| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 315261 | A. BUILDING _____ B. WING _____ | 09/01/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| LAKELAND NURSING & REHAB | 25 FIFTH AVENUE HASKELL, NJ 07420 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B.<br><br>Survey Dates: 08/29/22 through 09/01/22<br><br>Survey Census: 127<br><br>Sample Size: 25<br><br>Supplemental Residents: 0 | F 000 | | |
| F 561 SS=D | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the | F 561 | | 11/3/22 |

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

Electronically Signed | 10/03/2022

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 561 | Continued From page 1<br>facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, interviews, and review of facility policy, the facility failed to ensure one of one resident's (Resident (R) 101) right to make choices about his life that were important to him, were encouraged. Specifically, the facility failed to ensure R101 could go out for walks into the community, interact with members of the community, and encouraged to promote the self determination of needs for resident. The facility also failed to ensure R101 was being included and updated in any discussions about his choice to go for walks in the community. By not promoting resident choices this resident was left feeling as though his needs were not being met to address his right to go into the community for walks.<br><br>Findings include:<br><br>1. During observation and interview on 08/28/22 at 11:22 AM, R101 was observed walking independently from his room to look out a window on the first floor. R101 was well groomed, wearing shorts, t-shirt, and tennis shoes. During interview R101 stated, "I want to go walking. I love going outside and getting fresh air. I used to go outside all the time and walk the neighborhood, talk to people, go down to the police station, the stop shop car dealer place, and just walk the neighborhood." R101 stated, "I'm | F 561 | F561<br>I Corrective actions accomplished for residents found to have been affected by the deficient practice<br>Resident R101□s choice of activities and privileges were reviewed and the resident was encouraged to take his walks and was educated about the potential safety concerns.<br>II Identification of Residents who have the potential to be affected by the same deficient practice<br>All residents who have out of pass privileges are at risk for the same deficient practice.<br>III Measures put into place or systemic changes to ensure that the deficient practice will not recur.<br>All residents who have out of pass privileges will be reviewed upon admission and quarterly.<br>IV Monitoring of Corrective Actions<br>Social Worker and/or Activities Director or designee will review residents records monthly for 3 months and then quarterly to ensure residents choices are promoted and encouraged. Findings will be reported to the Director of Nursing and Administrator and be presented at quarterly QAPI meetings. | |

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able to walk independently. I feel alive when I'm able to go for walks. Now, NJ ex order 26.4b1 I get excited when I used to go for walks to get fresh air and just say hi to everyone in the neighborhood. NJ Ex.Order 26.4(b)(1) , and when able, he will come and get me and sign me out and we spend the day together." At this time, R101 stated, "There has been a new administrator that says I can't go for my walks anymore." When asked why, R101 stated, NJ ex order 2 This was about a year ago. Now, NJ ex order 26.4b1 I used to sign myself in/out when I came and when I left. They tell me now if I want to go outside, I have to have someone with me, but I used to take my walks everywhere by myself. We've had meetings about this, but I feel they don't want to help me." R101 stated, NJ ex order 26.4 and they had even asked me why I wasn't going on my walks outside anymore. I just love going outside and talking to people and getting fresh air. Since the COVID pandemic, NJ ex order 26.4b1

During observation on 08/29/22 at 9:00 AM, R101 was observed to be well dressed in shorts, shirt, socks, and tennis shoes. R101 was observed walking from his room (located NJ Ex.Order 26.4(b)(1) ) to the dining room, saying good morning to the staff and other residents, getting a cup of coffee, then returning to his room. During this time, R101 was observed not attempting to elope, wander or take the elevator downstairs to the ground floor, or make any attempts to leave the building.

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During observation on 08/31/22 at 8:36 AM, R101 was observed to be lying in bed and talking with housekeeping staff in his room.

During an observation and interview on 08/31/22 at 10:57 AM, R101 was observed coming out his room, well dressed in shorts, slippers, and t-shirt. R101 stated, "I washed my clothes today. Have a good morning."

Review of an undated "Profile" located in R101's electronic medical record (EMR) under the "Profile" tab revealed R101 NJ ex order 26.4b1 [redacted]

Review of an undated "Admitting Face Sheet" located in R101's paper chart also indicated R101 NJ ex order 26.4b1 [redacted]

Review of R101's medical diagnoses located in R101's EMR under the "Med (medical) Diag (diagnosis)" tab indicated R101 NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 [redacted]

Review of an "Elopement Risk Guide" located in R101's paper chart under the "Assessment" tab and dated NJ ex order 26.4b1 [redacted] indicated a score of [redacted] of 5 indicating NJ ex order 26.4b1 [redacted] It further indicated, R101 was NJ ex order 26.4b1 [redacted]

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NJ ex order 26.4b1 .

Review of "Social Progress Notes" located in R101's paper chart "Social Services" tab and dated NJ ex order 26.4b1 indicated, "NJ ex order 26.4b1 [redacted] He enjoys walking out and going for walks." Review of "Social Progress Notes dated NJ ex order 26.4b1 indicated, "He enjoys being outdoors." Review of "Social Progress Notes" dated NJ ex order 26.4b1 indicated, "NJ ex order 26.4b1 [redacted] . He enjoys going for walks."

Review of R101's annual "Minimum Data Set (MDS)" found in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of NJ ex order 26.4b1 indicated, it is NJ ex order 26.4b1 [redacted]

Review of R101's quarterly "MDS" found in the EMR under the "MDS" tab with an ARD date of NJ ex order 26.4b1 revealed the resident had a BIMS score of NJ ex order 26 which indicated the resident NJ ex ord [redacted] The MDS further indicated R101 NJ ex order 26.4b1 [redacted]

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Review of a "Recreation Department Assessment" found in the EMR under the "Misc" (Miscellaneous) tab dated NJ ex order 26.4b1 and NJ ex order 26.4b1 indicated, "Current Hobbies and Interest: like to take walks outside and in building and Outdoors . . . Cognitive: NJ ex order 26.4b1

Review of an "Interdisciplinary Team Meeting Form," located in R101's paper chart under the "Notes" tab and dated NJ ex order 26.4b1 indicated, NJ ex order 26.4b1

Review of a "Meeting Note" located in R101's paper chart dated NJ ex order 26.4b1 indicated, "We discussed the IC [Infection Control] aspect of NJ ex order 26.4b1 He was reminded of . . . signing the OOP [out on pass] book when he leaves and comes back, wearing a mask while in the community, stay at least 6 feet apart from others because don't know who is vaccinated or not, no close contacts such as hugging, shaking hands, not accepting any food items from people from the street. Upon return must do proper handwashing, days/times prefers to leave the building and return, and local health dept. [Department] NJ ex order 26.4b1

Review of R101's quarterly "MDS" found in the EMR under the "MDS" tab with an ARD date of NJ ex order 26.4b1, indicated a BIMS score of NJ ex 15 indicating the resident NJ ex order 26.4b1. The

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MDS further indicated no NJ Ex.Order 26.4(b)(1) [redacted]. The MDS indicated, NJ ex order 26.4b1 [redacted]

Review of a "Fall Risk Evaluation" found in the EMR under the "Assessment" tab, dated NJ ex order 26.4b1 and NJ ex order 26.4b1 indicated R101 was NJ ex order 26.4b1 [redacted]

Review of "Progress Notes" located in R101's EMR under the "Prog (progress) Note" tab revealed many different dates from NJ ex order 26.4b1 in which R101 has gone out on pass with family, has signed in/out and has returned within 1-2 hours for various activities.

Review of "Social Services Progress Notes" located in R101's EMR under the "Prog Note" tab indicated dates in NJ Ex.Orde[redacted] in which Interdisciplinary Team Meetings (IDT) were held to discuss R101's care. However, there was no documentation of R101's wishes to go outside for walks in the community. Notes indicated, "BIMS o[redacted] can make needs known, attends group activities, spending time in courtyard, remains independent with ADLS [activities of daily living], [redacted], family is passively involved."

Review of an additional "Wandering/Elopement Risk Assessment" located under the "Assessment" tab dated NJ ex order 26.4b1, indicated his NJ ex order 26.4b1 [redacted]

Review of a NJ ex order 26.4b1 [redacted]

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NJ ex order 26.4b1 " located in R101's paper chart revealed multiple dates/times in which R101 NJ ex order 26.4b1 .

During interview on 08/30/22 at 1:23 PM, the Administrator stated, he had only been the administrator since NJ ex order 26.4b1 and "This is just all hearsay, but before I got here, I had heard from the previous administrator and our DON [Director of Nursing] that said there was a history of him [referring to R101] NJ ex order 26.4b1 [R101] NJ ex order 26.4b1 that was a concern." The Administrator stated, "He [R101] would say that he always went on walks with no problems, but because of his safety NJ ex order 26.4b1 He was in agreement with this. . ." The Administrator stated, "Our plan we came up with was that I would take him for a walk. We set up a schedule, then that was always changing. We did speak to his family. We expressed NJ ex order 26.4b1 The Administrator stated, "We had a meeting with the team, and we were in agreement that NJ ex order 26.4b1 He is able to go out to the courtyard

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anytime." When the Administrator was asked if there was a written agreement or anything in writing set up with the facility and R101, he stated, "No." The Administrator stated, "He [R101] can sign himself in/out, but again its NJ ex order 26.4b1 [redacted] but now its frowned upon. From what I'm told, this is all based on his previous history." The Administrator stated, "No staff have ever come to me with concerns like he has been trying to get out of the building or targeting any certain staff to let him out to go for a walk. No. Whenever he asks, we can try to schedule to go for a walk with him. He doesn't come to me repeatedly and ask can I go out; can I go out. No, not at all." The Administrator stated, "He may have a day where he asks 'can I go out by myself?', and my response is its for your safety you don't. NJ ex order 26.4b1 [redacted] but due to those safety concerns he can't just go out for walks by himself."

During interview, on 08/31/22 at 8:45 AM, Licensed Practical Nurse (LPN) 4 stated, "He [referring to R101] will go outside to the back enclosed patio, he is able to do that on his own. He can get in the elevator by himself and go downstairs to the first floor without any problems and out into the courtyard. He likes to go to activities as well on the second floor to keep busy." LPN4 stated, "I've never known him [R101] to just go for walks into the community and I've never seen him wanting or trying to leave the facility out into the community. . . NJ ex order 26.4b1 [redacted]

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During interview on 08/31/22 at 9:09 AM, LPN2 stated, "I used to do recreational activities and from what I remember, he [R101] liked playing dominoes, he likes to dance, likes karaoke, and singing." LPN2 stated, "He used to go for walks in the community before COVID by himself, but I think they stopped it since COVID. I'm not sure if he is doing it now or not. I do remember he would sign himself in/out whenever he would go on his walks. Now, he walks in the outside courtyard. I haven't seen him wanting to leave the building or trying to go into the community now. He is pretty involved in activities."

During interview on 08/31/22 at 9:27 AM, Registered Nurse (RN) 1 stated, NJ ex order 26.4b1 [redacted]. I usually see him walking out in the courtyard, but not into the community. . . I've never known him to just wander off. He likes activities, bingo, movies, entertainment that comes from the community to sing, play music." RN1 stated, "He can take his NJ Ex.Order 26.4(b)(1) [redacted]

During interview on 08/31/22 at 9:51 AM, Recreational Assistant (RA) 1 stated, "He [R101] comes upstairs on his own for activities, likes to make his own signs, figures, baseball, likes group activities, dominoes, and Spanish music. He also loves to walk around the building." RA1 stated, "From what I heard, he is unable to go out into the community. Someone has to be with him. I have not seen him leave for walks into the community by himself . . . He likes to get exercise and will walk on each floor. He doesn't have to ask to go outside into the courtyard. That is also where the smokers go. He has never tried to

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leave the building. He stays busy. He can come upstairs whenever he wants to. He sticks with his routine." RA1 then stated, "He used to go out into the community years ago and wave to people, then he would come back without any problems, but I'm not sure what happened."

During an interview on 08/31/22 at 1:26 PM, the Social Services Director (SSD) stated, she had only heard of R101 wanting to go out for walks in the community as hearsay, and "From what I was told, he was waiting for the DON or Administrator to give the approval for him to go on walks on his own." The SSD stated, "I do know he was walked with our Administrator at times, and he likes to go on longer walks around the neighborhood." The SSD stated, "We have meetings quarterly every three months but, in those meetings, we just talk about things his medications, diet, weight, ADLs, and advanced directives. As far as any specific meetings about going for walks into the community, no. Not that I'm aware of. Since this new administrator started, there hasn't been much talk about him [R101] going out for walks. He [R101] is considered NJ Ex.Order 26.4(b)(1) [redacted]."

During an interview on 08/31/22 at 1:36 PM, the DON stated, "Prior to COVID-19, it was [redacted] for him [R101] to take walks around the blocks. We gave him that opportunity until things started to change." The DON stated, "NJ ex order 26.4b1 [redacted] When the DON was asked when this occurred, she stated, "I would say this was in [redacted] and at that time, he was free to go for

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walks. He would tell us what time he was leaving and would sign himself in/out and he would come back. Then after COVID we started to open things back up again. He wanted to start going out again. So, in NJ ex order 26.4b1 we had heard that NJ ex [redacted] but we were not sure. NJ ex order 26.4b1 [redacted]. When the previous administrator asked him about it, at first, he lied to us and said it never happened. Then in this year NJ ex order 2, he [R101 NJ ex order 26.4b1 [redacted] The DON stated, "Now this administrator says it's a safety issue. NJ ex order 26.4b1 [redacted]." The DON stated, "He [R101] agreed he could walk around the circumference of the facility. He has done well." The DON stated, "We are planning on having a discussion to see if we could put a plan into place, but that has not taken place with him yet. We could put a contract in place but that hasn't been put in place yet. We would have to get something set up and discuss with him that NJ ex order 26.4b1 [redacted] His thing is, he just wants to exercise and walk around the block. He likes to wave at the neighbors. We will have to start a new discussion, but I don't have anything in place. He does ask me, 'Are we still discussing when I can go out again.' I tell him, we are working on it." The DON started, "This has all been just verbal discussions, we were not documenting anything in his chart that we have a current plan in place . . . The only thing that we could actually prove that was NJ ex order 26.4b1 [redacted] He has been our NJ Ex.Or

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NJ Ex.Order 26.4(b)(1) . In early NJ Ex.Order we started having some talks again with the previous administrator, then he left, but nothing has been in writing." When the DON was asked if there would be any reason R101 could not go out into the community for walks, the DON stated, "Well, no. NJ Ex.Order 26.4(b)(1) that he can walk by himself. Make sure he watches for uneven surfaces. . . We think it is more of a NJ ex order 26.4b1 I will have to have another discussion with our administrator to see if he will give the green light." The DON stated, "His BIMS is NJ ex/15, he is not an NJ Ex.Order 26.4(b)(1). He has never been an NJ Ex.Order 26.4(b)(1) . . He is also a NJ ex order 26.4b1 The DON stated, "He [R101] approached me again today to ask, 'Are you working on me going out in the community?' I said, we are working on it. We don't have any concerns about him trying to NJ Ex.Order 26.4(b)(1). No. NJ ex order 26.4b1 . NJ Ex made sure he was safe to walk on sidewalks, cross the street, and make sure he uses the stop light."

During an interview on 08/31/22 at 2:16 PM, the Receptionist stated, "Everybody coming into the building I make sure they sign in/out into the Kiosk and get screened." Before COVID, she stated, "He [R101] NJ ex order 26.4b1 The receptionist stated, "He would sign out on the 'Resident Sign out Form' where we put a time in and time out. I would see him personally sign himself in/out and I would always check with the nurses as well who would verify he was going out." The receptionist stated, "After COVID, I've seen him with his son who has signed him out to

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go grocery shopping then comes right back."

During an observation and interview on 09/01/22 at 7:50 AM, R101 was observed coming out of his room and walking independently to the dining room. During interview R101 stated, "I asked the Administrator for an update on me being able to go outside for my walks. He used to take me out, just to go around the building, but that is not really walking to me. They don't feel comfortable with me walking out there I guess." R101 then stated, "I said I just want to walk outside by myself. I say hi to people. Every time before, I had to sign in/out which I did, but there is nothing set up like a contract. Too many people smoke in the courtyard. I don't smoke. The last time I walked with the Administrator was a couple of months ago. Like only two times that we went out. The previous guy gave me the okay and just to be careful." R101 stated, "As soon as I eat my breakfast, I would like to go out for just an hour and go outside. I like to come back about 10:30 AM or so. I like to take my time and say good morning, say hi to people. This stopped with the pandemic and nothing now. . . The previous guy in charge use to see me go for my walks. When I asked the director lady [referring to the Director of Nursing] yesterday about it, she just said, 'We are working on it. We are waiting for the state to give the okay'." R101 stated, "I feel happy, excited, healthier to get some fresh air. NJ ex order 26.4b1 [redacted] I'm not a troublemaker. I just love saying hello to everyone." When R101 was asked if there were any rules that were discussed with him about going outside by himself for walks, R101 stated, "Just to make sure I keep social distance, keep aware of driveways. Wash my hands." R101 stated, "Even my family knows how I am. My son

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comes to get me every three months. He is a [redacted]. NJ ex order 26.4b1 I just do my walking. Sometimes people will give me a couple of bucks or give me a cup of water in the summertime. At one time I had my own water bottle." R101 stated, "The new Administrator says he is just not comfortable with me walking out by myself because he is new here. I respect the rules, NJ ex order 26.4b1 ."

