 101 LSC K0324	Correction Completed 09/09/2024	ID Prefix _____ Reg. # NFPA 101 LSC K0345	Correction Completed 09/17/2024	ID Prefix _____ Reg. # NFPA 101 LSC K0353	Correction Completed 09/20/2024
ID Prefix _____ Reg. # NFPA 101 LSC K0371	Correction Completed 09/09/2024	ID Prefix _____ Reg. # NFPA 101 LSC K0761	Correction Completed 10/23/2024	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/6/2024		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>		