STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315348	A. BUILDING _____ B. WING _____	C 03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	255 UNION AVE BLOOMINGDALE, NJ 07403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #s: NJ168906, #169589, #169951, and #170357 Survey Date: 3/08/2024 Census: 101 Sample: 20 sample + 3 closed records = 23 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	F 585		4/15/24

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

Electronically Signed | 03/28/2024

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§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being

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F 585	Continued From page 2 investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Complaint# NJ169589 Based on interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to: a) ensure written [redacted] decisions met documentation requirements and b) maintain evidence of the	F 585	What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 352 was discharged from the facility.	

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F 585	Continued From page 3 result of all NJ Exec Order 26.4b1 for no less than three (3) years from the date the NJ Exec Order 26.4b1 decision was issued according to facility practice and policy. This deficient practice was identified for one (1) of five (5) residents (Resident #352) reviewed for complaints. This deficient practice was evidenced by the following: On 02/16/24 at 10:34 AM, the surveyor requested for all the reportable and NJ Exec Order 26.4b1 for the last NJ Exec Order 26.4b1 for Resident #352 from the U.S. FOIA (b) (6)). The surveyor reviewed the facility provided grievance log for NJ Exec Order 26.4b1 that included Resident #352. A review of the Complaint #NJ169589 dated NJ Exec Order 26.4b, reflected that the complainant had spoken with the U.S. FOIA (b) (6) around NJ Ex Order 26.4(b), to discuss concerns but conditions had not improved. The surveyor reviewed the closed record for Resident #352. The resident's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Exec Order 26.4b1 .	F 585	How the facility will identify other residents having the potential to be affected by the same deficient practice. Any resident filing a grievance has the potential to be affected. A review of the grievance log was completed, and no other residents were affected. What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur. Administrator and Director of Nursing (DON) reviewed the grievance process and timeliness of resolutions. The grievance process has been streamlined to include review at morning meetings, to ensure that written grievance met documentation and maintain evidence of result of all grievances. Education was provided to staff regarding grievances and the investigation process. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of systemic change. A weekly grievance audits up to 5 grievances will be completed by the Administrator or Designee for 4 weeks, then up to ten grievances monthly for a period of two months. The audits will	

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F 585	Continued From page 4 A review of the resident's most recent Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident was [redacted]. On 02/22/24 at 11:52 AM, during an interview with the surveyor, the [redacted] stated that they do their best to resolve the [redacted] and typically were investigated/resolved within 10 days. At that time, the [redacted] stated she had investigated the [redacted] for Resident #352 with the then [redacted]. At that time, the surveyor and the [redacted] discussed the [redacted] which also included an allegation that a Certified Nursing Assistant had told the resident "[redacted]" The day of the incident was documented on the [redacted] form to have occurred on a Wednesday or Thursday. At that time, the [redacted] informed the surveyor that no staff member was identified by the complainant and as a result no staff was identified. The [redacted] could not speak as to where the statements obtained during the investigation or if any was obtained. The surveyor and the [redacted] reviewed the findings and summary portion of the [redacted] investigation which revealed the process for investigation which included the following: -An interview with staff members having contact with the resident during the relevant periods and	F 585	capture that interviews are conducted, and statements are collected, and resolution or outcome is documented. Results of the audit will be reviewed with the team at the monthly Quality Assurance Performance Improvement (QAPI)t committee for a period of three months. After discussion any changes to the original plan of correction will be revised and reviewed at the next QAPI meetings.	

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shift of the alleged incident.
-Interviews with the resident's roommate, family members and visitors.

The surveyor and the U.S. FOIA did not observe any of the above documents included in the NJ Exec Order 26.4b1 investigation packet provided.

On 02/22/24 at 01:37 PM, during an interview with the surveyor, the U.S. FOIA (b) stated the U.S. FOIA (b) at that time was the nurse on duty and there were no statements on file for the investigation conducted regarding the resident's NJ Exec Order 26.4b1

On 02/23/24 at 11:39 AM, during an interview with the surveyors, the U.S. FOIA (b) confirmed that there no witness statements [to help determine the root cause] on file for Resident #352's NJ Exec Order 26.4b1

On 02/23/24 at 12:29 PM, during a meeting with the survey team, and the U.S. FOIA (b) (6)), the U.S. FOIA (b) stated that Quality Assurance Performance for Improvement (QAPI) was initiated for the NJ Exec Order 26.4b1 process and that the Social Worker was the gate keeper of all NJ Exec Order 26.4b1 The concern regarding the NJ Exec Order 26.4b1 process was communicated by the surveyor to the U.S. FOIA (b) (

On 02/26/24 at 12:05 PM, the surveyor interviewed the U.S. FOIA in the presence of the survey team. The U.S. FOIA stated that all staff were given education on the process for NJ Exec Order 26.4b1 and acknowledged that no investigation statements were included with Resident #352's NJ Exec Order 26.4b1 concern.

A review of the facility provided policy; Grievance/Complaints, Recording and

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F 585	Continued From page 6 Investigating dated/revised July 2023 under Policy and Interpretation and Implementation included the following: 4. The investigation and report will include, as applicable: d) the names of any witnesses and their account of the alleged incident f) the employees account of the alleged incident g) accounts of any other individuals involved, (i.e., employees, supervisor, etc.) NJAC 8:39-4.1(a)(35);13.2(c)	F 585		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 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: Based on the interview and review of pertinent facility documentation, it was determined that the	F 610	What corrective action (s) will be accomplished for those residents found to	4/15/24

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F 610	Continued From page 7 facility failed to complete a thorough investigation for six (6) of six (6) [redacted] of Resident #80 reviewed for [redacted]. This deficient practice was evidenced by the following: On 02/14/24 at 10:54 AM, the surveyor observed Resident #80, awake, and laying on a [redacted] with [redacted] in use. On 02/15/24 at 8:18 AM, the surveyor asked the [redacted]) for the resident's [redacted] for the [redacted] The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #80 as follows: According to the Admission Record (admission summary), Resident #80 was admitted to the facility with a diagnosis that included but was not limited to [redacted] The resident's comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the	F 610	have been affected by the deficient practice? Resident # 80 accidents and incidents reports were reviewed. How the facility will identify other residents having the potential to be affected by the same deficient practice. Any residents who has an accident/incident report completed has the potential to be affected. The facility had previously recognized this and had implemented their own internal plan of correction. What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur. The facility educator provided training to department staff members on their responsibilities regarding accident/incident report requirements to ensure the completion of a written or electronic witness statement is captured. Unit Manager/nursing supervisor to audit all incidents reports, collect supporting documentation for thorough investigation. A review by the Director of Nursing (DON) and Administrator of each accident/incident report will be reviewed electronically as well as the written elements of the investigation prior to activating the electronic signature. Incident reports and supporting	

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F 610	Continued From page 8 management of care, with an assessment reference date (ARD) of NJ Exec Order 26.4b revealed in NJ Exec Order 26.4b1 that the NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 showed that the resident's NJ Exec Order 26.4b was NJ Exec Order 26.4b A review of the provided last NJ Exec Order 26.4b1 ' incidents and accidents (Risk Management) reports by the U.S. FOIA (b) showed the following: 1. NJ Exec Order 26.4b1 =Licensed Practical Nurse #1 (LPN#1), the person preparing the report was notified by the housekeeping staff that the resident NJ Exec Order 26.4b1. The resident was NJ Exec Order 26.4b1 the incident. The NJ Exec Order 26.4b1 had NJ Exec Order 26.4 and there was no witness found. There were no statements from other staff and the facility did not identify the name of the housekeeping staff. 2. NJ Exec Order 26.4b1 =LPN#2, the person preparing the report documented that the resident was NJ Exec Orde on the resident's NJ Exec Order 26.4b1 was noted, and no witness was found. The resident was not able to describe the incident. There were no statements from other staff for the NJ Exec Order 26.4b1. 3. NJ Exec Order 26.4b1 =LPN#1, the person preparing the report was notified by the housekeeping staff that the resident NJ Exec Order 26.4b1. The resident was NJ Exec Order 26.4b1 incident. The NJ Exec Order 26.4b1 had a NJ Exec Order 26.4b1) and there was no witness found. There were no statements from other staff and the facility did not identify the name of the housekeeping staff. 4. NJ Exec Order 26.4b1 =LPN#3, the person preparing the report was called into the resident's room by a staff member and noted resident NJ Exec Order 26.4b1 on the right side of the bed. The	F 610	documentation will be placed in a filling system in chronological order. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of systemic change. The Director of Nursing/designee will collect random sample of five incidents report for review weekly for four weeks, then up to ten reports monthly for a period of two months. The audit will capture the collection of statements, conclusion of the investigation, and signatures of DON and Administrator. The Director of Nursing will report the audits result to the monthly Quality Assurance Performance Improvement (QAPI) meetings for a period of three months. After discussion, any changes to the original plan of correction will be revised and reviewed at the next QAPI meetings.	

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resident NJ Exec Order 26.4b1 the incident. The NJ Exec Order 26.4b1 incident had NJ Exec Order 26.4b1 and there was no witness found.
There were no statements from other staff and the facility did not identify the name of the staff member.
5. NJ Exec Order 26.4b1 at 4:00 PM NJ Exec Order 26.4b1=LPN#1, the person preparing the report was alerted by staff that the NJ Exec Order 26.4b1 on the left side of the bed. The resident was NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 the incident. The NJ Exec Order 26.4b1 had NJ Exec Order 26.4b1 and there was no witness found.
There were no statements from other staff and the facility did not identify the name of the staff who alerted LPN#1.
6. NJ Exec Order 26.4b1 at 8:30 PM NJ Exec Order 26.4b1=LPN#4, the person preparing the report walked by the resident's room and observed resident NJ Exec Order 26.4b1 on the left side of the bed. The resident NJ Exec Order 26.4b1 the incident. The NJ Exec Order 26.4b1 had NJ Exec Order 26.4b1 and there was no witness found.
There were no statements from other staff for an unwitnessed incident.

Further review of the facility's provided investigations of Resident #80 did not include statements from staff for all NJ Exec Order 26.4b1 incidents.

A review of the Progress Notes (PN) revealed that there was no documentation of the housekeeping staff's name from the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 incidents. The NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 at 4:03 PM PN did not identify the names of staff who reported the NJ Exec Order 26.4b1 to LPN#1 (NJ Exec Order 26.4b1 at 3:555 PM NJ Exec Order 26.4b1 and LPN#3 (NJ Exec Order 26.4b1). In addition, there was no documentation that the other staff

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provided statements for the six NJ Exec Order 26.4b1 that were NJ Exec Order 26.4b1

On 02/15/24 at 10:00 AM, the surveyor asked the U.S. FOIA (b) (6)) for complete investigations, specifically statements from staff, and she stated that she would get back to the surveyor.

On 02/15/24 at 12:47 PM, the surveyors met with LPN#1 for an interview regarding the resident's fall incidents. LPN#1 informed the surveyors that he used to be the NJ Exec floor U.S. FOIA (b) (6)) and currently working as a 3-11 shift staff nurse. He stated that he works 7-3 shifts at times. He further stated that the facility's NJ Exec Order 26.4b1 process is that a nurse, assess the resident, prepare the incident report, and notify the family and physician of the incident. He also included that the IDCP (interdisciplinary team) meets afterward to discuss the NJ Exec Order 26.4b1 and put interventions into place to prevent further NJ Exec O that eventually documented in the resident's care plan.

On that same date and time, LPN#1 was able to remember the NJ Exec Order 26.4 NJ Exec Order 26.4b1 when the housekeeping staff informed him that the resident was on the floor. LPN#1 was unable to remember the name of the housekeeping staff. He stated that statements from the staff including the housekeeping staff should had been gathered but LPN#1 was unable to remember if that happened. He acknowledged that as part of the facility's practice if the incident NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 the incident, staff statements must be provided. He confirmed that Resident #80 was NJ Exec Order 26.4b1.

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On 02/15/24 at 01:02 PM, the surveyor asked again the U.S. FOIA in the presence of LPN#1, U.S. FOIA (b) (6) and U.S. FOIA (b) (6)) about the statements from the resident's investigations. The facility management stated that they will get back to the surveyor about the statements.

On 02/15/24 at 01:16 PM, the U.S. FOIA stated that there were no statements for all the NJ Exec Order 26.4b1 of Resident #80. The U.S. FOIA informed the surveyor that the concern about missing statements from residents' investigations was identified as a concern back in NJ Exec Order 26.4b1 and was placed into QAPI (quality assurance and performance improvement) in the NJ Exec Order 26.4b1 meeting. The surveyor then asked, if the problem was identified back in NJ Exec Order 26.4b1, why statements were not obtained up to this time to complete the investigations, why the problem persists in the NJ Exec Order 26.4b1 (at 3:55 PM and 8:00 PM), and the U.S. FOIA did not respond.

Furthermore, the U.S. FOIA acknowledged that for all NJ Exec Order 26.4b1 incidents and residents unable to describe what had happened, staff statements should be gathered to consider the investigation as complete as per facility practice.

