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| E 000 | Initial Comments<br><br>This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>Survey Date: 11/03/22<br><br>Census: 107<br><br>Sample: 24 +3 closed records<br><br>Complaint #NJ00157677<br><br>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.<br><br>The following Immediate Jeopardy (IJ) situations were identified for F600, F689, F835, and F836.<br><br>During a Standard Survey conducted from 10/13/22 through 11/03/22, the survey team identified the following:<br><br>F600 (Free from Abuse and Neglect)<br><br>The survey team identified an immediate jeopardy situation (Past Non-Compliance) for F600 which began on 7/30/22.<br><br>On 7/30/22 during the evening shift, Resident #2 was a victim of physical abuse by a Licensed Practical Nurse (LPN #1) when LPN #1 [redacted] Resident #2 on the [redacted] with a | F 000 | | |

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

Electronically Signed | 12/02/2022

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[redacted] causing the resident to [redacted] to the ground. This incident was witnessed by two facility staff, a Certified Nursing Aide (CNA #1) and a second Licensed Practical Nurse (LPN #2). The resident exhibited [redacted] after the incident.

LPN#1's failure to prevent physical abuse by punching Resident #2 with a [redacted] causing the resident to fall posed a likelihood of serious harm, impairment or death to that resident on [redacted].

The facility immediately suspended and terminated LPN #1 and notified all necessary parties and governing agencies and implemented additional measures to protect other residents on the same day [redacted].

The facility was notified of the past non-compliance IJ on 10/26/22. The immediacy was lifted on 7/30/22.

No Plan of Correction is required for F600.

F689 (Free of Accidents/Hazards, Adequate Supervision). Three sepearte immediate jeopardy situations were identified for this requirement under F689 (Part A, B and C).

Part A (Falls): Over a period of six months from [redacted] through [redacted] the facility failed to ensure that Resident #47 who was assessed to be at high [redacted] and had a diagnosis of dementia received the necessary supervision and monitoring to prevent [redacted]. The resident had [redacted] and [redacted] of the [redacted] were unwitnessed and occurred in common areas. After each fall incident, the facility had a systems failure to prevent [redacted] when failing to conduct a complete

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investigation into each fall occurence, identify, assess and evaluate suitable interventions to prevent falls, update the resident's care plan, and provide individualized interventions to prevent reoccuring falls.

The resident continued to exhibit [redacted] and subsequently sustained [redacted] injuries including [redacted] and hospitalization. This resulted in an in immediate jeopardy situation.

The Immediate Jeopardy (IJ) situation began on 5/26/22. The facility was notified of the IJ on 10/21/22 at 3:21 PM. An Acceptable Removal Plan was received on 10/24/22 at 3:53 PM. The survey team attempted to verify the Removal Plan on 10/26/22 but the immediacy continued. The facility was notified that the immediacy had not yet been lifted on 10/26/22 at approximately 3:50 PM. The Immediacy continued through 10/26/22. The survey team was able to verify the Removal Plan on 10/27/22.

The non-compliance for F689 (Part A) remained on 10/27/22 for no actual harm with the potential for more than minimal harm.

Part B ([redacted]): The facility failed to implement a system to prevent further recurrences of Resident #98 from [redacted] in their room after he/she had been identified to have been [redacted] in their room on [redacted]. The resident would go out on pass from the facility on a daily basis.

The facility failed to act upon the first smoking

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incident through means of an investigation, and failed to reassess the resident for [redacted] update the care plan to prevent future instances of [redacted] in their room, and develop a system of accountability for monitoring of possession of [redacted] upon the resident's daily return from the facility after being out on pass. Further, there was no written [redacted] contract or [redacted] agreement reviewed with the resident to prevent future incidences.

The IJ situation began on 9/25/22. The facility was notified of the IJ on 10/26/22 at 3:52 PM. An Acceptable Removal Plan was received on 10/27/22 at 12:32 PM. The survey team verified the Removal Plan on 10/28/22. The IJ was lifted on 10/27/22.

The non-compliance for F689 (Part B) remained on 10/28/22 for no actual harm with the potential for more than minimal harm.

Part C ([redacted]: The facility failed to ensure Resident #88 who had a diagnoses of [redacted] and was assessed to be an [redacted] risk was provided adequate supervision to prevent an [redacted] and respond to an activated delayed-egress exit alarm in accordance with their [redacted] and [redacted] policy to ensure the safety of all residents. On [redacted], Resident #88 was able to exit the building unsupervised through a locked, alarming door at approximately 7:40 PM resulting in an elopement. A nurse disengaged the alarm without accounting for all residents on the unit. The staff were not aware the resident had [redacted] until the resident was returned to the facility by the local police department.

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| F 000 | Continued From page 4<br><br>The Immediate Jeopardy (IJ) situation began on 7/6/22. The facility was notified of the IJ on 10/20/22. An Acceptable Removal Plan was received on 10/21/22 at 12:59 PM. The survey team verified the Removal Plan on 10/21/22. The Immediacy was lifted on 7/7/22.<br><br>F835 (Administration)<br>(Refer to F689 and F836)<br><br>The Licensed Nursing Home Administrator (LNHA) failed to identify what sufficient staffing levels were necessary for the facility's resident population, and provide adequate staffing in accordance with state minimum staffing requirements ensure sufficient staffing on all shifts (Day, Evening, and Night shifts). Despite staffing levels to be significantly short of CNA's in the two weeks prior to the survey, the LNHA continued to admit new residents to the facility, particularly [redacted] new residents from [redacted]. The facility continued to admit new residents through [redacted]<br><br>The LNHA also failed to ensure systems were in place to prevent: a.) recurring [redacted] resulting in serious injury, b.) future occurences of unauthorized, unsupervised [redacted] in the room, and c.) failed to ensure adequate supervision to prevent an [redacted].<br><br>The IJ situation began on 5/26/22. The facility was notified of the IJ on 10/24/22 at 4:16 PM. An acceptable Removal Plan was received on 10/25/22 at 12:55 PM. The IJ was verified by the | F 000 | | |

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| F 000 | Continued From page 5<br>survey team on 10/25/22.<br><br>The non-compliance for F835 remained on 10/26/22 for no actual harm with the potential for more than minimal harm.<br><br>F836:<br><br>The facility failed to identify what sufficient staffing levels were necessary for the facility's resident population, and provide adequate staffing in accordance with state minimum staffing requirements ensure sufficient staffing on all shifts (Day, Evening, and Night shifts). Despite staffing levels to be significantly short of CNA's in the two weeks prior to the survey, the LNHA continued to admit new residents to the facility, particularly [redacted] new residents from [redacted] to [redacted] The facility continued to admit new residents through [redacted]<br><br>The IJ situation began on 5/26/22. The facility was notified of the IJ on 10/24/22 at 4:16 PM. An acceptable Removal Plan was received on 10/25/22 at 12:55 PM. The IJ was verified by the survey team on 10/25/22.<br><br>The non-compliance for F836 remained on 10/26/22 for no actual harm with the potential for more than minimal harm. | F 000 | | |
| F 600 SS=J | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This | F 600 | | |

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| F 600 | Continued From page 6<br>includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined the facility failed to ensure that Resident #2 was free from physical abuse from a staff Licensed Practical Nurse.<br><br>On 7/30/22 during the evening shift, Resident #2 was a victim of physical abuse by a Licensed Practical Nurse #1 (LPN#1) when LPN #1 punched Resident #2 on the [redacted] of the [redacted] with a [redacted] causing the resident to [redacted] to the ground. This incident was witnessed by two facility staff, a Certified Nursing Aide (CNA #1) and a second Licensed Practical Nurse (LPN #2). The resident exhibited pain after the incident.<br><br>LPN#1's failure to prevent physical abuse by punching Resident #2 with a [redacted] causing the resident to [redacted] posed a likelihood of serious harm, impairment or death to that resident on [redacted] resulting in an immediate jeopardy (IJ) situation that began on [redacted]<br><br>The facility immediately suspended and terminated LPN #1 and notified all necessary parties and governing agencies and implemented | F 600 | Past noncompliance: no plan of correction required. | |

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additional measures to protect other residents on the same day [redacted].

The facility was notified of the past non-compliance IJ on 10/26/22. The immediacy was lifted on 7/30/22.

This deficient practice was identified for 1 of 11 residents reviewed for abuse (Resident #2).

The evidence was as follows:

On 10/13/22 at 9:40 AM, the surveyor observed Resident #2 in bed with his/her eyes closed.

The surveyor reviewed the medical record for Resident #2 which revealed the following:

A review of the Admission Record face sheet (an admission summary) revealed that the resident was admitted to the facility with diagnoses which included: [redacted].

A review of the Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted], indicating that the resident's cognition was [redacted].

A review of the Resident #2's comprehensive individualized care plan included that the resident had a Behavioral Care Plan with an initiation date of [redacted] and revised on [redacted] with a focus

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area that Resident #2 had episodes of [redacted] to staff/co-residents if the resident did not get what the resident wants instantly. The interventions included allowing the resident to verbalize feelings, anticipate and meet the resident's needs, and caregivers to provide an opportunity for positive interaction, attention, approach/speak in a calm manner, and divert attention.

Further review of the resident's care plan revealed another focus area for behavioral if the resident's meals are not delivered to their room prior to the food truck being pulled down the hallway and staff delivering food trays. The interventions included that the staff will deliver the resident's meals to their room before passing trays out in the wing so the resident's food will be delivered hot, two staff members to assist the resident and deliver the food tray; and when the resident gets [redacted] to intervene before [redacted] escalates; if aggressive, staff to walk calmly away, and approach later.

A review of the Progress Notes (PN) revealed a health status note dated [redacted] at 9:35 PM which indicated, "Call received from nurse on duty that there was an incident between this resident and a nurse that resulted in a fall of this resident. The nurse and the resident were arguing over orange juice, food, and medication when the resident hit the nurse with an open hand. The nurse, in turn[redacted] the resident with a [redacted] causing the resident to lose balance and[redacted] Resident was able to move all extremities. Resident denied pain and discomfort. Noted no obvious injury."

The facility's investigation report titled, Allegation

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of Physical Abuse for Resident #2 dated [redacted] revealed that LPN#2 was a witness to the incident and heard a loud argument over an orange juice (OJ) and LPN#2 attempted to intervene by providing the OJ to the resident. The investigation report showed that LPN#1 (the perpetrator) and the resident were in each other's personal space (less than an arm's reach) and LPN#2 attempted to place herself in between the resident and LPN#1 to create a physical separation and de-escalate the situation, at the same time Certified Nursing Aide#1 (CNA#1) who was also a witness to the incident overheard the loud argument also went to the hallway where the incident was happening and attempted to help by separating the resident and LPN#1. When the ongoing verbal argument and the proximity of the resident and LPN#1 escalated to a [redacted] when the resident was able to hit LPN#1 in [redacted] and in response, LPN#1 hit the resident in their [redacted]. The hit caused the resident to [redacted] backward, the resident landed on floor hitting his/her [redacted] even though CNA#1 was behind the resident on the floor.

The facility interviews that were conducted post-incident revealed that LPN#2 and CNA#1 confirmed the above investigational report affirming their statements dated [redacted].

A written statement dated [redacted] from the perpetrator/LPN #1 revealed the following:

"...Resident #2 asked me for OJ, we were both in the hallway. I told the resident to grab the juice on the cart. The resident was unable to hear me, I said to go in the cart and grab it. The resident starts yelling, as resident started yelling my co-workers came and grab the resident as the

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resident is starting to approach me, yelling at me, as my coworkers trying to help the resident back to their room he/she hit me in the chest, and I hit him/her back. When the resident starts going to their room, Resident #2 tried to [redacted] on me, and the resident said he/she is going to kill me."

The incident narrative of the investigation report dated [redacted] showed that the witnessing LPN #2 called the Assistant Director of Nursing (ADON) to report the staff-to-resident physical abuse at about 9:43 PM. The ADON instructed LPN#2 to assess the resident while the ADON was en route to the facility. The ADON reported the incident to the LNHA. When the ADON reported to the facility around 10:26 PM, the ADON re-assessed the resident and initiated an immediate investigation. In addition, before the ADON reported to the facility, the resident and perpetrator/LPN#1 were already separated, then the local police department were notified and arrived to the facility to conduct an investigation, and the responsible party and physician of the resident were notified of the incident. The resident declined medical treatment and transfer to the emergency room at that time, the resident was monitored for any negative outcomes.

A review of the local Police Department Incident Report dated [redacted] at 10:38 PM revealed: "On the above date and time, police officer responded to the facility on the report of an assault. Upon, arrival, ...the [ADON] explained a nurse and patient of the facility were involved in an altercation which led to the nurse striking the elderly patient ...[LPN #1] stated he was trying to help the resident when he was pushed in the chest by [Resident #2]. [LPN #1] explained, in defense he then struck [Resident#2] in the [redacted]

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with a [redacted]. [Resident #2] explained that [LPN #1] was refusing to help [him/her] with [his/her] basic needs. [Resident #2] stated [he/she] asked [LPN #1] for food but was provided food [he/she] can not eat and was told to get something [him/her-self]. [Resident #2] stated that [LPN #1] also gave [him/her] [his/her] medicine late and would not help [him/her] take them. [Resident #2] further stated when [he/she] requested different pills from [LPN #1] he refused to give them to the resident. [Resident #2] stated [he/she] then stood up out of bed and pushed [LPN#1] out of the way. [Resident #2] stated at this time, [LPN #1] struck [him/her] on the [redacted] with a [redacted] It should be noted, I did not observe any bruising, redness, swelling etc. on [Resident #2's] face and [he/she] only complained [redacted]. [Resident #2] stated [he/she] did not need medical attention beyond what the nurses provided at the time of the incident..."

On 10/20/22 at 1:00 PM, the surveyor interviewed the Director of Nursing (DON), who used to be the ADON on the [redacted] incident. The DON stated that she suspended LPN#1 after the police left on [redacted] She further stated that the [redacted] incident was reported to the Department of Health, the Ombudsman office, and the New Jersey Board of Nursing. She indicated that all staff was re-educated regarding the facility's abuse policy right away. The DON provided documented evidence of the same.

On 10/24/22 at 10:25 AM, the surveyor interviewed the Director of Social Worker (DSW) who stated that the resident was alert and oriented. The DSW stated that the resident [redacted] staff who are [redacted] and the

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resident doesn't like it when staff say no without an explanation. She further stated that the resident could get agitated if the resident feels that the staff was coming across as rude. The SW stated that these behaviors have been evident and it is in the care plan. She also stated that when you talk calmly with the resident and explained why something can not be done, the resident will understand.

On 10/24/22 at 12:20 PM, the surveyor interviewed the DSW regarding any grievances that were filed by the resident. The DSW stated that the resident had filed no grievances.

On 10/25/22 at 9:45 AM, the surveyor interviewed Resident #2 who was observed having [redacted]. The resident agreed to be interviewed regarding the incident that occurred on [redacted] The surveyor asked the resident if he/she recalled the physical abuse on [redacted]. The resident stated that he/she was still experiencing [redacted] after the incident. The resident told the surveyor that he/she had no negative interaction with the nurse before the incident. The resident stated that they interacted with the nurse earlier in the day with no issue but somehow the nurse snapped.

On that same date and time, the resident stated that he/she was asking the nurse for orange juice and a snack. The food that was offered was a food that he/she was not allowed to consume. The resident further stated that he/she did not hit the nurse and that the resident put their hand on the nurse's [redacted]. The nurse then punched him/her in the [redacted]. The resident further stated that he/she had no issues with the facility. In addition, the resident stated that the facility

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immediately fired the nurse, made sure that he/she was safe, and they assessed the resident for any injuries.

The surveyor reviewed the facility provided documents of full staff education on abuse, the immediate notification of all parties and governing agencies and the New Jersey Board of Nursing letter dated 8/1/22 to confirm the immediacy had been lifted.

The surveyor reviewed the personnel file for the perpetrator/LPN #1. LPN #1 was hired on [redacted] and had a clear background check upon hire, license verification, and reference checks done that were also clear. The LPN #1 had been educated for abuse prevention on [redacted] prior to the [redacted] incident.

On 10/26/22 at 3:52 PM, the survey team met with the facility which included the Licensed Nursing Home Administrator (LNHA), Regional Registered Nurse (RRN), DON, and Regional LNHA#1. The LNHA acknowledged the staff-to-resident physical abuse occurred and that it was witnessed by CNA #1 and LPN #2. The surveyor team notified the facility that the failure to ensure Resident #2 was free from staff-to-resident physical abuse. LPN#1's failure to prevent physical abuse by [redacted] Resident #2 with a [redacted] causing the resident to [redacted] posed a likelihood of serious harm, impairment or death to that resident on [redacted], resulting in an immediate jeopardy (IJ) situation that began on 7/30/22. The LNHA and facility administrative team were made aware that a review of the facility documentation regarding this incident indicated that the immediacy was lifted on the same day 7/30/22.

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A review of the facility's policy for Abuse, Neglect and Exploitation that was 9/21 and was provided by the RRN indicated the following: "by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation ...It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property."

"Abuse means the willful infliction of injury, unreasonable confinement, intimidation, punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled using technology."
"Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment."
Under Training topics will include:
"5. Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect such as:
a. Aggressive and/or catastrophic reactions of residents.
b. Wandering or elopement-type behaviors.
c. Resistance to care.
d. Outbursts or yelling out; and

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| F 600 | Continued From page 15<br>e. Difficulty in adjusting to new routines or staff.<br><br>N.J.A.C. 4.1 (a) (3) (5) (12) (15) | F 600 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to accurately assess a resident's status in the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care. This deficient practice was identified for 2 of 24 residents, Resident #47 and #95.<br><br>This deficient practice was evidenced by:<br><br>1. On 10/13/22 at 10:39 AM, the surveyor observed Resident #47 seated in a wheelchair, awake and alert. The resident was able to maintain eye contact and smiled at the surveyor; however, the resident did not respond to the surveyor's inquiry.<br><br>The CMS's RAI Version 3.0 Manual Section G0110: Activities of Daily Living (ADL) Assistance reflected "Instructions for Rule of 3" indicated that "When an activity occurs at three times at multiple levels, code the most dependent, exemptions are total dependence (4) ...Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3)." It also indicated in the "Steps for Assessment" to "Review the documentation in the | F 641 | Resident #47 MDS assessment was modified to reflect extensive assist with ADL's in section [redacted] Resident #47 MDS assessment was modified to reflect wandering behavior in MDS Section [redacted] Resident #95 MDS modification was accepted with update to reflect wandering behavior in section [redacted] MDS department was re-educated on 10/25/2022 by Director of Nursing on accurate coding based on documentation, demonstration, and staff interviews. The Director of Nursing initiated a facility wide audit of open MDS assessments to ensure accurate coding and documentation supports the resident's status.<br><br>All residents in the facility have the potential to be affected by the deficient practice.<br><br>The Director of Nursing or designee will conduct weekly audits on all MDS assessments in the look back period for accurate coding to reflect residents status. The Director of Nursing and the Interdisciplinary Care Plan Team including | 1/20/23 |

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| F 641 | Continued From page 16<br>medical record for the 7-day look-back period."<br><br>The surveyor reviewed Resident #47's hybrid medical records:<br><br>The Admission Record (an admission summary) showed that the resident was admitted to the facility with diagnoses that included but not limited to [redacted]<br><br>The Annual Minimum Data Set (AMDS), an assessment tool with an assessment reference date (ARD) of [redacted] revealed a Brief Interview for Mental Status (BIMS) score of [redacted], which reflected that the resident had [redacted] The section [redacted] for Functional Status reflected that the resident was coded for "1" at a supervision level in bed mobility and transfer, and "2" for limited assistance in eating for ADL Self-Performance. The AMDS Section [redacted] Behavior reflected that the resident was not coded for [redacted] behavior.<br><br>The [redacted] "ADL Tracker Form" (used to document the resident's daily self-performance in ADLs each shift) reflected that the resident had the following:<br><br>From [redacted] through [redacted] times of extensive assistance [redacted] for self-performance for bed mobility.<br><br>From [redacted] through [redacted] times of extensive assistance [redacted] for self-performance for transfer. | F 641 | the MDS department will discuss Section [redacted] and Section [redacted] all due MDS assessments until submitted successfully.<br><br>The completion of audits will be monitored by the Administrator, Director of Nursing or designee weekly for 4 weeks, every two weeks for 2 months and monthly for 3 months. Audit findings will be discussed during monthly Quality Assurance / Performance Improvement Committee. QAPI committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan will be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly. | |

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| F 641 | Continued From page 17<br>From [redacted] through [redacted] times of extensive assistance [redacted] for self-performance for eating.<br><br>The electronic progress notes under Health Status Note (HSN) dated [redacted] at 01:42 PM revealed that the resident [redacted] continuously in the hallway, often entering other residents room."<br><br>The electronic progress notes under HSN dated [redacted] at 10:56 AM revealed that the resident was [redacted] at times".<br><br>The electronic progress notes under HSN dated [redacted] at 11:18 AM revealed that the resident [redacted] into another residents room..".<br><br>On 10/25/22 at 10:33 AM, the surveyor interviewed the Certified Nursing Aide#1 (CNA#1) who stated that she was familiar with Resident#47. The CNA informed the surveyor that the resident required extensive assistance to total dependence on ADLs assistance due to his/her [redacted] and [redacted]r. She stated that she documented the resident's self-performance in the paper-based ADL Tracker Form. The CNA reviewed the [redacted] ADL Tracker Form for Resident#47 in the presence of the surveyor, and she acknowledged the documentation recorded were accurate.<br><br>On 10/25/22 at 12:33 PM, the Regional Registered Nurse/MDS (RRN/MDS) met with the survey team. She acknowledged that the facility MDS Coordinator was responsible for completing section [redacted] in the MDS assessments. She informed the surveyor that the MDS Coordinator followed the MDS RAI (Resident Assessment | F 641 | | |

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Instrument) manual. She also stated that the MDS Coordinator obtained ADL information from staff interviews, nurses' notes in the electronic medical record (EMR), and the paper-based ADL Tracker Form completed by the CNAs in the nursing unit, to complete section [redacted] in the MDS assessment.

Additionally, the RRN/MDS reviewed the [redacted] ADL Tracker Form for Resident#47 in the presence of the survey team. She acknowledged that the resident had extensive assistance in self performance for bed mobility, transfer, and eating. She stated that the MDS Coordinator should have coded extensive assistance for bed mobility transfer and eating in the [redacted] AMDS.

During the interview, the RRN/MDS stated that for any discrepancy with staff ADL documentation and interview statements within the MDS ARD 7-day look-back period, the MDS Coordinator must "always" need to document a clarification note and specify the look-back period in the resident's EMR to support her MDS coding on section [redacted]

On 11/01/22 at 12:19 PM, the surveyor interviewed the LPN/MDS Coordinator (LPN/MDSC). The LPN/MDSC informed the surveyor that she was the facility's full-time MDS Coordinator and followed the MDS RAI manual. She stated that she was responsible for coding in section [redacted] by reviewing the resident's paper-based ADL Tracker Form sheets that were completed by the nurses or CNAs and staff interviews.

During the interview, the LPN/MDSC stated that when she conducted staff interviews to capture

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the residents' ADLs within the ARD look back period, she asked the CNAs to document what they told her in the resident's medical records. The LPN/MDSC stated "I go by documentation" to support her coding in the MDS.

Furthermore, the LPN/MDSC reviewed the [redacted] ADL Tracker Form for Resident#47 in the presence of the surveyor. She stated that the resident's self-performance for bed mobility, transfer, and eating would be extensive assistance. She also stated that she was not sure if she reviewed the resident's ADL Tracker Form and stated, "maybe I missed it or I assumed." She acknowledged that her coding in [redacted] AMDS section [redacted] for bed mobility, transfer, and eating did not reflect the documentation in the [redacted] ADL Tracker Form. The LPN/MDSC further stated that she would review the resident's medical records and MDS assessment again and would get back with the surveyor.

On 11/01/22 at 01:02 PM, the survey team met with Regional Licensed Nursing Home Administrator#1 (RLNHA#1) and #2, DON, and Regional RN (RRN). The surveyor discussed the above concerns.

On the same day at 1:46 PM, the LPN/MDSC met with the surveyor. She acknowledged that after reviewing the resident's medical records again, there was no supporting documentation to support her [redacted] AMDS coding for section [redacted] She stated that after verifying with the staff in the nursing unit, she acknowledged that the staff documentation in the [redacted] ADL Tracker Form were accurate. The LPN/MDSC further stated that she should have coded extensive

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| F 641 | Continued From page 20<br>assist for bed mobility, transfer, and eating in the [redacted] AMDS section [redacted]<br><br>On 11/01/22 at 01:51 PM, the surveyor interviewed the Director of Social Worker (DSW). The DSW stated that she was the full-time social worker in the facility and responsible of answering sections C (Cognition), D (Moods), E (Behavior), and Q (Participation in Assessment and Goal) in the MDS. She informed the surveyor that she followed the MDS RAI manual to complete the MDS assessments. Additionally, she stated that she reviewed the resident's medical records and captured the resident's behaviors which included wandering to complete the MDS section [redacted] within the ARD's 7-day look-back period.<br><br>On that same date and time, the surveyor reviewed the [redacted] AMDS Section [redacted] coding and the progress notes in the resident's (EMR) in the presence of the DSW. The DSW acknowledged that the resident had [redacted] behaviors documented in the EMR which should have been captured and coded in the AMDS dated [redacted].<br><br>On 11/03/22 at 11:36 AM, the RRN acknowledged the [redacted] AMDS coding inaccuracy in sections [redacted] and [redacted]<br><br>On the same day at 12:23 PM, the survey team met with the two RLNHA, DON, and RRN. The facility team did not provide additional information.<br><br>2. On 10/13/22 at 11:42 AM, the surveyor observed Resident #95 laying on the bed with eyes closed and [redacted] looking.<br><br>On 10/18/22 at 9:59 AM, the surveyor interviewed | F 641 | | |

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| F 641 | Continued From page 21<br>CNA#2. CNA#2 stated that Resident #95 was [redacted] and a [redacted] (moving about without a definite destination or purpose).<br><br>On 10/20/22 at 8:59 AM, the surveyor interviewed CNA#3. CNA#3 stated that Resident #95 was [redacted] and a [redacted] which was not something new to the resident.<br><br>The surveyor reviewed the resident's medical records:<br><br>The Admission Record disclosed that the resident had diagnoses that included but were not limited to [redacted]<br><br>The AMDS with an ARD of [redacted] showed that the resident had a BIMS score of [redacted] which means that the resident's [redacted]. The AMDS Section E Behavior reflected that the resident was not coded for wandering behavior.<br><br>The person-centered care plan did not show information about the [redacted] behavior and interventions.<br><br>The [redacted] HSN in the EMR of the resident included "resident was received sitting in chair in room watching tv, ...with confusion noted ... ..[redacted], ambulatory ....resident occasionally [redacted] in and out of other resident's rooms. calm verbal redirection successful after several attempts ...." | F 641 | | |

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| F 641 | Continued From page 22<br><br>On 10/31/22 at 10:29 AM, the surveyor interviewed the LPN/MDSC. The LPN/MDSC stated that the facility follows the RAI Manual as part of facility policy with regard to MDS. She further stated that she was not responsible for answering section [redacted] in the MDS. The LPN/MDSC indicated that the surveyor had to ask the DSW concerning section [redacted] in MDS.<br><br>During an interview on 10/31/22 at 10:41 AM by the surveyor, the DSW informed the surveyor that she was responsible for answering sections [redacted], [redacted] and [redacted] in the MDS. The DSW stated that the information in section [redacted] was gathered from the evaluation, [redacted] and [redacted] behavior notes that were reviewed in the resident's medical records.<br><br>On that same date and time, the surveyor asked the DSW why the [redacted] HSN that was written in the resident's progress notes for [redacted] behavior was not captured in the [redacted] MDS. The DSW stated that if it was documented in the [redacted] progress notes, then it should have been captured in the [redacted] MDS. She further stated that she will check and get back to the surveyor why it was not coded in the MDS.<br><br>On 10/31/22 at 02:06 PM, the survey team met with RLNHA#1, RRN, and DON and discussed the above concerns with MDS.<br><br>On 11/01/22 at 12:56 PM the survey team met with the RLNHA#1 and #2, RRN, and DON. The RRN acknowledged that the wandering behavior that was documented on [redacted] should have been captured in the resident's [redacted] MDS in section [redacted] The RRN further stated that the | F 641 | | |

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| F 641 | Continued From page 23<br>[redacted] was now modified to capture the behavior.<br><br>NJAC 8:39-11.2(e)1; 27.1(a) | F 641 | | |
| F 656 SS=E | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for | F 656 | | 1/20/23 |

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| F 656 | Continued From page 24<br>future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and review of medical records, it was determined that the facility failed to develop a person-centered comprehensive care plan to address: a) the use of [redacted] medication for 1 of 5 residents (Resident #15); b) use of [redacted] medication for 1 of 2 residents (Resident #15); c) use of [redacted] medication for 1 of 3 residents (Resident #61); and, d) [redacted] behavior for 1 of 3 residents (Resident #95) for a total of four months.<br><br>The deficient practice was evidenced by the following:<br><br>1. The surveyor reviewed Resident#15 and revealed the following:<br><br>On 10/17/22 at 6:33 AM, the surveyor observed Resident #15 in their room, lying in bed asleep but easily awaken by verbal stimulation.<br><br>The Admission Record (admission summary) reflected that the resident was admitted to the facility and had diagnoses that included [redacted] | F 656 | 11/1/2022 the interdisciplinary team initiated a care plan to reflect antipsychotic and anticoagulant use and monitoring for Resident #15. Initiated Resident #61 care plan to reflect use of [redacted] medication. Initiated Resident #95's care plan to reflect [redacted] behavior. Nursing department was educated on 11/1/2022 by Director of Nursing on initiating, updating and revising a care plan to meet the residents' needs. The Director of Nursing initiated a facility wide care plan audit with a focus on resident diagnosis, appropriate goals, interventions and preferences.<br><br>All resident in the facility have the potential to be affected by the deficient practice.<br><br>The Director of Nursing or designee will conduct random weekly audits on care plan completion and appropriateness in relation to resident diagnosis. The Director of Nursing or designee and Interdisciplinary Care Plan Team will update the care plans based on interventions needed to meet residents | |

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| F 656 | Continued From page 25<br><br>The Admission Minimum Data Set (AMDS), an assessment tool with an assessment reference date (ARD) of [redacted], revealed a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted] which reflected that the resident had a [redacted]<br><br>The [redacted] Order Summary Report (OSR) revealed physician orders (PO) that included the following medications:<br><br>[redacted] Tablet [redacted] mg (milligram) to give 1 tablet (tab) by mouth every 12 hours for [redacted] with an order date of [redacted].<br><br>[redacted] medication) Tab [redacted] mg Give 1 tab by mouth one time a day for [redacted] with [redacted] Target behavior of [redacted], [redacted]" with an order date of [redacted]<br><br>There was no comprehensive care plan for the use of [redacted] and [redacted] medications. It did not reflect that the resident was on [redacted] and [redacted] medications and/or included documented interventions to monitor for the presence of and to reduce the risk for adverse consequences.<br><br>On 10/19/22 at 11:32 AM, the surveyor interviewed the [redacted] Licensed Practical Nurse/UM#1 (LPN/UM#1) in the presence of another surveyor. LPN/UM#1 stated that she was responsible to initiate and update care plans for all the residents in her unit. She also stated that residents on [redacted] and [redacted] medications should have a care plan for it. She | F 656 | medical, nursing, and mental and psychosocial needs.<br><br>Audits will be monitored for completion by the Administrator, Director of Nursing or designee weekly for 4 weeks, every two weeks for 2 months and monthly for 3 months. Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly. | |

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acknowledged that Resident#15 was on [redacted] and [redacted] medications and that there was no care plan for [redacted] and [redacted] medications developed for the resident.