During interview on 09/01/22 at 7:58 AM, LPN6 stated, "Before COVID-19 he [R101] would walk back and forth into the community. After COVID, it was rumors that people had seen him [redacted] One person who worked here who no longer works here had said NJ ex order 26.4b1 [redacted] but I don't know if that was true or not. We just told him because of COVID, to be careful." LPN6 stated, "He just stays around here now. He is a very social person. I think they started letting him walk around the building and he does okay with that. For some reason, someone said something then it stopped." LPN6 stated, [redacted] " When asked if there was something like a written contract in place for R101 to continue to go outside for walks into the community, LPN6 stated, "No, there is nothing like that in place at this time. No. He can walk around the building, but not all the way into the community. No."

During interview on 09/01/22 at 12:15 PM, the Director of Rehabilitation stated, "NJ ex order 26.4b1 [redacted]. Then there was a different Administrator that at one time showed him how far he could go. He would come back. Just would make big circles in the community, then would

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come back. Then, I'm not sure, but something happened so that stopped. We tried sending out a recreation aide in the past. I've seen him walking and up until [NJ Ex.Order 26.4(b)(1)], he was taking all the appropriate precautions to cross the road. We have not seen him since the COVID pandemic and [NJ Ex.Order 26.4(b)(1)]."

During interview on 09/01/22 at 2:30 PM, the DON stated, "We are going to start to put a plan in place for him, but we have not actually sat down and talked to him as of yet. We don't have a plan in place as of yet and have not set up an actual meeting with him and everyone. From [NJ ex order 26.4b1] until now I guess we were just trying to see how he would do with the walks he was taking."

Review of the facility's undated policy titled, "Resident Self Determination and Participation," indicated, "Our facility respects the right of each resident to exercise his or her autonomy regarding with the resident considers to be important facets if his or her life. . . 1. Each resident is allowed to choose activities . . . that are consistent with his or her interests, values, assessments, and plans of care including: a. daily routine. . . 3. Residents are encouraged to make choices about aspects of their lives including . . . interacting with . . . members of the community; and participating in community activities inside and outside the facility. . ."

Review of the facility's 02/01/22 policy titled, "Resident Right-Self Determination," indicated, "The resident has the right to, and the facility will promote and facilitate resident self-determination through support of resident choice, including but not limited to the following: b. The resident has a

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| F 561 | Continued From page 16<br>right to make choices about aspects of his or her life that are significant to the resident . . . The resident has a right to interact with members of the community. . ."<br><br>Review of the facility's 02/01/22 policy titled, "Resident Right-Respect, Dignity/Right to have Personal Property," indicated, "Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care. . ."<br><br>Review of an undated "Admission Agreement-Appendix: Resident Rights," indicated, "As a nursing home resident, you have certain rights . . . Certain rights are . . . Leave the Nursing Home: Leaving for visits: If your health allows . . . you can spend time away from the nursing home visiting family or friends during the day or overnight. . ."<br><br>NJAC 8:39-4.1(a)25<br>NJAC 8:39-7.3(a) | F 561 | | |
| F 578 SS=D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. | F 578 | | 11/3/22 |

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| F 578 | Continued From page 17<br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.<br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.<br>Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and review of facility policy, the facility failed to ensure advance directives and Practitioner Orders for Life-Sustaining Treatment (POLST) information was completed and obtained for three of 25 sampled residents (Resident (R) 68, R62, and R105). The failure created the potential for residents to not have their wishes known should they suffer a health emergency. | F 578 | F578<br>I. Corrective actions accomplished for residents found to have been affected by the deficient practice<br>Social Worker immediately updated and completed Advance Directives and POLST (physician orders for life sustaining treatments) forms for resident R105, R78, R62 and R78. They were | |

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| F 578 | Continued From page 18<br><br>Findings include:<br><br>1. Review of R78's "Census" tab of R78's electronic medical record (EMR) revealed she NJ ex order 26.4b1 on NJ ex order 26.4b1. Review of R78's diagnoses, located under the "Diagnosis" tab of her EMR, NJ ex order 26.4b1 [redacted]<br><br>Review of R78's "Physician's Orders," located in R78's EMR under the "Orders" tab, revealed the resident had a code status of NJ ex order [redacted]' ([redacted]<br>Review of R78's "Minimum Data Set (MDS)" with an assessment reference date (ARD) of NJ ex order 26.4b1 revealed the facility assessed R78 to have a Brief Interview for Mental Status (BIMS) score of NJ ex out of 15 which indicated R78 was NJ ex order 26.4b1 [redacted]<br><br>Review of the medical record for R78 under the "Advance Directives" tab revealed document titled "New Jersey Practitioner Orders for Life-Sustaining Treatment (POLST)". The POLST document was signed by a Physician but undated.<br><br>Further review of R78's medical record revealed an NJ ex order 26.4b1 '.<br><br>During an interview on NJ ex order 26.4b1 at 10:23 AM, the Social Services Director (SSD) confirmed the above findings and stated that an undated POLST was not a completed POLST.<br><br>2. Review of the "Admission Record" located in the "Profile" tab of the EMR revealed, R62 was | F 578 | reviewed and signed by the physician to ensure documentation in residents medical record.<br>Social Service audited all residents to ensure all residents Advance Directives and POLST (physician orders for life sustaining treatments) were up to date and complete.<br><br>II. Identification of Residents who have the potential to be affected by the same deficient practice<br>All residents are at risk for this deficiency<br><br>III. Measures put into place or systemic changes to ensure that the deficient practice will not recur.<br>All appropriate staff were in-serviced on the facility policy Regarding Resident rights- advance directives. Emphasis was made on ensuring the life sustaining treatment wishes were reviewed and or completed upon admission and reviewed quarterly with the resident and or representative and completed with dates and signatures.<br><br>IV Monitoring of Corrective Actions<br>Director of Social Services or designee will review the medical records of 10 residents per unit per week x 4 weeks and monthly thereafter x 3 months. Findings will be reported to the Director of Nursing and Administrator and be presented at quarterly QAPI meetings. | |

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admitted to the facility on [NJ ex order 26.4b1] with diagnoses that included NJ ex order 26.4b1 [redacted]

Review of the quarterly "MDS" assessment with an ARD of [NJ ex order 26.4b1] revealed R62 had a "BIMS" of [NJ ex ord] which indicated NJ ex order 26.4b1 [redacted]

Review of the undated "New Jersey Practitioner Orders for Life-Sustaining Treatment (POLST)" revealed that R62 had signed the POLST indicating that he requested. . . [NJ ex order 26.4b] [redacted]

In addition, a physician signed the POLST however, the form was not dated and timed, as required, on the POLST form.

During an interview on 08/31/22 at 8:52 AM, Licensed Practical Nurse (LPN) 3 was asked to review R62's POLST form, located in the EMR. LPN3 confirmed that there was no date/time, either for the resident or the physician, indicated on the form and was incomplete.

During an interview on 08/31/22 at 9:30 AM, the SSD was asked if R62 was NJ ex order 26.4b1 [redacted] The SSD stated she had just started working at the facility in [NJ Ex.Order 26.4(] [redacted] and was not aware of his cognitive status before she started. The SSD was asked to review R62's POLST form. The SSD confirmed and verified that the POLST form was incomplete as it was not dated, as required on the form.

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3. Review of R105's "Census" tab of R105's EMR revealed he was admitted to the facility on NJ ex order 26.4b1 Review of R105's diagnoses, located under the NJ ex order 26.4b1

Review of R105's "Physician's Orders," located in R105's EMR under the "Orders" tab, revealed the resident had a code status of "NJ ex order 26.4b1

Review of R105's admission "MDS" with an ARD of NJ Ex.Order 26.4(b)( revealed the facility assessed R105 to have a BIMS score of NJ ex which indicated R105 NJ ex order 26.4b1

Review of the medical record for R105 revealed a blank POLST form under the 'Advance Directives' tab.

Review of a Social Services progress notes dated NJ ex order 26.4b1 at 11:22 AM in the "Progress Notes" tab in the EMR revealed "Advance Directives: [Social Worker] discussed various possibilities/options with Advanced Directives: i.e, NJ ex order 26.4b1 Facility protocol re: same discussed. Resident wife verbalized and demonstrated understanding of all discussed. Wife verbalized she has advanced directives at home and will bring facility a copy."

During an interview on 08/31/22 at 10:23 AM, the SSD stated that Advance Directives information had been provided to R105's spouse on

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admission and that DSS had made several attempts to discuss Advance Directives with R105's spouse, but the spouse was unwilling to discuss. SSD stated she had no documentation of follow-up discussions with R105's spouse. During a follow-up interview on 08/31/22 at 3:14 PM, SSD stated she spoke with R105's son who stated that the POLST form the family had, was never completed, and requested a fresh form.

Review of facility's Policy titled "Resident Right - Advanced Directive Tracking Program," dated 02/01/22 revealed as follows:

"It is the policy of the facility to honor the advance directives of all residents and to make information available to the resident on how to prepare such directives, should the resident not have them in place or to change existing directives.

PROCEDURE:
1. During the admission process the Social Services Director or designee will discuss with each resident and/or the person accompanying the resident the following:
a. Whether they have an advance directive such as a health care surrogate designation, living will or durable power of attorney?
b. Whether they have a POLST?
c. If they have those forms with them? If so, secure copies. If not, inquire as to where the documents can be found. . .
2. The resident and or the person accompanying them will be given a copy of the advance directives information, including the forms used by the facility, whether they have completed advance directives or not. The resident or the person accompanying them should sign that they

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| F 578 | Continued From page 22<br>have received this information. . .<br>4. Social Services or the appropriate designee will carefully review any and all advanced directive related documents to ensure that the information is complete and that the requirements of the law are met. If there is a question it is the responsibility of the reviewer to seek clarification."<br><br>NJAC 8:39-4.1(a)2<br>NJAC 8:39-9.6(a) | F 578 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State | F 609 | | 11/3/22 |

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| LAKELAND NURSING & REHAB | 25 FIFTH AVENUE HASKELL, NJ 07420 |

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| F 609 | Continued From page 23<br>Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews, record review, and review of the facility policies, the facility failed to report to administration when one of two residents (Resident (R) 68) in a total sample of 25 NJ ex order 26.4b1 . This failure placed the residents at risk for further altercations and a diminished quality of life.<br><br>Findings included:<br><br>1. Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed, R68 NJ ex order 26.4b1 [redacted]<br><br>Review of the NJ Ex.Order 26.4(b) "Behavior Care Plan" located in the "Care Plan" tab of the EMR revealed, ". . . NJ ex order 26.4b1 [redacted] ." | F 609 | I. Corrective actions accomplished for residents found to have been affected by the deficient practice<br>All staff were immediately in-serviced on reporting of any alleged violations. Nurses involved were counseled and in serviced on reporting any verbal altercations to administration immediately.<br>Resident R68s room was NJ Exec. Order 26:4.b.1 [redacted] to closely NJ Exec. Order 26:4.b.1 . R22s room was provided with a stop sign as an intervention.<br><br>II. Identification of Residents who have the Potential to be Affected by the Same Deficient Practice<br>All residents have the potential to be affected by this deficiency.<br><br>III. Measures put into Place or Systemic Changes to ensure that the Deficient Practice will not Recur.<br>All staff were in-serviced on the regulations and facility policy and procedures regarding reporting of alleged violations and regarding reporting in a timely manner.<br><br>IV Monitoring of Corrective Actions<br>The administrator or designee will in-service all staff monthly X 3 months and then quarterly thereafter. Findings will be reported to the Director of Nursing and | |

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| F 609 | Continued From page 24<br>Review of the quarterly "Minimum Data Set (MDS)" assessment with and Assessment Reference Date (ARD) of NJ ex order 26.4b1 revealed, R68 had a "Brief Interview of Mental Status (BIMS) of NJ ex out of 15 which indicated she NJ ex order 26.4b1<br><br>Review of the "Admission Record" located in the "Profile" tab of the EMR revealed, R22 was admitted to the facility on NJ ex order 26.4b1 with NJ ex order 26.4b1<br><br>Review of the quarterly "MDS" assessment with ARD of NJ ex order 26.4b1 revealed, R22 had a "BIMS" of NJ ex out of 15 which indicated NJ ex order 26.4b1<br><br>During a random observation on NJ ex order 26.4b1 at 10:37 AM, R68 was observed walking into R22's room (which was the room next door.) R22 was observed NJ ex order 26.4b1 at the foot of her bed. R68 NJ ex order 26.4b1 l at R22 to give her food and R68 NJ ex order 26.4b1 . R68 started to leave R22's room and saw the surveyor in the hall outside the room. R68 showed the surveyor that she had obtained a package of cookies and then put them into her pocket. R68 was NJ ex order 26.4b1 and stopped just outside her room door. This surveyor noted that no staff, licensed or certified, was in the hallways.<br><br>On 08/29/22 at 10:40 AM, Registered Nurse (RN) 2 was observed at the far end of the hall at the medication cart. RN2 was told about the altercation and was asked about R68's behaviors. RN2 stated that R68 NJ ex order 26.4b1 | F 609 | Administrator and be presented at quarterly QAPI meetings. | |

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| F 609 | Continued From page 25 | F 609 | | |

wandered into other residents' rooms in the past but had not done this for long-time. RN2 stated that R68 NJ ex order 26.4b1 [redacted]

During an interview on 08/30/22 at 3:29 PM, Licensed Practical Nurse (LPN) 2 was asked if she had been made aware of the NJ ex order 26 [redacted] between R68 and R22 on NJ ex order 26.4b1 LPN2 stated, "No, I did not know." LPN2 was asked what she would do if she witnessed or had become aware of a NJ Ex.Order 26.4(b)(1) [redacted] LPN2 stated she would separate the residents to make sure they were safe and to monitor them for any "affects." LPN2 was asked who would be notified of the altercation to ensure there was no potential abuse. LPN2 stated, "The DON [Director of Nursing]."

During an interview on 08/30/22 at 1:33 PM, LPN3 was asked if she had been made aware of the NJ Ex.Order 26.4(b)(1) between R68 and R22. LPN3 stated, "No, I had not heard that she had gone into R22's NJ ex order 26.4b1 ." LPN3 further stated that at one time, R68's NJ ex order 26.4b1 [redacted]

During an interview on 08/31/22 at 10:23 AM, the Social Services Director (SSD) was asked if she had been made aware of the NJ Ex.Order 26.4(b)(1) between R68 and R22. SSD stated, "No, I wasn't aware of it, and no one informed me."

During an interview on 08/31/22 at 10:27 AM, the Director of Nursing (DON) was asked if she was made aware of the NJ ex order 26.4b1 between R68 and R22 on NJ ex order 26.4b1 She stated no. The DON was

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| F 609 | Continued From page 26<br>told about the [NJ Ex.Order 26.4(b)(1)] that was witnessed and was reported to RN2. The DON stated, "Then it should have been reported to me." The DON further stated that an incident report should have been done to rule out potential abuse, statements should have been collected and interview with R22. The DON stated that RN2 was the night supervisor however, "she should have told me, that is our policy."<br><br>During an interview on 08/31/22 at 3:51 PM, R22 was asked about the [NJ ex order 26.4b1] R22 stated, "Yes, she comes in my room all the time. [NJ ex order 26.4b1] ometimes, and I tell her to leave. What bothers me is that when I'm asleep and I wake up, there she is, and it scares me. She has never hit me, but she talks loud to me."<br><br>Review of the facility policy titled, "Resident to Resident Altercations," dated July 2021 revealed, ". . .All altercations, including those that may represent resident-to-resident abuse, shall be investigated, and reported to the Nursing Supervisor, the Director of Nursing Services and to the Administrator . . . Facility staff will monitor residents for aggressive/inappropriate behavior towards other residents, family members, visitors, or to the staff. Occurrences of such incidents must be promptly reported to the Nurse Supervisor, Director of Nursing Services, and to the Administrator . . . If two residents are involved in an altercation, staff will . . . Complete an incident/accident report and document the incident, findings, and any corrective measures taken in the resident's medical/clinical record . . ." | F 609 | | |
| F 644 SS=D | Coordination of PASARR and Assessments | F 644 | | 11/3/22 |

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| F 644 | Continued From page 27<br>CFR(s): 483.20(e)(1)(2)<br><br>§483.20(e) Coordination.<br>A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.<br><br>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to identify the need for a new "Preadmission Screening and Resident Review (PASARR-a screening which looks for indicators that a person may have intellectual disability, related disability, or serious mental illness) when a resident had a new diagnosis of [redacted] for one of three residents (Resident (R) 17) reviewed for PASARR. This failure placed R17 [redacted]<br><br>Findings included:<br><br>1. Review of the "Admission Record" located in the "Profile" tab of the electronic medical record | F 644 | I. Corrective Actions Accomplished for Residents found to have been Affected by the Deficient Practice<br>The social worker immediately completed a new PASARR (preadmission screening and resident review) for resident R17 and updated their diagnosis to ensure they receive necessary services for [redacted] The MDS assessment was updated to include her new diagnosis and [redacted] authority was notified.<br><br>II. Identification of Residents who have the Potential to be Affected by the Same Deficient Practice<br>All residents with a mental illness | |