On 02/23/24 at 10:42 AM, the survey team met with the U.S. FOIA (b) and U.S. FOIA (b) The surveyor notified the facility management of the above concerns and findings.

A review of the provided facility's Accidents and Incidents-Investigating and Reporting Policy with a revised date of July 2017 that was provided by the U.S. FOIA (b) included that all accidents or incidents involving residents, employees, visitors, vendors,

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F 610	Continued From page 12 etc., occurring on facility premises shall be investigated and reported to the Administrator. Policy interpretation and implementation included on the Report of Incident/Accident form the name(s) of witnesses and their accounts of the accident or incident, any corrective action taken, follow-up information, and other pertinent data as necessary or required. Incident/accident reports will be reviewed by the Safety Committee for trends related to accidents or safety hazards in the facility and to analyze any individual resident vulnerabilities. On 02/26/24 at 12:04 PM, the survey team met with the [redacted] and [redacted]. The [redacted] and the [redacted] confirmed that there was no additional information and that there were no statements from staff for all unwitnessed fall investigations. NJAC 8:39-27.1(a)(b)	F 610		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on the interview, record review, and review of pertinent facility documentation it was determined that the facility failed to accurately code the Minimum Data Set (MDS) for one (1) of the 23 residents reviewed, Resident #80. This deficient practice was evidenced by the following: On 02/14/24 at 10:54 AM, the surveyor observed	F 641	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 80, MDS was reviewed, modified to reflect the accurate code, and submitted prior to survey team exit. How the facility will identify other residents	4/15/24

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F 641	Continued From page 13 Resident #80, awake, and NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 in use. The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #80 as follows: According to the Admission Record (admission summary), Resident #80 was admitted to the facility with a diagnosis that included but was not limited to essential NJ Exec Order 26.4b1 [redacted]. A review of the resident's Progress Notes (PN) showed the following information: NJ Exec Order 26 at 3:59 PM=revealed that Licensed Practical Nurse #1 (LPN#1) documented that at 3:45 PM the housekeeping staff notified LPN#1 that Resident #80 was NJ Exec Order 26.4b1, the resident NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 noted to the resident. NJ Exec Order 26.4b at 7:58 PM=revealed that LPN#2 documented that the NJ Exec Order 26.4b1 on the bedroom floor and there was NJ Exec Order 26.4 noted. NJ Exec Order 26.4b at 11:21 PM=revealed that LPN#1 documented that at 9:50 AM, the housekeeping staff notified LPN#1 that the res NJ Exec Order 26.4b1 . The resident NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1	F 641	having the potential to be affected by the same deficient practice. Any resident who has had a change in status has the potential to be affected. A review of falls was conducted, and no other residents were affected. What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur. Training was provided to the US FOIA (b)(6), and member of the inter disciplinary care plan to review the resident□s medical record for accurate coding. Quarterly, annual, and significant changes assessments will be reviewed during care planning by the MDS nurse. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of systemic change. DON/designee will conduct monthly MDS audits for up to five charts weekly for one month, then 10 charts monthly for two months. The audit will capture a review for data accuracy related to changes in the patient status. Results of the audit will be reviewed with the team at the monthly Quality Assurance Performance Improvement committee for a period of three months. After discussion	

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F 641	Continued From page 14 to the NJ Exec Order 26.4b NJ Exec Order 26.4 at 3:12 PM=revealed that LPN#3 documented that she was called into the room of the resident by a staff member. The resident NJ Exec Order 26.4b1 on the right side of the bed. No NJ Exec Order 26.4b1 upon assessment. NJ Exec Order 26.4 at 4:03 PM=revealed that LPN#1 documented that at 3:55 PM, he was alerted by staff that the resident was NJ Exec Order 26.4b1 on the left side of the bed and there was NJ E noted. 12/18/23 at 9:00 PM=revealed that LPN#4 documented that at 8:30 PM, when LPN#4 walked by the resident's room, the resident NJ Exec Or on the left side of the bed, and there was NJ Exec Order 26.4 noted. A review of the resident's comprehensive MDS (cMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of NJ Exec Order 26.4b revealed in NJ Exec Order 26.4b1 that the NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 that resident's NJ Exec Order 26.4b1 . The cMDS in NJ Exec Order 26.4b1 included that the resident had NJ Exec Order 2 since admission/entry or reentry or the prior assessment (OBRA [Omnibus Budget Reconciliation Act, assessment is due no less frequently than NJ Exec Order 26.4b1] or Scheduled PPS [Prospective payment system, completed when a Medicare Part A stay ends, but the resident remains in the facility]), whichever is more recent. A review of the MDS with an ARD of NJ Exec Order 26.4b showed that in Section NJ there was NJ Exec Order 2 that was captured NJ Exec Order 26.4b1 . Further review of the above MDS showed that the	F 641	any changes to the original plan of correction will be revised and reviewed at the next QAPI meeting.	

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NJ Exec Order 26.4b1 that happened on NJ Exec Order 26.4 and the NJ Exec Order 26.4b1 that happened on NJ Exec Order 26.4b (at 3:55 PM and 8:30 PM) were not captured in the NJ Exec Order 26.4b cMDS. The MDS with an ARD of NJ Exec Order 26.4 did not capture the NJ Exec Order 26.4b1 with a NJ Exec Order 26.4b1 that happened on NJ Exec Order 26.4 that resulted in a NJ Exec Order 26 to the NJ Exec Order 26.4.

On 02/20/24 at 9:15 AM, the surveyor in the presence of another surveyor, notified the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6) of the above findings regarding the MDS was not accurately done to capture the NJ Exec Order 26.4b1 of the resident.

On 02/20/24 at 9:32 AM, the surveyor interviewed the U.S. FOIA (b) (6)). The U.S. FOIA (b) (6) informed the surveyor that she was responsible for MDS assessment that included section N for NJ Exec O The U.S. FOIA (b) (6) stated that there was no facility-specific policy for MDS and that the facility follows the RAI (Resident Assessment Instrument) Manual. She further stated that the information she gathered from the electronic medical records, specifically in the Risk Management where NJ Exec Order 26.4b1 documentation can be located in answering section N of the MDS.

On that same date and time, the surveyor notified the U.S. FOIA (b) (6) of the above findings and concerns. The U.S. FOIA (b) (6) then opened her computer and verified the MDS concerns of the surveyor. The U.S. FOIA (b) (6) confirmed that the MDS with an ARD of NJ Exec Order 26.4b and NJ Exec Order 26.4 were not accurately coded to NJ Exec Order 26.4b1 of the resident. She further stated that she did not know what happened and "probably an oversight."

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F 641	Continued From page 16 On 02/23/24 at 10:42 AM, the survey team met with the U.S. FOIA (b) and U.S. FOIA (b) The surveyor notified the facility management of the above concerns. On 02/26/24 at 12:04 PM, the survey team met with the U.S. FOIA (b) and the U.S. FOIA (b) and there was no additional information provided by the facility management.	F 641		
F 684 SS=D	NJAC 8:39-33.2(d) Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation it was determined that the facility failed to: a) follow the NJ Exec Order 26.4b1 assessments schedule and documentation of the NJ Exec Order 26.4b1 assessment according to the order and facility policy for one (1) of 20 residents, (Resident #89) reviewed for quality of care and b) ensure appropriate care and services was provided to a resident with NJ Exec Order 26.4b1 for one (1) of two (2) residents, Resident #71, reviewed for NJ Exec Order 26.4b1. This deficient practice was evidenced by the	F 684	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 89 NJ Exec Order 26.4b1 was completed and documented. Resident # 71 was seen by NJ Exec Order 26.4b1 and provided NJ Exec Order 26.4b1 How the facility will identify other residents having the potential to be affected by the same deficient practice.	4/15/24

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F 684	Continued From page 17 following: 1. On 02/14/24 at 11:21 AM, the surveyor observed the resident out of bed (OOB) in a wheelchair with the call bell within reach. The resident was actively watching TV (television) and had NJ Exec Order 26.4b1 of the food or the staff. The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #89 as follows: The Admission Record (AR, an admission summary) reflected that that resident was a NJ Exec Order 26.4b1 resident at the facility and had diagnoses which included but were not limited NJ Exec Order 26.4b1 . The resident's comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b1 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which reflected that the resident's NJ Exec Order 26.4b1 A review of the resident's Care Plan (CP) revealed a focus area that the resident is at risk for NJ Exec Order 26.4b1 related to (r/t) NJ Exec Order 26.4b1 care, need for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1, increased NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 that was initiated on NJ Exec Order 26.4b1 A review of the resident's CP revealed a focus area that the resident is at NJ Exec Order 26.4b1 development r/t NJ Exec Order 26.4b1, NJ Exec Order 26.4b1	F 684	Residents who require a weekly skin assessment have the potential to be affected as well as any resident with a visual impairment that requires corrective lenses has the potential to be affected. What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur. Nursing staff were in-serviced regarding the facility protocol on weekly skin evaluations and documentation. US FOIA (b)(6) and nursing supervisors were in-service to reinforce the facility protocol for weekly skin evaluations to determine changes to the plan of care based on the evaluation. Nursing staff in service regarding missing items, documentation, and care plan, to ensure documentation of care and services are provided. The nursing unit will maintain a written log of consults pending. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of systemic change. The Director of Nursing or designee will audit orders for weekly skin evaluations for completion of the evaluation for up to 6	

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F 684	Continued From page 18 NJ Exec Order 26.4 and NJ Exec Order 26.4b1 and was initiated NJ Exec Order 26.4 and revised NJ Exec Order 26.4b1 Further review of the resident's CP revealed a focus area that the resident has NJ Exec Order 26. t/t NJ Exec Order 26. process was initiated NJ Exec Order 26.4 and revised NJ Exec Order 26.4b. A review of the NJ Exec Order 26.4b1 dated NJ Exec Order 26.4 revealed a score of NJ Ex which is NJ Exec Order 26.4b1. Under the section " NJ Exec Order 26.4b1 degree to which the NJ Exec D to NJ Exec Order 26.4 was # NJ Exec Order 26.4b1. A review of the NJ Exec Order 26.4b1 assessment documentation revealed a NJ Exec Order 26.4b1 assessment was completed on NJ Exec Order 26.4b. The next weekly NJ Exec Order 26.4b1 the surveyor could review was dated NJ Exec Order 26.4. The NJ Exec Order 26.4b1 assessments that should have been completed and were missing were for dates NJ Exec Order 26.4b1 The resident's treatment administration record (TAR) dated NJ Exec Order 26.4b1 revealed NJ Exec Order 2 assessment: Thursday every Day shift 7a-3p NJ Exec D assessment. A review of the resident's TAR dated NJ Exec Order 26.4b1 revealed NJ Exec Order 26.4b1 assessment: Thursday every Day shift 7a-3p NJ Exec D assessment. Further review of the TAR revealed that nursing documented completion of the above treatments on the TAR for every day for the dates of NJ Exec Order 26.4b1 There was no corresponding NJ Exec Order 26.4b1 Assessment completed in the assessment part of the electronic medical records to corresponds to	F 684	patients weekly for four weeks, then twelve patients monthly for a period of two months. Unit Manager or designee will audit the consultant log for up to three patients weekly for four weeks, then six patients monthly for two months. The audit will review that the consultant log entry has been completed, updated, and/or discontinued based on the patients need. Results of the audit will be reviewed with the team at the monthly Quality Assurance Performance Improvement committee for a period of three months. After discussion any changes to the original plan of correction will be revised and reviewed at the next QAPI meeting.	

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the signed TAR for dates NJ Exec Order 26.4b1 [redacted]

On 02/26/23 at 11:04 AM, the surveyor interviewed Licensed Practical Nurse #1 (LPN#1) who stated, "the Certified Nurses aids (CNA) are responsible during NJ Exec Order 26.4 or NJ Exec Order 26.4b the resident and they let the nursing staff know of any new issues, then the nursing staff document on the TAR and on the NJ Exec Order 26.4b1 assessment. LPN#1 further stated that there was an area to document if NJ Exec O was NJ Exec Orde it showed on TAR and cross reference so it cannot be missed. "We as nurses are responsible to document in both areas on the TAR and the NJ Exec Order 26.4b1 assessment form."

On 02/23/24 at 10:10 AM, the surveyor interviewed the U.S. FOIA (b) (6) [redacted]), she stated, "the treatments that are ordered and entered on the TAR for resident #89 are to help NJ Exec Order 26.4b1 The nurse was doing the NJ Exec Order 26.4b1 and signing off the TAR, but then needs to go into the NJ Exec Order 26.4b1 documentation and document what was observed during the weekly assessment. The staff was supposed to document in both areas, The weekly NJ Exec Order 26.4b1 form has a NJ Exec Order 26.4b1 [redacted] "

On 02/26/24 at 11:31 AM, the surveyor interviewed the U.S. FOIA (b) (6) [redacted]), who stated, the NJ Exec Order 26.4b1 assessment was a document completed on new admissions and ordered weekly. If there are any new areas of concern nursing would fill out the form completely. There was a section to mark if no new areas of concerns are applicable. Once the

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assessment was done then nursing will sign it off on the TAR. The [U.S. FOIA (b) (6)] further stated that the [NJ Exec Order 26.4b1] assessment was reviewed by multiple disciplines in the facility. That was how we communicate about the resident's [NJ Exec Order 26.4b1]

On 02/27/24 at 11:15 AM, the survey team met with the [U.S. FOIA (b) (6)], for the Exit Conference and there was no additional information provided by the facility.

