STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315142	A. BUILDING _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
E 000	Initial Comments Survey: 11/9/2023 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 Complaint #: NJ00167014, NJ00166757, NJ00168885 Survey Date: 11/9/2023 Census: 98 Sample: 22 + 2 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		11/14/23

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

Electronically Signed | 12/01/2023

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

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F 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, it was determined that the facility failed to maintain dignity during mealtime for a resident. This deficient practice was observed for 1 of 18 residents reviewed for dining observation, Resident #64 and was evidenced by the following: On 10/30/23 at 12:19 PM, the surveyor observed Resident #64 in the first floor dining room seated	F 550	Element I Resident #64 had no adverse effects related to the deficient practice related to serving meals. Element II All residents have the potential to be affected by the deficient practice.	

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F 550	Continued From page 2 in a wheelchair. Resident #64 was observed eating their lunch. The surveyor observed that the Licensed Practical Nurse #2 (LPN #2) feeding Resident #64 while standing over them. The surveyor further observed that LPN #2 was wandering around the dining room assisting other residents with their meal. On 10/30/23 at 12:25 PM, the surveyor interviewed LPN #2 who stated that staff should be seated next to the resident while assisting them during feeding time. LPN #2 further stated that she wasn't really feeding Resident #64 but was just wandering around. A review of the Admission Record for Resident #64 revealed that the resident was admitted to the facility with diagnoses which included but were not limited to *Ex Order 26. 4B1* [redacted]. A review of Resident #64's Quarterly Minimum Data Set, an assessment tool used to facilitate the management of care, dated [redacted], reflected that Resident #64 had a Brief Interview for Mental Status score of [redacted] out of 15, indicating [redacted]. The MDS further reflected that the resident required set up help for meals. On 11/9/23 at 11:05 AM, the surveyor met with the facility's Director of Nursing (DON) regarding the above concern. The DON stated that any staff feeding a resident must be seated next to the resident when feeding. No further information was provided. N.J.A.C. 8:39-4.1(a)12	F 550	Element III 11/10/23- Director of Nursing provided 1 to 1 education to LPN on sitting down with the resident at eye level when feeding it provides dignity to the resident. 11/10/23- The facility educator in-serviced all licensed nursing staff on the facility policies and procedures for steps to take when assisting the resident with feeding. This includes all LPN□s, RN□s and CNA□s whose assisting with feeding to position at eye level facing the resident. The Director of Nursing or designee will conduct weekly audits of residents who require assistance with feeding to assure proper techniques are used when feeding a resident. Director of Nursing/ ADON/DESIGNEE will provide continued education with current staff as well as newly hired staff with feeding a resident. Element IV Audits will be monitored for completion by the Administrator or Director of Nursing weekly for 4¿weeks,¿bi-weekly X 2 months and monthly¿X¿3 months¿and quarterly X 2. Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is	

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F 550	Continued From page 3	F 550	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.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		11/14/23

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F 584	Continued From page 4 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to provide a homelike environment during meal service in both dining rooms located in the facility. The deficient practice was observed on 2 of 2 facility floors, dining room 1 (DR1) and dining room 2 (DR2) during lunch service observation. This deficient practice was evidenced by the following: On 10/30/2023 at 11:55 AM, during the lunch service located on 2nd floor dining room (DR2), the surveyor observed that all meals in DR2 were served and remained on meal trays throughout the meal. On 10/30/2023 at 12:02, during the lunch service located on 1st floor dining room (DR1), the surveyor observed that all meals in DR1 were served and remained on meal trays throughout the meal. On 10/31/2023 at 11:45 AM, during the lunch service located on 2nd floor dining room (DR2), the surveyor observed that all meals in DR2 were	F 584	Element I All nursing staff including RN□s, LPN□s, CNA□s were re-educated on 11/02/2023 on the facility updated policies and procedures on serving a meal and creating a homelike environment by removing all food items from the meal trays before presenting the meals. Element II All residents that reside in the facility have the potential to be affected by the deficient practice. Element III 11/04/2023 - The facility educator in-serviced all licensed nursing staff on the facility policies and procedures for steps to take in creating a homelike environment. This includes all LPN□s, RN□s and CNA□s whose assisting with serving meals to remove all food items from the tray before serving the resident.	

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F 584	Continued From page 5 served and remained on meal trays throughout the meal. On 10/31/2023 at 12:11 PM, during the lunch service located on 1st floor dining room (DR1), the surveyor observed that all meals in DR1 were served and remained on meal trays throughout the meal. On 11/2/2023 at 11:46 AM, during the lunch service located on 2nd floor dining room (DR2), the surveyor observed that all meals in DR2 were served and remained on meal trays throughout the meal. On 11/3/2023 at 10:20 AM, the surveyor interviewed the Director of Nursing (DON). The DON agreed that all items should be removed off trays for resident in the dining room to create a homelike environment. Surveyor requested a copy of the facility policy that discusses homelike environment and dining. On 11/06/2023 at 12:35 PM, The DON provided the surveyor with a copy of the facility policy titled, "Serving a Meal" last updated on 9/20/2023. The facility policy does not address eating in the dining room or creating a homelike environment when eating. NJAC 8:39-4.1 (a)	F 584	-The facility educator/designee will provide continued education with current staff as well as newly hired staff with the proper techniques for serving meals. - The Director of Nursing/Unit Manager or Dietary Managers will monitor all trays served in the dining areas to assure the facility provides a homelike environment during serving a meal daily for 2 weeks, then 3 times a week for 2 months. Element IV Audits will be monitored for completion by the Administrator or Director of Nursing weekly for 4¿weeks,¿bi-weekly X 2 months and monthly¿X¿3 months¿and quarterly X 2. 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.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657		11/14/23

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F 657	Continued From page 6 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to revise the person centered comprehensive care plans (CCP) for 3 of 22 residents reviewed (Resident #63, #71, and #52). This deficient practice was identified by the following: 1. On 10/30/23 at 11:36 AM, the surveyor observed Resident #63 in bed, watching TV. The surveyor further observed a floor mat on both	F 657	Element I On 11/10/2023 Resident #63 was assessed with no adverse effects observed due to the deficit practice. Resident #63 care plan was reviewed on Ex Order 26. 4B1 and noted with the current intervention dated Ex Order 26. 4B1 by the IDCP team to reflect the physician orders to have in place the use of NJ Ex.Order 26.4(b)(1) [redacted] while in bed every shift for safety check for proper	

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F 657	Continued From page 7 sides of the bed. The surveyor reviewed Resident #63's hybrid medical records. The Admission Record (AR) reflected that Resident #63 was admitted to the facility with medical diagnoses that included but were not limited to, Ex Order 26. 4B1 . A review of the Significant Change Assessment Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Ex Order 26. 4B1 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of Ex Ord out of 15 indicating that the resident had Ex Order 26. 4B1 . A review of the Ex Order 26. 4B1 Order Summary Report (OSR) revealed a physician's order (PO) dated Ex Order 26. 4B1 for 'NJ Ex.Order 26.4(b)(1) t". The surveyor reviewed Resident #63's CCP which did not reflect a care plan for the resident's use of NJ Ex.Order 26.4(b)(1). On 11/9/23 at 11:05 AM, the surveyor met with the facility's Director of Nursing (DON) who stated that the use of NJ Ex.Order 26.4(b)(1) should have been included in Resident #63's CCP to reflect the current plan of care they are providing to the resident. The DON further stated that the current CCP for Resident #63 did not include the use of NJ Ex.Order 26.4(b)(1). 2. On 10/30/23 at 12:04 PM, the surveyor observed Resident #71 in the dining room seated in a Ex Order 26. 4B1 waiting for the lunch to	F 657	placement. Resident #71 was assessed with no adverse effects observed due to the deficit practice. Resident #71 care plan was reviewed by the IDCP. On Ex Order 26. 4B1 the Director of Rehab initiated an evaluation to assess the use of the Ex Order 26. 4B1. On 11/09/2023 a full house care plan audit was conducted by the Director of Nursing and the Director of Rehab on all residents that require use of orthotics with no other findings. Resident #52 was assessed with no adverse effects observed due to the deficit practice. Resident #52 care plan was reviewed and revised to reflect that the use of the Ex Order 26. 4B1 medication Ex Order 26. 4B1 had been discontinued on Ex Order 26. 4B1. The Director of Nursing provided one to one education to the unit manager who performed the deficient practice on the facility policy and procedure on initiating and revising a care plan to meet the residents' needs. Element II All residents in the facility have the potential to be affected by the deficient practice. Element III	

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F 657	Continued From page 8 be served. The surveyor reviewed Resident #71's hybrid medical records. The AR reflected that Resident #71 was admitted to the facility with medical diagnoses which included but not limited to, [redacted]. A review of the Quarterly Assessment Minimum Data Set (Q/MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a BIMS score of [redacted] out of 15 indicating that the resident was [redacted]. A review of the October 2023 OSR revealed a PO dated [redacted] to "Apply [redacted] daily after AM care for 3.5 hours every day shift for Impaired [redacted] ". The surveyor reviewed Resident #71's CCP which did not reflect a care plan for the resident indicating the use of [redacted] daily. A review of the facility's policy and procedure titled, "Comprehensive Care Plans" with a revised date of [redacted], documented under "#5.The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment." On 11/9/23 at 11:05 AM, the surveyor met with the facility's DON who stated that the use of [redacted] should have been included in Resident #71's CCP to reflect the current plan of care they are providing to the resident. The DON further	F 657	The Director of Nursing or designee will conduct 5 random weekly audits on care plan completion and appropriateness in relation to resident diagnosis, interventions, and or change in condition status. The Director of Nursing in-serviced the Interdisciplinary Care Plan Team on 11/02/2023 to initiate or revise the residents care plans immediately to meet the medical, nursing, and mental and psychosocial needs immediately as needed. Element IV Audits will be monitored for completion by the Administrator or Director of Nursing weekly for 4¿weeks,¿bi-weekly X 2 months and monthly¿X¿3 months¿and quarterly X 2. 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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F 657	Continued From page 9 stated that the current CCP of Resident #71 did not indicate the use of Ex Order 26. 4B1. 3. On Ex Order 26. 4B1 at 11:28 AM, the surveyor observed Resident #52 in their room. The resident was in bed, the bed was in the lowest position. Resident # 52 had a mattress leaning against the wall, no bed rails and/or floor mats were observed in the room. The surveyor reviewed Resident #52's hybrid medical record. The AR reflected that Resident #52 was admitted to the facility with medical diagnoses which included but not limited to Ex Order 26. 4B1 . A review of the Q/MDS, an assessment tool used to facilitate the management of care, dated Ex Order 26. 4B1 reflected that the resident had a BIMS of [redacted] out of 15 indicating that the resident had a Ex Order 26. 4B1 . A review of the Ex Order 26. 4B1 OSR revealed a PO dated Ex Order 26. 4B1 for Ex Order 26. 4B1 , 1 tablet via Ex Order 26. 4B1 two times a day related to Ex Order 26. 4B1 with NJ Ex.Order 26.4(b)(1). The PO for Ex Order 26. 4B1 had a discontinue date of Ex Order 26. 4B1. The medicine has not been re-order since Ex Order 26. 4B1. A review of Resident #52's CCP dated Ex Order 26. 4B1 shows an active care plan for Ex Order 26. 4B1 with a revision date of 10/2/2023.	F 657		

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F 657	Continued From page 10 On 11/2/2023 at 11:50 AM, the surveyor interviewed the 2nd floor Unit Manager (UM), who declared that she is the person who updates all the resident's CPs on her unit. The surveyor reviewed Resident #52's CP with the UM. The UM explained that Resident # 52 has not been treated with Ex Order 26. 4B1 since Ex Order 26. 4B1 and the CP should have been updated to reflect the discontinuation of Ex Order 26. 4B1. On 11/3/2023 at 10:20 AM, the surveyor interviewed the DON to discuss the above concerns. The DON stated that the CP was not updated to reflect Resident #52's the current medication regimen. There was no additional information provided. NJAC 8:39-11.2(i)	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to consistently follow standards of clinical practice with regards to: accurately documenting medication administration for 1 of 1 NJ Ex Order 26. 4B residents, Resident #40. This deficient practice was evidenced by the following:	F 658	Element I Resident #40 was assessed with no negative outcome due to the deficit practice. On Ex Order 26. 4B1 the primary physician was notified. 11/02/2023 All licensed nurses were immediately in-service by the facility	11/14/23

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F 658	Continued From page 11 Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 10/30/23 at 12:40 PM, the surveyor observed Resident #40 sitting in the dayroom. The resident was alert, conversant and stated that they were scheduled to go to [redacted] later in the afternoon. Resident #40 was scheduled for [redacted] every Monday, Wednesday, and Friday. The resident had no concerns with their care. A review of Resident #40's electronic health record (EHR) revealed the following:	F 658	educator on proper documentation pertaining to physician orders and signing the residents EMAR after medication administration. The nurse will report and document any adverse side effects or refusals, correct any discrepancies and report the findings to the nurse manager or designee. Element II All residents have the potential to be affected by this deficient practice. Element III - All RNs/LPN's will follow facility Policies and procedures on proper documentation of Physician orders into the residents EMARs, on completion of all vitals recording as ordered including timely signing of physician orders and refusals in the EMARs. - Facility Educator/Designee will continue to educate all RNs/LPNs on completing and signing off on all orders in the EMAR upon completion. Element IV -. Unit Managers and Nursing supervisors will conduct random daily audits of active residents EMARs to assurethey are completed and signed timely; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly X 3 months.	