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| F 644 | Continued From page 28<br>(EMR) revealed, R17 was admitted to the facility on 1[NJ ex order 26.4] with NJ ex order 26.4b1 [redacted]<br><br>Review of the [NJ Ex.Order 26.4(b)] "Level I PASARR" located in the "Miscellaneous" tab of the EMR revealed, R17 had a diagnosis NJ ex order 26.4b1 [redacted]<br><br>Review of the "Medical Diagnosis List" located in the "Medical Diagnosis" tab of the EMR revealed on [NJ ex order 26.4b1], R17 had a new diagnosi [NJ ex order 26.4b1] [redacted]<br><br>Review of the EMR did not show that a new Level I screening had been obtained to determine if R17 NJ ex order 26.4b1 [redacted]<br><br>Review of the annual "Minimum Data Set (MDS)" assessment with an Assessment Reference Date (ARD) of [NJ ex order 26.4b1] evealed, R17 had a "Brief Interview of Mental Status (BIMS)" of [NJ ex] out of 15 which indicated she NJ ex order 26.4b1 [redacted]<br><br>During an interview on 08/31/22 at 9:17 AM, Social Services Director (SSD) was asked if a new "Level I PASARR" was done in [NJ Ex.Order 26.4(b)(1]. The SSD stated, "No, it appears that one should | F 644 | diagnosis have the potential to be affected by this deficiency.<br><br>III. Measures put into Place or Systemic Changes to ensure that the Deficient Practice will not Recur.<br>Social Service and nursing staff were in serviced regarding reviewing new admissions and readmissions diagnoses list to ensure PASARR (preadmission screening and resident review) is up to date.<br><br>IV Monitoring of Corrective Actions<br>Social Services, MDS and or designee will audit 5 charts per unit X 4 weeks and quarterly thereafter of all current and new admissions PASARR (preadmission screening and resident review) as well as readmissions diagnosis. Findings will be reported to the Director of Nursing and Administrator and be presented at quarterly QAPI meetings. | |

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| F 644 | Continued From page 29<br>have been done especially with the diagnosis change."<br><br>Review of the facility policy titled, "Coordination - Pre-Admission Screening and Resident Review (PASRR) program," dated 02/01/22 revealed, ". . .A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. . ."<br><br>NJAC 8:39-5.1(a)<br>NJAC 8:39-11.2(a) | F 644 | | |
| F 646 SS=D | MD/ID Significant Change Notification<br>CFR(s): 483.20(k)(4)<br><br>§483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to notify the state mental health authority after a significant change in condition for one (Resident (R) 68) of three sample residents who were reviewed for Preadmission Screening and Resident Review (PASARR- a screening which looks for indicators that a person may have intellectual disability, related disability, or serious mental illness). This has the potential for failure for the facility to identify the resident's needs and provided services appropriate for the residents mental health. | F 646 | F646<br>I. Corrective Actions Accomplished for Residents found to have been Affected by the Deficient Practice<br>The NJ Exec. Order 26:4.b.1 authority was immediately notified of residents R68□s change in condition for revision of the (ID/DD) intellectual disability/developmental disabilities to ensure resident needs and appropriate services are met. | 11/3/22 |

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| F 646 | Continued From page 30<br><br>Finding included:<br><br>1. Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed, R68 was NJ ex order 26.4b1 [redacted]<br><br>Review of the NJ ex order 26.4b1 "Level I PASARR" located in the "Miscellaneous" tab of the EMR revealed, R68 was NJ ex order 26.4b1 [redacted]<br><br>Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ ex order 26.4b1 revealed, R68 had a "Brief Interview of Mental Status (BIMS)" of NJ ex out of 15 which indicated R68 was NJ ex order 26.4b1 [redacted] In addition, the assessment showed R68 NJ ex order 26.4b1 [redacted]<br><br>Review of the NJ ex order 26.4b1 "Level II PASARR" located in the "Miscellaneous" tab of the EMR revealed she was not referred for services related to her 'NJ ex order 26.4b1<br><br>Review of the NJ ex order 26.4(b) "Care Plan" located in the | F 646 | II. Identification of Residents who have the Potential to be Affected by the Same Deficient Practice<br>All residents with a mental illness diagnosis have the potential to be affected by this deficiency.<br><br>III. Measures put into Place or Systemic Changes to ensure that the Deficient Practice will not Recur.<br>Social Service and MDS coordinator were in serviced regarding reviewing new admissions and readmissions diagnoses list to reflect a correct level I and/or level II PASARR (preadmission screening and resident review) and revise accordingly.<br><br>IV Monitoring of Corrective Actions<br>Social Services, MDS coordinator and or designee will audit 5 charts per unit X 4 weeks and quarterly thereafter of all current and new admissions PASARR (preadmission screening and resident review) as well as readmissions diagnosis. Findings will be reported to the Director of Nursing and Administrator and be presented at quarterly QAPI meetings. | |

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"Care Plan" tab of the EMR revealed an update on NJ ex order 26.4b1 which showed, "R68 is NJ ex order 26.4b1 [redacted]

Review of the current quarterly "MDS" assessment with an ARD of NJ ex order 26.4b1 revealed, R68 had a "BIMS" of NJ ex out of 15, required limited assistance with ADL's NJ ex order 26.4b1 [redacted] during the observation period.

During an interview on 08/31/22 at 2:52 PM, the Social Services Director (SSD) was asked if R68 had improved since the previous assessment due to her NJ ex order 26.4b1, had NJ ex order 26.4b1 [redacted]." The SSD confirmed and verified that a new "Level II PASARR" should have been done as she, "might have missed out on something that she may have benefited from."

Review of the facility policy titled, " Coordination - Pre-Admission Screening and Resident Review (PASRR) program," dated 02/01/22 revealed, ". . .A nursing facility must notify the state mental

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| F 646 | Continued From page 32<br>health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. . ."<br><br>NJAC 8:39-5.1(a) | F 646 | | |
| F 655 SS=D | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission.<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders.<br>(B) Physician orders.<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-<br>(i) Is developed within 48 hours of the resident's admission.<br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of | F 655 | | 11/3/22 |

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| F 655 | Continued From page 33<br>this section).<br><br>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:<br>(i) The initial goals of the resident.<br>(ii) A summary of the resident's medications and dietary instructions.<br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and facility policy review, the facility failed to ensure that the resident and/or the resident's responsible party (RP) for two of two residents (Residents (R) 61 and R103) reviewed for baseline care plans, had baseline care plans developed and implemented to address the resident's immediate needs within 48 hours of admission to the facility. The facility failed to ensure the residents and/or representatives were in attendance of a baseline care plan and provided with a written summary of the baseline care plan that included, at a minimum, the initial goals of the resident; medications, nursing, and dietary instructions; and services and treatments to be administered by the facility and personnel.<br><br>Findings include:<br><br>Review of the facility's 02/02/22 policy titled, "Baseline Care Plan," indicated, "Intent: Every resident will have an Interdisciplinary Care Plan, with the Baseline Care Plan completed within 48 | F 655 | F655<br>I. Corrective Actions Accomplished for Residents found to have been Affected by the Deficient Practice<br>Residents R 61 and R103 baseline care plans were reviewed and updated immediately. All disciplines were in-serviced on completing the baseline care plans in a timely manner and families were informed.<br><br>II. Identification of Residents who have the Potential to be Affected by the Same Deficient Practice<br>All residents have the potential to be affected by this deficiency.<br><br>III. Measures put into Place or Systemic Changes to ensure that the Deficient Practice will not Recur.<br>All appropriate department heads were in-serviced on baseline care plans requirements to be completed within 48 | |

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| F 655 | Continued From page 34<br>hours of admission. The care plan will identify priority problems and needs to be addressed by the interdisciplinary team, and will reflect the resident's strengths, limitations and goals. The care plan will be complete, current, realistic, time specific and appropriate to the individual needs for each resident . . . The interdisciplinary plan of care will be developed through collaborative efforts of the Interdisciplinary Team and other health care professionals . . . The resident and/or family member will be involved in the care planning . . . The care plan will contain information about the physical, emotional/psychological, psychosocial, spiritual, educational, and environmental needs as appropriate. . . Procedure: The baseline care plan will: 1. Be developed within 48 hours of a resident's admission. 2. Include the minimum healthcare information necessary to properly care for a resident including but not limited to: a. initial goals based on admission orders. B. physician orders. C. dietary orders. D. Therapy services. E. Social services . . . 4. The facility will provide the resident and their representative with a summary of the baseline care plan prior to completion of the comprehensive care plan, that includes but is not limited to: a. the initial goals of the resident, b. a summary of the resident's medications and dietary instructions, c. any services and treatments to be administered by the facility personnel acting on behalf of the facility . . . 5. The facility will provide the resident and their representative with a summary of the baseline care plan prior to completion of the comprehensive care plan. . ."<br><br>1. During an observation on 08/29/22 at 10:25 AM, R61 was observed laying on his side and sleeping in bed. When attempting to interview the | F 655 | hours of admissions and readmissions and communication with the families.<br><br>IV Monitoring of Corrective Actions<br>Social workers or designee will audit monthly X 6 months and thereafter quarterly the progress of the baseline care plans completions and communications with the residents/families. Findings will be reported to the Director of Nursing and Administrator and be presented at quarterly QAPI meetings. | |

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resident, he stated, "Sleeping" and was [redacted] communicate his needs at this time.

During an interview on 08/29/22 at 4:13 PM, regarding base line care plans for the care R61 was going to receive, family member (F) 61 (R61's Responsible Party) stated, "[redacted], I vaguely recall a discussion that took place, but I never received anything in writing regarding a discussion about the care he was going to receive, or anything called a baseline care plan. No. I never received anything in writing that I recall."

During a second interview on 08/31/22 at 12:05 PM, R61 was observed finishing his lunch tray. At this time, the resident was not wanting to be interviewed.

Review of a "Face Sheet" located in R61's electronic medical record (EMR) under the "Med (medical) Diag (diagnosis)" tab revealed R61 was [redacted] with diagnoses to include [redacted].

Review of R61's EMR under the "Assessment" tab indicated no documentation for a baseline care plan. Further review of the medical record revealed no documentation that a baseline care plan was completed after admission to the facility on [redacted] or that R61 and F61 received any written documentation of a baseline care plan.

Review of a "Social Service Admission/Readmission Note" located in R61's EMR under the "Progress Notes" tab dated

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NJ ex order 26.4b1 (5 days after admission) by the social worker, indicated R61 was admitted to the facility on NJ ex order 26.4b1 ". . .requires NJ ex order 26.4b1 . was noted to be NJ ex order 26.4b1 . ." Further review of the Social Service notes revealed no documentation that a written summary of a baseline care plan was completed, or discussion with R61 or F61 took place upon admission or written documentation was given to F61.

Review of "Nursing Notes" located in R61's EMR under the "Progress Notes" tab indicated R61 NJ ex order 26.4b1 and returned to the facility on NJ ex order 26.4b1

Review of an "Admission Baseline Care Plan," located in R61's EMR under the "Assessment" tab dated NJ ex order 26.4b1 indicated an admission baseline care plan was initiated on NJ ex order 26.4b1 but no evidence of any written summary of initial goals, treatments, or various disciplines involved was given to R61 or F61 when R61 was re-admitted to the facility on NJ ex order 26.4b1 The portion of the baseline care plan labeled, "Signature of Resident and Representative" was blank.

During an interview on 09/01/22 at 8:42 AM, regarding baseline care plans, the Social Services Director (SSD) stated, "The process for the baseline care plans is I do that within 48 hours of admission, or the next business day. I go up and interview the patient and set up a family meeting with the families. Upon admission, I will set up a meeting with the family or resident and I do my section for social services. Most prefer to do them over the phone, and I do document that I

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attempted to call the family." When the SSD was asked if she had any documentation to provide that a written summary of the baseline care plan was provided to R61 or F61 and any information discussed from the first admission on [redacted] or the re-admission on [redacted], to include at a minimum, the initial goals of the resident, medications, nursing, dietary instructions, and any services to be administered by the facility, the SSD stated, "No, but going forward, I will ensure that I'm doing that."

2. Review of the undated "Admission Record" in the EMR under the "Profile" tab, revealed R103 was admitted to the facility on [redacted] with [redacted]

Review of the Significant Change "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] revealed the resident was [redacted]

Review of the "Baseline Care Plan" dated [redacted] and provided by the facility revealed the care plan was completed by a Registered Nurse (RN) on [redacted] following R103's admission to the facility. R103 required one-person physical assistance with most activities of daily living (ADLs). The resident was [redacted] he section for signature of the resident and representative was blank (not filled out). There was no evidence the summary of the

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baseline care plan including the initial goals of the resident, a summary of the resident's medications and dietary instructions, any services, and treatments to be administered was provided to the resident or family.

Review of the "Baseline Care Plan" dated [redacted] and provided by the facility revealed the care plan was completed by the SSD and a Registered Nurse (RN) on [redacted] following R103's readmission to the facility on [redacted] after [redacted]. R103 [redacted] The section for signature of the resident and representative was blank (not filled out). There was no evidence the summary of the baseline care plan was provided to the resident or family.

During an interview on 09/01/22 at 10:34 AM, R103 and his family member (F) 103 were interviewed together. F103 stated she had not been to a care plan meeting and had not been provided with a baseline care plan summary initially or following R103's readmission from the hospital on [redacted]. F103 stated she came to visit R103 daily from around 10:00 AM - 6:00 PM. R103 also denied being given a care plan summary or attending a baseline care plan meeting.

During an interview on 09/01/22 at 1:00 PM, the SSD stated she, the nurse, and representatives from other disciplines met usually the day after a

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resident's admission to discuss the baseline care plan. The SSD stated family members and the residents could attend. The SSD stated if families could not attend, the facility could call them and conduct the meeting over the phone. The SSD stated the facility typically set up a family meeting and reviewed the baseline care plan at the meeting. The SSD stated she documented if a family meeting occurred; however, had not provided a written baseline care plan summary to the resident or family. The SSD stated she would check her records to determine whether R103 or F103 had attended a baseline care plan meeting in person or via the phone.

During a follow up interview on 09/01/22 at 1:49 PM, the SSD stated she did not have documentation of giving the base line care plan summary to R103 or F103 within 48 hours of admission or upon readmission. The SSD further stated she had no record of having a baseline care plan meeting with R103 or F103.

Review of the facility's 02/02/22 policy titled, "Baseline Care Plan," indicated, "Intent: Every resident will have an Interdisciplinary Care Plan, with the Baseline Care Plan completed within 48 hours of admission. The care plan will identify priority problems and needs to be addressed by the interdisciplinary team, and will reflect the resident's strengths, limitations and goals. The care plan will be complete, current, realistic, time specific and appropriate to the individual needs for each resident . . . The interdisciplinary plan of care will be developed through collaborative efforts of the Interdisciplinary Team and other health care professionals . . . The resident and/or family member will be involved in the care planning . . . The care plan will contain

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| F 655 | Continued From page 40<br>information about the physical, emotional/psychological, psychosocial, spiritual, educational, and environmental needs as appropriate. . . Procedure: The baseline care plan will: 1. Be developed within 48 hours of a resident's admission. 2. Include the minimum healthcare information necessary to properly care for a resident including but not limited to: a. initial goals based on admission orders. B. physician orders. C. dietary orders. D. Therapy services. E. Social services . . . 4. The facility will provide the resident and their representative with a summary of the baseline care plan prior to completion of the comprehensive care plan, that includes but is not limited to: a. the initial goals of the resident, b. a summary of the resident's medications and dietary instructions, c. any services and treatments to be administered by the facility personnel acting on behalf of the facility . . . 5. The facility will provide the resident and their representative with a summary of the baseline care plan prior to completion of the comprehensive care plan. . ."<br><br>NJAC 8:39-11.2(d) | F 655 | | |
| F 656 SS=E | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must | F 656 | | 11/3/22 |

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| F 656 | Continued From page 41<br>describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff and resident interviews, the facility failed to develop a comprehensive plan of care directing measurable goals and interventions for five residents in a total sample of 25 (Resident (R) 3, R32, R43, R101, and R103). The facility failed to develop a care plan for pain for R3, resident | F 656 | F656<br>I. Corrective Actions Accomplished for Residents found to have been Affected by the Deficient Practice<br>Residents R3, R32, R101, R43 and R103 comprehensive care plans were reviewed and immediately updated to reflect the | |

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| F 656 | Continued From page 42<br>choices for R101, side rails for R32, behaviors for R43, and nutrition for R103. These failures placed the residents at risk for unmet care needs and a diminished quality of life.<br><br>Findings included:<br><br>1. Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R3 NJ ex order 26.4b1 with diagnoses that included NJ ex order 26.4b1<br><br>Review of the current "Order Summary" located in the "Orders" tab of the EMR revealed R3 was NJ ex order 26.4b1<br><br>Review of the quarterly "Minimum Data Set (MDS)" assessment with an Assessment Reference Date (ARD) of NJ ex order 26.4b1 revealed, R3 had a "Brief Interview of Mental Status (BIMS)" of NJ ex out of 15 which indicated she was NJ ex order 26.4b1<br><br>Review of the EMR showed a care plan NJ Ex.Order 26.4 had not been developed with measurable goals or resident-specific interventions.<br><br>During an initial interview on 08/29/22 at 11:37 AM, R3 was lying in bed, softly crying. She stated that NJ ex order 26.4b1. Licensed Practical Nurse (LPN) 2 was informed of the resident's NJ Ex.Order 26.4(b) stated, "She is scheduled to receive NJ ex order 26.4b1 at 12:00 but I will give it to her now." | F 656 | measurable goals or specific resident interventions.<br><br>II. Identification of Residents who have the Potential to be Affected by the Same Deficient Practice<br>All residents have the potential to be affected by this deficiency.<br><br>III. Measures put into Place or Systemic Changes to ensure that the Deficient Practice will not Recur.<br>All appropriate staff were in-serviced regarding developing and implementing the comprehensive care plans to ensure residents preferences and goals are being met. The facility initiated a new triggered based option to their EMAR system to utilize and provide patient centered comprehensive care plans. Training on comprehensive care plans will be provided to applicable healthcare nursing staff during initial orientation and will be incorporated into the facility□s annual education plan.<br><br>IV Monitoring of Corrective Actions<br>MDS coordinator or designee will audit all residents□ monthly to ensure development of comprehensive care plans are in accordance with our policy and procedures. Findings will be reported to the Director of Nursing and Administrator and be presented at quarterly QAPI meetings. | |

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During an interview on 09/01/22 at 8:30 AM, LPN3 was asked about R3's NJ Ex.Order 26.4(b)1 how it was managed. LPN3 stated NJ ex order 26.4b1

NJ ex order 26.4b1

LPN 3 was asked if there was a care plan for R3's NJ Ex.Order 26.4(b current interventions. LPN3 confirmed that a "Care Plan" NJ Ex.Order 26.4(b was not developed for R3's NJ Ex.Orde

2. Review of R32's printed "Admission Record" from the EMR "Profile" tab showed an admission date of NJ ex order 26.4b1, and a readmission date of NJ ex order 26.4b1, with medical diagnoses that included NJ ex order 26.4b1

Observation on 08/29/22 at 2:26 PM showed R32's bed had NJ ex order 26.4b1 and R32 was sitting up at the bedside NJ ex order 26.4b1. On NJ ex order 26.4b1 at 3:03 PM, R32's NJ ex ord

Review of R32's hard (paper) chart showed an ". . NJ ex order 26.4b1 assessment completed on NJ ex order 26.4b1 with a signed informed consent NJ ex ord dated NJ ex order 26.4b1

The consent form stated:
NJ ex order 26.4b1

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NJ ex order 26.4b1 ."