A review of the facility's Prevention of Pressure Injury policy, dated 2001, revised 6/2023 included:
Policy: The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors.
Section "Monitoring": #1) Evaluate, report and document potential changes in the skin. #2) review the intervention and strategies for effectiveness on an ongoing basis.

2. On 02/14/24 at 11:26 AM, during the initial tour, the surveyor observed Resident #71 in their room laying in bed. Resident #71 stated he/she was [NJ Exec Order 26.4b1] and requested for the nurses to administer [NJ Exec Order 26.4b1]. The resident further stated that the facility [NJ Exec Order 26.4b1]. The resident stated that resident informed the [U.S. FOIA (b) (6)]) that his/her [NJ Exec Order 26.4b1], and had [NJNJ Exec Order 26.4b1]

On that same date and time, Resident #71 stated that he/she reported to the floor nurse that their [NJ Exec Order 26.4b1]. The resident claimed that it was [NJ Exec Order 26.4b1] without the

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NJ Exec Order 26.4b1 as well as NJ Exec Order 26.4b1

The surveyor reviewed the hybrid medical records for Resident #71.

The Resident's AR reflected that Resident #71 was admitted to the facility with diagnosis which included NJ Exec Order 26.4b1

The quarterly MDS dated NJ Exec Order 26.4b1, reflected the resident's NJ Exec Order 26.4b1, and that there was NJ Exec Order 26.4b1 The assessment indicated that the resident had a BIMS score of [redacted] out of 15 which reflected that the resident's NJ Exec Order 26.4b1

A review of the resident's CP revealed that there was no care plan to reflect the care for resident's NJ Exec Order 26.4b1.

A review of resident's consultation in the electronic medical record reflected that the resident was seen and examined by the [redacted] with NJ Exec Order 26.4b which included. [redacted]

A review of the resident's medical records revealed that there was no documentation that

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F 684	Continued From page 22 reflected resident's NJ Exec Order 26.4b1. A review of Resident #71's Interdisciplinary Progress notes dated NJ Exec Order 26.4b1 indicated in the Clinical review note that Resident #71's NJ Exec Ord On 02/16/24 at 11:35 AM, the surveyor interviewed the U.S. FOIA (and requested a copy of Resident #71's NJ Exec Order 26.4b1 form. A review of NJ Exec Order 26.4b1 form with U.S. FOIA (b) both the surveyor and the U.S. FOIA (noted date of occurrence NJ Exec Order 26.4b, there was no follow up noted with NJ Exec doctor concerning resident's NJ Exec Order 26. The U.S. FOIA (stated that it was a possible that it was an oversight. The U.S. FOIA (further stated that the turn around time for follow up was 7-10 days, and the U.S. FOIA (acknowledged that it was not done. On 02/16/24 at 10:00 AM, the surveyor interviewed LPN#2 on the NJ Exec floor who was responsible for care planning. The LPN stated he was not good at care planning. The LPN acknowledged Resident #71 should have care planned for NJ Exec Order 26.4b1 At the same time, the surveyor interviewed the U.S. FOIA (b) (6)) who had acknowledged NJ Exec Order 26.4b1 should have been added to care plan. On 02/16/2024 at 10:30 AM, the surveyor interviewed the U.S. FOIA (who stated tha NJ Exec Order 26.4b should have been in the care plan. On 02/20/2024 at 11:07 AM, the surveyor reviewed the progress notes which reflected that the resident was seen and examined by an NJ Exec	F 684		

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doctor, and with recommendation to follow up with an [NJ Exec] specialist.

On 02/20/2024 at 11:55 AM, during an interview, Resident #71 stated they were seen by the [NJ Exec] doctor on [NJ Exec Order 26.4b1].

On [NJ Exec Order 26.4b] at 12:30 PM, the surveyor observed Resident #71 in bed with then eyes closed and their lunch tray on overhead table untouched.

On that same date and time, the surveyor interviewed the [U.S. FOIA] who delivered the tray. The [U.S. FOIA] stated that Resident #71 told her to leave the tray on the table. The [U.S. FOIA] informed the surveyor that the resident had no special needs and that she was aware of anything special about the patient needs.

On 02/22/2024 at 12:28 PM, the surveyor interviewed the [U.S. FOIA (b) (6)] regarding the facility's practice with regard to [NJ Exec] consult. The [U.S. FOIA (b) (6)] stated that he goes through all the patient chart monthly to find out who needs or have seen the [NJ Exec] doctor. He further stated that there was no policy or report that being generated.

On 02/22/2024 at 12:39 PM, the surveyor interviewed the [U.S. FOIA (b) (6)] The [U.S. FO] stated that he generate resident roster and sent to the [NJ Exec] doctor via email monthly.

A review of the Census (resident's assigned room while at the facility) line provided by administrator included the following:
[NJ NJ Exec Order 26.4b1] = Resident #71 was in room [NJ Exec Order]
[NJ Exec Order 26.4b] - Room moved from [NJ Exec Ord] to room [NJ Exec Ord]
[NJ Exec Order 26.4b] - [NJ Exec Order 26.4b1] completed following day

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HEALTH CENTER AT BLOOMINGDALE	255 UNION AVE BLOOMINGDALE, NJ 07403

(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 684	Continued From page 24 after resident moved. NJ Exec Order 26.4b1 located in NJ Exec Ord where patient was last physically in the room on NJ Exec Order 26.4b. On 02/23/24 at 12:45 PM, the surveyor interviewed the contracted U.S. FOIA (b) (6)) of the facility. The U.S. FOIA stated that yesterday, while doing her second check on room NJ Exec Ord for possible admission attempted to open drawer, she was unable to open, and she placed her hands underneath and found the NJ Exec Order 26.4b1. On 02/23/24 at 10:42 AM, the survey team met with the U.S. FOIA (b) and U.S. FOIA (b) The surveyor notified the facility management of the above findings and concerns regarding Resident #71. The U.S. FOIA (b) and U.S. FOIA stated that the U.S. FOIA found the NJ Exec Order 26.4b1 in the old room yesterday late afternoon. On 02/23/24 at 12:18 PM, the survey team met with the U.S. FOIA (b) and U.S. FOIA (b) U.S. FOIA (b) acknowledged that the resident's care plan was updated after surveyor's inquiry. The U.S. FOIA stated that the U.S. FO and nurses should properly assess the resident for NJ Exec Orde review the consult, and documents in the progress notes. The U.S. FOIA further stated that she was not sure where was the breakdown of the process why the assessment did not reflect of the NJ Exec Order 26.4b1. NJAC 8:39-27.1 (a)	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited	F 688		4/15/24

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F 688	Continued From page 25	F 688		

range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to ensure that the NJ Exec Order 26.4b1 was consistently applied according to the physician's order. This deficient practice was identified for one (1) of three (3) residents reviewed for the NJ Exec Order 26.4b1 (ROM), Resident #80.

This deficient practice was evidenced by the following:

On 02/14/24 at 10:54 AM, the surveyor observed Resident #80, awake and NJ Exec Order 26.4b1. The resident did not have a NJ Exec Order 26.4b1 at the time of observation. There was a NJ Exec Order 26.4b1 of the nightstand table.

On 02/15/24 at 01:07 PM, the surveyor and the U.S. FOIA (b) (6)) went inside the resident's room. The U.S. FOIA informed the surveyor that Resident #80 was in the activity in the dining

What corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Resident # 80 NJ Exec Orde were immediately placed on.

How the facility will identify other residents having the potential to be affected by the same deficient practice.

Residents with adaptive equipment have the potential to be affected. An audit was done for residents with adaptive devices and no other resident were affected.

What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur.

Director of Nursing and Educator provided

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F 688	Continued From page 26 area. Then both the surveyor and the U.S. FOIA went to the dining area and both observed that the resident was seated in a NJ Ex Order 26.4b wheelchair with NJ Exec Order 26.4b1. At this time, the U.S. FOIA informed the surveyor that the resident had NJ Exec Order 26.4b1 and that the NJ Exec Order 26.4b1 should been used at that time. Later on, both the surveyor and the U.S. FOIA went back to the resident's room. The U.S. FOIA stated that he would try to find the NJ Exec Order 26.4b1 and that the last time he saw it was on top of the nightstand table when he worked " NJ Exec Order 26.4b1 at 3-11 shift. He also confirmed that on NJ Exec Order 26.4b 3-11 shift he did not find the resident had it on when he was about to remove it at night as per the physician's order. The U.S. FOIA looked inside the resident's room NJ Exec Order 26.4b1 and it was not found. On 02/15/24 at 01:10 PM, the surveyor observed U.S. FOIA asked the assigned U.S. FOIA (b) (6)) of the resident regarding the NJ Exec Order 26.4b1 , and both went back to the resident's room to look for the NJ Exec Orde At this time, the U.S. FOIA found the NJ Exec Order 26.4b1 inside the second drawer of the nightstand table. The U.S. FOIA told the U.S. FOIA that she did not know that was the one NJ Exec Order 26.4b1 that they were looking for. The U.S. FOIA further stated, "I thought you were looking for the NJ Exec Order 26 " The U.S. FOIA stated that the resident did not NJ Exec Order 26.4b1 and the U.S. FOIA did not know where the NJ Exec Orde was. The U.S. FOIA further stated that this was not the first time that the resident NJ Exec Order 26.4b1 because she did not see that the resident NJ Exec Order 26.4b1 for a long time (U.S. FOIA was unable to state specific time period).	F 688	in-service education to nursing staff regarding scheduled, application and documentation of adaptive devices. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of systemic change. An observation audit will be completed during random unit rounds for up to six patients with adaptive equipment weekly for one month, then twelve residents monthly for an additional two months. The audit will capture the observation of the assistive device is in place. Results of the audit will be reviewed with the team at the monthly Quality Assurance Performance Improvement committee for a period of three months. After discussion any changes to the original plan of correction will be revised and reviewed at the next QAPI meeting.	

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F 688	Continued From page 27	F 688		

The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #80 as follows:

According to the Admission Record (admission summary), Resident #80 was admitted to the facility with a diagnosis that included but was not limited to NJ Exec Order 26.4b1 [redacted]

The resident's comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of NJ Exec Order 26.4b revealed in NJ Exec Order 26.4b1 that the NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 showed that the resident's NJ Exec Order 26.4b NJ Exec Order 26.4b1 [redacted]

The personalized care plan with a focus on the resident's NJ Exec Order 26.4b1 [redacted] recent hospitalization date initiated on NJ Exec Order 26 with an intervention that included NJ Exec Order 26.4b1 [redacted] and NJ Exec Order 26 on

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F 688	Continued From page 28 in AM (morning) and off in PM (afternoon) as tolerate initiated on [redacted]. Review of the [redacted] Order Summary Report showed an order date of [redacted] for a "patient (also known as a resident) to be [redacted] and [redacted] during the day and [redacted] of night. Please check for [redacted] before each placement one time a day and remove per schedule." The above order for [redacted] was transcribed to the [redacted] electronic Treatment Administration Record (eTAR) and was signed with a checkmark at 10:00 AM as applied and removed at 9:00 PM from [redacted] through [redacted]. There were two [redacted] out of [redacted] days that it was [redacted]. Further review of hybrid medical records revealed that there was no documentation that the [redacted] were [redacted] on [redacted]. On 02/23/24 at 10:42 AM, the survey team met with the U.S. FOIA (b) (6) [redacted]) and U.S. FOIA (b) (6) [redacted]). The surveyor notified the facility management of the above concerns and findings. On 02/26/24 at 12:04 PM, the survey team met with the [redacted] and [redacted] There was no additional information provided by the facility management. NJAC 8:39-27.1(a); 27.2(m)	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices	F 689		4/15/24

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F 689	Continued From page 29 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of other pertinent facility provided documentation, the facility failed to a) ensure a root cause analysis conclusion was included routinely in a resident's NJ Exec Order 26.4b1 report, b) implement the resident's care plan NJ Exec intervention, and c) ensure that NJ Exec assessments were done according to facility's practice and policy, and standard of practice, for one (1) of three (3) residents reviewed for NJ Exec C (Resident #80). This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized	F 689	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 80 was reassessed and immediately provided a NJ Exec Order 26.4b1 on the other side of her bed as per care plan. The care plan was reviewed, and no further revisions were entered into the record, and a NJ Exec assessment was completed. The pattern of NJ Exec C was reviewed and captured under Quality Assurance Performance Improvement regarding the root cause of the NJ Exec C How the facility will identify other residents having the potential to be affected by the same deficient practice. Any resident with the potential or actual falls has the potential to be affected. Residents with actual falls were reviewed to determine their interventions were noted in place and a fall evaluation was completed, no other residents were identified.	