On 11/01/22 at 01:02 PM, the survey team met with Regional Licensed Nursing Home Administrators #1 (RLNHA#1) and #2, Director of Nursing (DON), and Regional Registered Nurse (RRN)met with the survey team. The surveyor discussed with the administrative team the above concerns.

On 11/03/22 at 11:36 AM, the DON acknowledged that there was no careplan initiated for Resident#15's [redacted] and [redacted] medications. The DON informed the surveyor that [redacted] and [redacted] medications care plans were developed for the resident after the surveyor's inquiry.

2. On 10/13/22 at 11:47 AM, the surveyor observed Resident #61 in the activity room sitting on a [redacted]. The resident was alert and was participating in activities with other residents.

The surveyor reviewed the resident's medical records.

The Admission Record (AR) reflected that Resident #61 was admitted to the facility with diagnoses that included but were not limited to [redacted].

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| F 656 | Continued From page 27<br><br>The Quarterly MDS (QMDS) with an ARD of [redacted], revealed a BIMS score of [redacted] out of [redacted] which indicated that the resident was [redacted] The 9[redacted] QMDS showed that the resident had a [redacted] scale of [redacted] which indicated that the [redacted].<br><br>The [redacted] OSR revealed physician orders (PO) dated [redacted] for [redacted] mg 1 capsule by mouth every 6 hours for [redacted] and a PO dated [redacted] for [redacted] mg 1 tab every 6 hours as needed (PRN) for [redacted] to [redacted]<br><br>There was no comprehensive individualized care plan initiated for [redacted].<br><br>On 10/19/22 at 11:30 AM, the surveyor interviewed the [redacted]-floor LPN/UM#1. LPN/UM#1 stated that it's her responsibility as a UM to initiate and update the care plan for all the residents in her unit. She further stated that if a resident is on [redacted] medication they should have a [redacted] care plan. The UM acknowledged that the resident had no pain care plan.<br><br>On 11/01/22 at 01:10 PM, the survey team met with the two RLNHA, DON, and the RRN and were made aware of the above concerns.<br><br>3. On 10/13/22 at 11:42 AM, the surveyor observed Resident #95 laying on the bed with their eyes closed.<br><br>The surveyor reviewed the resident's medical records.<br><br>The AR indicated that the resident had diagnoses | F 656 | | |

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| F 656 | Continued From page 28<br>that included [redacted].<br><br>The [redacted] QMDS revealed a BIMS score of [redacted] out of [redacted], which reflected that the resident's cognition was [redacted].<br><br>According to the [redacted] Health Status Note of LPN#1 "resident occasionally [redacted] in and out of other resident's rooms. calm verbal redirection successful after several attempts ..."<br><br>A review of the resident's individualized care plan revealed that no care plan was initiated for the resident's [redacted] behavior.<br><br>On 10/18/22 at 9:59 AM, the surveyor interviewed Certified Nursing Aide#1 (CNA#1) about Resident #95. CNA#1 stated that the resident was [redacted], with [redacted], and was a [redacted]). She further stated that the resident was redirectable when staff observed the resident [redacted] from room to room.<br><br>On 10/20/22 at 8:59 AM, the surveyor interviewed CNA#2 in the presence of the survey team. CNA#2 stated that Resident #95 was [redacted] at times, and was a [redacted] which was not something new to the resident.<br><br>On 10/31/22 at 02:06 PM, the survey team met with RLNHA#1, RRN, and the DON and were | F 656 | | |

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| F 656 | Continued From page 29 | F 656 | | |

made aware of the above concern regarding the care plan not initiated for Resident #95's [redacted] behavior from [redacted] through [redacted] for a total of four months.

On 11/01/22 at 12:56 PM, the survey team met with RLNHA#1 and #2, RRN, and the DON. The RRN acknowledged that a care plan for wandering behavior should have been initiated. The DON stated that it was the responsibility of the Unit Manager (UM) to initiate the care plan.

On 11/03/22 at 10:37 AM, the surveyor interviewed LPN/UM#2 in the [redacted]-floor unit regarding the resident's care plan. LPN/UM#2 stated that she was not responsible for initiating the [redacted] care plan in [redacted] because she was not the UM at that time. She further stated that she started working as a UM on [redacted].

A review of the Use of [redacted] Drugs policy revised 09/2022 reflected "The effects of the [redacted] medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as: ....d. In accordance with nurse assessments and medication monitoring parameters consistent with ....and the resident's comprehensive plan of care."

The facility [redacted] Policy revised 09/2022 reflected "The resident's plan of care shall alert staff to monitor for adverse consequences." It also indicated that "The resident's plan of care shall include interventions to minimize risk of adverse consequences."

A review of the facility's policy for [redacted]

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| F 656 | Continued From page 30<br>Management that was undated and was provided by the DON revealed the following:<br>"The facility must ensure that [redacted] management is provided to residents who require such services, consistent with professional standards of practices, the comprehensive person-centered care plan and the residents' goals and preference."<br><br>A review of the facility's Comprehensive Care Plans dated [redacted] that was provided by the RRN included "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment...Policy Explanation and Compliance Guidelines: ...5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed..."<br><br>NJ 8:39-11.2(d); (e)(1-2); (i); 27.1(a) | F 656 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and | F 677 | | 1/20/23 |

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| F 677 | Continued From page 31<br>personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Complaint #NJ00157677<br><br>Based on observation, interview, and review of facility documents it was determined that the facility failed to ensure timely incontinence care to residents dependent on staff for care. This deficient practice was identified for 2 of 4 residents reviewed for incontinence (Resident #19 and #55).<br><br>1. On 10/17/22 at 06:57 AM, the surveyor observed Certified Nursing Aide#1 (CNA#1) providing morning (am) care to Resident #19. The resident's room smelled of [redacted] the resident's [redacted], and the linen and fitted sheet were [redacted] and [redacted]. The resident was positioned to the left side of the bed, facing toward the wall, and the [redacted] area was exposed with no reddened area and the skin was intact. Privacy was provided during the am care.<br><br>At that same date and time, CNA#1 stated that the resident was soaking wet with [redacted] including the side of the [redacted], and the [redacted] and that the room smelled [redacted]. The surveyor observed also the [redacted] was [redacted] and [redacted]. CNA#1 acknowledged that the soaked in [redacted] that was on the floor was from the resident and stated that the resident should not have a [redacted]. She further stated that she did not know who put the [redacted] on the resident because that was the first time she changed the resident's [redacted] since 11:00 PM yesterday ([redacted] because of being short staffed. She indicated that she was | F 677 | 10/31/22 Resident#19 was provided [redacted] care and skin integrity was observed with no redness or breakdown noted. 10/31/22 Resident #55 was provided [redacted] care. Skin integrity was observed with no redness or breakdown noted. 10/31/22 licensed nursing staff was re-educated by the Director of Nursing on the importance of timely and appropriate [redacted] care including no double application of [redacted] products such as [redacted]. 11/8/2022 Facility wide skin assessments were performed on all residents to ensure no signs of skin breakdown observed.<br><br>All residents have the potential to be affcted by this deficient practice.<br><br>The Director of Nursing or designee will conduct a weekly random audit of residents to ensure incontience care is being provided and no skin breakdown is noted. Intervention/re-education to staff if found to be non-compliant with providing incontinence care to the residents. Assistant Director of Nursing or designee will provide continued education to staff at least annually, upon hire and as needed.<br><br>Audits will be monitored for completion by the Administrator and Director of Nursing weekly for 4 weeks, every 2 weeks for 2 months and monthly for 3 months. Audits will be discussed during our monthly Quality Assurance Performance | |

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| F 677 | Continued From page 32<br>the only CNA for the [redacted]-floor unit for the 11-7 shift for [redacted] residents.<br><br>Furthermore, CNA#1 informed the surveyor that she worked the 3-11 shift [redacted] ) and there were two CNAs on the [redacted]-floor unit. CNA#1 stated that she was not assigned to the resident on the 3-11 shift and it was CNA#2 who took care of the resident. She further stated that the resident should have been changed and provided [redacted] care at least twice per shift. She stated that there were [redacted] residents on [redacted] and that she can only do so much.<br><br>On 10/17/22 at 7:07 AM, during the interview with the surveyor, the Registered Nurse (RN) stated that there were no regular CNA's for the 11-7 shift, the census (number of residents on the unit) was [redacted] residents on [redacted] and [redacted]. She further stated that there was one RN and one CNA who worked for the 11-7 shift and it was her and CNA#1. The RN stated that there were 24 out of [redacted] residents were offered [redacted] care for the 11-7 shift, 1 out of 24 refused care, [redacted] out of [redacted] were self-care, and [redacted] out of [redacted] were [redacted] and were provided incontinence care. Both the RN and CNA#1 stated that "we do what we can." The RN further stated that "we can not go to everyone to take care of them, I provided care to two residents only," and that she has to administer medications.<br><br>On 10/17/22 at 7:53 AM, two surveyors interviewed the RN. The RN stated that the [redacted]-floor unit have been short of staff and there was no nursing supervisor for the 11-7 shift. She further stated that the nursing supervisor left [redacted] months ago and was not replaced since then. | F 677 | Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly. | |

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The RN stated that "maybe" [redacted] or [redacted] months ago that she worked by herself in the unit for the 11-7 shift. The RN was not able to remember the exact dates that she worked by herself.

On that same date and time, the RN informed the surveyor that she was aware of some family complaints about being short of staff. She acknowledged that Resident #19 was [redacted] when CNA#1 changed the resident this morning. She further stated that the facility management was aware of the short staff.

The surveyor reviewed the medical records of Resident #19.

The Admission Record (or face sheet; admission summary) revealed that the resident was admitted to the facility with a diagnosis that included but was not limited to: [redacted]

The Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate management of care, dated [redacted], with a Brief Interview for Mental Status (BIMS) score of [redacted] which means that the resident's cognition was [redacted] In the Section [redacted] and [redacted] I revealed that the resident was always [redacted] of both [redacted] elimination. Section [redacted] of the QMDS showed that the resident had an

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[redacted] skin even though the resident was at risk for developing [redacted]

The focus personalized care plan that was created on [redacted] and revised on [redacted] showed that the resident has [redacted] with an interventions to use [redacted], change frequently as needed, check the resident as required for [redacted] wash, rinse and dry perineum, and change clothing PRN (as needed) after [redacted] episodes.

On 10/20/22 at 8:59 AM, the surveyor interviewed CNA#2 in the presence of the survey team. CNA#2 stated that Resident #19 was [redacted], total assistance was needed with activities of daily living (ADL) except eating, skin intact, and a [redacted]" with [redacted] elimination. He further stated that he worked on [redacted] at the 3-11 shift with CNA#1 and that he took care of Resident #19 on that day. He indicated that "I probably had more than 20 residents because I had the whole [redacted] hall residents plus one room in the [redacted] hall." CNA#2 stated that the last time he changed Resident #19 was at 10 PM on [redacted]

At that same time, CNA#2 stated that [redacted] was not the facility's standard of practice, "sometimes I see the [redacted] to those [redacted] when I come on a weekend." CNA#2 further stated that he did not know who put the [redacted] on the resident.

2. On 10/13/22 at 11:39 AM, the surveyor observed Resident#55 laying on the bed, with eyes closed, wheelchair near the bed at the right side, call bell within reach, breathing easy and

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unlabored, covered with a blanket.

The surveyor reviewed the medical records of Resident #55.

The Admission Record revealed that the resident was admitted to the facility with the diagnosis that included, but was not limited to the following:
[redacted]

The QMDS dated 8/25/22 indicated that the resident had a BIMS score of [redacted] out of [redacted] with means that the resident had [redacted] In a review of section [redacted], functional status indicated Resident #55 was a one-person physical assistant for toileting and personal hygiene.

On 10/17/22 at 6:13 AM, the surveyor observed the RN and CNA#3 providing am care to Resident #55. The resident's room smelled of [redacted] and the resident's [redacted] The surveyor observed that the [redacted] were [redacted] with [redacted] and [redacted] colored stains. The resident was positioned to the left side facing toward the window, the [redacted] area was not reddened, and no wounds were observed. The CNA and the RN both stated that the resident was [redacted] with [redacted] including the [redacted] being [redacted] and the room did smell of [redacted]

On that same date and time, the RN stated that the census was [redacted] and CNA#1 was the only aide working for the previous 11-7 shift. The RN further stated that CNA#3 came in before 6 AM

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today to help even though she was not asked to come early and that CNA#3 usually comes in early.

At that same time, CNA#3 indicated that she had to help because she's assigned to Resident # 55 today for the 7-3 shift "anyway" and "I know 11-7 are short staffed and I will be busy today because it will be short also today for 7-3 shift." Both the RN and CNA#3 stated "we do what we can here."

On 10/31/22 at 02:06 PM, the survey team met with the Regional Licensed Nursing Home Administrator#1 (RLNHA#1), Regional Registered Nurse (RRN), and the Director of Nursing (DON), and discussed the above concerns.

On 11/01/22 at 12:56 PM, the surveyors met with RLNHA#1 and #2, RRN, and the DON. The RRN stated that Residents #19 and #55 skin integrity evaluations were done and showed no skin impairment.

A review of the facility's Incontinence Policy that was provided by the DON with a revision date of 11/2021 included "Based on the resident's comprehensive assessment, all residents who are incontinent will receive appropriate treatment and services."

A review of the facility's Activities of Daily Living Tracker form for Resident # 55 Unit for [redacted]. Under the section titled, Toilet Use, which was documentation of changing residents, offering commodes, bed pans, urinal use, or cleansing self. The 11 to 7 shift was blank, indicating on that shift none of the toileting care occurred for Resident #55.

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| F 677 | Continued From page 37<br>A review of the facility's in-service dated [redacted] regarding residents requiring incontinence care with an attachment entitled [redacted] [name redacted]"- Do not [redacted]-up on [redacted] products...included "What to do instead? Check and Change. Check your resident every two hours to make sure they are dry and if not change them and clean them. Report to the nurse if resident needs to be changed more frequently."<br><br>A review of the facility's policy titled, ADL Care, dated 9/2022 which read that the policy of the facility was to provide ADL care to residents requiring such assistance to ensure all ADL needs were met on a daily basis. Policy explanation, number 7 indicated that care plan interventions will be communicated to the staff. The care plan interventions will be monitored on an ongoing basis for effectiveness and reviewed/revised as necessary. | F 677 | | |
| F 689 SS=K | NJAC 8:39-27.1 (a), 27.2 (h)<br>Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>PART A<br><br>Based on observation, interview, record review | F 689 | Part A<br>Resident #47 with history of [redacted] and dementia. Interdisciplinary Team met to | 1/20/23 |

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| F 689 | Continued From page 38<br>and review of other pertinent facility documentation, it was determined that the facility failed to ensure that Resident #47 who was at risk for [redacted] and with a diagnosis of [redacted] was supervised, assessed, evaluated, and monitored to determine the cause of each [redacted] and to prevent future[redacted], including a [redacted] that resulted in serious injury. This deficient practice was identified for 1 of the 3 residents reviewed for[redacted].<br><br>Resident #47 sustained [redacted] from [redacted] through [redacted] over a [redacted] month period of time. Seven [redacted] of the [redacted] of the [redacted] were unwitnessed falls with most of the [redacted] reoccurring in common areas (hallways and dining room).<br><br>A review of the Investigation reports for the [redacted] revealed that they were incomplete and did not conclude possible causes/root cause of the [redacted]. Further the investigations did not evaluate what interventions were in place at the time of the falls, nor did it address interventions or appropriate interventions to be put in place as a result of each [redacted], and the resident's care plan was not appropriate or specific to the resident's individualized needs to prevent[redacted].<br><br>After multiple [redacted], the resident had another [redacted] and suffered [redacted], [redacted] with [redacted], [redacted] and was hospitalized for approximately two weeks. After having the[redacted] with serious injury and returning from the hospital, the facility still did not update the resident's care plan to prevent future [redacted]<br><br>Interviews with staff (CNA's, Nurses, Therapy) revealed inconsistent theories on what they believed "close observation" meant to prevent | F 689 | review and update the plan of care to include the following: placed on close monitoring x 15 minutes x24 hours then every 2 hours thereafter. 10/21/2022 licensed staff was educated by the Director of Nursing on the post [redacted] procedure, documentation and completion timeline. The Interdisciplinary Team members were educated on 10/21/2022 on conducting weekly [redacted] meetings to determine the root cause of [redacted] and to note trends. The attending physician will be notified for each [redacted] and consulted as needed. 10/21/22 all licensed nursing staff on each shift was educated on [redacted] investigations, use of the resident monitoring tool, and notification of the Director of Nursing or designee of each fall immediately.<br><br>All residents are at risk for this deficient practice.<br><br>Director of Nursing or designee will audit [redacted] investigations, fall care plans for completeness and to ensure suitable interventions are implemented. [redacted] Prevention policy will be reviewed annually by all staff, upon hire and as needed.<br><br>The audits will be monitored by the Administrator and Director of Nursing as follows weekly x 4, bi-weekly x 2 weeks and monthly x 3. The audits will be discussed during our monthly Quality Assurance Performance Improvement meeting; Quality Assurance Performance Improvement committee will determine if | |

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| F 689 | Continued From page 39<br>falls for Resident #47. They confirmed it was unclear and was not measurable or resident-specific. The CNA, Unit Manager, and DON were aware of the resident's [redacted] and reported that supervision of residents was very challenging because they were so short staffed.<br><br>There was no Interdisciplinary Team (IDT) meeting or quarterly review note to review the resident's [redacted] and evaluate interventions. The physician progress notes or Physician orders did not address the frequency of the [redacted] or a plan to address the [redacted] There was no neurology/other physician consults or other medical work up to rule out if the [redacted] were occurring due to a medical change in condition.<br><br>The facility's failure to reassess after each fall, thoroughly investigate each [redacted] to determine possible root causes, evaluate interventions and update the care plan with new, resident-centered/specific inventions after each fall in an effort to mitigate future [redacted], or rule out a medical change in condition, and the failure of staff to verbalize or provide evidence of what they are actively doing to prevent [redacted] for Resident #47, when this resident already had a [redacted] with serious injury. This places this resident and all other residents at risk for the likelihood of serious harm, impairment or death as a result of recurring [redacted] if this practice was not immediately corrected.<br><br>The Immediate Jeopardy (IJ) situation began on 5/26/22. The facility was notified of the IJ on 10/21/22 at 3:21 PM. An Acceptable Removal Plan was received on 10/24/22 at 3:53 PM. The immediacy continued through 10/26/22. The | F 689 | continued auditing is necessary. Once 100% compliance threshold is achieved for two consecutive months. This plan can be amended when indicated. Adverse finding will be immediately addressed. Findings and trends will be reported to QAPI Committee.<br><br>Part B<br>Resident #98 10/26/22 A [redacted] assessment was conducted, [redacted]g Free Facility Contract/Acknowledgement was reviewed and signed by the resident, and the resident's care plan was updated to reflect the resident's agreement to adhere to the no [redacted] policy. The resident will be observed by staff every x15 minutes for 24 hours then every 1 hour for 24 hours then every 2 hours ongoing. 10/26/22 a [redacted] Questionnaire was implemented for resident #98 to be asked of resident upon each return to the building from out on pass. 10/26/22 No [redacted] signs were posted at all entrances, exits and common areas in the building. 10/26/22 All staff were re-educated on the facility's [redacted] Free status. 10/26/2022 A physician order was obtained for the resident to go out on pass. The resident was educated on the out on pass policy and procedure and his care plan was updated to reflect the education. The resident's out on pass privilege's remained intact. Staff was re-educated on the out on pass policy and procedure. 10/19/2022 The resident was issued at Thirty Day Discharge notice for | |

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| F 689 | Continued From page 40<br>survey team verified the implementation of the Removal Plan on 10/27/22.<br><br>The evidence was as follows:<br><br>On 10/13/22 at 10:39 AM, the surveyor observed Resident #47 seated in a wheelchair, awake and alert. The resident was able to maintain eye contact and smiled at the surveyor; however, he/she did not respond to the surveyor's inquiry.<br><br>The surveyor reviewed Resident #47's medical records.<br><br>The Admission Record (an admission summary) reflected that Resident #47 was admitted to the facility with diagnoses that included [redacted].<br><br>The Annual Minimum Data Set (AMDS), an assessment tool with an assessment reference date (ARD) of [redacted] and Quarterly MDS (QMDS) with an ARD of [redacted], revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted], which reflected a [redacted] cognition. Both MDS assessments revealed that the resident required staff supervision for transfer, walk-in room and corridor, locomotion on the unit, and limited assistance of one-person physical assist for locomotion off the unit.<br><br>The [redacted] Risk Evaluation (an assessment tool) reflected that anytime there was a total score of 10 or greater, the resident should be considered at "HIGH RISK" for potential [redacted] It also indicated that a prevention practice should be initiated | F 689 | non-compliance with facility policies and procedures with a discharge destination noted. The [redacted] resident with a BIM score of [redacted] elected to discharge from the facility on [redacted] own accord making [redacted] own discharge plans including transportation to [redacted] chosen destination. Interdisciplinary staff was educated on the policy and procedure for issuing a Thirty Day Discharge Notice to residents including attending physician collaboration.<br><br>All residents have the potential to be affected by this deficient practice.<br><br>An audit will be be performed by the Director of Nursing or designee to ensure a [redacted] assessment is documented for all admissions, readmissions, quarterly, annually and as needed and to ensure appropriate interventions are care planned and implemented when indicated. Staff will be educated upon hire, annually and as needed regarding the facility's [redacted] Free policy and procedure the Out on Pass policy and procedure including obtaining a physician order for such. The interdisciplinary team will review the policy and procedure for issuing a Thirty Day Discharge Notice to a resident including the need for attending physician collaboration at each time the issuance of a Thirty Day Discharge letter is considered.<br><br>The audits will be monitored by the Administrator and Director of Nursing as follows weekly x 4, bi-weekly x 2 weeks | |

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| F 689 | Continued From page 41<br>"immediately" and recorded on the resident's care plan.<br><br>A review of Resident #47's medical records reflected that the resident sustained [redacted] from [redacted] through [redacted], specifically on the following dates: [redacted] and [redacted].<br><br>The following were the reported and documented fall incidents:<br><br>1.) The [redacted] at 11:07 AM [redacted] incident revealed unwitnessed [redacted] without injuries. Documentation reflected that a nurse that passed by observed the resident lying with the back of his/her head at the base of the scale.<br><br>The printed form Change in Condition Evaluation (an evaluation tool for a resident change in condition) dated [redacted] included that the "resident [redacted] alone."<br><br>The Fall Risk Evaluation dated after the [redacted] on [redacted] revealed a score of [redacted] which classified the resident at high risk for [redacted]<br><br>2.) The 6/2/22 at 11:07 AM fall incident reflected that another resident witnessed that #47 ambulated and tripped over a [redacted] which was laying across the floor while Housekeeping (HK) was conducting a room cleaning. The resident sustained injuries related to the [redacted]: an [redacted], a [redacted] to the [redacted], a [redacted] to the [redacted] and a [redacted] level of [redacted]" as shown in the [redacted] Assessment Advanced [redacted] ([redacted]) tool. | F 689 | and monthly x 3. The audits will be discussed during our monthly Quality Assurance Performance Improvement meeting; Quality Assurance Performance Improvement committee will determine if continued auditing is necessary. Once 100% compliance threshold is achieved for two consecutive months. This plan can be amended when indicated. Adverse finding will be immediately addressed. Findings and trends will be reported to QAPI Committee.<br><br>Part C<br>Resident #88 [redacted] full body assessment completed with no findings. Resident placed on every 15 minute monitoring by staff. [redacted] evaluation and care plan was reviewed and updated to reflect [redacted] and [redacted] t risk. 7/6/2022 all staff including licensed nursing staff on all shifts received education on [redacted] and [redacted] policy by the Director of Nursing. 7/6/2022 An [redacted] audit was completed by Director of Nursing on all residents at risk for [redacted] and [redacted].<br><br>All residents have potential to be affected by this deficient practice.<br><br>7/6/22 Director of Nursing or designee will audit new admissions and readmissions to ensure the [redacted] risk assessment is completed and to ensure appropriate interventions are implemented. The Director of Nursing or designee will monitor all residents at risk for [redacted] | |

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| F 689 | Continued From page 42<br>The Advanced Practice Nurse (APN) Physician Progress Note dated [redacted] at 9:29 PM, authored by the Advanced Practical Nurse (APN) included "Accidental [redacted]" in her assessment and included a plan to implement [redacted] prevention and '[redacted] monitoring."<br><br>The fall incident report indicated that the witness was a resident, but it did not specify that this resident was a reliable source. In addition, the incident report did not include documented statements from the witness and HK staff.<br><br>The [redacted] Risk Evaluation dated [redacted] revealed a score of [redacted] which classified the resident at high risk for [redacted]<br><br>3.)The [redacted] at 9:26 PM fall incident revealed that the resident had an unwitnessed [redacted] and was found on the floor in the '[redacted]" without injuries. The [redacted] report did not specify who found the resident on the floor nor include documented evidence of witness statements that surrounded the occurrence of the [redacted]<br><br>In addition, the incident report included "Notes" dated [redacted] which indicated that the "staff continues to observe" and "redirect" the resident. It did not reflect specific interventions on what to observe or when and how to redirect the resident.<br><br>The [redacted] Risk Evaluation dated [redacted] revealed a score of [redacted] which classified the resident at high risk for [redacted]<br><br>4.) The [redacted] at 10:45 AM [redacted] incident reflected that the resident had an unwitnessed [redacted] in which it was indicated that the resident hit their [redacted] was [redacted], and had a [redacted]" numerical level of | F 689 | and elopement to ensure interventions are implemented and effective. Annual elopement drills and ad hoc elopement drills will be conducted as needed. The [redacted] and [redacted] Policy & Procedure will be reviewed by all staff annually, upon hire and as needed. Nursing staff will monitor wander guard wristbands for functioning daily. Maintenance will audit wander guard equipment for function at least daily.<br><br>The audits will be monitored by the Administrator and Director of Nursing as follows weekly x 4, bi-weekly x 2 weeks and monthly x 3. The audits will be discussed during our monthly Quality Assurance Performance Improvement meeting; Quality Assurance Performance Improvement committee will determine if continued auditing is necessary. Once 100% compliance threshold is achieved for two consecutive months. This plan can be amended when indicated. Adverse finding will be immediately addressed. Findings and trends will be reported to QAPI Committee. | |

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| F 689 | Continued From page 43<br>[redacted] at the time of the incident.<br><br>The electronic Health Status Note (HSN) dated [redacted] at 11:39 PM, indicated that the resident was sent to the hospital and returned to the facility the same day "with no recommendations received."<br><br>The Change in Condition Evaluation dated [redacted] under the "Evaluations" tab in the resident's electronic medical record (EMR) reflected an "In Progress" status, which was initiated but incomplete.<br><br>It was included in the Employee Statement report authored by the Nursing Supervisor that a CNA found the resident lying on the floor by the hallway towards the dining room door. However, there was no documented evidence of statements from this CNA.<br><br>4.) The 7/12/22 at 5:55 PM fall incident revealed that the resident had a witnessed [redacted] in which the resident tripped and landed on his/her [redacted] and faced forward down to the floor while ambulating in the [redacted] hallway. The resident sustained a [redacted] on the [redacted] and a [redacted] on the [redacted] from the [redacted]<br><br>The Change in Condition Evaluation dated [redacted] in the resident's EMR reflected an "In Progress" status, which was initiated but incomplete.<br><br>There was no documented evidence that a [redacted] Risk Evaluation related to the [redacted] incident was completed.<br><br>The Physical Therapy (PT) Discharge Summary | F 689 | | |

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| F 689 | Continued From page 44<br>indicated the date of service started on [redacted] and the discharge on [redacted]. It indicated that the resident had "poor safety awareness and poor ability to navigate obstacles and busy hallways." It also included recommendations to provide the resident with close supervision for ambulation without assistive devices to reduce the risk of [redacted].<br><br>The care plan was not updated related to the [redacted] incident to implement interventions to ensure resident safety and reduce the risk of further [redacted]. It also did not include or address the PT's discharge recommendations.<br><br>5.) The [redacted] at 02:33 PM fall incident revealed that the HK staff reported that the resident was found lying flat on the floor in the hallway. The report included that the resident "cried out" and was holding on to his/her [redacted], at the time of the incident. It also indicated that the resident sustained a [redacted] on the [redacted] from the [redacted]<br><br>The APN Physician Progress Note dated [redacted] at 04:23 PM reflected that she included "Accidenta[redacted]" in her assessment and included a plan to implement fall prevention and '[redacted] monitoring."<br><br>The facility [redacted] Evaluation Flow Sheet form (used to assess the [redacted] status of the resident) was initiated on [redacted] but was incomplete.<br><br>There was no documented evidence that a [redacted] Risk Evaluation related to the [redacted] incident was conducted. | F 689 | | |

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| F 689 | Continued From page 45<br>6.) The [redacted] at 8:29 PM [redacted] incident reflected that the resident had an unwitnessed [redacted] in which Resident #47 sustained a [redacted] on the [redacted]. It included that the staff were at the nursing station, heard a sound, looked up, and found the resident on the floor in the [redacted] hallway" near room [redacted]<br><br>There was no documented evidence that a [redacted] Risk Evaluation related to the [redacted] incident was conducted.<br><br>The electronic HSN dated [redacted] at 23:43 (11:43 PM) indicated that the resident was transferred and admitted to the hospital within the same day with a diagnosis of [redacted]).<br><br>The hospital records dated [redacted] revealed a Problem List for the current admission to the hospital that included a diagnosis of [redacted] n). It also included those diagnostic tests that were performed on the resident during hospitalization and showed results of [redacted] and [redacted].<br><br>The electronic HSN dated [redacted] at 7:12 PM was readmitted to the facility from the hospital via ambulance via stretcher.<br><br>The Readmission [redacted] Risk Evaluation dated [redacted] revealed a score of [redacted] which classified the resident at high risk for [redacted]<br><br>7.) The [redacted] at 5:20 PM [redacted] incident revealed that Licensed Practical Nurse#1 (LPN#1) was | F 689 | | |

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| F 689 | Continued From page 46<br>called by another resident from room [redacted] to see Resident#47 on the dining room floor. It did not indicate that the resident who reported the [redacted] was a reliable source nor include a documented statement from this resident.<br><br>Furthermore, the incident report indicated that LPN#1 was accompanied by Physician#1 who assessed Resident#47 with an order to send him/her to the hospital for evaluation following a fall with "[redacted]." The fall report did not reflect the identification of the causal factor that influenced the resident's [redacted]<br><br>CNA#1's statement dated [redacted] reflected that she did not witness the resident's [redacted]. She indicated that another resident notified her of Resident #47's [redacted] in the dining room.<br><br>The [redacted] incident report did not identify the resident who reported the [redacted] to CNA#1 nor indicate whether this resident was a reliable source.<br><br>There was no documented evidence of a statement from the resident who reported the [redacted] to CNA#1.<br><br>Additionally, CNA#2's statement dated [redacted] reflected that she did not witness the resident's fall in the dining room. She indicated that an activity staff was also in the dining room serving dinner to the residents.<br><br>There was no documented evidence of a statement from the activity staff that was in the dining room, which was mentioned in CNA#2's statement. | F 689 | | |

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| F 689 | Continued From page 47<br>CNA#1 and #2's statements did not reflect whether the resident was supervised by staff in the dining room when the fall occurred.<br><br>The [redacted] Risk Evaluation dated [redacted] revealed a score of [redacted] which classified the resident at high risk for [redacted]<br><br>The facility-provided hospital records dated [redacted], After Visit Summary, reflected [redacted] for "Reason for Visit" and Diagnosis of [redacted], initial encounter". The hospital records indicated the list of imaging tests conducted during the resident's visit. However, there was no documented evidence of the results that were included in the hospital records.<br><br>The HSN dated [redacted] at 6:06 AM, reflected that the resident returned to the facility from the hospital at "around" 12:40 AM.<br><br>The APN Physician Progress Note dated [redacted] at 13:06 (01:06 PM), reflected that the resident was readmitted to the facility from the hospital where he/she was diagnosed with [redacted] on [redacted] and [redacted].<br><br>In the same notes, the APN included in the "Plan" for [redacted] monitoring and closed monitoring. However, there was no documented evidence of accountability in the resident's medical records that the [redacted] monitoring was conducted. Close monitoring was not defined.<br><br>8.) The [redacted] at 12:40 PM fall incident revealed that the resident had a witnessed [redacted] in which the resident was sitting in a chair at the nursing station and attempted to rise from the chair which caused Resident #47 to [redacted] on the | F 689 | | |

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floor. It was indicated that the resident had a [redacted] level of [redacted] at the time of the incident. It also reflected that the resident's mobility assessment was ambulatory without assistance.

In the incident report, LPN#2's statement dated [redacted] reflected that she was in the [redacted] hall where she witnessed the resident fall to the floor. She indicated that the resident had poor balance and attempted to ambulate which caused him/her to land on the [redacted] and then hit his/her [redacted] "possibly" on the floor.

The [redacted] Risk Evaluation dated [redacted] revealed a score of [redacted] which classified the resident at high risk for [redacted]

The APN Physician Progress Note dated [redacted] at 01:32 PM, indicated that the APN was notified of the resident's [redacted] She included that the resident had "no apparent injury on examination other than minor [redacted] on the [redacted]." She included in the "Plan" that for [redacted] monitoring should be conducted. However, there was no documented evidence of accountability in the resident's hybrid medical records that the [redacted] monitoring was completed.

9.) The [redacted] at 5:28 PM [redacted] incident indicated that the resident had an unwitnessed [redacted] in which the resident was heard screaming, crying, and laying on the dining room floor.

The incident report included "Notes" dated [redacted] which indicated that the resident had a history of [redacted] no [redacted], and "being very spontaneous." It also included that the staff "distantly observes" the resident and anticipates his/her needs.

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| F 689 | Continued From page 49<br><br>A written statement from the Licensed Practical Nurse/Unit Manager#1 (LPN/UM#1) dated [redacted], reflected that she was called to the dining room where she observed the resident sitting on the floor in front of the wheelchair, crying, grimacing, and holding his/her [redacted]<br><br>The printed form Change in Condition Evaluation dated [redacted] under interventions specified "Frequent monitoring." It was also indicated that the primary care clinician was notified on [redacted] at 17:16 (2:16 PM) with recommendations for "[redacted] checks and Monitoring."<br><br>The PT Discharge Summary indicated the date of service started on [redacted] and the discharge on [redacted]. It included that the resident was discharged on a "Supervision or touching assistance" level for [redacted] transfer and [redacted] with rehab recommendations for use of a wheelchair for mobility due to [redacted]" and "HHA/CGA" ([redacted] assist/[redacted] assistance) "for all ambulation with staff as tolerated."<br><br>There was no documented evidence that the PT discharge recommendations mentioned above were updated in the resident's care plan interventions during the surveyor's record reviews.<br><br>The [redacted] care plan was inappropriately updated on [redacted] related to the [redacted], which included non-resident-centered interventions. Furthermore, there was no documented evidence that the intervention indicated in the [redacted] incident report which included that the staff | F 689 | | |

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| F 689 | Continued From page 50<br>distantly observed the resident, was recorded in the fall care plan interventions.<br><br>The [redacted] Risk Assessment dated [redacted] revealed a score of [redacted] which classified the resident at high risk for [redacted].<br><br>10.) The [redacted] at 02:19 PM [redacted] incident revealed that the resident had a witnessed [redacted] in which he/she was in the day room, stood up from the wheelchair, and took a few steps before [redacted] and hitting his/her [redacted] on the foot of the table and the resident had a [redacted] level of [redacted]" at the time of the incident.<br><br>The printed form Change in Condition Evaluation dated [redacted] indicated that the primary care clinician was notified on [redacted] at 14:00 with recommendations to "continue to monitor and initiate [redacted] checks (an assessment that detects [redacted], and [redacted] injuries or disorders)."<br><br>Furthermore, the [redacted] care plan intervention that was created on [redacted] included "Staff to provide close observation." It did not identify what "close observation" meant for Resident #47, when or how often it close observation occurs, nor did it specify if it meant the proximity between the observing staff and the resident to be considered "close observation."<br><br>The [redacted] Risk Assessment dated [redacted] revealed a score of [redacted] which classified the resident at high risk for [redacted].<br><br>The above [redacted] investigations showed the following: | F 689 | | |

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| F 689 | Continued From page 51<br>On [redacted] incidents, there was no documentation of a root cause analysis written in the summary and conclusion of the [redacted] investigation reports to evaluate what interventions were in place at the time of the [redacted] and whether they were effective or not. There was no determination as to whether the [redacted] were avoidable or unavoidable.<br><br>There was no documentation in the resident's medical record that the [redacted] check orders were implemented or immediate actions were taken on [redacted], and [redacted] in accordance with the [redacted] incidents that were initiated.<br><br>There was no documented evidence in the resident's hybrid medical records that the resident was seen and evaluated by a clinician following the [redacted] that occurred on [redacted] and [redacted].<br><br>There was no documented evidence that the Interdisciplinary team met to discuss the resident's falls that occurred on [redacted] and [redacted]. In addition, there was no evidence that these [redacted] occurrences, including those with major injury, were updated on the resident's care plan related to the incident and interventions to prevent further [redacted]<br><br>There was no documentation that the resident was screened by the Rehabilitation Department following the [redacted], and [redacted] incidents to determine if the resident could benefit from rehabilitation services or screen for the use of other durable medical equipment. | F 689 | | |

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| F 689 | Continued From page 52 | F 689 | | |

There was no documentation that the staff received education, training or in services on the residents' safety and prevention of further falls following the [redacted] incidents.

On 10/18/22 at 11:35 AM, the surveyor asked the DON to provide all the supporting documentation related to the resident's [redacted] incidents from [redacted] through [redacted]. The DON acknowledged to the surveyor that she provided the surveyor with "all" the documentation related to the resident's fall investigations except the hospital records. The DON stated that the [redacted] checks were completed on a paper form titled [redacted] Evaluation Flow Sheet, which was attached to the [redacted] reports that were given to the surveyor.

On the same day at 12:07 PM, the RDON and DON met with the survey team. The RDON informed the surveyors that the staff and resident statements for [redacted] investigations were paper documentation. He also stated that the statements were part of the [redacted] investigation and should be attached to the [redacted] incident report. Furthermore, he stated that after obtaining statements, the UM, DON, and LNHA would do a "full investigation" which included a [redacted] summary and conclusion.

During the interview, the RDON stated that the "interim" [redacted] investigation report should be electronically entered "immediately" and "completely" by the nurse within the shift. He stated that the printed interim [redacted] report should go to the UM to be reviewed for completion, then the DON and LNHA would be made aware of the investigation. The RDON acknowledged that the [redacted] incident investigations and reports were not

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| F 689 | Continued From page 53<br>being completed. The DON also agreed and stated that the completion of the investigation process "was not being done."<br><br>On 10/18/22 at 01:33 PM, the surveyor had a follow-up interview with the DON in the presence of the survey team. The DON stated that the [redacted] care plan should be updated by the UM within 24-72 hours of the fall occurrence, depending on when the [redacted] occurred. She further stated that the fall care plan should have included appropriate interventions related to each [redacted].<br><br>On that same date and time, the DON reviewed the resident's care plan and acknowledged that Resident #47's [redacted] care plan was not appropriately updated and stated, "You probably won't find the care plan updated."<br><br>At that same time, during the interview with the DON, the DON informed the surveyors that the LPN/UM#1 did not update the [redacted] care plan because she was not aware that she was supposed to update the resident's care plan to include appropriate interventions for each [redacted] occurrence.<br><br>On 10/19/22 at 11:32 AM, two surveyors interviewed LPN/UM#1. LPN/UM#1 informed the surveyors that she was responsible for care plan initiation and revision. She stated that with "each [redacted], there should be new intervention." She acknowledged that the resident had multiple [redacted] and his/her [redacted] care plan was not updated for each fall. She stated that the resident's [redacted] care plan interventions should have been adjusted accordingly on each [redacted] to prevent the resident from future [redacted]. The LPN/UM#1 stated that the resident had no safety awareness and needed | F 689 | | |

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[redacted] observation "only when they can due to short staffing." She also acknowledged that the resident's[redacted] investigation reports were incomplete.

On 10/20/22 at 10:41 AM, the surveyor interviewed the Director of Rehabilitation (Rehab) (DOR). The DOR informed the surveyor that the Rehab Department conducted Rehab screenings for residents every quarter, annually, for each new admission and readmission, and with a change in status. She stated that Rehab screenings were also initiated by staff or family referrals as needed, which included residents who had [redacted] to determine any decline in mobility, cognition, and communication that warrant rehab evaluation, treatment, and services. She informed the surveyor that the resident was referred for Rehab due to her multiple [redacted].

On that same date and time, the surveyor asked the DOR if the resident was screened and evaluated after each [redacted] incident. The DOR stated that she was not sure and would verify after reviewing the rehab notes. She also stated that she would provide the surveyor with a copy of the resident's rehab notes. In addition, she stated that the communication with the nursing department would be documented in the rehab daily notes.

On 10/20/22 at 12:09 PM, the DOR met with the survey team. She stated that the nursing department would send a referral to the rehab department for each[redacted] occurrence. The DOR further stated that the resident had a decline since his/her readmission from a hospitalization after a[redacted] incident. She stated that the resident

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| F 689 | Continued From page 55<br>was discharged from PT on [redacted]2 with recommendations for use of a wheelchair for mobility and Handheld Assist (HHA) or Contact Guard Assist (CGA) for "all" ambulation with staff as tolerated due to his/her [redacted]<br><br>During the interview, the surveyor also reviewed the PT Discharge Summary dated [redacted] in the presence of the DOR. It was documented by Rehab staff a recommendation that the resident required "close supervision for ambulation without an assistive device to reduce the risk of [redacted]."<br><br>Furthermore, the DOR stated that she expected that the rehab recommendations be included in the resident's care plan. The surveyor asked the DOR for documented evidence of accountability that the rehab recommendations were relayed to the nursing department. The DOR stated that the rehab recommendations were discussed in the weekly Utilization Review (UR) meeting with the nursing department. The surveyor asked the DOR to provide a copy of the accountability of the rehab discharge recommendations dated [redacted] and [redacted] in the UR meeting. The DOR did not provide further information at this time.<br><br>On 10/21/22 at 10:30 AM, LPN/UM#1 acknowledged that Resident #47 had frequent [redacted] She also stated that the resident could ambulate when the resident "wants to" and that the resident required staff supervision to prevent further [redacted] because of [redacted] and [redacted]. She further explained that the staff should be close enough to the resident to intervene as needed.<br><br>On the same day at 10:35 AM, the surveyor | F 689 | | |

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interviewed CNA#3. She acknowledged that the resident had frequent [redacted]. She stated that the resident "always needed to be closely supervised by staff" due to the resident's [redacted] and [redacted] to prevent him/her from future [redacted]

At that same time, CNA#3 further stated that due to staffing issues, they could not closely supervise the resident. She informed the surveyor that they were "short staff" and they needed "more staffing" to monitor the resident due to [redacted] and [redacted] behavior, and to provide for the resident's needs. The surveyor asked the CNA what close supervision meant. She stated that she sat by the resident so she can prevent [redacted] from [redacted].

The surveyor reviewed the staffing assignment sheets associated with the dates and shifts of each fall for the unit. The assignment sheets revealed insufficient staff during the times of the falls in accordance with New Jersey State minimum staffing requirement. Review of the staffing patterns for the days and shifts that Resident #47 falls occurred were as follows:

5/26/22: Census: 44, 4 CNAs, 2 Nurses
6/2/22: Census: 45, 3 CNAs, 2 Nurses
6/7/22: Census: 45, 3 CNAs, 2 Nurses
6/26/22: Census: 53, 4 CNAs, 2 Nurses
7/12/22: Census: 54, 5 CNAs, 2 Nurses
7/17/22: Census: 54, 4 CNAs, 2 Nurses
8/17/22: Census: 57, 4 CNAs, 2 Nurses
8/23/22: Census: 55, 4 CNAs, 2 Nurses
8/29/22: Census: 55, 3 CNAs, 2 Nurses
10/3/22: Census: 51, 3 CNAs, 2 Nurses
10/10/22: Census: 51, 3 CNAs, 2 Nurses

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| F 689 | Continued From page 57<br>On 10/21/22 03:14 PM, the survey team met with the LNHA, DON, and RDON. The surveyor informed the facility's management that the facility's failure to ensure that Resident #47 who is at risk for [redacted] and with diagnosis of [redacted] prevent the serious injury by failing to ensure that the resident was supervised, assessed, evaluated, and monitored to determine the cause of [redacted] and to prevent future [redacted] placing all residents at risk for serious injury, harm or death. From [redacted] through [redacted], for a period of [redacted] months, the facility failed to ensure Resident #47's safety who is at risk for [redacted] and [redacted] by preventing [redacted], and including [redacted] with major injuries (resident had [redacted], [redacted] and [redacted] and [redacted]). This resulted in an IJ situations. The surveyor notified the facility management that the facility had to provide an acceptable removal plan, and an IJ template was provided to the facility.<br><br>On 10/21/22 at 3:22 PM, the surveyor interviewed the Regional RN (RRN) in the presence of the survey team. The surveyor asked the RRN to define close supervision and close observation. The RRN responded that "they both meant the same." She further explained that when the resident was in the staff's "line of sight" they would be able to see the resident and attend to his/her as needed. The surveyor asked the RRN to interpret the "line of sight" and what was the expected distance between the resident and the staff providing observation. The RRN could not provide further information.<br><br>On 10/24/22 at 11:01 AM, the surveyor interviewed the resident's primary attending Physician#2. Physician#2 acknowledged that | F 689 | | |

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Resident # 47 was his resident. He stated that the resident had a [redacted] and was [redacted]l due to [redacted] He informed the surveyor that he or his NP were notified and made aware of the resident's[redacted]. However, he stated that he did not see and evaluate the resident after every [redacted]

At that same time, the surveyor asked Physician#2 if he had meetings with the IDCP team that discussed the resident's[redacted]. Physician#2 stated that he did not have a "formal actual meeting" with the IDCP team and stated, "I wouldn't go to the meeting" and that he went directly to the UM. The surveyor asked the physician about what he had done when he kept getting notified of the resident's[redacted]. He stated that he included recommendations for CNA observation of the resident. He further stated, "they can use the[redacted] if necessary" to prevent the resident from future[redacted]. He further stated, "As far as I know, the facility told me we cannot use an[redacted] for the resident because it's against the resident's rights."

On 10/24/22 at 11:54 AM, the survey team met with the RRN, DON, and LNHA. The RRN informed the survey team that "1:1 will never prevent[redacted]" She further stated that the facility did not use a personal alarm to prevent residents from[redacted] She also stated that they did not try to use an alarm for Resident#47. Additionally, she stated that[redacted] will not deter the resident from falling.

The RRN acknowledged that the resident's [redacted] investigations were reviewed for completion after the surveyor's inquiry which included checking the root cause analysis, interviews, and care plan revision and updates, and written statements

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| F 689 | Continued From page 59<br>related to the resident's [redacted].<br><br>An Acceptable Removal Plan was received on 10/24/22 at 3:53 PM.<br><br>The survey team attempted to verify the implementation of the Removal Plan on 10/26/22. However, the immediacy could not be lifted on 10/26/22.<br><br>On 10/26/22 at 11:30 AM, LPN#3 stated, "I feel extremely high burnout, no help since COVID." LPN#3 acknowledged that the resident had multiple[redacted] due to [redacted] cognition. She informed the surveyor that close supervision and close observation meant the same. She stated that because they were understaffed, "to be realistic, staff needs to observe the resident visually but to be idealistic, staff will observe resident physically" to prevent the resident from [redacted]. LPN#3 further stated that the resident required closed observation by sitting next to her.<br><br>On 10/26/22 at 11:30 AM, another surveyor interviewed an LPN employed since [redacted]. The LPN stated that when a resident is a[redacted] risk, we try to sit the resident closely within eye view and watch closely. Either by the nurses station, or mostly in the dining room...we usually do close observation, watching within eye view and if in a room we check every 15 minutes. Sometimes staff will sit outside a resident room to monitor. We dont have the staff to do a 1:1, so thats why we have to do close supervision. The Surveyor inquired about night shift when resident is in the bed/room. We do not use bed [redacted] so we have to closely monitor those at risk to [redacted] by checking every 15 minutes. Or as I said before, sometimes will sit outside the room to monitor. | F 689 | | |

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The surveyor interviewed the CNA at approximately 11:40 AM who stated that she was employed [redacted] years at facility. She stated that residents who are a fall risk we try to keep them safe by monitoring and round on them every two hours and mostly keep in the dining room within eye view to closely monitor. We use [redacted] on the floor next to bed for when the resident is in bed and also check on them frequently. We do not use any bed [redacted] and she would just have to monitor and check on frequently. We are always educated on how to closely monitor residents at risk. (This differed from the LPN's description of what close monitoring or close observation meant).

On 10/26/22 at 11:53 AM, the surveyor interviewed the Quality Assurance (QA) staff who stated they were employed with the company [redacted] years. The QA staff stated that the facility protocol for watching residents that are [redacted] risk was to closely monitor by keeping within eye view...usually at the nurses station in a chair and pointed to a large wooden chair across from nurses station, and also to mostly keep them in the dining room to closely watch. We do not keep them in their room so we can watch them. At night we use [redacted]. We do not use any alarm system. We are educated by the ADON regarding close monitoring of residents at risk for [redacted].

At 12:03 PM, the surveyor interviewed the LPN/UM who stated that they were employed at the facility since [redacted] The LPN/UM stated that we mostly keep our high [redacted] risk residents in the dining room, and either two CNA's/sometimes recreation or activities assistants will be in the dining room to monitor. If there was a recent [redacted],

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that resident would be put on close monitoring with every 15 minute checks x 24 hours. We were recently educated, a few days ago, on close supervision of [redacted] risk residents, but we are always educated on close supervision and monitoring of high [redacted] risk residents.

On 10/26/22 at approximately 3:50 PM, the survey team informed the facility administration that the immediacy continued due to inconsistent interviews with staff related to what level of supervision and specific monitoring necessary for Resident #47.

On 10/27/22 at 01:18 PM, the survey team verified the implementation of the Removal Plan through observation, interview, record review and review of pertinent facility documents. The immediacy continued through 10/26/22.

On 11/03/22 at 12:23 PM, the survey team met with Regional LNHA#1 (RLNHA#1), RLNHA#2, DON, and RRN. There was no further information provided during the meeting.

A review of the [redacted] Risk Assessment policy revised 09/2022 reflected that the "risk assessment will be completed by the licensed nurse upon admission, quarterly, post[redacted] incident, or when a significant change is identified." It also included that an "At Risk for [redacted]" care plan will be completed for the resident to address each item identified on the [redacted] assessment and will be updated accordingly. Additionally, the care plan will include "interventions, including consistent with a resident's needs, goals, and standards of practice in order to reduce the risk of an accident." Furthermore, it indicated that the effectiveness of

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| F 689 | Continued From page 62<br>the care plan interventions is monitored and modified as necessary, in accordance with the current standards of practice.<br><br>PART B<br><br>Based on observation, interview, and record review it was determined that the facility failed to ensure that a resident who was identified to have been [redacted] in their room on [redacted] had a system established to prevent a recurrence.<br><br>Resident #98 who was assessed for having [redacted] and had a diagnosis of [redacted] including [redacted] was known to go out on a pass from the facility daily.<br><br>On 9/25/22 Resident #98 was found by staff to be in their room with the smell of [redacted]. The resident relinquished to facility staff a [redacted] and a material used for [redacted]<br><br>The facility failed to initiate an investigation into the incident to determine the source of the [redacted] and further failed to assess the resident for safe [redacted] provide a [redacted] contract, initiate a care plan for [redacted] develop a system to monitor the resident upon his/her return from out on pass to determine possession of [redacted] materials or have a system for accountability to ensure the resident was being monitored to prevent another incident of [redacted] in the resident room.<br><br>This system failure resulted in an immediate jeopardy (IJ) situation.<br><br>The IJ situation began on [redacted]. The facility's | F 689 | | |

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Director of Nursing (DON), Regional Registered Nurse (RRN), Regional Licensed Nursing Home Administrator (RLNHA) #1 and RLNHA #2 were notified of the IJ on 10/26/22 at 3:52 PM. An acceptable Removal Plan was received on 10/27/22 at 12:32 PM. The survey team verified the Removal Plan on 10/28/22 through observation, interview, record review and review of other pertinent facility documents.

The evidence was as follows:

On 10/13/22 at 10:04 AM, the surveyor conducted an Entrance Conference with the LNHA and DON. Included as part of the Entrance Conference, the surveyor requested a copy of a list of residents who [redacted] at the facility and the facility told the surveyor that they were a [redacted] facility.

On 10/13/22 at 11:39 AM, the surveyor observed Resident #98 inside a [redacted] room, the resident was in bed watching television.

The surveyor reviewed the medical record for Resident #98.

The Admission Record revealed that Resident #98 was admitted to the facility with a diagnosis that included: [redacted].

The AMDS dated [redacted] reflected that the resident had a BIMS score of [redacted] out of [redacted] indicating that the resident had [redacted] cognition. The AMDS assessment further revealed that the section used to assess if the

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resident was a [redacted] reflected that they were not a current [redacted] user.

The Admission Assessments in the electronic medical record revealed that no [redacted] assessment was done for Resident #98.

The Progress Note (PN) dated [redacted] at 03:19 PM, under a behavioral note revealed the following: "smell of [redacted] in [room number redacted], resident handed [his/her] [redacted] to the nurse. Yesterday, resident was out on pass with a friend. Resident was made aware of facility [redacted] protocol." This PN was also entered as a Health Status note on [redacted] at 4:41 PM by nursing.

The Social Services PN dated [redacted] at 4:20 PM, revealed the following: "Administrator and unit manager met with resident to discuss discharge ...This writer and administrator agree that 30-day discharge letter would be given to resident. Resident does not meet nursing home criteria, has been caught [redacted] in room, and appears to have been under the influence of [redacted] when returning from pass. This was all explained as danger not only to the resident but the staff and residents at the facility ...."

Review of the comprehensive individualized care plan revealed no documented evidence of a care plan that addressed that the resident was a [redacted] or that an incident occurred on [redacted] when the resident was found [redacted] in their room. In addition, there was no documented evidence that interventions were in place for the facility staff to follow to prevent the resident from breaking the facility's [redacted] policy.

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Further review of the resident's comprehensive individualized care plan revealed that there was no documented evidence of a care plan that addressed the resident leaving the facility on pass with no system for monitoring and assessing the resident when they are out on pass and when they returned to the facility.

A review of the Release of Responsibility for Leave of Absence form for Resident #98 revealed that the form was incomplete.

Resident #98's medical records revealed that they were no [redacted] assessments for the resident on admission and after the resident was identified as [redacted] in their room.

The POS reflected that the resident had an physician's order dated [redacted] for [redacted] Patch [redacted] hours to apply 1 patch [redacted] once daily which was discontinued on [redacted] The surveyor was unable to find any documentation in the medical record which reflected the rationale for the discontinuation of Resident #98's [redacted] patch. The POS also reflected no documented evidence of a physician's order for the resident to go out on pass.

On 10/26/22 at 9:31 AM, the surveyor team interviewed the DON who stated that she was familiar with Resident #98. She told the surveyors that the resident was [redacted], and he/she could answer questions and was aware of the date and time, but the resident was also not cooperative.

On that same date and time, the DON discussed

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the process for a Leave of Absence, she stated that the resident would need a physician order to go out on pass and that it would need to be part of the medical record. The DON further stated that when Resident #98 went out on pass it was usually around 6:30 AM, the resident would sign out and on the [redacted] floor nursing unit then the resident would be escorted downstairs by a staff member and would leave the facility through the front door. The facility nursing staff would conduct a skin assessment when the resident returned to the facility. The surveyor asked the DON if the resident had any IDT meetings to address these concerns. The DON stated that she did not know, and the Unit manager would be part of the IDT meeting.

At that same time, the DON stated that the facility conducted a full investigation after the resident was caught [redacted] in their room, the resident was educated and no staff observed the resident holding a [redacted]. The DON acknowledged that if the investigation was done, they should have created a care plan after the [redacted] incident.

Furthermore, the surveyor followed up with the DON to show to the survey team where in the electronic medical record the investigation report was documented, and the DON stated that she will have to ask the regional team about it and will get back to the surveyors.

On 10/26/22 at 12:17 PM, the surveyor interviewed the facility Receptionist regarding the facility process for identifying residents who were going out on pass. The Receptionist stated that the DON and UM, updated the out-on-pass book, and the residents or the resident representative would sign them out on pass. The exit doors

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have a code, and the Receptionist would open the doors to let the resident exit the facility. The Receptionist told the surveyor that the nurse would call down to the reception area to let them know that a resident was coming downstairs and whether or not they were safe to exit the facility independently,

On 10/26/22 at 12:42 PM, the survey team interviewed the LNHA regarding the 30-day discharge letter that was provided to Resident #98. The LNHA stated that the discharge letter was presented to the resident due to being non-compliant with facility rules ([redacted] in the facility) and the non-compliance could endanger all the residents at the facility. He told the surveyors that one of the residents at the facility, Resident #61 complained that he/she felt uncomfortable around Resident #98.

On 10/26/22 at 01:00 PM, the surveyor team interviewed the Regional Director of Nursing (RDON) who stated that the facility was aware that the resident was allegedly [redacted] in their room. The RDON further stated that the resident acknowledge that they were craving a [redacted]. He stated that he initiated a risk management investigation for the resident and stated that the LNHA does not believe that the resident will [redacted] again inside the facility. He stated that he believes that the facility told him that the resident comes back smelling like [redacted] but it's hard to judge if the resident was [redacted].

On that same date and time, the surveyor asked the RDON to show it to the survey team where the above Facility's Investigation Report documented in the electronic medical record. The RDON then went to the computer and showed

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the [redacted] report. The surveyor then asked the RDON why the electronic medical record showed that the Facility's Investigation Report date had today's date and the [redacted] date was in red. The RDON responded that he initiated the risk management investigation (Facility's Investigation Report) for the resident's smoking incident "today" because he was told to do it. The RDON acknowledged that there was no investigation that was done on [redacted] when the resident was found with [redacted] inside the resident's room not until the surveyor's inquiry.

A review of the Facility's Investigation Report dated [redacted] at 03:40 PM and provided to the surveyor on 10/26/22 at that time, revealed the following under incident description, "As nurse was entering the room, nurse smelled [redacted] in the room. She then opened the bathroom and has a smell of [redacted]. The nurse asked the resident if they were [redacted]. The resident told the nurse not to tell anyone. The nurse asked the resident to give her the [redacted] and [redacted] which the resident did without complaints. The nurse stated to the resident that [redacted] was not allowed anywhere in the facility. The resident said the [he/she] understood. The nurse reported this to the Unit Manager. The resident admitted to [redacted] in the bathroom. The resident "promised I won't do it again." The facility investigational report also contained a statement regarding immediate action taken which revealed the following: "Nurse educated resident about facility [redacted] policy and offered [redacted] program which the resident refused." However, there was no care plan initiated in associated with this investigation.

On 10/26/22 at 03:52 PM, the surveyor team met

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with the facility which included the DON, RRN, RLNHA #1 and RLNHA #2. The surveyor team notified the facility of the Immediate Jeopardy situation in which Resident #98 was identified to be [redacted] in the room and found to have [redacted] materials in his/her possession, yet the facility continued to not assess, monitor, investigate the incident until surveyor inquiry, create a system for accountability to ensure the resident would not have another occurence of [redacted] in their room. This failure to ensure a system was in place for Resident #98 to prevent another [redacted] incident in their room, placed Resident #98 and all residents on that unit at risk for serious harm, impairment or death associated with [redacted] in the room which has the likelihood to cause a fire if not corrected.

On 10/26/22 at 4:15 PM, the surveyor in the presence of the Social Worker Director (SWD) interviewed Resident #98. The resident was seated in a wheelchair and was getting easily irritated. The resident stated that when they go out on pass, they would go with a friend who's helping the resident to find a place to live. The resident told the surveyor that they would leave the facility at 7 AM and would return between 10 PM to 12 midnight. The resident stated that when they leave the facility that they will sign out on the first floor and a staff member would come downstairs and let the resident out. The resident further stated that when he/she returned to the facility they will sign back in, but he/she was forgetful and would forget to sign in at times. The resident also stated that when they returned from a pass, the nurse did not do a body assessment or check their belongings.

On that same date and time, the resident stated

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that they do not [redacted] in their room but was unaware of any protocols in which they could not [redacted] when out on pass.

On 10/27/22 at 9:19 AM, the survey team interviewed Resident #98's physician. Physician#3 stated that he was familiar with the resident and stated that the resident was [redacted]. The physician further stated that he saw the resident back on [redacted] The physician was unaware that the resident was leaving the facility on a pass and stated that the resident needed a physician's order to go out on pass. He further stated that he would have not have authorized the resident to leave the facility.

At that same time, Physician#3 was unaware that the resident was identified to have been [redacted] in their room and that the nursing staff found a [redacted] in the resident's possessions. The physician stated that if he knew that the resident was [redacted] he would have never written an order for the [redacted] (used to treat [redacted] and he would have made sure that the resident was on a [redacted] program.

Furthermore, when the surveyor asked Physician#3 about the resident receiving a 30-day discharge letter from the facility, the physician stated that he was unaware that the facility gave the resident a 30-day discharge letter.

On 10/27/22 at 10:14 AM, the surveyor interviewed the APN who stated that she knew Resident #98. She stated that Resident #98 was not her resident, but she would check on the resident when the staff were concerned with the resident's behaviors. She told the surveyor that

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the resident was alert and oriented, but the resident was also non-compliant with the facility rules. The APN was unaware that the resident was going out on pass but stated that the resident had a right to go out on pass. The APN further stated that the resident required a physician's order to go out on pass, but she never wrote an order for this resident. She also stated that she would only reach out to the resident's physician if she had a significant concern.

On 10/27/22 at 12:25 PM, the surveyor interviewed the resident's nurse, LPN#6 who stated that she never observed the resident [redacted] She stated that she was notified by another nurse who was doing a treatment that she smelled [redacted] coming from the resident's room. She stated that she went into the resident's room and there was a strong smell of [redacted] LPN#6 further stated that she asked the resident if they were [redacted] and the resident handed her a [redacted].

At that same time, LPN#6 stated that when the resident returned from out on pass that the resident appeared [redacted] and would go right into their room. She acknowledged that she never assessed or checked Resident #98's belongings when they returned from out on pass. LPN#6 further stated that this was not the appropriate facility for this resident and that he/she should be at a place that could better address the resident's needs.

On 10/27/22 at 12:32 PM, the survey team received the acceptable removal plan from the RRN.

On 10/28/22 at 10:28 AM, the survey team

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verified the Removal Plan through observation, interview, record review and review of other pertinent facility documents.

A review of the facility's policy for Out on Pass/Leave of Absence that was 9/22 and was provided by the RRN indicated the following:

"A physician's order must be obtained for an Out on Pass (OOP)/Leave of Absence in the community."

"Residents leaving the facility without signing the appropriate form (so will be referred to Social Services."

A review of the facility's policy for Resident [redacted] that was dated 9/22 and was provided by the RRN indicated the following:

"Residents who smoke will be evaluated to determine whether or not supervision is required for [redacted], or if resident is safe to [redacted] at all."

"Any resident who is deemed safe to [redacted], with or without supervision, will be allowed to [redacted] in designated [redacted] areas (weather permitting), at designated times, and in accordance with his/her care plan."

"If a resident who [redacted] experience any decline in condition or cognition, he/she will be reassessed for ability to [redacted] independently and/or to evaluate whether any additional safety measures are indicated."

"All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be

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responsible for supervising residents while [redacted] Supervision will be provided as indicated on each resident's care plan."

PART C

Based on observations, interviews, record review, and review of other pertinent facility documentation, it was determined that on [redacted], the facility failed to ensure a resident with [redacted], who was at risk for [redacted] and had a known history of [redacted] behavior was appropriately supervised and monitored to ensure safety, prevent elopement, and/or exiting of the building, and the staff failed to follow their facility's policy and procedure on [redacted] and [redacted]

This deficient practice was identified for 1 of 3 residents (Resident #88) reviewed for unsafe [redacted], who had [redacted], and were at risk for elopement. This placed Resident #88, as well as all other residents with [redacted] t, who were at risk for or had a known history of [redacted] and/or elopement in Immediate Jeopardy (IJ).

On [redacted], Resident #88 was able to exit the building unsupervised through a locked, alarming door at approximately 7:40 PM. The next time the resident was seen by staff was after receiving a phone call from the local police and being returned to the facility by police on [redacted] at 9:25 PM (approximately two hours later).

The Immediate Jeopardy Past Non-Compliance started on [redacted] and was corrected on [redacted]

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when facility in-serviced all their staff on elopements and responding to alarms and all systems were updated.

The IJ for Resident #88 occurred on [redacted]. The facility was notified of the IJ on 10/20/22 at 02:18 PM when the LNHA and the DON were notified of the IJ situation.

The surveyor reviewed the medical record for Resident #88.

The Admission Record (AR), Resident #88 was admitted to the facility with diagnoses which included, but were not limited to, [redacted]

The AMDS with an ARD of [redacted] revealed that Resident #88 had a BIMS score of [redacted], which indicated that the resident had [redacted] Further review of the MDS, Section [redacted] for functional status, indicated that Resident #88 was a one-person physical assistance for dressing and hygiene and supervision for transfers and ambulating in the room. Section [redacted] of the AMDS titled "restraints/alarms" indicated that the resident was not using a [redacted]) at that time.

The admission facility [redacted] Evaluation dated [redacted] indicated that on admission to the facility Resident #88 was an [redacted] risk. In the section titled "Evaluation" number three was asked if the resident had a history of [redacted] or attempted to leave the facility without informing

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staff the answer was "yes." The section titled, "abnormalities" indicated that the resident had a history of [redacted] both at home and in the facility. The suggestions section of the evaluation included applying personal safety alarms, utilizing exit alarms, documenting specific behaviors, and notifying staff of [redacted] and [redacted] risks.

According to the resident's active individualized care plan revealed a focus area that Resident #88 was at risk for [redacted]. The care plan was initiated on [redacted] and revised on [redacted]. The goal was that Resident #88 would ambulate within the unit and not attempt to leave the floor. The interventions included the following: to provide care in a calm and reassuring manner, provide clear and simple instructions, reorient to surroundings, redirect calmly, clearly identify Resident #88 room and encourage resident to participate in activities.

The Nursing Progress Notes (PN) dated [redacted] at 9:22 PM revealed that the resident was [redacted] to other rooms and trying to open exit doors and was redirected by the facility staff.

The facility provided a police report from the local police department dated [redacted] at 9:00 PM which indicated that a person was on a porch of a home local to the nursing facility, confused and looking for a sibling. Police were called by the homeowner and found Resident #88 at the home. The police called the nursing home, and the nursing home identified the resident. Resident #88 was transported back to the nursing home by the police department.

The incident overview provided by the facility indicated that on [redacted] the Assistant Director of

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Nursing (ADON) was called by the nurse on duty from the facility at 9:30 PM to inform her that the local police department brought Resident #88 back to the facility. The staff was not aware that the resident had [redacted] from the building.

In addition, the incident overview that was provided by the facility on 1[redacted] for the above [redacted] included the Every 15 Minute Visual Monitoring for the resident that started on 7/06/22 at 9:45 PM.

A review of the Physician Order Sheet (POS) showed that a[redacted] to the [redacted], check every shift for placement and functioning was ordered for Resident #88 on [redacted]

The above [redacted] POS was transcribed to the [redacted] electronic Treatment Administration Record (eTAR) and signed by nurses every shift.

On 10/20/22 at 12:37 PM, the surveyor interviewed the DON regarding the [redacted] which took place on [redacted]. The DON told the surveyor that the resident was seen by the exit door at the end of the hallway on the '[redacted]" Unit, the [redacted] floor unit during the 3 PM to 11 PM evening shift. At that time CNA#4 heard the exit door at the end of the hallway alarm. The exit door led to a [redacted] that led to the [redacted] The CNA came out of a room where he was providing care and redirected the resident toward the nursing station. The CNA then reset the door alarm and went back into another resident's room to provide care.

At that same date and time, the DON told the

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surveyor she believes the alarm went off again and no resident was seen by the door. The DON further stated that LPN#4 who was working on the 3 PM to 11 PM shift reset the alarm. The DON stated, "The LPN had just returned from break and heard the alarm, she didn't see a resident at the door, so she reset the alarm and continued to pass medications."

At that time, the surveyor asked the DON what should have happened, and the DON stated, "the LPN should have checked the [redacted] door and the [redacted] to see if any residents were there and then should have done a head count to make sure all the residents were accounted for, which she failed to do." The DON stated, "she didn't think."

On 10/20/22 at 02:18 PM, the survey team met with the LNHA, DON, and the RDON. The surveyor informed the facility management that because of the facility's failure to ensure a resident with [redacted], who was at risk for [redacted] and had a known history of [redacted] and [redacted] behavior was appropriately supervised and monitored to ensure safety, prevent [redacted], and/or exiting of the building, and the staff failed to follow their facility's policy and procedure on [redacted] and [redacted]. Resident #88 reviewed for unsafe [redacted] and [redacted], who had [redacted], and were at risk for [redacted] was able to exit the building unsupervised through a locked, alarming door approximately at 7:40 PM on [redacted] resulted to an IJ and placed all other resident with [redacted], who were at risk for or had a known history of [redacted] at risk. The facility was provided an IJ template.

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| F 689 | Continued From page 78<br><br>On 10/21/22 at 10:27 AM, the surveyor observed Resident #88 in the day room, the resident had a [redacted] to the [redacted] The surveyor interviewed unit LPN#5 regarding [redacted]. LPN#5 stated that the staff check the resident's wrist every shift to make sure the [redacted] was in place and [redacted] were checked for function by bringing the residents near the elevators or the doors.<br><br>At that same time, the surveyor asked LPN#5 what if the resident does not go near the door or elevator, how would you know the [redacted] was functioning? LPN#5 responded, "the supervisor has a thing they check it with". The surveyor asked the nurse to demonstrate the checking of a device by bringing a resident near the door or elevator each time the alarms sounded.<br><br>Then the surveyor asked LPN#5 what would be done if an alarm sounded near an [redacted] door. The LPN said, "you would check the area of the alarm, then if no one was there you would check all the residents to be sure they are there." "If a resident was missing, we call code gray, and every employee looks around the entire facility and outside. If we cannot find a resident, we call the police".<br><br>On 10/21/22 at 12:07 PM, the surveyor spoke with CNA#4 who was with the resident on the night of the [redacted]. The CNA told the surveyor that he heard the alarm while he was in another resident room. At that time, he went to the door and saw Resident #88 attempting to run down the [redacted] The CNA stated that he "grabbed the resident's shirt" because he was afraid the | F 689 | | |

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resident would [redacted]. The CNA said that he put the resident back in the room and told the nurse on duty about the incident.

On that same date and time, the surveyor asked CNA#4 if he heard the second alarm and the CNA stated, "I went on break and the next thing I saw was the cops and I found out that the resident had been found a couple of doors down from the facility".

On 10/21/22 at 1:02 PM, the surveyor reviewed additional documents for the IJ that began on [redacted]. The IJ was corrected on [redacted] when the facility in-serviced all their staff on [redacted] and responding alarms and implemented systems to prevent recurrence. The surveyor reviewed and verified the provided documents that included in-service and monitoring. The resident had no other incidents of [redacted]

On 10/26/22 at 03:14 PM, the surveyor interviewed LPN#4 who was caring for Resident #88 on the evening of the [redacted] The LPN told the surveyor there were, "Two nurses working for the entire unit...And we were short with only three aides on a [redacted] unit...I was responsible for the resident. I saw [him/her] and put the resident to bed. I called the CNA when I put [him/her] to bed to do PM care...I then fed some residents, because we were so short-staffed...I then heard the door alarm, I didn't know how to turn it off, so I called the CNA to help me turn it off, I didn't open the door or look for any residents, I thought the resident was still sleeping...I didn't know the resident had a history [redacted]. A Police officer called and then I realized [he/she] was missing because the police asked me if I knew the resident, I was shocked."

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| F 689 | Continued From page 80<br><br>At that same time, the surveyor asked LPN#4 what process was put in place when the resident was returned to the unit by the police and the LPN told the surveyor, "I checked on the resident every fifteen minutes because I called the DON, and she said to check on the resident all night." Then the surveyor asked the LPN if she documented the checks that were done and she stated, "no." The LPN further stated that the next day "the DON asked me to write it down and then I was suspended." The LPN added she put a [redacted] on the resident on the day the resident came back with the police. The surveyor asked how she knew if the [redacted] was functioning properly. The LPN stated that she checked, and it was working but it was not documented.<br><br>The facility provided a policy titled, [redacted] and [redacted] Residents", recently revised on 11/2019 included that the facility ensures that residents who exhibit [redacted] behavior and/or are at risk for [redacted] receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the factors contributing to [redacted] or [redacted] risk. Under the policy explanation and compliance guidelines, number 3 stated the facility was equipped with door locks/alarms to help avoid [redacted] and alarms are not a replacement for necessary supervision. Staff is to be vigilant in responding to alarms in a timely manner. Section [redacted] indicated that residents would be assessed for risks of [redacted] and [redacted] on admission and throughout their stay and interventions would be put in place to increase staff awareness of the residents' risks. Section [redacted], subpart" [redacted] " indicated | F 689 | | |

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| F 689 | Continued From page 81<br>that adequate supervision will be provided to help prevent accidents or [redacted]<br><br>NJAC 8:39-27.1(a); 31.4(a); 33.1(d) | F 689 | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to ensure that a resident who was dependent on [redacted] had a valid physician's order for [redacted] in place.<br><br>This deficient practice was identified for 1 of 2 residents (Resident #355) reviewed for [redacted] care and was evidenced by the following:<br><br>On 10/14/22 at 10:15 AM, the surveyor observed Resident #355 in their room, lying in bed with the head of the bed elevated. The resident was awake but [redacted] and unable to be interviewed. The resident was observed with a [redacted] into | F 695 | Resident #355 MD was notified and orders were received for [redacted] 10/14/22 all licensed nurses were in-serviced by the Director of Nursing on obtaining physician orders for [redacted] use. Nursing reviewed medical records of all residents receiving [redacted] to ensure physician orders are in place.<br><br>All residents have the potential to be affected by this deficient practice.<br><br>The Director of Nursing or designee will conduct weekly audits of residents administered [redacted] to ensure orders are present and accurately recorded in the electronic medication administration record. The Assistant Director of Nursing or designee will provide continued education to staff on [redacted] use and | 1/20/23 |

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| F 695 | Continued From page 82<br>the ) connected to an (a free-standing device used to ) via a . The was at a ). A that contained a quarter full of clear water, was attached to the . The resident had no signs and symptoms of or distress.<br><br>The surveyor reviewed Resident#355 medical records and revealed the following:<br><br>The Admission Record (admission summary) reflected that the resident was admitted to the facility with diagnoses that included ).<br><br>There was no physician's order (PO) for the .<br><br>On 10/14/22 at 01:15 PM, the surveyor interviewed Registered Nurse (RN) while in the resident's room. The RN acknowledged that the resident was connected to an r with a via . The RN stated that the required a PO.<br><br>On that same date and time, the RN checked the PO in the resident's medical records, and she acknowledged that there was no PO for the<br><br>On 10/14/22 at 1:27 PM, the surveyor interviewed the floor Licensed Practical Nurse/Unit Manager (LPN/UM) and informed the LPN/UM | F 695 | obtaining accurate physician orders at annaully, upon hire and as needed.<br><br>Audits will be monitored for completion by the Administrator and Director of Nursing weekly for 4 weeks, every 2 weeks for 2 months and monthly for 3 months. Audits will be discussed during our monthly Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly. | |

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| F 695 | Continued From page 83<br>that the surveyor observed the resident on [redacted] in the presence of the RN. The LPN/UM acknowledged that there was no PO for the [redacted] and stated, "there should have been a doctor's order."<br><br>On 10/19/22 at 11:51 AM, the LPN/UM informed the surveyor that a PO for [redacted] was initiated for the resident on [redacted] after the surveyor's inquiry.<br><br>On 11/01/22 at 01:02 PM, survey team met with the two Regional Licensed Nursing Home Administrators (RLNHAs), DON and the Regional RN (RRN) and discussed the above concerns. The DON stated, "Apparently, that was an oversight."<br><br>A review of the [redacted] Administration policy revised 9/2022 reflected that [redacted] is administered under orders of a physician ..."<br><br>On 11/03/22 at 12:23 PM, the survey team met with the two Regional LNHAs, DON, and RRN. The facility team did not provide additional information. | F 695 | | |
| F 740 SS=D | NJAC 8:39-11.2(b); 27.1(a)<br>Behavioral Health Services<br>CFR(s): 483.40<br><br>§483.40 Behavioral health services.<br>Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and | F 740 | | 1/20/23 |

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| F 740 | Continued From page 84<br>mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of pertinent facility documentation, the facility failed to: a) appropriately care for a resident with behavioral needs and b) implement interventions to address the resident's behaviors. The deficient practice was identified for one 1 of 10 residents reviewed for behavioral needs (Resident #98).<br><br>This deficient practice was evidenced by the following:<br><br>On 10/13/22 at 11:39 AM, the surveyor observed Resident #98 inside a [redacted] room, the resident was in bed watching television.<br><br>The surveyor reviewed Resident #98's medical records.<br><br>The resident's Admission Record (or face sheet; an admission summary) revealed that Resident #98 was admitted to the facility with a diagnosis that included: [redacted]<br><br>The Admission Minimum Data Set (AMDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a Brief Interview for Mental | F 740 | Resident #98 [redacted] consult performed for behavioral health needs. Nursing received MD order for an out on pass from resident's attending physician. Resident #98 was educated on the procedure for signing in / out when going out on pass and that an assessment would be performed upon returning to the facility. All licensed staff caring for Resident #98 was in-serviced by the Director of Nursing on the new plan of care regarding assessment of the resident upon return to the facility when out on pass. 10/26/2022 all staff was in-serviced by the Regional registered nurse on the Out on Pass/Leave of Absence policy. 11/1/2022 the Social Worker and licensed nursing staff were in-serviced by the Director of Nursing on [redacted] services to be offered to residents for their physical, mental, and psychosocial well being. All residents were reviewed to determine if a referral to Behavioral Health services was indicated. All residents that go out on pass were reviewed to ensure MD orders were in place.<br><br>All residents have the potential to be affected by this deficient practice.<br><br>Director of Nursing or designee will conduct weekly audits being seen by behavioral health services to ensure | |

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| F 740 | Continued From page 85<br>Status (BIMS) score of [redacted], indicating that the resident was [redacted]. A review of Resident #98's Resident Mood Interview (D300) revealed that the resident a total severity score of [redacted] out of [redacted] indicating that the resident was [redacted].<br><br>The Progress Notes (PN) revealed the following:<br><br>a) Under the Physician Progress Note (PPN) (internal medicine note) dated [redacted] revealed that (Resident #98) had a tobacco use disorder and was on [redacted] replacement therapy and that the (resident) had an [redacted].<br><br>b) On [redacted] at 7:19 AM PN showed that the resident left the unit at 7 AM for out on pass and was advised not to [redacted] on the facility property while out on pass.<br><br>c) On [redacted] at 7:16 AM PN revealed that the resident left the facility at 7 AM, and was made aware by the Unit Manager (UM) that the resident's medications [redacted] (medication for [redacted] management) and [redacted] (medication for [redacted], and the (resident) became upset.<br><br>d) On 10/07/22 at 8:53 AM PN written by the UM revealed that the IDT (Interdisciplinary Team) met for a quarterly review of (Resident #98). The note showed that the resident was [redacted], independent with ADLs (activities of daily living), able to ambulate, continent of both bowel and bladder elimination, and with intact skin. In addition, the resident's [redacted] were recently titrated down (lowered the dose), and the (resident) was [redacted]. Also, the (resident) was found [redacted] in (their) bathroom, and the | F 740 | residents are being seen as needed. The Director of Nursing or designee will conduct daily audit of the out on pass signature sheet for Resident #98 compliance. Assistant Director or designee will provide continued education with current staff as well as newly hired staff on behavioral health services and the out on pass/leave of absence procedure.<br><br>Audits will be monitored for completion by the Administrator and Director of Nursing weekly for 4 weeks, every 2 weeks for 2 months and monthly for 3 months. Audits will be discussed during our monthly Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly. | |

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UM discussed the no-smoking policy in the building. Furthermore, the notes included that Social Worker (SW) will facilitate finding the residence in the community. The note included that the (resident) will be monitored for [redacted] consumption when [redacted] returns from out on pass (OOP).

e) On [redacted] at 7:12 PM PN included, "At around 3:50 PM SW came to nurse's station asked nurse on duty to inform MD (Medical Doctor) that (resident) threatening to go out to parking lot and [redacted]. MD was informed and order to send (resident) to Emergency Room (ER) for a [redacted] evaluation."

f) On [redacted] note showed that "10:45 PM the (resident) returned from hospital ER for [redacted] evaluation with no recommendation. Every [redacted] monitoring started no issues noted."

A review of Resident#98's [redacted] form that was dated [redacted] revealed that Resident #98 had an [redacted] and a [redacted] disorder. The [redacted] evaluated the resident and identified that the resident had no [redacted] but also wrote that a [redacted] of [redacted] was found in the resident's room.

The comprehensive individualized care plan revealed the following:
1. No care plan that addressed that the resident had a [redacted] disorder.
2. No care plan that addressed the resident had [redacted] disorder.
3. No care plan that the resident was using [redacted] ([redacted] for [redacted] disorder.
4. No care plan to address that the resident had an [redacted] disorder and no intervention to monitor

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the resident for [redacted] use, specifically since the resident frequently went OOP.
5. The care plan did not address the [redacted] that happened on [redacted] to include interventions and recommendations of the MD to monitor the resident.

The Order Summary Report (OSR) revealed a physician order dated [redacted] for [redacted] mg (milligram) 1 tablet (tab) by mouth every [redacted] hours for 14 days for [redacted].

On 10/25/22 at 02:16 PM, the surveyor team interviewed the SW who stated that she was familiar with Resident #98. The SW stated that the resident was [redacted] and could make their [redacted]. The resident was admitted to the facility for [redacted] care. The resident stay was extended after the facility was able to get [redacted] care from Medicaid when they were informed that the resident was evicted from their home.

On that same date and time, the SW stated that the resident was compliant until the resident started leaving the facility on OOP, then Resident #98's behavior started to change, and the resident started to become non-compliant with facility rules. She further stated that the resident was caught [redacted] and facility staff found an empty [redacted] inside the resident's room.

Furthermore, the SW informed the survey team that the facility on [redacted] provided the resident a 30-day discharge letter because the resident's non-compliance with facility rules could endanger the resident and all the residents at the facility. She further stated that the facility was going to initiate the letter earlier, but the resident tested

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| F 740 | Continued From page 88 [redacted] for [redacted] on [redacted]<br><br>On 10/26/22 at 9:31 AM, the survey team interviewed the Director of Nursing (DON) who stated that she was familiar with Resident #98. The DON stated that the resident is [redacted] and [redacted]. The DON further stated that the resident to be able to go OOP will need an order that will be part of the resident's medical record.<br><br>On that same date and time, the DON informed the surveyors that the facility was aware that the resident goes OOP. The DON was not aware of the IDT meeting that addresses the above concerns. The DON acknowledged that there should have created a care plan after the above incidents that will include interventions.<br><br>On 10/26/22 at 12:42 PM, the surveyor team interviewed the Licensed Nursing Home Administrator (LNHA) regarding the 30-day discharge letter that was provided to Resident #98. The LNHA stated that the discharge letter was presented to the resident due to being non-compliant with facility rules [redacted] in the facility) and [redacted] non-compliance could endanger all the residents at the facility.<br><br>On 10/26/22 at 4:15 PM, the surveyor in the presence of the SW interviewed Resident #98. The resident was seated in a wheelchair, [redacted] and was getting easily irritated. The resident stated that when they go to OOP, they will go with a friend who's helping the resident to find a place to live. The resident told the surveyor that they will leave the facility at 7 AM and will return between 10 PM to 12 midnight. The resident stated that when they leave the | F 740 | | |

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facility that they will sign out on the [redacted] floor and a staff member will come downstairs and let the resident out. The resident further stated that when he/she returns to the facility they will sign back in, but he/she is [redacted] and will forget at times to sign in. The resident also stated that when they return from OOP that nursing doesn't do a body assessment or check their belongings.

On 10/27/22 at 9:19 AM, the survey team interviewed Resident #98's physician. The physician stated that he was familiar with the resident and stated that the resident is [redacted]. The physician further stated that he saw the resident back on [redacted]. The physician was unaware that the resident was leaving the facility on OOP. The physician stated that the resident needed the order to go out on pass, and did not remember providing an order for OOP. He followed up that he would have not authorized the resident to leave the facility.

At that same time, the physician stated that he was not aware that the resident was caught [redacted] in their room and that the nursing staff found a [redacted] in the resident's possessions. The physician further stated that if he knew the resident was [redacted], he would have never written an order for [redacted] and he would have made sure that the resident was on a [redacted] program, he was unaware that the resident had no active order for [redacted] patches.

Furthermore, the physician stated that he was unaware that the facility gave the resident a 30-day discharge letter. The physician stated that a discharge letter required a physician order and nobody at the facility requested for him to write an

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order. The physician is unable to speak with a care plan and interventions that will direct the care of the resident to address the behavior and noncompliance of the resident concerning [redacted], and safety and if the team met to discuss the above concerns.

On 10/27/22 at 12:25 PM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that she did not observe the resident [redacted]. The LPN stated that she was notified by another nurse who was doing a treatment that she smelled [redacted] coming from the resident's room. She further stated that she went into the resident's room and smell a strong smell of [redacted] She asked the resident if they were [redacted], and the resident handed her a [redacted].

On that same date and time, the LPN stated that the resident was non-compliant and when the resident tested positive for [redacted] that she found an empty [redacted] in the resident's belongings. The LPN stated that when the resident returned from OOP that the resident appeared [redacted] and will go right into their room. She acknowledged that she did not assess or check Resident #98's belongings when they returned from OOP. The LPN showed the surveyor the empty [redacted] that she found in the resident's room. The bottle was kept inside the facility's medication room. When the surveyor followed up with the LPN regarding the resident appearing [redacted] when they return from OOP. The LPN stated that the resident always look a little [redacted] and it was not enough evidence to make her concerned. The LPN is unable to speak with a care plan and interventions that will direct the care of the resident to address the behavior

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| F 740 | Continued From page 91 | F 740 | | |

and noncompliance of the resident concerning [redacted], and safety.

On 10/31/22 at 9:15 AM, the surveyor interviewed the LPN regarding things that should have been put in place by the facility to address Resident #98's [redacted] disorder. The LPN stated that the resident has a history of [redacted], and the facility should have had a [redacted] consult and should have been evaluated for [redacted]. She further stated that some of the interventions that should have been put in place were for staff to monitor the resident's behaviors and changes in mood. The resident should have been assessed to make sure they were not consuming [redacted]. She also stated that the facility should have created a care plan specific for the resident's [redacted] with interventions that would detect and monitor if the resident is consuming [redacted] especially since the resident is always going out on leave. Finally, the LPN stated due to [redacted] age and [redacted] that she felt that this was not the right facility for the resident. The resident needed to be at a rehabilitation center that could help the resident with their [redacted].

On 11/01/22 at 01:05 PM, the surveyor met with two RLNHAs, DON, Regional Registered Nurse (RRN), and was made aware of the above concern.

A review of the facility's policy for Behavioral Health Services that was undated and was provided by the Regional RN indicated the following:

"It is the policy of this facility that all residents receive care and services to assist him or her to

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| F 740 | Continued From page 92<br>reach and maintain the highest level of mental and psychosocial functioning."<br><br>"The facility will ensure that each resident receives the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care."<br><br>"Behavioral health includes a resident's entire emotional and mental health, which includes the prevention and treatment of mental and substance use disorder."<br><br>On 11/03/22 at 12:23 PM, the survey team met with the two Regional LNHAs, DON, and RRN. The facility team did not provide additional information. | F 740 | | |
| F 755 SS=E | NJAC 8:39-5.1 (d)<br>Pharmacy Srvcs/Procedures/Pharmacist/Records<br>CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. | F 755 | | 1/20/23 |

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| F 755 | Continued From page 93<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to ensure daily inventory reconciliation (count) of controlled substance medications (narcotic medications) from August 2022 until October 24, 2022, as per facility policy. This deficient practice was identified for one of one electronic emergency (backup) storage machine [name redacted] and was evidenced as follows:<br><br>On 10/24/22 at 11:04 AM, the surveyor requested the [name redacted] Controlled Substance Report (CSR) from the Director of Nursing (DON).<br><br>On 10/24/22 at 11:30 AM, during an interview with the surveyor, the DON informed the surveyor that the backup machine was checked for the minimum and maximum quantity inventory limits, and expired medications, were audited and counted every day. This task was completed by | F 755 | The Director of Nursing initiated a Backup Narcotic Log for daily reconciliation of controlled substance medications. Unit Managers were educated on the Backup Narcotic Log and the process for daily reconciliation of controlled substance medications.<br><br>All residents have the potential to be affected by this deficient practice.<br><br>Director of Nursing or designee will audit the daily log to ensure reconciliation of medications are completed and signed each day.<br><br>Audits will be monitored for completion by the Administrator and Director of Nursing weekly for 4 weeks, every 2 weeks for 2 months and monthly for 3 months. Audits | |

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| F 755 | Continued From page 94<br>her (the DON) and the Unit Managers (UMs). The DON further stated that this task was also required of the Assistant Director of Nursing (ADON), and at that time was a vacant position.<br><br>On 10/24/22 at 11:49 AM, the surveyor in the presence of the second-floor Licensed Practical Nurse/Unit Manager (LPN/UM) and the DON entered the room that contained the backup machine. The surveyor observed that the facility did not have a backup paper narcotic log (narcotic log; paper version of the CSR). The DON and LPN/UM confirmed that the facility did not have a narcotic log for the backup machine. The DON also stated that the backup machine displayed the name of the narcotic medication but not all the narcotic medication had a corresponding quantity displayed. The DON was uncertain about how to print the CSR.<br><br>At that time, the unit inspection of the backup machine could not be conducted without the CSR or the narcotic log.<br><br>On 10/24/22 at 12:25 PM, the surveyor received the CSR for October 1, 2022, to October 24, 2022, from the Regional DON (RDON).<br><br>On 10/24/22 at 01:22 PM, the surveyor in presence of LPN/UM and RDON conducted the unit inspection of the backup machine.<br><br>At that time, the surveyor reviewed the CSR which indicated the name of the medication, date, time the machine was used, name of the patient [the intended resident recipient of the medication], quantity before removal, dose(s) removed from the machine, quantity remaining after removal, names of the employees involved, | F 755 | will be discussed during our monthly Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly. | |

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| F 755 | Continued From page 95 | F 755 | | |

discrepancy reason, the daily log when the narcotics were reconciled for accountability and quantity remaining (on-hand) of each narcotic during the nurses' shift to shift change.

Further review of the report from 10/01/22 to 10/24/22, revealed that 19 of 19 narcotic medications were not counted daily to verify the on-hand remaining during the nurses' shift-to-shift change.

On 10/24/22 at 01:30 PM, the surveyor interviewed the LPN/UM who confirmed the facility did not have a narcotic log for the backup machine. The LPN/UM stated she worked Monday through Friday and the Registered Nurse (RN) scheduled on the weekend completed the weekend on-hand counts. LPN/UM was unable to recall the process in the event of a discrepancy occurring during the on-hand count.

On 10/24/22 at 03:15 PM, the surveyor received the CSR for August 2022 to September 2022, which reflected the following:

-September 2022, 19 of 19 narcotic medications were not counted daily to verify the on-hand remaining during the nurses' shift to shift change.
-August 2022, 19 of 19 narcotic medications were not counted daily to verify the on-hand remaining during the nurses' shift to shift change.

On 10/24/22 at 04:30 PM, during an interview with the surveyor, the RDON stated that the CSR was used as an audit tool for narcotic count inventory. He acknowledged the missing dates on the CSR for August 2022, September 2022, and October 2022. The RDON stated that the narcotic audit for accountability and reconciliation

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| F 755 | Continued From page 96<br>should have occurred daily and was important for replenishment of stock, accuracy, and diversion. The RDON further stated the matter was addressed after surveyor inquiry.<br><br>A review of facility policy provided, Controlled Substance last reviewed 08/22, include but was not limited to the following:<br>Policy<br>It is the policy of this facility to promote, safe high quality patient care, compliant with state and federal regulations regarding monitoring the used of controlled substances. The facility will have federal safeguards in place to prevent loss, diversion, or accidental exposure.<br>Policy Explanation and Compliance Guidelines<br>General Protocols<br>2. The Director of Nursing ("DON") as designated by the facility, will be responsible for ensuring the facility's compliance with the terms of the policy.<br>Accounting for Back-Up stock Controlled Substances.<br>1. Back-Up Controlled Substances will be counted daily by the incoming and outgoing Unit Manager/Nurse Supervisor/Designee for accuracy of the number of doses currently on hand<br><br>NJAC 8:39-29.4(k); 33.1(d) | F 755 | | |
| F 756 SS=E | Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. | F 756 | | 1/20/23 |

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| F 756 | Continued From page 97<br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§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.<br>(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.<br>(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.<br>(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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to follow up on the Consultant Pharmacist's (CP) recommendations and report of irregularities for 4 of 27 residents (Resident #29, #46, #47, and #95) | F 756 | Resident #29' PRN [redacted] physician order was updated to reflect the duration of the medication order. Resident#46 following [redacted] parameters was addressed with all licensed nursing staff. | |

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| F 756 | Continued From page 98<br>reviewed for Medication Record Review (MRR).<br><br>This deficient practice was evidenced by the following:<br><br>1. On 10/13/22 at 11:28 AM, the surveyor interviewed Resident #29 in the resident's room. The resident was [redacted], appeared calm and pleasant.<br><br>The surveyor reviewed the resident's medical records.<br><br>The Admission Record (or face sheet; an admission summary) reflected that the resident was admitted to the facility with a diagnoses that included but were not limited to [redacted].<br><br>The Quarterly Minimum Data Set (QMDS), an assessment tool used for the management of care dated [redacted], revealed a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated that the resident was [redacted].<br><br>The [redacted] through [redacted] electronic Medication Administration Record (eMAR) included a documented Physician Order (PO) dated [redacted] for [redacted] mg (milligram) to give one tablet (tab) by mouth every [redacted] hours as needed (PRN) for [redacted].<br><br>The [redacted] eMAR documented the use of [redacted] mg give one tab every [redacted] hours PRN for [redacted] times for the month. There was no further documentation in the medical | F 756 | Resident #47's physician orders were updated to reflect the amount consumed for all supplements and fortified foods. Resident #95's orders were updated to reflect the amount consumed for supplements. 11/1/2022 all licensed nursing staff was in-serviced on documenting the duration for PRN [redacted] medications by the Director of Nursing. 11/1/2022 all licensed nursing staff was in-serviced on hold parameters for [redacted] medications. Licensed nurses and certified nursing assistants were in-serviced on documenting the amount consumed for supplements and fortified foods. 11/1/2022 the Director of Nursing in-serviced licensed nurses on completing the Pharmacy Consultant recommendations / therapeutic suggestions within 24 hours of the recommendation.<br><br>All residents have the potential to be affected by theis deficient practice.<br><br>The Director of Nursing or designee will audit any new PRN psychoactive medication orders daily to ensure the duration of medication does not exceed 14 days. If not used within the 14 days the nurse is to communicate with the MD to discontinue the order. The Director of Nursing or designee will audit daily [redacted] medications with parameters for compliance of medication administration. Interventions including education to be provided if nurse found not following MD order. Weekly the dietitian or designee will audit residents with an order for nutritional | |

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| F 756 | Continued From page 99<br>record which showed that Ativan was used after June of 2022.<br><br>Review of the CP Therapeutic Suggestions (MRR) sheets presented to the facility on [redacted] referred for Resident #29, "A duration must be specified for PRN [redacted] medications. First order is limited to only 14 days, but if rationale documented by prescriber to continue order, then the next duration may be longer, i.e.,30,60, or 90 days. Please update order for [redacted] per CMS regulations."<br><br>The above CP Evaluation for Resident #29 revealed that the CP recommended on [redacted], [redacted] and [redacted] that the PRN [redacted] needed a duration.<br><br>On 11/1/22 at 01:07 PM, the surveyor brought the concern to the Director of Nursing (DON). The surveyor after reviewing the CP Therapeutic Suggestions which showed no responses from the physician asked the DON if she can supply the surveyor with the physician responses.<br><br>At that time, the DON was unable to provide the physician responses to the CP Therapeutic suggestion. Then the surveyor asked the DON who reviews the CP Therapeutic Suggestions. The DON stated that the CP Therapeutic Suggestions are reviewed by the Unit Manager (UM) and it was the UMs job to notify the physician. The DON acknowledged that the physician should have responded to the CP Therapeutic Suggestions.<br><br>The surveyor was unable to interview the [redacted] floor UM because she was on vacation. | F 756 | supplements and /or fortified foods to ensure the amount consumed is documented daily. Intervention including education to be provided to staff if found not following MD order. Monthly the Director of Nursing or designee will audit the Pharmacy consultant Recommendations/Therapeutic Suggestions report for completion by nursing and the physician. The Assistant Director of Nursing or designee will provide ongoing education with staff documenting the duration for PRN [redacted], noting [redacted] parameters, Pharmacy Consultant Recommendations/Therapeutic Suggestions and documentation of the amount consumed for supplements/fortified foods at least anually, upon hire and as needed.<br><br>Audits will be monitored for completion by the Administrator and Director of Nursing weekly for 4 weeks, every 2 weeks for 2 months and monthly for 3 months. Audits will be discussed during our monthly Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly. | |

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A review of the facility's policy for Use of [redacted] Medications that was undated and was provided by the DON and indicated the following:

"PRN orders for all [redacted] drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record and for a limited duration (i.e 14 days)."

2. On 10/17/22 at 6:24 AM, the surveyor observed Resident #46 laying on the bed, calm and pleasant while conversing with Certified Nursing Aide#1 (CNA#1).

The surveyor reviewed the medical records of Resident #46.

The Admission Record (AR) showed that the resident was admitted to the facility with diagnoses including, but not limited to the following: [redacted]

The QMDS dated [redacted] had a BIMS score of [redacted] out of [redacted], meaning the resident had [redacted].

The PO dated [redacted] included [redacted] Tab [redacted] mg to give one tab by mouth three times a day for [redacted]) and to hold for [redacted]) less than [redacted]

The above order was transcribed to the eMAR for [redacted], and [redacted] There were

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| F 756 | Continued From page 101<br>[redacted] of 31 days in [redacted], [redacted] of 31 days in [redacted], and [redacted] of 31 days in [redacted] in eMAR that the medication [redacted] was given beyond the parameter (a certain number when you would not give the medicine).<br><br>The CP MRR from [redacted] through [redacted] showed that there was a review that the [redacted] medication was being administered outside of the parameters, which means that the PO dated [redacted] was not being followed and that medication was being given when the [redacted] was greater than [redacted].<br><br>The above CP MRR was seen on [redacted], [redacted], and [redacted] the pharmacist's monthly reports that the [redacted] is not always held as required by the physician hold order, advising the facility to please review, and follow physician orders.<br><br>On 11/01/22 at 11:55 AM, the surveyor interviewed the [redacted] floor nurse regarding the medication [redacted]. Licensed Practical Nurse#1 (LPN#1) stated that [redacted] was given to residents with [redacted], and doctors usually order a parameter for [redacted]. The surveyor asked the nurse what could happen if the resident was given the medicine when the [redacted] was outside of the parameters, and the nurse said the resident would end up with [redacted].<br><br>On 11/01/22 at 12:00 PM, the surveyor interviewed the [redacted] floor nurse LPN#2 who was caring for Resident #46. LPN#2 stated that the resident's [redacted] was monitored, and the resident had an order not to give the medication if the [redacted] was greater than [redacted] LPN#2 further | F 756 | | |

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| F 756 | Continued From page 102<br>stated that Resident 46's [redacted] was [redacted] today, "so it was not given". LPN#2 then told the surveyor that the resident does not need the medication much because the [redacted] was higher than the parameter.<br><br>On 11/01/22 at 01:33 PM, during an interview of the surveyor with the DON. The DON explained that if there were any recommendations, the unit manager would get the information and address the issues that were presented by the pharmacy consultant.<br><br>3. On 10/13/22 at 10:39 AM, the surveyor observed Resident #47 seated in a wheelchair, awake and alert. The resident was able to maintain eye contact and smiled at the surveyor; however, he/she did not respond to the surveyor's inquiry.<br><br>The surveyor reviewed Resident #47's hybrid medical records:<br><br>The AR showed that the resident was admitted to the facility with diagnoses that included [redacted]<br><br>The Annual MDS (AMDS) dated [redacted] and QMDS dated [redacted], revealed a BIMS score of [redacted] out of [redacted], which reflected that the resident had a [redacted].<br><br>The Order Summary Report (OSR) reflected a PO with an order date of [redacted] that included "Health Shake three times a day for [redacted] DOCUMENT % OF AMOUNT CONSUMED". | F 756 | | |

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| F 756 | Continued From page 103<br><br>The OSR reflected a PO with an order date of [redacted] that included "[redacted] one time a day DOCUMENT % OF AMOUNT CONSUMED" and "[redacted] one time a day DOCUMENT % OF AMOUNT CONSUMED".<br><br>The CP's Monthly Report dated [redacted] reflected a pharmacy recommendation for nursing to "update order to include documentation of amount consumed for the supplement [redacted], and Healthshake."<br><br>The [redacted] and [redacted] eMAR reflected the following PO:<br><br>"Health Shake three times a day for [redacted] 4 oz (ounces)" that was plotted to be given at 1000 (10:00 AM), 1400 (02:00 PM), and 2100 (9:00 PM).<br><br>[redacted] one time a day" was plotted at 0800 (8:00 AM).<br><br>[redacted] one time a day" was plotted at 1200 (12:00 PM).<br><br>There was no documented evidence of accountability for the resident's amount of consumption of the health shakes, [redacted] and [redacted] supplements in the September and [redacted] eMAR. The above recommendations of the CP on [redacted] was not followed.<br><br>On 10/25/22 at 10:13 AM, the surveyor interviewed LPN#2. She acknowledged that the resident has PO for a health shake, [redacted] and [redacted]. She informed the surveyor that | F 756 | | |

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the [redacted] and [redacted] came with the resident's meal trays while the health shakes were given separately.

During the interview, LPN#2 informed the surveyor that the consumption amount for the [redacted], health shake, and [redacted] should be documented in the resident's eMAR. The LPN acknowledged that there was no "actual physical amount" recorded in the resident's eMAR from [redacted] through [redacted]. She stated that there was no evidence of accountability for the resident's consumption amount for these supplements.

On 10/25/22 at 10:30 AM, during the follow up interview of the surveyor with LPN#2, LPN#2 informed the surveyor that the CP comes to the facility once a month. She stated that if there were CP's recommendations, the CP will "immediately" verbally notify the UM, then the UM would "carry out" the recommendations. She further stated that the "typed written" CP recommendations will be send to the UM in "about a week or so." Additionally, LPN#2 stated that the UM was responsible for carrying out the CP's recommendations.

On 10/26/22 at 11:41 AM, CNA#2 informed the surveyor that the resident received a health shake at 10 AM and 2 PM during her 7-3 shift. She also stated that the resident received [redacted] with the breakfast tray and a [redacted] with the lunch tray. She informed the surveyor that she observed the resident take these supplements with variable amounts depending on the resident's mood, from "25-100%." She stated that she reported the supplement consumption amount to the nurse. However, she

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acknowledged that there was no accountability for the supplement amount consumption because there was no paper form to document them.

On 11/1/22 at 01:02 PM, the two Regional LNHA, DON, and Regional RN (RRN) met with the survey team and were made aware of the above concerns.

4. On 10/13/22 at 11:42 AM, the surveyor observed Resident #95 laying on the bed with their eyes closed.

The surveyor reviewed the resident's medical records:

The AR disclosed that the resident had diagnoses that included but were not limited to [redacted]

The AMDS dated [redacted] showed that the resident had a BIMS score of [redacted] out of [redacted] which means that the resident's cognition was [redacted]

The [redacted] OSR showed an active order dated [redacted] for [redacted] one time a day for [redacted] maintenance 6 oz.

From [redacted] through [redacted], the eMAR revealed that the above corresponding physician's orders for the [redacted] did not include the documentation of the amount

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consumed for the supplement.

The Consultant Pharmacist's Monthly Report (CPMR) dated [redacted]2 reflected the CP's recommendation to "Please update order to include documentation of amount consumed for the supplement [redacted]."

A review of the [redacted], and [redacted] eMAR showed that the [redacted] amount intake was not documented and the recommendation of the CP's on [redacted] was not followed.

On 10/18/22 at 11:18 AM, the surveyor interviewed the Registered Nurse (RN). The RN stated that it was the UM's responsibility to respond to the CP's review and recommendations. She further stated that the resident is currently on specialized fortified food and supplements. The RN indicated that the resident's appetite varies. The surveyor asked the RN if she documented the amount of the supplements and the RN had no answer.

On 10/31/22 at 02:06 PM the survey team met with Regional LNHA#1, RRN, DON, and surveyor to discuss the above concerns.

On 11/01/22 at 12:56 PM, the survey team met with Regional LNHA #1 and #2, RRN, and the DON. The surveyor asked the facility management who was responsible for addressing the CP's recommendations. The DON stated that it was the UM's responsibility to respond to the CP's MRR. Then the surveyor asked why it was not done, the facility management did not respond. Later on, the DON stated that UM in the [redacted] floor unit was not the UM at that time on

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| F 756 | Continued From page 107<br>[redacted] which is why the [redacted] MRR recommendations were not followed.<br><br>On 11/03/22 at 10:37 AM, the surveyor interviewed the Licensed Practical Nurse/UM (LPN/UM) in the [redacted]-floor unit. The LPN/UM informed the surveyor that she started as a UM in the facility on [redacted] She further stated that she was not responsible for the [redacted] MRR recommendations of the CP and that she started "doing the MRR in [redacted]." She indicated that she was aware of the responsibility of the UM to make sure that the MRR recommendations will be followed up and that the supplement should be recorded in the eMAR with the amount intake.<br><br>A review of the facility's Medication Regimen Review dated 9/2022 that was provided by the DON, included "Policy Explanation and Compliance Guidelines: 1. Medication Regimen Review (MRR), or Drug Regimen Review, is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication.....7. Timelines and responsibilities for Medication Regimen Review:...f. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities."<br><br>On 11/03/22 at 11:36 AM, the survey team met with Regional LNHA #1 and #2, RRN, and the DON. There was no additional information was provided by the facility team.<br><br>NJAC 8:39-29.3 (a) (1) (6) | F 756 | | |

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| F 835 SS=L | Administration CFR(s): 483.70<br><br>§483.70 Administration.<br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Complaint NJ00157677<br><br>Refer F689, and F836<br><br>Based on observations, interviews, review of medical records, and review of facility documents, it was determined that the facility's Licensed Nursing Home Administrator (LNHA) failed to ensure that the policies and procedures were implemented to ensure resident safety and well-being to prevent serious harm, by failing to: a.) identify sufficient staffing numbers to address the population census and needs of their residents, and b.) ensure they were also meeting New Jersey state minimum staffing requirements for 32 of 42 total shifts over a two week period of time from 9/25/22 through 10/08/22, yet the LNHA continued to allow the admission of seven (7) new residents during this two week period prior to survey.<br><br>The LNHA's failure to identify their sufficient staffing benchmark and include it in the Facility Assessment and the failure to ensure the New Jersey state minimum staffing requirements were being met by a wide margin, all while continuing to admit new residents to the facility places all residents at risk for serious harm, impairment, or | F 835 | 10/24/2022 the Facility Assessment was reviewed and updated to the include the sufficient staffing assessment component. The update included staffing ratios that meet, at the minimum, state staffing requirements with consideration made based on census, acuities and special needs of residents. At a minimum CNA Staffing Ratios will be 1 cna to 8 residents on 7-3 shift; 1 cna to 10 residents on 3-11 shift; 1 can to 14 residents for 11-7 shift. 10/24/22 three Healthcare agenices were contracted to assist with meeting staffing requirements. 10/24/22 Provided premium pay to current staff who agrees to work or cover an additional cna shift. 10/24/22 a regional Administrator was appointed by the governing body to be responsible for the management and overall operation of the facility. 10/24/22 admissions were curtailed.<br><br>All residents have potential to be affected by this deficient practice.<br><br>Review of staffing sufficiency Monday through Friday with weekend projection of staffing sufficiency review on Friday by the | 1/20/23 |

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| F 835 | Continued From page 109<br>death if not corrected.<br><br>It was determined that the facility's LNHA had not ensured sufficient Certified Nursing Aide staffing for 14 of 14 day shifts in which most days, the facility was only meeting half of the required CNA's for the day shift (CNA's had between 13 to 26 residents each on their assignment when the NJ state requirement is 1 CNA to 8 Residents for the day shift). The Facility was also deficient in staffing the evening (3-11 PM) shift for 4 of 14 evening shifts, and 14 of 14 night (11 PM- 7 AM) shifts.<br><br>Staff interviews revealed "short staffing" had impacted resident outcomes, including Resident#47 who had 11 falls over the last six months, and seven of them were unwitnessed despite occurring in common areas. As a result of the [redacted] Resident#47 developed serious harm including [redacted] and [redacted]<br><br>The failure of the LNHA to ensure the facility established and maintained systems that were effective and efficient to operate the facility in a manner to safely meet resident's needs in compliance with federal, state, and local requirements as outlined in the Administrator Job Description, resulted in an Immediate Jeopardy (IJ) situation that began on 5/26/22. The facility's LNHA was notified of the IJ on 10/24/22 at 4:16 PM. The acceptable removal plan was submitted and verified by the survey team on 10/25/22 at 12:55 PM.<br><br>This deficient practice was evidenced by the following: | F 835 | Administrator, Director of Nursing and Staffing Coordinator to ensure certified aide shifts are covered and actions such as calling staff and agency coordinators is taken to minimize non-compliance. The staffing coordinator and Director of Nursing or designee maintain communication with the facility nursing staff on weekends to facilitate staffing coverage if needed. The facility will employ staff from healthcare agencies to fill staff openings until sufficient staff is hired to meet required staffing levels. Staffing coordinator, Administrator and Director of Nursing review resident ratios for every shift to determine sufficient staff to resident ratios at least weekly until staffing is stabilized and then for 3 months. Staff recruitment with regional recruiter and planning of recruitment events. Bonus' to staff for filling open shifts.<br><br>The facility licensed nursing home administrator will forward weekly reports to Department of Health and Senior Services of mitigating strategies for staffing until admission curtailment is lifted. Staffing grid submitted daily to NJDHSS. Staffing, turnover trends and recruitment efforts to be reported to Quality Assurance Performance Improvement Committee at each meeting monthly. | |

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A review of the facility's "Position Title: Administrator", revealed that the Position Summary of the Administrator included but was not limited to:

a) Comply with standards of business conduct in accordance with federal, state, and local health and regulatory standards and guidelines, as applicable.

b) Must maintain the highest standards in caring and servicing the needs of the residents and residents' family members and loves ones.

c) Must adhere to all facility policies and procedures.

The "Position Title: Administrator", showed that the Responsibilities/Accountabilities of the Administrator included but were not limited to:

a) Administrator is responsible for planning and is accountable for all activities and departments subject to rules and regulations promulgated by government agencies to ensure proper health care services to residents.

b) Concerns his/herself with the safety of all nursing facility residents in order to minimize the potential for fire and accidents.

c) Ensures that residents and families receive the highest quality of service in a caring and compassionate atmosphere which recognizes the individuals' needs and rights.

d) Protects residents from abuse, and cooperates with all investigations.

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The survey team has identified that due to inadequate supervision and not following protocols, one resident (Resident #47) has had multiple unwitnessed [redacted] in common areas resulting in serious harm with [redacted], due to inadequate supervision and not implementing their systems (investigating and updating care plan) to prevent recurring [redacted]

The LNHA's failure to assess their sufficient staffing par levels, and not following the state minimum staffing requirement while continuing to admit new residents to the facility places all residents at risk for the lack of supervision to prevent serious adverse outcomes, including [redacted] with a major injury.

1. On 10/18/22 at 11:35 AM, the surveyor asked the Director of Nursing (DON) to provide all the supporting documentation related to Resident #47's [redacted] incidents from [redacted] through [redacted]. The DON acknowledged to the surveyor that she gave "all" the documentation related to the resident's [redacted] investigations except the hospital records. She informed the surveyor that the neuro checks were completed in a paper form titled [redacted] Evaluation Flow Sheet, which was attached to the fall reports that were given to the surveyor.

On the same day at 12:07 PM, the Regional DON (RDON) and DON met with the survey team. The RDON informed the surveyors that the staff and resident statements for fall investigations were paper documentation. The RDON stated that the statements were part of the fall investigation and

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should be attached to the [redacted] incident report. He further stated that after obtaining statements, the UM (Unit Manager), DON, and LNHA would do a "full investigation" which included a [redacted] summary and conclusion.

At that same time, the RDON stated that the "interim" [redacted] investigation report should be electronically entered "immediately" and "completely" by the nurse within the shift. He stated that the printed interim [redacted] report would go to the UM to investigate for completion, then the DON and LNHA were made aware of the investigation. The RDON acknowledged the [redacted] incident investigations and reports were not being completed. The DON also agreed and stated the completion of the investigation process "was not being done."

On 10/18/22 at 12:07 PM, the survey team met with the RDON and DON. The surveyor asked the facility team what is the facility's protocol and standard of practice concerning the investigation/incident/accident reports. The RDON informed the surveyor that as per facility policy and protocol, once the incident/accident was identified by staff, the staff will initiate to document the investigation, and nursing staff will take statements from staff. The RDON stated that for example if the incident was about [redacted], the facility will require lookback statements from staff at least 72 hours, a full investigation to be done by the DON, UM, and the LNHA. He further stated that there should be a summary conclusion that will be put together in a separate paper.

On that same date and time, the surveyor asked the facility team if the above information, policy, and protocol for an investigation of an

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incident/accident were being followed for all residents including Resident #47. The RDON stated that he was the interim DON from [redacted] through [redacted] and it was not being done according to facility protocol because it was "chaos here."

At that time, the DON stated that when she became the DON, the policy and protocol for investigating an incident/accident was not followed. Then the surveyor informed the facility team of the above concerns.

The survey team reviewed the staffing for the dates and shifts on the unit associated with each [redacted]. The staffing assignment sheets revealed the following:
5/26/22:
Census: 44
4 CNA
2 Nurses

6/2/22:
Census: 45
3 CNA
2 Nurses

6/7/22:
Census: 45
3 CNA
2 Nurses

6/26/22:
Census: 53
4 CNA
2 Nurses

7/12/22:
Census: 54

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| F 835 | Continued From page 114<br>5 CNA<br>2 Nurses<br><br>7/17/22:<br>Census: 54<br>4 CNA<br>2 Nurses<br><br>8/17/22:<br>Census: 57<br>4 CNA<br>2 Nurses<br><br>8/23/22:<br>Census: 55<br>4 CNA<br>2 Nurses<br><br>8/29/22:<br>Census: 55<br>3 CNA<br>2 Nurses<br><br>10/3/22:<br>Census: 51<br>3 CNA<br>2 Nurses<br><br>10/10/22:<br>Census: 51<br>3 CNA<br>2 Nurses<br><br>On 10/19/22 at 11:32 AM, two surveyors interviewed Licensed Practical Nurse/Unit Manager (LPN/UM). She informed the surveyors that she was responsible for the care plan initiation and revision. She stated that "every [redacted], there should be new intervention." She | F 835 | | |

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acknowledged that the resident had multiple [redacted] and his/her [redacted] care plan was not updated on every [redacted]. She stated that the resident's [redacted] care plan interventions should have been adjusted accordingly on each fall to prevent the resident from future [redacted], but that it wasn't updated. LPN/UM stated that the resident had no safety awareness and needed continuous 1 on 1 observation "only when they can due to short staffing." She also acknowledged that the resident's [redacted] investigation reports were incomplete.

On 10/24/22 at 11:54 AM, the survey team met with the Regional Registered Nurse (RRN), DON, and LNHA, and were made aware of the above concerns that the facility LNHA was aware of the above investigations of Resident #47's [redacted] incidents with major injuries that the investigation process was not being done, and the care plan was not updated to reflect the interventions that will prevent the further [redacted] and injuries.

2. Upon a review of the Facility Assessment (FA), it was determined that the facility did not assess its benchmark (a standard or point of reference against which things may be compared or assessed) of sufficient staff numbers necessary to serve its resident population based on an average census and specific needs. The Facility Assessment was generic regarding staffing and had only specified that they would provide "sufficient staff" but there were neither numeric values for staffing nor did it address what "sufficient" staffing meant.

Despite not assessing their sufficient staff numbers within their Facility Assessment (dated October 15, 2021 to October 14, 2022) and in

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addition, not meeting the state minimum staffing requirements by a significant margin, the facility continued to admit new residents to their facility, particularly [redacted] new residents from [redacted] to [redacted] during this two week period of time in which staffing was evaluated. The facility continued to admit new residents through [redacted]

Interviews with the LNHA revealed that they could not speak to why they continued to admit new residents despite their significant staff deficit to care for the residents currently residing there. He was unable to speak to their Facility Assessment and why they had not assessed and documented their sufficient staff numbers/benchmark. The LNHA acknowledged that they were not meeting the State Minimum staffing requirement.

On 10/17/22 at 11:45 AM, the surveyor interviewed the LNHA, the DON, and the RDON in the presence of a second surveyor. The RDON stated that "instead of getting better the staffing issues have been getting worse." He stated that it had been a struggle to use agencies because "they get grabbed up quick." He further stated that when they did hire and orient staff, they did not return. The LNHA stated that they had hired hospitality aides and acknowledged that they were not able to provide direct resident care.

On that same date and time, the LNHA could not speak to why the facility continued to admit new residents when they were aware of their inability to provide sufficient staff. He stated that "which comes first if there are no admissions, we won't have money to pay for the staff." He further stated that "we try not to admit clinically complex residents." The LNHA could not speak to the

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facility's ability to provide appropriate care to the residents with insufficient staff.

At the same time, the RDON stated that "we have borrowed staff from other places to come here." The surveyor stated that there was one CNA for 53 residents on the 11 PM -7 AM night shift for the [redacted]-floor last night. The LNHA stated that "no" he was not aware of that. The RDON stated that "this should never have happened." The administrative team could not speak to why the facility continued to admit new residents with insufficient staff. In addition, the LNHA stated that "I can't provide an adequate answer to that question."

Furthermore, the DON stated that there had not been a nursing supervisor for the 11 PM -7 AM night shift for the last nine months and none for the 3 PM-11 PM evening shift since [redacted]. The LNHA and the RDON acknowledged the DON's statement. The RDON stated that "I agree there should be no admissions..." since the staffing was so short. The RDON added, "I am going to take care of that." The DON added, "I agree."

On 10/24/22 at 12:58 PM, the survey team met with the LNHA, the RRN, and the DON about the FA which was provided by the RDON on 10/14/22 at 12:48 PM. The LNHA stated that "I completed the FA." The LNHA could not speak to the benchmarks he used or how it was determined that staffing was sufficient. He stated that some of the numbers used for the FA came from the "MDS (Minimum Data Set, a tool used to facilitate the needs of a resident) and PBJ (payroll-based journal)." He was unable to speak to how he completed the FA, or if anyone else participated.

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Furthermore, the facility's administrative team including the LNHA could not speak to how the FA was determined and completed and requested the opportunity to review it and would further respond to the survey team.

A review of the "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two weeks beginning [redacted] and ending [redacted] revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements of CNAs on 14 of 14-day shifts, deficient in total staff for residents on 4 of 14 evening shifts, and deficient in total staff for residents on 14 of 14 overnight shifts.

A review of the list of new admissions from [redacted] to [redacted] revealed that the LNHA allowed for seven new admissions to the facility despite knowledge of the lack of staff to care for the residents that currently resided at the facility.

On 10/24/22 at 4:16 PM , the survey team met with the LNHA, DON, RDON, and the RRN. The failure of the LNHA to assess sufficient staffing benchmark in the FA, identify and provide state minimum staffing requirement while continuing to admit new residents places all residents at risk for serious harm, impairment or death. The LNHA's knowledge according to staff interviews revealed "short staffing" had impacted resident outcomes, including Resident #47 who had [redacted] over the last [redacted] months, and [redacted] of them were unwitnessed despite occurring in common areas, as a result of the [redacted], Resident #47 developed serious harm including [redacted], [redacted] with [redacted],

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and [redacted]. In addition, the failure of the LNHA to ensure the facility established systems that were effective and efficient to operate the facilitate in a manner to safely meet resident's needs in compliance with federal, state, and local requirements as outlined in the Administrator Job Description, resulted in an IJ situation that was identified.

On 10/25/22 at 11:30 AM, the surveyor met with the RRN and RLNHA#1. The RRN informed the surveyor that the RLNHA#1 started yesterday ([redacted]) and will oversee the LNHA until the facility's problems will be corrected. RLNHA#1 stated that "we understand" the staffing concerns and we will make sure to cover and address the concern.

On 10/25/22 at 12:55 PM, the survey team met with the RRN, Regional LNHA #1. The facility management provided a copy of the facility's removal plan. The team verified the removal and lifted the IJ.

On 10/26/22 12:42 PM, after the survey team interviewed the LNHA and left the conference room, RLNHA#1 entered the room and introduced RLNHA#2 to the survey team. RLNHA#1 stated that her and RLNHA#2 will be covering for the LNHA until the facility find another administrator.

A review of the "Facility Assessment" policy with a revised date of 9/2022, reflected that "The facility will conduct and document a facility-wide assessment to determine what resources are necessary to care for its resident competently during both day-to-day operation and emergencies." It also reflected that "The facility

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| F 835 | Continued From page 120<br>assessment will include but not limited to the following: ... The care required by the resident population considering the types of diseases, condition, physical and cognitive disabilities, overall acuity and other pertinent facts that are present within the population." In addition, the policy reflected that "The facilities resources, including but not limited to: ... All personnel, including manager, staff (both employees and those who provide services under contract) ..."<br><br>A review of the facility policy "Nursing Services and Sufficient Staff" with a revised date of 11/2021, reflected that the facility should "provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment." In addition, it reflected that "The facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans." This included except when waived, licensed nurses and other personnel "including but not limited to nurses aides."<br><br>NJAC 8:39-13.1(a)(b), 14.2(a), 33.1(d) | F 835 | | |
| F 836 SS=L | License/Comply w/ Fed/State/Locl Law/Prof Std<br>CFR(s): 483.70(a)-(c)<br><br>§483.70(a) Licensure.<br>A facility must be licensed under applicable State and local law.<br><br>§483.70(b) Compliance with Federal, State, and | F 836 | | 1/20/23 |

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| F 836 | Continued From page 121<br>Local Laws and Professional Standards.<br>The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.<br><br>§483.70(c) Relationship to Other HHS Regulations.<br>In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph.<br>This REQUIREMENT is not met as evidenced by:<br>Complaint #NJ00157677<br><br>Reference F677 and F689<br><br>Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to: a.) ensure the facility was meeting New Jersey state minimum staffing requirements, and b.) identify their own sufficient staffing numbers necessary to meet their census | F 836 | 10/24/2022 the Facility Assessment was reviewed and updated to the include the sufficient staffing assessment component. The update included staffing ratios that meet, at the minimum, state staffing requirements with consideration made based on census, acuities and special needs of residents. At a minimum CNA Staffing Ratios will be 1 cna to 8 residents on 7-3 shift; 1 cna to 10 residents on 3-11 | |

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| F 836 | Continued From page 122<br>population and resident needs.<br><br>The survey team reviewed the staffing levels for the two weeks prior to the survey (9/25/22 to 10/8/22). It was determined that the facility was significantly deficient in Certified Nursing Aide (CNA) staffing for 14 of 14 day shifts in which most days, the facility was only meeting half of the required CNA's for the day shift (CNA's had between 13 to 26 residents each on their assignment when the NJ state requirement is 1 CNA to 8 Residents for the day shift). The Facility was also deficient in staffing the evening (3-11 PM) shift for 4 of 14 evening shifts, and 14 of 14 night (11 PM- 7 AM) shifts.<br><br>Upon a review of the Facility Assessment (FA), it was determined that the facility did not identify or assess their benchmark of sufficient staff numbers necessary to serve their resident population based on an average census and specific population needs. The FA was generic regarding staffing and had only specified that they would provide "sufficient staff" but there were no numeric values.<br><br>Despite not assessing their own sufficient staff numbers within their FA and in addition was not meeting the state minimum staffing requirements by a significant margin, the facility continued to admit new residents to their facility, particularly [redacted] new residents from [redacted] to [redacted] during this two week period of time in which staffing was evaluated. The facility continued to admit new residents through [redacted]<br><br>All residents for [redacted] of [redacted] units were at risk for serious injury, harm, impairment, or death, which included multiple [redacted] (Resident #47) and | F 836 | shift; 1 cna to 14 residents for 11-7 shift. 10/24/22 three Healthcare agencies were contracted to assist with meeting staffing requirements. 10/24/22 Provided premium pay to current staff who agrees to work or cover an additional cna shift. 10/24/22 a regional Administrator was appointed by the governing body to be responsible for the management and overall operation of the facility. 10/24/22 admissions were curtailed.<br><br>All residents have potential to be affected by this deficient practice.<br><br>Review of staffing sufficiency by Administrator, Director of Nursing and Staffing Coordinator to determine the minimum number of cna's needed per resident unit based on resident census and acuities per shift for the day and for upcoming week Monday through Friday and projected weekend need review on Friday. Adjustments made as census changes are noted. Review of staffing sufficiency by Administrator, Director of Nursing and Staffing Coordinator to review number of aides needed to the actual number of cnas on the previous 24 hour shifts Monday through Friday with weeknd review on Monday. Follow up by Staffing Coordinator with staff for call outs and no calls/no show. Staffing review by Administrator, Director of Nursing and Staffing Coordinator with regional clinical and regional administrative staff to support actions needed to secure required staff including use of Healthcare agencies and recruiting efforts to hire staff weekly. | |

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| F 836 | Continued From page 123<br>[redacted] (Resident #88).<br><br>This placed all residents on [redacted] resident care units at risk for serious harm, impairment or death from a failure to identify sufficient staffing and failure to meet New Jersey State minimum staffing requirements by almost half on most days.<br><br>This resulted in an Immediate Jeopardy (I) which began on [redacted]. The facility's Director of Nursing (DON), Regional DON (RDON), Regional Registered Nurse (RRN) and Licensed Nursing Home Administrator (LNHA) were notified of the IJ on 10/24/22 at 4:06 PM. An acceptable Removal Plan was received on 10/25/22 at 12:55 PM. The IJ was verified by the survey team on 10/25/22 through observation, interview, record review and review of other pertinent facility documents.<br><br>The evidence was as follows:<br><br>Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes.<br><br>Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21.<br><br>1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff | F 836 | Facility will employ staff from healthcare agencies to fill staff openings until sufficient staff is hired to meet required staffing requirements. Staff recruitment with regional recruiter and planning of recruitment events. Bonus' to staff for filling open shifts.<br><br>The facility licensed nursing home administrator will forward weekly reports to Department of Health and Senior Services of mitigating strategies for staffing until admission curtailment is lifted. Staffing Coordinator, Administrator and Director of Nursing will audit the required cna to resident ratios for every shift Monday through Friday and on Friday for the weekend until staffing is stabilized and then weekly thereafter. Staffing and turnover trends to be reported to Quality Assurance Performance Improvement Committee at each QAPI meeting monthly. | |

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-to-resident ratios:

(1) one certified nurse aide to every eight residents for the day shift;

(2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and

(3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties

b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census.

c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place.

(2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.

(3) All computations shall be based on the midnight census for the day in which the shift begins.

d. Nothing in this section shall be construed to affect any minimum staffing requirements for

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nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... "

1. On 10/13/22 at 10:04 AM, the surveyor conducted an entrance conference with the DON, LNHA, and the Regional Quality Assurance Registered Nurse. The DON reported that the facility census was currently [redacted] residents, and they were currently holding one additional bed.

The surveyor reviewed the list of new admissions to the facility in the last 30 days provided upon entrance to the facility. The list was provided on a matrix list of current residents which indicated that there were a total of seven new residents admitted from 9/27/22 through 10/11/22.

At 11:21 AM, the surveyor interviewed the day shift (7 AM-3 PM) Licensed Practical Nurse/Unit Manager#1 (LPN/UM #1) for the [redacted] floor. The LPN/UM #1 stated that the unit census (number of residents in a unit) was 54 residents and three CNAs were working; therefore, the CNA-to-Resident ratio calculated to be 1 CNA for 18 residents that shift. The surveyor confirmed this by counting the number of CNA's present on the unit.

On 10/13/22 at 11:52 AM, the surveyor observed the Nursing Home Resident Care Staffing Report (NHRCSR) posted in the reception area/lobby area of the facility dated 10/7/22-Night Shift with Current Resident Census: 108, 1 CNA: 32 Residents. The receptionist provided a copy of the 10/7/22-Night Shift NHRCSR that was posted.

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The staffing report was not posted for the day of 10/13/22 which was six days late.

On 10/14/22 at 11:25 AM, the surveyor observed the NHRCSR posted in the reception area/lobby area of the facility dated 10/14/22-Day Shift which indicated a ratio of 1 CNA to 20.3 Residents. (This did not meet the New Jersey state minimum staffing requirement for the day shift of 1 CNA to 8 Residents).

On 10/17/22 at 6:11 AM, the surveyor made an observation on the night shift for the first floor. The surveyor observed that there was only one CNA assigned on the unit. The surveyor interviewed LPN #1 who was working the night (11 PM-7 AM) shift on the first floor. LPN#1 stated that the unit census was 52 residents and there was 1 CNA assigned to the residents this shift. LPN #1 acknowledged there was a staffing shortage and stated that "We do what we can do. We pitch in."

On 10/17/22 at 6:16 AM, the surveyor interviewed CNA #1. She acknowledged that she was the only CNA assigned to the first-floor unit for the current night shift. CNA#1 stated that nurses "try to help her out" to provide care and assistance to the residents. CNA #1 acknowledged there was a staffing shortage. She further stated that new staff start but leave since "it's always short in 11-7 [night shift], that's why they don't stay." In addition, she stated that facility "management" was aware of the staffing shortage and stated that it had been like this for two years since the start of the pandemic.

On 10/17/22 at 6:40 AM, LPN #2 stated to the surveyor that he was one of the two nurses that

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worked for the 11 PM to 7 AM night shift. He stated that he was aware of the facility's staffing shortage.

On 10/17/22 at 7:03 AM, the surveyor interviewed the Registered Nurse (RN) who had worked the 11 PM to 7 AM night shift on the second floor. The RN stated that the census was 53 residents and that there was only one CNA assigned to the unit.

On 10/17/22 at 7:37 AM, the surveyor interviewed CNA #2. She stated that she was assigned to work the 7 AM-3 PM day shift but started before 7:00 AM and provided incontinence care to a resident at 6:45 AM.

On 10/17/22 at 7:53 AM, the surveyor interviewed the RN who stated that the facility was short-staffed. In addition, she stated that there was no nursing supervisor and that he/she left nine months ago. The RN stated that there was a CNA who came in at 6 AM before the 7 AM-3 PM assigned shift to assist with care. In addition, she stated that she was aware of family complaints of staffing shortages.

On 10/17/22 at 10:16 AM, the surveyor interviewed the Hospitality Aide on the second floor. He stated that he has been working at the facility for a few months and assisted residents on the whole unit and was not assigned to specific rooms. He stated that he did not provide direct care to the residents but assisted the CNA's. He stated that "they have very few aides."

On 10/17/22 at 11:45 AM, the surveyor interviewed the LNHA, the DON and the RDON in the presence of a second surveyor. The RDON

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stated that "instead of getting better, the staffing issues have been getting worse." He stated that it had been a struggle to use agencies because "they get grabbed up quick." He further stated that when they did hire and orient staff, they did not return. The LNHA stated that they had hired hospitality aides and acknowledged that they were not able to provide direct resident care.

On that same date and time, the LNHA could not speak to why the facility continued to admit new residents when they were aware of their inability to provide sufficient staff. He stated that "which comes first if there are no admissions, we won't have money to pay for the staff." He further stated that "we try not to admit clinically complex residents." The LNHA could not speak to the facility's ability to provide the necessary care to the residents with insufficient staff.

At the same time, the RDON stated that "we have borrowed staff from other places to come here." The surveyor stated that there was one CNA for 53 residents on the 11-7 AM night shift for the second-floor last night. The LNHA stated that "no" he was not aware of that. The RDON stated that "this should never have happened." The administrative team could not speak to why the facility continued to admit new residents with insufficient staff. In addition, the LNHA stated that "I can't provide an adequate answer to that question."

Furthermore, the DON stated that there had not been a nursing supervisor for the 11-7 AM shift for the last nine months and none for the 3 PM-11 PM evening shift since August 2022. The LNHA and the RDON acknowledged the DON's statement. The RDON stated that "I agree there

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should be no admissions if we cannot provide care, I am gonna take care of that." The DON added, "I agree."

On 10/17/22 at 12:26 PM, the RDON approached the survey team and stated, "this should never have happened."

On 10/20/22 at 8:59 AM, the surveyor interviewed CNA #3 in the presence of the survey team. He stated that he worked the 3-11 PM evening shift on 10/16/22. He further stated that "I probably had more than 20 residents because I had the whole short hall resident plus one room on the long [hall]."

The surveyor reviewed the staffing for the two weeks prior to survey and all other pertinent facility staffing documents, which revealed the following:

A review of the "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two weeks beginning 9/25/22 and ending 10/08/22 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements of CNAs on 14 of 14-day shifts, deficient in total staff for residents on 4 of 14 evening shifts, and deficient in total staff for residents on 14 of 14 overnight shifts as follows:

-09/25/22 had 6 CNAs for 108 residents on the day shift, required 13 CNAs. (18 residents per CNA)
-09/25/22 had 10 total staff for 108 residents on the evening shift, required 11 total staff.
-09/25/22 had 6 total staff for 108 residents on the overnight shift, required 8 total staff.

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| F 836 | Continued From page 130<br>-09/26/22 had 6 CNAs for 107 residents on the day shift, required 13 CNAs. (17.83 residents per CNA)<br>-09/26/22 had 5 total staff for 108 residents on the overnight shift, required 8 total staff.<br>-09/27/22 had 7 CNAs for 107 residents on the day shift, required 13 CNAs. (15.28 residents per CNA)<br>-09/27/22 had 9 total staff for 107 residents on the evening shift, required 11 total staff.<br>-09/27/22 had 4 total staff for 107 residents on the overnight shift, required 8 total staff.<br>-09/28/22 had 7 CNAs for 106 residents on the day shift, required 13 CNAs. (15.14 residents per CNA)<br>-09/28/22 had 5 total staff for 106 residents on the overnight shift, required 8 total staff.<br>-09/29/22 had 8 CNAs for 105 residents on the day shift, required 13 CNAs. (13.12 residents per CNA)<br>-09/29/22 had 5 total staff for 105 residents on the overnight shift, required 7 total staff.<br>-09/30/22 had 6 CNAs for 105 residents on the day shift, required 13 CNAs. (17.50 residents per CNA)<br>-09/30/22 had 5 total staff for 105 residents on the overnight shift, required 7 total staff.<br>-10/01/22 had 7 CNAs for 105 residents on the day shift, required 13 CNAs. (15 residents per CNA)<br>-10/01/22 had 9 total staff for 105 residents on the evening shift, required 10 total staff.<br>-10/01/22 had 5 total staff for 105 residents on the overnight shift, required 7 total staff.<br>-10/02/22 had 6 CNAs for 105 residents on the day shift, required 13 CNAs. (17.50 residents per CNA)<br>-10/02/22 had 9 total staff for 105 residents on the evening shift, required 10 total staff. | F 836 | | |

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-10/02/22 had 6 total staff for 105 residents on the overnight shift, required 7 total staff.
-10/03/22 had 5 CNAs for 105 residents on the day shift, required 13 CNAs. (21 residents per CNA)
-10/03/22 had 5 total staff for 105 residents on the overnight shift, required 7 total staff.
-10/04/22 had 5 CNAs for 105 residents on the day shift, required 13 CNAs. (21 residents per CNA)
-10/04/22 had 4 total staff for 105 residents on the overnight shift, required 7 total staff.
-10/05/22 had 4 CNAs for 105 residents on the day shift, required 13 CNAs. (26.25 residents per CNA)
-10/05/22 had 5 total staff for 105 residents on the overnight shift, required 7 total staff.
-10/06/22 had 5 CNAs for 105 residents on the day shift, required 13 CNAs. (21 residents per CNA)
-10/06/22 had 6 total staff for 105 residents on the overnight shift, required 7 total staff.
-10/07/22 had 6 CNAs for 105 residents on the day shift, required 13 CNAs. (17.50 residents per CNA)
-10/07/22 had 5 total staff for 105 residents on the overnight shift, required 7 total staff.
-10/08/22 had 5 CNAs for 107 residents on the day shift, required 13 CNAs. (21.40 residents per CNA)
-10/08/22 had 6 total staff for 107 residents on the overnight shift, required 8 total staff.

Upon a review of the FA dated to cover October 15, 2021 through October 14, 2022, it was determined that the facility did not identify their benchmark of sufficient staff numbers necessary to serve their resident population based on an average census and specific resident needs. The

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FA was generic regarding staffing and had only specified that they provided "sufficient staff" but there were neither numeric values for staffing nor did it address what "sufficient" staffing meant.

Despite not assessing their own sufficient staff numbers within their FA, and not meeting the state minimum staffing requirements by a significant margin, the facility continued to admit new residents to their facility, particularly [redacted] new residents from [redacted] to [redacted] during this two-week period of time in which staffing was evaluated. The facility continued to admit new residents through [redacted].

On 10/24/22 at 12:58 PM, the survey team met with the LNHA, the RRN, and the DON about the FA which was provided by the RDON on 10/14/22 at 12:48 PM. The LNHA stated that "I completed the Facility Assessment." The surveyor and the LNHA reviewed together that there was no evidence that the facility identified sufficient staffing numbers to address their resident population and census data. The LNHA could not speak to why in the FA there were zero categories in which there were insufficiencies, and the FA indicated that there was sufficient staff. He stated that "it was probably written before COVID and those challenges."

The LNHA could not speak to the dates and time frame indicated on the FA as October 15, 2021 through October 14, 2022, and what that meant for the FA. He stated that the FA was based on observations and looking at data. He stated, "We are looking at staffing and staffing patterns, census, and resident diagnoses." The LNHA could not speak to identifying the benchmarks he used or how it was determined that staffing was

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sufficient. He stated that some of the numbers used for the FA came from the "MDS (Minimum Data Set, a tool used to facilitate the needs of a resident) and PBJ (payroll-based journal)." He was unable to speak to how he completed the FA, or if anyone else participated.

In addition, the LNHA did not have his own copy of FA to review. The RRN stated that she had not yet reviewed the FA. The RRN stated that the FA should be reviewed annually and during the Quality Assurance Performance Improvement (QAPI) committee meetings. She stated that the purpose of the FA was that "it will determine the needs of the residents and resident population, so we can provide the services required to take care of the residents." She further stated that if there was an area of concern it should have been discussed at the QAPI meeting.

Furthermore, the facility's administrative team could not speak to how the FA for staffing was determined and requested the opportunity to review it and would further respond to the survey team.

On 10/26/22 at 9:31 AM, the surveyor interviewed the DON in the presence of a second surveyor. The DON stated that for burnout prevention, she looked at the hours that staff had worked and if they worked other jobs. She further stated in reference to staffing status that "it's challenging." The DON stated that the staff tell her "I'm tired." They work long hours. "They try to kill themselves" to deliver the best care for the residents. She further stated that the administration and "higher-ups" were aware of the possibility of staff burnout.

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On 10/31/22 at 02:40 PM, the survey team met with a family representative. He/She expressed concerns over staffing shortages that had been noticed. He/She stated that "they are very short-staffed" and that "they do not have enough aides."

On 11/03/22 at 11:04 AM, the surveyor interviewed the Nursing Staffing Coordinator (SC). The SC acknowledged staff shortages for all three shifts weekdays and weekends. She stated that she was familiar with minimum staffing requirements but could not speak to "numbers off the top of my head but I have them." She also stated that "now we are working with four agencies" and "not previously... we had no agency."

At that same time, the SC stated that staffing has been a challenge and that the LNHA and DON were aware. She stated that she participated in weekly meetings with "corporate" regarding staffing challenges and that they try and provide staff from other buildings, however, "I work with sister facilities to solve staffing issues but unfortunately they are in the same boat."

2. On 10/20/22 at 12:37 PM, the surveyor interviewed the DON regarding an [redacted] which the DON acknowledged took place on [redacted] The DON told the surveyor that the resident was seen by the exit door at the end of the hallway on the "[redacted]" Unit, the [redacted] floor unit during the evening shift. At that time a CNA#4 heard the exit door at the end of the hallway alarm. The exit door led to a [redacted] that led to [redacted] floor. The CNA came out of a room where he was providing care and redirected the resident toward the nursing station.

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The CNA then reset the door alarm and went back into another resident's room to provide care.

At that same date and time, the DON told the surveyor that she believed the alarm went off again and no resident was seen by the door. The DON further stated that LPN#3 who was working on the evening shift just went ahead and reset the alarm without accounting for all the residents. The DON stated, "The LPN had just returned from break and heard the alarm, she didn't see a resident at the door, so she reset the alarm and continued to pass medications."

At that time, the surveyor asked the DON what should have happened, and the DON stated, "the LPN should have checked the exit door and the stairwell to see if any residents were there and then should have done a head count to make sure all the residents were accounted for, which she failed to do." The DON said, "she didn't think".

On 10/21/22 at 12:07 PM, the surveyor spoke with CNA#4 who was with Resident #88 on the night of an [redacted]. The CNA told the surveyor that he heard a door alarm while he was in another resident's room. At that time, he went to the door and saw Resident #88 attempting to run [redacted]. The CNA said that he "grabbed the resident's shirt" because he was afraid the resident would fall down the [redacted]. The CNA said that he put the resident back in the room and told the nurse on duty about the incident.

On that same date and time, the surveyor asked CNA#4 if he heard the second alarm and the CNA stated, "I went on break and the next thing I

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saw was the cops and I found out that the resident had been found a couple of doors down from the facility."

On 10/26/22 at 3:14 PM, the surveyor interviewed LPN#3 who was caring for Resident #88 on the evening of the [redacted] The LPN told the surveyor there were, "Two nurses working for the entire unit." "And we were short with only three aides on a [redacted] unit." "I was responsible for the resident. I saw [him/her], put the resident to bed. I called the CNA when I put [him/her] to bed to do PM care." "I then fed some residents, because we were so short-staffed." "I then heard the door alarm, I didn't know how to turn it off, so I called the CNA to help me turn it off, I didn't open the door or look for any residents, I thought the resident was still sleeping." "I didn't know the resident had a history of [redacted]." "A Police officer called and then I realized [he/she] was missing because the police asked me if I knew the resident. I was shocked."

3. On 10/18/22 at 11:35 AM, the surveyor asked the DON to provide all the supporting documentation related to multiple [redacted] incidents [redacted], some of which resulted in major injury for Resident #47 from [redacted] through [redacted]

On 10/19/22 at 11:32 AM, two surveyors interviewed LPN/UM#2. She informed the surveyors that the resident had no [redacted] and needed continuous [redacted] observation "only when they can due to short staffing."

The survey team reviewed the staffing for the dates and shifts on the unit associated with each [redacted] The staffing assignment sheets revealed the

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following:

5/26/22: Census: 44, 4 CNAs, 2 Nurses
6/2/22: Census: 45, 3 CNAs, 2 Nurses
6/7/22: Census: 45, 3 CNAs, 2 Nurses
6/26/22: Census: 53, 4 CNAs, 2 Nurses
7/12/22: Census: 54, 5 CNAs, 2 Nurses
7/17/22: Census: 54, 4 CNAs, 2 Nurses
8/17/22: Census: 57, 4 CNAs, 2 Nurses
8/23/22: Census: 55, 4 CNAs, 2 Nurses
8/29/22: Census: 55, 3 CNAs, 2 Nurses
10/3/22: Census: 51, 3 CNAs, 2 Nurses
10/10/22: Census: 51, 3 CNAs, 2 Nurses

On 10/21/22 at 10:30 AM, the surveyor conducted a follow-up interview with the LPN/UM#2, who acknowledged that Resident #47 had frequent falls. She also stated that the resident can ambulate when he/she "wants to" and required staff supervision to prevent further [redacted] because of [redacted] and [redacted]. She further explained that the staff should have been close enough to the resident to intervene as needed.

On the same day at 10:35 AM, the surveyor interviewed CNA#5. CNA#5 acknowledged that the resident had frequent [redacted]. She stated that due to staffing issues, they could not closely supervise the resident. She further stated that they were "short staffed" and they needed "more staffing" to monitor the resident due to their [redacted] and [redacted] behavior, and to provide for Resident #47's needs.

On 10/24/22 at 11:54 AM, the survey team met with the RRN, DON, and LNHA, and were made aware of the above concerns.

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On 10/26/22 at 11:30 AM, LPN#4 stated, "I feel extremely high burnout, no help since COVID." She acknowledged that the resident had multiple [redacted] due to [redacted] which resulted in major injury. She stated that because they were under staffed, "to be realistic, staff needs to observe the resident visually but to be idealistic, staff will observe resident physically" to prevent the resident from [redacted] LPN#4 further stated that the resident required close observation by sitting next to him/her.

4. On 10/17/22 at 6:13 AM, the surveyor observed the RN and CNA#2 providing morning care to Resident #55. The resident's room smelled of [redacted] and the resident's [redacted] was [redacted] The surveyor observed that the [redacted] were [redacted] with [redacted] and [redacted]. The resident was positioned to the left side facing toward the window, the [redacted] area was not reddened, and no wounds were observed. The CNA and the RN both stated that the resident was [redacted] with [redacted] which [redacted], and confirmed that the room smelled of [redacted]

On that same date and time, the RN stated that the census was 53 and CNA#6 was the only aide working for the previous 11 PM-7AM night shift. The RN further stated that CNA#2 came in before 6 AM today to help even though she was not asked to come early and that CNA#2 usually comes in early.

At that same time, CNA#2 indicated that she had to help because she was assigned to Resident #55 today for the 7AM to 3PM day shift "anyway" and "I know 11-7 [night shift] are short staffed and I will be busy today because it will be short also

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today for 7-3 [day] shift." Both the RN and CNA#6 stated, "We do what we can here."

5. On 10/17/22 at 6:57 AM, the surveyor observed CNA#6 providing morning care to Resident #19. The resident's room smelled of [redacted] the resident's [redacted], and the [redacted] in [redacted] with a [redacted] color. The resident was positioned to the left side of the bed, facing toward the wall, and the [redacted] area was exposed with no reddened area and the skin was intact.

At that same date and time, CNA#6 stated that the resident was [redacted] with [redacted] including the side of the [redacted], and the [redacted] and that the room smelled [redacted]. The surveyor observed that the resident was wearing [redacted] with [redacted]. CNA#6 acknowledged that the [redacted] on the floor which was [redacted] belonged to the resident, and stated that the resident should not have a [redacted]. She further stated that she did not know who put the [redacted] on the resident because that was the first time she changed the resident's [redacted] since 11:00 PM [redacted]) because of short staffing. She indicated that she was the only CNA for the [redacted]-floor unit for the 11PM-7AM night shift for 53 residents.

Furthermore, CNA#6 informed the surveyor that she worked the 3 PM- 11 PM evening shift [redacted] ([redacted]) and there were two CNAs on the second-floor unit. CNA#6 stated that she was not assigned to the resident on the evening shift and it was CNA#3 who took care of the resident. She further stated that the resident

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should have been changed and provided [redacted] care at least twice per shift. She indicated that there were 53 residents on 10/16/22 and that she can only do so much.

On 10/17/22 at 7:07 AM, during the interview with the surveyor, the RN stated that there was no regular CNA for the night shift, the census was 53 residents on 10/16 and 10/17/22. She further stated that only she and CNA #6 worked that night shift. The RN stated that 24 out of 53 residents were offered [redacted] care for the night shift, 1 out of 24 refused care, 3 out of 24 were self-care, and 18 out of 24 were incontinent and were provided [redacted] care. Both the RN and CNA#6 stated that "We do what we can." The RN further stated that "We cannot go to everyone to take care of them, I provided care to two residents only," and that she had to administer medications.

The facility was notified of the Immediate Jeopardy (IJ) on 10/24/22 at 4:06 PM. The facility's DON, RDON, RRN, and LNHA were informed that for Resident #47 and Resident #88, the failure to a.) ensure the facility was meeting New Jersey state minimum staffing requirements, and b.) identify their own sufficient staffing numbers necessary to meet their census population and resident needs, placed these and all residents on 2 of 2 resident care units at risk for serious harm, impairment or death.

On 10/25/22 at 12:55 PM, the facility provided the survey team with an acceptable removal plan.

On 10/25/22, survey team verified the removal plan through observation, interview, record review and review of other pertinent facility documents.

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A review of the facility policy "Facility Assessment" with a revised date of 9/2022, reflected that "The facility will conduct and document a facility-wide assessment to determine what resources are necessary to care for its resident competently during both day-to-day operation and emergencies." It also reflected that "The facility assessment will include but not limited to the following: ... The care required by the resident population considering the types of diseases, condition, physical and cognitive disabilities, overall acuity and other pertinent facts that are present within the population." In addition, the policy reflected that "The facilities resources, including but not limited to: ... All personnel, including manager, staff (both employees and those who provide services under contract) ..."

A review of the facility policy "Nursing Services and Sufficient Staff" with a revised date of 11/2021, reflected that the facility should "provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment." In addition, it reflected that "The facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans." This included except when waived, licensed nurses and other personnel "including but not limited to nurses aides." (However, there was no calculation to what the facility's sufficient staffing numbers were or what the information was based

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| F 836 | Continued From page 142<br>on).<br><br>On 11/03/22 at 12:23 PM, the survey team met with the DON, RRN, RLNHA #1 and RLNHA #2. There was no further information provided during the meeting. | F 836 | | |
| F 868 SS=E | NJAC 8:39-5.1(a); 25.2(b); 27.2(h)<br>QAA Committee<br>CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)<br><br>§483.75(g) Quality assessment and assurance.<br>§483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:<br>(i) The director of nursing services;<br>(ii) The Medical Director or his/her designee;<br>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role;<br><br>§483.75(g)(2) The quality assessment and assurance committee must:<br>(i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, it was determined that the facility failed to ensure the Quality Assurance Performance Improvement (QAPI) committee was composed of the required committee members that meet at least quarterly for two of three quarters reviewed.<br><br>This deficient practice was evidenced by the | F 868 | 11/3/2022 Ad Hoc Quality Assurance Performance Improvement Committee met. 11/2/2022 Department directors were in-serviced on QAPI expectations including meeting participation. The annual meeting calendar was established and sent to participants. | 1/20/23 |

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| F 868 | Continued From page 143<br>following:<br><br>On 10/13/22 at 10:04 AM, during the Entrance Conference meeting with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and the Quality Assurance/Regional Registered Nurse (QA/RRN), the LNHA stated that the facility conducted quarterly QAPI meetings. The surveyor asked the facility to provide a copy of the last three quarters' sign-in sheets, the QAPI policy and plan.<br><br>On 10/14/22 at 9:01 AM, the DON provided a copy of the 1/27/22 QAPI Sign-In sheet with Department Signatures which revealed that the LNHA and Medical Director (MD) were not present during the meeting. In addition, on 4/28/22 the QAPI Sign-In sheet revealed that the LNHA did not attend the meeting. The third quarter sign-in sheet was not provided.<br><br>On 10/17/22 at 10:50 AM, the DON provided the 7/15/22 QAPI Sign-In sheet which revealed that the LNHA was not present at the meeting.<br><br>On 10/18/22 at 9:01 AM, the survey team met with the LNHA and the DON and informed them of the above concerns.<br><br>On 10/18/22 at 10:11 AM, the surveyor interviewed the MD via phone. The MD stated that he was the MD for "less than a year now," and he was not sure if he started back in December 2021. The MD stated that he was always available via phone and that he was aware that the facility had monthly and quarterly QAPI meetings. He further stated that he gets the QAPI meeting minutes and information through the LNHA. He indicated that at the time he was | F 868 | All residents have the potential to be affected by the deficient pratice.<br><br>The Administrator or designee will review QAPI attendance sheets for participant attendance compliance including the Medical Director. Administrator or designee to send meeting reminders to vendors and meeting participants.<br><br>The Administrator will monitor meeting attendance for each scheduled committee meeting for 4 quarters.<br>The audits were be presented and discussed at each QAPI meeting for 4 quarters. QAPI committee will determine if continued auditing is necessary. Once 100% compliance threshold is achieved for two consecutive quarters. This plan can be amended when indicated. Adverse finding will be immediately addressed. Findings and trends will be reported to QAPI Committee. | |

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unable to leave the hospital and if he was needed at the facility, the facility could call him, and/or meet would with the LNHA afterward.

On that same date and time, the MD stated that he was not sure if he attended the QAPI meeting on 01/27/22 because "I think I was on call at the hospital," and "usually when I am not there, the following day I will meet with the LNHA and discuss what was discussed in the QAPI."

On 10/18/22 at 02:55 PM, the surveyor informed the LNHA that the MD called back and was interviewed regarding the QAPI meetings.

At that same time, the LNHA stated that "the MD means well, just caught in hospital responsibilities." The LNHA further stated that the MD was "always" invited at the QAPI meetings "but at times will come in after an hour of the QAPI meeting." Furthermore, the LNHA informed the surveyor that at times the MD will not attend the meeting, the LNHA will discuss what was presented in the QAPI meeting, and then the MD would sign the QAPI Sign-In sheet even though the MD was not present on the day of the QAPI meeting. The LNHA acknowledged that the MD should have attended the 1/27/22 and other QAPI meetings as was required and per facility policy and protocol.

On 11/02/22 at 10:34 AM, the survey team met with Regional LNHA#1 and #2, and the DON. The DON stated that the QAA (Quality Assessment and Assurance) committee existed at the facility. The Regional LNHA#1 further stated that the committee meet quarterly.

On that same date and time, the surveyor asked

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the two regional LNHA's and the DON, who were the QAA (or QAPI) committee required members and what was the requirement with regard to attendance at the QAPI meeting. The Regional LNHA#1 stated that the key personnel for the QAPI meeting that should be in attendance should be the LNHA, DON, and Medical Director. She further stated that when the MD was not available on the phone on the day of the QAPI meeting, the LNHA would brief the MD about the QAPI meeting "like later on the day." Then, the surveyor asked the Regional LNHA#1 if that was the regulation requirement, and the Regional LNHA#1 stated that it was not. The Regional LNHA#1 acknowledged that the regulation indicated that the required members should attend the QAPI, otherwise it should be rescheduled.

At that time, the surveyor informed the two Regional LNHAs and the DON about the above concerns with QAPI Sign-In sheets and the surveyor's interview with the MD and the LNHA.

On 11/02/22 at 12:01 PM, the surveyor showed the RRN and Regional LNHA#1 the provided QAPI Sign-In sheets of the DON. The Regional LNHA#1 stated that she acknowledged the concern with QAPI meeting attendees and the discrepancies, they knew the problem and that was why the LNHA was terminated.

On 11/03/22 at 9:35 AM, the survey team met with the RRN, Regional LNHA#1, and the DON. The Regional LNHA#1 provided a copy of the LNHA's time records from 1/23/22 through 2/05/22, and 4/17/22 through 4/30/22, which revealed that the LNHA did not work on 1/27/22 which was why the LNHA did not sign the 1/27/22

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QAPI meeting sheet.

At that same time, the facility was unable to provide the LNHA's time records on 7/15/22 for the QAPI Meeting which would have reflected that the LNHA was present during the meeting.

A review of the facility's Quality Assurance and Performance Improvement policy that was provided by the DON with a revised date of 9/2022 included "Policy Explanation and Compliance Guidelines: 1. The QAPI program includes the establishment of a Quality Assessment and Assurance (QA) Committee and a written QAPI Plan. 2. The QA Committee shall be interdisciplinary and shall: a. Consist at a minimum of: i. The Director of Nursing; ii. The Medical Director or his/her designee; iii. At least three other members of the facility's staff, at least one of which much be the administrator; owner, a board member or other individual in a leadership role; and iv. The infection Control and Prevention Officer..."

A review of the facility's Medical Director Responsibilities Policy dated 2019 that was provided by the Regional DON included "Policy Explanation and Compliance Guidelines:....4. The Medical Director's responsibilities include participation in:....b. Issues related to the coordination of medical care identified through the facility's QA committee and other activities related to the coordination of care;...d. Participate in the Q.A. Committee..."

On 11/03/22 at 11:36 AM, the survey team met with the RRN, DON, and Regional LNHA#1 and #2 and there was no additional information provided by the facility.

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| F 868 | Continued From page 147<br><br>NJAC 8:39-33.1(b)(e) | F 868 | | |
| F 881 SS=D | Antibiotic Stewardship Program<br>CFR(s): 483.80(a)(3)<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review of pertinent facility documentation, it was determined that the facility failed to ensure implementation of the antibiotic stewardship program including ongoing monitoring and use of nationally recognized surveillance criteria prior to consulting the prescriber. This deficient practice was identified for one (1) of two (2) residents reviewed for antibiotic stewardship, (Resident #87) and was evidenced by the following:<br><br>On 10/14/22 at 09:11 AM, the surveyor observed the resident who was in bed watching television. The resident was receiving nutrition via a gastrostomy tube (GT).<br><br>The surveyor reviewed the medical records of Resident #87.<br><br>The Admission Record (or Face Sheet; an admission summary) revealed that the resident was re-admitted to the facility with diagnoses | F 881 | 10/28/22 Resident #87's antibiotic therapy was reviewed and new orders were received by the Nurse Practitioner. 11/3/22 The Director of Nursing re-educated the licensed nurses on Antibiotic Stewardship Assessment tools to monitor antibiotic use. 11/3/22 all residents on antibiotic therapy wre reviewed by the Director of Nursing for appropriate usage.<br><br>All residents have the potential to be affected by this deficient practice.<br><br>Infection Preventionist and Director of Nursing will audit the antibiotic tracking log and Electronic Medication Administration Record daily to confirm appropriate antibiotic use on new admissions, readmissions and in house residents. Any findings/discrepancies will be evaluated and discussed with Medical | 1/20/23 |

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| F 881 | Continued From page 148<br>which included but were not limited to:<br>[redacted]<br><br>The Progress notes (PN) dated [redacted] at 10:44 AM showed that the Nurse Practitioner (NP) was made aware of the responsible party's (RP's) requests for [redacted] and [redacted] and [redacted]). The [redacted] PN included that the resident has no signs and symptoms of an infection.<br><br>A review of Resident #87's PN dated [redacted] at 10:53 AM showed that the results of [redacted] without [redacted] were relayed to the Medical Doctor (MD) and the MD ordered to recollect [redacted] specimen for [redacted] Also, the [redacted] PN indicated that the MD ordered to start the resident on [redacted] (medication to fight an [redacted] mg (milligram) [redacted] for 10 days.<br><br>The PN dated [redacted] at 04:10 PM revealed that the resident continues to be afebrile (no fever) and has no signs and symptoms of infection. In addition, the [redacted] PN showed that the NP received the resident's [redacted] and ordered to continue the current [redacted] order and to continue to monitor.<br><br>The October 2022 electronic Medication Administration Record (eMAR) revealed a Physician Order dated [redacted] for [redacted] [redacted] mg [redacted] by mouth [redacted] daily for 10 days | F 881 | Director. Infection Preventionist or designee will re-educate nursing staff annually, upon hire and as needed on Antibiotic stewardship program and protocols.<br><br>Infection Preventionist will prepare reports with outcomes and trends to be presented with the Quality Assurance Performance Improvement team monthly. | |

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| F 881 | Continued From page 149<br>for [redacted] with a discontinued date of [redacted]<br><br>A review of the facility's [redacted] for starting Antibiotic Therapy in Long Term Care which the facility used as a tool for their antibiotic stewardship program revealed that they did not follow these criteria when ordering [redacted] and starting [redacted] treatment for Resident #87. They were no progress notes from the physician which explained the reason for ordering a [redacted] and starting [redacted] treatment for a resident that did not meet the [redacted].<br><br>The [redacted] for Starting Antibiotic Therapy in Long Term Care for a Suspected [redacted] is as follows [redacted]:<br>"Either one of the following criteria:<br>-[redacted]), or<br>-Temp >37.9 C (100 F) OR 1.5 C (2.4 F) above baseline, and<br>-[redacted]<br>-[redacted] and [redacted].<br><br>On 10/31/22 at 12:45 PM, the surveyor interviewed Resident #87's nurse a Licensed Practical Nurse (LPN) who stated that the resident was admitted to the hospital on [redacted] with an admission diagnosis of [redacted]. The LPN informed the surveyor that the [redacted] was probably caused by an infection in the [redacted] rather than by a [redacted]<br><br>On 11/03/22 at 11:30 AM, the survey team met with the Director of Nursing (DON), the Regional Licensed Nursing Home Administrator#1 (RLNHA#1), and the Regional Registered Nurse (RRN). The RRN stated that the facility | F 881 | | |

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| F 881 | Continued From page 150 | F 881 | | |

acknowledged that the facility did not follow the facility tool [redacted] for Resident #87 and that there were no progress notes from the physician which justify the ordering of a [redacted] and starting [redacted] treatment. The facility team acknowledged that there were progress notes from a Unit manager and the facility's NP which included that the resident had no symptoms of a [redacted]

A review of the facility's policy for the Antibiotic Stewardship Program dated 11/17 and was provided by the DON and indicated the following:

"4. The program includes antibiotic use protocols and a system to monitor antibiotic use."

"a. Antibiotic use protocols."

"i. Nursing staff shall assess residents who are suspected to have an infection and complete an SBAR (Situation, Background, Assessment and Recommendation) form prior to notifying the physician."

"ii. Laboratory testing shall be in accordance with current standards of practice."

"iii. The facility uses the Surveillance Definitions of Infection in Long-Term Care Facilities: Revisiting the [redacted]."

"iv. The [redacted] are used to determine whether to treat an infection with antibiotics."

On 11/03/22 at 11:36 AM, the survey team met with the facility's administrative team which included Regional LNHA#1 and #2, RRN, and the

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| F 881 | Continued From page 151<br>DON. The facility's administrative team had no additional information to provide to the survey team.<br><br>NJAC 8:39-19.4 (a) (d) | F 881 | | |
| F 886 SS=D | COVID-19 Testing-Residents & Staff<br>CFR(s): 483.80 (h)(1)-(6)<br><br>§483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:<br><br>§483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to:<br>(i) Testing frequency;<br>(ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility;<br>(iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19;<br>(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;<br>(v) The response time for test results; and<br>(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.<br><br>§483.80 (h)((2) Conduct testing in a manner that | F 886 | | 1/20/23 |

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| F 886 | Continued From page 152<br>is consistent with current standards of practice for conducting COVID-19 tests;<br><br>§483.80 (h)((3) For each instance of testing:<br>(i) Document that testing was completed and the results of each staff test; and<br>(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.<br><br>§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms<br>consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.<br><br>§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.<br><br>§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state<br>and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.<br>This REQUIREMENT is not met as evidenced by:<br>Based on the interview, record review, and other pertinent facility documentation it was determined that the facility failed to perform covid-19 testing per facility policy for [redacted] residents (Resident #8 and Resident #355) and 1 of 2 staff members reviewed for [redacted] testing and in accordance with the Centers for Disease Control and Prevention guidelines (CDC) for infection control | F 886 | Resident #8 and Resident #355 monitored for signs and symptoms of [redacted] daily with no reported or observed findings. On 11/3/2022 the Director of Nursing re-educated all licensed Nurses on testing new admissions/readmissions and documenting results into the electronic | |

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| F 886 | Continued From page 153<br>to mitigate the spread of [redacted]<br><br>According to the U.S. CDC Interim Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated September 23, 2022, included "Defining Community Transmission of SARS-CoV-2 Select IPC measures (e.g., use of source control, screening testing of nursing home admissions) are influenced by levels of SARS-CoV-2 transmission in the community. Community Transmission is the metric currently recommended to guide select practices in healthcare settings to allow for earlier intervention, before there is strain on the healthcare system and to better protect the individuals seeking care in these settings. The Community Transmission metric is different from the COVID-19 Community Level metric used for non-healthcare settings. Community Transmission refers to measures of the presence and spread of SARS-CoV-2. COVID-19 Community Levels place an emphasis on measures of the impact of COVID-19 in terms of hospitalizations and healthcare system strain, while accounting for transmission in the community .... Perform SARS-CoV-2 Viral Testing<br>" Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for SARS-CoV-2 as soon as possible.<br>" Asymptomatic patients with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours | F 886 | medical administration report. On 11/3/2022 the Director of Nursing re-educated all staff on testing procedure for employees not up to date with vaccinations. Full Resident and staff audit was completed by the Director of Nursing on 11/3/2022<br>Testing policy was reviewed by Director of Nursing and Infection Preventionist on 11/3/2022.<br><br>All residents have the potential to be affected by this deficient practice.<br><br>Director of Nursing and/or designee will audit weekly the testing log for all residents and staff during the outbreak period for testing compliance. Director of Nursing and/or designee will audit weekly the testing log for all staff not up to date with vaccinations for compliance. The Infection Preventionist and/or designee will continue to test the non-boosted staff weekly depending on the community rate and track the staff to ensure they are adhering to using the required Personal Protective equipment as well as social distancing. Disciplinary action will be taken if found not adhering to the required precautions as it relates to the testing, Personal Protective Equipment, and social distancing.<br><br>The audits will be monitored by the Administrator and Director of Nursing as follows weekly x 4, bi-weekly x 2 weeks and monthly x 3. The audits will be discussed during our monthly Quality Assurance Performance Improvement | |

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| F 886 | Continued From page 154<br>after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5 ....<br>" Managing admissions and residents who leave the facility:<br>o Testing is recommended at admission and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. In general, admissions in counties where Community Transmission levels are high should be tested upon admission; admission testing at lower levels of Community Transmission is at the discretion of the facility.<br>o They should also be advised to wear source control for the 10 days following their admission. Residents who leave the facility for 24 hours or longer should generally be managed as an admission."<br><br>This deficient practice was evidenced by the following:<br><br>On 10/13/22 at 10:04 AM, during an Entrance Conference of the surveyor with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Quality Assurance/Regional Registered Nurse, the DON stated that the facility was on an outbreak with a [redacted] resident on [redacted]<br><br>On that same date and time, the DON stated that she was the facility Infection Preventionist (IP). The DON further stated that the facility follows the New Jersey Department of Health (NJDOH), CMS, and CDC guidelines for infection control.<br><br>Furthermore, the DON stated that testing frequency for staff who was not up to date with their [redacted] vaccinations is done twice a | F 886 | meeting; Quality Assurance Performance Improvement committee will determine if continued auditing is necessary. Once 100% compliance threshold is achieved for two consecutive months. This plan can be amended when indicated. Adverse finding will be immediately addressed. Findings and trends will be reported to QAPI Committee. | |

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week following the facility policy. She further stated that the residents were being tested for COVID-19 following the testing guidance for an outbreak on day one of the positive COVID-19 residents, day three, day five, day seven, and then weekly until no new cases in accordance with the facility policy.

The surveyor the medical records of Residents #8 and #355.

The Electronic medical record of Resident #8 reflected that the resident refused all vaccinations since admission to the facility. The record also showed that the resident was exposed to a [redacted] resident following the [redacted] outbreak.

The covid-19 testing logs showed that Resident #8 was tested on [redacted]. The surveyor could not locate any other test results for Resident #8. The DON was only able to provide one test from [redacted], which was three days after Resident #8 exposure.

The Admission Record (or face sheet; admission summary) for Resident #355 indicated that the resident was admitted to the facility during the period of the facility's [redacted] outbreak on [redacted]. The surveyor could not locate the [redacted] testing that was completed at the facility on admission or during the resident's stay, or documentation that Resident #355 refused the [redacted] testing.

The surveyor reviewed employees testing logs that were provided by the DON.

The Certified Nursing Assistant (CNA) was not up

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| F 886 | Continued From page 156<br>to date (CNA did not receive a [redacted]) on [redacted] vaccines. The testing log showed that the CNA was tested for [redacted] on [redacted] and again on [redacted]. There was no further testing done for [redacted] through [redacted] except for [redacted] and 1[redacted] The CNA was not tested for [redacted] twice a week according to the facility policy and CDC guidance for staff who are not up to date with their vaccinations.<br><br>On 11/3/22 at 9:36 AM, the surveyor followed up with the DON on the documents needed for Residents #8, and #355, and the CNA's testing logs. The DON stated that there were no additional documents to provide concerning the two residents and CNA's testing for [redacted]<br><br>A review of the facility's policy titled, "Covid Testing", a policy dated 9/2022. Under the section, "Testing of Staff and Residents in Response to an Outbreak Investigation", number 5, indicated that contact tracing or broad-based testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and if negative, again 48 hours after the second negative test. This will typically be on day one, day 3, and day 5. Testing should be repeated every three to seven days until no new cases are identified for at least 14 days."<br><br>Under the section titled, "Resident Testing-New Admissions", it indicated that resident admissions in counties where community transmission levels are high should be tested upon admission and if negative, again 48 hours after the first negative test and if negative again 48 hours after the second negative. Testing should be repeated | F 886 | | |

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| F 886 | Continued From page 157<br>every 3 to 7 days until no new cases are identified for at least 14 days.<br><br>On 11/03/22 at 11:36 AM, the survey team met with the two Regional LNHA, Regional Registered Nurse, and DON. The facility management had no additional information provided.<br><br>NJAC 8:39-19.4 (a) | F 886 | | |
| F 888 SS=C | COVID-19 Vaccination of Facility Staff<br>CFR(s): 483.80(i)(1)-(3)(i)-(x)<br><br>§483.80(i)<br>COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.<br><br>§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:<br>(i) Facility employees;<br>(ii) Licensed practitioners;<br>(iii) Students, trainees, and volunteers; and<br>(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.<br><br>§483.80(i)(2) The policies and procedures of this | F 888 | | 1/20/23 |

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section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of

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any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to

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| LLANFAIR HOUSE CARE & REHABILITATION CENTER | 1140 BLACK OAK RIDGE ROAD WAYNE, NJ 07470 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 888 | Continued From page 160<br>COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and<br>(x) Contingency plans for staff who are not fully vaccinated for COVID-19.<br><br>Effective 60 Days After Publication:<br>§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, it was determined that the facility failed to: a.) ensure that staff was up-to-date on their COVID-19 vaccinations for one (1) of five (5) staff reviewed for compliance, b.) track staff who had not received a booster and inaccurately identified the staff member as medically exempt for one of one reviewed for a medical exemption, and c.) update and implement their facility policy and delineate a contingency plan for not up-to-date vaccinated staff in accordance with Federal and State guidelines.<br><br>This deficient practice was evidenced by the following:<br><br>Reference: According to the Centers for Medicare and Medicaid Services (CMS) QSO-23-02-ALL " Revised Guidance for Staff Vaccination Requirements", dated 10/26/22 " ... A process for tracking and securely documenting | F 888 | 11/3/2022 The Director of Nursing re-educated all non-boosted staff on receiving the COVID-19 booster. Full staff COVID-19 vaccination audit was completed on 11/3/2022 by the Director of Nursing. Staff was reminded of the testing protocols for all non-boosted staff. Staff made aware of future facility booster clinics and the dates will be posted near staff time clocks. Next clinic scheduled for [redacted]<br><br>All residents have the potential to be affected by this deficient practice.<br><br>The Infection Preventionist and/or designee will continue to provide COVID-19 education prior to in-house booster clinics and monthly for all staff members who have declined the booster to ensure awareness of the Covid-19 | |

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| F 888 | Continued From page 161<br>information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements" And establish "Contingency plans for staff who are not fully vaccinated for COVID-19."<br><br>Reference: According to the New Jersey Executive Directive NO. 21-011 (2nd Revision), dated 9/2/22 " 'Up to date with COVID-19 vaccinations' means that covered workers in health care and high-risk congregate settings received a primary series (either a 2-dose primary series of a COVID-19 vaccine or a single-dose primary series COVID-19 vaccine) and the first booster dose for which they are eligible as recommended by the CDC."<br><br>" ...Each such covered setting (e.g., employer) shall maintain the following information ...: a. Exemptions from COVID-19 vaccination participation: i. Number of covered workers who have a documented medical exemption from COVID-19 vaccination ..."<br><br>On 10/13/22 at 10:04 AM, during an entrance conference, the surveyor met with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Registered Nurse (RN) Quality Assurance (QA) / Regional Nurse. The administrative team stated that they were in an outbreak with one positive resident from the date [redacted].<br><br>At that time, the administrative team informed the surveyor that the DON was also the facility's Infection Preventionist Nurse (IPN) and was responsible for the infection control program as well as oversight of the Covid-19 vaccination | F 888 | booster with the goal of 100% compliance. The Infection Preventionist and/or designee will continue to test non-boosted staff weekly depending on the community rate. The IP will track non-boosted staff for compliance with wearing the required Personal Protective equipment as well as observing social distancing. Disciplinary action will be taken if found not adhering to the required precautions as it relates to the testing, Personal Protective Equipment, and social distancing.<br><br>The Administrator and Director of Nursing will monitor vaccination rates and non-adherence to the precautions list weekly x 4, bi-weekly x 2 weeks and monthly x 3. The audits will be discussed during our monthly QAPI meeting; QAPI committee will determine if continued auditing is necessary. Once 100% compliance threshold is achieved for two consecutive months. This plan can be amended when indicated. Adverse finding will be immediately addressed. Findings and trends will be reported to QAPI Committee. | |

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| F 888 | Continued From page 162<br>effort.<br><br>On 10/31/22 at 11:45 AM, the surveyor met with the DON and requested documentation for the vaccination status of five staff members. The DON also stated that the last COVID-19 clinic was "probably" on [redacted]<br><br>On 11/01/22 at 8:50 AM, the surveyor reviewed the COVID-19 immunization documentation provided by the Regional RN (RRN) which reflected that 1 of the 5 staff reviewed, a Certified Nurse Aide (CNA) had vaccinations and [redacted] and [redacted], had no documented evidence of a booster and was indicated as medically exempt.<br><br>On 11/01/22 at 12:09 PM, the surveyor interviewed Regional LNHA#1 (RLNHA#1) and RRN in the presence of the survey team. The surveyor was provided with a copy of the CNA's vaccination card which indicated that she was vaccinated on [redacted] and [redacted]. In addition, the surveyor was provided with a signed copy of a "Declination of COVID-19 Vaccination" dated [redacted], which indicated that the CNA wanted to discuss the vaccination with her primary care physician. The surveyor requested a copy of the CNA's medical exemption documentation and LNHA#1 stated that the facility did not have any documentation.<br><br>At that time, the surveyor informed RLNHA#1 and the RRN about the New Jersey Department of Health (NJDOH) regulations in regard to facility staff is required to be fully vaccinated and with one booster. The RRN stated that "I thought the medical exemptions are only for the primary vaccinations." | F 888 | | |

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| F 888 | Continued From page 163 | F 888 | | |

On 11/02/22 at 9:07 AM, the surveyor interviewed the DON in the presence of the survey team. The DON stated that she was responsible for the COVID-19 vaccination status for staff, and the documentation for tracking according to regulation. She further stated that it had been the responsibility of the previous IPN and "right now it's me." The DON stated that she tracked everything for the most part and that this CNA fell through the crack in regard to following up on a medical exemption. She further stated that she thought the CNA had a medical exemption and acknowledged that it was not accurately tracked. The DON also acknowledged that the facility vaccination policy should have included the updated NJDOH guidance about Executive Orders and Executive Directives.

On 11/03/22 at 9:35 AM, the surveyor team met with RLNHA#1, the RRN, and the DON. The surveyor again reviewed concerns regarding the tracking of a medical exemption for the CNA and the fact that the facility vaccination policy was not updated to include NJDOH guidance for COVID-19 boosters for staff.

On 11/03/22 at 11:50 AM, the survey team met with RLNA#1 and #2, the RRN, and the DON. The facility team was unable to provide additional information related to survey teams' vaccination concerns or concerns as to why the facility vaccination policy was not updated and the contingency plan was not delineated. In addition, despite the survey team's request, the CNA had not called prior to exit.

A review of the facility's policy "Employee COVID-19 Vaccination" with a revised date of 01/2022, reflected that "It is the policy of this

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| F 888 | Continued From page 164 | F 888 | | |

facility to ensure that all eligible employees are vaccinated against COVID-19 as per applicable Federal, State and local guidelines." The policy also reflected that the definition of a "Booster" was "A dose of vaccine administered when the initial sufficient immune response to the primary vaccination series is likely to have waned over time." The policy further reflected that "The facility will establish contingency plans in the event that staff have indicated that they will not get vaccinated and do not qualify for an exemption or staff who are not fully vaccinated due to an exemption or temporary delay in vaccination." The policy reflected that "The facility will track and securely document the vaccination status of each staff member (current and as new employees are onboarded), to include: a. Individuals whose vaccination is delayed due to a clinical concern or consideration and the reason for the delay."

A review of the policy did not reflect that the staff was required to receive a booster vaccine, nor did it outline a contingency plan. The most recent guidance that the policy referenced was "Centers for Medicare and Medicaid Services: QSO-22-09-ALL Guidance for the Interim Final Rule - Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination (January 14, 2022)."

NJAC 8:39-5.1(a); 19.4(a)

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| | 061611 | A. BUILDING: _____ B. WING _____ | C 11/03/2022 |

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| S 000 | Initial Comments<br><br>The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations. | S 000 | | |
| S 560 | 8:39-5.1(a) Mandatory Access to Care<br><br>(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.<br><br>This REQUIREMENT is not met as evidenced by:<br>Part A:<br><br>Based on the interview and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This deficient practice was evidenced by the following:<br><br>Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes.<br><br>Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes | S 560 | Part A<br>10/24/2022 the Facility Assessment was reviewed and updated to the include the sufficient staffing assessment component. The update included staffing ratios that meet, at the minimum, state staffing requirements with consideration made based on census, acuities and special needs of residents. At a minimum CNA Staffing Ratios will be 1 cna to 8 residents on 7-3 shift; 1 cna to 10 residents on 3-11 shift; 1 cna to 14 residents for 11-7 shift. 10/24/22 three Healthcare agencies were contracted to assist with meeting staffing requirements. 10/24/22 Provided premium pay to current staff who agrees to work or cover an additional cna shift. 10/24/22 a | 1/20/23 |

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

Electronically Signed | 12/02/22

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| S 560 | Continued From page 1<br>effective 2/1/21.<br><br>1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios:<br>(1) one certified nurse aide to every eight residents for the day shift;<br>(2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and<br>(3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties<br><br>b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census.<br><br>c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place.<br>(2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, | S 560 | regional Administrator was appointed by the governing body to be responsible for the management and overall operation of the facility. 10/24/22 admissions were curtailed.<br><br>All residents have potential to be affected by this deficient practice.<br><br>Staffing sufficiency review by Administrator, Director of Nursing and Staffing Coordinator to determine minimum number of cna's needed per resident unit based on resident census and acuities per shift for day and for upcoming week Monday through Friday and Friday for the weekend. Adjustments made as census changes are noted. Staffing review by Administrator, Director of Nursing and Staffing Coordinator to review number of aides needed to the actual number of cnas or the previous 24 hour shifts Monday through Friday and Friday and Monday review for the weekend. Follow up with staff for call outs and no calls/no show. Staffing review by Administrator, Director of Nursing and Staffing Coordinator with regional clinical and administrative leadership to ensure actions are being taken to secure needed staff including use of Healthcare agencies and recruiting efforts to hire staff at least weekly. Facility will employ staff from healthcare agencies to fill staff openings until sufficient staff is hired to meet required staffing requirements. Staff recruitment with regional recruiter and planning of recruitment events. Bonus' to staff for filling open shifts. | |

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| S 560 | Continued From page 2<br>is fifty-one hundredths or higher.<br>(3) All computations shall be based on the midnight census for the day in which the shift begins.<br><br>d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ...<br><br>A review of the "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two weeks beginning 9/25/22 and ending 10/08/22 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements of CNAs on 14 of 14-day shifts, deficient in total staff for residents on 4 of 14 evening shifts, and deficient in total staff for residents on 14 of 14 overnight shifts as follows:<br><br>-09/25/22 had 6 CNAs for 108 residents on the day shift, required 13 CNAs. (18 residents per CNA)<br>-09/25/22 had 10 total staff for 108 residents on the evening shift, required 11 total staff.<br>-09/25/22 had 6 total staff for 108 residents on the overnight shift, required 8 total staff.<br>-09/26/22 had 6 CNAs for 107 residents on the day shift, required 13 CNAs. (17.83 residents per CNA)<br>-09/26/22 had 5 total staff for 108 residents on the overnight shift, required 8 total staff.<br>-09/27/22 had 7 CNAs for 107 residents on the day shift, required 13 CNAs. (15.28 residents per CNA) | S 560 | The facility licensed nursing home administrator will forward weekly reports to Department of Health and Senior Services of mitigating strategies for staffing until admission curtailment is lifted. Staffing coordinator, Administrator and Director of Nursing daily monitoring of cna to resident ratios for every shift until staffing is stabilized and then for 3 months and at least weekly thereafter. Staffing and turnover trends to be reported to Quality Assurance Performance Improvement Committee at each QAPI meeting monthly.<br><br>Part B<br>A registered nurse with the required training is designated as the Infection Preventionist at the building.<br><br>All residents have the potential to be affected by this deficient practice.<br><br>The Administrator and Director of Nursing will ensure the IPN at the building meets the minimum requirements for the position and will maintain education and training for an affective Infection Control program. The Administrator and Director of Nursing will audit minimum requirements for the IPN including education and training at least annually, upon new hire and as needed.<br><br>Audits will be monitored for completion by the Administrator and Director of Nursing monthly for 3 months. Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine | |

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| S 560 | Continued From page 3<br>-09/27/22 had 9 total staff for 107 residents on the evening shift, required 11 total staff.<br>-09/27/22 had 4 total staff for 107 residents on the overnight shift, required 8 total staff.<br>-09/28/22 had 7 CNAs for 106 residents on the day shift, required 13 CNAs. (15.14 residents per CNA)<br>-09/28/22 had 5 total staff for 106 residents on the overnight shift, required 8 total staff.<br>-09/29/22 had 8 CNAs for 105 residents on the day shift, required 13 CNAs. (13.12 residents per CNA)<br>-09/29/22 had 5 total staff for 105 residents on the overnight shift, required 7 total staff.<br>-09/30/22 had 6 CNAs for 105 residents on the day shift, required 13 CNAs. (17.50 residents per CNA)<br>-09/30/22 had 5 total staff for 105 residents on the overnight shift, required 7 total staff.<br>-10/01/22 had 7 CNAs for 105 residents on the day shift, required 13 CNAs. (15 residents per CNA)<br>-10/01/22 had 9 total staff for 105 residents on the evening shift, required 10 total staff.<br>-10/01/22 had 5 total staff for 105 residents on the overnight shift, required 7 total staff.<br>-10/02/22 had 6 CNAs for 105 residents on the day shift, required 13 CNAs. (17.50 residents per CNA)<br>-10/02/22 had 9 total staff for 105 residents on the evening shift, required 10 total staff.<br>-10/02/22 had 6 total staff for 105 residents on the overnight shift, required 7 total staff.<br>-10/03/22 had 5 CNAs for 105 residents on the day shift, required 13 CNAs. (21 residents per CNA)<br>-10/03/22 had 5 total staff for 105 residents on the overnight shift, required 7 total staff.<br>-10/04/22 had 5 CNAs for 105 residents on the day shift, required 13 CNAs. (21 residents per | S 560 | if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly. | |

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| S 560 | Continued From page 4<br>CNA)<br>-10/04/22 had 4 total staff for 105 residents on the overnight shift, required 7 total staff.<br>-10/05/22 had 4 CNAs for 105 residents on the day shift, required 13 CNAs. (26.25 residents per CNA)<br>-10/05/22 had 5 total staff for 105 residents on the overnight shift, required 7 total staff.<br>-10/06/22 had 5 CNAs for 105 residents on the day shift, required 13 CNAs. (21 residents per CNA)<br>-10/06/22 had 6 total staff for 105 residents on the overnight shift, required 7 total staff.<br>-10/07/22 had 6 CNAs for 105 residents on the day shift, required 13 CNAs. (17.50 residents per CNA)<br>-10/07/22 had 5 total staff for 105 residents on the overnight shift, required 7 total staff.<br>-10/08/22 had 5 CNAs for 107 residents on the day shift, required 13 CNAs. (21.40 residents per CNA)<br>-10/08/22 had 6 total staff for 107 residents on the overnight shift, required 8 total staff.<br><br>On 11/03/22 at 11:04 AM, the surveyor interviewed the Nursing Staffing Coordinator (SC). The SC acknowledged staff shortages for all three shifts weekdays and weekends. She stated that she was familiar with minimum staffing requirements but could not speak to "numbers off the top of my head, but I have them." She further stated that "now we are working with 4 agencies"; "not previously we had no agency."<br><br>On that same date and time, the SC stated that staffing has been a challenge and that the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) were aware. She further stated that she participated in weekly meetings with "corporate" regarding staffing | S 560 | | |

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challenges and that they try and provide staff from other buildings, however, "I work with sister facilities to solve staffing issues but unfortunately they are in the same boat."

A review of the facility policy "Nursing Services and Sufficient Staff" with a revised date of 11/2021, reflected that the facility should "provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity, and diagnoses of the resident population will be considered based on the facility assessment." In addition, it reflected that "The facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans." This included except when waived, licensed nurses and other personnel "including but not limited to nurse's aides."

Part B:

Based on the interview and review of pertinent facility documentation, it was determined that the facility failed to ensure that the Infection Preventionist who was assigned to oversee their infection prevention and control program met the minimum qualifications as mandated by the State of New Jersey. This deficient practice was identified and evidenced by the following:

Reference: New Jersey Executive Directive NO. 21-012 (Revised) "Directive for the Resumption of Services in all Long-Term Care Facilities" dated 4/21/22 directs the following: "Core infection prevention and control practices must be in place at all times. Maintaining core infection prevention

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| | 061611 | A. BUILDING: _____ B. WING _____ | C 11/03/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| LLANFAIR HOUSE CARE & REHABILITATION CENTEI | 1140 BLACK OAK RIDGE ROAD WAYNE, NJ 07470 |

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and control practices is key to preventing and containing outbreaks and is crucial in ensuring the delivery of quality, safe care. In addition to the requirements in N.J.A.C. 8:39-20, the following practices shall remain in place even as long-term care facilities resume normal activities ..."
Reference: NJ State requirement, CHAPTER 190, approved 8/5/21. An Act concerning infection control requirements for long-term care facilities and amending 2 P.L.2019, c.243.

Be it enacted by the Senate and General Assembly of the State of New Jersey: 1. Section 1 of P.L.2019, c.243 (C.26:2H-12.87) is amended to read as follows:

"e. (1) The department shall require each long-term care facility to establish an infection prevention and control committee and assign to the facility's infection prevention and control committee ...
(a) a physician who has completed an infectious disease fellowship, who shall be employed on a full-time or part-time basis or contracted with on a consultative basis; and
(b) an individual designated as the infection preventionist who
(i) has primary professional training in medicine, nursing, medical technology, microbiology, epidemiology, or a related field
(ii) is qualified by education, training, and at least five years of infection control experience, or by certification in infection control by the Certification Board of Infection Control and Epidemiology
(iii) is employed by the facility consistent with the requirements of subsection f. of this section; and
(iv) has completed specialized training in infection prevention and control."

"f. (1) An infection preventionist assigned to a

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long-term care facility's infection prevention and control committee pursuant to subsection e. of this section shall be a managerial employee and shall be employed: ...(b) in the case of a long-term care facility with a licensed bed capacity equal to more than 100 beds ...on a full-time basis."

On 10/13/22 at 10:04 AM, during an entrance conference, the surveyor met with the LNHA, the DON, and the Registered Nurse (RN) Quality Assurance (QA) / Regional Nurse. At that time the administrative team informed the surveyor that the DON was also the facility's Infection Preventionist Nurse (IPN) and was responsible for the infection control program as well as oversight of the Covid-19 vaccination effort. In addition, the RN/QA Regional Nurse stated that the facility was in the process of hiring an IPN. Both the RN/QA Regional Nurse and the DON acknowledged the guidelines that the IPN responsibilities were required to be a full-time role and should not have overlapped with the responsibilities of another position.

On 10/14/22 at 9:41 AM, the surveyor interviewed the Regional DON (RDON), who stated that the prior IPN was also the Assistant DON.

On 11/02/22 at 9:07 AM, the surveyor interviewed the DON in the presence of the survey team. The DON stated that she was the IPN of the facility. She further stated that she was responsible for Antibiotic Stewardship and tracking staff Covid-19 vaccination status. The DON could not speak to the requirements to be an Infection Preventionist, she stated that "off the top of my head I don't know the requirements", she stated that she knew some of the requirements but not all of them. In addition, she stated that she did not

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have five years of infection control experience, the DON stated, "no I do not have a requirement for IP for 5 years." She stated that most of her experiences were as a Unit Manager, handling resident care, staffing her unit, and providing education, but not specific to infection prevention. In addition, the DON acknowledged that the facility did not have an Infectious Disease physician on staff or as a consultant.

On 11/03/22 at 11:36 AM, the survey team met with the facility's administrative team which included Regional LNHA#1 and #2, Regional Registered Nurse (RRN), and the DON. The RRN stated that she was unsure whether or not the facility's Medical Director had a certification in Infection Prevention. At that time the facility's administrative team had no additional information to provide to the survey team.

On 11/03/22 at 11:42 AM, the administrative team acknowledged that the DON was also functioning in the IPN position and that the facility did not have an Infectious Disease consultant.

A review of the DON's resume that she provided to the surveyor on 10/14/22 at 9:01 AM, did not reflect professional experience in the area of Infection Prevention.

A review of the facility's "Infection Preventionist" job posting reflected the following "Required Qualifications":

"Minimum requirements include the following:
A nursing degree from an accredited college or university or be a graduate of an approved LPN (Licensed Practical Nurse)/RN program.
Three years of experience as an LPN/RN.
Eligible to participate in federally funded health

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| S 560 | Continued From page 9<br>care programs.<br>Must also meet state requirements for relevant licensures or certifications and have no disciplinary action in effect against professional license.<br>Education, training, experience, or certification in infection control and prevention.<br>Completed specialized training in infection prevention and control through accredited continuing education.<br>Show<br>Medical Specialty ...Infectious Disease ..." | S 560 | | |