Review of R32's care plan, from the EMR "Care Plan" tab, showed, in pertinent parts:
"Focus: [R32's name] has an ADL [activities of daily living] Self Care Performance Deficit secondary NJ Ex.Order 26.4(b)(1)
Date Initiated: NJ ex order 26.4b1
Revision on: NJ Ex.Order 26.4(b)(1) . . Focus: [R32's name] NJ ex order 26.4b1 [related to] NJ ex order 26.4b1 .
Date Initiated: NJ ex order 26.4b1
Revision on: NJ ex order 26.4b1 . .
Interventions: NJ ex order 26.4b1 NJ ex order 26.4b1 . . ."
Further review of R32's care plan did not address the use of NJ Ex.Order 26.4(b) with inherent risks.

During an interview on 08/31/22 at 4:48 PM, the Director of Nursing (DON) stated an expectation that NJ Ex.Order 26.4(b) would be care planned under ADLs.

3. Review of R43's printed "Admission Record" from the EMR "Profile" tab showed a facility admission date of NJ ex order 26.4b1 with medical diagnoses that included NJ ex order 26.4b1

Review of R43's care plan from the EMR "Care Plan" tab showed:
"Focus: [R43's name] is currently on NJ ex order 26.4b1

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DX[diagnosis] NJ ex order 26.4b1
[redacted]
[R43's name] NJ ex order 26.4b1
[redacted]
NJ ex order 26.4b1
[redacted]
Date Initiated: NJ ex order 26.4b1
Revision on NJ ex order 26.4b1
Goal: [R43's name] will have fewer behaviors weekly x 90 days
Date Initiated: NJ ex order 26.4b1
Revision on: NJ ex order 26.4b1
Target Date: NJ ex order 26.4b1
-[R43's name] will fewer s/s of NJ ex order 26.4b1 x 90 days
Date Initiated: NJ ex order 26.4b1
Revision on NJ ex order 26.4b1
Target Date: NJ ex order 26.4b1 ..."
Further review of the care plan did not address how many NJ ex order 26.4b1
[redacted] 43 experienced in the 90 days prior to the revision on NJ ex order 26.4b1 to have a baseline to measure if the goal had been attained.

During an interview on 09/01/22 at 4:10 PM the DON confirmed the care plan goals were not measurable and [the facility] could "tighten up" on the behavior and side effect monitoring.

4. During observation and interview on 08/28/22 at 11:22 AM, R101 was observed walking independently from his room to look out a window on the first floor. During interview, R101 stated, "I want to go walking. I love going outside and getting fresh air. I used to go outside all the time and walk the neighborhood, talk to people, go

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down to the police station, the stop shop car dealer place, and just walk the neighborhood." R101 stated, "I'm able to walk independently. I feel alive when I'm able to go for walks. Now [redacted] because the new administrator says I can't go outside. . ." At this time, R101 stated, "There has been a new administrator that says I can't go for my walks anymore." R101 stated, "I used to sign myself in/out when I came and when I left. They tell me now if I want to go outside, I have to have someone with me." R101 stated, "We've had meetings about this in the past, but I feel they don't want to help me."

During an observation and interview on 09/01/22 at 7:50 AM, R101 was observed walking around independently. He was observed well dressed in tennis shoes, socks, shorts, and a t-shirt. During interview R101 stated, "I asked the Administrator on an update about being able to go for my walks outside. I guess they don't feel comfortable with me walking out there. I would like to go for my walks on my own. I say hi to people. I would sign myself in/out. As soon as I eat my breakfast, I would like to take an hour, take my time, say hi to people and go for a walk. It makes feel excited, happier, and I feel better just to get fresh air."

Review of an undated "Profile" located in R101's electronic medical record (EMR) under the "Profile" tab revealed R101 was his own [redacted].

Review of R101's medical diagnosis located in R101's EMR under the "Med (medical) Diag (diagnosis)" tab indicated R101 was admitted to the facility on [redacted]. Diagnoses includes [redacted]

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NJ ex order 26.4b1

Review of an "Elopement Risk Guide" located in R101's paper chart under the "Assessments" tab and dated NJ Ex.Order 26.4(b)( indicated a score of NJ of 5 indicating NJ Ex.Order 26.4(b)(1). It further indicated, R101 was NJ ex order 26.4b1

Review of an "Interdisciplinary Team Meeting Form," located in R101's paper chart under the "Notes" tab and dated NJ ex order 26.4b1 indicated, "Likes to ambulate around the building, socializing . . . keeps busy on his own throughout the day by talking to peers, NJ ex order 26.4b1 "

Review of a "Meeting Note" located in R101's paper chart dated NJ ex order 26.4b1 indicated, "We discussed the IC [Infection Control] aspect of going out on pass in the community and return to the NH [Nursing Home]. He was reminded of . . . signing the OOP [out on pass] book when he leaves and comes back, wearing a mask while in the community, stay at least 6 feet apart from others because don't know who is vaccinated or not, no close contacts such as hugging, shaking hands, not accepting any food items from people from the street. Upon return must do proper handwashing, days/times prefers to leave the building and return, and local health dept. [Department] suggest do a NJ Ex.Order 26.4(b)(1) 5 days although NJ ex order 26.4b1 . He

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acknowledged understanding." Further review of the note revealed no documentation that a care plan would be developed with measurable goals, interventions regarding the possibility of R101 to go for walks into the community.

Review of R101's Annual "MDS" found in the EMR under the "MDS" tab with an ARD of [redacted] indicated, it is "Very Important" for R101 go outside to get fresh air when the weather is good."

Review of R101's Quarterly "MDS" found in the EMR under the "MDS" tab with an ARD date of [redacted], indicated a BIMS score of [redacted]. The MDS further indicated [redacted] The MDS indicated [redacted]

Review of a "Care Plan" initiated and revised on [redacted], found in R101's EMR under the "Care Plan" tab indicated, "[name of R101] is [redacted] Interventions listed were: "Enjoys being outside in courtyard and dancing to music when weather is warmer, enjoys walking around the building & socializing with his peers." Further review of the care plan located in the EMR revealed no resident person centered care plan specifically developed regarding R101's choice to go for walks in the community, being able to sign himself in/out, where to go, education, meetings held with the resident, or any specific goals,

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interventions put into place regarding his desire to go for walks into the community.

Review of a "General Nurses Note" located in R101's EMR under the "Prog Notes" tab dated [redacted], indicated, IDCP (Interdisciplinary Team) met . . . [name of R101] [redacted] . . Was permitted to go for a walk outside the facility this past quarter. [redacted] . The following is addressed in the CP (care plan) . . . " Further review of the note revealed no specific resident centered care plan was developed or implemented specifically with R101 wanting to go outside, specific measurable goals, or any interventions put into place to address wanting to go outside for walks.

Review of "Social Services Progress Notes" located in R101's EMR under the "Prog Note" tab indicated dates in [redacted] which Interdisciplinary Team (IDT) Meetings were held on [redacted] to discuss R101's care. However, there was no discussion or documentation of a person-centered care plan that was developed or implemented to discuss measurable goals and specific interventions put into place to address R101's wishes to go for walks by himself into the community.

Review of a "Plan of Care Note" located in R101's EMR under the "Prog Note" tab dated [redacted], [redacted] and [redacted] indicated, "Meeting took place in resident room with nurse and SWer (social worker) present . . . awake alert . . .

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remains verbally responsive and cam make his needs known to staff . . . He continues to enjoy spending time in the courtyard . . . " Further review of the Progress Notes revealed no discussion or documentation that took place regarding R101's wishes to go for walks into the community, and no documentation of a person-centered care plan being developed with measurable goals and interventions regarding R101's wishes to go out for walks into the community.

During an interview on 08/30/22 at 1:23 PM, the Administrator stated, "When I got here as the Administrator in [redacted NJ Ex.Order 26.4(b)(1)], I was told just from hearsay that there was a history of him [R101] [redacted NJ ex order 26.4b1] e would say that he always went on walks, but because of his safety, I can't allow him to go on walks by himself." When the Administrator was asked if there was a plan put into place, or a person-centered care plan that shows discussions took place about putting specific measurable goals into place with interventions regarding R101 wanting to go for walks into the community. The Administrator stated, "We came up with a plan. I told him I would start taking him on walks. . . Sometimes we did, and other days he hasn't wanted to go out for a walk. We came up with a schedule but that kept moving. We were all in agreement that is is not safe for him to go on these long walks. This was just all verbal, there is no written plan in place."

During an interview on 08/31/22 at 1:26 PM, the Social Services Director (SSD) stated, "We have had care plan meetings every quarter but mostly

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we cover his weight, ADLs, advanced directives, and meds [medications]. He [R101] is considered his NJ Ex.Order 26.4(b)(1). We have not discussed anything in his care plans regarding him wanting to go for walks into the community."

During an interview on 08/31/22 at 1:36 PM, the DON stated, "We started having some discussions about him going for walks back into the community, I want to say in NJ Ex.Order 26.4(b)(1) but then that administrator left, and we got a new one. Now, we will be starting some more discussions, but we were not officially documenting that in our computer charting." When the DON was asked if she could show documentation of a resident specific person centered care plan that has been developed specifically with measurable goals and interventions, meetings that took place, education, and a plan about R101 going on walks into the community, the DON stated, "We have a care plan that was initiated on NJ Ex.Order 26.4(b) but there was nothing specific about this issue. I don't see our discussions on it, or when we have spoken to him about this." The DON stated, "He [R101] approached me again this morning about where we were at with him wanting to go for walks into the community. I said to him that I'm working on it. Over the past couple of months, he has proven himself somewhat, but we don't have anything in writing like a care plan of our discussions."

5. Review of the undated "Admission Record" in the EMR under the "Profile" tab, revealed Resident (R103) NJ ex order 26.4b1

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NJ ex order 26.4b1

Review of the Significant Change "MDS" with an ARD of NJ ex order 26.4b1 revealed the resident was NJ ex order 26.4b1

During an interview on 08/29/22 at 10:58 AM, R103 and his family member (F)103 were interviewed together. F103 stated NJ ex order 26.4b1

Review of the Nurses' Notes revealed R103 NJ ex order 26.4b1

Review of a "Nurse's Note" dated NJ ex order 26.4b1 at 6:51 AM, in the EMR under the "Progress Notes" tab revealed, NJ ex order 26.4b1

Review of a Nurse's Note" dated NJ ex order 26.4b1 at 7:07 AM in the EMR under the "Progress Notes" tab revealed, NJ ex order 26.4b1 [seated upright]. NJ ex order 26.4b1

Review of a Nurse's Note" dated NJ ex order 26.4b1 at 7:15 AM in the EMR under the "Progress Notes" tab revealed, NJ ex order 26.4b1 NJ ex order 26.4b1 .

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MD called awaiting call back. supervisor aware."

Review of a "Nurse's Note" dated NJ ex order 26.4b1 at 07:35 AM in the EMR under the "Progress Notes" tab revealed, NJ ex order 26.4b1 ] NJ ex order 26.4b1

Review of the "Insulin Report" dated NJ ex order 26.4b1 in the EMR and under the "Orders" tab, revealed R103's recent NJ ex order 26.4b1

Review of the "Order Summary Report" dated NJ ex order 26.4b1 in the EMR and under the "Orders" tab, revealed R103's current NJ ex order 26.4b1 were as follows:

NJ ex order 26.4b1

During an interview on 08/30/22 at 01:23 PM, LPN5 and LPN1 stated there had also been NJ ex order 26.4b1 made to R103's regimen due to recent NJ ex order 26.4b1

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R103's "Care Plan" dated NJ ex order 26.4b1 in the EMR under the "Care Plan" tab was reviewed. There was no care plan specific for the problem of NJ ex order 26.4b1 to address NJ ex order 26.4b1 Review of the "Care Plan" dated NJ Ex.Order 26.4(b) in the EMR under the "Care Plan" tab revealed the only reference to NJ Ex.Or was as follows: "[R103] is at risk for NJ ex order 26.4b1 ..." The goal was "[R103] will have no further NJ Ex.Order 26.4(b)(1) x 90 days." Interventions included, NJ ex order 26.4b1 ; NJ Ex.O management as ordered, NJ Ex.Order 26.4( consults as needed; NJ ex order 26.4b1 for s/s [signs and symptoms] of infection. Treatment as ordered; Reposition every 2 hours as needed; NJ ex order 26.4b1 "

During an interview on 09/01/22 at 4:12 PM, the DON stated the MDS nurse was currently out of the facility and not available for interview. The DON verified R103 had a NJ ex order 26.4b1

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planned. The DON stated she would review the care plan and if she found any pertinent information, she would provide it. No additional information was provided to illustrate [redacted] was care planned for R103.

Review of the 02/01/22 facility policy titled "Comprehensive Resident Centered Care Plans" showed:
"Intent ... Every resident will have an Interdisciplinary Care Plan. The care plan will identify priority problems and needs to be addressed by the interdisciplinary team, and will reflect the resident's strengths, limitations and goals. The care plan will be complete, current, realistic, time specific and appropriate to the individual needs for each resident. There will be ongoing documentation of the nursing process related to resident needs from admission to discharge. The interdisciplinary plan of care will be developed through collaborative efforts of the Interdisciplinary Team and other health care professionals. It will be consistent with the medical plan of care and those disciplines that have direct involvement with the resident's care ....
It is our purpose to ensure that each resident is provided with individualized, goal- directed care, which is reasonable, measurable and based on resident needs. A resident's care should have the appropriate intervention and provide a means of interdisciplinary communication to ensure continuity in resident care."

Review of the "Resident Assessment Instrument [RAI] Manual," dated October 2019, page 4-8, showed: ". . .4.7 The RAI and Care Planning
As required at 42 CFR 483.21(b), the comprehensive care plan is an interdisciplinary

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| F 656 | Continued From page 56<br>communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. . ."<br><br>NJAC 8:39-11.2(i) | F 656 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(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.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced | F 657 | | 11/3/22 |

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| F 657 | Continued From page 57<br>by:<br>Based on observation, interview, and record review, the facility failed to ensure the care plan was updated for one of 29 residents (Resident (R) 96) reviewed. The failure to keep a care plan current could affect the appropriateness of care provided to any of the 127 current residents receiving care in the facility.<br><br>Findings include:<br><br>1. Observation of R96 on NJ ex order 26.4b1 at 12:45 PM showed a NJ ex order 26.4b1 [redacted] at 11:00 PM.<br><br>Review of R96's "Admission Record" printed from the electronic medical record (EMR) "Profile" tab showed an admission date of NJ ex order 26.4b1, and a readmission date of NJ ex order 26.4b1, with medical diagnoses that included NJ ex order 26.4b1 [redacted]<br><br>Review of R96's "Progress Notes," from the EMR "Prog Notes" tab showed:<br>NJ Ex.Order 26.4(b)(1) 12:09 [12:09 PM] General Nurses Note Note Text: ...Resident is presently NJ ex order [redacted] Dietician notified and will make adjustments to NJ Ex.Order order. MD [name] and [Resident Representative name] notified."<br><br>Review of a discharge "Minimum Data Set [MDS]," assessment reference date (ARD) | F 657 | F657<br>I. Corrective Actions Accomplished for Residents found to have been Affected by the Deficient Practice.<br>Resident R96s comprehensive care plan was immediately reviewed and revised to reflect the appropriate order for the NJ Exec. Order 26:4.b.1.<br><br>II. Identification of Residents who have the Potential to be Affected by the Same Deficient Practice.<br>All residents are at risk for the same deficiency.<br><br>III. Measures put into Place or Systemic Changes to ensure that the Deficient Practice will not Recur.<br>MDS coordinator and dietitian was in-serviced regarding developing and updating the residents comprehensive care plans in a timely manner.<br><br>IV. Monitoring of Corrective Actions<br>DON (Director of Nursing) or designee will audit all residents with changes monthly X 6 months and the quarterly to ensure that care plans are developed timely in accordance with our policy and procedures. Findings will be reported to the Administrator and be presented at quarterly QAPI meetings. | |

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NJ ex order 26.4b1 showed R96 NJ ex order 26.4b1 . The significant change of status "MDS" ARD NJ ex order 26.4b1 showed R96 NJ ex order 26.4b1

Review of R96's care plan from the EMR "Care Plan" tab showed:
"Focus: [R96 name] has a NJ ex order 26.4b1
NJ ex order 26.4b1
Date Initiated: NJ ex order 26.4b1
Revision on: NJ ex order 26.4b1
Goal: [R96 name] will maintain NJ ex order 26.4b1 as evidenced by maintaining NJ ex order 26.4b1 ], no s/sx [signs/symptoms] of NJ ex order 26.4b1 and NJ Exec. Order 26:4.b.1 of at least 3 meals daily through review date.
Date Initiated: NJ ex order 26.4b1
Revision on NJ ex order 26.4b1
Target Date: NJ ex order 26.4b1
-Monitor/document/report to MD PRN for s/sx of NJ ex order 26.4b1 Appears concerned during meals.
Date Initiated NJ ex order 26.4b1 ...
During an interview on 08/31/22 at 4:54 PM regarding the references to three meals a day and NJ ex order 26.4b1 , the Director of Nursing (DON) stated, "Yes, his care plan should have been updated by now."

Review of the 02/01/22 facility policy titled "Comprehensive Resident Centered Care Plans" showed:

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| LAKELAND NURSING & REHAB | 25 FIFTH AVENUE HASKELL, NJ 07420 |

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| F 657 | Continued From page 59 | F 657 | | |

"Intent . . . Every resident will have an Interdisciplinary Care Plan. The care plan will identify priority problems and needs to be addressed by the interdisciplinary team, and will reflect the resident's strengths, limitations and goals. The care plan will be complete, current, realistic, time specific and appropriate to the individual needs for each resident. . . Procedure:. . . 2. The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following:
a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; ...
Developing the Care Plan:
1. A comprehensive care plan will be: . . . c. Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. . .
. . . Updating Care Plans:
1. Care plans are modified between care plan conference when appropriate to meet the resident's current needs, problems and goals.
2. Meetings of the Director of Nursing, Social Services Coordinator (if appropriate), MDS Coordinator, Registered Dietitian, Activities Director and Therapy Professional are held to review the current status of skilled residents and determine needed interventions to meet resident goals.
The Care Plan will be updated and/or revised for

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| F 657 | Continued From page 60<br>the following reasons:<br>a. Significant change in the resident's condition.<br>b. A change in planned interventions. . ." | F 657 | | |
| F 689 SS=D | NJAC 8:39-11.2(h)<br>Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interview, record review, and policy review, the facility failed to ensure one of seven residents (Resident (R) 66) reviewed for falls received appropriate care and services following an unwitnessed fall in which she sustained a NJ Exec. Order 26:4.b.1. NJ Exec. Order 26:4.b.1 were not completed to rule out a NJ Exec. Order 26:4.b.1 after the fall.<br><br>Findings include:<br><br>1. Review of the undated "Admission Record" in the electronic medical record (EMR) under the "Profile" tab revealed R66 was NJ ex order 26.4b1 on NJ ex order 26.4b1 with diagnoses including NJ Exec. NJ ex order 26.4b1 | F 689 | F689<br>I. Corrective Actions Accomplished for Residents found to have been Affected by the Deficient Practice<br>Nursing staff were immediately in-serviced that upon any falls including an unwitnessed fall, NJ Exec. Order 26:4.b.1 are to be completed every shift for 72 hours to NJ Exec. Order 26:4.b.1.<br><br>II. Identification of Residents who have the Potential to be Affected by the Same Deficient Practice<br>All residents are at risk for the same deficiency.<br><br>III. Measures put into Place or Systemic Changes to ensure that the Deficient Practice will not Recur. | 11/3/22 |

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| F 689 | Continued From page 61<br>Review of the admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ ex order 26.4b1 in the EMR under the "MDS" tab revealed R66 was NJ ex order 26.4b1 core of NJ Exec. Ord indicates NJ ex order 26.4b1 ) out of 15. R66 NJ ex order 26.4b1 . R66 had not experienced NJ Exec. Order 26 in the preceding six-month period.<br><br>Review of the "Care Plan" dated NJ ex order 26.4b1 in the EMR under the "Care Plan" tab revealed the problem of, "[R66] NJ ex order 26.4b1 The goal was for R66 to be free of falls with injury. The care plan revealed, "The resident has had an actual fall on NJ ex order 26.4b1 with NJ ex order 26.4b1 . Patient said NJ ex order 26.4b1 . . The resident will resume usual activities without further incident through the review date."<br><br>Review of a "General Nurses Note" dated NJ ex order 26.4b1 at 11:30 PM in the EMR under the "Progress Notes" tab documented in full, "Found sitted [sic] on the floor. NJ Exec. Order 26:4.b.1 . NJ ex order 26.4b1<br><br>Review of the "#791 NJ ex order 26.4b1 dated NJ ex order 26.4b1 at 5:44 AM and provided by the facility revealed R66 was found sitting on the floor in her room and had NJ ex order 26.4b1 . The investigation noted R66 was assessed and was NJ ex order 26.4b1 , NJ ex order 26.4b1 and she NJ ex order 26.4b1 . The investigation documented vital signs were taken, and R66 NJ ex order 26.4b1 | F 689 | All nursing staff were in-serviced on the facility policy and procedures of the Fall reduction program to ensure all residents receive adequate supervision including neuro checks for any unwitnessed falls or for residents unable to communicate. Training on the Fall reduction program will be provided to all nursing staff during initial orientation and will be incorporated in the facility□s annual education plan.<br><br>IV Monitoring of Corrective Actions<br>DON (Director of Nursing) or designee will audit all residents with falls monthly X 3 months and the quarterly to ensure that neuro checks are completed in accordance with our policy and procedures. Findings will be reported to the Director of Nursing and Administrator and be presented at quarterly QAPI meetings. | |

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NJ ex order 26.4b1. The investigation noted a NJ ex order 26.4b1 NJ ex order 26.4b1 R66 NJ Exec. Order 26:4.b.1. Per the investigation, R66's family and physician were notified. R66 was noted to have a NJ ex order 26.4b1

Review of the "NJ ex order 26.4b1" form dated NJ ex order 26.4b1 at 5:44 AM and provided by the facility revealed staff completed neuro checks for R66 on NJ ex order 26.4b1 at 11:25 PM NJ ex order 26.4b1 . No additional "NJ Exec. Order 26:4.b.1" forms were completed for 72 hours after the fall in accordance with facility policy.

During an observation on NJ ex order 26.4b1 at 10:17 AM, R66 was sitting in a chair in her NJ Exec. Order 26:4 room visiting him (NJ Exec. Order 26:4.b.1), with a NJ ex order 26.4b1 R66 stated she NJ ex order 26.4b1 and visited NJ Exec. Order 26:4.b.1 who lived at the other end of the hallway. R66 stated she was NJ ex order 26.4b1 with activities of daily living. R66 verified NJ ex order 26.4b1 ; however, NJ ex after that time. R66 was unable to provide specific information about the fall that occurred in NJ ex order 26.4b1

During an interview on 09/01/22 at 3:15 PM, Licensed Practical Nurse (LPN)5 and (LPN)1 stated if a resident fell, the Registered Nurse (RN) on duty completed an assessment. LPN1 stated when a resident hit their head or if it was unwitnessed, the nurses completed neuro checks in the computer, if directed to do so by the

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| F 689 | Continued From page 63 | F 689 | | |

physician, to rule out a head injury. LPN1 showed the surveyor a document posted at the nursing station with the parameters for neuro checks. The undated "Neuro Checks as Follows" document indicated neuro checks should be completed every 15 minutes for the first hour, every hour for four hours, every two hours for four hours, and every eight hours for three days. LPN1 reviewed the EMR and stated there was one set [NJ Exec. Order 26:] completed on [NJ ex order 26.4b1] following R66's [NJ ex o]. LPN1 stated she could not tell if the physician ordered [NJ Exec. Order 26:4.b.1] to be completed or not because this information went away, and she could not retrieve it. LPN1 verified there were no other [NJ Exec. Order 26:4.b.1] completed.

During an interview on 09/01/22 at 3:57 PM, Registered Nurse (RN) 2 stated there had been a recent change in policy to complete neuro checks in the computer versus on paper. RN2 stated the facility protocol called for neuro checks to be completed every 15 minutes for the first hour, every hour for the next four hours, every two hours for the next four hours, then every eight hours for three days. RN2 stated, at times it was difficult to get all the neuro checks completed due to high use of agency nursing staff.

During an interview on 09/01/22 at 4:35 PM , the DON stated R66's fall occurred early in the morning on [NJ ex order 26.4b1] and not on [NJ ex order 26.4b1]. The DON stated, if a resident experienced a fall and hit their head, neuro checks had to be completed or the resident [NJ ex order 26.4b1]. The DON verified [NJ Exec. Order 26:4.b.1] was completed for resident R66 and if the physician wanted more [NJ Exec. Order 26:4.b.1], such as if there was a change in [NJ Exec. Order 26:4.b.1], the physician would have ordered additional checks. The DON

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| F 689 | Continued From page 64<br>verified R66 was noted with NJ ex order 26.4b1 [redacted]. The DON further stated R66 [redacted] so additional [redacted] were not warranted. The DON stated the facility did not have a specific neuro check policy. The DON verified the facility's "Fall Reduction Program" policy directed documentation of neuro checks for 72 hours and the policy did not specify a physician's order was necessary to proceed.<br><br>Review of the "Fall Reduction Program" policy dated 02/01/22 and provided by the facility revealed, "All residents will receive adequate supervision, assistance and assistive devices to aid in the prevention of falls. Investigative guidelines A. Check resident for injuries . . . ii. Neuro-checks, for head injuries or unwitnessed fall and resident unable to communicate if he hit his/her head . . . Document in the Nurse's Notes: i. Observed circumstances; resident fell, slid from chair, found on floor, etc . . . Neuro-checks . . . Each nurse, each shift will observe resident and document for 72 hours in the resident's medical record. i. Vital Signs ii. Neuro-checks iii. Neurological changes . . . Nursing staff is to document Q [every] shift for 72 hours."<br><br>NJAC 8:39-27.1(a) | F 689 | | |
| F 692 SS=G | Nutrition/Hydration Status Maintenance<br>CFR(s): 483.25(g)(1)-(3)<br><br>§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 | F 692 | | 9/30/22 |

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| F 692 | Continued From page 65<br>ensure that a resident-<br><br>§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;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and policy review, the facility failed to ensure resident's nutrition needs were met for one of nine residents (Resident (R)103) reviewed for nutrition. The facility failed to reconcile discrepancies between facility weights, reflecting stable weight, and hospital weights, reflecting NJ Exec. Order 26:4.b.1. R103 was NJ ex order 26.4b1 the most recent facility weight two weeks earlier was NJ ex order 2 pounds. Due in part to the failure to obtain accurate weights, review the NJ ex order 26.4b1 in the resident's record, and physically/clinically assess the resident, R103's NJ ex order 26.4b1<br><br>Findings include:<br><br>1. Review of the undated "Admission Record" in the electronic medical record (EMR) under the | F 692 | F692<br>I. Corrective Actions Accomplished for Residents found to have been Affected by the Deficient Practice<br>A reweight was completed immediately on Resident R103 and all assessments and progress notes were updated to reflect the discrepancy and NJ Exec. Order 26:4.b.1 increased to address NJ Exec. Order 26:4.b.1.<br>The RD (registered dietitian) was immediately disciplined.<br>All nursing staff were in-serviced on obtaining residents weights and reporting any weight discrepancies to administration in a timely manner.<br>All nursing staff were re-educated regarding the facility □weight management□ policy and procedures.<br>The RD (registered dietitian) was re-educated on reviewing hospital documentation for any new or readmitting resident. | |

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| F 692 | Continued From page 66<br>"Profile" tab, revealed R103 was admitted to the facility on NJ ex order 26.4b1 with diagnoses NJ ex order 26.4b1 [redacted]<br><br>Review of the hospital Physician "Progress Note" dated NJ ex order 26.4 2 (two days prior to admission) in the EMR under the "Misc" tab, revealed R103 NJ ex order 26.4b1 [redacted] "<br><br>In addition, review of the hospital "Infectious Disease Inpatient Note" NJ ex order 26.4b1 in the EMR under the "Misc" tab, revealed R103 had NJ ex order 26.4b1<br><br>Review of a "Nurse's Note" dated NJ ex order 26.4b1 at 7:35 AM, in the EMR under the "Progress Notes" tab revealed R103 NJ ex order 26.4b1 [redacted]<br><br>Review of the hospital "History and Physical" dated NJ ex order 26.4b1 and in the EMR under the "Misc" tab, revealed R103 was NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 [redacted] A NJ Exec. Order 26:4.b.1 was ordered. The resident was | F 692 | ll. Identification of Residents who have the Potential to be Affected by the Same Deficient Practice<br>All residents are at risk for the same deficiency. The DON and dietitian checked on the resident to ensure he was not adversely affected by the deficient practice<br><br>lll. Measures put into Place or Systemic Changes to ensure that the Deficient Practice will not Recur.<br>The RD (registered dietitian) will visualize the residents and be present by one of the first weekly weights obtained for all new or re-admissions. The RD (registered dietitian) will request a re-weight for any discrepancy.<br>The RD (registered dietitian) will review the weights weekly and generate a list of residents that need to be reweighed.<br><br>lV Monitoring of Corrective Actions<br>DON or RD (registered dietitian) or designee will in-service the nursing staff on the facilities policy and procedure on obtaining residents weights and reporting any weight discrepancies to administration in a timely manner; weekly X 6 and then monthly X 3 and then quarterly.<br>The regional RD (registered dietitian) or designee will conduct an monthly audit on all weight changes X 6 months, and review the hospital documentation and visualize the residents to ensure their appearance also reflects the given weight. Findings will be reported to the Director of Nursing and Administrator and be | |

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| F 692 | Continued From page 67<br>diagnosed with NJ ex order 26.4b1 [redacted]<br><br>Review of the hospital "Physician's Note" dated NJ ex order 26.4b1 and in the EMR under the "Misc" tab, revealed R103 had NJ ex order 26.4b1 [redacted]<br><br>Review of the hospital "Vitals and Labs" dated NJ ex order 26.4b1, in the EMR under the "Misc" tab, revealed R103 weighed:<br>-NJ ex order 26.4b1 [redacted].<br><br>R103 was hospitalized on NJ ex order 26.4b1 and returned to the facility on NJ ex order 26.4b1. Review of the hospital "History and Physical" dated NJ ex order 26.4b1 revealed R103's chief complaint was a NJ ex order 26.4b1 [redacted] The "History and Physical" revealed R103 NJ ex order 26.4b1 [redacted]<br><br>Review of the hospital RD "Progress Notes" dated NJ ex order 26.4b1 and in the EMR under the "Misc" tab, revealed R103 NJ ex order 26.4b1 [redacted], NJ ex order 26.4b1 [redacted]. R103's weight records documented in the progress note were:<br>NJ ex order 26.4b1 [redacted] | F 692 | presented at quarterly QAPI meetings. | |

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NJ ex order 26.4b1

Review of the Significant Change "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ ex order 26.4b1 in the EMR under the "MDS" tab, revealed R103 was NJ ex order 26.4b1 with a Brief Interview for Mental Status score (BIMS) of NJ ex order 26.4b1 15 NJ ex order 26.4b1 ). R103 was NJ ex " NJ ex order 26.4b1 according to the facility's weights. R103 was not coded as having NJ ex order 26.4b1

Review of the facility's "Weight Summary" from NJ ex order 26.4b1 in the EMR under the "Vitals" tab revealed R103's weights were:

NJ ex order 26.4b1

(this weight was noted as being an "error" on NJ ex order 26.4b1; however, there was no evidence of an immediate reweigh being obtained or a weight being obtained on NJ ex order 26.4b1 the day after readmission in accordance with facility policy).

NJ ex order 26.4b1

Review of the "Order Summary Report" dated NJ ex order 26.4b1 in the EMR and under the "Orders" tab, revealed an order for "Weekly weight x [for] 4 weeks." The order was dated NJ ex order 26.4b1. As of the survey on NJ ex order 26.4b1; R103 had not been weighed at the weekly interval following his most recent weight on NJ ex order 26.4b1. He would have been due for a weight on NJ ex order 26.4b1 and NJ ex order 26.4b1 As of the survey NJ ex order 26.4b1, R103 had not been weighed

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| F 692 | Continued From page 69 | F 692 | | |

since 08/13/22. A weight was requested.

During an observation on NJ ex order 26.4b1 at 10:58 AM, Certified Nurse Assistant (CNA) 4 weighed R103 using the NJ ex order 26.4b1. CNA4 stated R103 weighed NJ ex order 26.4b1, which was verified by the surveyor. R103 was reweighed a second time on NJ ex order 26.4b1 and again his weight was NJ ex order 26.4b1.

During an interview on 08/31/22 at 1:23 PM, CNA4 verbally confirmed R103's weight was NJ ex order CNA4 stated she had taken R103's weight before but could not remember when. She stated she did not know why there was such a huge disparity between his current weight of NJ ex order pounds and last recorded weight of NJ ex order 26.4b1 (two weeks earlier).

Review of the RD "Nutrition Evaluation" dated NJ ex order 26.4b1 and in the EMR under the "Assessment" tab, revealed R103's nutritional requirements were: NJ ex order 26.4b1 R103 required NJ ex order 26.4b1 R103 ate 25% of meals and was noted with a NJ Exec. Order 26:4.b.1 in food intake. R103 NJ ex order ) of NJ ex order and an NJ ex order 26.4b1 he resident's current body weight

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was NJ ex order 26.4b1. His weight was noted to be stable. The resident's intake was not great, and he was drinking more than eating, and because of this the resident was receptive to NJ Exec. Order 26:4.b.1 to his tray to NJ Exec. Order 26:4.b.1. The resident required limited assistance with meals. The resident was noted to be at NJ Exec. Order 26:4.b.1 due to need for NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1. Recommendations included: NJ ex order 26.4b1

Review of the Medication Administration Record (MAR) for NJ ex order 26.4b1 in the EMR under the "Orders" tab revealed the recommended interventions noted above (NJ Exec. Order 26:4.b.1 times a day was administered on NJ ex order 26.4b1 NJ ex order 26.4b1 three times a day was administered on NJ ex order 26.4b1 and NJ ex order 26.4b1) were implemented for no more than two days, until R103 was NJ ex order 26.4b1

Review of the "Nutrition Evaluation" dated NJ ex order 26.4b1 and in the EMR under the "Assessment" tab, revealed R103 NJ ex order 26.4b1. His admission weight dated NJ ex order 26.4b1 was NJ ex order pounds. R103 was documented with a NJ ex order 26 There was no evidence the Registered Dietitian reviewed the hospital documentation that showed the resident's hospital weights were NJ ex order pounds on NJ ex order 26.4b1, NJ ex order 26.4b1, and NJ ex order 26.4b1. The "Nutrition Evaluation" revealed a NJ ex order 26.4b1 NJ ex order .

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| F 692 | Continued From page 71<br>NJ ex order 26.4b1. R103 NJ ex order 26.4b1. He NJ ex order 26.4b1 which provided 2016 calories and 93 grams (gm) protein. R103 was NJ ex order 26.4b1 continued to NJ ex order 26.4b1 R103 was noted with NJ Exec. Order 26:4.b.1 needs. R103's calorie needs were NJ ex order 26.4b1 day and his protein needs were NJ ex order 26.4b1 . The RD recommended adjusting the NJ ex order hour for 20 hours, which provided NJ ex order 26.4b1, and NJ ex order 26.4b1. A recommendation for NJ ex order 26.4b1 was made which provided an additional NJ ex order One of the nutrition goals was for the resident to maintain weight within 5% of his current weight NJ ex order 26.4b1). There were no additional nutritional evaluations or notes until after the survey started at which time the resident's weight of NJ ex order 26.4b1 was obtained.<br><br>Review of the "Order Summary Report" dated NJ ex order 26.4b1 in the EMR and under the "Orders" tab, revealed current tube feeding orders as follows: NJ ex order 26.4b1 Up at 4:00 pm and down when NJ ex order 26.4b1. Provides NJ ex order , initiated on NJ ex order 26.4b1 In addition, R103 received a NJ ex order 26.4b1 equaling NJ ex order 26.4b1 and a total of NJ ex order 26.4b1. Review of the "Order Summary Report" dated NJ ex order 26.4b1 in the EMR and under the "Orders" tab, revealed NJ ex order was | F 692 | | |

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| F 692 | Continued From page 72<br>initiated on NJ ex order 26.4b1.<br><br>Review of the meal intake "Follow Up Question Report" for NJ ex order 26.4b1 and NJ ex order 26.4b1 and provided by the facility revealed R103 ate NJ Exec meals in the five-day period from admission on NJ ex order 26.4b1 until he was hospitalized on NJ ex order 26.4b1. For the month of NJ ex order 26t (from NJ ex order 26.4b1 noting he was NJ ex order 26.4b1 ) R103 was documented with meal intake on five days as follows: four meals with intake of NJ ex order 26 and one meal with intake o NJ ex order 26.4b1<br><br>Review of the wound care "Follow-up Progress Notes" dated NJ ex order 26.4b1 and in the EMR under the "Assessment" tab, revealed R103 was being seen by a NJ ex order 26.4b1 Nurse Practitioner starting on this date, and was seen weekly thereafter. The NJ ex order 26.4b1<br><br>Review of the wound care "Follow-up Progress Notes" dated NJ ex order 26.4b1 and in the EMR under the "Assessment" tab, revealed R103's NJ ex order 26.4b1 R103's NJ ex order 26.4b1 progress notes.<br><br>Review of the "Care Plan" initiated on NJ ex order 26.4b1 in the EMR and under the "Care Plan" tab, revealed: "The resident NJ ex order 26.4b1 . . NJ ex order 26.4b1 NJ ex order 26.4b1; Date Initiated: | F 692 | | |

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NJ ex order 26.4b1
- [R103] NJ ex order 26.4b1 through review date.
- [R103] NJ ex order 26.4b1
- [R103] will maintain adequate hydration and nutrition NJ ex order 26.4b1
- Administer medications as ordered. Monitor/Document for side effects and effectiveness.
- Continue NJ ex order 26.4b1
- Monitor/document/report to MD [Medical Doctor] PRN [as needed] for NJ ex order 26.4b1
- Offer ice chips for swallow stimulation
- Provide and serve supplements as ordered
- Provide NJ ex order 26.4b1 as ordered
- RD to evaluate and make diet change recommendations PRN."

During an observation on NJ ex order 26.4b1 at 10:44 AM, R103 and family member (F)103 were in R103's room. R103 was lying in bed while NJ ex order 26.4b1 The resident was wearing a hospital gown and wa NJ ex order 26.4b1 . R103's NJ ex order 26.4b1 , and NJ ex order 26.4b1

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During an interview on 09/01/22 at 10:34 AM, F103 stated she came daily and stayed with R103 from 10:00 AM until about 5:00 PM - 6:00 PM and she had not seen R103 weighed prior to today. F103 stated she observed R103 being weighed and his weight of NJ ex order 26.4b1 earlier that day. F103 stated, NJ ex order 26.4b1 ." F103 stated it had been quite a while since R103 weighed NJ ex order 26.4b1, verifying a NJ ex order 26.4b1. F103 stated R103 would not eat the pureed diet that was served to him even though staff brought it to him every meal. R103 was in the room and verified his weight of NJ ex order 26.4b1 today. R103 had a soft voice, and it was difficult to understand him.

During an interview on 08/30/22 at 1:23 PM, Licensed Practical Nurse (LPN)1 and LPN5 were interviewed. They stated R103 did not eat the pureed diet he was served. They stated R103's NJ Exec. Order 26:4.b.1 became NJ Exec. Order 26:4.b.1, and he had a NJ ex order 26.4b1 to help with NJ Exec. Order 26:4.b.1 as R103 was NJ Exec. Order 26:4.b.1. They stated R103 had NJ ex

During an interview on 08/30/22 at 2:37 PM, Certified Nursing Assistant (CNA)4 stated R103 was served a pureed diet; however, he did not eat it.

During an interview on 08/31/22 at 11:46 AM, the RD and Regional RD were interviewed and stated R103 was NJ ex order 26.4b1. The RD stated the facility weights indicated R103 had experienced a NJ Exec. Order 26:4.b.1. The RD stated nursing was responsible for obtaining the weights and she had not questioned the accuracy of his weights being in the NJ ex order 26.4b1 RD stated the

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resident was offered a pureed diet in addition to the [NJ Exec. Order 26:4.b.1]; she stated she was not aware he did not eat it. The RD reviewed the meal intake records in the computer and verified intake of [NJ ex order 26] of the pureed diet when it was documented. The RD and Regional RD stated the current [NJ Exec. Order 26:4.b.1] regimen was meeting R103's nutritional needs. They stated R103's calorie needs from the most recent assessment dated [NJ ex order 26.4b1] were based on his weight at that time and he required NJ ex order 26.4b1. The RD verified R103's current NJ ex order 26.4b1 provided NJ ex order 26.4b1, which was less than his assessed needs; however, they stated he also NJ ex order 26.4b1 [redacted].

During a follow up interview on 08/31/22 at approximately 1:30 PM, the RD and Regional RD stated they were aware of R103's weight of [NJ ex or] pounds. The RD stated she would assess R103's NJ ex order 26.4b1 with weight loss and a lower body weight (NJ ex order 26.4b1 [redacted] because this affected his nutrient needs. The RD stated, "We do base the nutrition assessment on his weight." The RD verified if the resident had been losing weight, the NJ ex order 26.4b1 was not sufficient to meet his needs and would need to be increased. The RD stated she had observed the resident and stated he was not overweight, and she did realize the facility's weights in the [NJ ex order 2] were incorrect. The RD stated she depended on the nurses to document accurate weights and verified she had not reviewed the hospital weights when completing her nutrition assessment on [NJ ex order 26.4b1]

During an interview on 09/01/22 3:40 PM, Registered Nurse (RN)2 stated she was the

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nurse who crossed out the weight of NJ ex order 26.4b1 (obtained on NJ ex order 26.4b1) because she thought it was a mistake. RN2 stated she usually asked the CNAs to obtain a reweigh if a weight was suspicious. RN2 stated she may have forgotten to have the CNAs reweigh him or to follow up. RN2 stated she did not observe the CNAs obtaining the weights. RN2 stated she should have asked staff to reweigh the resident. RN2 stated R103 was NJ Exec but she was not sure if he looked like he had NJ Exec. Order 26:4.b.1.

A call was made to R103's Physician on NJ ex order 26.4b1 at 11:37 AM and a message was left with the receptionist to ask the Physician to return the surveyor's call. R103's Physician did not return the call.

During an interview on 09/01/22 at 4:12 PM, the Director of Nursing (DON) stated whenever there was a weight discrepancy, the RD looked at it and requested a reweigh. The DON stated she was not sure why a reweigh was not done after the weight of NJ ex order 26.4b1 was obtained. The DON stated R103 NJ ex order 26.4b1, and he was NJ ex order 26.4b1, and he returned with NJ ex order 26.4b1. The DON stated the only thing R103 ate was ice cream. The DON stated R103 was NJ ex order 26.4b1. When a weight discrepancy was noted, a reweigh should be done. The DON stated it was the RD's responsibility to request a reweigh and she was not sure why this was not done. The DON stated the RD should have looked at the hospital weights. The DON verified when she had observed the resident, he was NJ Exec. She was not aware his weights had been recorded in the NJ ex order. The DON stated R103 was weighed twice yesterday to make sure the weight of NJ ex ord was

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| F 692 | Continued From page 77<br>correct, because it was "a big jump" from [redacted]<br>The DON stated the CNAs obtained the weights, but the RD oversaw the process. The DON stated if a weight were missing or a reweigh was needed, she would make sure the nurse does the weight, but this had not been reported to her.<br><br>Review of the "Weight Management" policy dated 02/01/22 and provided by the facility revealed all residents admitted to the facility would be weighed on the day of admission, the day after admission and then weekly for four weeks. The policy indicated, "A re-weight will be obtained for any weight change of +/- (3) lbs [pounds] from the previous weight unless other parameters have been ordered by the physician. . . All re-weights will be obtained immediately. The re-weight process will be visualized by a license nurse."<br><br>Review of the undated "Enteral Feeding" policy, provided by the facility revealed, "The Dietitian will be notified of the tube feeding orders and assess nutrition/hydration needs of the resident. Based on the outcome of assessment the dietitian will make recommendations for tube feeding type, rate, volume, and water flushes."<br><br>NJAC 8:39-17.1(c)<br>NJAC 8:39-17.2(d)<br>NJAC 8:39-27.2(e) | F 692 | | |
| F 883 SS=D | Influenza and Pneumococcal Immunizations<br>CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the influenza immunization, | F 883 | | 11/3/22 |

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each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the

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| F 883 | Continued From page 79<br>following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, facility policy review, and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to offer two of five residents (Resident (R) 31 and R103) reviewed for NJ Exec. Order 26:4.b.1 and/or their representatives, the opportunity for the resident to be vaccinated in accordance with nationally recognized standards. The facility failed to offer R31 the opportunity to b NJ ex order 26.4b1 and if this vaccination was not available to offer NJ ex order 26.4b1 The facility failed to offer R103 the opportunity to NJ ex order 26.4b1 in accordance with nationally recognized standards.<br><br>Findings include:<br><br>1. Review of R31's "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed, R31 was NJ ex order 26.4b1 and was NJ ex order 26.4b1 of age at the time of admission.<br><br>Review of the "Immunizations" located in the "Immunization" tab of the EMR revealed R31 had | F 883 | F883<br>I. Corrective Actions Accomplished for Residents found to have been Affected by the Deficient Practice<br>Resident R31 was immediately offered NJ ex order 26.4b1 NJ ex order 26.4b1 in addition to the NJ ex order 26.4b1 . Resident R103s records were updated to reflect the NJ ex order 26.4b1 he received.<br>Audit was completed on all residents medical records to confirm they were up to date on the pneumonia vaccines in accordance with the nationally recognized standards.<br><br>II. Identification of Residents who have the Potential to be Affected by the Same Deficient Practice<br>All residents are at risk for the same deficiency.<br><br>III. Measures put into Place or Systemic Changes to ensure that the Deficient Practice will not Recur. | |

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| F 883 | Continued From page 80<br>"historical" documentation that he had [NJ ex order 26.4b1] however, when he admitted to the facility, he was not offered the NJ ex order 26.4b1, as recommended. There was no documentation to show that he had refused the second vaccine.<br><br>During an interview on 08/31/22 at 9:35 AM, the Infection Control Preventionist (ICP) stated that she had been employed at the facility for the [NJ Exec] and was not aware that R31 was not offered or refused the PCV-20 or PPSV-23.<br><br>2. Review of the "Admission Record" located in the "Profile" tab of the EMR revealed, R103 was NJ ex order 26.4b1 and was [NJ ex order] at the time of admission.<br><br>Review of the "Immunizations" located in the "Immunization" tab of the EMR revealed R103 had a documented "[NJ ex order 26.4b1] however, there was NJ ex order 26.4b1 had or documentation to show if R103 would potentially require an additional dose.<br><br>During an interview on 08/31/22 at 9:35 AM, the ICP stated that she had reached out to the R103's physician to determine which vaccine he had but had not heard back since he [NJ ex order 26.4b1]<br><br>Review of Center of Disease Control (CDC) website titled "Pneumococcal Vaccination: Summary of Who and When to Vaccinate," indicated ". . . CDC recommends pneumococcal vaccination for all adults 65 years or older. The tables below provide detailed information . . . For adults 65 years or older who have not previously received any pneumococcal vaccine, CDC | F 883 | All appropriate staff were in-serviced on reviewing residents files upon admission and readmission to ensure all immunizations are up to date and documented upon and offer vaccinations accordingly.<br><br>IV Monitoring of Corrective Actions<br>The DON (Director of Nursing) or designee will audit 5 residents records per month X 3 the quarterly thereafter. Findings will be reported to the Administrator and be presented at quarterly QA | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 883 | Continued From page 81 | F 883 | | |

recommends you . . . Give 1 dose of PCV15 or PCV20 . . . If PCV15 is used, this should be followed by a dose of PPSV23 at least one year later. The minimum interval is 8 weeks and can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak . . . If PCV20 is used, a dose of PPSV23 is NOT indicated . . . For adults 65 years or older who have only received a PPSV23, CDC recommends you . . . May give 1 dose of PCV15 or PCV20 . . . The PCV15 or PCV20 dose should be administered at least one year after the most recent PPSV23 vaccination. Regardless of if PCV15 or PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it. For adults 65 years or older who have only received PCV13, CDC recommends you . . . Give PPSV23 as previously recommended. . . For adults who have received PCV13 but have not completed their recommended pneumococcal vaccine series with PPSV23, one dose of PCV20 may be used if PPSV23 is not available. If PCV20 is used, their pneumococcal vaccinations are complete . . . " The CDC guidelines went into effect on 10/21/21 per recommendations from the Advisory Committee on Immunization Practices (ACIP).