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F 689	Continued From page 30 physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 02/14/24 at 10:54 AM, the surveyor observed Resident #80, awake, NJ Exec Order 26.4b1 with a NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 in use. On 02/15/24 at 8:18 AM, the surveyor asked the U.S. FOIA (b) (6)) for the resident's NJ Exec Order investigations for the NJ Exec Order The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #80 as follows: According to the Admission Record (admission summary), Resident #80 was admitted to the facility with a diagnosis that included but was not limited to NJ Exec Order 26.4b1	F 689	What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. The Educator provided additional in-service to nursing staff regarding Accident and Incident protocol that included completion of the fall risk evaluation and implementing interventions. In addition, the leadership team will document the root cause analysis during the IDT meeting. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of systemic change. DON or designee will audit up to ten accident and incident reports weekly for a period of four weeks, then twenty reports monthly for an additional two months. The audit will capture that the report captures that a fall evaluation was completed, interventions are actively in place and a root cause is documented. Results of the audit will be reviewed with the team at the monthly Quality Assurance Performance Improvement committee for a period of three months. After discussion any changes to the original plan of correction will be revised and reviewed at the next QAPI meeting.	

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NJ Exec Order 26.4b1 [redacted]

The resident's comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of NJ Exec Order 26.4b revealed in NJ Exec Order 26.4b1 that the NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 showed that the resident's NJ Exec Order 26.4b1 [redacted]

The surveyor received from the U.S. FOIA (b) a total of six NJ Exec investigations. The provided six NJ Exec investigations were dated NJ Exec Order 26.4b1 [redacted] (3:55 PM and 8:30 PM). All six NJ Exec investigations were NJ Exec Order 26.4b1 [redacted]

The following were the immediate actions taken post fall from the provided fall investigations and care plan status:
NJ Exec Order 26.4b1 [redacted] =assessed NJ Exec Order 26.4b1 and NJ Exec Orde [redacted] to be placed.
A NJ Exec Order 26.4b1 was added as an intervention in the care plan with a created date of NJ Exec Order 26.4b1 [redacted].
NJ Exec Order 26.4b1 [redacted] =floor mats to be put in place.
NJ Exec Order 26.4b1 [redacted] were added as an intervention in the care plan with a created date of NJ Exec Order 26.4b [redacted].
NJ Exec Order 26.4b1 check initiated will suggest NJ Exec Order 26.4b [redacted] to the right side of the bed."
The care plan did not reflect a NJ Exec Orde check and NJ Exec Order 26 [redacted] to the right side of the bed. There was a

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F 689	Continued From page 32	F 689		

care plan intervention that was created on NJ Exec Order 26.4b for NJ Exec Order 26.4b1 consult for NJ Exec Order 26.4b1
There was a NJ Exec Order 26.4b1 check form that was provided for dates NJ Exec Order 26.4b and NJ Exec Order 26.4b. NJ Exec Order 26.4 =assessment completed and returned resident to bed.
There were no changes to the care plan.
NJ Exec Order 26.4b 3:55 and 8:30 PM=assessed for NJ Exec O NJ Exec Order 26.4b1 and NJ Exec Orde NJ Exec Order 26.4b1 screen for NJ Exec Order 26.4b1 w/c (wheelchair) trial to increase time NJ Exec Order 26.4b1 as added as an intervention in the care plan with a created date of NJ Exec Order 26.4b.

A review of the provided last NJ Exec Order 26.4b1 incidents and accidents (Risk Management) reports by the U.S. FOIA (b) showed that there was no root cause analysis documented for NJ Ex incidents dated NJ Exec Order 26.4b1

The Progress Notes (PN) showed the following:
1. Late Entry created on NJ Exec Order 26.4b the effective date of NJ Exec Order 26.4b1 that was electronically signed by Licensed Practical Nurse #1 (LPN#1, also known as the facility's U.S. FOIA (b) (6) which included that "the IDT (interdisciplinary) team met regarding resident's NJ Exec NJ Exec Order 26 to be placed to side of the bed and NJ Exec Orde consult for evaluation of NJ Exec Order 26.4b1
2. Late Entry created on NJ Exec Order 26.4, the effective date of NJ Exec Order 26.4, that was electronically signed by U.S. FOIA (b) (6) (also known as the facility's U.S. FOIA (b) (6)) which included that "The IDCT (interdisciplinary team) met to discuss the residents NJ Exec Resident #80 was noted laying on the NJ Exec Order 2 on the right side of the bed. Resident NJ Exec Order 26.4b1 staff what

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happened. NJ Exec Order 26.4b1. Resident has episodes of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 The intervention that is in place is working, plan of care as is to continue."

Further review of the resident's electronic medical records showed that there was no documentation of root cause analysis of the resident's NJ Ex incidents on NJ Exec Order 26.4b1 in the PN.

A review of the hybrid medical records showed that the last NJ Exec Risk Assessment NJ Exec Or) was done on NJ Exec Order 26

On 02/15/24 at 12:47 PM, the surveyor in the presence of another surveyor interviewed LPN#2. LPN#2 stated that he remembered the NJNJ Exec Order 26 NJ Exec Order 26.4b1 of the resident when the housekeeping staff informed him that the resident NJ Exec Order 26.4b1. LPN#2 stated that there was NJ Exec Order 26.4b1 in use at that time on the left side of the bed and there was none on the right side. He further stated that was why he recommended to put a NJ Exec Order 26 on the right side of the bed as a new intervention. LPN#2 also stated that he remembered that when he recommended to add a NJ Exec Order 26.4b to the right side of the bed, someone had told him that the resident should had NJ Exec as a previous intervention.

On that same day and time, LPN#2 confirmed that there was only NJ Exec Order 26.4b1 at the time of the incident on NJ Exec Order 26.4b and he did not know why it was not NJ Exec Order 26.4b1. He acknowledged that the facility should follow the care plan and previous intervention for NJ Exec Order 26.4b1

On 02/20/24 at 9:15 AM, the surveyor in the

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F 689	Continued From page 34	F 689		

presence of another surveyor interviewed the U.S. FOIA (b) (6)), and U.S. FOIA (b) (The U.S. FOIA (informed the surveyor that NJ Exe assessments were done upon admission, quarterly, and when there were NJ Exec Order 26.4b1. The U.S. FOIA (stated, "I don't think we do NJ Exe assessments every time there's a NJ Exe incident." The U.S. FOIA (further stated that NJ Exe assessments were done in the electronic medical record. Both the U.S. FOIA (b) and the U.S. FOIA (were unable to state the facility's policy regarding NJ Exe assessment, and both stated that they would get back to the surveyor.

At that same time, the surveyor notified the facility management of the above concerns and findings.

On 02/20/24 at 9:32 AM, the surveyor interviewed the U.S. FOIA (b) (6)). The U.S. FOIA (b) (6) stated that the NJ Exe assessment should be done quarterly corresponding to the MDS schedule and it should be done in the evaluation part of the electronic medical records. The U.S. FOIA (b) (6) indicated that she was not sure if the facility's practice was to do another NJ Exe risk assessment when there was a NJ Exe incident that happened.

At that same time, the surveyor then notified the U.S. FOIA (b) (6) of the above concerns. She did not have an answer as to why the last NJ Exec O was done on NJ Exec Order 2 when it should have been done quarterly.

On 02/20/24 at 9:57 AM, the surveyor interviewed LPN#3 regarding NJ Exe investigations. The LPN stated that the NJ Exe assessment done upon admission and readmission in evaluation part of the electronic medical record.

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HEALTH CENTER AT BLOOMINGDALE	255 UNION AVE BLOOMINGDALE, NJ 07403

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F 689	Continued From page 35	F 689		

On 02/20/24 at 10:36 AM, the surveyor interviewed LPN#2 regarding the [NJ Ex] assessments. The LPN stated that [NJ Exec O] done quarterly by the U.S. FOIA (b) (6) or the U.S. FOIA (b) (6) in the electronic medical record, in the evaluation section.

At this time, the surveyor asked LPN#2 to show the surveyor if the [NJ Exec O] was done quarterly. The surveyor then asked the LPN why the [NJ Exec O] last done was on [NJ Exec Order 2] and the LPN had no response.

On 02/23/24 at 10:42 AM, the survey team met with the [U.S. FOIA (b)] and [U.S. FOIA (b)] The surveyor notified the facility management of the above concerns and findings.

A review of the facility's Fall Risk Assessment Policy with a revised date of March 2018 that was provided by the [U.S. FOIA (b)] included that the nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information. Policy interpretation and implementation: upon admission, the nursing staff and the physician will review the resident's record for a history of falls, especially falls in the last 90 days and recurrent or periodic bouts of falling over time. ...Assessment data shall be used to identify underlying medical conditions that may increase the risk of injury from falls (such as osteoporosis).

On 02/26/24 at 12:04 PM, the survey team met with the [U.S. FOIA (b)] and [U.S. FOIA (b)] There was no additional information provided by the facility

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F 689	Continued From page 36 management. N.J.A.C. 8:39-27.1 (a); 33.1(d)	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		4/15/24

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F 690	Continued From page 37 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to consistently document NJ Exec Order 26.4b1 according to the physician orders. This deficient practice was identified for one (1) of two (2) residents reviewed for NJ Exec Order [redacted] (Resident #13) and was evidenced by the following. On 02/14/24 at 10:45 AM, during the initial tour, the surveyor did not observe the resident in the room. The resident's bed was at a NJ Exec Order 26.4b1 and the bedside table was at the foot of the resident's bed. On the side of the bed was an NJ Exec Order 26.4b1 [redacted] that appeared to have been administered completely. At 02:14 PM, the surveyor observed the resident in the NJ Exec Order 26.4b1 room with one of the NJ Exec Order 26.4b1 staff. Resident #13 greeted the surveyor. Resident #13 was seated in front of the NJ Exec Order 26.4b1 Director and was assisted by the NJ Exec Order 26.4b1 Aid. The surveyor reviewed the medical record for Resident #13. Resident #13's Admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Exec Order 26.4b1 [redacted]	F 690	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 13 was assessed, and supplemental documentation was added to record the NJ Exec Order 26.4b1. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents who require documentation of urinary output have the potential to be affected. An audit was completed, and no other residents were affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. In-service was provided by the facility educator to nursing staff regarding urine output documentation as well as order entry, to ensure that all patients with foley catheter or other patients on intake and output have supplemental documentation in place. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of	

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F 690	Continued From page 38 NJ Exec Order 26.4b1 [redacted] A review of Resident #13's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident had an [redacted]. The resident's care plan (CP) initiated on [redacted], included a focus that the resident was at risk for NJ Exec Order 26.4b1 [redacted] The CP interventions included monitor [redacted] for [redacted] and [redacted] which was initiated on [redacted]. A review of the Order Summary Report (OSR) for [redacted] reflected an order to monitor the resident's [redacted] every shift and document. The [redacted] Treatment Administration Record (TAR) revealed the [redacted] was not documented for the following days and shifts: [redacted]	F 690	systemic change. The results of audits will be reported to the monthly Quality Assurance Performance Improvement committee for 6 months. The unit manager will audit up to four resident records that require documentation of urinary output weekly for four weeks, then eight patients monthly for an additional two months. The audit will capture that output is measured and documented. Results of the audit will be reviewed with the team at the monthly Quality Assurance Performance Improvement committee for a period of three months. After discussion any changes to the original plan of correction will be revised and reviewed at the next QAPI meeting.	

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NJ Exec Order 26.4b to NJ Exec Order 26.4b all three shifts
NJ Exec Order 26.4b not applicable/hospital leave
NJ Exec Order 26.4b to NJ Exec Order 26.4b all three shifts

The OSR for NJ Exec Order 26.4b1 reflected an order to monitor the resident's NJ Exec Order 26.4b1 every shift and document.

The NJ Exec Order 26.4b1 TAR revealed the NJ Exec Order 26 was not documented for the following days and shifts:

NJ Exec Order 26.4b1
NJ Exec Order 26.4b to NJ Exec Order 26.4b all three shifts
NJ Exec Order 26.4b day shift and evening shift
NJ Exec Order 26.4b to NJ Exec Order 26.4b
NJ Exec Order 26.4b day shift and evening shift
NJ Exec Order 26.4b night shift
NJ Exec Order 26.4b not applicable/hospital leave
NJ Exec Order 26.4b all three shifts

The OSR for NJ Exec Order 26.4b1 reflected an order to monitor the resident's NJ Exec Order 26.4b1 every shift and document initiated on NJ Exec Order 26.4b.

The NJ Exec Order 26.4b1 TAR revealed the NJ Exec Order 2 was not documented for the following days and shifts:

NJ Exec Order 26.4b1:
NJ Exec Order 26.4b to NJ Exec Order 26.4b all three shifts

On 02/26/24 at 10:49 AM, during an interview with two surveyors, the U.S. FOIA (b) (6) NJ Exec Order 26.4b1 was documented in the point of care system and reported to the nurse. The nurse records the NJ Exec Orde into the electronic Medication Administration Record (eMAR).

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At that time, the U.S. FOIA (b) (6) confirmed that the output was not recorded in NJ Exec Order 26.4b1 and that it should have been.