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	315142	A. BUILDING _____ B. WING _____	C 11/09/2023

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F 658	Continued From page 12 According to the Admission Record (an admission summary), Resident #40 was admitted with diagnoses that included but not limited to, [redacted]. An Annual Minimum Data Set (MDS) assessment, a tool used to facilitate management of care, dated [redacted], indicated that the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #40 scored a [redacted] out of 15, which indicated the resident was [redacted]. A physician's order, dated [redacted] read: '[redacted] Give 2 tablet by mouth in the morning for [redacted] for 1 Day (before breakfast) and Give 1 tablet by mouth in the afternoon for [redacted] for 1 Day (after lunch) and Give 1 tablet by mouth in the evening for [redacted] for 1 Day (after supper) and Give 2 tablet by mouth at bedtime for [redacted] for 1 Day." A physician's order, dated [redacted] read: '[redacted] Give 1 packet by mouth one time only for [redacted] for 6 Days." A review of the October 2023 documentation in the electronic medication administration record (eMAR) for [redacted] revealed that [redacted] out of 4 doses to be administered were not signed by the nurses as administered. The eMAR was left blank for the 4 doses. A review of the [redacted] 2023 documentation	F 658	-Audits will be monitored for completion by the Administrator and Director of Nursing weekly X 4 weeks, bi-weekly X 4 weeks, monthly x 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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F 658	Continued From page 13 in the electronic medication administration record (eMAR) for Ex Order 26. 4B1 revealed that [redacted] out of 4 doses to be administered were not signed by the nurses as administered. The eMAR was left blank for the 4 doses. Further review of the NJ Ex.Order 26.4(b)(1) 2023 eMAR revealed that on Ex Order 26. 4B1 the following medication entries had no nurse's signature as administered and were left blank: - 'Ex Order 26. 4B1 Give 1 tablet by mouth in the morning for Ex Order 26", which was scheduled for 0900 [9AM]. - 'Ex Order 26. 4B1 Give 1 tablet by mouth in the morning", which was scheduled for 0900. - 'Ex Order 26. 4B1 Give 1 tablet by mouth one time a day", which was scheduled for 0900. - 'Ex Order 26. 4B1 Give 1 tablet by mouth in the evening", which was scheduled for 1800 [6PM]. - 'Ex Order 26. 4B1 Give 1 tablet by mouth in the evening", which was scheduled for 1800. - "Ex Order 26. 4B1 Give 1 tablet by mouth in the morning", which was scheduled for 0900. - 'Ex Order 26. 4B1 Give 1 tablet by mouth one time a day", which was scheduled for 0600 [6AM]. - 'Ex Order 26. 4B1 Give 1 tablet by mouth in the morning", which was scheduled for 0900. - 'Ex Order 26. 4B1 Give 1 tablet by mouth at bedtime", which was scheduled for 2100 [9PM]. - 'Ex Order 26. 4B1 Give 1	F 658		

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F 658	Continued From page 14 tablet by mouth two times a day", which was scheduled for 0900 and 1700 [5PM]. - "Ex Order 26. 4B1 Give 1 capsule by mouth two times a day", which was scheduled for 0900 and 1700. - "Ex Order 26. 4B1 Ex Order 26. 4B1 Give 3 capsule by mouth every 8 hours", which was scheduled for 0600, 1400 [2PM], and 2200 [10PM]. - "Ex Order 26. 4B1 Give 1 tablet by mouth before meals", which was scheduled for 0730 [7:30AM], 1100 [11AM], and 1600 [4PM]. On 11/8/23 at 1:35 PM, the surveyor discussed the concerns of the missing nursing signatures for the administration of medication found on the eMAR for September and October 2023 with the Director of Nursing (DON), in the presence of the regional clinical nurse. The DON reviewed the resident's eMAR with the surveyor. The DON could not explain why the eMAR entries were not signed and stated it was expected for the nurses to sign the medications at the scheduled time of administration. The DON added that entries on the eMAR should not be left blank. The nurses should sign the eMAR to indicate that medication was administered to the resident. If the medication was not administered, it should be documented that it was not administered, and the physician should be made aware. The surveyor reviewed the facility provided policy titled "Medication Administration", with a review date of Ex Order 26. 4B1. Documented under Policy, it read: "Medications are administered by licensed nurses, or other staff who are legally authorized	F 658		

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F 658	Continued From page 15 to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection." Under Policy Explanation and Compliance Guidelines, it read: " ...17. Sign MAR after administered ...19. Report and document any adverse side effects or refusals ...20. Correct any discrepancies and report to nurse manager/designee.)" On 11/9/23 at 12:50 PM, the survey team met with the DON, Licensed Nursing Home Administrator, and regional nurses. No additional information was provided by the facility. NJAC 8:39-11.2 (b); 29.2(d)	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide safety measures and follow interventions for a resident who has a history of being at high risk for [NJ Ex Ord]. This deficient practice was identified for 1 of 3 residents reviewed for [NJ Ex Ord], Resident #52. The deficient practice was evidenced by the	F 689	Element I Resident #52 has been observed with no adverse effects related to the deficient practice. On [Ex Order 26. 4B1] Resident #52□s care plan has been reviewed to show the need for the use of [NJ Ex.Order 26.4(b)(1)] as an intervention	11/14/23

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F 689	Continued From page 16 following: On 10/30/2023 at 11:28 AM, the surveyor observed Resident #52 in their room. The resident was in bed, the bed was in the lowest position. Resident # 52 had a mattress against the wall, no bed rails and/or floor mats were observed. The surveyor reviewed Resident #52's hybrid medical record. The Face Sheet (FS) (A one-page summary of important information about a patient) reflected that Resident #52 was admitted to the facility with medical diagnoses which included but were not limited to [redacted]. A review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a Brief Interview for Mental Status (BIMS) of [redacted] out of 15 indicating that the resident has [redacted]. Review of section [redacted] for functional status indicated the resident required total dependence for all [redacted]. A review of Resident #52's Fall Risk Evaluation dated [redacted], revealed that the resident had a fall risk score of [redacted], indicating the resident is at [redacted] of [redacted]. A review of the resident's fall care plan (CP) initiated on [redacted] and reviewed on 10/2/23, reflected an intervention of "[redacted] on the floor in their room."	F 689	due to resident being at high risk for falls and ensuring the [redacted] are in place when resident is in the bed. The facilities educator provided in service on 11/03/2023 on the facility policy and procedures on care plans and interventions to provide a safe environment. Element II All residents in the facility have the potential to be affected by the deficient practice. Care plans for all residents at high risk for falls will be reviewed to make sure appropriate interventions are in place for the residents' safety. Element III The Director of Nursing or designee will conduct random weekly audits on care plan completion and appropriateness in relation to resident diagnosis and or change in condition status and appropriate interventions needed in order to care for the residents. The Director of Nursing or designee and Interdisciplinary Care Plan Team will update the care plans based on interventions needed to meet residents' medical, nursing, and mental and psychosocial needs. Element IV	

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F 689	Continued From page 17 On 11/2/2023 at 11:50 AM, the surveyor and 2nd floor Unit Manager (UM) entered Resident #52's room. The UM acknowledged that Resident #52 does not have a NJ Ex.Order 26.4(b)(1) and that there was no physician order (PO) for the [redacted] The UM stated [redacted] are not ordered as a PO but used as CP interventions only, but stated the [redacted] need to be on Resident #52's floor as it was documented as an intervention on the resident's CP. On 11/3/2023 at 10:20 AM, the surveyor interviewed the Director of Nursing (DON) to discuss the above concern. The DON explained that Resident #52's CP intervention was not being followed for the [redacted]. There was no further information provided by the facility.	F 689	Audits will be monitored for completion by the Administrator or Director of Nursing weekly for 4¿weeks,¿bi-weekly X 2 months and monthly¿X¿3 months¿and quarterly X 2. 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.	
F 692 SS=D	NJAC 8:39-27.1 Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	F 692		12/15/23

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F 692	Continued From page 18 §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to: a) ensure that a resident identified with a *Ex Order 26. 4B1* was comprehensively evaluated and assessed, and b) ensure accurate weights were obtained for a resident identified with *Ex Order 26. 4B1*. This deficient practice was identified for 2 of 6 residents, Resident #89 and #85 reviewed for nutrition and was evidenced by the following: 1. On 10/30/2023 at 12:00 PM, the surveyor observed Resident #89 walking in the hallways of the unit. The resident was alert, oriented to self and verbally responsive. On 11/3/23 at 9:45 AM, the surveyor reviewed the electronic health record (EHR) of Resident #89 which revealed the following: According to the Admission Record (an admission summary), Resident #89 was admitted with diagnoses that included but were not limited to, *Ex Order 26. 4B1*. An Annual Minimum Data Set (MDS) assessment, a tool used to facilitate management of care, dated *Ex Order 26. 4B1*, indicated the facility assessed the resident's cognition using a Brief	F 692	Resident number 85 and 89 were reviewed with appropriate interventions put into place and care plans updated. A full house audit of residents who triggered for a significant, unplanned *NJ Ex Order 26. 4B1* completed. The residents identified confirmed to have interventions in place to address the *Ex Order 26. 4B1*, as well as the care plan updated. Nursing staff to be educated on implementing weekly weights along with the time constraints of the policy. The dietician was educated on comprehensively assessing the resident after a *NJ Ex Order 26. 4B1* and ensuring care plans updated. The dietician also re-educated on the facility weight policy. All residents in the facility have the potential to be affected by the deficient practice. The Dietician/designee will conduct weekly audits on all residents who trigger for a significant weight change to ensure interventions are in place, care plan updated and the facility policy has been followed. The DON/designee to educate nursing staff on weight policy including obtaining monthly and weekly weights, until all staff have been in-serviced.	