Review of the facility policy titled, "Pneumococcal Vaccine," dated 2021, revealed, ". . .All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal Infections . . . Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Assessments of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315261 | A. BUILDING _____ B. WING _____ | 09/01/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKELAND NURSING & REHAB | 25 FIFTH AVENUE HASKELL, NJ 07420 |

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|---|---|---|---|---|
| F 883 | Continued From page 82<br>pneumococcal vaccination status will be conducted with five (5) working days of the resident's admission if not conducted prior to admission. . ."<br><br>NJAC 8:39-19.4(i) | F 883 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 061621 | A. BUILDING: _____ B. WING _____ | 09/01/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKELAND NURSING & REHAB | 25 FIFTH AVENUE HASKELL, NJ 07420 |

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|---|---|---|---|---|
| S 000 | Initial Comments<br><br>THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS. | S 000 | | |
| S 560 | 8:39-5.1(a) Mandatory Access to Care<br><br>(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.<br><br>This REQUIREMENT is not met as evidenced by:<br>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:<br><br>Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes.<br>Be It Enacted by the Senate and General | S 560 | S560<br>S560<br>I. Corrective Actions Accomplished for Residents found to have been Affected by the Deficient Practice.<br>Additional aides were immediately requested from the staffing agencies and bonuses were offered as well to accommodate the unit's needs. The facility has a job fair planned and has signed contract with additional staffing agencies to provide more Certified Nursing Assistants. Efforts to hire facility | 11/3/22 |

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

Electronically Signed | 10/03/22

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 061621 | A. BUILDING: _____ B. WING _____ | 09/01/2022 |

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|---|---|---|---|---|
| S 560 | Continued From page 1<br>Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21.<br><br>1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios:<br>(1) one certified nurse aide to every eight residents for the day shift;<br>(2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and<br>(3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties<br>b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census.<br>c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place.<br>(2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, | S 560 | staff will continue until there are adequate staff to serve all residents. The facility will continue to utilize staffing agencies to fill any open spots in the schedule.<br><br>ll. Identification of Residents who have the Potential to be Affected by the Same Deficient Practice<br>All residents are at risk for the same deficiency.<br><br>lll. Measures put into Place or Systemic Changes to ensure that the Deficient Practice will not Recur.<br>Contracts with additional staffing agencies have been secured and additional contracts are being worked on to supplement the facility Certifies Nursing Assistants staff. Hiring and recruitment efforts include having a job fair planned, wage analysis and adjustments. Online job listings, shift differentials, referral bonuses are being utilized to become more competitive as well. In addition, we are advertising on online job boards postings on facility website and social media platforms and also attempting to land contracts with Certified Nursing Assistants school's. The facility will be hosting network events and build relationships with universities, colleges and technical schools to provide potential candidates.<br><br>lV Monitoring of Corrective Actions<br>The Administrator and DON (Director of Nursing) or designee together with HR (human resource) department will review staffing schedules weekly to ensure adequate staffing for all shifts. The results | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 061621 | A. BUILDING: _____ B. WING _____ | 09/01/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKELAND NURSING & REHAB | 25 FIFTH AVENUE HASKELL, NJ 07420 |

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|---|---|---|---|---|
| S 560 | Continued From page 2<br>is fifty-one hundredths or higher.<br>(3) All computations shall be based on the midnight census for the day in which the shift begins.<br>d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ...<br><br>A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 8/14/22 and 8/21/22, revealed the following:<br><br>The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:<br><br>- 08/14/22 had 10 CNAs for 133 residents on the day shift, required 17 CNAs.<br>- 08/15/22 had 12 CNAs for 133 residents on the day shift, required 17 CNAs.<br>- 08/16/22 had 14 CNAs for 133 residents on the day shift, required 17 CNAs.<br>- 08/17/22 had 14 CNAs for 133 residents on the day shift, required 17 CNAs.<br>- 08/18/22 had 13 CNAs for 133 residents on the day shift, required 17 CNAs.<br>- 08/19/22 had 11 CNAs for 133 residents on the day shift, required 17 CNAs.<br>- 08/20/22 had 12 CNAs for 134 residents on the day shift, required 17 CNAs.<br>- 08/21/22 had 10 CNAs for 133 residents on the day shift, required 17 CNAs.<br>- 08/22/22 had 10 CNAs for 132 residents on the day shift, required 17 CNAs.<br>- 08/23/22 had 11 CNAs for 132 residents | S 560 | of these reviews will be submitted to the Quality Assurance Performance Committee (QAPI) every month through the rest of the year and every three months based on the outcome of the audits. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 061621 | A. BUILDING: _____ B. WING _____ | 09/01/2022 |

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|---|---|---|---|---|
| S 560 | Continued From page 3<br>on the day shift, required 17 CNAs.<br>- 08/24/22 had 9 CNAs for 132 residents on the day shift, required 17 CNAs.<br>- 08/25/22 had 13 CNAs for 130 residents on the day shift, required 16 CNAs.<br>- 08/26/22 had 11 CNAs for 129 residents on the day shift, required 16 CNAs.<br>- 08/27/22 had 11 CNAs for 129 residents on the day shift, required 16 CNAs. | 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 |
|---|---|---|
| 315261 Y1 | A. Building<br>B. Wing Y2 | 11/9/2022 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKELAND NURSING & REHAB | 25 FIFTH AVENUE<br>HASKELL, NJ 07420 |

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 F0561 | Correction | ID Prefix F0578 | Correction | ID Prefix F0609 | Correction |
| Reg. # 483.10(f)(1)-(3)(8) | Completed | Reg. # 483.10(c)(6)(8)(g)(12)(i)-(v) | Completed | Reg. # 483.12(c)(1)(4) | Completed |
| LSC | 11/03/2022 | LSC | 11/03/2022 | LSC | 11/03/2022 |
| ID Prefix F0644 | Correction | ID Prefix F0646 | Correction | ID Prefix F0655 | Correction |
| Reg. # 483.20(e)(1)(2) | Completed | Reg. # 483.20(k)(4) | Completed | Reg. # 483.21(a)(1)-(3) | Completed |
| LSC | 11/03/2022 | LSC | 11/03/2022 | LSC | 11/03/2022 |
| ID Prefix F0656 | Correction | ID Prefix F0657 | Correction | ID Prefix F0689 | Correction |
| Reg. # 483.21(b)(1) | Completed | Reg. # 483.21(b)(2)(i)-(iii) | Completed | Reg. # 483.25(d)(1)(2) | Completed |
| LSC | 11/03/2022 | LSC | 11/03/2022 | LSC | 11/03/2022 |
| ID Prefix F0692 | Correction | ID Prefix F0883 | Correction | ID Prefix | Correction |
| Reg. # 483.25(g)(1)-(3) | Completed | Reg. # 483.80(d)(1)(2) | Completed | Reg. # | Completed |
| LSC | 09/30/2022 | LSC | 11/03/2022 | 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? |
|---|---|
| 9/1/2022 | ☐ YES ☐ NO |

# STATE FORM: REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 061621 Y1 | A. Building<br>B. Wing Y2 | 11/9/2022 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKELAND NURSING & REHAB | 25 FIFTH AVENUE<br>HASKELL, NJ 07420 |

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

| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|---|---|---|---|---|---|
| ID Prefix S0560 | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # 8:39-5.1(a) | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | 11/03/2022 | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| 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? |
|---|---|
| 9/1/2022 | ☐ YES ☐ NO |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315261 | A. BUILDING **01**<br>B. WING _____ | **09/01/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LAKELAND NURSING & REHAB** | **25 FIFTH AVENUE**<br>**HASKELL, NJ 07420** |

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|---|---|---|---|---|
| E 000 | Initial Comments<br><br>An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 08/30/22. The facility was found to be in compliance with 42 CFR 483.73. | E 000 | | |
| K 000 | INITIAL COMMENTS<br><br>A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 08/30/22. The facility was found not to be in compliance with the requirements of 42 CFR 483.90. | K 000 | | |
| K 161 SS=F | Building Construction Type and Height<br>CFR(s): NFPA 101<br><br>Building Construction Type and Height<br>2012 EXISTING<br>Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7<br>19.1.6.4, 19.1.6.5<br><br>Construction Type<br>1 I (442), I (332), II (222) Any number of stories<br>non-sprinklered and sprinklered<br><br>2 II (111) One story non-sprinklered<br>Maximum 3 stories sprinklered<br><br>3 II (000) Not allowed non-sprinklered<br>4 III (211) Maximum 2 stories | K 161 | | 4/15/24 |

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

Electronically Signed | 10/03/2022

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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| | 315261 | A. BUILDING **01**<br>B. WING _____ | **09/01/2022** |

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| K 161 | Continued From page 1<br>sprinklered<br>5 IV (2HH)<br>6 V (111)<br><br>7 III (200) Not allowed<br>non-sprinklered<br>8 V (000) Maximum 1 story<br>sprinklered<br>Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)<br>Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure the construction of the building was protected in accordance with NFPA 101 Life Safety Code (2012 Edition) Table 19.1.6.2. This deficient practice had the potential to affect the safety of all 107 residents.<br><br>Findings include:<br><br>Document review of the facility Fire Safety Evaluation System (FSES) revealed the annex building is a 3-story building with a basement consisting of Type V(000) unprotected combustible construction. The entire building is classified as a health care occupancy and requires that full sprinklered health care occupancies of Type V(000) construction be no more than one story in height. | K 161 | K161<br>1. How the corrective action will be accomplished for the residents affected by the deficient practice:¿<br>The plan of corrections for the annex buildings portion of corridors maintaining less than the required corridor width, is to have an FSES - (Fire Safety Evaluation System) applied, as an equivalent to being¿in compliance.¿<br><br>2. How the facility will identify other residents having the potential to be affected by the same deficient practice:<br>All residents will have the potential to be affected by the same deficient practice.<br><br>3. Measures or systemic changes made to ensure no recurrence:¿ | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315261 | A. BUILDING **01**<br>B. WING _____ | **09/01/2022** |

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| K 161 | Continued From page 2<br>During an interview at 4:30 PM on 8/30/22, the Administrator confirmed a FSES is in place for the Annex building.<br><br>NJAC 8:39-31.2(e) | K 161 | An FSES was submitted in which zone 10 did not pass. A time limited waiver is being requested, (see uploaded file attached) with a plan to install smoke detection adding the additional points necessary to achieve a passing FSES. We will notify the DCA (Department of Community Affairs) CN&L as appropriate, relative to the smoke detection addition in zone 10.<br><br>We anticipate completing the installation by April 15th, 2024.<br>Project milestones are as follows.<br>1. Review, re-design by facility contractor by February 29, 2024<br>2. Zoning approval by March 15, 2024<br>3. Parts and supplies ordered and delivered by March 30, 2024<br>4. System installed by April 10, 2024<br>5. Compliance/Completion on April 15, 2024<br>The maintenance supervisor will tour the basement 3 days a week until the smoke detection is installed to ensure the space does not pose any undue fire or life safety risks including excessive unorganized combustible materials and blocked exits.<br><br>4. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by:¿¿<br>Quality Assurance Committee will monitor the on-going implementation quarterly. Any additional issues will also be reviewed by the Quality Assurance committee and will monitor the facility practices and will recommend action/changes as situations warrant. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315261 | A. BUILDING **01**<br>B. WING _____ | **09/01/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **LAKELAND NURSING & REHAB** | **25 FIFTH AVENUE**<br>**HASKELL, NJ 07420** |

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| K 232 SS=F | Aisle, Corridor, or Ramp Width<br>CFR(s): NFPA 101<br><br>Aisle, Corridor or Ramp Width<br>2012 EXISTING<br>The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5.<br>19.2.3.4, 19.2.3.5<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure the corridors serving as exit access were at least 4 feet and maintained to provide the convenient removal of non-ambulatory patients as required by NFPA Life Safety Code (2012 edition) 19.2.3.5.<br><br>Findings include:<br><br>Document review of the facility Fire Safety Evaluation System (FSES) revealed a portion of the corridor on Floors 1 and 2 were less than the minimum required width of 48 (inches) in. in clear width.<br><br>During an interview on 8/30/22 at 4:30 PM, the Administrator confirmed a FSES was in place for the width of the corridors and would be renewed.<br><br>NJAC 8:39-31.2(e) | K 232 | K232-¿<br>1. How the corrective action will be accomplished for the residents affected by the deficient practice:¿<br>The plan of corrections for the annex buildings portion of corridors maintaining less than the required corridor width, is to have an FSES - (Fire Safety Evaluation System) applied, as an equivalent to being¿in compliance.¿<br><br>2. How the facility will identify other residents having the potential to be affected by the same deficient practice:<br>All residents will have the potential to be affected by the same deficient practice.<br><br>3. Measures or systemic changes made to ensure no recurrence:¿<br>The FSES submitted was completed and the zones passed the FSES. Zone 11 and zone 12 which wee found deficient were included in the facilities FSES and passed.<br><br>4. The facility will monitor its corrective | 10/28/22 |

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| | 315261 | A. BUILDING **01**<br>B. WING _____ | **09/01/2022** |

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| **LAKELAND NURSING & REHAB** | **25 FIFTH AVENUE**<br>**HASKELL, NJ 07420** |

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| K 232 | Continued From page 4 | K 232 | actions to ensure that the deficient practice is being corrected and will not recur by:¿¿<br>Quality Assurance Committee will monitor the on-going implementation. Any additional issues will also be reviewed by the Quality Assurance committee and will monitor the facility practices and will recommend action/changes as situations warrant.<br>Completion Date 10/28/2022. | |
| K 293<br>SS=F | Exit Signage<br>CFR(s): NFPA 101<br><br>Exit Signage<br>2012 EXISTING<br>Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.<br>19.2.10.1<br>(Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interviews, the facility failed to ensure directional signs, which showed the direction of travel, were placed in every location where the direction of travel to reach the nearest exit was not apparent in accordance with NFPA 101 (2012 edition) section 7.10.2.1. This had the potential to affect the safety of all 107 residents.<br><br>Findings include:<br><br>Observations between 11:36 AM and 12:00 PM revealed directional signs were not placed to | K 293 | K293 Directional Exit Signage<br><br>I. Corrective Actions Accomplished for Residents found to have been Affected by the Deficient Practice.<br>No residents were affected. The Plan of corrections for K293 is to have additional directional emergency exit signs installed on all three floors to indicate direction when smoking barriers are also closed. This deficiency has been remediated and all directional emergency signs have been installed on all floors. | 11/1/22 |

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| K 293 | Continued From page 5<br>indicate the direction of travel when the smoke barrier doors were closed on the first and second floors.<br><br>During an interview at the time of the observations, the Director of Maintenance confirmed that the direction of travel was not apparent when the smoke barrier doors were closed on the first and second floors.<br><br>NJAC 8:39-31.1(c), 31.2(e) | K 293 | II. Identification of Residents who have the Potential to be Affected by the Same Deficient Practice<br>All residents are at risk for the same deficiency.<br><br>III. Measures put into Place or Systemic Changes to ensure that the Deficient Practice will not Recur.<br>The Administrator will In-service the maintenance director on markings of Exits and exit access doors to ensure a directional exit sign is readily visible from any direction of egress travel and when barriers are closed. The administrator or designee will report any negative findings to the QAPI committee.<br><br>IV Monitoring of Corrective Actions<br>The Maintenance Director or designee will complete weekly Audits x 4 than quarterly X 2 of all directional emergency exits signs. Results of audits will be presented during the quarterly QAPI meetings. The QAPI committee will monitor the ongoing implementation of current facility policy and procedures to ensure appropriate and consistent implementation, which meet standard and quality of care needs for the facility and the residents. | |
| K 345 SS=F | Fire Alarm System - Testing and Maintenance<br>CFR(s): NFPA 101<br><br>Fire Alarm System - Testing and Maintenance<br>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National | K 345 | | 10/25/22 |

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| K 345 | Continued From page 6<br>Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interview, and document review, the facility failed to ensure smoke detection sensitivity was completed of the facility smoke detectors in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2. This had the potential to affect all 107 residents.<br><br>Findings include:<br><br>Observations of the facility smoke detectors on 8/30/22 from 10:45 AM to 2:33 PM revealed smoke detectors located in the corridors and other concealed areas throughout the building.<br><br>Review of the facility fire alarm "Inspection and Testing Form" dated 10/8/21 revealed no reference to a smoke detection sensitivity test.<br><br>During an interview with the Administrator and the Director of Maintenance on 8/30/22 at 4:15 PM, the Administrator contacted the contracted fire alarm company and requested the report. The fire alarm company confirmed a smoke detector sensitivity report had not been completed and one was scheduled.<br><br>NJAC 8:39-31.1(c), 31.2(e)<br>NFPA 70, 72 | K 345 | K 345- Fire Alarm testing and maintenance<br><br>I. Corrective Actions Accomplished for Residents found to have been Affected by the Deficient Practice<br>No residents were identified or immediately affected by this deficient practice. The Plan of corrections for K 345 is to have a smoke detection sensitivity test completed. This deficiency has been remediated and the smoke detection test was completed on 10/25/2022 by the facilities contracted fire alarm vendor.<br><br>II. Identification of Residents who have the Potential to be Affected by the Same Deficient Practice<br>All residents are at risk for the same deficient practice.<br><br>III. Measures put into Place or Systemic Changes to ensure that the Deficient Practice will not Recur.<br>The Administrator will In-service the maintenance team on the fire alarm system testings and inspections to ensure completed timely. The administrator will audit the results and act upon any findings or recommendations. | |

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| K 345 | Continued From page 7 | K 345 | IV Monitoring of Corrective Actions<br>The Maintenance Director or designee will conduct quarterly audits X 3 to ensure the sensitivity test is completed and act upon any negative findings. Results of audits will be presented during the quarterly QAPI meetings. | |
| K 351<br>SS=F | Sprinkler System - Installation<br>CFR(s): NFPA 101<br><br>Spinkler System - Installation<br>2012 EXISTING<br>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.<br>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.<br>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.<br>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)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure sidewall spray sprinklers were installed at the bottom of the elevator hoistway not more than 2 ft (0.61m) above the floor of the pit that contained combustible hydraulic fluids in accordance with NFPA 13 Standard for the Installation of Sprinkler | K 351 | K 351 Sprinkler System Installation<br><br>I. How the corrective action will be accomplished for the residents affected by the deficient practice:<br>The Plan of corrections for K351 is to have a sidewall sprinkler head installed at | 12/7/22 |

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| K 351 | Continued From page 8<br>Systems (2010 Edition) section 8.15.5.1 and 8.15.5.2. This deficient practice had the potential to affect all 107 residents.<br><br>Findings include:<br><br>Document review of the facility "Fire Sprinkler Inspection Report" dated 8/10/22, 5/24/22 and 3/3/22 revealed the floor of the elevator pit did not have a sidewall sprinkler installed at the bottom of the elevator hoistway.<br><br>Document review of a proposal of repairs from the elevator company confirmed the elevator is hydraulic.<br><br>Observation at 11:22 AM on 8/30/22 revealed the bottom of the elevator hoistway contained a five-gallon bucket of hydraulic fluid on the floor of the pit and sidewall spray sprinklers were not installed at the bottom of the elevator hoistway not more than 2 ft (0.61m) above the floor of the pit.<br><br>During an interview at the time of the observation, the Director of Maintenance confirmed a sidewall spray sprinkler was not installed at the bottom of the elevator hoistway.<br><br>NJAC 8:39-31.1(c), 31.2(e)<br>NFPA 13 | K 351 | the bottom of the elevator hoist way not more than 2 ft from the bottom of the pit in addition to the current sprinkler at the top of the elevator shaft. The facility administrator has contracted with the facilities sprinkler vendor to install a sidewall sprinkler at the bottom of the elevator.<br><br>II. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by this deficiency.<br><br>III. Measures or systemic changes made to ensure no recurrence:<br>The administrator will in-service maintenance director in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems, and to ensure a sidewall spray sprinkler is installed at the bottom of the elevator hoistway not more than 2 ft (0.61m) above the floor of the pit that contained combustible hydraulic fluids. The facility maintenance supervisor or designee will audit the elevator shaft following the installation of the additional sprinkler heads to ensure the area is fully sprinklered.<br><br>IV. The Facility will Monitor its corrective actions to ensure the corrective actions are being corrected and will not recur:<br>The maintenance director or designee will check the sprinklers quarterly X 4 to ensure its efficacy. Results of the audit will be reported to and reviewed by the assurance performance improvement | |

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| K 351 | Continued From page 9 | K 351 | (QAPI) committee to determine if current interventions are adequate or additional actions are needed.<br>QAPI committee will monitor the ongoing implementation of current facility policy and procedures to ensure appropriate and consistent implementation which meets the standards of quality of care needs for facility and residents. | |
| K 363<br>SS=F | Corridor - Doors<br>CFR(s): NFPA 101<br><br>Corridor - Doors<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the | K 363 | | 9/3/22 |

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| K 363 | Continued From page 10<br>smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interviews, the facility failed to ensure corridor doors closed and latched in their frames with no impediments to the closing of the doors on two of three floors (first and second floors), and were maintained to resist the passage of smoke in accordance with NFPA 101 Life Safety Code (2012 edition) 19.3.6.3 This deficient practice had the potential to affect the safety of all 107 residents.<br><br>Findings include:<br><br>Observations on 8/30/22 between 1:31 PM and 2:33 PM revealed the following:<br><br>The door to Rooms 252, 260, 115, and 108 failed to latch when closed.<br><br>The door to Room 258 had a 1" gap between the door and the door frame.<br><br>The door to Rooms 102 and 129 were blocked by beds and failed to close and latch.<br><br>The door to Room 139 was binding with the door frame and failed to close and latch. | K 363 | K363 Corridor Doors<br><br>I. How the corrective action will be accomplished for the residents affected by the deficient practice:<br>No residents were identified or immediately affected by this deficiency. The Plan of corrections for K363 is to have the corridor doors closed and latching in their frames with no impediments. K363 was remediated immediately. A new strike plate was installed in room 258 to seal the gap between the door and the frame. The beds in rooms 102 and 129 were moved to allow doors to close and latch. The door for room 139 was shaved to ensure proper closing and latching in their frames. The locks for room 260, 252, 115, and 108 were replaced immediately and close and latch in their frames with no impediment.<br><br>II. How the facility will identify other residents having the potential to be affected by the same deficient practice: | |

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| K 363 | Continued From page 11<br><br>The Director of Maintenance was present at the time of each observation and confirmed the doors failed to latch when closed, the 1" gap between the door and the door frame, the doors that were blocked by the beds and the door that was binding with the door frame and failed to close and latch.<br><br>NJAC 8:39-31.1(c), 31.2(e) | K 363 | All residents have the potential to be affected by this deficient practice.<br><br>III. Measures or systemic changes made to ensure no recurrence:<br>The administrator will in-service the Maintenance team on ensuring all corridor doors can resist the passage of smoke with no impediments to the closing of the doors.<br><br>IV. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by:<br>The Maintenance Director or designee will audit all doors monthly x 6 months and then quarterly x 3 to ensure all doors are latching with no impediments. The administrator will audit 8 corridor doors weekly for 4 weeks to ensure they operate and latch appropriately. Results of the audits completed will be brought to and reviewed by the quarterly QAPI committee to determine if current interventions are adequate or additional actions are needed.<br>QAPI committee will monitor the ongoing implementation of current facility policy and procedures to ensure appropriate and consistent implementation which meets the standards of quality of care needs for facility and residents. | |
| K 372 SS=E | Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101<br><br>Subdivision of Building Spaces - Smoke Barrier | K 372 | | 9/3/22 |

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| K 372 | Continued From page 12<br>Construction<br>2012 EXISTING<br>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.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system in REMARKS.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interviews, the facility failed to ensure penetrations in smoke barriers on two of three floors (first and second floors) were protected by a system or material capable of restricting the transfer of smoke. This deficient practice had the potential to affect all 107 residents.<br><br>Findings include:<br><br>Observation at 11:26 AM on 8/30/22 revealed the smoke barrier, located adjacent to Room 139 and the first-floor exam room, had four white wires and two blue wires which penetrated the smoke barrier and were not protected by a system or material capable of restricting the transfer of smoke.<br><br>Observation at 11:43 AM revealed the smoke barrier, located adjacent to the second-floor shower room and Room 251 had two gray and two red wires which penetrated the smoke barrier and were not protected by a system or material capable of restricting the transfer of smoke. | K 372 | K372 Subdivision of building spaces (penetration in smoke barriers)<br><br>1. How the corrective action will be accomplished for the residents affected by the deficient practice:<br>No residents were identified or immediately affected by this deficiency. The Plan of corrections for K 372 is to have the smoke barrier adjacent to room 139, 261 and 251 repaired with fire rated materials capable of protecting and restricting the transfer of smoke. K 372 was remediated immediately.<br><br>2. How the facility will identify other residents having the potential to be affected by the same deficient practice:<br>All residents have the potential to be affected by this deficient practice.<br><br>3. Measures or systemic changes made:<br>The administrator will in-service the Maintenance team to ensure penetrations | |

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| K 372 | Continued From page 13<br><br>Observation at 12:06 PM revealed the smoke barrier, located adjacent to Room 261 and second-floor soiled linen had a ½" flexible conduit which penetrated which penetrated the smoke barrier and was not protected by a system or material capable of restricting the transfer of smoke.<br><br>During an interview at the time of each observation, the Director of Maintenance confirmed the penetrations in the smoke barriers were not protected.<br><br>NJAC 8:39-31.1(c), 31.2(e) | K 372 | in smoke barriers are protected by a system or material capable of restricting the transfer of smoke.<br><br>4. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by:<br>The maintenance director and or designee will audit 8 rooms a week for 4 weeks to ensure all smoke barriers are intact without any penetration.<br>The administrator will audit 10 rooms to ensure no penetration of smoke for 3 months. Results of the audits completed will be brought to and reviewed by the quarterly QAPI committee to determine if current interventions are adequate or additional actions are needed.<br>QAPI committee will monitor the ongoing implementation of current facility policy and procedures to ensure appropriate and consistent implementation which meets the standards of quality-of-care needs for facility and residents. | |
| K 741 SS=E | Smoking Regulations<br>CFR(s): NFPA 101<br><br>Smoking Regulations<br>Smoking regulations shall be adopted and shall include not less than the following provisions:<br>(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. | K 741 | | 10/3/22 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315261 | A. BUILDING **01**<br>B. WING _____ | **09/01/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LAKELAND NURSING & REHAB** | **25 FIFTH AVENUE**<br>**HASKELL, NJ 07420** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| K 741 | Continued From page 14<br>(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.<br>(3) Smoking by patients classified as not responsible shall be prohibited.<br>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.<br>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.<br>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.<br>18.7.4, 19.7.4<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure ashtrays of noncombustible material and safety design and a metal container with a self-closing cover devices into which ashtray could be emptied was readily available to the smoking area located on a section of the patio in accordance with NFPA 101 Life Safety Code (2012 Edition) section 19.7.4 (5) (6). This deficient practice has the potential to affect the safety of two residents.<br><br>Findings include:<br><br>Review of the facility "Smoking Policy and Procedure" revealed the facility would provide an "ashtray" in the designated smoking area.<br><br>Observation at 2:40 PM on 8/30/22 revealed the smoking area located on a section of the patio had a freestanding plastic cigarette butt | K 741 | K741- Smoking regulations<br><br>II. How the corrective action will be accomplished for the residents affected by the deficient practice:<br>No residents were identified or immediately affected by this deficiency. The Plan of corrections for K741 is to replace the current ashtray with a self-closing cover, safe, metal noncombustible ashtray. K741 was remediated and a new self-closing metal ashtray was installed for use.¿<br><br>II. How the facility will identify other residents having the potential to be affected by the same deficient practice:<br>All residents have the potential to be affected by this deficient practice. | |

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| | 315261 | A. BUILDING **01**<br>B. WING _____ | **09/01/2022** |

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| K 741 | Continued From page 15<br>receptacle and did not have an ashtray of noncombustible material and a metal container with a self-closing cover.<br><br>During an interview at the time of the observation, the Director of Maintenance confirmed there was not an ashtray of noncombustible material and a metal container with a self-closing cover in the designated smoking area.<br><br>NJAC 8:39-31.2(e), 31.6(e)2 | K 741 | III. Measures or systemic changes made:<br>The administrator will in-service the maintenance team and all smoking supervisors to ensure there are readily available ashtrays of noncombustible material with safety design and a metal container with a self-closing cover device s into which ashtray could be emptied in the smoking area.<br><br>IV. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by:<br>The maintenance director and or designee will audit the smoking area two times a week X 4 weeks to ensure there is a metal self-closing ashtray present and working appropriately. Results of the audits completed will be brought to and reviewed by the quarterly QAPI committee to determine if current interventions are adequate or additional actions are needed.<br>QAPI committee will monitor the ongoing implementation of current facility policy and procedures to ensure appropriate and consistent implementation which meets the standards of quality-of-care needs for facility and residents. | |
| K 761 SS=E | Maintenance, Inspection & Testing - Doors<br>CFR(s): NFPA 101<br><br>Maintenance, Inspection & Testing - Doors<br>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.<br>Non-rated doors, including corridor doors to | K 761 | | 11/5/22 |

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| | 315261 | A. BUILDING **01**<br>B. WING _____ | **09/01/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **LAKELAND NURSING & REHAB** | **25 FIFTH AVENUE**<br>**HASKELL, NJ 07420** |

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| K 761 | Continued From page 16<br>patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.<br>Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.<br>Written records of inspection and testing are maintained and are available for review.<br>19.7.6, 8.3.3.1 (LSC)<br>5.2, 5.2.3 (2010 NFPA 80)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview the facility failed to ensure fire doors were free of holes due to changes or removal of hardware and repaired by the following methods: (1)Install steel fasteners that completely fill the holes (2)Fill the screw or bolt holes with the same material as the door frame in accordance with NFPA 80 Standard for Fire Doors and Other Opening Protectives (2010 Edition) Section 5.2.15.4(1)(2). This deficient practice had the potential to affect 15 residents.<br><br>Findings include:<br><br>Observation at 1:58 PM on 8/30/22 revealed the fire door to the stairway adjacent to the first floor Clinic Room had two holes, one above the doorknob and one below the doorknob.<br><br>During an interview at the time of the observation, the Director of Maintenance affirmed the holes in the fire door.<br><br>NJAC 8:39-31.1(c), 31.2(e)<br>NFPA 80 | K 761 | K 761 Maint/Inspection and testing-Doors<br><br>1. How the corrective action will be accomplished for the residents affected by the deficient practice:<br>No residents were identified or immediately affected by this deficiency.<br>The Plan of corrections for K761 is to install a steel fastener that completely fills the holes or fill the holes with the same materials as the door frame. This deficiency has been remediated and the holes above and below the first-floor clinic door have been filled with same material as the door.<br><br>2. How the facility will identify other residents having the potential to be affected by the same deficient practice:<br>All residents have the potential to be affected by this deficient practice.<br><br>3. Measures or systemic changes made:<br>The administrator will in-service the maintenance team on fire doors inspections and testing and to ensure no | |

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| | 315261 | A. BUILDING **01**<br>B. WING _____ | **09/01/2022** |

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| K 761 | Continued From page 17 | K 761 | changes are made to any fire rated doors. The facility will contract with the fire door vendor to evaluate and repair or replace as appropriate any fire doors identified.<br><br>4. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by:<br>The maintenance director and or designee will audit 5 fire doors each week X 4 weeks and then 5 doors quarterly X 3 to ensure each function and have no damage. Results of the audits completed will be brought to and reviewed by the quarterly QAPI committee to determine if current interventions are adequate or additional actions are needed.<br>QAPI committee will monitor the ongoing implementation of current facility policy and procedures to ensure appropriate and consistent implementation which meets the standards of quality-of-care needs for facility and residents. | |
| K 911 SS=F | Electrical Systems - Other<br>CFR(s): NFPA 101<br><br>Electrical Systems - Other<br>List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.<br>Chapter 6 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interviews, the facility | K 911 | K911- Electrical System | 11/1/22 |

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|---|---|---|---|
| | 315261 | A. BUILDING **01**<br>B. WING _____ | **09/01/2022** |

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| **LAKELAND NURSING & REHAB** | **25 FIFTH AVENUE**<br>**HASKELL, NJ 07420** |

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| K 911 | Continued From page 18<br>failed to ensure electrical junction boxes were maintained and closed with a suitable cover securely fastened in place in accordance with NFPA 70 (2011 Edition) section 314.72(E). This deficient practice had the potential to affect the safety of all 107 residents.<br><br>Findings include:<br><br>Observation between 11:26 AM and 12:05 PM revealed open junction boxes without covers above the ceiling tiles at the smoke barrier walls near the following: Room 139, first floor shower room, second floor tub room and Room 261.<br><br>Interviews with the Director of Maintenance at the time of each observation confirmed the condition of the junction boxes.<br><br>NJAC 8:39-31.2(e), 31.2(i)<br>NFPA 70 | K 911 | 1. How the corrective action will be accomplished for the residents affected by the deficient practice:<br>No residents were identified or immediately affected by this deficiency. The Plan of corrections for K911 is to cover all open junction boxes identified at the time of survey near room 139, first floor shower room, second floor tub room and room 261. This deficiency has been remediated and those junction boxes near first floor shower room, second floor tub room, room 139 and 261 have been covered.<br><br>2. How the facility will identify other residents having the potential to be affected by the same deficient practice:<br>All residents have the potential to be affected by this deficient practice.<br><br>3. Measures or systemic changes made:<br>The administrator will in-service the maintenance director to ensure electrical junction boxes are maintained and closed with a suitable cover securely fastened in place.<br><br>4. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by:<br>The maintenance director and or designee will audit 3 electric junction boxes per week X 4 weeks to ensure there is no damage and there is an appropriate covered installed. Results of the audits completed will be brought to and reviewed by the quarterly QAPI | |

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| **LAKELAND NURSING & REHAB** | **25 FIFTH AVENUE**<br>**HASKELL, NJ 07420** |

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| K 911 | Continued From page 19 | K 911 | committee to determine if current interventions are adequate or additional actions are needed.<br>QAPI committee will monitor the ongoing implementation of current facility policy and procedures to ensure appropriate and consistent implementation which meets the standards of quality-of-care needs for facility and residents. | |
| K 918 SS=F | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and | K 918 | | 11/28/22 |

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| | 315261 | A. BUILDING **01**<br>B. WING _____ | **09/01/2022** |

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| **LAKELAND NURSING & REHAB** | **25 FIFTH AVENUE**<br>**HASKELL, NJ 07420** |

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| K 918 | Continued From page 20<br>readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure Emergency Power Supply (EPS) was equipped with a remote manual stop station to a type to prevent inadvertent or unintentional operation located outside the room housing the EPS in accordance with NFPA 110 Emergency and Standby Systems (2010 Edition) 5.6.5.6. This deficient practice had the potential to affect the safety of all 107 residents.<br><br>Findings include:<br><br>Document review of the Generator "Incident" reports revealed the EPS was serviced and inspected on 8/18/22 and 7/29/21 and a remote manual stop station had not been installed.<br><br>Observation at 1:05 PM on 8/30/22 revealed the EPS was not equipped with a remote manual stop station.<br><br>At the time of the observation of the EPS, the Director of Maintenance confirmed the EPS did not have a remote manual stop station.<br><br>NJAC 8:39-31.2(e)<br>NFPA 99, 110 | K 918 | K 918- Electrical System- Essential Electric system<br><br>1. How the corrective action will be accomplished for the residents affected by the deficient practice:<br>No residents were identified or immediately affected by this deficiency. The Plan of corrections for K 918 is to have a facility□s generator vendor install a remote manual stop station for the generator. This deficiency has been remediated and a generator stop station has been installed near the generator housing unit.<br><br>2. How the facility will identify other residents having the potential to be affected by the same deficient practice:<br>All residents have the potential to be affected by this deficient practice.<br><br>3. Measures or systemic changes made:<br>The administrator in-serviced the maintenance director to ensure the (EPS) Emergency power supply was equipped with a remote manual stop station to prevent inadvertent or unintentional operations. | |

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| K 918 | Continued From page 21 | K 918 | 4. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by:<br>The maintenance director and or designee will audit the generator remote stop after installation each week X 4 weeks to ensure the remote manual stop for the generator appropriately installed and working properly. Results of the audits completed will be brought to and reviewed by the quarterly QAPI committee to determine if current interventions are adequate or additional actions are needed.<br>QAPI committee will monitor the ongoing implementation of current facility policy and procedures to ensure appropriate and consistent implementation which meets the standards of quality-of-care needs for facility and residents. | |

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| | 315261 | A. BUILDING **01**<br>B. WING _____ | R<br>**08/24/2023** |

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| {E 000} | Initial Comments | {E 000} | | |
| {K 000} | INITIAL COMMENTS<br><br>The facility was found to be not in compliance with with the requirements of 42 CFR 483.90.<br><br>The facility is composed of two separate buildings: 1) Annex and 2) Nursing Center.<br><br>The Annex building is a 3 story building with a basement with 4 smoke zones. The construction type is Type V (000) unprotected steal and combustible material.<br><br>The Nursing Center building is a 3 story building with 9 smoke zones. The construction type is Type II (000) unprotected metal infrastructure.<br><br>The facility conducted a Fire Safety Evaluation System (FSES) survey documenting 13 out of 14 smoke zones passing. The one smoke zone that failed was Zone 14 of the Annex building. The facility is requesting a time-limited waiver to install smoke detection which should result in a passing score for Zone 14. | {K 000} | | |

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

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.