In addition, the U.S. FOIA (b) (6) stated that the resident was hospitalized in NJ Exec Order 26.4b1 because of a NJ Exec Order 26.4 from the NJ Exec Order 26.4b1. The resident received NJ Exec Order care daily and the NJ Exec Order doctor saw the resident once a week who NJ Exec Order 26.4b1.

Furthermore, the U.S. FOIA (b) (6) stated that monitoring the resident's NJ Exec Order 26.4b1 was important to help monitor the resident's NJ Exec Order 26.4b1

On 02/26/24 at 12:05 PM, during a meeting with the survey team, the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6)), the surveyor discussed the concerns regarding missing NJ Exec Order 26.4b1 documentation for the resident fo NJ Exec Order 26.4b1.

At that time, the U.S. FOIA stated the NJ Exec Order 26.4b1 should have been monitored as per physician's order to ensure that there was no NJ Exec Order , assessment of the NJ Exec Or to indicate NJ Exec Order 26.4 and/or NJ Exec Order 26.4b1.

On 02/27/24 at 10:26 AM, during a follow-up meeting with the surveyors, the U.S. FOIA stated the supplementary documentation for the NJ Exec Order was a data entry error which led to the elimination of the area for documentation of the quantity.

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F 690	Continued From page 41 A review of the provided facility policy, Output, Measuring and Recording dated/revised in October 2010, under Steps in Procedure included section 8. Record the amount noted on the output side if the intake and output record. Record in mls (milliliters) and 9. Record the time the output was measured. A review of the provided facility policy; Emptying a Urinary Collection Bag dated revised in June 2023 under Documentation included: The following information should be recorded in the resident's medical record ... 1 The date and time the procedure was performed. 2 The amount of urine emptied from the drainage bag. 4. Character of the urine such as color ...	F 690		
F 692 SS=D	NJAC 8:39-27.1(a) 33.2 (c) 5 Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident	F 692		4/15/24

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F 692	Continued From page 42 preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, records review, and review of other facility documentation, it was determined that the facility failed to: a.) monitor the resident's NJ Exec Order 26.4b1 [redacted], b.) implement and monitor weekly NJ Exec Order 26.4 and c.) ensure the accuracy of a resident's NJ Exec Order who had a history of NJ Exec Order [redacted]. This deficient practice was identified for one (1) of three (3) residents reviewed for NJ Exec Order 26 (Resident #45) and was evidenced by the following: Reference: American Thyroid Association A review of the brochure of Thyroid Function Test included, -A high TSH (thyroid stimulating hormone) level indicates that the thyroid gland is not making enough thyroid hormone (primary hypothyroidism). -TSH level is low, usually indicates that the thyroid is producing too much thyroid hormone (hyperthyroidism). A review of the brochure of The relationship between thyroid and weight included the following: Thyroid hormone regulates metabolism in both animals and humans. Metabolism is determined	F 692	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 45 was NJ Exec Order 26.4b1 assessed, NJ Exec Order completed, NJ Exec Order 26.4b1 reviewed. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents who require nutritional supplementation and weekly weights have the potential to be affected. A review of residents who are monitored by the dietician were assessed and no other residents were affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. In-services provided to nursing staff by the facility educator and the dietitian regarding monitoring supplement intake, implementation, and monitoring of weekly weight, and ensuring the accuracy of	

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by measuring the amount of oxygen used by the body over a specific amount of time. If the measurement is made at rest, it is known as the basal metabolic rate (BMR). Patients whose thyroid glands were not working were found to have low BMRs, and those with overactive thyroid glands had high BMRs.
Since the BMR in the patient with hypothyroidism (see Hypothyroidism brochure) is decreased, an underactive thyroid is generally associated with some weight gain. The weight gain is often greater in those individuals with more severe hypothyroidism.
Since the BMR in patients with hyperthyroidism (see Hyperthyroidism brochure) is elevated, many patients with an overactive thyroid do, indeed, have some weight loss.

On 02/14/24 at 10:59 AM, the surveyor observed Resident #45 in their room. The resident stated he/she NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 but did not recall informing anyone of resident's preference.

On 02/15/24 at 11:59 AM, the resident stated that NJ Exec Order 26.4b1

The surveyor reviewed the hybrid (combination of paper and electronic) medical record for Resident #45.

The resident's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited t NJ Exec Order 26.4b1

resident weight.

How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of systemic change.

The unit manager or designee will audit up to ten records weekly for four weeks, then 20 weights monthly for an additional two months. The focus of the audit will include that weekly weights are captured for completion and if a re-weight is required, it is also completed as well.

The dietician or designee will audit up to five records weekly for four weeks, then 10 records monthly for an additional two months. Focus of the audit will include completion of supplement order and assessment for effectiveness.

Results of the audit will be reviewed with the team at the monthly Quality Assurance Performance Improvement committee for a period of three months. After discussion any changes to the original plan of correction will be revised and reviewed at the next QAPI meeting.

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NJ Exec Order 26.4b1

The resident's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ E out of 15, which indicated the resident was NJ Exec Order 26.4b1. Additionally, the MDS revealed that the resident required NJ Exec Order 26.4b1

A review of the resident's Care Plan (CP) initiated on NJ Exec Order 26.4, revealed the resident was at NJ Exec Order 26; need for NJ Exec Order 26.4b1; NJ Exec Order 26.4b1 ...The goal included that the resident would NJ Exec Order 26.4b1 .

Interventions included the following:
-NJ Exec Order 26.4b1
NJ Exec Order 26.4b1)
NJ Exec Order 26.4b1) initiated on NJ Exec Order 26.4b and discontinued on NJ Exec Orde.

The resident's CP included an intervention of weekly NJ Exec Order 26 for four (4) weeks that was initiated on NJ Exec Order 26.4b.

A review of the resident's NJ Exec Order 26 and Vital Summary revealed the following:
On NJ Exec Order 26.4b the resident NJ Exec Order 26.4b1
On NJ Exec Order 26.4b the resident NJ Exec Order 26.4b1
On NJ Exec Order 26.4 the resident NJ Exec Order 26.4b1
from NJ Exec Order 26.4b1

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[redacted] to NJ Exec Order 26.4b1.
On [redacted] the resident NJ Exec Order 26.4b1
On [redacted] the resident NJ Exec Order 26.4b1
On [redacted] the resident NJ Exec Order 26.4b1

Further review of the [redacted] data reflected, the [redacted] from [redacted], when the resident NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1, when the resident NJ Exec Order 26.4b1 indicated another NJ Exec Order 26.4b1 of approximately NJ Exec Order 26.4b1.

A review of the [redacted] Progress Note on [redacted] reflected the resident was [redacted] related to NJ Exec Order 26.4b1 [redacted] ... Recommendations included NJ Exec Order 26.4b1 [redacted] to deter further NJ Exec Order 26.4b1.

A review of the [redacted] Progress Note dated [redacted], included that the resident [redacted] for an NJ Exec Order 26.4b1 [redacted] The resident's [redacted], and that the resident had requested for the [redacted] to be discontinued. A recommendation of weekly [redacted] for four (4) weeks was added.

The Order Summary Report (OSR) from [redacted] to [redacted] revealed a weekly [redacted] order, one time a day every 7 days, which was initiated from NJ Exec Order 26.4b1.

A review of the electronic Medication Administration Record (eMAR) and electronic Treatment Record (eTAR) for NJ Exec Order 26.4b1 did not reflect an order for the NJ Exec Order 26.4b1

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The [NJ Exec Order 26.4b1] record revealed an order for the [NJ Exec Order 26.4b1] without documentation of administration, refusal or amount consumed from [NJ Exec Order 26.4b] to [NJ Exec Order 26].

On 02/20/24 at 12:31 PM, during an interview with the surveyor, Certified Nursing Aide #1 (CNA #1) stated that the task of obtaining daily and weekly [NJ Exec Order 26] of the residents were assigned to the CNAs through the nurses and that the task of obtaining monthly [NJ Exec Order 26] of the residents were assigned to the CNA through the Unit Manager.

At that time, the CNA #1 stated that the resident's [NJ Exec Order 26] were logged into the roster in the [NJ Exec Order] book. The [NJ Exec Order] book was located at the front desk of the nurses' station. CNA #1 also stated that once the [NJ Exec Order] was obtained and logged into the book, and the CNAs reported to the nurses who documented the [NJ Exec Order] into the eMR.

At that time, CNA #1 stated that the [NJ Exec Order 26.4] informs nursing who needed [NJ Exec Order 26.4b] and the nurses delegated the [NJ Exec Order] task to us, the CNAs.

On 02/20/23 at 12:38 PM, the surveyor requested for the [NJ Exec Order] book from the U.S. FOIA (b) (6)). At that time, the [U.S. FOIA (b) (6)] could not locate the [NJ Exec Order] book.

At that same time, the [U.S. FOIA (b) (6)] stated the daily and weekly [NJ Exec Order 26] were documented into the eMAR or the eTAR. The [NJ E] - [NJ Exec Order 26] were documented on the [NJ Exec Order] book as per the [NJ Exec Order 26.4b]

On 02/23/24 at 9:45 AM, during a follow-up visit with the resident, the surveyor observed the

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resident lying in bed. The resident stated that he/she had NJ Exec Order 26.4b1 The resident stated he/she was NJ Exec Order 26.4b1 and informed the surveyor that he/she NJ Exec Order 26.4b1

On 02/23/24 at 9:50 AM, during an interview with the surveyor, CNA #2 stated the resident had his/her breakfast.

On 02/23/24 at 9:52 AM, during an interview with the surveyor CNA #3 stated that the NJ Exec Orde were given by the nurses assigned to the medication cart.

On 02/23/23 at 9:54 AM, during an interview with the surveyor, the U.S. FOIA (b) (6)) stated that if an order was placed into the NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 of the electronic medical record (eMR) the order did not show on the eMAR for the nurses to administer or document on. The surveyor and the U.S. FOIA reviewed the resident's NJ Exec Order 26.4b1 record together.

At that time, the U.S. FOIA confirmed that there were no documentation of the administration, refusal and/or amount consumed of the NJ Exec Order 26.4b1 from NJ Exec Order 26.4b1, for the U.S. FOIA (b) (6) to monitor, and estimate the resident's NJ Exec Order 26.4b1 needs in accordance with standard of practice.

On 02/23/24 at 10:17 AM, during an interview with the surveyor, the U.S. FO stated that there was an issue with the NJ Exec Order 26.4b1 in NJ Exec Order 26.4b1 wherein the NJ Exec Order 26.4b1 were given

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during lunch and the resident NJ Exec Order 26.4b1 [redacted]. Since then, we adjusted for the NJ Exec Order 26.4b1 to be given in between meals.

At that time, the U.S. FC confirmed that the consumption was not being recorded. The U.S. FC stated she had spoken with the resident who wanted the NJ Exec Order 26.4b1 discontinued.

At that time, the U.S. FC stated she was unable to ensure the that the NJ Exec Order 26.4b1 intervention was appropriate without the proper documentation of the consumption of the NJ Exec Order [redacted]

In addition, the U.S. FC stated that the goal for the resident was to NJ Exec Order 26.4b1. The resident had a NJ Exec Order 26.4b1 and that the NJ Exec Order 26.4b1

At that time, the U.S. FC confirmed that her recommendation and PO were not followed since the weekly NJ Exec Order 26 were only completed once out of the four (4) weeks.

Furthermore, the U.S. FC stated she should have communicated with the nursing about the missing weekly NJ Exec Order 26 which was discontinued on NJ Exec Order 26.4b1. The U.S. FC also stated that the weekly NJ Exec Order 26 were to ensure the interventions against NJ Exec Order 26.4b1 were working.

The surveyor and the U.S. FC reviewed the resident's medical record for the NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 [redacted] of the resident together as followed:

On NJ Exec Order 26.4b1, the resident NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1, when the resident NJ Exec Order 26.4b1 which indicated a

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NJ Exec Order 26.4b1 of approximately NJ Exec Order

On NJ Exec Order 26.4b1 when the resident NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1, when the resident NJ Exec Order 26.4b1 which indicated another NJ Exec Order 26.4b1 of approximately NJ Exec Order 26.

At that time, the U.S. FO confirmed that she had not asked for NJ Exec Order 26.4b on NJ Exec Order 26.4b1

At that time, the U.S. FO stated that NJ Exec Order 26.4b1 were necessary to ensure the accuracy of NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1. The U.S. FO also stated that a resident's NJ Exec Order 26.4b1 had a NJ Exec Order 26.4b1 on the resident's NJ Exec Order

On 02/23/24 at 12:29 PM, during an interview with the surveyor, The U.S. FOIA (b) (6) stated he was aware of the resident's NJ Exec Order 26.4b1

On that same date and time, during a meeting with the surveyors, U.S. FOIA (b) (6) and U.S. FOIA (b) (6)), the surveyor discussed the concerns regarding the missing documentation for the NJ Exec Order 26.4b1, the incomplete weekly monitoring and the missing NJ Exec Order 26.4b for Resident #45.