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F 692	Continued From page 19 Interview Mental Status (BIMS) test. Resident #89 scored a [redacted] out of 15, which indicated that the resident had *Ex Order 26. 4B1* [redacted]. A review of the resident's weights documented in the EHR included: On [redacted] Resident #89 weighed [redacted] pounds (lbs.). On [redacted], the resident weighed [redacted] lbs. The weight results indicated the resident had an *Ex Order 26. 4B1* [redacted] in one month. There were no further weights documented after [redacted]. The nutrition notes, dated [redacted], written by the Registered Dietician (RD), identified the *Ex Order 26. 4B1* [redacted] for the month of October 2023. The RD documented recommendations which included "Continue current diet order/nutrition POC [Plan of Care]. Will monitor the need for extras on trays. Will monitor weights/trends, appetite/intake, & labs & will follow up make changes PRN (as needed)." There were no further nutrition notes documented after [redacted]. A physician's order, dated [redacted] read, "[redacted]." There were no additional nutritional orders found for the resident. A care plan (CP) with a focus that read, "[Resident #89] is potential for nutritional risk related to *Ex Order 26. 4B1* [redacted] as last revised on [redacted] Interventions	F 692	Audits will be monitored for completion by the Director of Nursing or designee weekly for 3 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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F 692	Continued From page 20 included, modify diet as appropriate according to Resident's food tolerances and preferences. Date Initiated: Ex Order 26. 4B1 ...Provide diet: Ex Order 26. 4B1 [redacted] as requested. Date Initiated Ex Order 26. 4B1 ..." There was no documentation that Resident #89's CP was revised or updated with an intervention for the identified Ex Order 26. 4B1 [redacted]. On 11/3/23 at 12:03 PM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) #1 about the process of obtaining residents' weights and identifying Ex Order 26. 4B1 [redacted]. LPN/UM #1 stated weights were obtained monthly starting the 1st of the month and completed by the 5th of the month. The weights would be entered into the EHR to be reviewed by the RD. LPN/UM #1 explained that nurses also were expected to review weights and if there was a Ex Order 26. 4B1 [redacted] of [redacted] lbs., a re-weigh of the resident should be completed. She further explained that the RD would follow up on the residents who have been identified with Ex Order 26. 4B1 [redacted] to make any recommendations. LPN/UM #1 stated that she was not aware that Resident #89 had a Ex Order 26. 4B1 [redacted] in NJ Ex.Order 26.4(b) [redacted] 2023. She further stated the RD did not discuss and make her aware that Resident #89 had a Ex Order 26. 4B1 [redacted]. On 11/3/23 at 12:23 PM, the surveyor interviewed the RD about residents identified with NJ Ex Order 26. 4B1 [redacted]. The RD stated NJ Ex Order 26. 4B1 [redacted] in 1, 3, and/or 6 months would be automatically identified in the EHR. He explained	F 692		

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that he reviews the weights of a resident on the EHR for triggered [redacted] and would review residents previously identified with [redacted].

The RD stated when a resident was identified with a [redacted], he would review the EHR, the resident's overall health status, including appetite, and weight trends. The RD added that he would discuss with the nursing staff, about the resident's appetite, visit with the resident, and review for any weight changes in the last 6-12 months.

The RD further explained that there were interdisciplinary weight meetings held monthly to discuss residents who were identified with [redacted]. The RD did not have documentation of the weight meetings and stated that the LPN/UM #1 should have them. The surveyor requested further information in reference to Resident #89's [redacted].

On 11/8/23 at 1:35 PM, the surveyor informed the Director of Nursing (DON) of the concern regarding Resident #89's identified [redacted], having no interventions, or monitoring to address the [redacted]. The DON stated they would provide further information.

On 11/9/23 at 11:20 AM, the surveyor interviewed the RD who stated Resident #89 ate independently, had a good appetite, and did not have [redacted] in the last 3 or 6 months. The RD stated he reviewed the options of extra food items provided on the resident's tray and that at the time there was no indication of additional interventions needed. The RD stated a

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F 692	Continued From page 22 re-weigh was not requested for the resident as there was no indication it was needed, and the resident's Ex Order 26. 4B1 was an isolated occurrence . The RD acknowledged additional interventions to monitor the resident's weights and appetite should have been initiated. The RD could not recall if he reviewed the resident's CP and that Ex Order 26. 4B1 would be discussed with the interdisciplinary team. The RD stated nursing would follow up with the physician regarding a resident's status, including RD recommendations, and could not say if the physician was aware of the resident's identified Ex Order 26. 4B1 . The surveyor reviewed the facility provided policy titled "Medical Nutrition Therapy: Assessment and Care Planning", with a revised date of 9/2017. Under Procedures it read, " ...7. The RDN [Registered Dietitian/Nutritionist] or other clinically qualified nutrition professional will be responsible for ensuring follow up and appropriate documentation of recommended changes in the plan of care ...8. The RDN or other clinically qualified nutrition professional will be responsible for ensuring that all assessments meet current standards of practice ..." The surveyor reviewed the facility provided policy titled "Weight Monitoring", with a revised date of 9/2023. Under Policy Explanation and Compliance Guidelines it read, " ...A significant change in weigh is defined as: a. 5% change in weight in 1 month (30) days) ...3. Documentation: a. The physician should be informed of a significant change in weight and may order nutritional interventions ...c. Meal consumption information may be recorded and may be referenced by the interdisciplinary care team as needed ...f. Observations pertinent to the	F 692		

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resident's weight status should be recorded in the medical record as appropriate ...g. The interdisciplinary plan of care communicated care instructions to staff ..."

On 11/9/23 at 12:50 PM, the surveyor discussed the weight issue with the Director of Nursing (DON) referring to the lack of monthly interdisciplinary weight meetings documentation. No additional information was provided by the facility.

2. On 10/30/2023 at 12:22 PM, the surveyor observed Resident #85 in the day room, eating lunch independently under the supervision of nursing staff.

On 11/3/23 at 9:45 AM, the surveyor reviewed the electronic health record (EHR) of Resident #85 which revealed the following:

According to the Admission Record (an admission summary), Resident #85 was admitted with diagnoses that included but were not limited to, *Ex Order 26. 4B1* [redacted].

An Annual Minimum Data Set (MDS) assessment, a tool used to facilitate management of care, dated *Ex Order 26. 4B1* [redacted], indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #85 scored *Ex* [redacted] out of 15, which indicated that the resident had a *Ex Order 26. 4B1* [redacted].

A review of the resident's weights documented in the EHR included:
On *Ex Order 26. 4B1* [redacted] Resident #89 weighed *Ex Order 26. 4* [redacted] lbs. On *Ex Order 26. 4B1* [redacted], the resident weighed *Ex Order 26. 4B1* [redacted]. The

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F 692	Continued From page 24 weight results indicated the resident had a [redacted] in one month. There were no further weights documented after [redacted] in the EHR. The nutrition notes, dated [redacted], written by the RD, identified the [redacted] for the one month. The RD documented recommendations which included "Re-weigh pending d/t multiple month [redacted] triggers to determine if CBW [current body weight] is accurate." There were no further nutrition notes documented after [redacted]. A physician's order, dated [redacted] read, "[redacted]." A physician's order, dated [redacted] read, "Resident is At Risk for [redacted] (Refer to Dietitian and/or MD documentation)". There were no additional nutritional orders found for the resident. The CP was reviewed with a focus that read, "As per MNA, [Resident #85] is at risk for [redacted]." was last revised on [redacted]. Interventions included, "Monitor PO intake, diet tolerance, labs, and other nutrition related parameters and follow up as needed. Date Initiated: [redacted] ... RD to monitor and make changes PRN. Date Initiated: [redacted] ... Weigh as per facility policy. Date Initiated: [redacted] ..."	F 692		

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There was no documentation that Resident #85's CP was revised or updated after the identified *Ex Order 26. 4B1* .

On 11/3/23 at 11:52 AM, the surveyor interviewed Certified Nursing Aide (CNA) #1 about obtaining residents' weights. CNA #1 stated that the CNAs are responsible for obtaining monthly weights. The CNA continued explaining that monthly weight results are recorded on monthly weight forms kept at the nurses' station. The nurses would let the CNAs know if additional weights needed to be obtained for a resident. The CNA continued to explain that when a resident refused the nurses would document this in the Nurse's notes.

On 11/3/23 at 12:03 PM, the surveyor interviewed LPN/UM #1 about Resident #85's weights and identified *Ex Order 26. 4B1* . LPN/UM #1 retrieved the [redacted] 2023 monthly weight form that was used to document residents' weights obtained prior to entering in the EHR. LPN/UM #1 reviewed the list with the surveyor, Resident #85's weight on [redacted] was [redacted] lbs. and could not explain why the weight was not entered into the EHR. LPN/UM #1 stated she was not aware that the resident had a *Ex Order 26. 4B1* in September, and the RD did not discuss it with her.

On 11/3/23 at 12:23 PM, the surveyor interviewed the RD about the weights for Resident #85 and the identified *Ex Order 26. 4B1* . The RD reviewed the last nutrition note, dated [redacted], which indicated a re-weigh was pending. The RD stated that he recalled placing a call to the unit and spoke to one of the nurses to request a re-weigh. The RD stated he could not recall which

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F 692	Continued From page 26 nurse he spoke to and did not document it. The surveyor and RD discussed the lack of follow up weights in the EHR after [redacted]. The RD stated a re-weigh for a resident should be done at least within 24-48 hours and that it was difficult at times to obtain re-weighs requested from the nursing staff. The RD acknowledged it was also his responsibility to ensure weights were obtained for residents. The RD further explained there were monthly interdisciplinary weight meetings held to discuss residents who were identified with [redacted]. The RD did not have documentation of the weight meetings and stated LPN/UM #1 should have them. On 11/8/23 at 1:35 PM, the surveyor informed the DON of the concern regarding Resident #85's identified [redacted] and no re-weigh was obtained to confirm the accuracy of the weight. The DON stated the facility would provide further information. On 11/9/23 at 11:20 AM, the surveyor interviewed the RD who stated that he called the nurses twice to request the resident's weight and that it was not done. The RD acknowledged he should have obtained a re-weigh for the resident to ensure the accuracy of the resident's weight and address potential [redacted]. The RD stated besides the nursing staff, it was also his responsibility to ensure weights were accurate and obtained by the staff. The surveyor reviewed the facility provided policy titled "Medical Nutrition Therapy: Assessment and Care Planning", with a revised date of 9/2017.	F 692		

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F 692	Continued From page 27 Under Procedures it read, " ...7. The RDN [Registered Dietitian/Nutritionist] or other clinically qualified nutrition professional will be responsible for ensuring follow up and appropriate documentation of recommended changes in the plan of care ...8. The RDN or other clinically qualified nutrition professional will be responsible for ensuring that all assessments meet current standards of practice ..." The surveyor reviewed the facility provided policy titled "Weight Monitoring", with a revised date of 9/2023. Under Policy Explanation and Compliance Guidelines it read, " ...A significant change in weigh is defined as: a. 5% change in weight in 1 month (30) days) ...3. Documentation: a. The physician should be informed of a significant change in weight and may order nutritional interventions ...c. Meal consumption information may be recorded and may be referenced by the interdisciplinary care team as needed ...f. Observations pertinent to the resident's weight status should be recorded in the medical record as appropriate ...g. The interdisciplinary plan of care communicated care instructions to staff ..." On 11/9/23 at 12:50 PM, the surveyor discussed the lack of follow up weights for Resident #85. No further documentation of monthly interdisciplinary weight meetings, and no additional information was provided by the facility. NJAC 8:39-17.1 (c); 17.2 (d); 27.2(a)	F 692		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis.	F 698		11/14/23

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F 698	Continued From page 28 The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a) ensure a resident's medication times were adjusted to accommodate their Ex Order 26. 4B1 schedule, b) monitor fluid intake for a Ex Order 26. 4B1 on Ex Order 26. 4B1, and c) ensure communication with a Ex Order 26. 4B1 regarding a resident's medication regimen. The deficient practice was evidenced for 1 out of 1 NJ Ex.Order 26.4(1 resident (Resident #40) reviewed, Resident #40. This deficient practice was evidenced by the following: a) On 10/30/23 at 12:40 PM, the surveyor observed Resident #40 sitting in the dayroom. The resident was alert, conversant and stated they were scheduled to go to Ex Order 26. 4B1 later in the afternoon. Resident #40 was scheduled to go to Ex Order 26. 4B1 every Monday, Wednesday, and Friday. The resident had no concerns with their care at the facility. A review of Resident #40's electronic health record (EHR) revealed the following: According to the Admission Record (an admission summary), Resident #40 was admitted with diagnoses that included but were not limited to, Ex Order 26. 4B1,	F 698	Element I Resident # 40 was assessed with no adverse effects related to the deficit practice of provide ongoing communication documentation with the Ex Order 26. 4B1. The primary physician was made aware on Ex Order 26. 4B1 of the deficient practice with no new orders. On 10/30/2023 a full house audit of all residents receiving dialysis services was audited by the Director of Nursing with no other findings. On 11/01/2023 1:1 education for all nurses who were noted with the deficit practice on the facility policy and procedures on medication administration with signed documentation in the residents' EMAR. On 11/02/2023 the facility educator provided in-services to all license nurses on medication administration and dialysis	

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F 698	Continued From page 29 [redacted] . An Annual Minimum Data Set (MDS) assessment, a tool used to facilitate management of care, dated [redacted], indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #40 scored [redacted] out of 15, which indicated the resident was [redacted]. Review of the physician's orders revealed the following: A physician's order dated [redacted] read: "[redacted] Give 1 tablet by mouth in the evening for supplement." A physician's order, dated [redacted] read: "[redacted] Give 2 capsules by mouth in the evening every Mon, Wed, Fri for Supplement." A physician's order, dated [redacted] read: '[redacted] Give 1 capsule by mouth two times a day for [redacted] hold dose if loose [redacted]." A physician's order, dated [redacted] read: "[redacted] Give 1 tablet by mouth two times a day for [redacted]." A physician's order, dated [redacted] read: '[redacted] Give 1 capsule by mouth two times a day for [redacted]." A physician's order, dated [redacted] read: '[redacted]	F 698	communication form. Element II All residents that reside in the facility that requires hemodialysis have the potential to be affected by the deficit practice. Element III - The Assistant Director of Nursing will provide continued education to all License staff on the facility policy and procedures for all resident that require dialysis must assurethat medications and/or treatments are timed according to the resident's dialysis schedule. -The Director of Nursing or the Assistant Director of Nursing will monitor the dialysis communication documentation to indicate the time dialysis ended or the time the resident returned to the facility three times a week. Element IV	

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F 698	Continued From page 30 Give 1 tablet by mouth in the evening for Supplement." A physician's order, dated Ex Order 26. 4B1 read: 'Ex Order 26. 4B1 Give 1 tablet by mouth three times a day for Ex Order 26. 4B1 take before meals." A review of the NJ Ex.Order 26.4(b) 2023 electronic medication administration record (eMAR) revealed the resident was scheduled to receive the following medications at 5pm and 6pm: 'Ex Order 26. 4B1 Give 1 tablet by mouth in the evening" which was scheduled to be administered at 1800 [6PM]. 'Ex Order 26. 4B1 Give 2 capsule by mouth in the evening every Mon, Wed, Fri" which was scheduled to be administered at 1800. 'Ex Order 26. 4B1 Give 1 capsule by mouth two times a day" which was scheduled to be administered at 0900 [9AM] and 1700 [5PM]. 'Ex Order 26. 4B1 Give 1 tablet by mouth two times a day" which was scheduled to be administered at 0900 and 1700. 'Ex Order 26. 4B1 Give 1 capsule by mouth two times a day" which was scheduled to be administered at 0900 and 1700. 'Ex Order 26. 4B1 Give 1 tablet by mouth in the evening" which was to be administered at 1800.	F 698	Audits will be monitored for completion by the Administrator or Director of Nursing weekly for 4¿weeks,¿bi-weekly X 2 months and monthly¿X¿3 months¿and quarterly X 2. 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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'*Ex Order 26. 4B1* Give 1 tablet by mouth three times a day" which was to be administered at 0900, 1300 [1PM], and 1700.

On 11/1/23 at 10:30 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) #1 who confirmed Resident #40 was scheduled for *Ex Order 26. 4B1* on Monday, Wednesday, and Friday. The LPN/UM #1 explained that the resident is picked up for *Ex Order 26. 4B1* from 2:00 to 2:30 PM and returns to the facility from *Ex Order 26. 4B1* approximately 7:30 to 8:00 PM. The LPN/UM #1 provided Resident #40's *Ex Order 26. 4B1* .

A review of the resident's *Ex Order 26. 4B1* and *Ex Order 26. 4B1* revealed that Resident #40 was out of the facility and returned from *Ex Order 26. 4B1* after the scheduled medication times on *Ex Order 26. 4B1* .

The *Ex Order 26. 4B1* forms for the following dates did not indicate the time *Ex Order 26. 4B1* ended or the time the resident returned to the facility on: *Ex Order 26. 4B1* .

On 11/2/23 at 11:45 AM, the surveyor interviewed LPN/UM #1 about the protocol for the timing of medications for *Ex Order 26. 4B1* not in the facility during *NJ Ex Order 26. 4B1*. LPN/UM #1 stated that resident's medication timing schedule should be coordinated with their *Ex Order 26. 4B1* .

The surveyor reviewed the timing of Resident #40's timing for their medication with the LPN/UM

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F 698	Continued From page 32 #1. The LPN/UM #1 stated Resident #40 should not have medications timed from 2:00 PM until 8:00 PM on Monday, Wednesday and Friday as the resident would be away from the facility at [redacted]. On 11/2/23 at 12:01 PM, the surveyor informed the Director of Nursing (DON) and the Regional Clinical Nurse about the concerns of the timing conflict of the resident's medication while they are out for [redacted]. The DON acknowledged the resident's medications should be scheduled in accordance with their *Ex Order 26. 4B1* . On 11/2/23 at 2:07 PM, the surveyor interviewed over the phone the Licensed Practical Nurse (LPN) #3 who cared for Resident #40 on the 3-11 shift. LPN #3 stated the resident usually returned from [redacted] from 8:00 PM to 9:00 PM. She added that upon the resident's return from [redacted] she would administer the resident's medication, which included the medications timed for 1700 (5:00 PM) and 1800 (6:00 PM). LPN #3 acknowledged that scheduled medications should be given an hour before or an hour after the time they are scheduled. The surveyor reviewed the facility provided policy titled "Medication Administration", with a reviewed date of 07/2023. Under Policy, it read: "Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection." Under Policy Explanation and Compliance Guidelines, number 11 it read: " ...11. Compare medication source (bubble pack, vial, etc.) with	F 698		

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F 698	Continued From page 33 MAR to verify resident name, medication name, form, dose, route, and time ...b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician ..." The surveyor reviewed the facility provided policy titled "Dialysis Policy", with a reviewed date of 9/2023. Under Policy Explanation and Compliance Guidelines, number 2 read: "The admitting nurse must ensure that medications and/or treatments are timed according to the resident's dialysis schedule." b) A review of Resident #40's electronic health record (EHR) revealed the following: A physician's order dated Ex Order 26. 4B1 read: '*Ex Order 26. 4B1* [redacted]" There was no documentation found for the monitoring of the resident's Ex Order 26. 4B1. On 11/2/23 at 10:30 AM, the surveyor interviewed LPN #2 who was assigned to care for Resident #40 in reference to Ex Order 26. 4B1 residents who have orders for *Ex Order 26. 4B1*. LPN #2 stated residents on *Ex Order 26. 4B1* would be monitored for their Ex Order 26. 4B1 and it was to be documented in the eMAR. LPN #2 informed the surveyor that there was no entry found for the monitoring of Resident #40's Ex Order 26. 4B1 and acknowledged that the eMAR should have documentation to reflect it. On 11/2/23 at 11:45 AM, the surveyor interviewed LPN/UM #1 about residents with NJ Ex Order 26. 4B1 and the monitoring of their Ex Order 26. 4B1. LPN/UM	F 698		

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F 698	Continued From page 34 #1 stated a resident on Ex Order 26. 4B1 would be monitored for their Ex Order 26. 4B1 per day and that it would be documented by the nurses in the eMAR during each shift. LPN/UM #1 acknowledged Resident #40's Ex Order 26. 4B1 was not being documented and was made aware of the concern after LPN #2's interview with the surveyor. LPN/UM #1 stated the Ex Order 26. 4B1 was only included in the resident's dietary order and that there should have also been another order entered into the eMAR for nurses to document the resident's Ex Order 26. 4B1. On 11/2/23 at 12:01 PM, the surveyor informed the DON and regional clinical nurse about the concerns of Resident #40's Ex Order 26. 4B1 monitoring and documentation. The DON stated it would be expected for there to be documentation of the Ex Order 26. 4B1 for a resident on Ex Order 26. 4B1. A review of a facility provided policy titled, "Fluid Restriction" with a revised date of 9/2017, under Procedure read: " ...4. The Nursing Services will be responsible for tracking and documenting the total volume consumed in accordance with facility policy ..." No other policy was provided by the facility related to fluid restrictions and monitoring fluid intake. c) A review of Resident #40's EHR revealed the following: A physician's order dated Ex Order 26. 4B1 read: "Ex Order 26. 4B1 [redacted] in the evening every Mon, Wed, Fri for Ex Order 26. 4B1". The order was discontinued on Ex Order 26. 4B1. The NJ Ex.Order 26.4(b)(1) 2023 MAR revealed the entry for	F 698		

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	315142	A. BUILDING _____ B. WING _____	C 11/09/2023

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F 698	Continued From page 35	F 698		

the '*Ex Order 26. 4B1* [redacted] in the evening every Mon, Wed, Fri" scheduled for 1800 (6:00 PM) was signed by the assigned nurse on *Ex Order 26. 4B1* as not administered to the resident. The entry for the medication on *Ex Order 26. 4B1* was not signed by the nurse and left blank.

The NJ Ex.Order 26.4(b) 2023 MAR revealed the entry for the *Ex Order 26. 4B1* [redacted] in the evening every Mon, Wed, Fri" scheduled for 1800 (6:00 PM) was signed by the assigned nurses on *Ex Order 26. 4B1*, *Ex Order 26. 4B1*, and *Ex Order 26. 4B1* as not administered to the resident. The entry for the medication on *Ex Order 26. 4B1* was not signed by the nurse and was left blank.

The *Ex Order 26. 4B1* forms dated *Ex Order 26. 4B1* did not document the resident receiving *Ex Order 26. 4B1* in *Ex Order 26. 4B1*.

On 11/2/23 at 11:45 AM, the surveyor interviewed LPN/UM #1 about the *Ex Order 26. 4B1* medication order and reviewed the order entry on the eMAR. LPN/UM #1 stated the medication could have been given in *Ex Order 26. 4B1* but was not sure. The LPN stated that if the medication was given in *Ex Order 26. 4B1* or if the medication could not be administered, the nurses should have called the resident's physician. LPN/UM #1 stated she would have to follow up with the *Ex Order 26. 4B1* to see if the medication was given as it was not documented on the *Ex Order 26. 4B1* form.

On 11/2/23 at 12:01 PM, the surveyor informed the DON and the regional clinical nurse about the concerns of the *Ex Order 26. 4B1* medication not

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F 698	Continued From page 36 signed as well as signed not given, for Resident #40. The DON stated she would review and provide further information. On 11/8/23 at 12:45 PM, the DON provided the surveyor with documentation from the dialysis center that indicated the resident received *Ex Order 26. 4B1* [redacted], on *Ex Order 26. 4B1* [redacted]. The DON stated that if the medication was given at *Ex Order 26. 4B1* [redacted] it should not have been ordered to be administered in the facility. She further stated it should have been followed up by the nurses who were to give the medication and that there was lack of communication between the facility nurses and the *Ex Order 26. 4B1* [redacted]. The surveyor reviewed the facility provided policy titled "Medication Administration", with a reviewed date of 07/2023. Under Policy, it read: "Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection." Under Policy Explanation and Compliance Guidelines read: " ...20. Correct any discrepancies and report to nurse manager/designee." The surveyor reviewed the facility provided policy titled "Dialysis Policy", with a reviewed date of 9/2023. Under Policy it read, "It is the policy of this facility to ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences."	F 698		

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F 698	Continued From page 37 On 11/9/23 at 12:50 PM, the survey team met with the DON, Licensed Nursing Home Administrator, and regional nurses. The DON could not explain why the NJ Ex.Order 26.4(b)(1) was documented on the eMAR but was administered at [redacted] without informing the facility of this. No additional information was provided by the facility regarding the above concerns.	F 698		
F 711 SS=D	NJAC 8:39-27.1(a) Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the resident's primary physician accurately dated physician progress notes (PPN) during his visit to ensure that the resident's current medical regimen was up to date. This deficient practice	F 711	Element I Resident #91 was assessed with no adverse effect due to the deficient practice.	11/14/23

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F 711	Continued From page 38 was observed for 1 of 6 residents, Resident #91. This deficient practice was evidenced by the following: On 10/30/2023 at 11:51 AM, the surveyor observed Resident # 91 in their room eating. During the interview progress, the resident stated they could not recall the last time they saw their physician. The surveyor reviewed the hybrid medical records (paper and electronic) for the Resident #91 which revealed that the resident's primary physician had inaccurately dated 10 physician progress notes written on Ex Order 26. 4B1 [redacted] Per the guidelines, (Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17) §483.30(b) Physician Visits The physician must- §483.30(b)(2) Write, sign, and date progress notes at each visit. A review of the resident's Face Sheet (FS) (A one-page summary of important information about a patient) reflected that Resident #91 was initially admitted to the facility on Ex Order 26. 4B1 with diagnoses that included Ex Order 26. 4B1 [redacted]. A review of the Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate care management dated Ex Order 26. 4B1, indicated a Brief Interview for Mental Status (BIMS) scored at Ex [redacted], which indicated that the resident was Ex Order 26. 4B1 [redacted]. A review of the PPN's in the electronic medical	F 711	On 11/10/2023 the administrator reviewed with the physician provider the regulatory guidelines and the facility policy for physician visits and delegation to assure the primary physician accurately dates, writes and signs all physician progress notes during his/her visit to assure that the resident□s current medical regiment is up to date. Element II All residents that are provided physician services have the potential to be affected by the deficient practice. Element III -Modifications were made to the physician visit process, method of communication and follow-up by staff nurse(s) with physicians regarding any recommendations or documentation during the visit. -The medical records personnel or designee will conduct random audits of 5 medical charts a week to assure the primary physician is accurately documenting and dating all visits after completion of services. Element IV Audits will be monitored for completion by	

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F 711	Continued From page 39 record revealed the following had a "LATE ENTRY" (Any documentation that is recorded in the medical record beyond 24-48 hours of the encounter is classified as a Late Entry.) designation which indicates the notes were not written on the effective date (Date of service): 1. Ex Order 26 with an effective date of Ex Order 26. 4B1, but with a created date of Ex Order 26. 4B1. 2. Ex Order 26 with an effective date of Ex Order 26. 4B1, but with a created date of Ex Order 26. 4B1. 3. Ex Order 26 with an effective date of Ex Order 26. 4B1, but with a created date of Ex Order 26. 4B1. 4. Ex Order 26 with an effective date of Ex Order 26. 4B1, but with a created date of Ex Order 26. 4B1. 5. Ex Order 26 with an effective date of Ex Order 26. 4B1, but with a created date of Ex Order 26. 4B1. 6. Ex Order 26 with an effective date of Ex Order 26. 4B1, but with a created date of Ex Order 26. 4B1. 7. Ex Order 26 with an effective date of Ex Order 26. 4B1, but with a created date of Ex Order 26. 4B1. 8. Ex Order 26 with an effective date of Ex Order 26. 4B1, but with a created date of Ex Order 26. 4B1. 9. Ex Order 26 with an effective date of Ex Order 26. 4B1, but with a created date of Ex Order 26. 4B1. 10. Ex Order 26 with an effective date of Ex Order 26. 4B1, but with a created date of Ex Order 26. 4B1. On 11/2/2023 the Director of Nursing (DON) provided the surveyor with a copy of the facility policy titled, Physician Visits and Delegation, with a revision date of September 2023. Under the policy explanation and compliance guidelines of the policy it states, 1." The Physician should: d. Date, write and sign a progress note for each visit." On 11/3/2023 at 10:57 AM, the surveyor interviewed the DON. The DON acknowledged that Resident #91's physician had backdated	F 711	the Administrator or Director of Nursing weekly for 4¿weeks,¿bi-weekly X 2 months and monthly¿X¿3 months¿and quarterly X 2. 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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F 711	Continued From page 40 multiple PPN and that is not the expected practice for the facility physicians. The DON further stated the facility expects the physicians to write, sign and date the PPN at the time the physician assesses the resident. The DON added that 2 month backdating of PPNs is not acceptable. No further information was provided. NJAC 8:39-23.2(b)	F 711		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate	F 755		11/14/23

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F 755	Continued From page 41 reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that expired medications were removed from a resident's active inventory after it had expired, and medications were administered according to manufacturer's recommendations. These deficient practices were identified for 1 of 2 units inspected during the facility unit inspection process and related to Resident #78. This deficient practice was evidenced by the following: On 10/30/23 at 10:00 AM, the surveyor inspected the 1st floor short hall medication cart. The surveyor noted a Ex Order 26. 4B1 [redacted] The Ex Order 26. 4B1 refill unit was stored in a plastic pharmacy provider bag labeled for Resident #78 and delivered to the facility on Ex Order 26. 4B1. Further review of the medication storage bag presented a label, "Refrigerate Until Opened Date Opened:_____" that was blank and another label, "Store Using Directions Provided. Throw Away Any Medicine That Remains 28 Days After First Use." During the inspection, the surveyor inspected the refrigerator located in the medication storage room on the unit. The surveyor found a plastic pharmacy provider bag labeled with Ex Order 26. 4B1 [redacted] for Resident #78, unused and delivered to the facility on Ex Order 26. 4B1.	F 755	Element I Resident #78 was assessed with no adverse effects due to the deficit practice. The primary physician was made aware on Ex Order 26. 4B1 with no new orders. The director of nursing provided 1 to 1 education on 11/01/2023 to the LPN regarding medication administration and to always follow the manufacturers recommended usage of NJ Ex.Order 26.4(b)(1) with the suggested pen device and to be discarded after 28 days of use. The facility will develop and maintain policies and procedures for the monthly drug regimen review that included but are not limited to the process and steps the pharmacist must take when identifying irregularities that require urgent actions to protect active residents. The facility will 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. Element II	

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F 755	Continued From page 42 On 10/30/23 at 12:30 PM, the surveyor interviewed Resident #78's Licensed Practical Nurse (LPN) #1 who stated that there was no pen device available for administering the Ex Order 26. 4B1 [redacted]. LPN#1 stated that the NJ Ex.Order 26.4(b)(1) is not administered during her shift, and she was not aware how the *Ex Order 26. 4B1* is administered when there was no pen device available. The surveyor reviewed Resident #78's Face Sheet (FS) (A one-page summary of important information about a patient) with an initial admission date of Ex Order 26. 4B1 and a readmission of Ex Order 26. 4B1. The FS documented the resident's diagnosis which included but was not limited to *Ex Order 26. 4B1* [redacted]. Review of Resident #78's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Ex Order 26. 4B1 reflected that the resident had a Brief Interview for Mental Status (BIMS) of Ex Ord[redacted] out of 15 indicating that the resident had cognition that was Ex Order 26. 4[redacted]. Review of Resident #78's Care Plan (CP) that was initially created on Ex Order 26. 4B1 evidenced a CP for NJ Ex.Or[redacted]. The CP highlighted, "Ex Order 26. 4B1 medication as ordered by doctor. Monitor/document for side effects and affectiveness." Review of the NJ Ex.Order 26.4(b)(1) electronic medication	F 755	All residents that reside in the facility have the potential to be affected by the deficient practice. Element III -The Director of Nursing or designee will audit daily completion of all new admission, monthly reports or residents with change in condition for pharmacy consultant reviews and recommendations. -The facility educator or designee will provide on-going education to maintain compliance with the facility policy and procedures for pharmacy consultation. -The Director of Nursing or designee will audit the Pharmacy consultant Recommendations/Therapeutic Suggestions report monthly for completion by the licensed nurse and the physician. Element IV Audits will be monitored for completion by the Administrator or Director of Nursing weekly for 4¿weeks,¿bi-weekly X 2 months and monthly¿X¿3 months¿and quarterly X 2. 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	

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F 755	Continued From page 43 administration record for Resident #78, revealed that Ex Order 26. 4B1 was ordered as a sliding scale at bedtime for Ex Order 26. 4B1 with different doses ordered depending on the Ex Order 26. 4B1 when tested. The Ex Order 26. 4B1 was administered [redacted] times in NJ Ex.Order 26.4(b)1 2023 without the use of a Pen device. On 10/31/23 at 10:44 AM, the surveyor called the Provider Pharmacy and spoke with the Pharmacist (RPh). The RPH reviewed the order and explained that the Ex Order 26. 4B1 was ordered by the facility with a start date of Ex Order 26. 4B1, no pen device was ordered by the facility or sent by the Provider Pharmacy. The RPh informed the surveyor that the Ex Order 26. 4B1 was delivered to the facility on Ex Order 26. 4B1. The RPh revealed that the Ex Order 26. 4B1 can only be used with a Pen device and must be discarded after 28 days of use. The RPh explained that the Ex Order 26. 4B1 Ex Order 26. 4B1 was outdated and should have been discarded when the new vial was delivered to the facility. On 10/30/23 at 12:00 PM, the surveyor interviewed the Director of Nursing (DON) who stated that she believed that the Ex Order 26. 4B1 was being removed from the refill vial and administered to Resident #78 without the use of a Pen device. The DON could not explain why the Ex Order 26. 4B1 was delivered by the Provider Pharmacy and Nursing was administering the Ex Order 26. 4B1 without the use of a Pen device. Review of manufacturer recommendations for the administration of Novolog Pen refill insulin explains, "Never withdraw insulin from a cartridge	F 755	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 44 or prefilled pen using a needle and syringe. This contaminates the insulin and interferes with accurate dose determination using the pen device." The manufacturer of the Novolog Pen refill insulin only recommends using the refill insulin vials with the suggested pen device. On 11/8/23 at 3:30 PM, the administration of the NJ Ex.Order 26.4(b)(1) refill was once again discussed with the DON and Licensed Nursing Home Administrator. No further information was provided. NJAC 8:39-29.4(g)	F 755		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug,	F 756		11/14/23

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F 756	Continued From page 45 and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure required monthly visits by the Consultant Pharmacist (CP) for the months of August, September, and October 2023. This irregularity was identified for 17 of 17 residents reviewed by the survey team for CP review, Resident #78, #8, #89, #71, #85, #40, #86, #90, #52, #91, #68, #75, #24, #46, #63, #59, #22, #70, #88 and #36. The deficient practice was evidenced by the following: On 10/30/23 at 12:30 PM, after completing the facility unit inspection, the surveyor asked the Director of Nursing (DON) for the Consultant Pharmacist (CP) 2023 previous unit inspections. The DON informed the surveyor that the facility had unit inspections performed by the CP until July 2023. The DON also informed the surveyor that the facility did not have a CP perform monthly	F 756	Resident #78 was assessed with no adverse effects due to the deficit practice. The primary physician was made aware on Ex Order 26. 4B1 with no new orders. The director of nursing provided 1 to 1 education on 11/01/2023 to the LPN regarding medication administration and to always follow the manufacturers recommended usage of NJ Ex.Order 26.4(b)(1) with the suggested pen device. Residents #8, # 89, #71, #85, #40, #86, #90, #52, #91, #68, #75, #24, #46, #63, #59, #22, #70, #88, and #36 were assessed with no adverse effects due to the deficit practice. 11/02/2023 The facility educator in-serviced all nurses on the policy and procedures of medication administration	

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	315142	A. BUILDING _____ B. WING _____	C 11/09/2023

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F 756	Continued From page 46 medication reviews as they received notification in July 2023 that the CP company would no longer service the facility. On 11/2/23 at 10:00 AM, the DON informed the surveyor that the previous Consulting Pharmacist company could no longer service the facility as of August 2023. The DON further explained that the new Consulting Pharmacist company was contacted immediately but could not service the facility until 11/2/23. This meant that the facility did not have resident medication regimen reviews or unit inspections for August, September, and October 2023. On 11/2/23 at 11:43 AM, the surveyor interviewed the owner of the new Consulting Pharmacy company who explained that the facility responded in September 2023 to the agreement (contract) submitted to the facility. The owner of the Consulting Company further explained that the contract was not signed for their services until November 2023. The surveyor reviewed the 7/26/23 at 3:47 PM email sent to the facility which informed the facility that the Pharmacy Consulting company was terminating the facility servicing contract. The surveyor also reviewed the contract agreement with the new Pharmacy Consulting company which documented, "This agreement is entered into as of this 1st day of November 2023" and was signed by the facility on 11/1/23. 1. The surveyor reviewed Resident #78's Face Sheet (FS) (A one-page summary of important information about a patient). The FS documented the resident's diagnosis which	F 756	according to the manufacturer recommendations. This includes return demonstrations for all residents that require medication administration with an insulin refill pen or insulin vial. 11/02/2023-The facility educator in-serviced all nurses on proper storage of medications, labeling of medications and disposal of medications that have expired, and importance of cleanliness of all medication storage areas. Element II All residents that reside in the facility have the potential to be affected by the deficit practice. Element III -The facility educator or designee will provide continued education with current staff as well as newly hired staff on the facility policy of medication administration and labeling and disposal of expired medication. - Director of Nursing or designee will conduct weekly random audits for medication storage, labeling of medications, disposal of expired medication, and cleanliness of all medication storage areas. Element IV Audits will be monitored for completion by the Administrator or Director of Nursing weekly for 4¿weeks,¿bi-weekly X 2	

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F 756	Continued From page 47 included but was not limited to *Ex Order 26. 4B1* [redacted]. Review of the CP Evaluation sheet revealed documentation by the CP of monthly medication reviews (MMR) with the last review dated [redacted]. There were no further documentations by the CP after the final entry of [redacted], when reviewed on [redacted]. 2. The surveyor reviewed Resident #8's FS. The FS documented the resident's diagnosis which included but was not limited to *Ex Order 26. 4B1* [redacted]. Review of the CP Evaluation sheet revealed documentation by the CP of MMR with the last review dated [redacted] There were no further documentations by the CP after the final entry of [redacted], when reviewed on 11/2/23. 3. The surveyor reviewed Resident #71's FS. The FS documented the resident's diagnosis which included but was not limited to *Ex Order 26. 4B1* [redacted]. Review of the CP Evaluation sheet revealed documentation by the CP of MMR with the last review dated [redacted]. There were no further documentations by the CP after the final entry of [redacted], when reviewed on 11/3/23. 4. The surveyor reviewed Resident #63's FS. The FS documented the resident's diagnosis which	F 756	months and monthly¿X¿3 months¿and quarterly X 2. 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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F 756	Continued From page 48 included but was not limited to Ex Order 26. 4B1 [redacted]. Review of the CP Evaluation sheet revealed documentation by the CP of MMR with the last review dated NJ Ex.Order 26.4(b)(1). There were no further documentations by the CP after the final entry of Ex Order 26. 4B1, when reviewed on 11/3/23. 5. The surveyor reviewed Resident #22's FS. The FS documented the resident's diagnosis which included but was not limited to Ex Order 26. 4B1 [redacted]. Review of the CP Evaluation sheet revealed documentation by the CP of MMR with the last review dated NJ Ex.Order 26.4(b)(1). There were no further documentations by the CP after the final entry of Ex Order 26. 4B1, when reviewed on 11/8/23. 6. The surveyor reviewed Resident #36's FS. The FS documented the resident's diagnosis which included but was not limited to Ex Order 26. 4B1 [redacted]. Review of the CP Evaluation sheet revealed documentation by the CP of MMR with the last review dated NJ Ex.Order 26.4(b)(1). There were no further documentations by the CP after the final entry of Ex Order 26. 4B1, when reviewed on 11/8/23. 7. The surveyor reviewed Resident #70's FS. The FS documented the resident's diagnosis which	F 756		

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F 756	Continued From page 49 included but was not limited to Ex Order 26. 4B1 [redacted]. Review of the CP Evaluation sheet revealed documentation by the CP of MMR with the last review dated NJ Ex.Order 26.4(b)(1 [redacted] There were no further documentations by the CP after the final entry of Ex Order 26. 4B1 [redacted], when reviewed on 11/9/23. 8. The surveyor reviewed Resident #88's FS. The FS documented the resident's diagnosis which included but was not limited to Ex Order 26. 4B1 [redacted]. Review of the CP Evaluation sheet revealed documentation by the CP of MMR with the last review dated NJ Ex.Order 26.4(b)(1 [redacted] There were no further documentations by the CP after the final entry of Ex Order 26. 4B1 [redacted], when reviewed on 11/9/23. 9. The surveyor reviewed Resident #52's FS with an initial admission date of Ex Order 26. 4B1 [redacted] and a readmission of Ex Order 26. 4B1 [redacted]. The FS documented the resident's diagnosis which included but was not limited to Ex Order 26. 4B1 [redacted]. Review of the CP Evaluation sheet revealed documentation by the CP of MMR with the last review dated NJ Ex.Order 26.4(b) [redacted] There were no further documentations by the CP after the final entry of Ex Order 26. 4B1 [redacted], when reviewed on 11/6/23. 10. The surveyor reviewed Resident 90's FS with an initial admission date of Ex Order 26. 4B1 [redacted]. The FS documented the resident's diagnosis which included but was not limited to Ex Order 26. 4B1	F 756		

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F 756	Continued From page 50 [redacted]. Review of the CP Evaluation sheet revealed documentation by the CP of MMR with the last review dated [redacted] There were no further documentations by the CP after the final entry of [redacted], when reviewed on 11/6/23. 11. The surveyor reviewed Resident #91's FS with an initial admission date of [redacted] and a readmission of [redacted]. The FS documented the resident's diagnosis which included but was not limited to [redacted]. Review of the CP Evaluation sheet revealed no documentation by the CP of MMR for Resident #91. 12. The surveyor reviewed Resident 24's FS with an initial admission date of [redacted] and a readmission of [redacted]. The FS documented the resident's diagnosis which included but was not limited to [redacted]. Review of the CP Evaluation sheet revealed documentation by the CP of MMR with the last review dated [redacted] There were no further documentations by the CP after the final entry of [redacted], when reviewed on 11/6/23. 13. The surveyor reviewed Resident 86's FS with an initial admission date of [redacted]. The FS documented the resident's diagnosis which included but was not limited to [redacted].	F 756		

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F 756	Continued From page 51 Review of the CP Evaluation sheet revealed documentation by the CP of MMR with the last review dated [redacted]. There were no further documentations by the CP after the final entry of [redacted], when reviewed on 11/6/23. 14. The surveyor reviewed Resident #40's Face Sheet (FS) (A one-page summary of important information about a patient) with an initial admission date in [redacted] and a readmission date in [redacted]. The FS documented the resident's diagnoses which included but were not limited to [redacted]. Review of the CP Evaluation sheet revealed documentation by the CP of monthly medication reviews (MMR) with the last review dated [redacted]. There was no further documentation by the CP after the final entry of [redacted], when reviewed on 11/2/23. 15. The surveyor reviewed Resident #85's Face Sheet (FS) (A one-page summary of important information about a patient) with an initial admission in [redacted]. The FS documented the resident's diagnoses which included but were not limited to [redacted]. Review of the CP Evaluation sheet revealed documentation by the CP of monthly medication reviews (MMR) with the last review dated [redacted]. There was no further documentation by the CP after the final entry of [redacted], when reviewed on 11/2/23.	F 756		

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F 756	Continued From page 52 16. The surveyor reviewed Resident #89's Face Sheet (FS) (A one-page summary of important information about a patient) with an initial admission in [redacted] and readmission in [redacted]. The FS documented the resident's diagnoses which included but were not limited to [redacted]. Review of the CP Evaluation sheet revealed documentation by the CP of monthly medication reviews (MMR) with the last review dated [redacted]. There was no further documentation by the CP after the final entry of [redacted], when reviewed on 11/2/23. 17. The surveyor reviewed Resident #75's Face Sheet (FS) (A one-page summary of important information about a patient) with an initial admission in [redacted] and readmission in [redacted]. The FS documented the resident's diagnoses which included but were not limited to [redacted]. Review of the CP Evaluation sheet revealed documentation by the CP of monthly medication reviews (MMR) with the last review dated [redacted]. There was no further documentation by the CP after the final entry of [redacted], when reviewed on 11/2/23. 18. The surveyor reviewed Resident #46's Face Sheet (FS) (A one-page summary of important information about a patient) with an initial admission in [redacted] and readmission in	F 756		

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F 756	Continued From page 53 Ex Order 26. 4B1. The FS documented the resident's diagnoses which included but were not limited to Ex Order 26. 4B1 Review of the CP Evaluation sheet revealed documentation by the CP of monthly medication reviews (MMR) with the last review dated NJ Ex.Order 26.4(b). There was no further documentation by the CP after the final entry of Ex Order 26. 4B1, when reviewed on 11/2/23. 19. The surveyor reviewed Resident #59's Face Sheet (FS) (A one-page summary of important information about a patient) with an initial admission in NJ Ex.Order 26.4(b)(1). The FS documented the resident's diagnoses which included but were not limited to Ex Order 26. 4B1 . Review of the CP Evaluation sheet revealed there was no documentation by the CP for monthly medication reviews (MMR) in NJ Ex.Order 26.4(b)(1), when reviewed on 11/2/23.	F 756		
F 812 SS=D	NJAC 8:39 - 29.3 (a 1, 6) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		11/10/23

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F 812	Continued From page 54 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies, it was determined that the facility failed to properly clean and sanitize kitchen equipment as well as store, label, and discard potentially hazardous foods in a manner to prevent food borne illness. This deficient practice was evidenced by the following: On 10/30/2023 at 09:19 AM, the surveyor in the presence of the Food Service Director (FSD) observed the following during the kitchen tour: 1. On the Chef prep table, the surveyor observed on the inside of the microwave had caked on yellowish debris on microwave door and greyish debris observed on top and sides of microwave. The FSD stated the microwave should have been cleaned of debris after each use and at the end of the evening. 2. In the Standing freezer located next to the chef prep table, surveyor observed: a. Two frozen turkey burgers wrapped in plastic wrap, not labeled.	F 812	The microwave was immediately cleaned and sanitized. All undated items , Brussel sprouts, chicken tenders and biscuits were immediately discarded and FSD went through all refrigerators and freezers to be sure all other items were properly sealed and dated. All residents could have been affected here. All dietary staff were educated and in serviced on the following: - Proper sanitation practices - Proper Infection Control practices - Proper labeling and dating of all foods. - How to properly clean the microwave oven after each use. The microwave oven was removed from the kitchen and will no longer be used.	

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F 812	Continued From page 55 b. One, 32oz bag of chopped spinach not labeled. c. One, 40oz bag Brussel sprouts not labeled. FSD stated, everything in the freezer should be labeled with the delivery date, open date and/or use by/discard date. No further explanation given for missing labels provided. 3. In the walk-in freezer, the surveyor observed: a. One bag of frozen chicken tenders not labeled. b. Three, 40oz bags of frozen Brussel Sprouts not labeled. c. One opened bag of frozen biscuits not labeled. FSD stated everything in the freezer should be labeled and indicate the delivery date, open date, and/or use by/discard date. On 11/2/2023 at 2:05 PM, the FSD provided the surveyor with a copies of facility policies for Environment and Food storage of cold foods. A review of the facility policy titled, "Environment", with a revised date of September 2017 revealed under the procedure, 3. "All contact surfaces will be cleaned and sanitized after each use." 4. "The Dining Services Director will ensure routine cleaning is in place for all cooking equipment, food storage areas, and surfaces." A review of the facility policy titled, "Food Storage: Cold Foods", with a revised date of April 2018 revealed under the procedures, 5. "All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross	F 812	Critical Control Points were established to ensure all food items placed in any freezer or refrigerator are always properly wrapped, sealed, covered, and dated. Daily sanitation rounding logs were implemented and are being completed twice daily by FSD or kitchen supervisor. Quapis have been put into place for labeling and dating, and sanitation. The Quapis will be discussed among the team weekly for the first month, monthly for the next 2 months and then quarterly.	

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F 812	Continued From page 56 contamination." On 11/3/2023 at 10:20 AM, the surveyor interviewed the Director of Nursing (DON). The DON agreed that all kitchen equipment should be clean and sanitized after each use and all kitchen foods in the kitchen should be labeled with either a delivery, open and/or discard date. NJAC 8:39-17.2(g)	F 812		

New Jersey Department of Health

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	061611	A. BUILDING: _____ B. WING _____	C 11/09/2023

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, 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. Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. 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. 1. a. Notwithstanding any other staffing	S 560	The facility held 5 career open house meetings this quarter for the following open positions, which included Licensed nurses, and CNAs with effective results. The facility initiated the Tuition Reimbursement program, which pays full school fees for staff interested in continuing their education in the certified nursing assistance training program. We had 21 students who were onboarded with the facility from the approved accredited certified nursing assistant program and successfully completed the course. All tuition expenses will be	11/14/23

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

Electronically Signed | 12/01/23

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	061611	A. BUILDING: _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LLANFAIR HOUSE CARE & REHABILITATION (	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) COMPLETE DATE
S 560	Continued From page 1 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: (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	S 560	covered by Llanfair Care and Rehabilitation Center. Provide adequate staffing by initiating an emergency staffing plan which requires licensed staff and management to assist with all hands-on deck to meet the needs of the residents. Element II All residents that reside in the facility have the potential to be affected by deficient practice. Element III - The facility Recruiter along with the Director and Administrator will conduct a career open house to be held every quarter or sooner to include a sign on and employee referral bonuses. - The administrator/designee will review the Retention program to assure staff turnover is at minimum and address immediately. -Administrator or designee to review staffing schedule daily on a continuous basis. -DON or designee to audit staffing ratio daily on a continuous basis and addresses immediately to maintain compliance with the state ratio for staffing requirements. -Managers on duty to randomly interview	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061611	A. BUILDING: _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LLANFAIR HOUSE CARE & REHABILITATION C	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) COMPLETE DATE
S 560	Continued From page 2 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 ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 2-week period beginning 10/15/23 and ending 10/28/23 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements for 14 of 14 days. The facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 3 of 14 evening shifts, deficient in CNAs to total staff on 1 of 14 evening shifts and deficient in total staff for residents on 10 of 14 overnight shifts as follows: -10/15/23 had 7 CNAs for 100 residents on the day shift, required at least 12 CNAs. -10/15/23 had 9 total staff for 100 residents on the evening shift, required at least 10 total staff. -10/15/23 had 4 total staff for 100 residents on the overnight shift, required at least 7 total staff. -10/16/23 had 4 CNAs for 100 residents on the day shift, required at least 13 CNAs. -10/16/23 had 9 total staff for 100 residents on the evening shift, required at least 10 total staff. -10/16/23 had 5 total staff for 100 residents on the overnight shift, required at least 7 total staff. -10/17/23 had 4 CNAs for 99 residents on the day shift, required at least 12 CNAs.	S 560	residents about staffing response to care request twice weekly and report to Administrator/DON or designee immediately when care needs are not being met. Element IV Audits will be monitored for completion by the Administrator or Director of Nursing weekly for 4¿weeks,¿bi-weekly X 2 months and monthly¿X¿3 months¿and quarterly X 2. 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061611	A. BUILDING: _____ B. WING _____	C 11/09/2023

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

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S 560	Continued From page 3	S 560		

-10/18/23 had 5 CNAs for 99 residents on the day shift, required at least 12 CNAs.
-10/18/23 had 9 total staff for 99 residents on the evening shift, required at least 10 total staff.
-10/18/23 had 5 total staff for 99 residents on the overnight shift, required at least 7 total staff.
-10/19/23 had 7 CNAs for 98 residents on the day shift, required at least 12 CNAs.
-10/20/23 had 5 CNAs for 98 residents on the day shift, required at least 12 CNAs.
-10/20/23 had 6 total staff for 98 residents on the overnight shift, required at least 7 total staff.
-10/21/23 had 5 CNAs for 98 residents on the day shift, required at least 12 CNAs.
-10/21/23 had 5 total staff for 98 residents on the overnight shift, required at least 7 total staff.
-10/22/23 had 5 CNAs for 98 residents on the day shift, required at least 12 CNAs.
-10/22/23 had 5 total staff for 98 residents on the overnight shift, required at least 7 total staff.
-10/23/23 had 6 CNAs for 96 residents on the day shift, required at least 12 CNAs.
-10/23/23 had 6 total staff for 96 residents on the overnight shift, required at least 7 total staff.
-10/24/23 had 5 CNAs for 96 residents on the day shift, required at least 12 CNAs.
-10/24/23 had 5 total staff for 96 residents on the overnight shift, required at least 7 total staff.
-10/25/23 had 6 CNAs for 96 residents on the day shift, required at least 12 CNAs.
-10/25/23 had 4 CNAs to 10 total staff on the evening shift, required at least 5 CNAs.
-10/26/23 had 5 CNAs for 96 residents on the day shift, required at least 12 CNAs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061611	A. BUILDING: _____ B. WING _____	C 11/09/2023

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S 560	Continued From page 4 -10/27/23 had 5 CNAs for 96 residents on the day shift, required at least 12 CNAs. -10/27/23 had 6 total staff for 96 residents on the overnight shift, required at least 7 total staff. -10/28/23 had 7 CNAs for 97 residents on the day shift, required at least 12 CNAs. -10/28/23 had 6 total staff for 97 residents on the overnight shift, required at least 7 total staff. On 11/3/23 at 2:00 PM , the surveyor discussed the lack of required staff with the Director of Nursing who did not provide any further information.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315142 Y1	A. Building B. Wing Y2	1/11/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LLANFAIR HOUSE CARE & REHABILITATION CENTER	1140 BLACK OAK RIDGE ROAD WAYNE, NJ 07470

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0584	Correction	ID Prefix F0657	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed
LSC	01/09/2024	LSC	01/09/2024	LSC	01/09/2024
ID Prefix F0658	Correction	ID Prefix F0689	Correction	ID Prefix F0692	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(g)(1)-(3)	Completed
LSC	01/09/2024	LSC	01/09/2024	LSC	01/09/2024
ID Prefix F0698	Correction	ID Prefix F0711	Correction	ID Prefix F0755	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.30(b)(1)-(3)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	01/09/2024	LSC	01/09/2024	LSC	01/09/2024
ID Prefix F0756	Correction	ID Prefix F0812	Correction	ID Prefix	Correction
Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed
LSC	01/09/2024	LSC	01/09/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
11/9/2023	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
061611	A. Building B. Wing	1/11/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LLANFAIR HOUSE CARE & REHABILITATION CENTER	1140 BLACK OAK RIDGE ROAD WAYNE, NJ 07470

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 01/09/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 11/9/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315142	A. BUILDING **01** B. WING _____	**11/09/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/30/2023 and 10/31/2023, and Llanfair House Care and Rehab. was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy This facility is a 3-story building that was built in 70's, It is composed of Type I fire resistant construction. The facility is divided into 10- smoke zones. The facility has 2 generators 65 KW (Diesel) and 75 KW (Natural Gas).	K 000		
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility documentation on 10/30/2023 and 10/31/2023, in the presence of facility Management it was	K 311	The deficient practices identified 6 out of the 6 sets of exit access stairwell double doors tested failed to maintain the 1-1/2	1/9/24

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

Electronically Signed | 12/01/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 311	Continued From page 1 determined that the facility failed to ensure that 6 of 6 sets of exit access stairwell double doors tested, were capable of maintaining the 1-1/2 hour fire rated construction. This is evidenced by the following, On 10/30/2023 (day one of survey) during the survey entrance at approximately 9:20 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a three (3) story building. There are two (2) interior stairwells that Residents, Visitors and Staff could use in the event of an emergency. There are Resident sleeping rooms on the first (1st,), second (2nd.) and third (3rd.) floors. Starting at approximately 9:33 AM on 10/30/2023 and continued on 10/31/2023 in the presence of the facility's MD a tour of the facility was conducted. Along the two (2) day tour, the surveyor inspected and conducted closure test of six (6) sets of corridor double doors that lead into exit stairwells with the following results, On 10/30/2023: 1) At approximately 10:51 AM, when the surveyor tested the corridor double stairwell "B" doors (next to Resident room #59) by opening to a 90 degree opening to the door frame and allowed to self-close, both doors closed into their frame and did not positive latch into its frame. This test was performed two additional times with the same results. The surveyor observed the doors latching	K 311	hour fire rated wall construction, the doors closed into the frame and did not positive latch into its frame. All residents that reside in the facility have the potential to be affected by the deficit practice. The maintenance director or assigned designee will inspect all listed double stairwell doors with plans to bring doors into compliance with latching system mechanisms work estimates will follow inspection completion. Audits will be monitored for completion by the maintenance director, weekly for 2 months and monthly for the next 2 months, quality assurance performance improvement committee meeting. QAPI This plan can be amended when indicated.	

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K 311	Continued From page 2 mechanisms did not engage. A review of an emergency evacuation diagram posted in the corridor identifies that stairwell as the primary exit to reach an exit discharge door. 2) At approximately 10:56 AM, when the surveyor tested the corridor double stairwell "A" doors (next to elevators) by opening to a 90 degree opening to the door frame and allowed to self-close, both doors closed into their frame and did not positive latch into its frame. This test was performed one additional time with the same results. A review of an emergency evacuation diagram posted in the corridor identifies that stairwell as the primary exit to reach an exit discharge door. 3) At approximately 11:10 AM, when the surveyor tested the corridor double stairwell "B" doors (next to Resident room #31) by opening to a 90 degree opening to the door frame and allowed to self-close, both doors closed into their frame and did not positive latch into its frame. This test was performed two additional times with the same results. The surveyor observed the doors latching mechanisms did not engage. A review of an emergency evacuation diagram posted in the corridor identifies that stairwell as the primary exit to reach an exit discharge door. 4) At approximately 11:59 AM, when the surveyor tested the corridor double stairwell "A" doors (next to elevators) by opening to a 90 degree opening to the door frame and allowed to self-close, both doors closed into their frame and did not positive latch into its frame. The surveyor observed the doors latching mechanisms did not engage.	K 311		

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K 311	Continued From page 3 A review of an emergency evacuation diagram posted in the corridor identifies that stairwell as the primary exit to reach an exit discharge door. On 10/31/2023: 5) At approximately 10:48 AM, when the surveyor tested the corridor double stairwell "B" doors (near the Commercial Laundry room) by opening to a 90 degree opening to the door frame and allowed to self-close, both doors closed into their frame and did not positive latch into its frame. The surveyor observed the doors latching mechanisms did not engage. 6) At approximately 11:00 AM, when the surveyor tested the corridor double stairwell "A" doors (next to elevators) by opening to a 90 degree opening to the door frame and allowed to self-close, both doors closed into their frame and did not positive latch into its frame. The surveyor observed the doors latching mechanisms did not engage. The stairwell doors would need to positive latch into its frame to maintain the 1-1/2 hour fire rated construction to prevent fire, smoke and poisonous gases to enter the exit stairwell in the event of a fire. The facility MD confirmed the findings at the time of observations. The Administrator was informed of the deficiency during the survey exit on 10/31/2023 at approximately 12:15 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 324	Continued From page 4	K 324		
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview conducted on 10/30/2023 and 10/31/2023 in the presence of facility Management, it was determined that the facility failed to ensure that the fire suppression system nozzles over the cooking stove were in the proper position to protect against the extension of fire, in accordance with NFPA 96.	K 324	The deficient practice identified on 10/30/2023-10/31/2023 was observed by the surveyor the facility failed ensure the fire suppression system nozzles over the cooking stove were in the proper position to protect against the extension of fire. The deficient practice was immediately corrected by the Maintenance director on	1/9/24

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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
K 324	Continued From page 5 This deficient practice was evidenced by the following: On 10/30/2023 (day one of survey) during the survey entrance at approximately 9:20 AM, a request was made to the Administrator and Maintenance Director (MD) to provide all the mandatory inspection from 06/01/2022 through 10/30/2023 for review later. At approximately 12:50 PM on 10/30/2023 a review of the mandatory inspections identified the Kitchen,s semi-annual (every 6 months) fire suppression system was inspected on the following dates, -10/06/2022 and 04/28/2023. Later at approximately 1:50 PM, during an interview with the MD, the surveyor requested if the facility had any additional semi-annual inspections for the kitchen suppression system. The MD told the surveyor that the vendor did the kitchen suppression system inspection on 10/24/2023, and he is waiting for the report. Starting at approximately 10:00 AM on 10/31/2023 the building tour continued in the presence of the facility's MD. At approximately 10:57 AM an inspection of the facility Kitchen was performed. The surveyor observed over the 6-burner cooking stove that 3 of 3 fire suppression nozzles were not in the proper position to protect against the extension of fire. The three fire suppression nozzles were directed toward the front (employee standing area) of the working cooking stove and in the event of a fire, would offer no protection against the extension of fire. In an interview with the MD at the time of the	K 324	10/30/2023 All residents could have been affected All maintenance and dietary staff were in serviced on Proper suppression nozzle system setup/Position Management or designee will audit fire suppression system weekly x3 then monthlyx3 for compliance, findings will be shared during monthly QAPI meeting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315142	A. BUILDING **01** B. WING _____	**11/09/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
K 324	Continued From page 6 observation, he confirmed that the three fire suppression nozzles at the working 6-burner cooking stove's were facing away from the 6-burner stove and to the front and would offer no fire protection in the event of a fire. The Administrator was informed of the deficiency during the survey exit on 10/31/2023 at approximately 12:15 PM. NJAC 8:39-31.2(e) 19.3.2.5.3*(5)(a) NFPA 96	K 324		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 10/30/2023, in the	K 351	Sprinkler System □ installation	1/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315142	A. BUILDING **01** B. WING _____	**11/09/2023**

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K 351	Continued From page 7 presence of facility management it was determined that: 1) The Facility failed to properly install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. The deficient practice is evidenced by the following, On 10/30/2023 (day one of survey) during the survey entrance at approximately 9:20 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a three (3) story building with the following, - The Ground floor has thirty-one (31) Resident sleeping rooms, two (2) Resident shower rooms, common areas and offices. - The First floor has twenty-five (25) Resident sleeping rooms, two (2) Resident shower rooms and common areas. - The Second floor has twenty-five (25) Resident sleeping rooms, two (2) Resident shower rooms and common areas. Starting at approximately 9:33 AM on 10/30/2023 and continued on 10/31/2023 in the presence of the facility's MD a tour of the facility was conducted. Along the tour, the surveyor observed the following locations that failed to provide proper fire sprinkler coverage:	K 351	Based on the observations on 10/30/2023, in the presence of management the facility failed to properly install sprinklers as required by CMS 483.90(a) Th deficient practice showed the sprinkler system in showers 2ndfl #1, 2ndfl #2 and 1stfl shower rooms 1 and 2 showed no evidence to cover the shower stalls. All residents that reside in the facility have the potential to be affected by the deficit practices. The maintenance director/management will inspect areas 2nd fl 1 and 2 showers and 1st floor showers 1 and 2, attached with a work plan and work estimates to bring sprinklers into compliance. All sprinkler barriers will be removed. And new sprinkler head added. The maintenance director will audit all shower areas and present findings to QAPI committee monthly x3 x3 months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 351	Continued From page 8 On 10/30/2023: 1) At approximately 10:36 AM, the surveyor observed inside the second (2nd.) floor Resident shower room #1 (across from the Nursing Station) no evidence of a fire sprinkler system to cover the 46 inch by 54 inch shower stall. At this time the surveyor asked the MD, "Do you see a fire sprinkler in the shower stall." The MD looked up and around and said, No. 2) At approximately 10:39 AM, the surveyor observed inside the second (2nd.) floor Resident shower room #2 (next to Resident room #49) no evidence of a fire sprinkler system to cover the 48 inch by 51 inch shower stall. At this time the surveyor asked the MD, "Do you see a fire sprinkler in the shower stall." The MD looked up and around and said, No. 3) At approximately 11:09 AM, the surveyor observed inside the first (1st.) floor Resident shower room #1 (across from the Nursing Station) no evidence of a fire sprinkler system to cover the 46 inch by 52 inch shower stall. 4) At approximately 11:12 AM, the surveyor observed inside the first (1st.) floor Resident shower room #1 (next to Resident room #19) no evidence of a fire sprinkler system to cover the 46 inch by 52 inch shower stall. The MD confirmed the finding at the time of observations. The Administrator was informed of the deficiency during the survey exit on 10/31/2023 at approximately 12:15 PM. Fire Safety Hazard.	K 351		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 351	Continued From page 9 NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 10/30/2023 and 10/31/2023 in the presence of facility management, it was determined that the facility failed to: 1) Perform a monthly examinations for 2 of 30 portable fire extinguishers, 2) Replace 1 of 30 portable fire extinguishers when discharged, 2) Install portable fire extinguishers with-in the required height for 4 of 30 fire extinguishers observed, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent	K 355	The deficient practice of non-compliance with facility monthly fire extinguishers 2 of 30 extinguishers during 10/30/2023 and 10/30/2023 during surveyor tour. One of the 30 portable extinguishers was immediately replaced out. Install portable fire extinguishers to required height, 6.1.3.8.3 fire extinguishers having a gross weight not exceeding 40lb shall be installed so the top of type fire extinguisher is not more than 5 feet above the floor. All residents in the facility have the potential to be affected by the deficient practice. The maintenance director or designee will inspect all fire extinguishers monthly as	1/9/24

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K 355	Continued From page 10 intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Reference #2 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 6.1.3.8 Installation Height. - 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb shall be installed so that the top of type fire extinguisher is not more than 5 feet above the floor. - 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 inches. The findings include the following, On 10/30/2023 (day one of survey) during the survey entrance at approximately 9:20 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. Starting at approximately 9:33 AM on 10/30/2023 and continued on 10/31/2023 in the presence of the facility's MD a tour of the facility was	K 355	required/ supported with a monthly log. All extinguishers found to be out of compliance will be immediately replaced out, and or corrected to the required height. The maintenance director/ designee will audit all extinguishers x7 days, then weekly x3, then monthly x3 months for continued compliance. All findings will be shared with the QAPI committee monthly.	

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K 355	Continued From page 11 conducted. During the two day building tour the surveyor observed and inspected thirty (30) portable fire extinguishers in various locations. These 30 portable fire extinguishers were last annually inspected in January 2023 with the surveyor observing the following issues that were identified: On 10/30/2023: 1) At approximately 9:36 AM, the surveyor observed one (1) "ABC-Type" fire extinguisher near the second floor Sensory room appeared to be mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at was mounted 5'- 2" to the center of the pressure indicating needle. On 10/31/2023: 2) At approximately 10:19 AM, the surveyor observed one "ABC-Type" fire extinguisher, inside the Maintenance shop/ storage room that was last annually inspected January 2023. There was no evidence of monthly visual examination performed and documented for August, September and October 2023. 3) At approximately 10:45 AM, the surveyor observed one (1) "ABC-Type" fire extinguisher, inside the Commercial Laundry Dryer room appeared to be mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at was mounted 5'-3-1/2" to the center of the pressure indicating needle. Further inspection identified that the pressure indicating needle was in the "RED" discharge zone of the pressure indicating gauge. This fire extinguisher would not function properly in the	K 355		

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K 355	Continued From page 12 event of a fire. At this time a request was made to the MD to replace the fire extinguisher. The MD complied with the request. 4) At approximately 10:50 AM, the surveyor observed one "ABC-Type" fire extinguisher in the service corridor near the Main Electrical room that appeared to be mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at was mounted 5'- 7" to the center of the pressure indicating needle. 5) At approximately 11:00 AM, the surveyor observed one "ABC-Type" fire extinguisher inside the main Kitchen that appeared to be mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at was mounted 5'- 7" to the center of the pressure indicating needle. 6) At approximately 11:05 AM, the surveyor observed one "ABC-Type" fire extinguisher inside the "Villas" building basement boiler room was last annually inspected January 2023. There was no evidence of monthly visual examination performed and documented for June, July, August, September and October 2023. The facility's MD confirmed the findings at the time of observations. The Administrator was informed of the deficiency during the survey exit on 10/31/2023 at approximately 12:15 PM. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 372	Continued From page 13	K 372		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations, interview and review of facility provided documentation on 10/30/2023, it was determined that the facility failed to maintain the integrity of smoke barrier partitions for four (4) of eight (8) smoke barrier walls inspected as evidenced by the following: On 10/30/2023 (day one of survey) during the survey entrance at approximately 9:20 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a three-story (3)building with eight (8) smoke barrier walls in the facility. Starting at approximately 9:33 AM on 10/30/2023 and continued on 10/31/2023 in the presence of the facility's MD an inspection above the corridor	K 372	The deficient practices on inspection 4 out of 8 smoke barrier walls failed to maintain the 1/2 hour rated construction as required, resident rooms #35, #49, #3, and #19, had one approximately 1-1/4 penetration and one approximately 1-1/4 with an approximately 1 inch plastic pipe running through the barrier wall indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other door All residents that reside in the facility have the potential to be affected by the deficit practice. On 11/10/2023 the maintenance director corrected sealing 35,49/3/ and 19 barrier	11/10/23

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K 372	Continued From page 14 ceiling tiles of eight (8) smoke barrier walls was performed. The surveyor observed the following smoke barrier wall failed to maintain the 1/2 hour fire rated construction as required by code in the following locations, On 10/30/2023: 1. At approximately 10:37 AM, the surveyor observed on the second floor above the ceiling tiles of the corridor double smoke doors (next to Resident room #35) had one (1) approximately 1-1/4" penetration and one (1) approximately 1-1/4" penetration with an approximately one (1) inch plastic pipe running through the barrier wall. These penetrations were observed on both sides through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. 2. At approximately 10:44 AM, the surveyor observed on the second floor above the ceiling tiles of the corridor double smoke doors (next to Resident room #49) had one (1) approximately 1-1/4" penetration with an approximately one (1) inch plastic pipe running through the barrier wall. This penetration was observed on both sides through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. At this time the MD told the surveyor that the facility had some drain piping installed for the air conditioning units. 3. At approximately 11:00 AM, the surveyor observed on the first floor above the ceiling tiles of the corridor double smoke doors (next to	K 372	walls. The maintenance director will audit/inspect all barrier walls, to ensure they meet fire code requirements, x7 days then weeklyx3 then x3 months, Findings will be shared during the monthly QAPI committee meeting.	

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K 372	Continued From page 15 Resident room #3) had one (1) approximately 1-1/4" penetration with an approximately one (1) inch plastic pipe running through the barrier wall. This penetration was observed on both sides through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. 4. At approximately 11:00 AM, the surveyor observed on the first floor above the ceiling tiles of the corridor double smoke doors (next to Resident room #19) had one (1) approximately 1-1/4" penetration with an approximately one (1) inch plastic pipe running through the barrier wall. This penetration was observed on both sides through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. The facility MD confirmed the findings at the time of observations. The Administrator was informed of the deficiency during the survey exit on 10/31/2023 at approximately 12:15 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e).	K 372		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315142 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/11/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LLANFAIR HOUSE CARE & REHABILITATION CENTER	1140 BLACK OAK RIDGE ROAD WAYNE, NJ 07470

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0311	01/09/2024	LSC K0324	01/09/2024	LSC K0351	01/09/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0355	01/09/2024	LSC K0372	01/09/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/9/2023	☐ YES ☐ NO