On 02/23/24 at 12:53 PM, during an interview with the surveyor, the U.S. FOIA (b) (6) explained the process for NJ Exec Order 26. The U.S. FOIA (b) (6) stated that the NJ Exec would conduct an assessment for a resident, enter the orders for NJ Exec Order 26 and inform her. All residents newly admitted were NJ Exec Order 26.4 weekly for four (4) weeks. Residents that required weekly

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NJ Exec Order monitoring were entered by the NJ Exec herself.

At that time, the surveyor and the U.S. FOIA (b) (6) reviewed the hybrid medical record for the resident's NJ Exec Order monitoring. The physician's order (PO) reflected a NJ Exec Order order, one time a day every 7 days, which was initiated from NJ Exec Order 26.4b1. The hybrid medical record revealed that the resident was NJ Exec Order 26.4 once on NJ Exec Order 26.4b. The U.S. FOIA (b) (6) could not explain why the recommendation of the U.S. FO and the PO was not followed. The U.S. FOIA (b) (6) also confirmed there were no documented NJ Exec Order 26.4b on the hybrid medical record.

On 02/26/24 at 12:05 PM, during a meeting with the survey team, the U.S. FOIA stated that the order for the NJ Exec Order 26.4b1 was placed in the eMR and confirmed that the amount of consumption or refusal was not documented. A NJ Exec Order 26 was done on NJ Exec Order 26.4b and there was no NJ Exec Order change. An education was started, and the glitch in the eMR was fixed regarding documentation of the supplements.

On 02/27/24 at 10:08 AM, during a meeting with the survey team, the U.S. FOIA (b) and the U.S. FOIA (b) the U.S. FOIA (b) (6) stated that the NJ Exec Order 26.4b1 on NJ Exec Order 26.4 was identified by the U.S. FO who recommended the addition of the NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 was provided by NJ Exec Order and was given with the meal trays. The U.S. FOIA provided the meal tickets that reflected the NJ Exec Order 26.4b1 was included with the meal.

The U.S. FOIA also stated the resident's NJ Exec level was drawn on NJ Exec Order 26.4, and the NJ Exec Order 26.4b1

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F 692	Continued From page 51 NJ Exec Order 26.4b1 The NJ Exec Order 26.4b1 was on NJ Exec Order 26.4b1, which resulted in a level of NJ Exec Order 26.4b1, which resulted in NJ Exec Order 26.4b1. The U.S. FOIA stated that the NJ Exec Order 26.4b1 levels may have contributed to the NJ Exec Order 26.4b1. At that time, the U.S. FOIA confirmed that the NJ Exec Order 26.4b1 for the NJ Exec Order 26.4b1 were not documented, the weekly NJ Exec Order 26.4b1 should have been obtained and caught during the monthly meeting. Additionally the U.S. FOIA confirmed the NJ Exec Order 26.4b1 should have been done for Resident #45 who experienced NJ Exec Order 26.4b1 A review of the provided facility policy, Food and Nutritional Services, under Policy Interpretation and Implementation included 7. Nursing personnel, with the assistance of the food and nutrition services staff, will evaluate (and document as indicated) food and fluid intake of residents with, or at risk for, significant nutritional problems. 7(b) a nurse will evaluate the significance of such information and report it, as indicated to the attending physician and dietitian. A review of the facility provided Clinical Dietician Job Description under Responsibilities and Duties included the following: -Review all monthly and weekly weights, complete assessments and make modification to the nutrition plan of care as clinically indicated. NJAC 8:39-27.1(a),27.2(a)	F 692		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		4/15/24

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F 755	Continued From page 52 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a) maintain consistent documentation of accounting of backup controlled substance inventory, b) ensure accurate accounting and reconciliation of backup controlled substances,	F 755	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The automated system was counted and	

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F 755	Continued From page 53 and c) ensure that the facility management was notified of the identified discrepancies in the backup controlled substances according to the facility's practice, policy, and standard of practice. This deficient practice was identified in one (1) of two (2) medication storage rooms during the medication storage review. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. On 02/20/24 at 10:14 AM, the surveyor	F 755	inventoried immediately and there were no discrepancies, and the count was reconciled without discrepancy. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents who require a medication out of the automated system have the potential to be affected. There were no patients affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. The pharmacy consultant provided an in-service to nursing leadership. The facility educator provided an in -service to the licensed nurses regarding back-up medications and daily count. to ensure that the facility maintain consistent documentation of accounting of back up controlled substances and identified discrepancies in adherance of facility policy and standard practice. A binder was placed back next to the automated medication system to document the narcotic count. The Director of Nursing (DON) or designee to audit back-up medication system four times weekly for four weeks, then 10 random days monthly for an additional two months. The audit will capture the documentation of the narcotic	

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F 755	Continued From page 54 interviewed the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)) regarding the facility's routine controlled backup medications (meds) monitoring and accounting. Both the U.S. FOIA (b) and the U.S. FOIA (b) (6) stated that the routine counting of backup controlled meds was done this morning. The U.S. FOIA (b) (6) stated that the counting of backup controlled meds is done every shift. The U.S. FOIA (b) (6) further stated that there was no accountability or log to show that the routine monitoring and counting of controlled backup meds were done, and there was no printed report. On that same date and time, the U.S. FOIA (b) (6) stated that if there was a discrepancy, it will show in the automated/electronic (a/e) system. The surveyor then asked for a printout of today's count of controlled backup meds from the a/e system and the U.S. FOIA (b) (6) stated that she would get back to the surveyor. On 02/21/24 at approximately 11:08 AM, during an inspection of the 2nd-floor med room with the use of an a/e system for controlled backup meds, the surveyor observed both the U.S. FOIA (b) (6) and the U.S. FOIA (b) on-the-spot count and there was no discrepancy noted. On that same date, during an interview with the surveyor, the U.S. FOIA (b) (6) in the presence of the U.S. FOIA (b) (6) stated that on weekends, it was the responsibility of the supervisors to make sure that the daily counting and monitoring of backup controlled meds are done even though there was no accountability and documents that will show that the process was done.	F 755	count, that the system was reconciled, and that if there were discrepancies, they were reconciled. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of systemic change. The Director of Nursing will report the results of the audit to the team at the monthly Quality Assurance Performance Improvement committee for a period of three months. After discussion any changes to the original plan of correction will be revised and reviewed at the next QAPI meeting.	

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At that same time, the surveyor asked the [redacted] and the [redacted] if they had encountered or received reports of discrepancy and what the facility's process about discrepancies identified with backup controlled meds in the a/e system. Both the [redacted] and the [redacted] stated that it would show in the machine that there is a discrepancy, and it would be them ([redacted] and [redacted]) who would fix the discrepancy shown in the monitor of the a/e system. The surveyor then asked the [redacted] and [redacted] how about the weekend, and the days when both of them do not work, who will be responsible for the discrepancy. Both stated that it would be fixed when both of them come back on Monday or the following day when they report to work.

Furthermore, the surveyor asked both the [redacted] and the [redacted] if they had to notify the [redacted]) of the discrepancy that was identified and corrected by both of them and if there was a report that had to be generated to show the investigation done for the discrepancy. The [redacted] stated that as far as she knew, she did not need to notify the [redacted] of the discrepancy, and no report was done because everything was in the a/e system.

Furthermore, the surveyor asked again for the printed report to show that the daily monitoring and counting of backup controlled meds was done.

On 02/21/24 at 11:48 AM, the surveyor asked the [redacted] and the U.S. FOIA (b) (6) for the facility's policy regarding controlled meds and the report of any discrepancy for the last six months.

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On 02/21/24 at 12:52 PM, the [U.S. FOIA (b)] provided a copy of the Discrepancy/User Report for the date range of 9/01/23-02/21/2024 and there were discrepancies in the report.

On 02/21/24 at 01:09 PM, the surveyor met with the [U.S. FOIA (b)] and [U.S. FOIA (b)] The surveyor asked the facility management about their process of monitoring and accounting for controlled backup meds. Both the [U.S. FOIA (b)] and the [U.S. FOIA] were unable to state the facility's process and policy.

On that same date and time, the surveyor asked the facility management what will be the expectations and standard of practice if there were a backup controlled meds discrepancy. Both the [U.S. FOIA (b)] and the [U.S. FOIA] stated that the discrepancy should be reported immediately to them ([U.S. FOIA (b)] and [U.S. FOIA (b)] fill out a form, and do the investigation. Both the [U.S. FOIA] and the [U.S. FOIA (b)] acknowledged that they were unaware of the discrepancies that were printed in the report and there was no accountability for routine monitoring and accounting of backup controlled meds until the surveyor's inquiry.

At this time, the surveyor also notified the facility management that the provided discrepancy report showed that on 01/04/24 at 7:54 AM there was a discrepancy noted for Alprazolam (an antianxiety med) 0.5 milligram (mg) that was corrected by the [U.S. FOIA (b)] and there was no witness.

On 02/23/24 at 10:42 AM, the survey team met with the [U.S. FOIA (b)] and [U.S. FOIA (b)] The surveyor notified the facility management of the above concerns and findings. The facility management acknowledged that they were not aware of the discrepancies that happened in the last six

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months and had no accountability for the routine counting of controlled backup meds in the a/e system. The [redacted] stated that [redacted] had a super user identification that could open the a/e system backup machine for controlled meds without the presence of another nurse/witness which the facility management found out after the surveyor's inquiry. The [redacted] provided documentation that the Alprazolam was accounted for and the discrepancy was resolved.

At that same time, both the [redacted] and the [redacted] acknowledged that there should be routine monitoring and accounting for the backup controlled meds and they should be notified of the discrepancies to make sure that proper investigation will be done.

A review of the facility's Controlled Substances Policy with a revised date of June 2023 that was provided by the [redacted] included that the facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled meds. Policy interpretation and implementation included that controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift. Controlled meds are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together. Any discrepancies in the controlled substance count are documented and reported to the Director of Nursing Services (DNS) immediately. The DNS investigates all discrepancies in controlled med reconciliation to determine the cause and identify any responsible parties and reports the findings to the Administrator. The DNS consults with the provider pharmacy and the Administrator to

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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 755	Continued From page 58 determine whether further legal action is indicated. Automated/Electronic (a/e) Systems that includes narcotics-this system maintains a constant inventory as each nurse removes or adds medications. An alert is triggered on the screen when the count does not reconcile. In the event of such an alert (e.g. discrepancy, miss-count), the discrepancy must be reconciled. On 02/26/24 at 12:04 PM, the survey team met with the [redacted] and [redacted] There was no additional information provided by the facility management. NJAC 8:39-29.4(k)	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication observation conducted on 02/16/23, the two (2) surveyors observed four (4) nurses administer medications to five (5) residents. There were 32 opportunities, and two errors were observed which resulted in a medication error rate of 6.25%. This deficient practice was identified for two (2) of six (6) residents (Resident #22 and #354), that was administered by two (2)	F 759	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #354 had their order clarified for [redacted] and the LPN #2 received education regarding the transcription and administration of the order. Resident #22 received the correct [redacted] dose and LPN#1 received coaching directly regarding medication	4/15/24

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	315348	A. BUILDING _____ B. WING _____	C 03/08/2024

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F 759	Continued From page 59 of four (4) nurses. This deficient practice was evidenced by the following: A review of the manufacturer's specifications for Cosopt PF under section 17.4 Handing the Single-Use Container included: COSOPT PF is a sterile solution that does not contain a preservative. The solution from one individual unit is to be used immediately after opening for administration to one or both eyes. Since sterility cannot be maintained after the individual unit is opened, the remaining contents should be discarded immediately after administration. A review of the manufacturer's specifications for Cosopt under section 11 Description included: COSOPT is supplied as a sterile, clear, colorless to nearly colorless, isotonic, buffered, slightly viscous, aqueous solution ... Benzalkonium chloride 0.0075% is added as a preservative. 1. On 02/16/24 at 8:27 AM, the surveyor observed the Licensed Practical Nurse #1(LPN #1) prepare medications (meds) for Resident #22. The meds included a physician's order of NJ Exec Order 26.4b1 give 1 tablet by mouth one time a day for NJ Exec Order 26.4b1 with an order date of NJ Exec Order 26. At that time, the surveyor observed the LPN #1 pour NJ Exec Order 26.4b1 into a med cup for administration to Resident #22. LPN #1 informed the surveyor that the container of NJ Exec Order 26.4b1 was a house stock (facility	F 759	administration. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents who receive medications have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. Facility educator completed Medication Pass in-service with Licensed Practical Nurse 1 and Licensed Practical Nurse 2. Facility educator will completed medication pass observation/ training to all licensed nurses to ensure that the facility adhere to regulation regarding medication error. Facility educator/Supervisors or designee will conduct weekly medication pass observation for up to two random nurses for four weeks, then six nurses monthly for a period of two months. The medication pass observation will capture medication preparation and administration of the medication ordered by the physician. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of	

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F 759	Continued From page 60 supply) bottle. At 8:45 AM, LPN #1 confirmed with the surveyor that she was ready to administer the resident's meds and walked toward the resident's room threshold. At 8:46 AM, the surveyor stopped the med pass observation at the resident's room threshold and asked LPN #1 to walk back to the med cart parked at the hallway. At that time, the surveyor and the LPN #1 reviewed the electronic Medication Administration Record (eMAR) against the house stock bottle from which the Vitamin D3 1,250 mcg was poured from. At that time, LPN #1 confirmed she had poured the wrong dose and recognized the physician order was for Vitamin D3 25 mcg as opposed to the poured dose of 1,250 mcg. A review of the pharmacy provider invoice dated 01/29/24 revealed an order for six (6) bottles of Vitamin D3 (25 mcg) 1000 IU was shipped to the facility. A review of LPN #1's most recent competency for Medication Pass dated 02/02/24, conducted by the U.S. FOIA (b) (6)) reflected that LPN #1 had passed the facility's competency assessment without a concern. 2. On 02/16/23 at 9:09 AM, the surveyor observed LPN #2 prepare meds for Unsampled Resident #354. The meds included a physician order of NJ Exec Order 26.4b1	F 759	systemic change. The Director of Nursing will report the results of the observations to the team at the monthly Quality Assurance Performance Improvement committee for a period of three months. After discussion any changes to the original plan of correction will be revised and reviewed at the next QAPI meeting.	

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F 759	Continued From page 61	F 759		

NJ Exec Order 26.4b1

NJ Exec Order 26.4b1

Wait NJ Exec Order 26.4b1 between NJ Exec Order 26.4b1, with an order date of NJ Exec Order 26.4.

At that time, the surveyor observed LPN #2 pull an NJ Exec Order 26.4b1 from an unlabeled clear plastic bag that contained NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 med had a pharmacy label which indicated it was for Unsampled Resident #354, and the name of the med, NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 observed by the surveyor was a NJ Exec Order 26.4b1 bottle that did not have a pharmacy label to indicate for which resident it belonged to, nor did it indicate the name of the med. The surveyor observed the manufacturer's label on the NJ Exec Order 2

At 9:18 AM, LPN #2 confirmed with the surveyor that he was ready to administer the resident's meds, turned and stepped into the threshold of the Resident's door. The surveyor stopped the med pass observation.

At 9:20 AM, the surveyor and LPN #2 reviewed the bottle of NJ Exec Order 2 at the med cart. LPN #2 confirmed with the surveyor that the bottle of NJ Exec Order 2 did not have a label from the pharmacy that indicated the name of the resident or the med. LPN #2 informed the surveyor that he had labeled the date NJ Exec Order 26.4b, when it arrived from the pharmacy.

At that time, the surveyor asked LPN #2 if the med should be labeled with the resident's name and the name of the med since NJ Exec Order 26.4b1 was not the same as NJ Exec Order 26

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At that time, LPN #2 stated he would not administer the med to the resident and would call the pharmacy to confirm if the med was correct and inquire about receiving the [redacted] for the resident.

The surveyor reviewed the medical record for Unsampled Resident #354.

A review of the Resident's Admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted].

Resident's most recent admission Minimum Data Set (aMDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that [redacted].

A review of the resident Order Summary Report (OSR) that were active as of [redacted], indicated the resident had an [redacted].

A review of LPN #2's most recent competency for Medication Pass dated [redacted], conducted by the [redacted] reflected that LPN #2 had passed the facility's competency assessment without a concern.

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At 10:26 AM, the surveyor called the [US FOIA (b)(6)] for the facility and left a message.

On 02/16/24 at 10:28 AM, in the presence of the [U.S. FOIA (b) (6)]) and the [U.S. FOIA (b) (6)]) the surveyor discussed the concerns regarding the med administration observation concerns.

At 10:29 AM, in the presence of the surveyor and the [U.S. FOIA (b) (6)] the [U.S. FOIA] stated that the expectation and the policy were that the nurses read, and checked the eMAR and the label to ensure the meds administered were correct before administration. The [U.S. FOIA] also stated that the policy required all meds were labeled. The medication bottle itself should have had an identifier to ensure the right med was administered to the correct resident.

At that time, the [U.S. FOIA] stated she would investigate as to why the resident's [NJ Exec Order 2] was not labeled and the reason why the [NJ Exec Order 2] the active inventory for the resident instead of the physician order [NJ Exec Order 26.4b1]

On 02/20/24 at 8:57 AM, during a meeting with the surveyors, the [U.S. FOIA (b) (6)] the [U.S. FOIA] stated that Unsampled Resident #354 came from the hospital with an order for [NJ Exec Order 2] and that the [NJ Exec Order 26.4b1] was a transcription error made by the nurse and when a nurse is unsure a clarification call to the prescriber was expected from the transcribing nurse. The [U.S. FOIA] stated at that time, the facility did not have a process to check all orders entered within the 24-hour period and that they were considering adding a second check.

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At that time, the [redacted] addressed the concern regarding the missing label for the [redacted] for Unsampled Resident #354. The [redacted] stated the med came from the hospital, and upon receiving a med from the hospital the facility's nurses were expected to ensure a label with the resident's name was on the bottle. The [redacted] also stated that the bottle had a label when received from the hospital but was unsure when the label had fallen off or was ripped off.

At that time, the [redacted] addressed the concern regarding Resident 22's [redacted] and stated that LPN #2 was [redacted] and admittedly picked up the wrong dose for administration during the med pass observation. The [redacted] stated the correct dose was available in the med cart.

At that time the [redacted] confirmed that both nurses did not follow the expectation or the policy for med pass administration.

A review of the facility provided policy; Administering Med dated/revised in April 2019, under Policy Interpretation and Implementation, included the following:

4. Meds are administered in accordance with prescriber orders, including any required time frame.

10. The individual administering the med checks the label THREE (3) times to verify the right resident, right med, right dosage, right time and write method (route) of administration before giving the med.

A review of the facility provided policy; Med Orders dated/revised in November 2014, under Recording Orders included:

1. Med Orders - When recording orders for

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F 759	Continued From page 65 meds specify the type, route, dosage, frequency, strength, and the reason for administration. A review of the facility policy provided; Accepting Delivery of Meds dated/revised in February 2021, under Policy heading included: 2. Any errors noted in receiving med shall be brought to the attention of the pharmacist and director of nursing services. The Policy and Interpretation and Implementation included: 2. Before signing to accept the delivery, the nurse must reconcile the med in the package with the delivery ticket or order receipt. A review of the facility policy provided; Labeling of Med Containers dated/revised in April 2019 reflected under Policy Statement, that all medications maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations. The Policy Interpretation and Implementation included the following: 3. Labels for individual resident meds include all necessary information such as: a) The resident's name. d) The name, strength, and quantity of the drug. f) The date that the medication was dispensed. NJAC 8:39-11.2 (b), 29.2 (d), 29.4(a)	F 759		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		4/15/24

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F 812	Continued From page 66 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to store potentially hazardous foods in a manner to prevent food borne illness as evidenced by the following: On 02/14/24 at 9:55, in the presence of the U.S. FOIA ([redacted]) the surveyor observed the following: 1. In the freezer, the surveyor observed a pack of opened manufactured Cheese Omelet a bag of crunchy fish fillets, and a bag of tot potatoes. All were unlabeled and not dated with expiration or open dates. The U.S. FOIA manager was unable to say when the package was received, opened, or the expiration date. 2. The Manual counter attached can opener and holder and blade unit was unclean with wipeable by the U.S. FOIA with sticky brown substance and crumbs. The U.S. FOIA acknowledged that it needed to be cleaned.	F 812	What corrective action will be accomplished for those found to have been affected by the deficient practice. The foods observed that were unlabeled with dating were discarded immediately from the freezer. The can opener was immediately cleaned, and the blade replaced. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents who receive food items from the facility kitchen have the potential to be affected. The remaining food in the freezer was checked and no other items were found to not be labeled.	

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F 812	Continued From page 67 On 02/15/24 at 11:34 AM, the surveyor interviewed the [U.S. FOIA (] who stated, "Having a dirty can opener can cause cross contamination of products being opened and can attract unwanted pests. It is cleaned daily but needs to be scrubbed prior to putting in the dishwasher." He further stated, "Food labeling is essential for movement of product and knowledge for the whole staff on when things will expire. It also prevents food born illnesses from expired or freezer burned food." At 02/23/23 at 10:23 AM, the surveyor discussed the kitchen concerns with the [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)]. A review of the facility's Cooks Job Description, Duties, and Responsibilities that was provided by the [U.S. FOIA] included: #3 All food is correctly labeled and dated. A review of the facility's Food Receiving and Storage Policy dated 2001 and revised 10/2017 that was provided by the [U.S. FOIA] included: Foods shall be received and stored in a manner that complies with safe food handling practices, #1) Food Services or other staff, will maintain clean food storage areas at all times, and #8) All foods stored in the refrigerator or freezer will be covered, labeled, and dated ('use by" date). On 02/26/23 at 12:33 PM, the survey team met for an Exit conference with [U.S. FOIA (b)] and the [U.S. FOIA (b] and there were no additional information provided by the facility management. NJAC 8:39-17.2(g)	F 812	What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. The food service director (FSD) provided in-services with dietary staff immedialtely to ensure that opened products are labeled and dated and can opener are kept clean. In-services/Education provided to all dietary personnel by the FSD on infection prevention and sanitation, labeling and dating of food in the freezer. FSD will complete weekly random observation audits for dating and labelling two times a week for four weeks, then four times monthly for an additional two months. The observation audits will capture review of dating and labeling as well as visual inspection of the can opener. FSD will inspect can opener twice a week for cleanliness for four weeks, then four times monthly for two months. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of systemic change. The Food Service Director will report the results of the observation audits that will be reviewed with the team at the monthly	

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F 812	Continued From page 68	F 812	Quality Assurance Performance Improvement committee for a period of three months. After discussion any changes to the original plan of correction will be revised and reviewed at the next QAPI meeting.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		4/15/24

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F 880	Continued From page 69 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview, and review of	F 880	What corrective action will be accomplished for those found to have been affected by the deficient practice.	

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F 880	Continued From page 70 pertinent facility documents, it was determined that the facility failed to follow appropriate infection control practices for performing hand hygiene to decrease the possibility of spreading infection. This deficient practice was observed during dining observation with four (4) of four (4) facility staff in one (1) of three (3) dining areas, in accordance with the facility's practice, policies, and Centers for Disease Control and Prevention (CDC) guidelines for infection control. This deficient practice was evidenced by the following: According to the CDC Hand Hygiene in Healthcare Settings, Hand Hygiene Guidance, last reviewed on January 30, 2020, included that Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient Before performing an aseptic task or handling invasive medical devices Before moving from work on a soiled body site to a clean body site on the same patient After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal. On 02/21/24 at 8:07 AM, the surveyor observed the 1st-floor dining area with 25 residents seated for breakfast being served with steam table food assisted by multiple staff wearing gloves while serving food. The U.S. FOIA (b) (6) [redacted] informed the surveyor that once a month residents were being served with steam table food for breakfast and today was that	F 880	One-to-one hand hygiene education with competency was provided to each of the staff members who assisted in the dining room. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents being served in the dining room have the potential to be affected. No residents were affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. The Facility educator/Infection Preventionist (IP) /Designee provided an in- service and return demonstration competency to staff who assist during meal services related to hand hygiene and PPE use of gloves. The dining program education guide was reviewed and revised to expand on glove use. The Facility Educator/Infection Preventionist/Designee will observe audits up to three meals each week for a period of four weeks, then six meal observations monthly for an additional two months. The observation audits will capture donning and doffing of gloves, when to use gloves related to the assigned task, and hand hygiene after the use of gloves.	

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	315348	A. BUILDING _____ B. WING _____	C 03/08/2024

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F 880	Continued From page 71 day. There were no hand wipes, handwashing stations, or alcohol-based hand rub (ABHR) inside the dining area. Inside the dining area, the surveyor observed the U.S. FOIA (b) (6)) with one glove in use while providing coffee to residents and providing sugar. The surveyor asked the U.S. FOIA (b) (6)) if it was appropriate for all staff in the dining area to wear gloves while serving food to the residents, the U.S. FOIA stated that she thought it was ok but she would ask the U.S. FO anyway. The surveyor observed the U.S. FOIA asked the U.S. FO about the gloves and the U.S. FO went to the surveyor. At that time, the surveyor asked the U.S. FO if it was appropriate for all staff in the dining area to serve food with the use of gloves and the U.S. FO stated "yes." The surveyor and the U.S. FO observed that Activity Staff #1 (AS#1) was wearing gloves while serving food, removed gloves, and threw the used gloves into the covered garbage receptacle near the breakfast tray area where the steam table was located. Afterward, AS#1 went to the table with the box of gloves and took a pair of new gloves about to wear when the surveyor asked the U.S. FO if that was appropriate for AS#1 to wear a new pair of gloves without performing hand hygiene. The U.S. FO instructed AS#1 to wash hands after the surveyor's inquiry. Then, the surveyor observed AS#2, U.S. FOIA (b)), and U.S. FOIA (b) (6)) inside the 1st-floor dining area serving plated breakfast, coffee, and other drinks to different residents from one table to another wearing same gloves without performing hand hygiene.	F 880	How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of systemic change. The Infection Preventionist/Designee will review the observations and audit with the team at the monthly Quality Assurance Performance Improvement committee for a period of three months. After discussion any changes to the original plan of correction will be revised and reviewed at the next QAPI meeting.	

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F 880	Continued From page 72	F 880		

Later on, the [U.S. FOIA redacted] removed the gloves, threw the used gloves in a garbage receptacle without performing hand hygiene, and got out of the dining area. Upon exiting the dining area, the [U.S. FOIA redacted] instructed the [U.S. FOIA redacted] to wash hands. The [U.S. FOIA redacted] did not perform hand hygiene, went to another room across the dining area where the copying machine was located, the [U.S. FOIA redacted] took a piece of cardboard broke it into two pieces folded it, went back to the dining area, and placed the 1st piece of cardboard to the foot part of one table with residents and placed the other one of cardboard paper to another table, she went outside the dining room and went across the room to wash her hands for 14 seconds then she went back to get soap and wash again hands for 11 seconds took a paper to dry hands.

Afterward, the surveyor interviewed the [U.S. FOIA redacted] The [U.S. FOIA redacted] stated that it was okay to wear gloves when serving plated food, coffee, and other breakfast food. The surveyor then asked the [U.S. FOIA redacted] if wearing the same gloves to multiple residents and directly touching the resident with the same gloves was appropriate without performing hand hygiene, and the [U.S. FOIA redacted] did not respond. The [U.S. FOIA redacted] had no answer when asked if the residents in the 1st-floor dining area were on isolation or infection control precautions that she had to wear gloves while serving food.

On 02/21/24 at 8:25 AM, the surveyor interviewed Resident #88 seated at a table of other two residents in the 1st-floor dining area while having breakfast. The resident was happy with the breakfast meal and was not bothered that the staff were serving food with gloves in use. The resident acknowledged that four staff ([U.S. FOIA redacted] AS#1

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F 880	Continued From page 73	F 880		

and #2, and [redacted] who were serving breakfast were with gloves.

On 02/21/24 at 9:17 AM, the surveyor in the presence of another surveyor interviewed the [redacted] The [redacted] informed the surveyors that it was a mistake that "we" were wearing gloves in the dining area. The [redacted] further stated that when the surveyor notified the [redacted] of the concern about wearing gloves in the dining area the [redacted] stated that she looked around and realized that everyone in the dining area serving breakfast had gloves on and it should not be. She further acknowledged that at the time the surveyor was watching the breakfast, there were no hand wipes at that time because they used it before breakfast. The [redacted] also stated that there were no hand hygiene sanitation areas inside the dining area and had to go to the back to wash their hands. This time the surveyor notified the [redacted] of the above findings and concerns.

On 02/23/24 at 10:42 AM, the survey team met with the [redacted] and [redacted] The surveyor notified the facility management of the above concerns and findings.

A review of the facility's Handwashing/Hand Hygiene policy with a revised date of October 2023 that was provided by the [redacted] included that single-use disposable gloves should be used: when in contact with a resident, or the equipment or environment of a resident, who is on contact precautions. The use of gloves does not replace hand washing/hand hygiene. The indications for hand hygiene is indicated immediately after touching a resident, after touching a resident, and immediately after glove removal. Washing hands includes rubbing hands together vigorously for at

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F 880	Continued From page 74 least 20 seconds, covering all surfaces of the hands and fingers. On 02/26/24 at 12:04 PM, the survey team met with the [redacted] and [redacted] There was no additional information provided by the facility management. NJAC 8:39-19.4(1)	F 880		

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S 000	Initial Comments Complaint #s: NJ#169951 and #170357 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint # NJ169272 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey	S 560	How the corrective action will be accomplished for those found to have been affected by the deficient practice. The health center at Bloomingdale intent to keep minimum staffing requirements in □□Compliance with N.J.S.A (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing home,□□ indicated the New Jersey Governor signed into Law P.L. 2020 c 112, codified at N.J.S.A 30:13-18 (the Act (, which established minimum staffing requirements in nursing home.	4/15/24

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

Electronically Signed | 03/28/24

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S 560	Continued From page 1 Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. 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 CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and 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 CNA and perform CNA duties. For the 2 weeks of Staffing prior to survey from 01/28/2024 to 02/10/2024, the facility was deficient in CNA staffing for residents on 8 of 14 day shifts as follows: -01/28/24 had 11 CNAs for 97 residents on the day shift, required at least 12 CNAs. -01/30/24 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs. -01/31/24 had 11 CNAs for 97 residents on the day shift, required at least 12 CNAs. -02/01/24 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs. -02/03/24 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs. -02/04/24 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs. -02/05/24 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs. -02/10/24 had 11 CNAs for 101 residents on the	S 560	The management team will monitor Certified Nursing Assistant (CNA) staffing ratios and by offering incentives to current direct staff and use of agency. If staffing is inadequate, admissions will be paused until additional staff are available. How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility acknowledges that all residents have the potential to be affected by this practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. The health center at Bloomingdale has contracted with several staffing agencies for assistance with staffing. Human Resources recruits from colleges in the area, schools with CNA programs and attendance at job Fairs. Leadership holds routine meetings to develop strategies for recruitment and retention of CNA□s. Weekend shift differential implemented for direct care staff. Unlimited overtime is allowed for nursing staff. Flexible schedule offered to accommodate CNA personal schedules. When staff call outs, we asked the current staff in the facility to stay on for the next	

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S 560	Continued From page 2 day shift, required at least 13 CNAs. For the weeks of Complaint staffing from 09/10/2023 to 09/16/2023 for the 02/27/2024 the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -09/10/23 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs. -09/11/23 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -09/12/23 had 7 CNAs for 108 residents on the day shift, required at least 13 CNAs. -09/13/23 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. -09/15/23 had 8 CNAs for 107 residents on the day shift, required at least 13 CNAs. -09/16/23 had 12 CNAs for 107 residents on the day shift, required at least 13 CNAs. For the weeks of Complaint staffing from 10/22/2023 to 11/04/2023, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts as follows: -10/22/23 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. -10/24/23 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs. -10/28/23 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs. -10/29/23 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs. -10/30/23 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs. -11/01/23 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs. -11/04/23 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs. For the weeks of Complaint staffing from 12/17/2023 to 12/23/2023, the facility was	S 560	shift or stay additional hours. We contact staff that are off to cover the shift. We contact the agencies to request temporary help. The facility offers monetary incentives and bonuses when necessary, and transportation. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of systemic change. The Direction of Nursing (DON) will be proactive by monitoring the staffing and projected census daily for upcoming shifts to assure adequate staffing. DON will review staffing levels and will report monthly to the Quality Assurance Performance Improvement (QAPI) committee for 4 quarters.	

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deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 1 of 7 evening shifts as follows:
-12/17/23 had 7 CNAs for 109 residents on the day shift, required at least 14 CNAs.
-12/18/23 had 7 CNAs for 107 residents on the day shift, required at least 13 CNAs.
-12/18/23 had 9 total staff for 107 residents on the evening shift, required at least 11 total staff.
-12/19/23 had 9 CNAs for 107 residents on the day shift, required at least 13 CNAs.
-12/20/23 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs.
-12/21/23 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs.
-12/22/23 had 9 CNAs for 109 residents on the day shift, required at least 13 CNAs.
-12/23/23 had 7 CNAs for 109 residents on the day shift, required at least 14 CNAs.

1. On 02/23/24 at 11:30 AM, surveyor #1 interviewed the Staffing Coordinator (SC) regarding staffing. The SC acknowledged that the facility was aware of the number of CNAs required but did not always have the required number of CNAs.

On 02/23/24 at 12:07 PM, surveyor #1 interviewed the Director of Nursing (DON) who stated, "I know we have been short of staff. The DON stated that the SC will come to me with holes in the schedule and we try our best to fill them with bonuses, employee incentives and staffing agencies. The DON further stated that "We" also offer an added bonus to the weekend called the "weekend warrior shift" paying a bonus on top of the regular bonus."

On 02/23/23 at 12:21 PM, surveyor #1 interviewed the Licensed Nursing Home

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Administrator (LNHA) regarding staffing. The LNHA acknowledged that the facility was aware of the number of CNAs required but did not always have the required number of CNAs. The LNHA further stated that "we" are in the process of contracting with another staffing agency.

On 02/26/23 at 12:33 PM, the survey team met for an Exit conference with LNHA and the DON. The surveyor notified the facility management the concern with staffing. The facility management informed the survey team that there was no additional information.

A review of the facility staffing policy, dated 2001 and revised 10/2017 and provided by the LNHA, included: Policy statement; Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. Policy interpretation and Implementation: #2) Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care, in addition to the State and Federal requirements.
2. On 02/27/24 at 8:36 AM, during an interview with surveyor #2 and the LNHA, the DON stated that they had followed the New Jersey Regulations for staffing ratios but due to staffing shortage the requirement was not met. The DON also stated that they were working with four agencies and offered bonuses and shift differentials.

On 02/27/24 at 8:51 AM, during an interview with surveyor #3 for the weeks of 09/10/2023 to 09/16/2023 and the 12/17/2023 to 12/23/2023 staffing shortages, the SC stated for the most

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S 560	Continued From page 5 part the staffing guidelines were met but acknowledged the facility had staffing difficulties. At that time, the SC informed the surveyor that in the year 2023, the facility had worked with one nursing agency and now in the year 2024, the facility had added three more nursing agencies to assist with their staffing needs. The SC also stated that she would forward the anticipated schedule with open shift (unassigned shift to a nursing staff) to the agencies three weeks in advance. In addition to the nursing agency, the facility offered bonuses and shift differential in pay.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315348	A. Building B. Wing	4/21/2024

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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 F0585 Reg. # 483.10(j)(1)-(4) LSC	Correction Completed 04/15/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 3/8/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315348 Y1	A. Building B. Wing Y2	4/21/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	255 UNION AVE BLOOMINGDALE, NJ 07403

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 F0585	Correction	ID Prefix F0610	Correction	ID Prefix F0641	Correction
Reg. # 483.10(j)(1)-(4)	Completed	Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.20(g)	Completed
LSC	04/15/2024	LSC	04/15/2024	LSC	04/15/2024
ID Prefix F0684	Correction	ID Prefix F0688	Correction	ID Prefix F0689	Correction
Reg. # 483.25	Completed	Reg. # 483.25(c)(1)-(3)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	04/15/2024	LSC	04/15/2024	LSC	04/15/2024
ID Prefix F0690	Correction	ID Prefix F0692	Correction	ID Prefix F0755	Correction
Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.25(g)(1)-(3)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	04/15/2024	LSC	04/15/2024	LSC	04/15/2024
ID Prefix F0759	Correction	ID Prefix F0812	Correction	ID Prefix F0880	Correction
Reg. # 483.45(f)(1)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	04/15/2024	LSC	04/15/2024	LSC	04/15/2024
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?
3/8/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061631 Y1	A. Building B. Wing Y2	4/21/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	255 UNION AVE BLOOMINGDALE, NJ 07403

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 04/15/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/8/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061631		4/21/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	255 UNION AVE BLOOMINGDALE, NJ 07403

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 04/15/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 3/8/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ **YES** ☐ **NO**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315348	A. BUILDING **01** B. WING _____	**03/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	**255 UNION AVE** **BLOOMINGDALE, NJ 07403**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 03/08/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 03/08/24 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Health Center at Bloomingdale is a three-story building that was built in 1994. It is composed of Type II protected construction. The facility is divided into eight - smoke zones. The generator does approximately 75 % of the building per the Maintenance Director. The current occupied beds are 108 of 120.	K 000		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.	K 761		4/15/24

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

Electronically Signed | 03/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315348	A. BUILDING **01** B. WING _____	**03/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	**255 UNION AVE** **BLOOMINGDALE, NJ 07403**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 1 Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure the fire doors were inspected annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 108 residents who resided at the facility. Findings include: A review of the facility's "Fire Safety Binder" revealed the facility's no documented evidence that the required annual fire door inspections were completed. An observation of the facility's fire doors on 03/08/24 from 11:48 AM to 01:30 PM revealed the doors lacked the required inspection tags to be placed on the doors after completed inspections. The U.S. FOIA (b) (6) was present at the time of the observation and confirmed the fire doors were not inspected annually. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 761	what corrective action will be accomplished for those found to have been affected by the deficient practice. All fire doors were inspected immediately, documented in Fire Safety Binder, and placed inspection tags in accordance with NFPA 101 life safety code (2012) Section 7.2.2.15. How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility recognizes that all residents have potential to be affected by this practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. Maintenance Director in-service maintenance personnel regarding annual fire door inspections in accordance with NFPA 101 life safety code (2012) Section 7.2.2. 15.. Administrator/ designee will randomly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315348	A. BUILDING **01** B. WING _____	**03/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	**255 UNION AVE** **BLOOMINGDALE, NJ 07403**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 2	K 761	check fire doors and Fire safety binder for documentation monthly for 3months for safety and compliance. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of systemic change. Results will be reviewed in the monthly Quality Assurance Performance Improvement meetings for 3 months.	

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
315348 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	4/21/2024 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT BLOOMINGDALE	255 UNION AVE BLOOMINGDALE, NJ 07403

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0761	Correction Completed 04/15/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/8/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO