

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

PRINTED: 05/24/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/31/2023
NAME OF PROVIDER OR SUPPLIER ABINGDON CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 ROCK AVE GREEN BROOK, NJ 08812		
(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	E 000			
E 004 SS=F	This facility is not in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities. Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the	E 004			11/15/23

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

TITLE

(X6) DATE

Electronically Signed

11/24/2023

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

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E 004	Continued From page 1 requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's Emergency Preparedness Plan and Program (EPP), it was determined that the facility failed to ensure that the EPP was maintained, reviewed, and updated at least annually. This deficient practice was evidenced by the following: On 10/26/23 at 9:53 AM, the surveyor began to review the facility provided EPP book which contained either incorrect or missing documentation as follows: The surveyor was unable to locate any documentation to verify the EPP was updated at least annually. The table of content failed to identify any documentation to verify annual updates. The Key Personnel Contact list included the previous Director of Nursing's (DON) contact information and not the current DON. The Communications Risks/Crisis Communicator listed the previous Licensed Nursing Home	E 004	1. All residents were potentially impacted by the impact of this specific deficient practice. 2. The facility had updated the information, removed old manuals to ensure that manuals were reflective of all current personnel their respective contact numbers and were reviewed for the current calendar year. 3. All prior documents that were not applicable were removed, by the Administrator LNHA and dated to reflect current year review. This information contained and changes will be monitored by Administrator LNHA and Maintenance Director. Then outcomes will be reported to qapi committee and reviewed by Director of nursing, Maintenance Director/designee, Administrator LNHA, and staffing		

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E 004	Continued From page 2 Administrator (LNHA) and not the current LNHA. The Emergency Phone Procedures indicated a date of [REDACTED] and listed the incorrect LNHA, incorrect DON, and incorrect Director of Maintenance (DOM) with their cell phone numbers. The correct LNHA, DON, and DOM and their contact information was not listed. The Chain of Command page indicated a date of [REDACTED]. This page listed the incorrect LNHA, incorrect DON, incorrect DOM, failed to list the nursing supervisor, failed to list the food service director, and failed to list the director of Social Services. The Emergency Contacts page indicated a date of [REDACTED]. This contact page listed the incorrect LNHA with her cell and home phone numbers; the incorrect DON with her cell and home phone numbers; the incorrect DOM with his cell and home phone numbers; and the incorrect Medical Director with his/her office phone number. The Corporate Contacts page indicated a date of [REDACTED]. On 10/27/23 at 8:23 AM, the surveyor went to the Warren unit of the facility and observed the EPP manual. A review of the EPP manual revealed the following: A page dated [REDACTED], which listed the incorrect LNHA with her cell and home phone number and email address; the incorrect DOM with his cell phone and email address; and the incorrect Medical Director with his/her cell phone number. An Organization Information page, dated [REDACTED], with the incorrect LNHA listed and his contact information. A Facility Emergency Notification Form page listed a date of [REDACTED]. The page listed the previous LNHA as the contact along with her	E 004	coordinator to ensure accurate information.. 4. The facility qapi will monitor this for 2 quarters and updates for staff phone numbers will be added or deleted as appropriate.		

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E 004	Continued From page 3 email address. On 10/27/23 at 8:33 AM, the surveyor went to the Nobel unit of the facility but was unable to find the EPP book at the nursing desk. The Registered Nurse Unit Manager (RN UM) was present at that time and also looked at the nursing desk to try to locate the EPP. The RN UM stated she was unable to locate the EPP on that unit. The RN UM stated there should be an EPP on every nursing unit to ensure the staff know the procedures to follow in case of any emergency. On 10/27/23 at 8:37 AM, the surveyor went to the receptionist desk in the facility lobby. The Receptionist stated her responsibilities and provided the EPP manual she was to follow. The surveyor reviewed the reception desk EPP manual which revealed the following: An Emergency Contact Numbers page undated. The page listed the incorrect LNHA with his phone number, an assistant Administrator who no longer worked at the facility with his phone number, the incorrect Medical Director, an incorrect DON with his/her phone number, the incorrect DOM with his phone number, an incorrect Nobel Hall unit manager with her phone number, and an incorrect Warren hall unit manager with her phone number. On 10/27/23 at 9:31 AM, the LNHA stated she and the DOM would be responsible to update the EPP manual. She stated there should be an EPP manual at each nursing unit, with the maintenance department, at the front reception desk, and with her. The LNHA further stated she was the Risk Coordinator and that the EPP should have a "review page" in each manual. The	E 004			

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E 004	Continued From page 4 LNHA stated it was important for all the EPP books to be on all the units and to be updated and correct in case of an emergency.	E 004			
F 000	NJAC 8:39-31.6 INITIAL COMMENTS Survey Date: 10/31/23 Census:101 Sample: 21 + 17 = 38 Complaint #: NJ 162113 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. THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000			
F 570 SS=F	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure the surety bond contained	F 570	10On NJ Ex Order 26. 4B1 , the facility secured Surety Rider in the amount of NJ Ex Order 26. 4B1 to ensure adequate funds were		11/1/23

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F 570	Continued From page 5 sufficient funds to protect the residents' trust funds. This deficient practice had the potential to affect all residents who resided in the facility that had <u>NJ Ex Order 26. 4B1</u> and was evidenced by the following: On 10/19/23 a 12:45 PM, the Licensed Nursing Home Administrator (LNHA), provided the surveyor with a three-page document labeled "Checking Account Statement, Statement Type: Bank, Trust Account [number redacted]." The document was dated <u>NJ Ex Order 26. 4B1</u> through <u>NJ Ex Order 26. 4B1</u>. The document revealed a beginning balance <u>NJ Ex Order 26. 4B1</u>, and a balance of <u>NJ Ex Order 26. 4B1</u>. Additionally, the surveyor was provided with a 2-page Checking Account Statement dated <u>NJ Ex Order 26. 4B1</u> which was labeled as <u>NJ Ex Order 26. 4B1</u>. On 10/19/23 1:10 PM, the LNHA provided a copy of the Surety Bond. The document revealed a <u>NJ Ex Order 26. 4B1</u> for an anniversary premium Period dated <u>NJ Ex Order 26. 4B1</u> in the amount of <u>NJ Ex Order 26. 4B1</u>. The surveyor observed that the Surety Bond did not cover the balance of the funds in the account labeled <u>NJ Ex Order 26. 4B1</u> " by more than a <u>NJ Ex Order 26. 4B1</u> as of the <u>NJ Ex Order 26. 4B1</u> balance. On 10/19/23 at 1:26 PM, the surveyor interviewed the LNHA regarding the purpose of the PNA. The LNHA stated the PNA was to ensure that any resident money for resident's that had over <u>NJ Ex Order 26. 4B1</u> was held in an interest-bearing account. The LNHA stated the resident would have access to their money 7 days a week and 365 days per year and and the person who handled the PNA would be able to explain things further.	F 570	available to protect the residents' trust. Upon audit amount insignificant request made to increase the amount of bond to ensure entire amount was covered. 2 All residents who deposit their personal needs funds in the facility PNA account have the potential to be affected by this deficient practice. 3 The RCM (Revenue Cycle Manager), LNHA (Administrator) and/or their designee shall review/audit the Resident Trust fund balance monthly for three months, then quarterly thereafter, to ensure Surety Rider contains sufficient funds to protect the resident's trust fund. The LNHA (Administrator) and/or Designee shall provide a monthly PNA audit, indicating current total resident trust fund balance and Surety Rider amount, for three months, then quarterly thereafter to the facility QAPI Committee to ensure compliance. Completion Date:		

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F 570	Continued From page 6 On 10/19/23 at 1:44 PM, the surveyor interviewed the Revenue Cycle Manager (RCM) in the presence of the LNHA. The RCM stated she was the person responsible for the centralized oversight of the business office functions for the facility which included the PNA funds. The RCM stated that the resident's PNA was kept the in an interest-bearing account. The surveyor asked the RCM about the purpose of the surety bond. The RCM stated it was an insurance policy because the money in the account "does not belong to us." She stated that each facility had a surety bond, and "the bond should cover what is in the trust, normally we don't have that much money in the account". The RCM stated that from [REDACTED] each resident received [REDACTED] from the [REDACTED] money and maybe there had been money left in the account. On 10/26/23 at 1:52 PM, the surveyor interviewed the RCM in the presence of the LNHA. The RCM stated to the surveyor that there was an oversight, and the facility surety bond did not cover the full amount of funds as documented in the resident PNA account statement. The RCM confirmed that facility had not been aware of the surety bond was not meeting the total amount of the PNA funds held by the facility until brought to the facility's attention during the survey. NJAC 8:39-9.5(c)(3) Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including	F 570			
F 584 SS=E		F 584			11/23/23

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F 584	Continued From page 7 but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was	F 584	Safe/Clean/Comfortable/Homelike		

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F 584	Continued From page 8 determined that the facility failed to maintain resident common areas, resident rooms and equipment in a clean, sanitary and safe functional manner as evidenced by the following: During the initial tour of the Noble unit on 10/18/23 at 10:14 AM, the surveyor observed in Room 245 the air conditioner unit with blue tape and card board around the bottom of the unit. On 10/18/23 at 10:30 AM, the surveyor toured the Warren unit day room and observed an unsampled resident (UR #1) ambulating independently and was looking out of a window that was above an air conditioning unit, and another unsampled resident (UR #2) was sitting at a table watching the television. Upon entering the day room, the surveyor observed a row of wooden cabinets that appeared visibly soiled on the exterior, and the cabinet door appeared to be loose on its hinges. At 10:32 AM, the Activity Director entered the day room, and the surveyor showed her the debris on the wooden cabinets and upon opening the cabinets there was debris observed inside along with a black garbage bag. The surveyor asked the AD if the cabinets were clean and she stated, "not clean". The surveyor observed that there were three window air conditioner units in the day room. All three units were visible soiled, one was missing an entire grate and one had a broken grate. The unit closest to the wooden cabinets had a lifted and broken piece that the surveyor touched and observed that it was a sharp and jagged hard piece of material and showed it to the AD. The surveyor asked the AD if the jagged hard piece posed a safety concern to the residents and the AD stated, "yes, that is unsafe". The surveyor also observed a stained beige chair and the	F 584	Environment CFR(s): 483.10(i)(1)-(7) Warren and noble dining rooms were deep cleaned by the housekeeping Director and floor technicians. All chairs and sofas were extracted, table legs, chairs legs, cabinets, walls, corners and edges, window frames, window blinds and floor were scrubbed and deep cleaned. Noble and Warren shower rooms were scrubbed and completely cleaned by the Housekeeping Director and floor technicians. A total of 3 shower chairs showing signs of wear and tear, were taken out of use from the noble and warren units and replaced. I.V poles throughout the building were cleaned by the Housekeeping Director and unit housekeeper. IV pole, pump, wheels and legs were scrubbed. Areas around the IV poles were detailed cleaned including walls, nightstands, dressers, bed frames, bed rails and floors. All residents could have been affected. Thorough inspections were made on all three dining rooms By Regional Director and Housekeeping Director which included warren, noble and the Main dining room on the first floor. Inspections included chairs, chairs legs, tables, tables legs, windows, chair fabrics, PTAC units, cabinets, and windows. Shower rooms in noble and Warren units		

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F 584	Continued From page 9 round table bases were soiled. When asked about the UR #1 who was peering out of the window, the AD stated the resident likes to look out of the window and people walk in and out of the day room. On 10/18/23 at 11:20 AM, the surveyor toured the Noble unit shower rooms. At that time, the surveyor interviewed a Licensed Practical Nurse (LPN) who confirmed that the residents utilize the shower rooms. The shower room closest to the elevator contained a shower chair with a blue mesh back that was soiled and had a pink substance on the seams. On 10/18/23 at 11:32 AM, the surveyor entered the 2nd shower room with the Registered Nurse and observed ripped cushions with exposed foam on both shower chairs. One was a large burgundy colored chair and the other one was a teal backed chair. Both chairs were also soiled, and the burgundy chair had a broken knob with sharp edges in the leg area. In addition, the drain cover was missing and a broken tile was observed. The surveyor showed the RN the ripped cushion and the broken knob and asked if that was okay. The RN stated that the cushion was an "infection control problem" and the broken knob was a "potential injury problem for sure" and the RN confirmed that one of the Certified Nurse Aides used the shower room that morning to shower a resident. On 10/18/23 at 11:31 AM, the surveyor interviewed three Certified Nurse Aides (CNA). One CNA stated she used the big chair yesterday, however, she did not any rips or broken areas.	F 584	were inspected but the Regional Director and Housekeeping Director. The inspection included wall cleaning, grout condition, dust, signs of mold or mildew, corners and edges, shower heads, shower hoses and floors. Shower chairs were inspected on warren and noble units. Inspection included signs of mold or mildew, rips on seat cushion, wear or tears on the mesh and any signs of broken PVC or lose screws. A total of two feeding poles are currently in use within the facility. These poles were identified and inspected for compliance by the Regional and Housekeeping Director. Inspection included poles, pumps, wheels and legs cleanliness. The IV pole surrounding areas were also inspected looking for signs of dried-up substances such as on walls, nightstands, floors, bed frames, and bed rails. An audit log was implemented by the Regional Director of EVS to be utilized by the Housekeeping Director daily to document the proper cleaning of all Dining rooms. This audit includes checks on furniture fabric, chairs, tables, PTAC units, windows, windowsills, kitchen cabinets, refrigerators, and floors. This log will be used for the 60-day improvement plan or continued if cleanliness satisfaction is not achieved. An audit log was implemented by the Regional Director of EVS to be utilized by		

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F 584	Continued From page 10 On 10/20/23 at 8:03 AM, the surveyor observed Resident #14's room on the [redacted] unit. The resident was in bed, eyes were open, and the resident was [redacted] to the surveyor. It was observed that the resident received a [redacted], and the [redacted] and the [redacted] were visibly soiled with stuck on splatters, including the black base. The bed had visible splatters on it and was visibly soiled. The wall behind the bed had drips stuck to it, ripped areas and splatters throughout. The mechanical [redacted] for the bed and the black [redacted] was visibly dusty with debris. The windowsill was visibly soiled as was the air conditioner unit. Both nightstands were also soiled with visible debris. There was a large black wheelchair in the resident's room that appeared soiled with various debris throughout the metal part of the wheelchair, the leg rests, and the wheels. The Registered Nurse accompanied the surveyor during the observations and confirmed the areas were not clean, including the [redacted], and the resident used the wheelchair yesterday. On 10/27/23 at 10:46 AM, the Licensed Nursing Home Administrator, Director of Nursing, Regional Director of Operations Regional Clinical Nurse and Regional Infection Preventionist were made aware of the surveyor's observations. A Resident Room Cleaning and Bathroom Policy, both undated revealed: Purpose: "To provide a detailed description of the steps that are to be completed daily in the cleaning of a resident room. Daily cleaning will ensure optimum levels of cleanliness and sanitation, prohibit and control the spread of infection and bacteria and maintain the outward appearance of the facility ...	F 584	the Housekeeping Director daily to document the proper cleaning of shower rooms and shower chairs. This audit includes checks on shower room walls, grout condition, shower heads, shower hoses and floors. Shower chairs cleaning includes, mesh, seat cushion, PVC and overall appearance. This log will also have to be filled out by Management to assure quality completion. This log will be used for the 60-day improvement plan or continued if cleanliness satisfaction is not achieved. An audit log was implemented by the Regional Director of EVS to be utilized by the Housekeeping Director daily to document the proper cleaning of each IV pole. This log will include checks on poles, legs, wheels, pumps and surrounding areas such as walls, bed frames, bed rails, nightstands and floors. This log will be used for the 60-day improvement plan or continued if cleanliness satisfaction is not achieved. Housekeeping staff members were re-educated and trained in medical equipment upkeep. One on one training was conducted with each housekeeping staff member showing the correct cleaning practices of the medical equipment such as the I.V poles. Conducted by the Regional and Housekeeping Director. Housekeeping staff were educated on the correct cleaning practices of dining areas. One on one training was conducted		

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F 584	Continued From page 11 NJAC 8:39 - 31.2(e); 31.4(a)	F 584	showing every area of the dining room in need of detail attention. Conducted by the Regional and Housekeeping Director. Housekeeping staff were re-educated on the proper cleaning procedures to clean the shower room areas as well as shower chairs. One on one training was conducted showing each area in need of detailed attention and proper cleaning methods to remove build up. Housekeeping staff were also instructed to report any defective equipment to their supervisor immediately. Conducted by the Regional and Housekeeping Director. Audit logs will be reviewed as part of our monthly QAPI for the duration of the 60-day improvement plan. Regional Director of EVS will monitor the process on weekly facility visits to ensure quality improvement is achieved and prevent it from re-occurring. This process is ongoing.		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609			12/1/23

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F 609	Continued From page 12 mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §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 interview, record review and review of pertinent documents, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) two incidents for one resident (NJ Ex Order 26. 4B1) for injuries that resulted in NJ Exec Order 26.4b1 The deficient practice was identified for 1 of 2 (Resident #52) residents reviewed for reportable events and was evidenced by the following: On 10/23/23 at 12:24 PM, the facility provided incident reports for Resident #52. The documents revealed Resident #52 had a NJ Ex Order 26. 4B1 [REDACTED] which occurred on	F 609	F610 SS=E: Investigate/Prevent/Correct Alleged Violation Element I Resident #52 primary physician was made aware was assessed with no adverse effects due to the deficit practice. Resident # 356 no longer resided in the facility at the time of state visit. Element II All residents that reside in the facility have		

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F 609	Continued From page 13 ^{NJ Ex Order 26. 4B1} . Resident #52 also had an incident dated ^{NJ Ex Order 26. 4B1} , which resulted in a ^{NJ Ex Order 26. 4B1} [REDACTED] On 10/25/23 at 12:41 PM, Surveyor #1 interviewed the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA). The DON spoke to the incident/accident process, stating that an investigation should start immediately, statements would be collected and if warranted, the incident/accident must be reported to the NJDOH within a two-hour window. The LNHA stated, "it is important to get statements for a full account of what occurred and need to report to the NJDOH because it is regulatory and a moral obligation." The LNHA acknowledged that there were no statements and that both incidents should have been reported to NJDOH, and then confirmed both had not been reported. On 10/26/23 at 10:51 AM, Surveyor #1 interviewed the LNHA. The LNHA confirmed she had been aware of both incidents that occurred on ^{NJ Ex Order 26. 4B1} , resulting in ^{NJ Ex Order 26. 4B1} . The LNHA stated that the previous DON informed her that both incidents had been investigated and it was concluded that there were ^{NJ Exec Order 26.4b1} . The LNHA stated that she "only" received "verbal re-assurance" that the incidents had been completed, but that no documentation was provided to her. The LNHA stated that it was "ultimately" her responsibility to ensure that an investigation was conducted and that the ^{NJ Exec Order 26. 4B1} were reported to NJDOH. On 10/27/23 at 12:30 PM, Surveyor #1 reviewed	F 609	the potential to be affected by this deficient practice. Element III -10/27/2023 The Regional Clinical Nurse in-serviced the Director of Nursing, and the Administrator on the facility policy and procedures on Incident and Accident Investigation to maintain compliance with reporting to the New Jersey Department of Health within five working days of the incident in accordance with the State Law. -10/27/2023 IDCP team educated on conducting weekly fall meetings to determine the root cause of falls and to note trends. The attending physician will be notified for each fall and consulted as needed. 10/27./2023 all licensed nursing staff on each shift was educated on the facility policy and procedure on incident and accident investigations, use of the resident monitoring tool, and notification of the Director of Nursing or designee of each fall immediately. -Director of Nursing or designee will audit fall investigations, fall care plans for completeness and to ensure suitable interventions are implemented weekly X 4 weeks, bi-weekly X 4 weeks, then monthly X 3 months. - Incident and Accident Investigation policy will be reviewed annually by all staff, upon hire and as needed.		

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F 609	Continued From page 14 the facility provide policy, "Abuse, Neglect and Mistreatment of The Elderly", undated, which included but was not limited to; Section F (reporting) which revealed: 1.) The Director of Nursing/Administrator or designee reports to the New Jersey Department of Health and Senior Services immediately any occurrences of suspected abuse, neglect or mistreatment. The facility maintains records of all documentation sent to the (NJ) DOH including the name of the person the records were sent to and the date sent. 2.) Any incidents of suspected or actual abuse that is reported to the police must be called into the New Jersey Office of Ombudsman and the New Jersey State Department of Health and Senior Services Licensure office immediately followed by written notification within 72 hours of verbal confirmation. 3.) If there is a finding against a staff member, the (facility) notifies the State Nurse Aide Registry and/or other licensing authority of any knowledge it has of any actions taken by a court of law which would indicate that an employee is unfit for service. NJAC 8:39-9.4(f)	F 609	Element IV - The Director of Nursing, Unit Managers, Nursing supervisors will conduct daily audits of all incident and accident reports daily to ensure they are completed and signed timely with summary and conclusion attached. IDCP Team will review, and all findings will be reported to the administrator to rule out neglect or abuse. The audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly X 3 months. -Audits will be monitored for completion by the Administrator and Director of Nursing weekly X 4 weeks, bi-weekly X 4 weeks, monthly x 3 months. - -Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.		
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:	F 610		12/1/23	

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F 610	Continued From page 15 §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 interview, record review and review of pertinent documents it was determined that the facility failed to complete and document a thorough investigation and follow the facility Abuse Policy for a.) two incidents that resulted in two different ^{NJ Ex Order 26.4b1} for one resident who resided on a secure unit with a diagnosis of ^{NJ Ex Order 26.4b1}, and b.) failed to conduct an investigation for a resident who was observed ^{NJ Ex Order 26.4b1} with an ^{NJ Exec Order 26.4b1}. This deficient practice occurred for 2 residents (Resident #52 and Resident #356) reviewed for accidents and incidents and was evidenced by the following: a.) On 10/18/23 at 9:47 AM, Surveyor #1 observed Resident #52 seated in a chair next to the bed. The Resident was ^{NJ Exec Order 26.4b1} ^{NJ Exec Order 26.4b1}. At that time, the RN (Registered Nurse) was present and explained the resident can get ^{NJ Exec Order 26.4b1} at times and needed ^{NJ Exec Order 26.4b1} often. The RN also stated the	F 610	F610 SS=E: Investigate/Prevent/Correct Alleged Violation Element I Resident #52 primary physician was made aware was assessed with no adverse effects due to the deficit practice. Resident # 356 no longer resided in the facility at the time of state visit. Element II All residents that reside in the facility have the potential to be affected by this deficient practice. Element III -10/&./2023 The Regional Clinical Nurse in-serviced the Director of Nursing, and the Administrator on the facility policy and		

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F 610	Continued From page 16 resident had a diagnosis of [NJ Ex Order 26.4B1]. On 09/20/23 at 9:50 AM, Surveyor #2 reviewed the Electronic Medical Record (EMR) and reviewed a nurse's documentation of an [NJ Ex Order 26.4B1] as follows: "Resident chief complaint (c/o) [NJ Ex Order 26.4B1] about [NJ Ex Order 26.4B1], noted [NJ Ex Order 26.4B1], [NJ Ex Order 26.4B1], [NJ Ex Order 26.4B1]. Vitals stable, called placed to MD (Medical Doctor), new order for [NJ Ex Order 26.4B1] of [NJ Ex Order 26.4B1] for c/o [NJ Ex Order 26.4B1] and [NJ Ex Order 26.4B1], telephone order, family called and made aware, waiting for [NJ Ex Order 26.4B1] company". The [NJ Ex Order 26.4B1] results concluded on [NJ Ex Order 26.4B1] at 3:21 PM, read as follows: [NJ Ex Order 26.4B1] [NJ Ex Order 26.4B1] [NJ Ex Order 26.4B1]. There is a [NJ Ex Order 26.4B1]. The remainder of the [NJ Ex Order 26.4B1] are unremarkable." On 9/23/23 at 4:26 PM, the surveyor reviewed a nurse's documentation of an [NJ Ex Order 26.4B1] as follows: "at approximately 3 PM, writer heard a loud thud coming from the dining room area, on getting to the dining room resident was [NJ Ex Order 26.4B1] and [NJ Ex Order 26.4B1] from his/her [NJ Ex Order 26.4B1], resident had a [NJ Ex Order 26.4B1] above the [NJ Ex Order 26.4B1] of his/her [NJ Ex Order 26.4B1], resident was [NJ Ex Order 26.4B1] PRN (as needed) [NJ Ex Order 26.4B1] was given for [NJ Ex Order 26.4B1], resident's [NJ Ex Order 26.4B1] was [NJ Ex Order 26.4B1], and cotton buds applied to [NJ Ex Order 26.4B1], but [NJ Ex Order 26.4B1] couldn't just be controlled. MD was made aware, MD [physician] advised resident should be transferred to the ER (emergency room) for treatment and further evaluation. Resident was transferred to the ER via stretcher and accompanied by two EMT (emergency medical transporters) at 3:30 PM. Residents [family] was also made aware of incident and subsequent transfer to the ER."	F 610	procedures on Incident and Accident Investigation to maintain compliance with reporting to the New Jersey Department of Health within five working days of the incident in accordance with the State Law. -10/27/23 IDCP team educated on conducting weekly fall meetings to determine the root cause of falls and to note trends. The attending physician will be notified for each fall and consulted as needed. 10/27/2023 all licensed nursing staff on each shift was educated on the facility policy and procedure on incident and accident investigations, use of the resident monitoring tool, and notification of the Director of Nursing or designee of each fall immediately. -Director of Nursing or designee will audit fall investigations, fall care plans for completeness and to ensure suitable interventions are implemented weekly X 4 weeks, bi-weekly X 4 weeks, then monthly X 3 months. - Incident and Accident Investigation policy will be reviewed annually by all staff, upon hire and as needed. Element IV - The Director of Nursing, Unit Managers, Nursing supervisors will conduct daily audits of all incident and accident reports daily to ensure they are completed and signed timely with summary and		

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F 610	Continued From page 18 the Licensed Nursing Home Administrator (LNHA). The DON stated that after an incident or an accident, an investigation would start immediately. The DON stated statements would be collected. Per the DON, the incident or an accident would then be reported to the NJDOH (New Jersey Department of Health) within two hours. The LNHA stated, "It is important to get statements for a full account of what occurred and need to report to NJDOH because it is regulatory and moral obligation." On 10/26/23 at 10:51 AM, Surveyor #1 interviewed the LNHA. The LNHA stated that the facility did not have a policy for injuries of unknown origin. The LNHA stated she had knowledge of both incidents on <u>NJ Ex Order 26. 4B1</u> [REDACTED]. The LNHA stated both incidents were discussed in morning meeting with the previous DON who informed her that he conducted and initiated the investigations. The LNHA stated that she was informed by the previous DON that the <u>NJ Exec Order 26.4b1</u> was concluded for both dates and there were <u>NJ Exec Order 26.4b1</u> [REDACTED]. The facility was unable to provide a completed and thorough investigation for either incident conducted on <u>NJ Ex Order 26. 4B1</u> [REDACTED]. Per the LNHA, the previous DON gave the LNHA "verbal re-assurance" that both incidents were concluded. The facility failed to provide a determination of any causal factors or provide any statements. The LNHA acknowledged that Resident # 52's investigations dated for <u>NJ Ex Order 26. 4B1</u> [REDACTED] had no follow up, no summary, no conclusion, and confirmed that there was no thorough investigation completed. On 10/26/23 at 12:00 PM, Surveyor #1	F 610			

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F 610	Continued From page 19 interviewed LPN #2 who provided care for Resident #52 on [REDACTED] NJ Ex Order 26.4B1. LPN #2 stated he was familiar with the incident that happened on [REDACTED] NJ Ex Order 26.4B1. LPN #2 informed the surveyors that Resident #52 [REDACTED] NJ Ex Order 26.4B1 to his/her room when he/she [REDACTED] NJ Ex Order 26.4B1 their [REDACTED] NJ Ex Order 26.4B1 on the door frame [REDACTED] NJ Ex Order 26.4B1 and said [REDACTED] NJ Ex Order 26.4B1. After Resident #52 [REDACTED] NJ Ex Order 26.4B1 his/her [REDACTED] NJ Ex Order 26.4B1 the LPN #2 went to get the resident and assisted the resident to the chair. LPN #2 stated there was no [REDACTED] NJ Ex Order 26.4B1 or [REDACTED] NJ Ex Order 26.4B1 until an hour and a half later when he noticed the [REDACTED] NJ Ex Order 26.4B1 and resident had a c/o [REDACTED] NJ Ex Order 26.4B1 at which time he reported to the previous DON via telephone. LPN #2 stated, "I did not document that resident [REDACTED] NJ Ex Order 26.4B1 [his/her] [REDACTED] NJ Ex Order 26.4B1 in the EMR". LPN #2 acknowledged that he needed to get all the information together and should have documented in the EMR, and he did not. He stated he "only documented on paper." LPN #2 stated he did not have a copy of his written incident report that he stated had happened on [REDACTED] NJ Ex Order 26.4B1. The facility was unable to provide the survey team with investigation reports of the incident that occurred on [REDACTED] NJ Ex Order 26.4B1. On 10/27/23 at 10:46 AM, the above concerns were addressed with the facility. The facility had no documented evidence to provide regarding a completed and thorough investigation for both incidents. On 10/27/23 at 12:30 PM, Surveyor #1 reviewed the facility provided policy, "Abuse, Neglect and Mistreatment of The Elderly", undated, which included but was not limited to; Section D (Investigation) which read as followed: 1.) The Director of Nursing/designee is designated as the individual who conducts the	F 610			

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F 610	Continued From page 20 investigation. 2.) He/she: A) Reviews the accident/incident report B) Obtains written statements of staff assigned to the resident for the shift during which the allegation is noted, and 16 hours prior if indicated C) Interviews witnesses if any D) Reviews the residents record E) If a formal report is made attaches the following: Face Sheet; Current related MDS (minimum data set) standardized assessment that measures health status; Current applicable portions of the comprehensive care plan; Progress notes, which include events 48 hours prior to allegation; Copy of x-ray report, if applicable; Copy of the most recent psychiatric evaluation/progress note; Copy of current physical order sheet; Copy of current Medication Administration Record; Proof of staff assignment for that time; Reviews staff performance; Takes corrective action including but not limited to progressive counseling; in-services; and increased supervision; Re-evaluates policies and revise if necessary to prevent recurrences; Reports all findings to the Administrator. b. On 10/20/23 at 10:31 AM, Surveyor #3 conducted a review of the closed EMR for Resident #356 which revealed the following: A Health Status Nursing Note, Effective Date: NJ Ex Order 26. 4B1 at 18:51:37 Note Text: "This nurse went to check resident's NJ Ex Order 26. 4B1 prior to dinner. NJ Ex Order 26. 4B1, resident was refuse [refused] coverage and was seen with a NJ Exec Order 26.4b1	F 610			

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F 610	Continued From page 21 This nurse asked [him/her] what [redacted] [he/she] used, resident reply in [his/her] own words" how do you know its [redacted]. " Resident was very [redacted] and [redacted] and [redacted] at this nurse. Resident refuse coverage and said go get my nurse ... On 10/23/23 at 12:41 PM, Surveyor #3 conducted a telephone interview with the Nurse who documented the [redacted] note. The Nurse stated he recalled the incident and stated he watched Resident #356 [redacted]. The nurse stated he reported it to the supervisor and the Director of Nursing (DON) at the time. The surveyor asked the Nurse if he was asked to write a statement or participated in an investigation. The Nurse stated, "I don't think they ever asked to write a statement". When asked if the Nurse knew what the resident [redacted] he stated, "well "we assumed it was [redacted], but we cannot definitely know it was [redacted]. On 10/25/23 at 9:36 AM, Surveyor #3 interviewed the Director of Nursing (DON) about what type of investigations would be completed. The DON stated, incidents including a fall, a bruise of unknown origin, or an injury of unknown origin, and abuse allegations. The surveyor asked if there would be an investigation for the incident that occurred with the resident [redacted]. The DON stated, "that would be investigated as well". The surveyor requested any investigations for Resident #356 regarding the incident with the [redacted]. 10/31/23 10:34 AM at 10:20 AM, Surveyor #3 interviewed the Regional Clinical Operation	F 610			

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F 610	Continued From page 22 Nurse. The RCO stated that she spoke to the Nurse who observed Resident #356 [NJ Ex Order 26. 4B1] with a [NJ Ex Order 26. 4B1] and the RCO stated it was the "our duty to investigate" and stated that she had a conversation with the former DON who stated there was an investigation completed and was in the DON's office. The RCO then stated there was no investigation located in the DON's office and confirmed that there was no investigation or incident report located that had been completed when Resident #356 [NJ Ex Order 26. 4B1] with an [NJ Ex Order 26.4b1].	F 610			
F 658 SS=D	NJAC 8:39-4.1 (a) (5), 27.1 (a); 35.2 (c) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint # NJ 162113 Based on interview, and record review it was determined that the facility failed to ensure that resident temperatures were documented per physician order for 1 of 1 closed record (Resident #356) reviewed for physician orders. The deficient practice was evidenced by the following: On 10/20/23 at 10:31 AM, a review of the closed medical record for Resident # 356 revealed a Physician Order dated [NJ Ex Order 26. 4B1] for [NJ Ex Order 26. 4B1] monitoring every shift, [NJ Ex Order 26. 4B1], [NJ Ex Order 26. 4B1].	F 658	658 SS = D Services Provided Meet Professional Standards Element I Resident #356 no longer resided in the facility at the time of state visit. 10/24/23 licensed nurses were immediately in-service by the Regional Registered Nurse on proper documentation pertaining to physician orders of vitals in the electronic medical records with a comprehensive care plan		12/1/23

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F 658	Continued From page 23 NJ Ex Order 26. 4B1, NJ Ex Order 26. 4B1 every shift for NJ Ex Order 26. 4B1 monitoring. The Electronic Medical Record (EMR) documentation of Temp was reviewed from NJ Ex Order 26. 4B1 when resident was transferred to the hospital and indicated the following: <table border="0"> <tr> <td>Date:</td> <td>Time:</td> <td>Temp:</td> </tr> <tr> <td>NJ Ex Order 26. 4B1</td> <td>09:04 [7AM-3PM shift]</td> <td>NJ Ex Order 26. 4B1</td> </tr> <tr> <td>NJ Ex Order 26. 4B1</td> <td>23:27 [3PM-11PM shift]</td> <td>NJ Ex Order 26. 4B1</td> </tr> <tr> <td>NJ Ex Order 26. 4B1</td> <td>13:20 [3PM-11PM shift]</td> <td>NJ Ex Order 26. 4B1</td> </tr> <tr> <td>NJ Ex Order 26. 4B1</td> <td>00:25 [11 PM-7AM shift]</td> <td>NJ Ex Order 26. 4B1</td> </tr> <tr> <td>NJ Ex Order 26. 4B1</td> <td>14:45 [7AM-3PM shift]</td> <td>NJ Ex Order 26. 4B1</td> </tr> <tr> <td>NJ Ex Order 26. 4B1</td> <td>00:15 [11 PM-7AM shift]</td> <td>NJ Ex Order 26. 4B1</td> </tr> <tr> <td>NJ Ex Order 26. 4B1</td> <td>19:37[3PM-11PM shift]</td> <td>NJ Ex Order 26. 4B1</td> </tr> <tr> <td>NJ Ex Order 26. 4B1</td> <td>00:59[11 PM-7AM shift]</td> <td>NJ Ex Order 26. 4B1</td> </tr> <tr> <td>NJ Ex Order 26. 4B1</td> <td>17:07[3PM-11PM shift]</td> <td>NJ Ex Order 26. 4B1</td> </tr> <tr> <td>NJ Ex Order 26. 4B1</td> <td>01:33[11 PM-7AM shift]</td> <td>NJ Ex Order 26. 4B1</td> </tr> <tr> <td>NJ Ex Order 26. 4B1</td> <td>20:47[3PM-11PM shift]</td> <td>NJ Ex Order 26. 4B1</td> </tr> <tr> <td>NJ Ex Order 26. 4B1</td> <td>23:41 [3PM-11PM shift]</td> <td>NJ Ex Order 26. 4B1</td> </tr> <tr> <td>NJ Ex Order 26. 4B1</td> <td>12:45 [11 PM-7AM shift]</td> <td>NJ Ex Order 26. 4B1</td> </tr> <tr> <td>NJ Ex Order 26. 4B1</td> <td>01:12 [11 PM-7AM shift]</td> <td>NJ Ex Order 26. 4B1</td> </tr> <tr> <td>NJ Ex Order 26. 4B1</td> <td>17:13 [3PM-11PM shift]</td> <td>NJ Ex Order 26. 4B1</td> </tr> <tr> <td>NJ Ex Order 26. 4B1</td> <td>15:38 [3PM-11PM shift]</td> <td>NJ Ex Order 26. 4B1</td> </tr> </table>	Date:	Time:	Temp:	NJ Ex Order 26. 4B1	09:04 [7AM-3PM shift]	NJ Ex Order 26. 4B1	NJ Ex Order 26. 4B1	23:27 [3PM-11PM shift]	NJ Ex Order 26. 4B1	NJ Ex Order 26. 4B1	13:20 [3PM-11PM shift]	NJ Ex Order 26. 4B1	NJ Ex Order 26. 4B1	00:25 [11 PM-7AM shift]	NJ Ex Order 26. 4B1	NJ Ex Order 26. 4B1	14:45 [7AM-3PM shift]	NJ Ex Order 26. 4B1	NJ Ex Order 26. 4B1	00:15 [11 PM-7AM shift]	NJ Ex Order 26. 4B1	NJ Ex Order 26. 4B1	19:37[3PM-11PM shift]	NJ Ex Order 26. 4B1	NJ Ex Order 26. 4B1	00:59[11 PM-7AM shift]	NJ Ex Order 26. 4B1	NJ Ex Order 26. 4B1	17:07[3PM-11PM shift]	NJ Ex Order 26. 4B1	NJ Ex Order 26. 4B1	01:33[11 PM-7AM shift]	NJ Ex Order 26. 4B1	NJ Ex Order 26. 4B1	20:47[3PM-11PM shift]	NJ Ex Order 26. 4B1	NJ Ex Order 26. 4B1	23:41 [3PM-11PM shift]	NJ Ex Order 26. 4B1	NJ Ex Order 26. 4B1	12:45 [11 PM-7AM shift]	NJ Ex Order 26. 4B1	NJ Ex Order 26. 4B1	01:12 [11 PM-7AM shift]	NJ Ex Order 26. 4B1	NJ Ex Order 26. 4B1	17:13 [3PM-11PM shift]	NJ Ex Order 26. 4B1	NJ Ex Order 26. 4B1	15:38 [3PM-11PM shift]	NJ Ex Order 26. 4B1	F 658	to reflect any behaviors of refusals. Element II All residents have the potential to be affected by this deficient practice. Element III - All RNs/LPN's will follow facility Policies and procedures on proper documentation of Physician orders into eMARs, on completion of all vitals recording as ordered including timely signing of physician orders and refusals in the eMARs. - Facility Educator/Designee will continue to educate all RNs/LPNs on completing and signing off on all orders in the eMAR upon completion. Element IV - Unit Managers and Nursing supervisors will conduct random daily audits of active residents eMARs to ensure they are being completed and signed timely; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly X 3 months. -Audits will be monitored for completion by the Administrator and Director of Nursing weekly X 4 weeks, bi-weekly X 4 weeks, monthly x 3 months. - Audits will be discussed during Quality Assurance Performance Improvement		
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F 658	Continued From page 24 NJ Ex Order 26. 4B1 20:25 [3PM-11PM shift] NJ Ex Order 26. 4B1 NJ Ex Order 26. 4B1 15:03[3PM-11PM shift] NJ Ex Order 26. 4B1 NJ Ex Order 26. 4B1 04:28[11 PM-7AM shift] NJ Ex Order 26. 4B1 NJ Ex Order 26. 4B1 20:18[3PM-11PM shift] NJ Ex Order 26. 4B1 NJ Ex Order 26. 4B1 14:37[7AM-3PM shift] NJ Ex Order 26. 4B1 NJ Ex Order 26. 4B1 00:14[11 PM-7AM shift] NJ Ex Order 26. 4B1 NJ Ex Order 26. 4B1 13:56[7AM-3PM shift] NJ Ex Order 26. 4B1 NJ Ex Order 26. 4B1 22:18[3PM-11PM shift] NJ Ex Order 26. 4B1 NJ Ex Order 26. 4B1 12:57[7AM-3PM shift] NJ Ex Order 26. 4B1 NJ Ex Order 26. 4B1 23:25[3PM-11PM shift] NJ Ex Order 26. 4B1 NJ Ex Order 26. 4B1 19:34[3PM-11PM shift] NJ Ex Order 26. 4B1 NJ Ex Order 26. 4B1 13:43[7AM-3PM shift] NJ Ex Order 26. 4B1 A review of the TEMP documentation from NJ Ex Order 26. 4B1 revealed that Resident #356's temperature was not documented 6 times on the 7AM-3PM shift, 5 times on the 3PM-11-PM shift, and 6 times on the 11PM-7AM shift. On 10/25/23 at 09:12, the Registered Nurse Unit Manager (RN UM) stated that it was important for a resident's vitals to be monitored and documented on the Medication Administration Record (MAR) so the nurse would know how the resident was doing. She added that it was important to know the resident's vitals because if the resident had an elevated temperature, it would be a concern and could be a sign of NJ Ex Order 26. 4B1. NJAC 8:39- 27.1(a)	F 658	Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.		
F 677 SS=F	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		12/1/23	

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F 677	Continued From page 25 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility provided documents, it was determined that the facility failed to consistently provide appropriate Activities of Daily Living (ADLs) care, for residents dependent on staff assistance for care, by failing to provide: a) nail care, b) assistance with [NJ Exec Order 26.4b1] c) personal hygiene care, and d) provide [NJ Exec Order 26.4b1] care, including prior to delivering a meal tray. This deficient practice was identified for 5 of 21 residents reviewed for ADLs (Resident #7, #13, #14, #41, and #73) on 2 of 2 resident care units [NJ Ex. Order 26.4(b)(1)]. This deficient practice was evidenced by the following: a. On 10/18/23 at 9:40 AM, Surveyor #1 toured the [NJ Exec Order 26.4b1] unit and observed Resident #7 lying in his/her bed. The surveyor observed Resident #7's fingernails to be [NJ Ex. Order 26.4(b)(1)] with a [NJ Ex. Order 26.4b1] under the fingernails. Resident #7's [NJ Ex. Order 26.4b1] had a long fingernail that was [NJ Exec Order 26.4b1] and in direct contact with the resident's [NJ Exec Order 26.4b1] On 10/19/23 at 10:42 AM, Surveyor #1 observed Resident #7 lying in bed with his/her fingernails visibly [NJ Ex. Order 26.4(b)(1)]. Resident #7's right hand ring finger's fingernail was [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] and in direct contact with the resident's [NJ Exec Order 26.4b1] A review of the medical record revealed Resident	F 677	F 677 SS=F: ADL Care Provided for Dependent Residents Element I Resident #7 fingernails were cleaned and filed down neatly. No adverse effect due to the deficit practice. Resident #13 was provided [NJ Ex. Order 26.4b1] immediately. [NJ Exec Order 26.4b1] was observed with [NJ Ex. Order 26.4b1] to the [NJ Ex. Order 26.4b1]. M.D. was notified (date) with new treatment order in place for [NJ Ex. Order 26.4b1]. Resident #14 was provided [NJ Ex. Order 26.4b1] to anticipate and meet the resident's needs. No adverse effect due to the deficit practice was noted. Resident #41 was provided [NJ Ex. Order 26.4b1] care. [NJ Ex. Order 26.4b1] was observed with no [NJ Ex. Order 26.4b1] or [NJ Ex. Order 26.4b1] noted.		

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F 677	Continued From page 26 #7 had diagnoses that included but were not limited to; <i>NJ Ex Order 26. 4B1</i> [REDACTED]. A review of the quarterly Minimum Data Set (MDS) an assessment tool to facilitate care, dated <i>NJ Ex Order 26. 4B1</i>, included but was not limited to; a Brief Interview for Mental Status (BIMS) documented as not conducted "resident is <i>NJ Exec Order 26.4b1</i>". Section <i>NJ</i> Functional Status documented that Resident #7 required extensive assistance with one-person physical assist for <i>NJ Exec Order 26.4b1</i>. Section <i>NJ</i> Behavior indicated that the resident did not exhibit rejection of care. A review of the person-centered comprehensive Care Plan (CP) included but was not limited to; a focus area revised <i>NJ Ex Order 26. 4B1</i>, <i>NJ Ex Order</i> [REDACTED] <i>NJ Exec Order 26.4b1</i> with interventions that included to encourage the resident to participate; and a focus area revised <i>NJ Ex Order 26. 4B1</i> <i>NJ Exec Order 26.4b1</i> related to <i>NJ Ex Order 26.4b1</i> Interventions included avoid <i>NJ Ex Order 26.4b1</i> and keep fingernails short; a focus are revised <i>NJ Ex Order 26. 4B1</i> <i>NJ Ex Order 26. 4B1</i> and interventions that included to adjust provision of <i>NJ Ex Order 26. 4B1</i> to compensate for the resident's changing abilities and to work cooperatively with the <i>NJ Ex Order 26. 4B1</i>. A review of the "My Daily Rhythm of Life" form dated <i>NJ Ex Order 26. 4B1</i>, included but was not limited to; <i>NJ Ex Order 26. 4B1</i> [REDACTED] On 10/19/23 at 11:21 AM, a Certified Nursing Assistant (CNA) #1 stated he was not Resident #7's care giver. He further stated that the <i>NJ Ex Order 26. 4B1</i> comes in the mornings to care for the	F 677	Resident #73 <i>NJ Ex Order</i> care was provided immediately. No adverse effects due to the deficit practice. 10/23/2023 a full house audit was performed on all residents that require incontinence care to ensure no signs of skin breakdown were observed. All Licensed nurses and Certified Nursing Assistance were immediately in-serviced by the Director of Nursing / Unit Manager on the importance of timely and appropriate incontinence care and nail care including no double application of incontinence products such as briefs. Intervention/re-education of staff if found to be non-compliant with providing timely care to the residents. Element II All residents have the potential to be affected by this deficient practice. Element III		

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F 677	Continued From page 27 resident. On 10/19/23 at 11:35 AM, Surveyor #1 observed the Licensed Practical Nurse (LPN) #1 in Resident #7's room. The LPN was encouraging the resident who was feeding themselves lunch. LPN #1 exited the room. On 10/19/23 at 12:17 PM, LPN #1 stated that she was not familiar with the resident as she usually worked on the other unit. On 10/19/23 at 12:20 PM, CNA #2 stated she was familiar with Resident #7. She stated that the resident was [NJ Exec Order 26.4b1], could move around in their bed, was [NJ Exec Order 26.4b1], and that [NJ Exec Order 26.4b1] usually came in the morning. CNA #2 entered Resident #7's room with the surveyor. When asked about the resident's nail care, CNA #2 stated, "they need to be cut". She stated that [NJ Ex Order 26.4b1] would clean the resident up in the morning. CNA #2 further stated that if [NJ Ex Order 26.4b1] did not provide care, the facility staff would be responsible for Resident #7's care. On 10/19/23 at 12:22 PM, LPN #1 entered Resident #7's room with the surveyor. When asked about the resident's nail care, LPN #1 stated, "The nails need to be cut. I don't do that." When asked where the documentation of nail care would be, LPN #1 stated there was a book on the unit. LPN #1 showed Surveyor #1 the CNA book for resident care but was unable to locate any documentation for Resident #7. On 10/19/23 at 12:30 PM, the Director of Nursing (DON) stated that the [NJ Ex Order 26.4B1] was not the only staff responsible for the resident's care. She stated that nail care should be completed at least	F 677	-10/23/2023 Facility Educator or Designee in-service licensed nursing staff on facility policy and procedures on Incontinence Care and Interventions. -Director of Nursing or designee will provide continued education with current staff as well as newly hired staff on timely incontinence care. -Director of Nursing/Unit Mangers, Nursing Supervisor and Infection Preventionist will conduct a weekly random audit of 5 residents to ensure incontinence care is being provided and interventions will immediately be put into place if any findings should be noted. - The Director of Nursing or designee will provide continued education with current staff as well as newly hired staff on timely incontinence care and no double application of incontinence brief. Element VI - Unit Managers and Nursing supervisors		

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F 677	Continued From page 28 once per week and as needed. She further stated that filing the fingernails may need to be done by a nurse. The DON was in Resident #7's room with the surveyor. The DON stated the resident's fingernails were too long and "should not look like that". The DON further stated that the reason would be for personal hygiene, skin integrity, and dignity. When asked about the documentation of fingernail care, the DON stated she had only been at the facility ^{NJ Ex. Order 26.4(b)(1)} and was not sure where the documentation would be located. On 10/20/23 at 8:13 AM, the ^{NJ Ex. Order 26.4B1} stated that Resident #7 was ^{NJ Ex. Order 26.4b1} which consisted of ^{NJ Ex. Order 26.4b1} him/her but that he/she could ^{NJ Ex. Order 26.4b1} him/herself. The ^{NJ Ex. Order 26.4B1} further acknowledged that Resident #7's fingernails needed to be trimmed but that she did not complete nail care for the resident. On 10/23/23 at 8:44 AM, Surveyor #1 observed Resident #7 lying in bed. Resident #7 held both hands out, motioned with ^{NJ Ex. Order 26.4B1} that he/she was ^{NJ Ex. Order 26.4b1} the other ^{NJ Ex. Order 26.4b1} and was simultaneously shaking his/her head to indicate no. When asked if he/she enjoyed his/her nails shorter and clean, the resident shook his/her head to indicate ^{NJ Ex. Order 26.4b1} On 10/31/23 at 10:00 AM, upon interview, the DON stated that there was no documentation in the Progress Notes or in the Resident #7's Care Plan (CP) that the resident was ^{NJ Ex. Order 26.4(b)(1)} ^{NJ Ex. Order 26.4b1}. She further stated that moving forward the facility would make multiple attempts to provide nail care, document any refusal, and update the CP as needed. The DON stated that the reason for keeping residents nails shorter and clean was for infection control purposes.	F 677	from every shift will conduct weekly observation audits of residents who require total assistance with incontinence care. -Audits will be monitored for completion by the Administrator and Director of Nursing weekly X 4 weeks, bi-weekly X 2 months and monthly for 3 months. - Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.		

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F 677	Continued From page 29 b. On 10/18/23 at 10:05 AM, the surveyor observed <u>NJ Ex Order 26.4B1</u> provided to Resident #13, who was in bed, the head of the bed was elevated, and the resident was <u>NJ Exec Order 26.4b1</u>. The surveyor observed the resident was unshaven and the facial area was covered with <u>NJ Ex Order 26.4b1</u>. The CNA informed the surveyor that Resident #13 required <u>NJ Ex Order 26.4(b)(1)</u> for all ADLs, including to be fed all meals and the surveyor observed that there were no <u>NJ Ex Order 26.4B1</u> observed on the resident or <u>NJ Exec Order 26.4b1</u> at that time. The surveyor observed while the <u>NJ Ex Order 26.4B1</u> were exposed, and large number of <u>NJ Exec NJ Ex Order 26.4B1</u> were observed on the bed. On 10/19/23 at 8:30 AM, the surveyor observed Resident #13 in bed. The head of the bed was elevated. The resident was still unshaven, and the <u>NJ Exec Order 26.4b1</u> were still observed. On 10/20/23 at 10:30 AM, the surveyor returned to the room and observed the resident in the same position. The resident indicated that he/she had received care this morning. On 10/20/23 at 10:45 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who had Resident #13 on her assignment. The CNA revealed that she had been on vacation for two weeks, she reported to work this morning and observed some changes regarding Resident #13's care. On 10/23/23 at 9:00 AM, the surveyor observed Resident #13 in bed. Upon inquiry, the resident stated that he/she had not received morning care yet.	F 677			

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F 677	Continued From page 30 On 10/23/23 at 9:20 AM, the resident informed the surveyor that he/she was [REDACTED] and would like to be washed. The surveyor alerted two CNAs of the request and the surveyor then observed the care provided to the resident. The surveyor along with the CNAs, who [REDACTED] the resident had observed that Resident #13 was wearing two [REDACTED] <i>NJ Ex Order 26.4B1</i>, and both were [REDACTED] with [REDACTED] <i>NJ Ex Order 26.4B1</i> from the back. The gown including the pulled sheet were also [REDACTED] <i>NJ Ex Order 26.4B1</i> and [REDACTED] <i>NJ Ex Order 26.4B1</i>. Resident #13 could not elaborate if he/she was cared for on the prior shift. On the same day, at 9:52 AM, another surveyor entered the room with the Director of Nursing (DON). At the surveyor's request, the resident's [REDACTED] <i>NJ Ex Order 26.4B1</i> was checked by staff. The resident was observed to be saturated with [REDACTED] <i>NJ Ex Order</i>. Also observed were some [REDACTED] <i>NJ Ex Order 26.4B1</i> on the [REDACTED] <i>NJ Ex Order</i> and [REDACTED] <i>NJ Ex Order 26.4B1</i> to the [REDACTED] <i>NJ Ex Order 26.4B1</i> which was not observed on [REDACTED] <i>NJ Ex Order 26.4B1</i> during the surveyor's observations. The DON was asked about her expectations for [REDACTED] <i>NJ Ex Order 26.4B1</i> and the DON replied, "better then what I just observed." The surveyor attempted to interview the resident a short while later, but he/she could not elaborate on any care received on [REDACTED] <i>NJ Ex Order 26.4B1</i> during the 11:00 PM-7:00 AM shift. On 10/26/23 at 11:55 AM, the surveyor interviewed the DON regarding the observation of Resident #13 wearing two [REDACTED] <i>NJ Ex Order 26.4B1</i>. The DON stated Resident #13 should not have had two [REDACTED] <i>NJ Ex Order 26.4B1</i> on. The DON stated the facility's protocol was to provide [REDACTED] <i>NJ Ex Order 26.4B1</i> every two hours and as needed. The DON further stated that she would address the above	F 677			

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F 677	Continued From page 31 concerns. On 10/26/23 at 12:30 PM, the surveyor interviewed the CNA who cared for Resident #13 on [REDACTED] NJ Ex Order 26.4b1. The CNA stated that she reported to work on [REDACTED] NJ Ex Order 26.4b1 at 6:50 AM. The CNA stated she had to care for another resident that was [REDACTED] NJ Ex Order 26.4b1 with [REDACTED] NJ Ex Order 26.4b1 at that time. The CNA stated, "It was so bad, I had to call the clinical director to verify that care was not provided on the prior shift." On 10/26/23 at 12:45 PM, the surveyor reviewed Resident #13's electronic medical record (EMR). Resident #13's Admission Record (AR) revealed, Resident #13 was admitted to the facility with diagnoses which included but were not limited to: [REDACTED] NJ Ex Order 26.4b1 [REDACTED]. The Annual Minimum Data Set (MDS) assessment tool used by the facility to prioritize care, dated [REDACTED] NJ Ex Order 26.4b1, revealed that Resident #13 was [REDACTED] NJ Ex Order 26.4b1. Resident #13 received a score of [REDACTED] NJ Ex out of 15 on the Brief Interview for Mental Status (BIMS). Section [REDACTED] NJ Ex of the MDS which referred to Activities of Daily Living (ADLs) revealed that Resident #13 was [REDACTED] NJ Ex Order 26.4b1 on staff for care. Review of the Care Plan for Resident #13 initiated on [REDACTED] NJ Ex Order 26.4b1, included a "Focus" for [REDACTED] NJ Ex Order 26.4b1 related to: [REDACTED] NJ Ex Order 26.4b1, [REDACTED] NJ Ex Order 26.4b1. The goal was for Resident #13 to maintain current level of function in [REDACTED] NJ Ex Order 26.4b1, [REDACTED] NJ Ex Order 26.4b1, [REDACTED] NJ Ex Order 26.4b1, and [REDACTED] NJ Ex Order 26.4b1 through [REDACTED] NJ Ex Order 26.4b1.	F 677			

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F 677	Continued From page 32 the review date. The interventions were to assist with <u>NJ Exec Order 26.4b1</u>. Encourage to get out of bed. Resident #13 required the <u>NJ Exec Order 26.4b1</u> of one care partner for help with <u>NJ Exec Order 26.4b1</u> and <u>NJ Exec Order 26.4b1</u> while resting in bed. The care plan did not specify when staff were to provide care to the resident and the frequency for staff to <u>NJ Exec Order 26.4b1</u> the resident. c. On 10/23/23 at 11:00 AM, the surveyor observed Resident # 14 in bed. The surveyor left the room to review the assignment sheet. The staff informed the surveyor that the assigned CNA was on break. The surveyor asked the Licensed Practical Nurse (LPN) and 2 random CNAs to assist with a care tour observation. The CNAs <u>NJ Exec Order 26.4b1</u> the resident to the left side. The surveyor observed that the resident's <u>NJ Ex Order 26.4B1</u> were covered with <u>NJ Ex Order 26.4B1</u> were expelling from both side of the <u>NJ Ex Order 26.4B1</u>. Resident #14's <u>NJ Ex Order 26.4B1</u> was covered with <u>NJ Ex Order 26.4B1</u>. The staff informed the surveyor that morning care had not yet been provided. The resident was <u>NJ Exec Order 26.4b1</u> and could not be interviewed. On 10/23/23 at 12:30 PM, an interview with the LPN assigned to the Noble Unit, revealed that staff should have checked the resident at the start of shift to ensure that the resident was not <u>NJ Exec Order 26.4b1</u>. The surveyor then reviewed Resident #14's EMR which revealed the following: Resident #14 was admitted to the facility with diagnoses which included but were limited to: <u>NJ Ex Order 26.4B1</u>	F 677			

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F 677	Continued From page 33 NJ Ex Order 26. 4B1. The Quarterly Minimum Data set (MDS) an assessment tool used by the facility to prioritize care dated NJ Ex Order 26. 4B1, revealed that the resident was NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 on staff for all Activities of Daily Living (ADLs). All needs must be anticipated. Resident #14 required two persons physical assist for NJ Ex Order 26. 4B1 and NJ Exec Or use. Resident #14's Comprehensive Care Plan dated NJ Ex Order 26. 4B1 with a revision date of NJ Exec Order 26.4b reflected a focus for NJ Ex Order NJ Exec Order 26.4b1 and is NJ Exec Order 26.4b1 on staff for all NJ Ex Order 26 related to NJ Ex Order 26. 4B1 and NJ Exec Order 26.4b1. The MDS also reflected that Resident #14 had a NJ Ex Order 26. 4B1 in place and was always NJ Ex Order 26. 4B1. The goal was for staff to anticipate and meet all Resident #14's needs with Target date of NJ Ex Order 26. 4B1. The interventions included: for NJ Exec Order 26.4b1: Resident #14 required NJ Ex Order 26. 4B1 with NJ Exec Order 26.4b1. According to the MDS) dated NJ Ex Order 26. 4B1, Resident #14 had a BIMS score of NJ Ex out of 15 which was indicative of NJ Ex Order 26. 4B1. On 10/23/23 at 12:30 PM, the surveyor interviewed the assigned CNA who stated that she did not check the resident that morning and she was not aware that the resident was not NJ Exec Order 26.4b during the prior shift. On 10/23/23 at 12:45 PM, the surveyor interviewed the RN/UM who stated that the facility's protocol was for all CNAs to check and provide NJ Exec Order 26.4b1 care to their residents right after morning report. The UM further stated that she was not aware that some of the residents	F 677			

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F 677	Continued From page 34 were not provided with NJ Ex Order 26. 4B1 during the prior shift. d. On 10/18/23 at 10:45 AM, the surveyor observed Resident #41 sitting in bed. The resident was wearing a brightly colored gown on and informed the surveyor that they were at the facility for NJ Exec Order 26.4b1. On 10/19/23 at 12:55 PM, the surveyor observed Resident #41 in bed the same gown and the Resident stated that they had lunch already. The surveyor reviewed Resident #41's EMR which revealed: the resident was admitted to the facility with diagnoses which included but were not limited to: NJ Ex Order 26. 4B1 [REDACTED] On 10/20/23 at 10:29 AM, the surveyor returned to the unit and observed the resident in bed and was wearing the same gown. On 10/20/23 at 10:35 AM the surveyor interviewed the Unit Manager (UM) who revealed that she was not aware that the resident had not been changed. The surveyor escorted the UM to Resident #41's room where the resident confirmed to the UM that they had not been changed and agreed to have their clothing changed. On 10/23/23 at 9:42 AM, the surveyor observed Resident #41 in bed, their NJ Ex Order 26. 4B1 appeared NJ Ex Order 26. 4B1 and NJ Ex Order 26. 4B1 with large amount of NJ Ex Order 26. 4B1 on the bed. The surveyor escorted the DON to the room where we all observed the same. The	F 677			

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F 677	Continued From page 35 surveyor asked the DON how the facility would address [REDACTED] NJ Exec Order 26.4b1. The DON showed to the surveyor the [REDACTED] NJ Exec Order 26.4b1 at the Resident's bedside. On 10/23/23 10:43 AM, the surveyor again visited the resident after AM care was provided. The resident stated, "NJ Ex Order 26. 4B1 [REDACTED] [REDACTED]" On 10/23/23 the surveyor reviewed Resident #41's EMR which revealed: Resident #41 had a care plan initiated on [REDACTED] NJ Ex Order 26. 4B1 and last revised [REDACTED] NJ Exec Order 26.4b1 for [REDACTED] NJ Exec Order 26.4b1 related to [REDACTED] NJ Exec Order 26.4b1. The goal was for resident #41 to improve current level of function in ADL tasks through the review date ([REDACTED] NJ Ex Order 26. 4B1). The interventions were for Resident #41 to participate in [REDACTED] NJ Ex Order 26. 4B1 to promote strengthening. Encourage to participate to the fullest extent possible with each interaction. Resident #41 also had a care plan for [REDACTED] NJ Ex Order 26. 4B1 integrity related to [REDACTED] NJ Exec Order 26.4b1, [REDACTED] NJ Ex Order 26. 4B1 use, [REDACTED] NJ Exec Order 26. 4B1 to [REDACTED] NJ Ex Order 26. 4B1, [REDACTED] NJ Ex Order 26. 4B1. The goal was for Resident #41 to be free from [REDACTED] NJ Exec Order 26.4b1. The interventions included: Avoid [REDACTED] NJ Exec Order 26.4b1 and keep hands and body parts from [REDACTED] NJ Exec Order 26.4b1. Keep [REDACTED] NJ Exec Order 26.4b1. Use [REDACTED] NJ Exec Order 26.4b1. (The care plan was not being followed). On 10/24/23 at 10:01 AM, the surveyor asked the UM who is directing the resident care to ensure it is happening. The UM stated, "myself and the DON." The surveyor then interviewed the UM regarding her responsibilities. The UM stated that	F 677			

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F 677	Continued From page 36 her role was to ensure the care was being delivered, communicate with staff, check assignment, and make rounds. The surveyor then asked the UM if she made rounds this morning to ensure the residents had received care. The UM replied, "No" e. On 10/26/23 at 9:04 AM, the surveyor smelled a [NJ Exec Order 26.4b1] that permeated the hallway and detected a [NJ Exec Order 26.4b1] while approaching Resident #73's room. The surveyor asked a CNA to assist the surveyor with a care observation. The CNA identified the [NJ Ex Order 26. 4B1] as coming from Resident #73's room. The surveyor then entered Resident #73's room and observed the resident seating in the wheelchair eating breakfast. The top sheet was visibly [NJ Ex Order 26. 4B1] with dried [NJ Ex Order 26. 4B1]. The resident's [NJ Ex Order 26. 4B1] along with the pants were noted to be on the floor and were [NJ Exec Order 26.4b1] with [NJ Ex Order 26. 4B1]. The padding to protect the bed was observed on the floor [NJ Exec Order 26.4b1] with [NJ Ex Order 26. 4B1]. When inquired if the resident was assisted with [NJ Ex Order 26. 4B1] prior to breakfast, the CNA stated that the resident was not on her assignment. The surveyor then exited the room to review the daily assignment and identified the CNA assigned to the resident that day. The surveyor escorted the UM to the room where we all observed Resident #73 eating breakfast in the same manner and the UM stated that should not happened. The UM proceeded to remove the [NJ Exec Order 26.4b1] clothing from the floor and then stripped the resident's bed. On 10/26/23 at 9:30 AM, the surveyor interviewed the CNA assigned to Resident #73 who stated that she did not serve breakfast to the resident. On 10/26/23 at 10:00 AM the surveyor went to the	F 677			

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F 677	Continued From page 37 kitchen and inquired regarding tray delivery in the morning. The kitchen aid provided the signed log that the breakfast trays was delivered on the NJ Ex Order 26.4(b)(1) side at 8:32 AM. On 10/26/31 at 11:15 AM, the UM informed the surveyor that the activity staff delivered the tray to Resident #73. On 10/26/23 at 12:30 PM, an interview with the activity staff revealed that she did not observe the NJ Ex Order 26.4(b)(1) clothing on the floor. She stated that the resident was in bed, she did not realize that the sheet was NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1). She did not comment on the NJ Ex Order 26.4B1 that permeated in the hallway and became stronger while approaching Resident #73's room. On 10/31/23 at 9:00 AM, during an interview with the UM, she stated that staff were to complete resident rounds, and check the resident for NJ Ex Order 26.4B1 prior to serving breakfast. On 10/26/23 the surveyor reviewed Resident #73's EMR which revealed: Resident #73 was admitted to the facility with diagnoses which included but were not limited to: NJ Ex Order 26.4B1 According to the Quarterly Minimum Data Set (MDS) dated NJ Ex Order 26.4B1, Resident #73 had a BIMS score of NJ Ex Order 26.4B1 out of 15 which was indicative of NJ Ex Order 26.4B1. However, Resident #73 had NJ Ex Order 26.4B1 and was unable to NJ Ex Order 26.4B1. When asked how he/she felt regarding eating breakfast without being NJ Ex Order 26.4B1, he/she just waived their NJ Ex Order 26.4B1 and did not offer any comment.	F 677			

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F 677	Continued From page 38 The MDS also indicated that Resident #73 required limited assistance for Activities of Daily Living (ADL) and was occasionally NJ Ex Order 26.4B1 of NJ Ex Order. An additional interview with the CNA revealed that the resident did not use the bathroom during the night. The CNA added that the resident would be NJ Ex Order 26.4B1 with NJ Ex Order most of the time. She could not provide the rationale for not checking the resident for NJ Ex Order 26.4B1 prior to breakfast. Review of the Care Plan for Resident #73 initiated on NJ Ex Order 26.4B1 and last revised NJ Ex Order 26.4B1, revealed a focus for NJ Ex Order NJ Ex Order 26.4b1 NJ Ex Order 26 related to limited NJ Ex Order 26.4B1. The goal was for Resident #73 to maintain current level of function in NJ Ex Order 26.4B1 through the review date NJ Ex Order 26.4B1. The interventions included: Encourage to participate to the fullest extent possible with each interaction. Resident to use bell to call for assistance. The care plan did not provide specifics to the direct care staff regarding the resident care. The above concerns with NJ Ex Order 26.4B1 and NJ Ex Order 26.4B1 were discussed during the survey and again on NJ Ex Order 26.4B1 again on. The DON indicated that the staff were in -served. The surveyor then asked the facility what had been done to improve the care, if any investigations were done regarding residents not being NJ Ex Order 26.4B1 and NJ Ex Order and NJ Ex Order 26.4B1 not being cared for after NJ Ex Order 26.4b1 care was provided. The DON indicated she would continue to address the above concerns. A review of the facility provided, "ADL Care"	F 677			

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F 677	Continued From page 39 policy, revised 10/2023, included but was not limited to; Policy: to provide ADL care to residents requiring such assistance to ensure all ADL needs are met on a daily basis. Guidelines: 3. The level of assistance needed for any ADL activity will be included on the resident's plan of care. 5. The CP will include approaches to address distress triggers or behaviors and to facilitate completion of ADL tasks. 6. A variety of approaches will be utilized in assisting the dementia unit residents with ADLs.	F 677			
F 684 SS=G	NJAC 8:39-27.2 (g) 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 facility documents, it was determined that the facility failed to ensure: a) a resident assessment was completed to rule out injury, and the physician was immediately notified when staff witnessed a resident who [REDACTED] hard on a door frame and yelled [REDACTED]. This resulted in a delay in treatment for one and a half hours, and the resident experienced [REDACTED] and was subsequently diagnosed with a [REDACTED], and b) appropriate	F 684	F 684 The corrective action that was taken for Resident #52 incident and accident report was reviewed on [REDACTED] with no additional adverse findings due to the deficient practice. The Director of Nursing and the Regional Nurse assessed resident #52 [REDACTED] on [REDACTED] with no signs of [REDACTED]. On [REDACTED] the Resident #52 incident report was		1/4/24

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F 684	Continued From page 40 NJ Ex Order 26. 4B1 and related services were provided for two residents dependent on staff for care. The deficient practice was identified for 1 of 2 residents reviewed (Resident #52) for accidents and 2 of 6 residents who were dependent on care and reviewed for provision of NJ Ex Order 26. 4B1 (Resident #13 who did not have a NJ Ex Order 26. 4B1 prior to not being provided with NJ Ex Order 26. 4B1 for NJ Ex hours which then resulted in a facility acquired NJ Ex Order 26. 4B1, and Resident #14 who had not been provided with NJ Ex Order 26. 4B1 for over 12 hours and was left NJ Exec Order 26.4b1 with NJ Ex Order and embedded NJ Ex Order 26. 4B1 and had a NJ Ex Order 26. 4B1 and Resident #14) and was evidenced by the following: a.) On 10/18/23 at 9:46 AM, the surveyor observed Resident #52 in his/her room. The resident looked at the surveyor but did not speak to the surveyor. The resident had one shoe on and was wearing a non-skin sock on the other foot. On 10/19/23 at 11:07 AM, the surveyor observed Resident #52 wearing non-skid socks and NJ Exec Order 26.4b1 around the nurse's station with staff holding his/her NJ Ex Order for NJ Exec Order 26.4b1. Resident #52 was easily redirected. On 10/20/23 at 7:54 AM, the surveyor observed the resident in a wheelchair in front of the nurse's station. A review of the EMR revealed that Resident #52 had diagnoses which included but were not limited to; other symptoms and signs involving the NJ Ex Order 26. 4B1.	F 684	reviewed by the Administrator, Director of Nursing, and the Regional Nurse with a timeline of the occurrence. The LPN assigned to residents at the time of the incident was interviewed by the Director of Nursing, and the Regional Nurse to conclude the summary and investigation. Our investigation revealed that the LPN failed to follow the facility policy and procedure for incident and accident. 1. A 1:1 education was immediately provided to the LPN by the Director of Nursing and Regional Clinical Nurse on the facility protocol to immediately evaluate the resident and report any incidents or accident that may occur in the facility to the Primary Care Physician to provided immediate treatment as ordered. The LPN was able to return to demonstrate that future incident reports will include evaluation of the resident's vitals, pain assessment, skin assessment and first aid application after the incident will be documented and maintained in the residents' medical records. In addition, the Director of Nursing, Administrator, and the resident representative will be informed, and the investigation of the occurrence will be completed. The Unit Manager, Director of Social worker, Director of Recreation, Director of Therapy, MDS, Dietician, LPN's, RNs, and CNAs were provided with education on the facility policy and procedure on incident/accident reporting within the auspices of their licensure on 10/27/23 by the Regional Clinical Nurse.		

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F 684	Continued From page 41 A review of the most recent quarterly Minimum Data Set (MDS) an assessment tool used to facilitate a resident's treatment, dated [REDACTED] NJ Ex Order 26. 4B1, included but was not limited to; was [REDACTED] NJ Ex Order 26.4(b), [REDACTED] so a Brief Interview for Mental Status (BIMS) could not be conducted, [REDACTED] NJ Ex Order 26. 4B1, continuous behaviors of [REDACTED] NJ Ex Order 26.4b1 and [REDACTED] NJ Ex Order 26.4b1, [REDACTED] daily, required limited assistance of at least one staff member when [REDACTED] NJ Ex Order 26.4b1 in the hallway, and as having had a [REDACTED] NJ Ex Order [REDACTED] with [REDACTED] since admission or readmission. A review of the Order Summary Report included a physician's order dated [REDACTED] NJ Ex Order 26. 4B1, for [REDACTED] NJ Ex Order 26. 4B1 give two tablets by mouth every 6 hours as needed for [REDACTED] NJ Ex Order 26. 4B1. An order dated [REDACTED] NJ Ex Order 26. 4B1, to refer the resident to a [REDACTED] NJ Ex Order 26. 4B1 for a [REDACTED] NJ Ex Order 26. 4B1. A review of the [REDACTED] NJ Ex Order 26.4b1, Medication Administration Record (MAR) included but was not limited to; the [REDACTED] NJ Ex Order 26. 4B1 order to administer two tablets every 6 hours for [REDACTED] NJ Ex Order 26. 4B1. There was no documentation on [REDACTED] NJ Ex Order 26. 4B1, that [REDACTED] NJ Ex Order 26. 4B1 had been administered for [REDACTED] NJ Ex Order 26. 4B1. A review of the person-centered comprehensive Care Plan (CP) included but was not limited to; a focus area of being at risk for [REDACTED] NJ Ex Order 26. 4B1 with actual [REDACTED] NJ Ex Order 26. 4B1 on [REDACTED] NJ Ex Order 26. 4B1. Interventions included but were not limited to; ensure the resident is wearing appropriate footwear, review information on past [REDACTED] NJ Ex Order 26. 4B1 and attempt to determine cause of [REDACTED] NJ Ex Order 26. 4B1. A focus area of having a potential for [REDACTED] NJ Ex Order 26. 4B1. Interventions included but were not limited to; monitoring/record [REDACTED] NJ Ex Order 26. 4B1 characteristics, monitor/record/report any s/sx	F 684	The Regional Clinical of Operations provided 1:1 education on 10/27/23 with the Director of Nursing and the Administrator the facility policy and procedure for incidents and accidents with reporting significant events according to the state regulations. All incidents and accidents will be reviewed by the Director of Nursing, Administrator and or designee (Unit Manager, Nursing Supervisor, Social worker or Manager on Duty) by utilizing the incident and accident audit tools sheets for improving patient safety for all incidents reported. All reportable events that result in injury as defined by regulatory standards will be reviewed for documentation in medical records, revised care plan, and the summary and conclusion reviewed at the IDCP team meeting post incident. Resident #13 [REDACTED] NJ Ex Order 26. 4B1 [REDACTED] NJ Ex Order 26. 4B1 was provided with assistance. [REDACTED] NJ Ex Order 26. 4B1 was assessed and noted with [REDACTED] NJ Ex Order 26. 4B1 on [REDACTED] NJ Ex Order 26. 4B1. The primary physician was made aware with a new order for [REDACTED] NJ Ex Order 26. 4B1 secondary to diagnosis of [REDACTED] NJ Ex Order 26. 4B1. The resident was referred to the [REDACTED] NJ Ex Order 26. 4B1 for follow up on [REDACTED] NJ Ex Order 26. 4B1 and weekly thereafter. The Care Plan was revised to reflect the changes in [REDACTED] NJ Ex Order 26.4b1. 10/23/23 1:1 education was provided to the CNA's by the Director of Nursing on the facility policy and procedures on		

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F 684	Continued From page 42 (signs and symptoms) of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 On 10/26/23 at 12:00 PM, during an interview with Surveyor #1, the Licensed Practical Nurse (LPN) #1 stated he was familiar with Resident #52 and remembered the incident on NJ Ex Order 26.4b1. LPN #1 stated he saw the resident "getting up" and NJ Ex Order 26.4b1 his/her NJ Ex Order 26.4b1 on the door frame. LPN #1 stated he had not documented what happened in the electronic medical record (EMR), and stated "I went to get [him/her] and I assisted [him/her] to the a chair and stated Resident #52 NJ Ex Order 26.4b1" when the resident NJ Ex Order 26.4b1 [his/her] NJ Exec Order 26.4b1. LPN #1 stated, "I sat him/her back in his/her chair and took his/her vital signs." LPN #1 then stated, "It was an hour and a half later that the resident's NJ Ex Order 26.4b1 was NJ Ex Order 26.4b1 and the resident was in NJ Ex Order 26.4b1." When the surveyor inquired if an assessment was immediately conducted upon observing the resident NJ Ex Order 26.4b1 [his/her] NJ Ex Order 26.4b1 or any care that had been provided to Resident #52, the LPN stated, "I don't have the documentation of assessing the resident's NJ Ex Order 26.4b1." LPN #1 stated he only placed Resident #52 in a chair. LPN #1 confirmed that he had not contacted the physician at the time the resident NJ Ex Order 26.4b1 [his/her] NJ Ex Order 26.4b1 and stated he "should have maybe done something". When inquired to LPN #1 what should be done when a resident has a NJ Exec Order 26.4b1, the LPN stated further the process would have been to assess the resident, call the nursing supervisor or Director of Nursing (DON), call the physician, and notify the family. LPN #1 stated that an assessment should have been completed and documented, and confirmed it had not been completed. A review of the Progress Notes (PN) revealed	F 684	incontinence care with the appropriate use of incontinence products. 10/23/23 A facility house audit was completed for all residents that required total assistance with incontinence and ADL's care were monitored for double diapers and cleanliness. Resident #14 NJ Ex Order 26.4b1 was provided with two-person assistance. On NJ Ex Order 26.4b1 NJ Exec Order 26.4b1 was assessed and noted with a new NJ Ex Order 26.4b1. The primary physician was made aware with a new treatment in place. The care plan was revised to reflect the changes in NJ Ex Order 26.4b1 On 10/23/23, all licensed nurses were educated on the facility policy and procedure, as well as, the standard of practice for following physician's orders when a new skin abnormality is observed prior to providing treatment. 2. All residents have the potential to be affected by the deficit practice, when care is not rendered in a timely matter. a. DON or Unit Manager, Minimum Data System Coordinator, in conjunction with the Inter Disciplinary team members, which include, but are not limited to the Administrator, Director of Social Services, Director of Recreation, Director of Therapy, Dietician, Nursing Supervisor and direct care staff, will perform weekly audits of those residents at risk for injury related to an incident.		

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F 684	Continued From page 43 documentation by the LPN #1 dated [NJ Ex Order 26.4B1] at 9:50 AM, revealed "Resident c/o [complaint of] [NJ Exec Order 26.4b1] about [NJ Ex Order 26.4B1], noted [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1]. Vitals stable, called placed to md [medical doctor], new order for [NJ Ex Order] of the [NJ Ex Order 26.4B1] for c/o [NJ Exec Order] and [NJ Ex Order 26.4B1]." On 10/26/23 at 12:30 PM, the Medical Director (MD) during a telephone interview with the surveyors, stated that she was Resident #52's physician. The MD stated she was aware Resident #52 had [NJ Ex Order] but could not remember everything about the [NJ Ex Order 26.4B1] incident. The MD stated her expectations would be that if a resident [NJ Ex Order], the staff should "tend to the resident, call the physician, and describe the injury so she would know the course of action." The MD further stated that if a staff member witnessed the resident [NJ Ex Order] their [NJ Ex Order], she would expect a call "immediately". She accessed her EMR and informed the surveyors that she was informed the [NJ Ex Order 26.4B1] was [NJ Ex Order 26.4B1] on [NJ Ex Order 26.4B1], [NJ Ex Order 26.4B1] ago" and the staff was not sure how the [NJ Ex Order 26.4B1] occurred. On 10/27/23 at 10:46 AM, the above concern was addressed with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Director of Operations, and the Regional Clinical Nurse (RCN). On 10/31/23 at 8:21 AM, during an interview with the surveyor, LPN #2 stated if she witnessed a resident [NJ Exec Order] into something or [NJ Exec Order] themselves, she would assess their "whole body", write an incident report, but give first aid immediately in case the resident had [NJ Exec Order] and next call the doctor.	F 684	b. Residents who require incontinence care were checked for soiled incontinence brief on October 23, during shift change at 3pm. Residents continued to be checked at random daily during each shift. Any deficient practices found were corrected and addressed immediately. 3. The systemic changes that will occur to prevent recurrence. a. Incident and Accident During clinical review meeting, the Director of Nursing or Unit Manager will review the 24-hour report with the clinical team to identify possible incident/accident occurrence, as well as reporting any incidents/accidents during shift to shift report. During Wrap-up meeting, which occurs at end of day, all department heads will report any incidents/accidents that were observed or reported to them during the working day. Assessments will be reviewed and any stop and watch episodes reported and incorporated. If any incidents/accidents occur, the clinical team, lead by the Director of Nursing, will follow facility protocol with initiating, investigating and completing an incident/accident report. Care plans for corresponding residents will be reviewed and updated accordingly, as well as reviewed with the direct care team. All staff have been in-serviced on the facility policy and procedures for reportable events. All licensed staff have		

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F 684	Continued From page 44 On 10/31/23 at 8:22 AM, LPN #3 stated if she witnessed a resident [REDACTED] themselves, she would immediately assess the resident and provide first aid and inform the doctor. She stated she would provide first aid "definitely right away" to protect the resident. On 10/31/23 at 10:24 AM, the Regional Clinical Nurse (RCN) stated LPN #1 should have called the doctor, used [REDACTED] and [REDACTED] management immediately given the resident [REDACTED] [REDACTED]. She stated the expectation would have been to assess for [REDACTED] and administer the already ordered [REDACTED] for [REDACTED]. The facility had no additional documentation or policies to provide. b. 1.) On 10/18/23 at 10:35 AM, Surveyor #2 toured the [REDACTED] Unit ([REDACTED]), and observed Resident #13 in bed. Their eyes were open and the resident was able to communicate with the surveyor. A care tour was completed with the Certified Nursing Assistant (CNA) assigned to the unit and revealed the following: Resident #13 was unshaven, the skin on the face was covered with flakes. The [REDACTED] extended to the [REDACTED] had areas that were covered with [REDACTED] [REDACTED] areas with [REDACTED] which were noted on the bed also. The adult [REDACTED] that the resident was wearing, was secured properly and was not [REDACTED]. The skin on the [REDACTED] and [REDACTED] was intact and there were no open areas. No redness was noted. There was no documentation that Resident #13 had been non-compliant with care. An interview with the CNA revealed that the	F 684	been in-serviced on completing incidents and accidents that involve any resident that resides in the facility. This is inclusive of timely notification to the physician, timely completion of pain, skin and risk assessments and application of first aide, if deemed appropriate. b. Incontinence care Random spot checks and resident care interviews will be conducted for incontinent patients by a designee, which can include, but not limited to, Director of Nursing, Unit Manager, Nursing Supervisor, Social Services, Administrator, Director of Therapy, MDS, Recreation Director and Weekend Manager on Duty. Any deficient practice found will be reported to the Administrator, will be investigated and mitigated immediately. If there is a change in the CNA assignment, a revision will be made to the assignment as needed to ensure that all resident care needs will be met. Notification of the revision will be noted in the 24-hour report and reported to the Administrator and Director of Nursing. 4. Audits will be monitored for completion by the Administrator and Director of Nursing weekly for 4 weeks, every 2 weeks for 2 months and monthly for 3 months. Results of the audits will be presented to the administrator and the monthly Quality		

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F 684	Continued From page 45 resident required extensive assistance of two staff for <u>NJ Ex Order 26. 4B1</u> and <u>NJ Ex Order 26. 4b</u>. The CNA added that the resident remained in bed and would refuse to get out of the bed. When the surveyor inquired about the <u>NJ Ex Order 26. 4b</u> noted on the <u>NJ Ex Order</u> and the <u>NJ Ex Order 26. 4B1</u>, the CNA stated, "There is a <u>NJ Ex Order 26. 4b1</u> that could be applied." On 10/19/23 at 8:45 AM, Surveyor #2 observed the resident in bed. The resident was unshaven and the <u>NJ Ex Order</u> was <u>NJ Ex Order</u>. An interview with the Registered Nurse Unit Manager (RN/UM) revealed that the <u>NJ Ex Order 26. 4B1</u> visited the resident on <u>NJ Ex Order 26. 4B1</u>, and there were no new orders. On 10/20/23 at 7:45 AM, Surveyor #2 observed the resident in bed, their eyes were closed, and the side-rails were elevated. The surveyor returned during lunch and observed the resident was in bed, unshaven, and large number of <u>NJ Ex Order</u> and <u>NJ Ex Order 26. 4B1</u> were noted on the bed. On 10/23/23 at 9:00 AM, Surveyor #2 returned to the unit and observed Resident #13 in bed. A CNA was at the bedside assisting Resident #13 with the breakfast meal. The resident was unshaven, and their face was covered with <u>NJ Ex Order</u>. The surveyor asked the resident if he/she would consider getting out of the bed today. The resident replied, "<u>NJ Ex Order 26. 4B1</u>." On 10/23/23 at 9:30 AM, after breakfast Surveyor #2 asked two CNAs to assist with a care tour. The surveyor observed that Resident #13 was wearing two <u>NJ Ex Order 26. 4B1</u> which were both <u>NJ Ex Order 26. 4b1</u> with <u>NJ Ex Order</u>. The gown that the resident was wearing was <u>NJ Ex Order 26. 4B1</u>. The pulled sheet was also <u>NJ Ex Order 26. 4B1</u>. Resident #13	F 684	Assurance and Performance Improvement (QAPI) meetings for review and revision as deemed appropriate. This plan can be amended when indicated. Adverse findings will be immediately addressed.		

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F 684	Continued From page 46 was noted with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 to the NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. The Registered Nurse Unit Manager (RN/UM) was not available on the NJ Exec Order Unit. The surveyor summoned another surveyor to the room along with the Director of Nursing (DON). On NJ Ex Order 26.4b1 at 9:52 AM, the DON in the presence of Surveyor #2 verified that NJ Ex Order 26.4b1 had not been provided on the prior shift. (11:00 PM-07:00 AM shift). Surveyor #2 left the room and reviewed the 11:00 PM-7:00 AM staffing. The Census was 52, and only 1 CNA had been assigned to care for 52 residents. On 10/26/23 at 11:00 AM, Surveyor #2 conducted a telephone interview with the CNA who worked the prior 3:00 PM-11:00 PM shift. The CNA revealed that she provided care to Resident #13 on NJ Ex Order 26.4b1 at 6:30 PM and applied two NJ Exec Ord NJ Ex Order 26.4b1 on the resident. The CNA stated that at 6:30 PM, she had to change the sheets including the gown, as Resident #13 was NJ Exec Order 26.4b1 with NJ Ex Order. The CNA confirmed that she applied two NJ Ex Ord NJ Ex Order 26.4b1 prior to finishing her shift. She informed the surveyor that she clocked out at 7:00 PM. On 10/26/23 at 12:53 PM, Surveyor #2 conducted a telephone interview with the 3:00 PM -11:00 PM Registered Nurse (RN) who worked on the NJ Exec Order Unit. The RN stated that two CNAs left at 7:00 PM, and the other CNA on the unit did not ask for assistance with care. He stated that staffing was lacking but he would assist if requested. He could not elaborate on whether NJ Ex Order 26.4b1 had been provided. On 10/27/23 at 9:25 AM, Surveyor #2 checked	F 684			

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F 684	Continued From page 47 Resident #13 again and observed the [NJ Ex Order 26. 4b1] was still present. A [NJ Ex Order 26. 4b1] to the [NJ Ex Order 26. 4B1] was observed and there was no documentation regarding the newly [NJ Ex Order 26. 4b1] which was not measured or provided a treatment. On 10/27/23 at 9:32 AM, Surveyor #2 asked the RN/UM to measure the affected area. The [NJ Ex Order 26. 4b1] measured: [NJ Ex Order 26. 4B1]. The [NJ Ex Order 26. 4B1]. On 10/27/23 at 9:49 AM, Surveyor #2 conducted an interview with the RN/UM regarding the process to ensure that the residents were being cared for. The RN/UM stated that in the morning, she would get a verbal report from the 11:00 PM-7:00 AM shift and would follow up on anything important. She stated she would assign nurses and gave report to CNAs. The CNAs should check the residents as soon as they received their report. Residents' dependent on staff for care should be checked at minimum every two hours and as needed. The RN/UM further stated that she was not aware that some of the residents did not receive care during the 11:00 PM-7:00 AM shift. In the morning during report, she was informed that adequate staffing was an issue, and the night nurse did not elaborate further. She went on to state, if she was made aware of residents not having received care, she would have asked the CNAs to check and change the residents that were not changed during the prior shift "immediately." On 10/27/23 at 7:50 AM, Surveyor #2 conducted a face-to-face interview with the Licensed Practical Nurse (LPN) who worked the 11:00 PM-7:00 AM shift on [NJ Ex Order 26. 4B1]. The LPN informed the surveyor that staffing had been an issue at	F 684			

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F 684	Continued From page 48 the facility for the last 5 years. The LPN made it clear that on [NJ Ex Order 26. 4B1] during the night, they provided safety and answered call lights. When inquired regarding if she aided the CNAs to change and turn some of the residents, she stated, "No, I was busy also. We provided safety that is all we could do." When asked if the administrative staff was aware of the staffing issue, she stated, "yes". On 10/27/23 at 8:40 AM, Surveyor #2 conducted a telephone interview with the CNA who cared for the resident during the 11:00 PM -7:00 AM shift on [NJ Ex Order 26. 4B1]. The CNA confirmed that he did not provide [NJ Ex Order 26. 4B1] to the resident during the shift (8 hours). The CNA told the surveyor he was "overwhelmed and could not get to the resident." He stated that for that shift he provided care for 30 residents. The CNA stated he provided safety and ensured the call lights were being answered. On 10/27/23 at 10:55 AM, the DON revealed she was not aware that the facility had one CNA working for the 11:00 PM- 7:00 AM shift. She further stated, if she had been made aware, she would have call to get more staff. She added that she was not aware that [NJ Ex Order 26. 4B1] had not been provided. Her expectations were that all residents looked cleaned and received the care they deserve. A statement from the LPN assigned to the 7:00 AM-3:00 PM shift indicated that she was informed by the CNA that Resident #13 was heavily [NJ Ex Order 26. 4b1] with [NJ Ex Order 26. 4B1] and had 2 [NJ Ex Order 26. 4B1] on. She informed the DON and applied periguard cream to the skin. She rechecked the resident in the afternoon after care was provided and there was no [NJ Ex Order 26. 4b1] observed.	F 684			

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F 684	Continued From page 49 On 10/27/23 Surveyor #2 reviewed Resident #13's EMR. The admission Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; <u>NJ Ex Order 26.4B1</u> <u>NJ Ex Order 26.4B1</u>. Review of R 13's most recent annual MDS with an Assessment Reference Date (ARD) of <u>NJ Ex Order 26.4B1</u>, reflected that Resident #13 had <u>NJ Ex Order 26.4B1</u>. Resident #13 scored <u>NJ Ex 4</u> out of 15 on the <u>NJ Ex Order 26.4B1</u>. Section <u>NJ</u>, Care Area Assessment (CAA) Summary, Section <u>NJ</u> 02000. CAA and Care Plan (CP) decision, documented <u>NJ Exec Order 26.4b1</u>, Activities of daily living, <u>NJ Exec Order 26.4b1</u>, and <u>NJ Exec Order 26.4b1</u> were triggered and identified to develop a care plan. Record Review (RR) of Resident #13 revealed that R #13 did not have a <u>NJ Ex Order 26.4B1</u>. Section <u>NJ</u> which addressed <u>NJ Exec Order 26.4b1</u>, coded Resident #13 to be <u>NJ Ex Order 26</u>. Surveyor #2 reviewed Resident #13's Care Plan (CP), last reviewed/revised on <u>NJ Exec Order 26.4b1</u>. The CP had a focus area for <u>NJ Exec Order 26.4b1</u> related to healing <u>NJ Ex Order 26.4B1</u>, <u>NJ Ex Order 26.4B1</u> and <u>NJ Ex Order 26.4B1</u> and <u>NJ Ex Order 26.4B1</u> and <u>NJ Ex Order 26.4B1</u> insufficiencies. The goal was for Resident #13 to develop no <u>NJ Exec Order 26.4b1</u>. The interventions included, keep <u>NJ Exec Order 26.4b1</u> and <u>NJ Ex</u>. <u>NJ Exec Order 26.4b1</u>. <u>NJ Exec Order 26.4b1</u> and <u>NJ Exec Order 26.4b1</u> at frequent intervals while in bed. The care plan did not reflect that Resident #13 had a <u>NJ Ex Order 26.4B1</u> to the <u>NJ Ex Order 26.4B1</u> extended to the <u>NJ Ex Order 26.4B1</u>.	F 684			

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F 684	Continued From page 50 A review of an interdisciplinary (IDCP) meeting conducted by the facility on [REDACTED] NJ Ex Order 26. 4B1, timed 15:44 (3:44) PM, reflected the following: IDCP met to review Quarterly plan of care. Resident had not had a significant change(s) in condition. Resident is compliant with care and takes his/her meds. NJ Exec Order 26.4b1 ... Despite the observed [REDACTED] NJ Ex Order 26. 4B1 verified by the facility staff on [REDACTED] NJ Ex Order 26. 4B1, there was no documentation that the physician or the Resident Representative (RR) was informed of the issue with [REDACTED] NJ Ex Order 26. 4B1 resulting in [REDACTED] NJ Ex Order 26.4B1. The care plan was not revised. On 10/31/23 at 9:30 AM, the RN/UM informed Surveyor #2 that the resident was seen by the [REDACTED] NJ Ex Order 26. 4B1 team and provided the following progress notes dated [REDACTED] NJ Ex Order 26. 4B1 timed 13:06 (1:06) PM. Resident was seen on [REDACTED] NJ Ex Order 26. 4B1 resolved. [REDACTED] NJ Ex Order 26. 4B1 [REDACTED] NJ Ex Order 26.4b1 measuring [REDACTED] NJ Ex Order 26. 4B1 [REDACTED] NJ Ex Order 26. 4B1 is intact. Treatment, [REDACTED] NJ Ex Order 26. 4B1 [REDACTED] NJ Ex Order 26. 4B1 present. [REDACTED] NJ Ex Order 26. 4B1 present. Treatment with [REDACTED] NJ Ex Order 26. 4B1 twice daily. b. 2.) On 10/23/23 at 11:00, Surveyor #2 entered Resident #14's room with two CNAs for a care tour. The surveyor observed that Resident #14 was not provided with [REDACTED] NJ Ex Order 26. 4B1. Large amount of [REDACTED] NJ Ex Order 26. 4B1 was noted on the sheet. Strong [REDACTED] NJ Ex Order 26. 4B1 was noted in the room. During the care tour at 11:15 AM, the surveyor along with facility's staff observed Resident #14's [REDACTED] NJ Ex Order 26. 4B1 and [REDACTED] NJ Ex Order 26. 4B1 which were covered with [REDACTED] NJ Ex Order 26. 4B1. Resident #14 had a [REDACTED] NJ Ex Order 26. 4B1 that was covered with [REDACTED] NJ Ex Order 26. 4B1. The [REDACTED] NJ Ex Order 26. 4B1 covering the [REDACTED] NJ Ex Order 26. 4B1 was noted in the [REDACTED] NJ Ex Order 26. 4B1	F 684			

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F 684	Continued From page 51 covered with [REDACTED] exposing the [REDACTED] [REDACTED] that were also covered with [REDACTED]. On 10/23/23 at 12:30 PM, Surveyor #2 interviewed the CNA assigned to Resident #14. The CNA confirmed that she had not checked or changed the resident prior to go on break at 11:00 AM. On 10/27/23 at 8:40 AM, Surveyor #2 conducted a telephone interview with the 11:00 PM-7:00 AM CNA. The CNA informed the surveyor that he checked the resident "possibly at 6:00 AM" and the resident was not [REDACTED]. When inquired about who assisted him with the resident, he stated, "I did it alone". (Resident #14 required extensive assist of two persons for [REDACTED]). The surveyor then asked the CNA what he observed on the resident [REDACTED], he stated there was nothing in place. Resident #14 had a [REDACTED] and a [REDACTED] was to be in place but was missing per the CNA. On 10/27/23 the 11:00 PM- 7:00 AM CNA provided the following statement, "I was the only CNA on the unit last night. I did rounds, offered water to the residents but did not provide [REDACTED]. I was alone and it was difficult. I did not ask for assistance from the nurse. It just escaped my mind. I must be honest, I made rounds, offered water but I did not change or check the residents." A telephone statement from the LPN dated [REDACTED], indicated the following: "I was the only nurse and he was the only CNA. I helped the CNA with residents that he could not change alone. I have one CNA who could not do the entire floor. The LPN stated that at 6:00 AM, she	F 684			

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F 684	Continued From page 52 observed that Resident #14 was in bed, appeared to be comfortable and he/she was covered. I did not noticed any [redacted] during my rounds." The surveyor reviewed Resident #14's clinical record. The admission Face Sheet reflected that Resident #14 was admitted to the facility with diagnoses which included but were not limited to; [redacted] NJ Ex Order 26. 4B1 [redacted]. The Quarterly Minimum Data set (MDS) an assessment tool used by the facility to prioritize care dated [redacted] NJ Ex Order 26. 4B1 [redacted], revealed that the resident was [redacted] NJ Ex Order 26.4b1 [redacted] and [redacted] NJ Ex Order 26.4b1 [redacted] on staff for all [redacted] NJ Ex Order 26. 4B1 [redacted]. All needs must be anticipated. Resident #14 required two persons physical assist for [redacted] NJ Ex Order 26. 4B1 [redacted] and [redacted] NJ Ex Order 26. 4B1 [redacted]. Resident #14's Comprehensive Care Plan dated [redacted] NJ Ex Order 26. 4B1 [redacted], with a revision date of [redacted] NJ Ex Order 26.4b1 [redacted], reflected a focus for [redacted] NJ Ex Order 26.4b1 [redacted] and is [redacted] NJ Ex Order 26.4b1 [redacted] on staff for all [redacted] NJ Ex Order 26. 4B1 [redacted] related to [redacted] NJ Ex Order 26. 4B1 [redacted] and [redacted] NJ Ex Order 26. 4B1 [redacted]. The goal was for staff to anticipate and meets all Resident #14's needs with Target date of [redacted] NJ Ex Order 26. 4B1 [redacted]. The interventions included: for [redacted] NJ Ex Order 26.4b1 [redacted]; Resident #14 required [redacted] NJ Ex Order 26. 4B1 [redacted] with [redacted] NJ Ex Order 26.4b1 [redacted]. Resident #14 also had a focus for impairment to [redacted] NJ Ex Order 26.4b1 [redacted] on [redacted] NJ Ex Order 26. 4B1 [redacted] related to [redacted] NJ Ex Order 26. 4B1 [redacted]. The goal was for the [redacted] NJ Ex Order 26. 4B1 [redacted] to show sign and symptoms of healing through the review date of [redacted] NJ Ex Order 26.4b1 [redacted]. Interventions included: [redacted] NJ Ex Order 26.4b1 [redacted] with care initiated [redacted] NJ Ex Order 26. 4B1 [redacted]. Follow facility protocols for treatment of [redacted] NJ Ex Order 26. 4B1 [redacted]. Identify causative factors and eliminate/resolve where possible. keep [redacted] NJ Ex Order 26. 4B1 [redacted] clean and [redacted] NJ Ex Order 26. 4B1 [redacted] revision date [redacted] NJ Ex Order 26. 4B1 [redacted] to [redacted] NJ Ex Order 26.4b1 [redacted] ([redacted] NJ Ex Order 26. 4B1 [redacted]).	F 684			

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F 684	Continued From page 53 [REDACTED] and [REDACTED] every 2 hours. [REDACTED] assessments by licensed nurse with a revision date of [REDACTED] On 10/20/23 at 11:15 AM, Surveyor #2 conducted a face to face interview with Resident #14's Representative (RR). The RR revealed concerns with the care delivery. The RR stated that the facility did not have enough staff to care for the residents. The RR went on to state that during visits, the RR would observe the resident [REDACTED] and laying in bed with a [REDACTED] for long periods of time and could not find any available staff to [REDACTED] the resident. The RR stated this had been discussed with the RN/UM and the prior Director of Nursing. On 10/23/23 at 11:00 AM, Surveyor #2 conducted a care tour with two CNAs assigned to [REDACTED] Unit [REDACTED]. On 10/23/23 at 11:15 AM, in the presence of the LPN assigned to the unit and two CNAs, Surveyor #2 observed that Resident #14 was [REDACTED] with [REDACTED]. The [REDACTED] and the [REDACTED] were covered with [REDACTED]. The CNA assigned to the resident was on break and could not be interviewed. On 10/23/23 at 12:30 PM, the surveyor interviewed the CNA assigned to the 7:00 AM-3:00 PM. The CNA revealed that she reported to work at 6:50 AM, and had not yet checked the resident during the shift. Statements from the CNA who worked the 11:00 PM-7:00 AM shift indicated that [REDACTED] was not provided during the prior shift because he was the only CNA.	F 684			

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F 684	Continued From page 54 Resident #14 was <u>NJ Exec Order 26.4b1</u> on staff for care. Resident #14 was not provided <u>NJ Ex Order 26.4B1</u> for over 12 hours. During <u>NJ Ex Order 26.4B1</u> on <u>NJ Ex Order 26.4B1</u> at 11:30 AM, a <u>NJ Exec Order 26.4b1</u> was noted on the <u>NJ Ex Order 26.4B1</u> which was not measured by the nurse. The nurse <u>NJ Exec Order 26.4B1</u> the <u>NJ Ex Order 26.4B1</u> with <u>NJ Ex Order 26.4B1</u> and secured the <u>NJ Ex Order 26.4B1</u> with the <u>NJ Ex Order 26.4B1</u>. A review of the indication for <u>NJ Ex Order 26.4B1</u> indicated the following: "Do not use on <u>NJ Exec Order 26.4B1</u> and <u>NJ Exec Order 26.4b1</u>." The LPN did not have an order to apply <u>NJ Ex Order 26.4B1</u> to the <u>NJ Ex Order 26.4B1</u>. On 10/23/23 at 12:40 PM, during an interview with the Director of Nursing, she stated that the nurse should have applied a <u>NJ Exec Order 26.4B1</u> <u>NJ Ex Order 26.4B1</u> until she got an order from the physician. Review of the <u>NJ Exec Order 26.4B1</u> evaluation dated <u>NJ Exec Order 26.4b1</u> provided by the facility, revealed that the resident had a <u>NJ Ex Order 26.4B1</u> to the <u>NJ Ex Order 26.4B1</u>. The <u>NJ Exec Order 26.4b1</u> to the <u>NJ Ex Order 26.4B1</u> was identified on <u>NJ Ex Order 26.4B1</u>, during care and <u>NJ Ex Order 26.4B1</u>. Review of the Physician Order Sheet (POS) dated <u>NJ Ex Order 26.4B1</u>, reflected an order to <u>NJ Exec Order 26.4B1</u> the <u>NJ Ex Order 26.4B1</u> with <u>NJ Exec Order 26.4B1</u> and pat dry. Apply <u>NJ Ex Order 26.4B1</u>, cover with <u>NJ Exec Order 26.4B1</u> and <u>NJ Exec Order 26.4b1</u>. <u>NJ Ex Order 26.4B1</u> was to be applied to the <u>NJ Ex Order 26.4B1</u>. There was no order to apply <u>NJ Ex Order 26.4B1</u> to the <u>NJ Ex Order 26.4B1</u>. A Progress Notes dated <u>NJ Ex Order 26.4B1</u> timed 6:20 PM, revealed the following: <u>NJ Ex Order 26.4B1</u> <u>NJ Ex Order 26.4B1</u> <u>NJ Ex Order 26.4B1</u> <u>NJ Ex Order 26.4B1</u>	F 684			

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F 684	Continued From page 55 The facility provided, "NJ Exec Order 26.4B1 Evaluation" dated NJ Ex Order 26.4B1, indicated that a new issue was identified: Noted with NJ Ex Order 26.4B1, NJ Ex Order 26.4B1 to NJ Ex Order 26.4B1 and NJ Exec Order 26.4b1 of NJ Ex Order 26.4B1 to NJ Ex Order 26.4B1. A review of the Comprehensive Care Plan did not include documentation of the NJ Exec Order 26.4B1 identified on NJ Ex Order 26.4B1. The rationale for not revising the care plan after the NJ Exec Order 26.4b1 was identified was not provided. The above concerns were discussed with the administrative staff during the survey and again on NJ Ex Order 26.4B1, during the pre-exit conference. The DON added that she started the investigation and would provide the investigation on NJ Ex Order 26.4B1. The DON provided the investigation on NJ Ex Order 26.4B1. All staff involved with Resident #13's and #14 care on NJ Ex Order 26.4B1, were interviewed. The 3:00 PM-11:00 PM shift confirmed she provided care to Resident #13 at 6:30 PM, and applied 2 NJ Ex Order 26.4B1 on the resident. The 11:00 PM-7:00 AM CNA provided a statement which reflected that he did not provide NJ Ex Order 26.4B1 to the residents. Resident #13 and #14 did not receive care according to their plan of care. The resident (#13) was last NJ Ex Order 26.4b1 at 6:30 PM on NJ Ex Order 26.4B1. On 10/31/23 at 11:30 AM, in the presence of the survey team, the DON acknowledged that based on the investigation and her observation specifically for Resident #13, NJ Ex Order 26.4B1 was not provided. The DON further stated that all residents dependent on staff for care should have been checked and NJ Ex Order 26.4b1 every 2 hours and as needed. A review of the facility provided, "Abuse, Neglect and Exploitation," policy revised 09/2022, included	F 684			

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F 684	Continued From page 56 but was not limited to; Policy: to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. "Neglect" is defined as the failure of the facility to provide goods or services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. A review of the facility provided, "Abuse, Neglect and Mistreatment of the Elderly Policy", undated, included but was not limited to; B. Prevention: 4. adequate staffing levels are maintained at all times so that the needs of residents are met. D. Identification: 2. examples of neglect may include: a. pressure sores, b. poor personal hygiene, e. dirty, soiled bed, fecal or urine odor. A review of the facility provided, "Certified Nurse Aide" position summary, undated, included but was not limited to; Responsibilities: handles and attends to residents in a manner conducive to their safety and comfort; bathes the resident....cleans and cuts fingernails and gives shampoos; and reports changes in resident's condition to the charge nurse or supervisor. A review of the facility provided, "Licensed Practical Nurse" position summary, undated, included but was not limited to; Responsibilities: takes an active role in direct resident assessment and care; assesses each resident daily and implements a change in the course of action as needed; maintains accurate resident care records and documents pertinent data; ensure that residents receive the highest quality of service...promoting dignity and respect;	F 684			

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F 684	Continued From page 57 A review of the facility provided, "Registered Nurse", position summary, undated, included but was not limited to; takes an active role in direct resident assessment and care; must have the ability to recognize and identify symptoms and to make decisions quickly in emergencies; assess each resident daily and implements a change in the course of action as needed; ensures that residents and families receive the highest quality of service...promoting dignity and respect. A review of the facility provided, "Director of Nursing Services", position summary, undated, included but was not limited to; monitors nursing care to assure that all residents are treated fairly, with kindness, dignity and respect; completes daily rounds on the unit to observe residents and determine if nursing needs are being met; reviews nursing progress notes to ensure they are informative and descriptive of the nursing care provided; and provides direction to the nursing staff.	F 684			
F 695 SS=E	NJAC 8:39-27.1 (a), 27.2 (c)(d)(g)(h)(j) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced	F 695			12/1/23

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F 695	Continued From page 58 by: Based on observation, interview and record review, it was determined that the facility failed to ensure a.) a resident who was dependent on <u>NJ Ex Order 26. 4B1</u> was provided with <u>NJ Ex Order 26. 4B1</u> to maintain their <u>NJ Ex Order 26. 4B1</u> according to the physician's order and the facility's policy, b) that a resident received <u>NJ Ex Order 26. 4B1</u> as ordered by the physician, and c) <u>NJ Ex Order 26. 4B1</u> treatments were provided in a manner to prevent the spread of infection. This deficient practice was identified for 2 of 2 residents reviewed for <u>NJ Ex Order 26. 4B1</u>, Resident #14 and #92 and was evidenced by the following: 1.) On 10/18/23 at 09:10 AM, the surveyor observed Resident #14 in bed. The resident was <u>NJ Ex Order 26. 4B1</u>. The resident had a <u>NJ Ex Order 26. 4B1</u>, and was connected to an <u>NJ Ex Order 26. 4B1</u>. The <u>NJ Ex Order 26. 4B1</u> was set to deliver <u>NJ Ex Order 26. 4B1</u> at <u>NJ Ex Order 26. 4B1</u> per minute via the <u>NJ Ex Order 26. 4B1</u>. The surveyor observed the label on the <u>NJ Ex Order 26. 4B1</u> dated <u>NJ Ex Order 26. 4B1</u>. The following observations were made of Resident #14: 10/18/23 at 9:10 AM, Resident #14 was observed lying in bed with <u>NJ Ex Order 26. 4B1</u> at <u>NJ Ex Order 26. 4B1</u> via the <u>NJ Ex Order 26. 4B1</u>. The date/label on the <u>NJ Ex Order 26. 4B1</u> reflected that the <u>NJ Ex Order 26. 4B1</u> was last changed <u>NJ Ex Order 26. 4B1</u>. On 10/19/23 at 9:33 AM-Resident #14 was observed lying in bed with <u>NJ Ex Order 26. 4B1</u> at <u>NJ Ex Order 26. 4B1</u> via the <u>NJ Ex Order 26. 4B1</u> and the <u>NJ Ex Order 26. 4B1</u>. The <u>NJ Ex Order 26. 4B1</u> dated <u>NJ Ex Order 26. 4B1</u>.	F 695	Resident #98 primary physician was notified, and physician orders were reviewed and will continue the residents active <u>NJ Ex Order 26. 4B1</u> prescribed. <u>NJ Ex Order 26. 4B1</u> all licensed nurses were in-serviced by the Director of Nursing on assess <u>NJ Ex Order 26. 4B1</u> with the physician orders for all residents who requires <u>NJ Ex Order 26. 4B1</u>. Resident # 98 was assessed with <u>NJ Ex Order 26. 4B1</u> or adverse effect due to the deficit practice. Resident 14 orders were re-reviewed and entered into EMR as such. Care plan interventions were also updated to reflect aforementioned changes. Staff reeducated by the Director of nursing the importance of reviewing orders including the application of new tubing as outlined in the facility policy. <u>NJ Ex Order 26. 4B1</u> company contacted as well, to inform them of the occurrence. Element II All residents that reside in the facility have the potential to be affected by this deficient practice. Element III - The Director of Nursing /or designee will conduct weekly audits of residents administered oxygen to ensure orders are present and accurately recorded in the electronic medication administration record. Staff shall also document initial and residents need for ongoing oxygen use, any changes in condition, will all be assessed and reported to MD as		

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F 695	Continued From page 59 On 10/19/23 at 11:33 AM-Resident #14 was observed lying in bed with <u>NJ Ex Order 26. 4B1</u> at <u>NJ Ex Order 26. 4B1</u>. The date on the <u>NJ Ex Order 26. 4B1</u> indicated that the <u>NJ Ex Order 26. 4B1</u> was changed <u>NJ Ex Order 26. 4B1</u>. On 10/20/23 at 07:17 AM, the surveyor (#1) reviewed the New Jersey Universal Transfer Form (NJUTF) dated <u>NJ Ex Order 26. 4B1</u> which revealed that the resident was sent to the hospital for <u>NJ Ex Order 26. 4B1</u>. The physician order dated <u>NJ Ex Order 26. 4B1</u> was for Resident #14 to receive <u>NJ Ex Order 26. 4B1</u> every shift for <u>NJ Ex Order 26. 4B1</u> to maintain <u>NJ Ex Order 26. 4B1</u> at or greater than <u>NJ Ex Order 26. 4B1</u>. On 10/20/23 at 7:15 AM an interview was conducted with the Registered Nurse (RN) #1 who worked the 11:00 PM-7:00 AM). Nurse #1 confirmed she was the nurse responsible for Resident #14. Nurse #1 stated the <u>NJ Ex Order 26. 4B1</u>, and the <u>NJ Ex Order 26. 4B1</u> was to be changed every week on Wednesday and as needed. Nurse #1 reported the weekly change was completed by the 11:00 PM-7:00 AM nurse and it was documented on the Treatment Administration Record (TAR). Nurse #1 reviewed the TAR and stated there was no documentation on the TAR of the <u>NJ Ex Order 26. 4B1</u> being changed and it must have accidentally been omitted when the resident returned from the hospital <u>NJ Ex Order 26. 4B1</u>. On 10/20/23 at 8:03 AM, a surveyor (Surveyor #2) entered Resident #14's room and observed the resident in bed with eyes open and the	F 695	applicabe -The Assistant Director of Nursing or designee will provide continued education to staff on oxygen use and obtaining accurate physician orders. Element VI -Audits will be monitored for compliance by the Administrator and Director of Nursing weekly for 4 weeks, bi-weekly X 2 months and monthly for 3 months. Audits will reflect need, change in condition orders are reflected properly, verify equipment meets standards, changed according to policy on a weekly basis. -- Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.		

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F 695	Continued From page 60 resident [NJ Exec Order 26.4b1] to the surveyor. There was an [NJ Ex Order 26. 4B1] observed upon entering the room and there were visible beige and various colored splatters embedded on the machine. Next to the visible splatter, an [NJ Ex Order 26. 4B1] that delivered [NJ Ex Order 26. 4b] to the resident, had a piece of tape on it that had [NJ Ex Order 26. 4B1] written on it. There was also a [NJ Ex Order 26. 4B1] that was observed with caked with on beige debris and was in on the nightstand. The surveyor observed a nurse enter the room, she identified herself as RN #1 for the 11:00 PM to 7:00 AM shift and stated she was the night supervisor. The surveyor brought her attention to the [NJ Ex Order 26. 4B1] and she knelt down to read the label, looked at the date and stated, "oh", then looked at the [NJ Exec Order 26.4b1] and stated "a little stained". At that time the night supervisor RN left the room and the day shift RN entered. The surveyor brought her attention to the [NJ Ex Order 26. 4B1] and the date. The day RN stated, "that needs to be cleaned for infection control", asked if it was clean and stated, "no". The surveyor then asked the RN about the [NJ Exec Order 26. 4B1] that was on the opposite nightstand, into a drawer and on the floor, and was attached to a white machine. The RN stated, "no, the way this it, it should not be on the floor it it is infection control, and I will replace it". The RN stated that the [NJ Exec Order 26. 4B1] should be rapped up and put into the drawer. On 10/20/23 at 8:13 AM, the RN responded to Surveyor #2 about the [NJ Exec Order 26. 4B1] dated [NJ Ex Order 26. 4B1] and stated it should be changed weekly on the 11-7 shift. On 10/20/23 at 8:15 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding the label on the [NJ Exec Order 26. 4B1]. The LPN stated that the	F 695			

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F 695	Continued From page 61 NJ Ex Order 26.4B1 was scheduled to be changed on the 11:00 PM -7:00 AM shift and she did not look at the NJ Exec Order. She further stated that the order to change the NJ Exec Order should have been entered into the Electronic Patient Point of Care (EPOC). The LPN and the RN both reviewed the October EPOC and confirmed that the order to change the NJ Ex Order 26.4B1 was not populated into the Physician Order Sheet (POS). Further review of the POS for NJ Exec Order 26.4b1 did not include an order to change the NJ Ex Order 26.4B1. On 10/20/23 at 9:46 AM, surveyor #2 interviewed the Director of Nuring (DON) regarding the NJ Exec Order 26.4b1 and who was responsible for cleaning, in addition to the NJ Exec Order dated NJ Ex Order 26.4B1. The DON stated that nursing should have cleaned the NJ Exec Order 26.4b1, not housekeeping. On 10/20/23 at 9:51 AM, the surveyor reviewed the Physician Order Sheet (POS) dated NJ Ex Order 26.4B1, with the Unit Manager. The UM revealed that the resident did not have an order for the NJ Ex Order 26.4B1 to be changed. When asked regarding the facility's policy, the UM stated, "It is a blanket statement that all NJ Ex Order 26.4B1 to be changed weekly on the 11:00 PM-7:00 AM shift." She was not too sure if the facility had a policy. The UM further stated, "Because there was no order, that does not mean it should not have been done." On 10/20/23 at 11:15 AM, the LPN on the medication cart reviewed the POS and informed the surveyor that the order to change the NJ Ex Order 26.4B1 was not populated after the last admission. When inquired regarding monthly Recap (Reviewing the new MARS against the physicians orders to ensure accuracy before the start of the	F 695			

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F 695	Continued From page 62 next month), the LPN stated that the 11:00 PM-07:00 AM shift was responsible to check the orders. The LPN indicated that she was not sure if any other shift will review the chart for missing orders. The LPN stated, "They have a supervisor on the 11:00 PM-7:00 AM shift. I do not know." On 10/20/23 at 11:30 AM, during an interview with the Director of Nursing (DON) she stated that she was made aware of the date on the [NJ Ex Order 26. 4B] [REDACTED]. The DON was unable to provide documented evidence that the [NJ Ex Order 26. 4B1] [REDACTED] had been changed prior to [NJ Ex Order 26. 4B1] [REDACTED]. The DON did not speak to whether the resident's order for [NJ Ex Order 26. 4B1] [REDACTED] was verified upon readmission from the hospital. A review of the Physician Order Sheet (POS) for [NJ Ex Order 26. 4B1] [REDACTED] reflected an order dated [NJ Ex Order 26. 4B1] [REDACTED] to administer [NJ Ex Order 26. 4B1] [REDACTED] at [NJ Ex Order 26. 4B1] [REDACTED] every shift for [NJ Ex Order 26. 4B1] [REDACTED]. Maintain [NJ Ex Order 26. 4B1] [REDACTED] at or greater than [NJ Ex Order 26. 4B1] [REDACTED]. A review of the Treatment Administration Record did not include an order to change the disposable [NJ Ex Order 26. 4B1] [REDACTED], [NJ Ex Order 26. 4B1] [REDACTED] of the [NJ Ex Order 26. 4B1] [REDACTED]. A review of the resident's individualized care plan reflected that the resident [NJ Ex Order 26. 4B1] [REDACTED] [REDACTED] Interventions included to administer [NJ Ex Order 26. 4B1] [REDACTED] as ordered by the physician, on at all times while the resident was resting in bed. (The intervention was not implemented. Resident #14 was observed with [NJ Ex Order 26. 4B1] [REDACTED] at [NJ Ex Order 26. 4B1] [REDACTED] for 3 days. [NJ Ex Order 26. 4B1] [REDACTED]	F 695			

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F 695	Continued From page 63 NJ Ex Order 26. 4B1 was verified to be at NJ Ex Order 26. 4B1 on NJ Ex Order 26. 4B1). The above concerns were discussed with the administrative staff on NJ Ex Order 26. 4B1 and again NJ Ex Order 26. 4B1. The DON stated that her expectation was that the NJ Ex Order 26. 4B1 be changed weekly and documented in the Treatment Administration Record (TAR). 2.) On 10/18/23 at 9:56 AM, the surveyor was conducting a tour on the NJ Ex Order 26. 4B1 Unit and observed Resident #98, NJ Ex Order 26. 4B1, sitting in a NJ Ex Order 26. 4B1 chair in their room and was being administered NJ Ex Order 26. 4B1 by way of (via) NJ Ex Order 26. 4B1 at NJ Ex Order 26. 4B1. The surveyor observed that the NJ Ex Order 26. 4B1 was hooked up to an NJ Ex Order 26. 4B1 located next to the resident's bed. This was observed again on 10/19/23 at 10:57 AM The surveyor reviewed the Resident's Physician Order Summary (POS) which reflected orders for: - NJ Ex Order 26. 4B1 at NJ Ex Order 26. 4B1 every day shift for NJ Ex Order 26. 4B1 dated NJ Ex Order 26. 4B1. On 10/20/23 at 10:21 AM, the surveyor observed Resident #98 sitting in a NJ Ex Order 26. 4B1 chair wearing NJ Ex Order 26. 4B1 via NJ Ex Order 26. 4B1. The resident stated "it should be on NJ Ex Order 26. 4B1." At that time, the surveyor accompanied by the assigned Licensed Practical Nurse (LPN), entered Resident #98's room. The LPN confirmed that the resident was wearing NJ Ex Order 26. 4B1 via a NJ Ex Order 26. 4B1 set to NJ Ex Order 26. 4B1. The LPN then checked the Physicians Order (PO) in the Electronic Medical Record (EMR) and stated "the order says NJ Ex Order 26. 4B1 and it should be on NJ Ex Order 26. 4B1." The LPN stated that when a resident	F 695			

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F 695	Continued From page 64 was ordered [NJ Ex Order 26.4b] the nurse should check that the [NJ Ex Order 26.4b] was set at the level that the doctor had ordered. During an interview with the surveyor on 10/20/23 at 10:39 AM, the Registered Nurse Unit Manager (RN UM) stated that when a resident is on [NJ Exec Order 26], the nurses should verify the [NJ Exec Order 26] physicians order including the the right flow and the right route. The nurses should document in the resident's Treatment Administration Record (TAR) and in the progress notes in the EMR. The RN UM stated that if the resident was not wearing the [NJ Exec Order 26.4b1], then the nurse should assess the resident for any [NJ Exec Ord] or [NJ Exec Order 26.4b1] [redacted] notify the doctor and obtain a new physicians' order. The RN UM further stated that the facility had a [NJ Exec Order 26.4b1] who would come to the facility weekly to evaluate all residents on [NJ Exec Order 26.4b1]. The surveyor reviewed the EMR and the paper chart and was unable to find any [NJ Ex Order 26.4B1] notes for Resident #98. According to the Admission Record, Resident #98 was admitted to the facility with the diagnoses which included but was not limited to [NJ Ex Order 26.4B1] [redacted], The Admission Minimum Data Set (MDS-an assessment tool utilized to facilitate the care of a resident), dated [NJ Ex Order 26.4B1], indicated that the resident was [NJ Ex Order 26.4B1] and required moderate assistance with [NJ Exec Order 26.4] and [NJ Exec Order 26.4b1]. The MDS also indicated that the resident was on [NJ Ex Order 26.4b] - The surveyor reviewed the [NJ Exec Order 26.4b1]	F 695			

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F 695	Continued From page 65 Treatment Administration Record (TAR) which reflected a physician's order for [REDACTED] at [REDACTED] via [REDACTED] every day shift for [REDACTED]. On 10/23/23 at 9:41 AM, the surveyor observed Resident #98, [REDACTED] sitting in a [REDACTED] chair wearing [REDACTED] via a [REDACTED] at [REDACTED]. Again, the resident stated [REDACTED]. On 10/23/23 at 9:56 AM, the surveyor reviewed Resident #98's POS and the physician order date [REDACTED] was still active for [REDACTED] at [REDACTED] via [REDACTED] every day shift for [REDACTED]. During an interview with the surveyor on 10/24/23 at 10:17 AM, the Director of Nursing (DON) stated during the nurses' rounds, the nurses should monitor the resident's [REDACTED] and [REDACTED] as well as that the level of [REDACTED] on the [REDACTED] matches the physician's order. The nurse should document the [REDACTED] level in the TAR and in the progress notes. If the nurse observed the resident was not wearing the correct [REDACTED] per physician's order, I would expect them to assess the resident and call the doctor to clarify the physician order. When the resident returned from the hospital, I would have expected a [REDACTED] to evaluate the resident. On 10/24/23 at 12:31 PM, the surveyor observed Resident #98 [REDACTED] sitting in a [REDACTED] chair wearing [REDACTED] at [REDACTED] via [REDACTED]. The resident stated, "what it's on, [REDACTED]?" When asked if the resident adjusted the [REDACTED], he/she stated [REDACTED].	F 695			

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F 695	Continued From page 66 During an interview with the surveyor on 10/24/23 at 12:35 PM, the LPN stated that the nurse has to make sure that the resident is wearing the correct NJ Exec Order 26 level that was prescribed by the doctor. The LPN stated that the resident kept adjusting the NJ Exec Order 26.4b1 to NJ Exec Order 26 because he/she thought NJ Exec Order 26.4b1. We have to keep educating him/her. The LPN stated that the nurse should have documented in the progress notes that the resident adjusted the NJ Exec Order 26.4b1 and that education was provided to the resident. The surveyor reviewed the NJ Exec Order 26.4b1 progress notes which did not indicate that the resident was observed wearing Ex Order 26.4B1 at Ex Order 26.4B1 via Ex Order 26.4B1, the doctor was notified, or education was provided. A review of Resident #98's care plan revealed an intervention to give Ex Order 26.4B1 as ordered by the physician. The care plan did not include that the resident was adjusting his Ex Order 26.4B1, noncompliance of the Ex Order 26.4B1 or education was provided to the resident. On 10/24/23 at 12:39 PM, the surveyor observed the Ex Order 26.4B1 in Resident's # 98's room. At that time, the surveyor interviewed the RT who stated that this was the first time evaluating the resident and she was just consulted for him/her. She stated that her role was to assess the resident, review what level of Ex Order 26.4B1 the resident should be ordered according to the assessment and provide education to the resident. A review of the facility's policy titled, "Oxygen Administration," reviewed 09/2023, revealed	F 695			

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F 695	Continued From page 67 oxygen was to be administered under orders of a physicians except in cases of an emergency. The staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy .Staff shall notify the physician of any changes in the residents condition, including changes in vital signs, oxygen concentrations, or evidence of complications associated with the use of oxygen. The policy also included to change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated.	F 695			
F 698 SS=F	NJAC 8:39-19.4(a) Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation, it was determined that the facility failed to: a.) ensure that staff were competent and appropriate care was provided for the <u>Ex Order 26. 4B1</u> <u>Ex Order 26. 4B1</u> , and staff were trained to differentiate between an <u>Ex Order 26. 4B1</u> <u>Ex Order 26. 4B1</u> , and a <u>Ex Order 26. 4B1</u> , and b.) ensure that staff were trained to properly assess, and document care of the <u>Ex Order 26. 4B1</u>	F 698	F 698 Dialysis Element 1 Resident # 90 was assessed with no signs of <u>NJ Exec Order 26.4B1</u> or adverse effect due to the deficit practice. <u>Ex Order 26. 4B1</u> -Nurses who were involved in committing the deficient practice involving Resident # 90 were in serviced on the facility policy and procedures <u>Ex Order 26. 4B1</u> . Ensuring the type and location of the		12/1/23

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F 698	Continued From page 68 sites which includes the <u>Ex Order 26. 4B1</u> [REDACTED] to assure <u>NJ Exec Order 26.4b1</u> and to monitor the <u>Ex Order 26. 4B1</u> for <u>NJ Exec Order 26.4b1</u>, signs of <u>NJ Exec Order 26.4b1</u> and <u>NJ Exec Order 26.4b1</u>. This deficient practice was identified for 1 of 4 residents (Resident #90) reviewed for <u>Ex Order 26. 4B1</u> and was evidenced by the following: On 10/19/23 at 10:55 AM, the surveyor observed Resident #90 laying in bed awake, watching television with snacks on his/her bedside table. Resident #90 stated that he/she had been going to <u>Ex Order 26. 4B1</u> "for a while." The resident stated that he/she used to have a <u>Ex Order 26. 4B1</u> in his/her <u>NJ Exec Order 26.4b1</u> while pointing to his/her <u>Ex Order 26. 4B1</u> but now had a <u>Ex Order 26. 4B1</u> in his/her <u>Ex Order 26. 4B1</u>, pointing to his/her <u>Ex Order 26. 4B1</u>. The surveyor did not observe any <u>Ex Order 26. 4B1</u> or <u>Ex Order 26. 4B1</u> in resident's <u>Ex Order 26. 4B1</u>. The surveyor observed <u>Ex Order 26. 4B1</u> on the resident's <u>Ex Order 26. 4B1</u>. There were no <u>NJ Exec Order 26.4b1</u> on the 2 sites and some <u>Ex Order 26. 4B1</u> was noted. Resident #90 stated "<u>Ex Order 26. 4B1</u>." The resident added that he/she goes to <u>Ex Order 26. 4B1</u> every Monday, Wednesday and Friday and takes a communication binder to his/her treatments, which the facility staff kept at the nurse's desk. A review of the Admission Record reflected that Resident #90 was admitted to the facility with diagnoses which included, but were not limited to, <u>Ex Order 26. 4B1</u>	F 698	<u>Ex Order 26. 4B1</u> is in the resident's medical records. Resident # 90 was assessed with <u>NJ Exec Order 26.4b1</u> or adverse effect due to the deficit practice. 10/27./2023 -Full house audit was completed for all residents who require renal dialysis on 11/1/2023, no other resident were affected from the deficient practice. Element II -All residents that reside in the facility that are required to receive dialysis have the potential to be affected by the deficient practices. Element III 10/27/23 All Nursing Licensed Staff were in-serviced on facility policies and procedures on Dialysis. The licensed nurse RN and LPN will ensure the type and location of the dialysis access device is documented in the resident's medical records. In addition, monitoring for patency of the dialysis access will be documented in the resident's medical records. 10/27/23 The Director of Nursing or designee will provide continued education to all license staff on the facility Dialysis policy. -All Licensed Nursing Staff have completed dialysis competency and skill training which is necessary to care for all		

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F 698	Continued From page 69 <i>Ex Order 26. 4B1</i> [REDACTED] A review of the Quarterly Minimum Data Set (MDS) an assessment tool used by the facility to prioritize care dated <i>Ex Order 26. 4B1</i>, revealed that Resident #90 received a score of <i>Ex Order 26. 4B1</i> out of 15 on the <i>Ex Order 26. 4B1</i>. <i>Ex Order 26. 4B1</i>. Section <i>Ex Order 26. 4B1</i> of the MDS titled "Special Treatments, Procedures, and Programs" revealed that the resident received <i>Ex Order 26. 4B1</i> outside the facility. A review of Resident #90's physician's orders dated <i>Ex Order 26. 4B1</i> indicated: Monitor <i>Ex Order 26. 4B1</i> to <i>Ex Order 26. 4B1</i> wall for signs and symptoms of <i>NJ Exec Order 26.4B1</i> and <i>NJ Exec Order 26.4B1</i> every shift for monitoring. A review of Resident #90's Dialysis Communication Records in the resident's <i>Ex Order 26. 4B1</i> binder dated <i>Ex Order 26. 4B1</i> revealed on each record documentation: <i>Ex Order 26. 4B1</i>. <i>Ex Order 26. 4B1</i> did not indicate type of <i>NJ Exec Order 26.4B1</i>, location of <i>NJ Exec Order 26.4B1</i> and what kind of <i>NJ Exec Order 26.4B1</i> assessment was performed by the nurse. <i>Ex Order 26. 4B1</i>. The <i>Ex Order 26. 4B1</i> documentation did not indicate type of <i>NJ Exec Order 26.4B1</i> location of <i>NJ Exec Order 26.4B1</i>, and what kind of <i>NJ Exec Order 26.4B1</i> assessment was performed by the nurse.	F 698	residents that require renal dialysis needs as identified through resident assessment and described in the plan of care. Element IV -Audits will be monitored for completion by the Administrator or Director of Nursing weekly for 4 weeks, bi-weekly X 2 months and monthly for 3 months. -Audits will be reviewed and discussed during Quality Assurance Performance Improvement Committee meeting. QAPI Committee will review the information then determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed with . Any adverse findings and trends will be reported to QAPI Committee on a quarterly basis. To prevent reoccurrence all residents who have a potential need for dialysis, will be included in the review .		

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F 698	Continued From page 70 A review of Resident #90's Medication Administration Record (MAR) dated <u>Ex Order 26. 4B1</u> indicated: Monitor <u>Ex Order 26. 4B1</u> to <u>Ex Order 26. 4B1</u> wall for signs and symptoms of <u>NJ Exec Order 26.4b</u> and <u>NJ Exec Order 26.4b</u> every shift for monitoring. Surveyor observed check marks for each shift from <u>Ex Order 26. 4B1</u> indicating documentation that nurses administered or signed off for monitoring of the resident's <u>NJ Exec Order 26. 4B1</u>. During an interview with the surveyor on 10/19/23 at 11:27 AM, the assigned Licensed Practical Nurse (LPN) for Resident #90 stated that the resident had a <u>Ex Order 26. 4b</u> in his/her <u>NJ Exec Order 26. 4B1</u> while pointing at <u>Ex Order 26. 4B1</u> and that the <u>Ex Order 26. 4B1</u> must be checked, while pointing at <u>Ex Order 26. 4B1</u>, before and after the resident's <u>Ex Order 26. 4B1</u> and then documented. During an interview with the surveyor on 10/19/23 at 11:41 AM, another LPN on the same unit stated that the protocol for <u>Ex Order 26. 4B1</u> was to monitor their <u>Ex Order 26. 4B1</u> for <u>Ex Order 26. 4B1</u>. The LPN demonstrated on <u>Ex Order 26. 4B1</u> with 2 fingers how to feel the <u>Ex Order 26. 4B1</u>, and added that if it was in the <u>Ex Order 26. 4B1</u>, she would check for <u>NJ Exec Order 26.4b</u> or <u>NJ Exec Order 26.4b</u> and can change the <u>NJ Exec Order 26.4b</u> if needed. The LPN stated that the facility educated the staff regarding monitoring and notifying the doctor or the <u>Ex Order 26. 4B1</u> of any problems or issues. During an interview with the surveyor on 10/19/23 at 11:42 AM, the Registered Nurse/Unit Manager (RN UM) stated that her expectations of the staff for <u>Ex Order 26. 4B1</u> was to take vital signs, assess and monitor the <u>NJ Exec Order 26.4b</u>, and check the <u>Ex Order 26. 4b</u> in the <u>Ex Order 26. 4B1</u> for <u>Ex Order 26. 4B1</u>, while pointing to <u>Ex Order 26. 4B1</u>. The RN UM stated that	F 698			

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F 698	Continued From page 71 there should be a physician order to listen and check the <u>Ex Order 26. 4B1</u>. The RN UM revealed that the staff were educated on how to care for <u>Ex Order 26. 4B1</u> and how to monitor and check for the <u>Ex Order 26. 4B1</u>. During an interview with the surveyor on 10/19/2023 at 12:03 PM, an LPN from another unit stated that the process for a <u>Ex Order 26. 4B1</u> was to check the vital signs and monitor the site. The LPN added that should also check the <u>Ex Order 26. 4B1</u>. The surveyor asked if the nurse used a stethoscope to check for <u>Ex Order 26. 4B1</u>? The LPN responded, "No." The LPN demonstrated by placing her 2 fingers on her <u>Ex Order 26. 4B1</u> and stated to feel for the <u>Ex Order 26. 4B1</u>. She also stated that if a resident had a <u>Ex Order 26. 4B1</u> in the <u>Ex Order 26. 4B1</u> that staff do not touch the <u>Ex Order 26. 4B1</u> and to only check for <u>NJ Exec Order 26.4b</u> or <u>NJ Exec Order 26.4b</u> at the site and that the <u>NJ Exec Order 26.4b</u> is okay. A review of Resident #90's care plan indicated a focus that Resident #90 needed <u>Ex Order 26. 4B1</u> related to <u>Ex Order 26. 4B1</u>. <u>Ex Order 26. 4B1</u> created <u>Ex Order 26. 4B1</u>, <u>Ex Order 26. 4B1</u> with an initiation date of <u>Ex Order 26. 4B1</u> and a Revision date of <u>NJ Exec Order 26.4b1</u>. The care plan did not clearly indicate the resident's type of <u>NJ Exec Order 26.4</u> and location of the <u>NJ Exec Order 26.4</u>. Interventions included but not limited to check and change <u>NJ Exec Order 26.4b</u> at <u>Ex Order 26. 4B1</u> per MD's (medical doctor's) order and document. The interventions did not include checking of <u>Ex Order 26. 4B1</u> as stated by the nursing staff interviewed by the surveyor. A review of the Facility Assessment, with an effective date of 11/2017, indicated that residents requiring hemodialysis are treated at the dialysis	F 698			

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F 698	Continued From page 72 center in the community. Care and treatment for these residents is a joint effort of the facility and the dialysis center staff. The facility assessment would include staff competencies that are necessary to provide the level and types of care needed for the resident population. A review of the facility's Dialysis Policy ,with a revision date of 03/2023, indicated that the nurse will ensure the type and location of the dialysis access device in the resident's medical record. In addition, monitoring for patency of the dialysis access will be documented in the resident's medical record. A review of the Nursing Services and Sufficient Staff policy ,with a revised date of 09/2022, revealed that the facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for resident's needs as identified through resident assessment and described in the plan of care. On 10/19/2023 at 12:59 PM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) orientation packets or any documentation of competencies, education, or training for their staff nurses regarding care of residents who received dialysis . During an interview with the surveyor on 10/23/2023 at 10:47 AM, the DON stated that her expectations of the nursing staff in caring for residents that receive NJ Exec Order 26 was to check the resident's vital signs, follow the physician's orders for medications, and to know what medications to hold prior to going to NJ Exec Order 26.4b1. The DON added to also monitor the resident's diet, to check	F 698			

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F 698	Continued From page 73 the [NJ Exec Order 26.4b1] and monitor for any signs of [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1], or [NJ Exec Order 26.4b1]. The DON stated the nurses should document in the communication binder that accompanied the resident to the [NJ Exec Order 26.4b1] facility and communicate any changes with the resident to the [NJ Exec Order 26.4b1] center. The DON stated that when the resident returned from their [NJ Exec Order 26.4b1] treatment, the nurses should check the resident's vital signs, check the [NJ Exec Order 26.4b1], and note any changes in the communication binder from the [NJ Exec Order 26.4b1] center. She revealed that the nurses would check the [NJ Exec Order 26.4b1] of the [NJ Exec Order 26.4b1] site. The DON stated if the resident had a [NJ Exec Order 26.4b1], the [NJ Exec Order 26.4b1] would have a [NJ Exec Order 26.4b1] and the nurses should only check the site for [NJ Exec Order 26.4b1] and not do anything else with the [NJ Exec Order 26.4b1]. The surveyor asked if the nurses were trained in the checking of the [NJ Exec Order 26.4b1] of a [NJ Exec Order 26.4b1]? The DON stated that she "would expect the nurses to already know how to do that." The DON revealed that she was not sure if there was any facility education regarding residents who received [NJ Exec Order 26.4b1] that was provided to the nursing staff. The DON stated that there should be a physician order for checking the [NJ Exec Order 26.4b1] of an [NJ Exec Order 26.4b1] and that should also be included in the resident's care plan. The surveyor requested from the DON for any documented education or training for their nursing staff regarding [NJ Exec Order 26.4b1]. During an interview with the surveyor on 10/23/2023 at 10:51 PM, the LNHA stated that her expectations of the nursing staff in caring for residents receiving [NJ Exec Order 26.4b1] was to document in the [NJ Exec Order 26.4b1] communication binder the resident's vital signs, checking of the [NJ Exec Order 26.4b1] site, weights, dietary changes and any unusual occurrences. She stated that the nurses should also check the	F 698			

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F 698	Continued From page 74 NJ Exec Order 26.4b1 and for any NJ Exec Order 26.4 or signs of NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1 site. The LNHA added that if the resident had a NJ Exec Order 26.4b1, the nurses should check for signs of NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 at the site. The LNHA stated the NJ Exec Order 26.4b1 were changed at the NJ Exec Order 26.4b1 center, and the facility nurses did not change the NJ Exec Order 26.4b1 or do anything else with the NJ Exec Order 26.4b1. The LNHA confirmed that there should be a physician's order to check the NJ Exec Order 26.4b1 of a NJ Exec Order 26.4b1 and should also be documented on the resident care plan. The surveyor, again, requested from the LNHA any staff education, training, or competencies related to NJ Exec Order 26.4b1. On 10/23/2023 at 12:01 PM, the surveyor observed Resident #90 in bed awake with NJ Exec Order 26.4b1 on at Ex Order 26.4B1 and watching television. The resident stated that he/she just returned from Ex Order 26.4B1. The surveyor observed residents Ex Order 26.4B1 with no NJ Exec Order 26.4b1 on the sites. Resident #90 stated that he/she removed the NJ Exec Order 26.4b1 because they were NJ Exec Order 26.4b1. The resident stated, "Ex Order 26.4B1." The resident revealed that his/her NJ Exec Order 26.4b1 had not been assessed yet today since returned from Ex Order 26.4B1. On 10/23/2023 at 12:27 PM, the surveyor reviewed Resident #90's communication binder and observed that the Ex Order 26.4B1 was not completed. The surveyor asked the assigned LPN what time Resident #90 returned from his/her Ex Order 26.4B1? The LPN stated that she wasn't sure if the resident had returned back from Ex Order 26.4B1 yet, "they may still be working with him/her." The surveyor informed the LPN that the resident had returned	F 698			

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F 698	Continued From page 75 back from <u>Ex Order 26. 4B1</u> and was in his/her room. On 10/23/23 at 1:57 PM, the surveyor observed Resident #90's assigned LPN perform an assessment of the resident's <u>Ex Order 26. 4B1</u>. The LPN sanitized a stethoscope and then applied gloves. The LPN did not perform hand hygiene before applying the gloves to her hands. The LPN explained to the resident that she will be checking his/her <u>NJ Exec Order 26.4b1</u>. The LPN had resident extend his/her <u>Ex Order 26. 4B1</u> and stated to the surveyor, "You take 2 fingers to feel the <u>Ex Order 26. 4B1</u>." The LPN applied 2 fingers on the <u>Ex Order 26. 4B1</u> area of the resident's <u>Ex Order 26. 4B1</u> and the LPN stated that she could feel the <u>NJ Exec Order 26.4b1</u>. The LPN then placed the stethoscope to the resident's <u>Ex Order 26. 4B1</u> and stated to the surveyor that she could hear the <u>Ex Order 26. 4B1</u>. The LPN then removed and discarded her gloves, closed the resident's overhead light and thanked the resident. The LPN did not perform hand hygiene after removing her gloves or sanitize the stethoscope after performing an assessment of the resident's <u>Ex Order 26. 4B1</u>. In addition, the LPN failed to place her fingers just above the <u>NJ Exec Order 26. 4B1</u> to feel for the <u>Ex Order 26. 4B1</u>, and did not place the stethoscope near the <u>Ex Order 26. 4B1</u> to listen for the <u>Ex Order 26. 4B1</u>. On 10/23/2023 in the presence of the survey team, the DON stated that there was no specific time requirement for the <u>NJ Exec Order 26.4b1</u> to be removed from the <u>Ex Order 26. 4B1</u>. The DON added that when a resident returned from <u>Ex Order 26. 4B1</u> and there was no <u>NJ Exec Order 26.4b1</u> at the <u>NJ Exec Order 26. 4B1</u>, the nurses could remove the <u>NJ Exec Order 26.4b1</u>.	F 698			

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F 698	Continued From page 76 During an interview with the surveyor on 10/25/2023 at 9:40 AM, the charge nurse at Resident #90's <u>Ex Order 26. 4B1</u> stated that she was familiar with Resident #90. The charge nurse stated she would expect the facility nurses to visually check a <u>Ex Order 26. 4B1</u> which included to check the <u>Ex Order 26. 4b</u> for <u>NJ Exec Order 26. 4b</u> , check the <u>Ex Order 26. 4B1</u> , and remove the <u>NJ Exec Order 26. 4b</u> the following day; in 24 hours. The charge nurse added that if there was no <u>Ex Order 26. 4B1</u> and/or the nurses have difficulty assessing the <u>Ex Order 26. 4B1</u> , the nurses can call the center and the center can help with the <u>NJ Exec Order 26. 4b</u> and/or set-up for the resident to be seen by the <u>NJ Exec Order 26. 4b</u> center if needed. For a <u>Ex Order 26. 4B1</u> , the facility nurses should not touch the <u>NJ Exec Order 26. 4b</u> and do not change the <u>NJ Exec Order 26. 4b</u> and to monitor the <u>NJ Ex Order 26. 4B1</u> for <u>NJ Exec Order 26. 4b1</u> or <u>NJ Exec O</u> and notify the center. If a resident was pulling at a <u>Ex Order 26. 4B1</u> or pulled out a <u>Ex Order 26. 4B1</u> even slightly, notify the center and the resident would need to be sent out for an <u>Ex Order 26. 4b</u> to check for placement or for a <u>Ex Order 26. 4B1</u> exchange. The surveyor asked the charge nurse if the facility should notify the center if Resident #90 removed the <u>NJ Exec Order 26. 4B1</u> from his/her <u>Ex Order 26. 4B1</u> due to <u>NJ Exec Order 26. 4b</u> when he/she returned to facility after her <u>Ex Order 26. 4B1</u> ? The charge nurse stated "that the nurses should notify the <u>Ex Order 26. 4B1</u> because the <u>NJ Exec Order 26. 4b1</u> should not be removed for 24 hours, and the center could possibly change the tape on the <u>NJ Exec Order 26. 4b1</u> to <u>Ex Order 26. 4B1</u> ." The charge nurse added that the nurses should not apply any <u>NJ Exec Order 26. 4b1</u> to the <u>NJ Ex Order 26. 4b</u> due to the possibility of <u>NJ Exec Order 26. 4b</u> to the sites. The charge nurse stated that she would expect the communication form to be accurate and complete and the nurses "should immediately	F 698			

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F 698	Continued From page 77 assess the <u>Ex Order 26. 4B1</u> upon return to the facility from their <u>Ex Order 26. 4B1</u>." On 10/26/2023 at 09:37 AM, the facility was unable to provide any documented proof for nurse competencies, signed in-services, education, or any training regarding the care of <u>Ex Order 26. 4B1</u> . During a phone interview with the surveyor and in the presence of the survey team on 10/26/2023 at 12:48 PM, the Medical Director (MD) stated that she was familiar with Resident #90 and would expect the nurses to know how to care for any resident's <u>NJ Exec Order 26. 4b1</u> , either a <u>Ex Order 26. 4B1</u> or a <u>Ex Order 26. 4b1</u> , and to keep the <u>NJ Exec Order 26. 4b1</u> clean and monitor for <u>NJ Exec Order 26. 4b1</u> . On 10/27/2023 at 10:47 AM, in the presence of the survey team, the LNHA stated that it was important for the nurses to know about the <u>NJ Exec Order 26.4b1</u> and perform hand hygiene when checking the <u>NJ Exec Order 26.4b1</u> to prevent <u>NJ Exec Order 26.4b1</u> of the <u>NJ Exec Order 26.4b1</u> . The Infection Preventionist (IP) stated that it was important for the nurses to know what body part to assess, check the vital signs, and make sure no <u>NJ Exec Order 26.4b1</u> at the site. The IP revealed that the facility would need to educate the nursing staff regarding assessment of a <u>NJ Exec Order 26.4b1</u> . On 10/31/2023 at 10:52 AM, and in the presence of the survey team, the IP confirmed that the nursing staff should have identified Resident #90's <u>Ex Order 26. 4B1</u> in the physician orders and it should have been discovered and/or corrected on the 24-hour chart check. The IP informed the survey team that, since surveyor brought to the facility's attention, in- service	F 698			

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F 698	Continued From page 78 education was done regarding care of the residents receiving <u>Ex Order 26. 4B1</u> and identification and care of <u>NJ Ex Order 26. 4B1</u> .	F 698			
F 725 SS=F	NJAC 8:39-27.1(a) Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Complaint # NJ 00162113	F 725			12/1/23
			F725 Staffing		

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F 725	Continued From page 79 Based on observation, interview and review of pertinent documents it was determined that the facility failed to ensure sufficient staff were available to (a) provide assistance ^{NJ Exec Order 26.4b1}, provide ^{NJ Exec Order 26.4b1} and ^{NJ Exec Order 26.4b1} care for residents who were dependent on staff for Activities of Daily Living (ADLs), b) provide nail care for a resident who was dependent on staff for ADLs, and c) respond to call lights in a timely manner. This deficient practice was identified for 5 of 21 residents (Resident #13, #14, #41, #73 and #7) on 2 of 2 nursing units. This deficient practice was evidenced by the following: Refer to 684G and 677F. Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," 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 homes. The following ratio(s) were effective on 2/01/21: 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	F 725	Element I The facility continues to follow a recruitment plan to attract Certified Nurse assistants staff and licensed staff to meet the ratio requirement. Leadership has met and will continue to meet on an ongoing basis to identify staffing challenges and areas of improvement for licensed certified nursing needs. The Administrator along with Director of Nursing reviewed the staffing ratio requirements with the Staffing Coordinator to ensure the minimum state required staffing are met daily as of 11/8/2023. Element II All residents in the facility have the potential to be affected by the deficient practice. Element III Ongoing efforts to recruit and retain staff are in place. Bonus shifts, referral bonus program and CNA school programs. The facility continues to conduct job fairs with immediate interviews and contingency offers. The facility will begin an expedited but robust onboarding process for new hires. The Administrator, Director of Nursing, and staffing coordinator will conduct weekly meetings to review call outs and facility census vs. Staffing needs. identify compliance and adjust interventions as needed to ensure		

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F 725	Continued From page 80 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. On 10/18/23 at 9:24 AM, Surveyor #1 interviewed the Registered Nurse Unit Manager (RN UM) of the Noble Unit who stated that the unit's census was 51 and staffing today was 2 Licensed Practical Nurses (LPN)s and 5 Certified Nursing Assistants (CNA)s. During the initial tour of the Warren Unit on 10/18/23 at 9:51 AM, the surveyor interviewed an LPN who stated that they are usually short staffed, not only on the weekends but during the week too. During an interview with the surveyor on 10/18/23 at 10:32 AM, the CNA stated that she has worked at the facility for [REDACTED] (U Ex Order 26.4(b)(3)). The CNA stated that staffing was an issue. She further stated that on that day she had 10 residents and 5 of those residents were total assists (needed total assistance with all activities of daily living). "We usually have a lot more residents, sometimes there are only two CNAs on the unit and sometimes there are 3 or 4 CNAs on the day shift." During an interview with the surveyor on 10/18/23 at 10:35 AM, the CNA on the Noble Unit stated that she had 10 residents for day shift. The CNA further stated that sometimes there are only 2 CNAs on the unit. A review of the staffing sheet provided by the facility for the 11 PM-7 AM shift on Sunday 10/22/23 on the Noble Unit revealed one Registered Nurse (RN), one LPN and one CNA	F 725	staffing ratios are met. Element IV -Audits will be monitored for completion by the Administrator or Director of Nursing weekly for 4 weeks, bi-weekly X 2 months and monthly for 3 months. -Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.		

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F 725	Continued From page 81 were scheduled to provide care for all residents on the unit. a).A review of the medical record revealed Resident #13 had a diagnosis, including but not limited to: <u>Ex Order 26. 4B1</u> [REDACTED] On 10/23/23 at 9:30 AM, Surveyor #1 asked two CNAs to assist with a care tour and observed Resident #13 wore 2 <u>NJ Exec Order 26.4b1</u> which were <u>NJ Exec Order 26.4b1</u> with <u>Ex Order 26. 4B1</u>. The gown including the pulled sheet were <u>Ex Order 26. 4B1</u>. Resident #13 could not elaborate if he/she was cared for on the prior shift. At 09:52 AM, another surveyor entered the room with the Director of Nursing (DON). At the surveyor's request, the resident's <u>Ex Order 26. 4B1</u> was checked by staff. The resident was observed to be <u>NJ Exec Order 26.4b1</u> with <u>Ex Order 26. 4B1</u>. Also noted were some <u>NJ Exec Order 26.4b1</u> on the <u>Ex Order 26. 4B1</u> and <u>NJ Exec Order 26.4b1</u> to the <u>Ex Order 26. 4B1</u> which were not observed on <u>Ex Order 26. 4B1</u> during the observed <u>Ex Order 26. 4B1</u>. When asked about her expectations, the DON replied, "better then what I just observed." The DON verified that the <u>Ex Order 26. 4B1</u> had not been provided on the prior shift (11:00 PM-7:00 AM). On 10/26/23 at 11:55 AM, Surveyor #1 interviewed the DON who stated that Resident #13 should not have had two <u>Ex Order 26. 4B1</u> on. The facility's protocol was to provide <u>Ex Order 26. 4B1</u> every 2 hours and as needed. On 10/26/23 at 11:00 AM, the surveyor completed a telephone interview with the CNA who provided care to Resident #13 on <u>Ex Order 26. 4B1</u> 3:00 PM-11:00	F 725			

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F 725	Continued From page 82 PM shift. The CNA stated that she had applied 2 adult <u>Ex Order 26. 4B1</u> on Resident #13. The CNA confirmed that she had provided <u>Ex Order 26. 4B1</u> to Resident #13 at 6:30 PM on <u>Ex Order 26. 4B1</u> which included <u>NJ Exec Order 26.4B1</u> the resident and their sheets due to being <u>NJ Exec Order 26.4B1</u> with <u>Ex Order 26. 4B1</u>. The CNA stated she clocked out at 7 PM. On 10/26/23 at 12:53 PM, the surveyor conducted a telephone interview with the Registered Nurse (RN) who worked the 3:00 PM-11:00 PM shift on <u>Ex Order 26. 4B1</u> who confirmed that that 2 CNAs had left at 7 PM on that shift and the other CNA on the unit did not ask for assistance with care. On 10/26/23 at 12:30 PM, Surveyor #1 interviewed the CNA who cared for Resident #13 who stated that she reported to work on <u>Ex Order 26. 4B1</u> at 6:50 AM and had to care for another resident that was <u>NJ Exec Order 26.4B1</u> with <u>Ex Order 26. 4B1</u>. The CNA stated, "It was so bad, I had to call the clinical director to verify that care was not provided on the prior shift." On 10/27/23 at 7:50 AM, the surveyor interviewed the LPN who had worked the 11:00 PM -7:00 AM shift on <u>Ex Order 26. 4B1</u> who stated that she did not assist the CNAs to change and turn some residents. The LPN stated "No I was busy also. We provided safety that is all we could do." On 10/27/23 at 8:40 AM, the surveyor interviewed the CNA who cared for Resident #13 during the 11:00 PM-7:00 AM shift on <u>Ex Order 26. 4B1</u> who stated that he did not provide <u>Ex Order 26. 4B1</u> to the residents during the 8 hr. shift. The CNA stated that he provided care for 30 residents that night and he was "overwhelmed and could not get to the resident."	F 725			

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F 725	Continued From page 83 b) A review of the medical record revealed Resident #14 had a diagnosis, including but not limited to Ex Order 26. 4B1 [REDACTED] On 10/23/23 at 11:00 AM, Surveyor #1 observed Resident # 14 in bed and was informed that the CNA assigned to this resident was on break. The surveyor asked the LPN and 2 random CNAs to assist with a care tour. The CNAs repositioned Resident #14 to the left side. The surveyor observed that the resident's Ex Order 26. 4B1 were covered with Ex Order 26. 4B1 were expelling from both side of the Ex Order 26. 4B1. Resident #14's Ex Order 26. 4B1 was covered with Ex Order 26. 4B1. The staff informed the surveyor that morning care had not been provided yet. On 10/23/23 at 12:30 PM, Surveyor #1 interviewed the LPN assigned to the Ex Order 26. 4B1 Unit who stated that staff should have checked the resident at start of shift to ensure that the resident was Ex Order 26. 4B1. Surveyor #1 interviewed the assigned CNA who stated that she did not check the resident this morning. She was not aware that the resident was not Ex Order 26. 4B1 during the prior shift. On 10/23/23 at 12:45 PM, Surveyor #1 interviewed the RN/UM who stated that the facility's protocol was for all CNAs to check and Ex Order 26. 4B1 their residents right after morning report and that she was not aware that some of the	F 725			

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F 725	Continued From page 84 residents were not provided with <u>Ex Order 26. 4B1</u> during the prior shift. On 10/27/23 at 8:40 AM, Surveyor #1 conducted a telephone interview with the 11:00 PM-7:00 AM CNA. The CNA informed the surveyor that he checked the resident "possibly at 6:00 AM" and the resident was <u>NJ Exec Order 26.4b1</u>. When inquired about who assisted him with the resident, he stated, "I did it alone". (Resident #14 required extensive assist of two persons for <u>Ex Order 26. 4B1</u>.) c)A review of the medical record revealed Resident #41 was admitted to the facility with diagnoses which included but were not limited to; <u>Ex Order 26. 4B1</u> On 10/18/23 10:45 AM, Surveyor #1 observed Resident #41 sitting in bed dressed in a colorful gown. The resident informed the surveyor that she was here for <u>NJ Exec Order 26.4b1</u> On 10/19/23 at 12:55 PM, Surveyor #1 observed Resident #41 in bed with same clothing as day prior. Resident stated that she had lunch already. On 10/20/23 at 10:29 AM, Surveyor #1 returned to the unit and observed Resident #41 in bed with the same clothing as days prior. On 10/20/23 at 10:35 AM, Surveyor #1 interviewed the Registered Nurse Unit Manger (RN UM) who stated that she was not aware that the resident had not been changed. The surveyor escorted the RN UM to the Resident #41's room where the resident confirmed she had not been changed and agreed to have her clothing change.	F 725			

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F 725	Continued From page 85 On 10/23/23 at 09:42 AM, Surveyor #1 observed Resident#41 in bed, their [redacted] and [redacted] with large amount of [redacted] on the bed. The surveyor escorted the DON to the room where we all observed the same. The surveyor asked the DON if they have any [redacted] for the [redacted]. She stated yes and showed to the surveyor the [redacted] at the bedside. 10/23/23 10:43 AM, Surveyor #1 revisited the resident after AM care was provided. The resident stated, "Ex Order 26. 4B1 [redacted] [redacted]." The resident observed with the same colorful gown noted on in bed this morning. 10/24/23 10:01 AM, Surveyor #1 asked the RN UM who was directing the care, she stated, "Myself and the DON." The RN UM stated that her role was to ensure the care was being delivered, communicate with staff, check assignments, and make rounds. The surveyor then asked the RN UM if she made rounds this morning. The RN UM replied, "No." d)A review of the medical record revealed Resident #73 was admitted to the facility with diagnoses which included but were not limited to; [redacted] Ex Order 26. 4B1 [redacted] [redacted] [redacted]. On 10/26/23 at 9:04 AM, Surveyor #1 smelled a strong [redacted] permeated the hallway and was stronger while approaching Resident #73's room.	F 725			

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F 725	Continued From page 86 The surveyor asked a random CNA to assist with a care tour and when they entered Resident #73's room, they observed the resident seating in the wheelchair eating breakfast. The top sheet was visibly [redacted] with [redacted]. Resident #73's [redacted] along with the pants were noted on the floor [redacted] with [redacted]. The padding to protect the bed were noted on the floor [redacted] with [redacted]. When inquired if the resident was assisted with [redacted] prior to breakfast, the CNA stated that the resident was not on her assignment. The surveyor left the room to review the daily assignment and identified the CNA assigned to the resident that day. The surveyor escorted the RN UM along with the assigned CNA to the room where we all observed Resident #14 eating breakfast in an unsanitary environment. The RN UM stated that should not have happened and proceeded to remove the [redacted] clothing from the floor and removed the linens from the bed. On 10/26/31 at 11:15 AM, the RN UM informed the surveyor that the activity staff delivered the breakfast tray to Resident #73. On 10/26/23 at 12:30 PM, Surveyor #1 interviewed the activity staff who delivered the breakfast tray who stated that she did not observe the [redacted] clothing on the floor. She stated that the resident was in bed, and she did not realize that the sheet was [redacted] with [redacted]. Resident #73 was not checked for [redacted] prior to receiving the breakfast tray. Staff reported to work at 7:00 AM and had not checked the resident until the surveyor brought the issue to their attention.	F 725			

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F 725	Continued From page 87 On 10/27/23 at 10:44 AM, Surveyor #1 interviewed the RN UM who stated that the CNAs were to check the residents and provide care prior to breakfast. On 10/27/23 at 11:15 AM, Surveyor #1 interviewed the CNA and inquired about the ^{NJ Ex. Order 26.4b1} clothing observed on the floor the morning of ^{Ex Order 26.4b1}. The CNA stated, "I did not check the resident, nor provided care yet." The CNA further stated that the resident would be ^{NJ Exec Order 26.4b1} with care. There was no documentation in the clinical record regarding rejection of care. 2.) A review of the medical record revealed Resident #7 had diagnoses that included but were not limited to: ^{Ex Order 26.4b1} ^{Ex Order 26.4b1} On 10/18/23 at 9:40 AM, Surveyor #2 observed Resident #7 lying in his/her bed. The surveyor observed Resident #7's fingernails to be ^{NJ Ex. Order 26.4(b)(1)} with a ^{Ex Order 26.4b1} under the fingernails. Resident #7's ^{Ex Order 26.4b1} had a long fingernail that was ^{NJ Exec Order 26.4b1} and ^{NJ Exec Order 26.4b1} with the resident's ^{Ex Order 26.4b1}. On 10/19/23 at 10:42 AM, Surveyor #2 observed Resident #7 lying in bed with his/her fingernails visibly ^{NJ Ex. Order 26.4(b)(1)}. Resident #7's ^{Ex Order 26.4b1} was ^{NJ Exec Order 26.4b1} and ^{NJ Exec Order 26.4b1} with the resident's ^{Ex Order 26.4b1}.	F 725			

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F 725	Continued From page 88 On 10/19/23 at 11:21 AM, Surveyor #2 interviewed the CNA who stated that he was not Resident #7's care giver. He further stated that the <u>Ex Order 26.4B1</u> comes in the mornings to care for the resident. On 10/19/23 at 11:35 AM, Surveyor #2 observed an LPN in Resident #7's room and was encouraging the resident who was feeding themselves lunch then the LPN exited the room. On 10/19/23 at 12:17 PM, the surveyor interviewed LPN #1 who stated that she was not familiar with the resident as she usually worked on the other unit. On 10/19/23 at 12:20 PM, CNA #2 stated she was familiar with Resident #7. She stated that the resident was <u>NJ Exec Order 26.4b1</u> could move around in their bed, was <u>NJ Exec Order 26.4b1</u>, and that <u>Ex Order 26.4B1</u> usually came in the morning. CNA #2 and the surveyor entered Resident #7's room and when asked about the resident's nail care, CNA #2 stated, "they need to be cut". She stated that <u>Ex Order 26.4B1</u> would clean the resident up in the morning. CNA #2 further stated that if <u>Ex Order 26.4B1</u> did not provide care, the facility staff would be responsible for Resident #7's care. On 10/19/23 at 12:22 PM, LPN #1 and the surveyor entered Resident #7's room and when asked about the resident's nail care, LPN #1 stated, "The nails need to be cut. I don't do that." When asked where the documentation of nail care would be, LPN #1 stated there was a book on the unit. LPN #1 showed Surveyor #1 the CNA book for resident care but was unable to locate any documentation for Resident #7.	F 725			

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F 725	Continued From page 89 On 10/19/23 at 12:30 PM, the DON stated that the <u>Ex Order 26.4B1</u> was not the only staff responsible for the resident's care. She stated that nail care should be done at least once a week and as needed. The DON was in Resident #7's room with the surveyor. The DON stated the resident's fingernails were too long and "should not look like that". On 10/20/23 at 8:13 AM, the surveyor interviewed the <u>Ex Order 26.4B1</u> who acknowledged that Resident #7's fingernails needed to be trimmed but that she did not do that for the resident. On 10/31/23 at 10:00 AM, the DON stated that there was no documentation in the Progress Notes or in the CP that the resident was resistant to nail care. 3. On 10/19/23 at 10:59 AM, Surveyor #3 observed the call light illuminated outside room <u>NJ Exec 9</u> and room <u>NJ Exec 9</u> which were located at the end of the hallway. At 11:05 AM, the surveyor observed room <u>NJ Exec 9</u>'s call light was turned off, but the surveyor did not observe any staff had entered the room. (Total 6 minutes the call light was on). At 11:06 AM, the surveyor observed a housekeeper enter room <u>NJ Exec 9</u> to answer the call bell and the call light was turned off (total 7 minutes the call light was not answered). During an interview with the surveyor on 10/19/23 at 11:21 AM, the LPN stated that staffing today consisted of 2 LPNs and 3 CNA's (census 51). During an interview with Surveyor #3 on 10/19/23 at 11:24 AM, the unit secretary (US) stated that the resident call system console was located at	F 725			

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F 725	Continued From page 90 the nurse's station behind a computer monitor. The US stated that the call light could be turned off from the nurse's station[at the resident call system console] but you needed to go see what the resident needed before you turned off the call light. On 10/19/23 at 11:40 AM, Surveyor #3 observed the call light illuminated outside room [REDACTED] NJ Ex-Ord. At 11:50 AM, room [REDACTED] NJ Ex-Ord's call light still illuminated in the hallway. Surveyor #3 observed an LPN at the medication cart with another surveyor but no other personnel in the hallway. The surveyor observed the resident call system console was not emitting a visual red light or an audible sound from the console. At 11:51 AM, Surveyor #3 observed the RN UM sitting at the nurse's station next to the resident call system console. The surveyor asked the RN UM if there were any call lights activated and she looked at the resident call system console and noted there were no red lights emitting from the monitor and stated "no." The RN UM stated that when a resident pressed the call bell, a light will go on outside the resident's room, there would be a ringing sound and a red light will light on the resident call system console. On 10/19/23 at 11:57 AM, Surveyor #3 observed room [REDACTED] NJ Ex-Ord call light was still illuminated outside the resident's room. The LPN stated she was looking for the CNA who was assigned to Room [REDACTED] NJ Ex-Ord. At that time there were 2 other CNAs in the hallway by the nurse's station, but the call light was not answered. At 12:00 PM, the LPN who was assigned to room [REDACTED] NJ Ex-Ord answered the call light.(call light was unanswered for 20 minutes)	F 725			

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NAME OF PROVIDER OR SUPPLIER ABINGDON CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 ROCK AVE GREEN BROOK, NJ 08812		
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F 725	Continued From page 91 On 10/19/23 at 12:02 PM, the surveyor informed the RN UM that Room [REDACTED] 's call light was not answered for 20 minutes. The RN UM stated that anyone can answer a call light, such as CNA's, housekeepers, nurses, then they would get the appropriate person to assist the resident. The RN UM stated that an appropriate response time for a call light to be answered would be 2-3 minutes. On 10/24/23 at 10:30 AM, Surveyor #3 interviewed the DON who stated that she would expect the staff to respond to a call light as soon as the call light was on and that the response time would be about 5 minutes. The DON stated that anyone could answer a call light. A review of the facility's policy titled "Nursing Services and Sufficient Staff," reviewed 09/22, revealed that the facility will supply services by sufficient numbers of each of the following personnel types on a 24 hour basis to provide nursing care to all residents in accordance with resident care plans, a. except when waived, licensed nurses; and b. other nursing personnel; including but not limited to nurse aides. A review of the facility's policy titled " Call lights: Accessibility and Timely Response", reviewed 09/22, revealed that all staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified.	F 725			
F 756 SS=F	NJAC 8:39- 4.1(a)11; 27.1(a) Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756			12/1/23

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F 756	Continued From page 92 §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F 756			

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F 756	Continued From page 93 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure: a) a Medication Regimen Review (MRR) of each resident was performed at least once a month by a licensed pharmacist, and b) provide documentation that the recommendations were acted upon in a timely matter. This deficient practice was observed for 2 of 2 nursing units with a census of 101, for August 2023 and September 2023, and was evidenced by the following: During an interview with the surveyor on 10/25/23 at 9:22 AM, the Registered Nurse Unit Manager (RN UM) stated that MRR were completed monthly, but the facility had changed pharmacy consultants and not sure how the reporting was being done at present. The process with the prior consultant pharmacy was that the Consultant Pharmacist (CP) would email all recommendations to the Director of Nursing (DON) then the DON would email them to the Unit Manager. On 10/25/23 at 10:07 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding the presence of a consultant pharmacist. The LNHA stated that she thought the pharmacy consultants stopped coming in July 2023 and it was a corporate level decision that may have been related to finances. When asked if it was important for the pharmacist to come to the facility, the LNHA stated, "absolutely, it is important to have a continuum of care". On 10/25/23 at 12:40 PM, the surveyor requested	F 756	756 Drug Regimen Element 1 All residents were assessed and there were not any adverse effects due to deficient practice. This was done to ensure the deficient practice would not be repeated and no one resident was impacted with a negative outcome 11/4/2023 The Regional Clinical Nurse in-serviced licensed nurses on completing the Pharmacy Consultant recommendations / therapeutic suggestions 11/4 The regional CLinical Nurse also inserviced the Director of Nursing on the pfacility policy and procedures on completing the pharmacy consultant recommendations and theraputic suggestions. Team met with Pharmacy consultant Nov 4 to discuss the review and process ad provide in-service training to the licensed nurses. The facility has developed policies and procedures for the monthly drug regimen review that included but are not limited to the process , steps the pharmacist must take when identifying irregularities that require urgent actions to protect active residents. Element II		

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F 756	Continued From page 94 all CP recommendations for August and September 2023. During an interview with the surveyor on 10/25/23 at 12:56 PM, the DON stated that CP would complete monthly drug reviews on each resident, complete medication passes with the nurses, review medication storage and review residents' charts. The CP recommendations would then be emailed to the DON and the facility has the responsibility to carry out the recommendations. On 10/26/23 at 9:10 AM, the DON provided "Pharmacy Recommendations" and stated, "this is all we have, it's not much". A review of the documents provided included a Quality Assurance Performance Improvement Program(QA PIP) for the "absence of Pharmacy Consultant" and no pharmacy recommendations for any residents for <u>NJ Ex Order 26. 4B1</u> and <u>NJ Ex Order 26. 4B1</u>. During an interview with the surveyor on 10/26/23 at 10:07 AM, the DON stated that she started at the facility on <u>NJ Ex Order 26. 4B1</u>. The DON stated that the facility did not have a CP for the month of <u>NJ Ex Order 26. 4B1</u>. A new CP started in September, but the reports were sent to the previous DON, and she could not access the reports. The DON confirmed that the MRR was not completed for <u>NJ Ex Order 26. 4B1</u> and could not provide any CP recommendations for <u>NJ Ex Order 26. 4B1</u>. During an interview with the surveyor on 10/26/23 at 10:52 AM, the LNHA stated that the previous CP terminated their contract with the facility in <u>NJ Ex Order 26. 4B1</u>. The surveyor requested a copy of the termination letter but it was not provided.	F 756	All residents that reside in the facility have the potential to be affected by the deficient practices. Element III -The Director of Nursing or designee will audit daily new admission or residents with change in condition pharmacy review for compliance of the facility policy and procedures for pharmacy consultant reviews and recommendations. -The Director of Nursing or designee will continue interventions including on-going education to be provided if nurse is found not to be following primary physician orders. -The Director of Nursing or designee will audit the Pharmacy consultant Recommendations/Therapeutic Suggestions report monthly for completion by nursing and the physician. Element IV -Audits will be monitored for completion by the Administrator and Director of Nursing weekly for 4 weeks, bi-weekly X 2 months, monthly X 3 months, and quarterly X 2. -- Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance		

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F 756	Continued From page 95 During an interview with the surveyor, in the presence of the survey team, on 10/26/23 at 11:24 AM, the LNHA stated that the role of the CP was to come to the facility, review residents mediations and charts, check the nursing units, complete random medication passes with the nurses for competencies and then email the recommendations to the DON who would then send to the unit managers to take action on it with the doctors. The LNHA stated it was important for MRR to be completed monthly because there could be drug interactions, polypharmacy, allergies, drug side effects and behavior monitoring needed for certain medications. When asked what was implemented when there was an absence of CP services, the LNHA stated they implemented a QAPI. During an interview with the surveyor on 10/26/23 at 11:52 AM, the Medical Director stated that she was aware of the interruption of service from the pharmacy consultant. During a telephone interview with the surveyor on 12/26/23 at 12:53 PM, the CP (from the new consultant corporation) stated that they started in September 2023. She stated she only reviewed residents on one unit and her medication recommendations were then emailed to the DON. She further stated that the facility could access the recommendations through a portal. The facility was unable to provide any further documentation that a MRR was completed for NJ Ex Order 26. 4B1 and NJ Ex Order 26. 4B1. A review of the facility's policy titled, "Addressing Medication Regimen Review Irregularities", dated 11/2017, revealed that the medication regimen of	F 756	threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee quarterly.		

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F 756	Continued From page 96 each resident must be reviewed by a licensed pharmacist at least once a month (or more frequently, as indicated by the resident's condition). The policy is to provide a MRR for each resident in order to identify irregularities and respond to those irregularities in a timely manner to prevent the occurrence of an adverse drug event.	F 756			
F 761 SS=D	NJAC 8:39-29.3 (a) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761			12/1/23

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F 761	Continued From page 97 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documents it was determined that the facility failed to properly label and date medications in 2 of 4 medication carts inspected. The deficient practice was evidenced by the following: 1. On 10/19/23 at 11:00 AM, the surveyor inspected the NJ Exec Order 26.4b1 Unit medication cart on the 2nd floor with the Licensed Practical Nurse (LPN#1) who was assigned to the cart. Inside of the medication cart the surveyor observed following: -1 bottle of Nitroglycerin tablet (medication used to treat angina) with an expiration date of 07/23 -1 multi dose vial of insulin opened but not dated, a pack of Oxycodone 5/325 milligrams(mg) (medication to treat pain) with an expiration date of 09/23 -5 multi dose vials of Insulin that had an open date and no expiration date -1 multi doses vial of Aspart Insulin opened 09/07/23 last used 10/19/23. 2. The surveyor inspected the medication storage room on the Noble Unit with LPN #1. Inside the locked medication refrigerator was the following: -1 multi doses vial of PPD (Purified Protein Derivative) vaccine opened but not dated An inspection of the medication cabinets revealed 3 bottles of Vitamin E with an expiration date of 09/23. At that time, the surveyor interviewed LPN #1.	F 761	761 Label/Storage Element I 11/4/2023 Director of Nursing or designee in-serviced all nurses and central supply personnel on proper medication storage, labeling, and importance of cleanliness of all medication storage areas. All residents were assessed with no adverse effect due to the deficit practice. Element II All residents that reside in the facility have the potential to be affected by the deficit practice. Element III -11/4/2023 Regional Clinical Nurse in-serviced all nurses and central supply employees on proper medication storage, labeling, and importance of cleanliness of all medication storage areas. - The Director of Nursing and/or designee will complete weekly audits and check all medication storage areas for proper labeling of medications, expired medications, and cleanliness of areas to assure continued compliance. - Central Supply personnel will complete audits of all house-stock medication storage areas weekly for 3 months to		

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F 761	Continued From page 98 The LPN #1 stated the Pharmacy Consultant and the Unit Manager were responsible to check all medication rooms for expired medications and/or removing medications from active inventory if indicated from the medication room. The LPN added that the nurses were responsible for checking the medications inside the medication carts prior to administration. She could not comment on why expired medications were inside the medication cart. 3. On 10/19/23 at 11:15 AM, the surveyor inspected the second medication cart on the  unit with LPN #2 which revealed the following: -5 Flexpen insulin with the open date only. -1 Lantus Flexpen dated on the box 09/14, pen not dated. The manufacturer specification on the box, reviewed with the LPN, directed to discard the insulin after 28 days. During an interview with LPN #2, he stated that insulin could be used for 30-60 days. The surveyor interviewed both nurses on the medication carts, no explanation was offered as to why the multi-dose vials of Insulin were not labeled with the open date and the expiration date. On 10/20/23 at 11:30 AM the surveyor interviewed the Unit Manager regarding the the facility's process to date insulin. The UM stated that the process was to date with the date the insulin was opened only. However the Clinical Director stated upon interview on 10/20/23 that all insulin vials and Flexpens should be dated with an open and expiration date.	F 761	assure compliance in these areas. Element IV -Audits will be monitored for completion by the Administrator or Director of Nursing weekly for 4 weeks, bi-weekly X 2 months and monthly X 3 months and quarterly X 2. Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.		

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F 761	Continued From page 99 On 10/23/23 at 11:30 AM, the surveyor reviewed the facility's policy and procedure which was titled " Medication Storage" with a review date of 09/22, Under "Policy Explanation and Compliance Guidelines" Interpretation and Implementation" #5. Unused medications, The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, expired and outdated medications. These medications are destroyed in accordance with the facility policy. The facility provided the policy labeled" 7.0 Insulin Pen Labeling and Packaging" with the following instructions: Insulin pens are placed in a resealed bag with the following/labels/stickers Prescription label in accordance with the labeling regulations. Refrigerate until opened Keep Insulin in bag sticker. A yellow "Date/Expiration" sticker. None of the Insulin observed on both medication carts had a yellow sticker for identifying the expiration date. On 10/20/23 at 11:00 AM, the surveyor interviewed the DON who stated that the nurses were responsible for discarding expired items found in all storage rooms.	F 761			
F 804 SS=E	NJAC 8:39-29.4 (b)2 Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides-	F 804			12/1/23

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F 804	Continued From page 100 §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that the meals were served at a palatable temperature for 2 of 2 Residents reviewed for food (Resident #23 & Resident #87). The deficient practice was evidenced by the following: On 10/18/23 11:29 AM, the surveyor observed Resident #87 <u>NJ Exec Order 26.4b1</u> sitting in bed. The surveyor asked about the food at the facility and Resident #87 stated the <u>"Ex Order 26. 4B1"</u>. On 10/18/23 at 11:40 AM, the surveyor observed Resident #23 <u>NJ Exec Order 26.4b1</u> sitting in wheelchair inside the resident's room. When asked about the meals, Resident #23 stated <u>"Ex Order 26. 4B1"</u>. On 10/20/23 at 8:27 AM, the surveyor observed the meal cart brought to the second floor by the dietary staff. On 10/20/23 at 8:32 AM, the second to last tray was delivered and the requested the last tray which belonged to Resident #23 and proceeded to check the temperatures of the food items in the presence of the Registered Nurse. The meal tray was labeled "Regular" diet and	F 804	483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Element 1 The kitchen prepared fresh scrambled and hard- boiled eggs. The new batches of eggs were placed in the kitchen steam table and then tempted at 182 degrees. All residents who stated their eggs were cold received fresh, hot eggs immediately. The temperature was documented in the daily food service line temperature log. Element 2 All residents could have been affected here. Deficient practice rectified immediately, To prevent deficient act from reoccurring temperatures will be monitored, by a two step process. The cook will take temperatures , record outcome, followed by the Dietary manager and or designee to verify compliance, upon completion, the trays may be released to the residents, Element 3 In-services and education were done on proper food temperatures for cooking, holding, and serving The training included the following to ensure the prevention of reoccurrence of the deficient practice as follows :		

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F 804	Continued From page 101 contained scrambled eggs which were 122 degrees Farenheight (F), a hard cooked egg which was 132 F, and 8 ounces of milk which was 53 F. At 10/20/23 at 8:50 AM, the surveyor interviewed the Food Service Director in the kitchen. The surveyor asked the FSD what the temperatures should be for the meals that are served to the residents. The FSD stated our standards are 165 F or better, and stated "there is no temperature on the floor that the food should be, as long as it leaves the kitchen at 165 F it is palatable" and stated "it can be reheated". When asked about a food temperature policy the FSD stated they don't have one. 10/20/23 at 8:55 AM, the surveyor asked the FSD to show the surveyor the kitchen food temperatures for the cooked items. The FSD looked at the kitchen food temperature log, and the surveyor also observed that the scrambled eggs and hard cooked egg were not listed. On 10/20/23 at 8:56 AM, the FSD went to the cook who made the breakfast and took the temperature log to the cook to ask him what the temp was for the scrambled egg. The FSD then stated to the cook "you didn't put it down", and when the cook wanted to document the temperatures at that time, the FSD stated "it is too late to put it down". The FSD stated to the surveyor that he forgot to put the egg down and they should be 145 or better '(not the 165 F that the FSD previously stated). The FSD stated "he didn't write it down and it did not exist." NJAC 8:39- 17.4(a)2	F 804	Critical control points were established to help check and maintain proper food temperatures throughout the process from the time the food is prepared to the time the food is enjoyed by the residents. All hot food items will be tempted upon being pulled from the oven to be sure all food items are properly cooked to the proper minimum temperature requirements and recorded All hot foods will be tempt again after being placed in the steam table prior to service. Dietary management will follow up daily for all 3 meals checking to be sure the cooks properly log temperatures for all food items on the service lines hot and cold in the service line log book. Random test trays will be done on the various units to be sure residents are enjoying their foods at palatable temperatures. Monthly menu committees will be conducted to ensure residents' concerns are met and resident satisfaction achieved. Element 4 Audits that will monitor but not limited to the following items on the temperatures, palatability, will be done on a weekly basis for the first month, continued monthly, refereed to Qapi Committee for their review.		

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F 814 F 814 SS=F	Continued From page 102 Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that garbage was regularly removed from the facility in a manner to prevent the potential spread of infection and vermin infestation. The deficient practice was evidenced by the following: On 10/18/23 at 8:53 AM, during the initial approach from the parking area/rear of the building, the surveyor observed a large pile of garbage bags that covered approximately one-half of the loading dock. The garbage bags were piled up against the back wall of the loading dock and adjacent to a chain link fence cage that appeared to have oxygen cylinders inside with a sign affixed "Danger, No Smoking, No Open Flames" to the outside of the cage and above a pile of the garbage bags. The garbage bags that were piled up against the back wall obstructed a sign "Notice all cardboard needs to be ..." making it unreadable in it's entirety. There was a large compacter type dumpster below the loading dock, and an uncovered cardboard type dumpster next to it. There was also debris strewn about next to the compacter dumpster and cardboard type dumpster which included papers, wood, etc. On 10/18/23 at 11:11 AM, the surveyor observed the loading dock of the building and observed two trucks for a [junk removal service] and two men were loading the garbage bags into the [junk removal service trucks]. At that time, in the	F 814 F 814	814 Dispose Garbage Element I all residents were potentially affected by this deficient practical refuse was removed by an alternative company . A larger container wrequested to accomdate increased use. Element II the maintenance director and or designee will continue to monitor the amount of refuse and report any lapse in service to the Administrator(LNHA) for situation to be rectified. Element III This will be discussed on a daily basis at morning meeting by Maintenance Director, Enviromental Service Supervisor and Adminsitrator (LNHA) Element IV -Audits will be monitored for completion by the Administrator or Director of Nursing weekly for 4 weeks, bi-weekly X 2 months and monthly X 3 months and quarterly x 2. - Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is	12/1/23	

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F 814	Continued From page 103 presence of the Food Service Director (FSD), the surveyor asked one of the workers if the facility contracted with them for garbage removal and he responded "no, only for today", then asked the FSD who was going to continue to remove the garbage and he stated, "that is above my pay grade". On 10/25/23 at 9:48 AM, the surveyor interviewed the LNHA regarding if she had been made aware of the garbage not being picked up. The LNHA stated there was daily "stand up" meetings for clinical and one for operations. When asked about the garbage piling up, the LNHA stated they [garbage company] were "not paid timely", and she had followed up with the facility corporate office and confirmed to the surveyor that she observed that the garbage had been piled up. The LNHA confirmed that there was a delay in rectifying the garbage situation, and stated she had not been made aware of the garbage piling up until a day or so before the surveyor brought it to her attention. The surveyor asked the LNHA if leaving the garbage piled up outside was okay and the LNHA stated, "no, it was not okay", that the facility was in a wooded area and you "cannot chance it."	F 814	necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.		
F 847 SS=E	NJAC 8:39-31.4 (b) Entering into Binding Arbitration Agreements CFR(s): 483.70(n)(2)(i)(ii)(3)-(5) §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section.	F 847		11/23/23	

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F 847	Continued From page 104 §483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n) (5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees,	F 847			

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F 847	Continued From page 105 and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on interview and document review it was determined that the facility failed to ensure that a process was in place for explaining the arbitration agreement to a resident prior to having the resident sign the agreement. This deficient practice occurred for 1 of 2 residents reviewed for arbitration agreements (Resident #16) and was evidenced by the following: On 10/18/23 at 12:19 PM, the Licensed Nursing Home Administrator (LNHA) informed the surveyor that the facility utilized arbitration agreements which were part of the admission agreement and would provide a list of residents who have signed the agreement. The LNHA stated the Admission Director was responsible for having the residents sign the agreements. On 10/23/23 at 11:30 AM, the surveyor received the list of facility arbitration agreements which include resident #16. A reviewed of Resident #16's electronic medical record (EMR) revealed Resident #16 entered into the [redacted] (NJ Exec Order 26.4b1) by signing the [redacted] (NJ Exec Order 26.4b1) on [redacted] (NJ Ex Order 26.4b1). The [redacted] (NJ Exec Order 26.4b1) revealed 1. NJ Exec Order 26.4b1. "Any and all claims or controversies between Patient, the Patient Representative and Facility that arise out of the Patient's stay at the Facility, with the exception of eviction proceedings, and including but not limited to, violations of any right granted by law, including statutory resident's right, or by the Admission Agreement, breach of contract, fraud or misrepresentation, negligence, gross negligence,	F 847	1. All residents have the potential to have been affected by the deficient practice. The facility corrected the issue was rectified with resident 16, by having the [redacted] (NJ Ex.Order 26.4(b)(1)) reviewed again, to which resident 16 acknowledged she understood having no further issues. Follow up was do On October 24 Admissions Director was reeducated on the binding arbitration agreement. The admissions director was asked to do a return demonstration of how she would present this so that all key points were covered, she was able to do so without issue. 2. The resident #16 had the agreement reviewed with her, by the social worker to ensure resident understood explanation as presented by the Admissions Director. To prevent reoccurrence an audit to be done on a monthly basis by LNHA Administrator with results reported to the Qapi committee. Any issues will be immediately addressed with those outcomes incorporated in the reporting to the QAPI committee. 3 The facility shall review the arbitration admission agreement audits completed by the LNHA, Regional Director of admissions and or designee and then submit monthly to the QAPI committee for		

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F 847	Continued From page 106 malpractice or any other claim based on any alleged departure from accepted standards of medical or health care or safety, whether sounding in tort resulting in personal injury, or in contract, shall be submitted to binding arbitration, which shall be the sole means by which said claims or controversies shall be resolved." Additionally, the agreement revealed "This binding Arbitration Agreement constitutes a binding legal agreement between the parties. The patient and/or the patient representative have read and understand this arbitration agreement and understand that by signing this arbitration agreement each has waived his/her rights to a trial before a judge and/or a jury and voluntarily consent to all of the terms of this section." On 10/23/23 at 10:56 AM, the surveyor interviewed Resident #16 in the resident's room. The surveyor asked Resident #16 if the resident recalled being asked to enter into an [REDACTED] NJ Exec Order 26.4b1 and if recalled signing such an agreement. The surveyor stated to Resident #16 regarding being informed that by signing the [REDACTED] NJ Exec Order 26.4b1, the resident gives up their [REDACTED] NJ Exec Order 26.4b1 per the [REDACTED] NJ Exec Order 26.4B1 he/she signed [REDACTED] NJ Ex Order 26.4B1 [REDACTED]. Resident #16 stated when he/she was asked to sign the admission agreement, [REDACTED] NJ Ex Order 26.4B1 [REDACTED]. Resident #16 stated that she has no recall of anyone explaining such an agreement. The surveyor asked Resident #16 if he/she would have signed such a document if it had been explained and Resident #16 stated, "NJ Ex Order 26.4B1", and that he/she [REDACTED] NJ Ex Order 26.4B1 [REDACTED]. Resident #16 stated the Admission Director is the one that had him/her sign the [REDACTED] NJ Exec.	F 847	three (3) months to ensure compliance. The QAPI committee will reevaluate after three months, and if compliance is met will continue to monitor on a quarterly basis for one calendar year.		

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F 847	Continued From page 107 On 10/23/23 at 12:14 PM, the surveyor conducted an interview with Admisison Director (AD). The surveyor asked the AD what her role entailed and she stated that she has would come weekly and have residents sign consents for care. The surveyor asked about [REDACTED] and the AD stated "it is in the admission agreements". The surveyor asked the AD if she documented any discussion she may have had with any residents. The AD stated that she did not go into the resident's charts, and kept no formal files or documents to track when she met with any residents. The surveyor asked what was told to the residents regarding signing the [REDACTED]. The AD stated that she would briefly educate the resident and tell them "this is if something happens, it would go through [REDACTED] instead", and tell them that it is "from lawyer to lawyer, and not a court thing". On 10/23/23 at 12:20 PM, the surveyor asked the AD if she had met with Resident #16 and explained the [REDACTED]. The AD stated Resident #16 already signed one and that she [REDACTED] "went over it with the resident because the AD thought it had been done already been reviewed with Resident #16. The AD stated that the person from the company had asked that she have Resident #16 sign the [REDACTED]. The surveyor asked the AD if someone had provided her with documented education on the [REDACTED] and the AD stated, "no", nothing was documented. The AD stated she would go visit residents and verbally explain the [REDACTED] to them, and then had the residents sign the [REDACTED]. The AD provdied the surveyor with a copy of the AA and stated, "they [the residents] should all have that". NJAC 8:39- 13.1(a)	F 847			

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F 880 SS=F	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 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:	F 880			12/1/23

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F 880	Continued From page 109 (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: Based on observation, interview, record review and review of facility documents, it was determined that the facility failed to follow facility policy to limit the spread of potential infection by ensuring: a.) hand hygiene at the lunch meal service, b.) hand hygiene and clean procedure during the care of a [NJ Exec Order 26.4b1], c.) the demonstration of a [NJ Exec Order 26.4b1], and d.) the "Clean [NJ Exec Order 26.4b1] Change Policy" was followed for 1 of 1 resident (Resident #14) observed during a [NJ Ex Order 26.4B1]	F 880	880 Hand Hygiene Element I Resident #358 [NJ Ex Order 26.4B1] was assessed with no [NJ Exec Order 26.4b1] or adverse effect due to the deficit practice. Resident #90 [NJ Ex Order 26.4B1] was assessed and noted with [NJ Exec Order 26.4b1] or adverse effects due to the		

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F 880	Continued From page 110 treatment observation. This deficient practice was identified for 3 residents (Resident #358, #90, and #14) on 2 of 2 nursing units and was evidenced by the following: a.) On 10/19/23 at 11:48 AM, Surveyor #1 observed the Warren unit staff passed out the lunch meal trays. A Certified Nursing Assistant (CNA) #1 was observed not performing hand hygiene prior to, or after delivery of meal trays as follows: 11:50 AM, into room 262. 11:51 AM, into room 263 and another tray into room 262. 11:53 AM, another tray into room 263 and into room 264. 12:01 PM, another tray into room 264. 12:03 PM, a tray into room 265. 12:04 PM, a tray into room 288. 12:05 PM, prior to moving the lunch tray cart. On 10/19/23 at 12:13 PM, during an interview with Surveyor #1, CNA #1 stated the process for the meal delivery was to check the meal tickets, clean the resident's hands, and help set the resident's meal up. When asked about performing hand hygiene, CNA #1 stated "yeah ok, I should have cleaned hands." On 10/19/23 at 12:34 PM, during an interview with Surveyor #1, the Director of Nursing (DON) stated the process to deliver the meal trays was to assist the residents with hand hygiene, check the meal ticket, staff performs hand hygiene, deliver the meal tray, set up any resident who needs help, and staff performed hand hygiene again. The DON stated the staff needs to perform hand hygiene because of infection control and	F 880	deficit practice. Resident #14 The NJ Exec Order 26.4b1 preventionist conducted 1:1 education immediate upon notification of the nursing staff that did not perform proper hand hygiene, glove removal, and use clean scissors while performing a NJ Exec Order 26.4b1 for Resident #14. No adverse effects due to the deficit practice. 10/26/2023 The Infection Preventionist conducted a facility wide in-service on the importance of proper hand hygiene techniques in preventing the transmission of healthcare-associated infections. Element II All residents that reside in the facility have the potential to be affected by the deficit practices. Element III- all staff were reeducated on when and methodology to perform hand hygiene during meal pass, during wound care, in when interacting with residents, prior to care and after care of residents. Interactions with families, visitors, volunteers to the unit. Element III -IP will conduct an on-going mandatory infection control prevention and management in-service with all employees on proper handwashing techniques prior to and after delivery of meal trays, during clean dressing treatment, hemodialysis access, and		

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F 880	Continued From page 111 currently the facility was in an outbreak of [REDACTED] NJ Ex Order 26. 4B1. b.) On 10/20/23 at 6:58 AM, Surveyor #1 observed a Licensed Practical Nurse (LPN) #1 during care of Resident #358's [REDACTED] NJ Ex Order 26. 4B1. Surveyor #1's observations included but were not limited to the following: LPN #1 had donned (put on) gloves without first performing hand hygiene and removed the [REDACTED] NJ Ex Order 26. 4B1 surrounding the [REDACTED] NJ Ex Order 26. 4B1 insertion. LPN #1 next used the same soiled gloves to pick up clean [REDACTED] NJ Ex Order 26. 4B1, open the [REDACTED] NJ Ex Order 26. 4B1, pour the [REDACTED] NJ Ex Order 26. 4B1 on the [REDACTED] NJ Ex Order 26. 4B1, and clean the exposed [REDACTED] NJ Ex Order 26. 4B1. LPN #1 doffed (removed) her gloves, did not perform hand hygiene, picked up a new [REDACTED] NJ Ex Order 26. 4B1, reached into a pouch she was wearing and obtained a marker and scissors, dated the [REDACTED] NJ Ex Order 26. 4B1, and used the scissors to cut the [REDACTED] NJ Ex Order 26. 4B1 to fit the site. LPN #1 completed flushing the residents [REDACTED] NJ Ex Order 26. 4B1 procedure, and during an interview at that time, LPN #1 stated that she should have performed hand hygiene in between changing her gloves and going from dirty to clean supplies. A review of the medical records revealed that Resident #358 had diagnoses which included but were not limited to; [REDACTED] NJ Ex Order 26. 4B1. A review of the most recent Annual Minimum Data Set (MDS) an assessment tool, dated [REDACTED] NJ Ex Order 26. 4B1, included but was not limited to; [REDACTED] NJ Ex Order 26. 4B1 as the resident was [REDACTED] NJ Ex Order 26. 4B1. Functional Status revealed the resident was [REDACTED] NJ Ex Order 26. 4B1 on staff for Activities of Daily Living including [REDACTED] NJ Ex Order 26. 4B1. A review of the patient-centered comprehensive	F 880	during the care of a feeding tube change. - IP will conduct 10 random hand washing competency weekly for 4 weeks, bi-weekly X 2 months, monthly X 3 months and quarterly X 2. -All License nursing staff and non-license staff was in-service on infection control policies and procedures paying particular attention to handwashing/hand hygiene Element IV -Audits will be monitored for completion by the Administrator or Director of Nursing weekly for 4 weeks, bi-weekly X 2 months, monthly X 3 months and quarterly X 2. - Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly		

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F 880	Continued From page 112 Care Plan included but was not limited to; a focus area of NJ Exec Order 26.4b1 with interventions that included NJ Exec Order 26.4b1. On 10/20/23 at 9:42 AM, the DON stated that hand hygiene should be performed between glove changing, removing the dirty NJ Exec Order 26.4b1, and not touching clean supplies with dirty gloves. The DON further stated it was important to break the chain of NJ Exec Order 26.4b1. A review of the facility provided, "Treatment Competency" dated 04/19/23, revealed that LPN #1 had been deemed competent performing treatments including but not limited to; removes gloves and washes hands; wash hands before treatment; removes soiled dressing; removes gloves and wash hands; clean and apply dressing; wears gloves: disinfect scissors. A review of the facility provided, "Preventing Spread of Infection" policy, revised 09/2023, included but was not limited to; Hand Hygiene continues to be the primary means of preventing the transmission of infection. Some situations that require hand hygiene: before and after direct resident contact, before and after changing a dressing, after handling soiled dressings, after handling soiled equipment, and after removing gloves. c.) On 10/23/2023 at 1:57 PM, Surveyor #2 observed Resident #90's assigned Licensed Practical Nurse (LPN) perform an assessment of the resident's NJ Ex Order 26. 4B1. The LPN sanitized a stethoscope and then applied	F 880			

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F 880	Continued From page 113 gloves. The LPN did not perform hand hygiene before applying the gloves to her hands. The LPN explained to the resident that she will be checking his/her [REDACTED] NJ Exec Order 26.4B1. The LPN had resident extend his/her [REDACTED] NJ Ex Order 26.4B1 and stated to the surveyor, "You take 2 fingers to feel the [REDACTED] NJ Ex Order 26.4B1." The LPN applied 2 fingers on the [REDACTED] NJ Ex Order 26.4B1 of the resident's [REDACTED] NJ Ex Order 26.4B1 and the LPN stated that she could feel the [REDACTED] NJ Exec Order 26.4b1. The LPN then placed the stethoscope to the resident's [REDACTED] NJ Ex Order 26.4B1 and stated to the surveyor that she could hear the [REDACTED] NJ Ex Order 26.4B1. The LPN then removed and discarded her gloves, closed the resident's overhead light and thanked the resident. The LPN did not perform hand hygiene after removing and discarding her gloves or sanitize the stethoscope after performing an assessment of the resident's [REDACTED] NJ Ex Order 26.4B1. A review of the Admission Record reflected that Resident #90 was admitted to the facility with diagnoses which included, but were not limited to, [REDACTED] NJ Ex Order 26.4B1 [REDACTED] A review of the Quarterly Minimum Data Set (MDS), an assessment tool used by the facility to prioritize care, dated [REDACTED] NJ Ex Order 26.4B1, revealed that Resident #90 received a score of [REDACTED] NJ Ex 4 out of 15 on	F 880			

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F 880	Continued From page 114 the Brief Interview for Mental Status (BIMS) indicative of <u>NJ Ex Order 26. 4B1</u>. On 10/27/2023 at 10:47 AM, in the presence of the survey team, the LNHA stated that it was important for the nurses to know about the <u>NJ Ex Order 26. 4B1</u> and perform hand hygiene when checking and or assessing the <u>NJ Ex Order 26. 4B1</u> to prevent infection of the <u>NJ Ex Order 26. 4B1</u>. A review of the facility provided, "Hand Hygiene" policy, revised 10/2023, included but was not limited to; staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection. Policy: 2. Staff will perform hand hygiene when indicated. A review of the facility provided, "Preventing Spread of Infection" policy, revised 09/2023, included but was not limited to; Hand Hygiene continues to be the primary means of preventing the transmission of infection. Some situations that require hand hygiene: before and after direct resident contact, before and after changing a dressing, after handling soiled dressings, after handling soiled equipment, and after removing gloves. d.) On 10/23/23 at 11:15 AM the surveyor observed the following during the <u>NJ Ex Order 26. 4</u> <u>NJ Ex Order 26. 4</u> for Resident #14: The Licensed Practical Nurse (LPN) disinfected the bedside table and set up the clean field in the hallway. The LPN then gathered her treatment supplies and placed them on the overbed table. The LPN turned the faucet on, wet her hands, applied soap, rubbed her hands together, then rinsed under the running water, turned off the faucet, dried her hands with the paper towel for	F 880			

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F 880	Continued From page 115 15 seconds. Then the LPN donned clean gloves, assisted the CNAs to reposition the Resident to his/her right side. The LPN then continued to perform the treatment by cleansing the [NJ Ex Order 26.4b1] with [NJ Ex Order 26.4b1], using the same gloves then LPN #1 dried the area with [NJ Ex Order 26.4b1], used a pair of scissors that were not disinfected to cut the [NJ Ex Order 26.4b1]. The LPN then packed the [NJ Ex Order 26.4b1] and left 2-3 inches of the [NJ Ex Order 26.4b1] hung on the resident's [NJ Ex Order 26.4b1]. The Surveyor then observed LPN #1 with the same gloves on, proceeded to take a clean [NJ Ex Order 26.4b1] to secure the [NJ Ex Order 26.4b1] on the resident's [NJ Ex Order 26.4b1]. Resident #14 had 2 other [NJ Ex Order 26.4b1], one to the [NJ Ex Order 26.4b1] and a [NJ Ex Order 26.4b1] which was discovered on the [NJ Ex Order 26.4b1] during the treatment. The LPN went to the sink washed her hands and returned to care for the [NJ Ex Order 26.4b1] to the [NJ Ex Order 26.4b1]. The LPN don gloves, cleansed the [NJ Ex Order 26.4b1] with [NJ Ex Order 26.4b1], pat the [NJ Ex Order 26.4b1], then used the same gloves hands to reach for the [NJ Ex Order 26.4b1] that was to be applied to the [NJ Ex Order 26.4b1] per the Physician's order. The LPN opened the [NJ Ex Order 26.4b1] and noted that the jar was emptied. The LPN then proceeded to apply a [NJ Ex Order 26.4b1] to the [NJ Ex Order 26.4b1]. The LPN did not measure the [NJ Ex Order 26.4b1]. She cleansed the [NJ Ex Order 26.4b1] with [NJ Ex Order 26.4b1] and applied the [NJ Ex Order 26.4b1] to the [NJ Ex Order 26.4b1]. A review of the indication noted on the [NJ Ex Order 26.4b1] indicated the following, "for external use. Do not used on [NJ Ex Order 26.4b1] or [NJ Ex Order 26.4b1]." The LPN gathered all the dirty/used supplies and threw them in the garbage, then she performed	F 880			

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F 880	Continued From page 116 hand washing under running water for 5.62 seconds. The LPN then returned the pair of scissors inside the treatment cart without first being disinfected. The surveyor conducted an interview with LPN #1 on 10/23/23 at 12:17 P.M., she stated that hand washing should have been performed for at least 15 to 20 seconds, that gloves should have been changed after contact with soiled surfaces, then wash hands, don (put on) new gloves, then proceed with NJ Exec Order 26.4b1 care. On 10/23/23 at 1:15 PM, The above concerns were discussed with the Director of Nursing and the Regional Clinical Nurse. The surveyor also requested the NJ Exec Order 26.4b1 care competency for the LPN. On 10/24/23 at 10:15 AM, the facility provided the competency evaluation and the protocol for NJ Exec Order 26.4b1 care. The protocol did not include how to pack a NJ Exec Order 26.4b1. The Clinical nurse informed the surveyor that she observed the LPN on 10/24/23, and she was not deemed competent to care for the NJ Exec Order 26.4b1. The surveyor interviewed the DON about her expectations, she added that the nurse should have done a NJ Exec Order 26.4b1, measured the NJ Exec Order 26.4b1 and called the physician. A review of the facility's " Wound Treatment Management" dated 11/2012 last revised 09/2023 indicated under Policy explanation: 1. "Wound treatment will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. 2. In the absence of treatment orders, the	F 880			

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F 880	Continued From page 117 licensed nurse will notify physician to obtain treatment orders.	F 880			
F 919 SS=D	NJAC 8:39-19.4(a) Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to maintain the resident nurse call system to operate as designed with visual and audible signals at the nursing station for 1 of 21 residents (Resident #15) on 1 of 2 units (Noble). This deficient practice was evidenced by the following: On 10/19/23 at 10:59 AM, the surveyor observed when Resident#15's call bell was illuminated, there was no audible or visual signal emitting from the resident call system console located at the NJ Exec Order 20.451 nurse's station. At 11:06 AM, the surveyor observed the call light outside Resident #15's room was not illuminated (turned off). On 10/19/23 at 11:40 AM, the surveyor observed that the nurse call light outside Resident #15's	F 919	F919 Call Bell Element I Resident #15 had no adverse effects related to the communication system Resident 15 was provided with an alternative mechanism while awaiting repair,instructions on use, staff educated to be on alert for alternate sound from the room of resident 15. While awaiting repair staff provided additional monitoring. The Call bell repair completed 10/27/23. Element II All residents that reside in the facility have the potential to be affected by the deficit practice.		12/1/23

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F 919	Continued From page 118 room was illuminated. The surveyor observed the Registered Nurse Unit Manager (RN UM) sitting at the nurse's station next to the resident call system console. At that time, the surveyor interviewed the RN UM who stated that when a resident activated the call light from their room, the call light will have a ringing sound and a red light will show on the resident call system console. The RN UM confirmed that Resident #15's call light was illuminated outside Resident #15's room but there was no audible or a red light visual emitting from the residents call system console located at the nurse's station. The RN UM stated that she will put in a work order for maintenance. On 10/20/23 at 10:17 AM, the surveyor observed the nurse call light outside Resident #15's room was illuminated but there was no audible or visual signal emitting from the resident call system console located at the NJ Exec Order 26.4b1 nurse's station. During an interview with the surveyor on 10/20/23 at 10:20 AM, the RN UM stated that she had put in a repair request to maintenance yesterday and had notified the Director of Maintenance (DM). The RN UM confirmed that that resident call system console was still not emitting a visual or audible signal when the call light was illuminated for Resident #15's room. The RN UM further stated that she will notify the DM and that when the call system is not functional, the resident would be given an manual hand bell. On 10/24/23 at 9:45 AM, the surveyor observed a gold hand bell on the overbed table in Resident #15's room. Resident #15 stated "the call bell is still not fixed."	F 919	Element III On 10/27./2023 all staff to include (Maintenance Department) will were educated on acceptable call bell response time, routine rounding procedure, checking to ensure that call bells are functioning and are within resident's reach during routine rounds. Interventions includes to continue with maintenance log immediately when the call system has malfunctioned and provide the resident with alternative measure as the tap bell system. Call bells will be checked on a weekly basis by maintenance dept for functionality. Random call bell tests will also be performed by dept managers during enviornmental rounds. Element IV -Audits will be monitored for completion by the Administrator or Director of Nursing weekly for 4 weeks, bi-weekly X 2 months and monthly for 3 months. - Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.		

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F 919	Continued From page 119 A review of the medical record revealed Resident #15 was admitted to the facility with diagnosis including but not limited to: <u>NJ Ex Order 26. 4B1</u> [REDACTED]. According to the Quarterly Minimum Data Set (MDS)(an assessment tool According to the Admission Record, Resident #15 was admitted to the facility with the diagnoses which included but was not limited to <u>NJ Ex Order 26. 4B1</u> [REDACTED], The Admission Minimum Data Set (MDS-an assessment tool utilized to facilitate the care of a resident), dated <u>NJ Ex Order 26. 4B1</u>, indicated that the resident was <u>NJ Ex Order 26. 4B1</u> and required moderate assistance with <u>NJ Ex Order 26. 4B1</u> and <u>NJ Ex Order 26. 4B1</u>. The MDS also indicated that the resident was on <u>NJ Ex Order 26. 4B1</u>. The surveyor reviewed the <u>NJ Ex Order 26. 4B1</u> Treatment Administration Record (TAR) which reflected a physician's order for <u>NJ Ex Order 26. 4B1</u> via <u>NJ Ex Order 26. 4B1</u> every day shift for <u>NJ Ex Order 26. 4B1</u>. Resident #15 had a BIMS score of <u>NJ Ex Order 26. 4B1</u> out of 15 indicative of <u>NJ Ex Order 26. 4B1</u>. The MDS also indicated that Resident #15 required extensive assistance of 2 people for <u>NJ Ex Order 26. 4B1</u> and <u>NJ Ex Order 26. 4B1</u>, and <u>NJ Exec Order 26.4b1</u> in a wheelchair on the unit. and <u>NJ Ex Order 26. 4B1</u>. During an interview with the surveyor on 10/24/23 at 2:28 PM, the Director of Maintenance (DM) and the Maintenance Technician (MT) provided the maintenance logbook from the <u>NJ Exec Order 26.4b1</u> that indicated that on <u>NJ Ex Order 26. 4B1</u>, "maintenance urgent	F 919			

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F 919	Continued From page 120 call bell repair needed Room [Resident #15's room] ." The MT stated that on ^{NJ ES Order 16, 481} he checked the call light and found that the switch by Resident #15's bed was broken, and the call light could only be turned off by the nurse's station. It wasn't until the next day on ^{NJ ES Order 16, 481} that the MT was made aware that the residents call system console was not functioning and he provided the resident with a hand bell. The DM stated that the vendor was contacted and would be in on ^{NJ ES Order 16, 481} to fix the call light for Resident #15. A review of the facility's policy titled, "Call Lights: Accessibility and Timely Response," dated 09/22, that staff will report problems with a call light or a call system immediate to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem can be remedied.	F 919			
F 940 SS=E	NJAC 8:39-31.2(e), 31.8(c)9 Training Requirements CFR(s): 483.95 §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to- This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, it was determined that the facility failed to	F 940	Element 1 Residents who are receiving dialysis		12/1/23

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F 940	Continued From page 121 provide education and assess staff competencies for staff who provided care for residents who received <u>NJ Exec Order 26.4B1</u> [REDACTED] as identified as "residents with skilled needs" per the Facility Assessment. The deficient practice was evidenced by the following: On 10/19/23 at 10:55 AM, the surveyor observed Resident #90 lying in bed awake, watching television with snacks on his/her bedside table. Resident #90 stated that he/she had been going to <u>NJ Ex Order 26.4B1</u> <u>NJ Ex Order 26.4B1</u>. The resident stated that he/she used to have a <u>NJ Ex Order 26.4B1</u> in his/her <u>NJ Ex Order 26.4B1</u>, while pointing to his/her <u>NJ Ex Order 26.4B1</u>, but now had a <u>NJ Ex Order 26.4B1</u> in his/her <u>NJ Ex Order 26.4B1</u>, pointing to his/her <u>NJ Ex Order 26.4B1</u>. The surveyor did not observe any <u>NJ Ex Order 26.4B1</u> or <u>NJ Ex Order 26.4B1</u> in resident's <u>NJ Ex Order 26.4B1</u>. The surveyor observed <u>NJ Ex Order 26.4B1</u> on the resident's <u>NJ Ex Order 26.4B1</u> <u>NJ Exec Order 26.4B1</u>. There were no <u>NJ Exec Order 26.4B1</u> on the 2 sites and some <u>NJ Ex Order 26.4B1</u> was noted. Resident #90 stated <u>NJ Ex Order 26.4B1</u> <u>NJ Ex Order 26.4B1</u>. The resident added that he/she goes to <u>NJ Ex Order 26.4B1</u> every Monday, Wednesday and Friday and takes a communication binder to his/her treatments, which the facility staff kept at the nurse's desk. A review of the Admission Record reflected that Resident #90 was admitted to the facility with diagnoses which included, but were not limited to, <u>NJ Ex Order 26.4B1</u> [REDACTED]	F 940	services or the have potential to have to receive dialysis services would be impacted. To prevent reoccurrence reeducation has been provided to licensed staff on how to provide care to dialysis residents which includes assessment, bp access signs symptoms of infection. Element 2 An audit was done of those residents currently receiving dialysis services which were done by Corp regional nurses, and unit manager. An Inservice was provided(by(regional corp nurse & Director of Nursing) of how to do an assessment on a resident pre and post dialysis session. This would include assessing permacath, dressing, weight, thrill and bruit of fistula for swelling or signs of infection. All licensed staff completed competencies relating to procedures to be followed with hemodialysis residents. These competencies will be performed with all new hires, on an annual basis. If the QAPI teams notes any trends this will be ammended to reflect the outcomes as presented. Element 3 Monthly review will be done with Infection Preventiomalist as a part of continuing educaton. Element 4 This will be referred to the QAPI committee for ongoing monitoring a monthly for six months		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 940	Continued From page 122 <i>NJ Ex Order 26. 4B1</i> [REDACTED] A review of the Quarterly Minimum Data Set (MDS), an assessment tool used by the facility to prioritize care, dated <i>NJ Ex Order 26. 4B1</i>, revealed that Resident #90 received a score of <i>NJ Ex</i> out of 15 on the Brief Interview for Mental Status (BIMS) indicative of <i>NJ Ex Order 26. 4B1</i>. Section <i>NJ Ex</i> of the MDS titled "Special Treatments, Procedures, and Programs" revealed that the resident received <i>NJ Ex Order 26</i> outside the facility. A review of the Facility Assessment indicated that the intent was the services and care provided assist people to reach their highest level of practicable potential and maintain their ability to participate in life activities as long as they are able. The facility assessment collects information about the facility's resident population to identify, but not limited to, the care required and the staff competencies. The facility's resources are identified and evaluated to ensure that care can be provided to meet residents' needs during the day to day and emergency operations. The facility assessment indicated that residents requiring hemodialysis are treated at the dialysis center in the community. Care and treatment for these residents is a joint effort of the facility and the dialysis center staff. The Facility Assessment would include staff competencies that are necessary to provide the level and types of care needed for the resident population. On 10/19/2023 at 12:59 PM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) any documentation of competencies,	F 940			

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F 940	Continued From page 123 education, or training for their staff nurses regarding care of [redacted] residents. During an interview with the surveyor on 10/23/2023 at 10:47 AM, the DON stated that her expectations of the nursing staff in caring for residents that receive [redacted] was to check the resident's vital signs, follow the physician's orders for medications, and to know what medications to hold prior to going to [redacted] NJ Ex Order 26. 4B1. The DON added to also monitor the resident's diet, to check the [redacted] and monitor the [redacted] for any signs of [redacted] NJ Ex Order 26. 4b1. The nurses should document in the communication binder that accompanies the resident to the [redacted] facility and communicate any changes with the resident to the [redacted] NJ Ex Order 26. 4B1. The DON stated that when the resident returns from their [redacted] NJ Ex Order 26. 4B1, the nurses should check the resident's vital signs, check the [redacted] NJ Ex Order 26. 4b1, and note any changes in the communication binder from the [redacted] NJ Ex Order 26. 4B1. She revealed that the nurses would check the [redacted] NJ Ex Order 26. 4B1 of the [redacted] NJ Ex Order 26. 4B1. If the resident had a [redacted] NJ Ex Order 26. 4B1, the [redacted] NJ Ex Order 26. 4B1 would have a [redacted] NJ Ex Order 26. 4b1 so should only check the site for [redacted] NJ Ex Order 26. 4b1 and not do anything else with the [redacted] NJ Ex Order 26. 4b1. The surveyor asked if the nurses were trained in the checking of the [redacted] NJ Ex Order 26. 4B1 of a [redacted] NJ Ex Order 26. 4b1? The DON stated that she would expect the nurses to already know how to do that. The DON revealed that she was not sure if any facility education regarding [redacted] NJ Ex Order 26. 4B1 residents was provided to the nursing staff. The DON stated that there should be a physician's order for checking the [redacted] NJ Ex Order 26. 4B1 of an [redacted] NJ Ex Order 26. 4B1 and should also be included in the resident's care plan. The surveyor requested from the DON for any documented education or training for their staff nurses	F 940			

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F 940	Continued From page 124 regarding NJ Ex Order 26. 4B1. During an interview with the surveyor on 10/23/2023 at 10:51 PM, the LNHA stated that her expectations of the nursing staff in caring for residents receiving NJ Ex Order 26. 4B1 was to document in the NJ Ex Order 26. 4B1 communication binder the resident's vital signs, checking of the NJ Ex Order 26. 4B1, weight, dietary changes, and any unusual occurrences. She stated that the nurses should also check the NJ Ex Order 26. 4B1 or signs of NJ Ex Order 26. 4B1 of the NJ Ex Order 26. 4B1. The LNHA added that if the resident had a NJ Ex Order 26. 4B1, the nurses should check for signs of NJ Ex Order 26. 4B1 at the site. The NJ Ex Order 26. 4B1 are changed at the NJ Ex Order 26. 4B1. The facility nurses do not change the NJ Ex Order 26. 4B1 or do anything else with the NJ Ex Order 26. 4B1. The LNHA confirmed that there should be a physician's order to check the NJ Ex Order 26. 4B1 of a NJ Ex Order 26. 4B1 and should also be care planned. The surveyor requested from the LNHA again for any staff education, training, or competencies related to NJ Ex Order 26. 4B1 residents. On 10/23/23 at 01:50 PM, in the presence of the survey team, the surveyor asked the DON if the staff had been trained on NJ Ex Order 26. 4B1? The DON stated, "No." The DON revealed that there were no staff competencies related to NJ Ex Order 26. 4B1 and stated that it was important based on the NJ Ex Order 26. 4B1 patient population. On 10/26/2023 at 09:37 AM, The facility was unable to provide any documentation of licensed nurse competencies, signed in-services, education, or training regarding care of NJ Ex Order 26. 4B1 residents. NJAC 8:39-33.4	F 940			

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
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 # NJ 001622113 Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to: a) maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey (a), from 02/26/2023 to 03/04/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 5 of 7 overnight shifts, from 10/01/2023 to 10/14/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 3 of 14 overnight shifts, and (c) train two (2) appointed designated staff members as required and then train the facility staff within the required	S 560	F725 Staffing Element I The facility continues to follow a recruitment plan to attract Certified Nurse assistants staff and licensed staff to meet the ratio requirement. Leadership has met and will continue to meet on an ongoing basis to identify staffing challenges and areas of improvement for licensed certified nursing needs. The Administrator along with Director of Nursing reviewed the staffing ratio requirements with the Staffing Coordinator to ensure the minimum state required staffing are met daily as of 11/8/2023.	12/1/23

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

TITLE

(X6) DATE

Electronically Signed

11/24/23

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S 560	Continued From page 1 time frames for the LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Queer/questioning [one's sexual or gender identity], Intersex [person is born with a combination of male and female biological traits] positive) and HIV+ (Human Immunodeficiency Virus [a virus that attacks cells that help the body fight infection] positive) program. Findings included: a. 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 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. Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the	S 560	Element II All residents in the facility have the potential to be affected by the deficient practice. Element III Ongoing efforts to recruit and retain staff are in place. Bonus shifts, referral bonus program and CNA school programs. The facility continues to conduct job fairs with immediate interviews and contingency offers. The facility will begin an expedited but robust onboarding process for new hires. The Administrator, Director of Nursing, and staffing coordinator will conduct weekly meetings to review call outs and facility census vs. Staffing needs. identify compliance and adjust interventions as needed to ensure staffing ratios are met. Element IV -Audits will be monitored for completion by the Administrator or Director of Nursing weekly for 4 weeks, bi-weekly X 2 months and monthly for 3 months. -Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be	

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S 560	Continued From page 2 facility was deficient in CNA staffing as follows: 1. For the week of Complaint staffing from 02/26/2023 to 03/04/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 5 of 7 overnight shifts as follows: -02/26/23 had 8 CNAs for 109 residents on the day shift, required at least 14 CNAs. -02/26/23 had 4 total staff for 109 residents on the overnight shift, required at least 8 total staff. -02/27/23 had 5 CNAs for 108 residents on the day shift, required at least 13 CNAs. -02/27/23 had 5 total staff for 108 residents on the overnight shift, required at least 8 total staff. -02/28/23 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs. -02/28/23 had 7 total staff for 108 residents on the overnight shift, required at least 8 total staff. -03/01/23 had 9 CNAs for 108 residents on the day shift, required at least 13 CNAs. -03/02/23 had 9 CNAs for 108 residents on the day shift, required at least 13 CNAs. -03/02/23 had 6 total staff for 108 residents on the overnight shift, required at least 8 total staff. -03/03/23 had 9 CNAs for 108 residents on the day shift, required at least 13 CNAs. -03/04/23 had 8 CNAs for 108 residents on the day shift, required at least 13 CNAs. -03/04/23 had 5 total staff for 108 residents on the overnight shift, required at least 8 total staff. 2. For the 2 weeks of staffing prior to survey from 10/01/2023 to 10/14/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 3 of 14 overnight shifts as follows:	S 560	immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.		

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S 560	Continued From page 3 -10/01/23 had 8 CNAs for 103 residents on the day shift, required at least 13 CNAs. -10/01/23 had 6 total staff for 103 residents on the overnight shift, required at least 7 total staff. -10/02/23 had 12 CNAs for 103 residents on the day shift, required at least 13 CNAs. -10/03/23 had 9 CNAs for 103 residents on the day shift, required at least 13 CNAs. -10/04/23 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs. -10/05/23 had 8 CNAs for 106 residents on the day shift, required at least 13 CNAs. -10/06/23 had 8 CNAs for 104 residents on the day shift, required at least 13 CNAs. -10/07/23 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs. -10/07/23 had 6 total staff for 104 residents on the overnight shift, required at least 7 total staff. -10/08/23 had 11 CNAs for 104 residents on the day shift, required at least 13 CNAs. -10/09/23 had 5 CNAs for 104 residents on the day shift, required at least 13 CNAs. -10/10/23 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs. -10/11/23 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs. -10/12/23 had 9 CNAs for 103 residents on the day shift, required at least 13 CNAs. -10/13/23 had 9 CNAs for 103 residents on the day shift, required at least 13 CNAs. -10/14/23 had 9 CNAs for 103 residents on the day shift, required at least 13 CNAs. -10/14/23 had 5 total staff for 103 residents on the overnight shift, required at least 7 total staff. During an interview with the surveyor on 10/25/23 at 11:06 AM, the Director of Nursing (DON) stated that the staffing coordinator was on	S 560			

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S 560	Continued From page 4 vacation and she was covering for the staffing coordinator. The DON stated she was aware of the NJ mandated CNA staffing ratios requirements as 1:8 day shift, 1:10 evening shift and 1:14 night shift. b. Reference: New Jersey Department of Health (NJDOH) memo, dated 04/19/22, "Statutory Amendments Regarding the Rights of LGBTQI+ and HIV+ Residents of Long-Term Care Facilities Pursuant to N.J.S.A. 26:2H-12.101-10 7." The memorandum concerned the rights of LGBTQI+ and HIV+ residents of long-term care facilities; N.J.S.A. 26:2G-12, 101-107 ("LGBTQI+ Law"), and a facility's responsibilities under the LGBTQI+ Law. The LGBTQI+ Law was signed on March 3, 2021 and took effect on August 30, 2021. The requirements of the LGBTQI+ Law will be included in N.J.A.C 8:39 in future rulemaking. Specifically, the LGBTQI+ Law establishes specific rights and protections for lesbian, gay, bisexual, transgender, undesignated/non-binary, questioning, queer, and intersex ("LGBTQI+") older adults and people living with HIV ("HIV+") in long-term care facilities ("Facilities"). The LGBTQI+ Law ensures that LGBTQI+ and HIV+ residents in facilities have equitable access to health care and provides the same legal protections as everyone else regardless of their sexual orientation or health status. Prohibited Actions The LGBTQI+ Law prohibits facilities from taking any of the following actions based on a person's sexual orientation, gender identity, gender expression, intersex status, or HIV status: 1. Denying admission to a facility, transferring or	S 560			

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S 560	Continued From page 5 refusing to transfer a resident within a facility or to another facility, or discharging, or evicting a resident from a facility; 2. Denying a request by residents to share a room; 3. Where rooms are assigned by gender, assigning or reassigning a room based on gender, subject to the provisions of 42 C.F.R. 483.10 (e) (5); 4. Forbidding a resident from, or harassing a resident who seeks to use or does use, a restroom available to other residents of the same gender identity, regardless of whether the resident is making a gender transition, has taken or is taking hormones, has undergone gender affirmation surgery, or presents as gender-nonconforming. For the purposes of this paragraph, harassment includes, but is not limited to, requiring a resident to show identity documents in order to gain entrance to a restroom available to other persons of the same gender identity; 5. Repeatedly failing to use a resident's chosen pronouns or the name the resident chooses to be called, despite being clearly informed of the resident's choice; 6. Denying a resident from wearing preferred clothing, accessories, or cosmetics, or participating in grooming practices; 7. Restricting a resident's right to visit and have conversations with other resident's or with visitors including the right to have consensual sexual relations;	S 560			

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S 560	Continued From page 6 8. Denying, restricting, or providing unequal medical or non-medical care, which is appropriate to the resident's bodily needs and organs, or providing medical or nonmedical care that, to a similarly-situated resident, causes avoidable discomfort or unfairly demeans the resident's dignity; and 9. Declining to provide any service, care, or reasonable accommodation requested by the resident, subject to the provisions of 42 C.F.R. 483.10(c)(6). Resident Records Additionally, facilities are required to ensure that resident records include the resident's gender identity and the resident's chosen name and pronouns, as indicated by the resident. Confidentiality The LGBTQI+ Law also requires facilities to maintain the confidentiality of certain resident information. Unless required by state or federal law, personal identifying information regarding a resident's sexual orientation, whether a resident is transgender or undesignated/non-binary, a resident's gender transition status, a resident's intersex status, or a resident's HIV status shall not be disclosed. Further, facilities are required to take appropriate steps to minimize the likelihood of inadvertent or accidental disclosure of such information to other residents, visitors, or facility staff, except to the minimum extent necessary for facility staff to perform their duties. Unless expressly authorized, facility staff not directly involved in providing direct care to a transgender, undesignated/non-binary, intersex,	S 560			

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S 560	Continued From page 7 or gender-nonconforming resident, shall not be present during a physical examination of, or the provision of personal care to, that resident if the resident is partially or fully unclothed. Doors, curtains, screens, or other effective visual barriers to providing bodily privacy, when partially or fully unclothed, shall be used. Informed consent is required in relation to any non-therapeutic examination or observation of, or treatment provided to, a resident of the facility. Facilities shall also provide transgender residents with access to transition-related assessments, therapy, and treatments as having been recommended by the resident's health care provider, including, but not limited to, transgender-related medical care, including hormone therapy and supportive counseling. Violations A facility or an employee of a facility that violates the requirements of the LGBTQI+ Law is subject to civil or administrative action. Training Facilities shall designate two employees, including one employee representing management at the facility and one employee representing direct care staff at the facility, to receive in-person training within six months after the effective date of the LGBTQI+ Law. The required training shall be provided by an entity that has demonstrated expertise in identifying the legal, social, and medical challenges faced by, and in creating safe and affirming environments for LGBTQI+ and HIV+ seniors who reside in long-term care facilities in New Jersey. The required training shall address: 1. Caring for LGBTQI+ seniors and seniors living	S 560			

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S 560	Continued From page 8 with HIV; 2. Preventing discrimination based on sexual orientation, gender identity or expression of intersex status, and HIV status; 3. The definition of terms commonly associated with sexual orientation, gender identity and expression, intersex status, and HIV; 4. Best practices for communicating with or about LGBTQI+ and HIV+ seniors, including the use of a resident's chosen name and pronouns; 5. A description of the health and social challenges historically experienced by LGBTQI+ and HIV+ seniors, including discrimination when seeking or receiving care at long-term care facilities, and the demonstrated physical and mental health effects within the LGBTQ community; 6. Strategies to create a safe and affirming environment for LGBTQI+ and HIV+ seniors, including suggested changes to facility policies and procedures, forms, signage, communication between residents and their families, activities, and staff training and in-services; and 7. An overview of the provisions of LGBTQI+ Law. Facilities are responsible for maintaining records documenting the completion of the training, as well as the cost of providing the training. On 10/18/23 at 12:30 PM, the surveyor requested the requested the documentation from the Licensed Nursing Home Administrator (LNHA) supporting the : New Jersey Department of	S 560			

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S 560	Continued From page 9 Health (NJDOH) memo, dated 04/19/22, "Statutory Amendments Regarding the Rights of LGBTQI+ and HIV+ Residents of Long-Term Care Facilities Pursuant to N.J.S.A. 26:2H-12.101-10 7." The LNHA stated the Social Worker and the Recreation Director had the training, and the surveyor requested all the documented training that included all staff. On 10/26/23 at 9:23 AM, the surveyor interviewed LNHA regarding the training requirement and the LNHA stated that she was aware of the required training/and two staff persons required to be trained. The LNHA stated she was trying to locate her training certificate from a former employer. On 10/31/23 at 10:52 AM, during the exit conference held with th facility, LNHA and corporate administration were unable to provide proof that 2 employees received the LGBTQI+ training (which included the 1 staff member representing administration and 1 staff member representing direct care staff), as required by state law.	S 560			
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment.	S1405			12/1/23

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S1405	Continued From page 10 The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced by: Based on interview and review of 10 recently hired employee files, it was determined that the facility failed to ensure that 2 of 10 newly hired employees had completed a health history and received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to employment or upon employment. This deficient practice was evidenced by the following: A review of the ten randomly selected newly hired employee files since last recertification survey date of [NJ Ex Order 26, 48] included the following: Staff #1 (an Assistant Director of Nursing), who was hired on [NJ Ex Order 26, 48], did not have documented evidence of a health history or physical. Staff #2 (a Registered Nurse) who was hired on [NJ Ex Order 26, 48], did not have documented evidence of a health history or physical. On 10/24/23 at 10:30 AM, the surveyor interviewed the Regional Clinical Nurse (RNC) who stated she was unable to locate Staff #1 or	S1405	Elements 1 All residents could be potentially impacted by this practice for employees For the employees involved a health examination was done. Element 2 Policy reviewed with all Department managers. Prior to anyone being onboarded the personnel file including scheduling of physicals examination will be audited (Administrator LNHA Infectious Disease to ensure health records are reviewed if immunizations are required they are obtained, employee health exam is done, and Human resources to ensure all components are completed . Element 3 All files to be audited for compliance and accuracy. No new hire will be onboarded without the three point check, Department Manager is responsible for the initial process, Infection Control to review employee health, Administrator to review file for accuracy , and Human Resources will process the finished product. Element 4	

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S1405	Continued From page 11 Staff #2's physicals. On 10/25/23 at 11:17 AM, the surveyor interviewed the Infection Preventionist (IP), who stated that Staff #1 does not work at the facility (termination date of 10/15/2022) anymore and her physical was either archived or misfiled. Staff #2 still works at the facility but she was unable to locate his physical. The IP further stated that there have been three Directors of Nursing (DON)s and Assistant Directors of Nursing (ADON)s in the past year and files could have been misfiled. On 10/25/23 at 12:47 AM, in the presence of the survey team, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The LNHA stated a screen physical examination would be signed off by the Infection Preventionist Nurse then the doctor would complete the physical prior to the start of employment. The DON would then review the process. The LNHA stated that the health physicals were kept separate from the pre-employment files in human resources. The facility could not provide documented evidence that the two newly hired employees had a health history and physical done upon hire. A review of the facility policy titled, "Employee Health," with a revised date of 07/03/2023, included the following: All new employees will receive a health history and examination performed by a physician or advanced practice nurse (APN) or a New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee received a nursing assessment by a registered professional nurse upon employment,	S1405	We will review this monthly for six months to ensure compliance and if compliance is met this will become part of the Qapi meetings agenda on a quarterly basis .If any issue should arise it will be addressed then added to the report for the committees review or action as necessary.	

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S1405	Continued From page 12 the physician's or APN's examination is deferred for up to 30 days of the first day of employment,	S1405			

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{E 000}	Initial Comments	{E 000}			
	Revisit conducted 01/08/24 for the 10/31/23 Standard Survey. This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.				
{F 000}	INITIAL COMMENTS	{F 000}			
	An onsite revisit was conducted on 01/08/2024 to verify the POC regarding the 10/31/2023 Recertification survey. The facility was found to be not in compliance. Standard Survey Date:10/31/23				
	Revist Date: 01/08/24				
	Census:98				
	Sample: 11				
	An Onsite Revist Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.				
{F 698}	Dialysis	{F 698}			1/12/24
SS=E	CFR(s): 483.25(l)				
	§483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:				

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

TITLE

(X6) DATE

Electronically Signed

01/22/2024

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

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{F 698}	Continued From page 1 NOT CORRECTED, Plan of Correction (POC) Element Three, "All nursing licensed staff were educated on facility policies and procedures regarding Dialysis ... All licensed nursing staff have completed dialysis competency and skill training which is necessary to care for all residents that require renal dialysis needs as identified through resident assessment and described in the plan of care." The POC was not fully implemented as determined during a re-visit survey conducted on 01/08/24. Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure: a.) all licensed staff were competent to provide appropriate care for residents who received <u>NJ Ex Order 26. 4B1</u> and for the <u>NJ Ex Order 26. 4B1</u>, and b.) all <u>NJ Ex Order 26. 4B1</u> resident-centered plans of care were specific to the type of <u>NJ Ex Order 26. 4B1</u> that the resident had and the care that was required. This deficient practice was identified for 3 of 3 residents (Resident #2, #3, and #4) reviewed for <u>NJ Ex Order 26. 4B1</u> and was evidenced by the following: During the revisit survey conducted on 01/08/24 the surveyor reviewed the education binder to validate the staff had been educated per the POC regarding the assessment of the <u>NJ Ex Order 26. 4B1</u> and staff could differentiate between a <u>NJ Ex Order 26. 4B1</u> which required the staff to monitor for <u>NJ Ex Order 26. 4B1</u> and signs/symptoms of <u>NJ Ex Order 26. 4B1</u>; and the <u>NJ Ex Order 26. 4B1</u> which required staff to check for <u>NJ Ex Order 26. 4B1</u>.	{F 698}	esponse Element 1 Resident #2 was reassessed on <u>NJ Ex Order 26. 4B1</u> with <u>NJ Exec Order 26.4b1</u> due to the deficient practice. Resident #2 care plan was revised with documentation to reflect the <u>NJ Ex Order 26. 4B1</u>. Resident # 3 was reassessed on <u>NJ Ex Order 26. 4B1</u> with <u>NJ Exec Order 26.4b1</u> due to the deficient practice. The primary physician was made aware, and the <u>NJ Ex Order 26. 4B1</u> was revised to reflect the <u>NJ Ex Order 26. 4B1</u> currently not in use for <u>NJ Ex Order 26. 4B1</u> and the <u>NJ Ex Order 26. 4B1</u> in use for <u>NJ Ex Order 26. 4B1</u>. Resident#4 was re-assessed on <u>NJ Ex Order 26. 4B1</u> with <u>NJ Exec Order 26.4b1</u> due to the deficient practice. The care plan was reviewed and revised to reflect the <u>NJ Ex Order 26. 4B1</u>. On 1/8/2024 The Director of Nursing provided 1:1 education with the Unit Manager on the facility revised Dialysis Policy which includes to ensure the type and location of the dialysis access device, monitoring for the AV fistula or Perma Catheter, name, address, and phone number of the dialysis center, dialysis schedule days of week and time is documented in the resident's dialysis care plan.		

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{F 698}	Continued From page 2 On 01/08/24 at 9:15 AM, the surveyor interviewed the Registered Nurse (RN) #1 on [NJ Exec Order 26.4b1] who stated that she had received education on the care required for [NJ Exec Order 26.4b1] residents. When asked about the assessment of the [NJ Exec Order 26.4b1] RN #1 stated that she would "[NJ Exec Order 26.4b1]." The surveyor inquired how to assess a [NJ Exec Order 26.4b1]. The RN #1 stated "I would do a [NJ Exec Order 26.4b1]. I would do the same thing. We do the [NJ Exec Order 26.4b1] [change]." On 01/08/24 at 9:30 AM, the Licensed Practical Nurse (LPN) #1 on [NJ Exec Order 26.4b1] stated that she had received education on [NJ Ex Order 26.4B1] residents. LPN #1 further stated she cared for a [NJ Ex Order 26.4B1] resident (Resident #1) on her assignment and that the resident had a [NJ Exec Or] in [his/her] [NJ Ex Order 26.4B1]. When inquired regarding the assessment of Resident #2's [NJ Ex Order 26.4B1], LPN #1 stated that she would "[NJ Exec Order 26.4b1]" On 01/08/24 at 9:42 AM, the RN Unit Manager (RN UM) accompanied the surveyor to the Warren Hall. The RN UM asked RN #1 to demonstrate how to assess a [NJ Ex Order 26.4B1] as if the RN UM was the resident with the [NJ Ex Order 26.4B1]. RN #1 obtained a stethoscope to listen to the [NJ Ex Order 26.4B1], and next RN #1 [NJ Exec Order 26.4b1] to feel for a [NJ Ex Order 26.4b1]. RN #1 then stated she would check the [NJ Ex Order 26.4b1] for any [NJ Ex Order 26.4b1] and again stated that with a [NJ Ex Order 26.4B1], she would assess for a [NJ Ex Order 26.4b1]. At that time, the RN UM stated to RN #1 that the assessment "was incorrect."	{F 698}	On 1/8/2024 LPN #1 and RN#1 were removed from the unit and provided 1:1 education on the facility revised policy and competency for caring for residents receiving hemodialysis treatment with AV shunt access and caring for a resident receiving hemodialysis treatment with Permcath Access. LPN#1 and RN#1 were able to successfully observe, verbalize, and demonstrate methods of education to differentiate between the two sites prior to caring for any residents requiring hemodialysis. LPN#1 and RN#1 will continue to have 1:1 on going education. On 1/8/2024 a full house audit for all residents receiving dialysis was completed to ensure all MD orders needed are in place, care plans were revised of all dialysis patients. There were no other residents affected by the deficient practice. Element 2 Any resident whose diagnosis indicates dialysis is needed have the potential to be affected by the deficient practice. Element 3 All Liscense Nurses were in-serviced by the Director of Nursing and Unit Manager on the facility revised Dialysis Policy on 1/11/2024. The revised policy is noted to be consistent with the standard of practice when caring for a resident with an AV fistula dialysis site or a Perma Catheter		

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{F 698}	Continued From page 3 On 01/08/24 at 9:50 AM, LPN #1 was also asked to demonstrate how to assess a [NJ Ex Order 26. 4B1] as if the RN UM was the resident with the [NJ Ex Order 26. 4B1]. LPN #1 used her [NJ Ex Order 26. 4B1] [NJ Ex Order 26. 4B1] and next used a stethoscope to listen to the area. At that time, the RN UM stated to LPN #1 that the assessment "was incorrect." A review of Resident #2's Admission Record revealed the resident had diagnoses which included [NJ Ex Order 26. 4B1]. A review of the resident-centered care plan included but was not limited to; a focus area of [NJ Ex Order 26. 4B1] and had a [NJ Ex Order 26. 4B1]. Interventions included but were not limited to; [NJ Ex Order 26. 4B1] for s/s [signs and symptoms] of [NJ Ex Order 26. 4B1] and PRN [as needed], protect resident [NJ Ex Order 26. 4B1] from [NJ Ex Order 26. 4B1] by: [NJ Ex Order 26. 4B1] [NJ Ex Order 26. 4B1] on affected [NJ Ex Order 26. 4B1], such as carrying purse and constrictive clothing, Not allowing [NJ Ex Order 26. 4B1] to be taken on limb with [NJ Ex Order 26. 4B1]. (The resident did not have a [NJ Ex Order 26. 4B1], as the facility provided documentation revealed that Resident #2 had a [NJ Ex Order 26. 4B1].) A review of Resident #3's Admission Record revealed diagnoses which included but were not limited to; [NJ Ex Order 26. 4B1]. A review of the resident-centered care plan included but was not limited to; a focus area of at risk for complications related to [NJ Ex Order 26. 4B1] and noted the type and location of [NJ Ex Order 26. 4B1] as	{F 698}	site. All Licensed Nurses were provided and educated on the facility revised skilled competency for caring for a resident receiving hemodialysis treatment with AV shunt access and skilled competency for caring for a resident receiving hemodialysis treatment with Perma Catheter Access on [NJ Ex Order 26. 4B1] by the Director of Nursing and the Unit Manager. The Dialysis competency includes a description to the license staff on the type of hemodialysis assessments to perform based on the location of the access site and care needed for the specific site in use and not in use. The dialysis communication form will be reviewed upon return from the dialysis center with the appropriate hemodialysis access site for a Perma catheter in the chest or the AV fistula that is inserted into the arm and maintained at the nurse's station. Element 4 The Director of Nursing, Unit Managers, Nursing supervisors will conduct daily audits of all incident and accident reports daily to ensure they are completed and signed timely with summary and conclusion attached. IDCP Team will review, and all findings will be reported to the administrator to rule out neglect or abuse. The audits will be conducted		

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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 698}	Continued From page 4 NJ Ex Order 26. 4B1. Interventions included but were not limited to; Protect resident NJ Ex Order 26. 4B1 from NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 on affected NJ Ex Ord, such as carrying purse and constrictive clothing. Not allowing NJ Ex O to be taken on NJ Ex Order 26. 4B1. (The care plan failed to address the NJ Ex Order 26. 4B1 not currently in use for NJ Ex Order 26. 4B1. A review of the facility provided documentation revealed that Resident #3 had a NJ Ex Order 26. 4B1 A review of Resident #4's Admission Record revealed diagnoses which included but were not limited to; NJ Ex Order 26. 4B1. A review of the resident-centered included but was not limited to; on NJ Ex Order 26. 4B1 r/t [related to] NJ Ex Order 26. 4B1. Frequently noncompliant with attending NJ Ex Ord appts [appointments]. Frequently cancels and reschedules at [his/her] own leisure. NJ Ex Order 26. 4B1. A review of the facility provided documentation revealed that Resident #4 had a NJ Ex Order 26. 4B1. A review of the facility provided education, "Care of the resident receiving dialysis treatment", dated 11/15/23, for both RN #1 and LPN #1 included but was not limited to; Steps: 1. Able to locate HD [hemodialysis] access, differentiate between permacath and AV fistula. 4. Monitor for infection or clotting of the access area. Do not take the bp [blood pressure] in the arm with the dialysis access site, monitor for swelling, pain, redness, or drainage of the shunt, monitor bruit as ordered. RN #1 was documented as "completed" and signed by RN #1 and the observer. LPN #1 was documented under Step 1 "comments" to "review permacath education". LPN #1 signed along with	{F 698}	weekly X 4 weeks, bi-weekly X 4 weeks, then monthly X 3 months. -Audits will be monitored for completion by the Administrator and Director of Nursing weekly X 4 weeks, bi-weekly X 4 weeks, monthly x 3 months. - -Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.		

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

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{F 698}	Continued From page 5 an observer's signature. A review of the facility provided one to one education, "Dialysis Education AV shunt/Chest port", dated 11/22/23, included but was not limited to; "return demonstration" which included an attachment with a picture of a perma-catheter and a picture of an AV fistula. The education included the "Care of the resident receiving dialysis treatment" form and again under Step 1. "comments" to "continue to review successful completion". The one-to-one education was signed by LPN #1 and by the instructor. On 01/08/24 at 10:54 AM, the interim Director of Nursing (DON) was made aware of RN #1 and LPN #1's incorrect assessment of a <u>NJ Ex Order 26. 4B1</u>. When asked about the competencies and education, the DON stated that LPN #1 was confused during the education and had required additional education by the DON. On 01/08/24 at 11:53 AM, the DON and the Licensed Nursing Home Administrator (LNHA), in the presence of two surveyors, reviewed the medical records for the three <u>NJ Ex Order 26. 4B1</u> residents. The DON stated that the facility had no <u>NJ Ex Order 26. 4B1</u> policies or procedures. When inquired as how to monitor a <u>NJ Ex Order 26. 4B1</u> for <u>NJ Ex Order 26.4(b)(1)</u> as per the care plan for Resident #2 and #3, the DON stated the care plans should have reflected an assessment of a <u>NJ Ex Order 26. 4B1</u> and not of a <u>NJ Ex Order 26. 4B1</u>. The DON further stated the care plans should be specific and all the orders and information should be clear for the staff to understand the type of care they needed to provide.	{F 698}			

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NAME OF PROVIDER OR SUPPLIER ABINGDON CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 ROCK AVE GREEN BROOK, NJ 08812		
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{F 698}	Continued From page 6 On 01/8/24 at 12:30 PM, the surveyor requested the [NJ Ex Order 26. 4B1] communication book for Resident #4. The communication book could not be located at the nursing station. The Unit Secretary (US) informed the surveyor that Resident #4 went to [NJ Ex Order 26. 4B] on Saturday and the book could possibly be at the bedside. The Unit Secretary went to the room and was unable to locate the [NJ Ex Order 26. 4B] communication book. Around 1:30 PM the US informed the surveyor that the resident did not have the communication book and the book was at the [NJ Ex Order 26. 4B1]. There was no documentation in the medical record that staff had been aware, contacted the [NJ Ex Order 26. 4B], or reviewed any recommendations. On 01/08/24 at 1:35 PM, the surveyors reviewed Resident #2, #3, and #4's Comprehensive Care Plans (CCP) with the DON. The CCP's were not specific based on the type of [NJ Ex Order 26. 4B1] and the care required by the residents. The CCPs failed to provide directives to the licensed staff on the type of assessment to perform based on the location of the [NJ Ex Order 26. 4B1], and care of the specific [NJ Ex Order 26. 4B1] in use and when not in use. A review of the Facility Assessment, with an effective date of 11/2017, indicated that residents requiring hemodialysis are treated at the dialysis center in the community. Care and treatment for these residents is a joint effort of the facility and the dialysis center staff. The facility assessment would include staff competencies that are necessary to provide the level and types of care needed for the resident population. A review of the facility's Dialysis Policy with a revision date of 03/2023, indicated that the nurse	{F 698}			

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{F 698}	Continued From page 7 will ensure the type and location of the dialysis access device in the resident's medical record. In addition, monitoring for patency of the dialysis access will be documented in the resident's medical record. A review of the Nursing Services and Sufficient Staff policy ,with a revised date of 09/2022, revealed that the facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for resident's needs as identified through resident assessment and described in the plan of care. NJAC 8:39-27.1(a)	{F 698}			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315141	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/8/2024
NAME OF FACILITY ABINGDON CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 303 ROCK AVE GREEN BROOK, NJ 08812	

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0570	Correction	ID Prefix F0584	Correction	ID Prefix F0609	Correction
Reg. # 483.10(f)(10)(vi)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed
LSC	11/01/2023	LSC	11/23/2023	LSC	12/01/2023
ID Prefix F0610	Correction	ID Prefix F0658	Correction	ID Prefix F0677	Correction
Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.24(a)(2)	Completed
LSC	12/01/2023	LSC	12/01/2023	LSC	12/01/2023
ID Prefix F0684	Correction	ID Prefix F0695	Correction	ID Prefix F0725	Correction
Reg. # 483.25	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.35(a)(1)(2)	Completed
LSC	01/04/2024	LSC	12/01/2023	LSC	12/01/2023
ID Prefix F0756	Correction	ID Prefix F0761	Correction	ID Prefix F0804	Correction
Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(d)(1)(2)	Completed
LSC	12/01/2023	LSC	12/01/2023	LSC	12/01/2023
ID Prefix F0814	Correction	ID Prefix F0847	Correction	ID Prefix F0880	Correction
Reg. # 483.60(i)(4)	Completed	Reg. # 483.70(n)(2)(i)(ii)(3)-(5)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	12/01/2023	LSC	11/23/2023	LSC	12/01/2023
REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	

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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 10/31/2023		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315141	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/8/2024
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0610	Correction	ID Prefix F0725	Correction	ID Prefix	Correction
Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.35(a)(1)(2)	Completed	Reg. #	Completed
LSC	12/01/2023	LSC	12/01/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 10/31/2023		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315141	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/8/2024
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix E0004	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.73(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/15/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 10/31/2023		☐ 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 061805	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/8/2024
NAME OF FACILITY ABINGDON CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 303 ROCK AVE GREEN BROOK, NJ 08812	

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S1405	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-19.5(a)	Completed	Reg. #	Completed
LSC	12/01/2023	LSC	12/01/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 10/31/2023		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0698	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.25(l)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/12/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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 10/31/2023		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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K 000	INITIAL COMMENTS NJ Exec Order 26.4b1 A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/19/23 and 10/20/23, 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 Abingdon C&R Center is a 2- building that was built in 1970's, It is composed of Type II protected construction. The facility is divided into 12- smoke zones. The generator does approximately 50 % of the building as per the Regional Plant Operations Director. The current occupied beds are 101 of 180. * Currently the first-floor Heritage Hall wing is closed resident rooms 101 to 131	K 000			
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches	K 321			1/31/24

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

TITLE

(X6) DATE

Electronically Signed

11/24/2023

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER ABINGDON CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 ROCK AVE GREEN BROOK, NJ 08812		
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K 321	Continued From page 1 from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/20/23, in the presence of the Maintenance Director (MD) and Maintenance Director from a Sister Facility (MDSF), it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice was identified in five (5) of nine (9) hazardous storage areas in the facility and was evidenced by the following: 1). At 9:52 AM, the surveyor, MD and MDSF observed in the Closed Heritage Hall wing that resident rooms were turned into hazardous storage rooms. The rooms were identified as 102, 122 and 130, and	K 321	K321 Hazardous area - As of 11-8-23 rooms 102,122, and 130 have self automatic door closers and keylocks that have been installed. These rooms were not designated for storage and all the articles removed and relocated to appropriate storage areas. Area is not currently in use. Private dinning room has been restored to its original purpose To ensure compliance Daily rounds will be done Maintenance Director and or designee All residents may have the potential to be affected by the deficient practice. Soiled Linen door staff corridor: fire rating now visible was covered by a substance which was removed allowing the fire rating		

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K 321	Continued From page 2 stored combustible cardboard boxes, portable AC units, and over bed tables. The room's were greater than 50 square feet in size and the door's were not provided with an auto-closing device. 2). At 10:07 AM, the surveyor, MD and MDSF observed that the private dining room was turned into a central supply storage room. The doors to the room were not rated and were not provided with an auto closing device. The room was greater than 50 square feet in size and filled with combustible cardboard boxes. 3). At 10:45 AM, the surveyor, MD and MDSF observed that the soiled linen door to the exit/egress staff corridor was observed to have no fire rating on the door. 4). At 10:50 AM, the surveyor, MD and MDSF observed the kitchen door to the dish cleaning section was not labeled, and would not latch into its frame as the striker in the the frame was missing. 5). At 11:06 AM, the surveyor, MD and MDSF observed the kitchen door to the dining room, had a label on the door to determine the fire rating of the door, but the label was painted over and the rating could not be determined. The MD and MDSF both confirmed the finding's, during the observations The Administrator and Regional Staff were informed of the findings at the Life Safety Code Exit Conference on 10/20/23. NJAC 8:39-31.2(e)	K 321	to be clearly seen. Dish machine door latch is fixed, and door sign had been Installed. All doors that had the Fire rating label that was previously blocked are now visible, paint was able to be removed with out the impacting the doors fire rating. Staff were educated by Maintenance Director on appropriate areas for storage and where to discard cardboard appropriately. Weekly rounds are being conducted to ensure the proper operation of the doorby the Maintenance Director and/or designee. Maintenance Director or designee will inservice all staff on the proper closure of the door. Maintenance director will report any issues at Safety Meeting and QAPI monthly.		

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K 345 K 345 SS=E	Continued From page 3 Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review on 10/20/23, in the presence of the Maintenance Director (MD), and Maintenance Director from a Sister Facility (MDSF), it was determined that the facility failed to ensure that their building's fire alarm system was maintained in accordance with the requirements of NFPA 70 and 72. This deficient practice was evidenced from the most recent document provided by the facility from the fire alarm vendor dated: 9/22/23. At 9:45 AM, on 10/20/23 the Administrator produced the fire alarm and life safety system inspection report. The report indicated 1 of 353 initiating devices failed. The device was located on the 2nd story at the top of the stairs by resident room 292. The MD and Administrator confirmed the finding during document review of the fire alarm inspection certificate dated 9/22/23. On 10/19/23 at 11:30 AM the Corporate Director	K 345 K 345	K345 FIRE ALARM SYSTEM 1-Maintenance called vendor to come out and fix the 1 of 353 devices. The device was replaced on the top of the second story to abate the device that was not working On 10-31-23 2- All residents have the potential to be affected by the alleged deficient practice. 3- Maintenance Director and or designee will be responsible on a monthly basis to review the required facility inspections to ensure compliance. Maintenance will be sure to call for Vendor service regarding any deficient items found within the Inspections as soon as Inspection reports are received and address all imminent needs immediately.		12/15/23

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K 345	Continued From page 4 of Environmental Services indicated the facility was in the process of updating the fire alarm system. The surveyor informed the Administrator and Regional staff at the Life Safety Code Exit Conference on 10/20/23. NFPA 70 NFPA 72 NJAC 8:39-31.2(e) NFPA 101- 2012 edition 9.6.1.3- 9.6.1.5	K 345	4- Maintenance director will report the results of the assessments to the quality assurance as a part of the preventative maintenance program. We will audit on a monthly basis for one quarter to ensure 100 percent compliance is achieved and then review on a quarterly basis there after.		12/15/23
K 347 SS=F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review on 10/20/23, in the presence of the Maintenance Director and Maintenance Director from a Sister Facility (MDSF), it was determined that the facility failed to ensure a testing and maintenance of battery-operated smoke detectors in resident rooms, in an existing structure. This deficient practice was evidenced for 50 of 50 observed battery-operated smoke detectors observed in resident rooms and evidenced by the following: The MD stated that new battery-operated smoke detectors were installed on 7/11/23 in resident	K 347	Performance I K 347 SMOKE DETECTION 1- On 10-26-23 Brand new 10 year smoke detectors had been installed in every resident room of Heritage Hall(existing structure). 2- All residents have the potential to be affected by the alleged deficient practice. 3- Maintenance Director and designee have amended the monthly smoke detector inspection. The inspection to comply (manufacturer recommendations for the new detectors in use) to be tested on a weekly basis. Said detectors will be		

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K 347	Continued From page 5 rooms, but indicated no information above was documented or logged other than resident room numbers, good and 10 year battery. The operating manual provided by the MD indicated the smoke detectors must be tested weekly. The Abingdon smoke detector check form did not provide any testing since the detectors were installed on 7/11/23. The Administrator and Regional Staff were informed of the findings at the Life Safety Code exit conference on 10/20/23. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.3.6.1, 19.3.4.5.2	K 347	checked and outcomes recorded. Maintenance Director, reviewed recommendations, inserviced the two maintenance assistants on the new procedure for testing, and recording of the information obtained. The ammendment to testing was instituted on 10-27-23 4- Maintenance director will report the results of the outcomes of the testing to the QAPI committee on a monthly basis. Any adverse events will be addressed immediately. Those outcomes will be reported to QAPI committee for period of three months for their review and action Upon completion of the three month cycle of reporting outcomes to QAPI it will become a semi -annual review. The testing will remain as outlined by manufacturer just the reporting to QAPI will be ammended.		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by:	K 521		12/22/23	

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K 521	Continued From page 6 Based on observation and interview conducted from 10/19/23 to 10/20/23, in the presence of the Maintenance Director (MD) and Maintenance Director from a Sister Facility (MDSF), it was determined that the facility failed to maintain their Packaged Terminal Air Conditioner (PTAC) units in a safe and optimal condition. This deficient practice was identified for 6 of 38 PTAC units observed and was evidenced by the following: While touring the facility from 10/19/23 to 10/20/23 from approximately 09:00 AM, to 01:30 PM, the surveyor observed dirty PTAC filters that were clogged and dirty throughout the facility including broken grills that produced sharp edges. The units identified: Resident room: 108 dirty (2) filters, 242 Island Aire unit had no filter's Main dining room: 2 of 4 PTAC units with clogged and dirty filters and 2 of 4 PTAC units with no filters When interviewed at the time of the observations, the MD and MDSF agreed that PTAC unit's had clogged and dirty filters including broken grills that produced sharp edges throughout the facility. The MD indicated the island air units that produced AC in the summer months were not working and required the resident rooms to have portable AC units installed. No policy and procedure on the maintenance of PTAC units were provided or a PTAC filter cleaning log, at the time of the Life Safety Code exit.	K 521	K 521 HVAC 1-Maintenance removed and cleaned room 108 PTAC filters Maintenance removed the filters of the 2 Main Dining room Units and cleaned them. Maintenance purchased 32 brand new Island Aire filters and replaced multiple filters throughout the facility, also Installed 2 in the Missing Main Dining 2 units and rm 242. All ptac covers that were broken have been replaced by new ones November 15, 23. 2- All residents have the potential to be affected by the alleged deficient practice 3-Maintenance will inspect all Ptac and Island Aire unit filters weekly x3, and address accordingly. 4- Maintenance director will report the results of the assessments to the quality assurance THis will be done on a monthly basis, for a period of 3 months, then semi annually for review.		

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K 521	Continued From page 7 The Administrator and Regional Staff were notified of the findings at the Life Safety Code exit conference on 10/20/23.	K 521			
K 531 SS=F	N.J.A.C. 8:39 - 31.2(e) 19.5.2.1 Heating, Ventilating, and Air-Conditioning. Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: During record review on 10/19/23, in the presence of the Maintenance Director (MD), and Regional Plant Operations Director (RPOD), it was determined that the facility failed to test and inspect the elevator's annually with the New Jersey Department of Community Affairs Division	K 531			12/23/23
			1. ALL residents had the potential to be affected due to this deficient practice The facility will reconfigure the record keeping system to ensure vendors appointments are arranged far enough in advance so there is no lapse moving forward		

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K 531	Continued From page 8 of Codes and Standards Elevator Safety Division. This deficient practice was evidenced by the following: At 10:45 AM, a review of the facility's elevator inspection certificate's, revealed that 2 of 2 elevator devices #1 and #2 were last inspected 11/10/21 and were good for use until 10/31/22. The annual elevator inspection was over 11-months overdue. In an interview, at 11:30 AM, the facility's MD and RPOD, stated they will communicate with their contracted elevator vendor to have DCA schedule an inspection as soon as possible. The observation of the signed off elevator certificate in the elevator room confirmed, the inspection was not up to date and last inspected: 11/10/21. The Administrator and Regional staff were informed of the findings at the Life Safety Code exit conference on 10/20/23. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3.	K 531	2. The elevator inspection was completed on December 10, 23. 3 To prevent reoccurrence the main director and or designee will review calendar of required inspections on a monthly basis for the forward month to prevent inspection not getting done. 4 This will be part of the monthly qapi agenda, reporting trends noted this will be ongoing for 12 months.		
K 741 SS=E	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the	K 741			12/15/23

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K 741	Continued From page 9 international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/20/23, in the presence of the Surveyor, Maintenance Director (MD) and Maintenance Director from a Sister Facility (MDSF), the facility failed to maintain smoking areas and in accordance with the requirement of NFPA 101, 2012 Edition, Section 19.7.4. The practice of dumping cigarette butts and ash into trash cans with other combustibles, increases the risk of fire to facility occupants. This deficient practice was evidenced for 1 of 1 smoking areas observed and was evidenced by the following: At 10:20 AM, the surveyor, MD, and MDSF observed in the smoking courtyard on floor #1 that a combustible red top plastic garbage can next to the building was filled with 40 plus cigarette butts and combustible cups, paper and cigarette boxes. The area was observed to have	K 741	K 741 SMOKING REGULATIONS 1- 10-23-23 Maintenance held an Inservicefor staff on how to dispose of cigarette butts appropriate;y in marked containers for that purpose THe recreation team reviewed again the smoking policy with the residents to whom it is applicable and that there is a clear understanding. Assessments were reviewed to ensure residents are able to continue smoking safely even though they are supervised. Container with self closing lid. These dispensers are existing in the smoking areas.		

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K 741	Continued From page 10 2- outdoor cigarette receptacles. The smoking area was provided with an approved self-closing covered metal (red) container for the disposal of cigarette butts and ashes in the area and was observed to be empty. The MD and MDSF confirmed the findings during the observations in the resident smoking courtyard. The Administrator and Regional staff were informed of the finding's at the Life Safety Code exit conference on 10/20/23. NJAC 8:39-31.2(e)	K 741	2- All residents have the potential to be affected by the alleged deficient practice. 3- Maintenance will audit the smoking area to ensure compliance during their daily rounds , Any issues will be immediately addressed. T 4- Maintenance director will report the results of the assessments to the qapi committee on a quarterly basis for six-month . Upon completion this auditing tool will become a part of the preventative mamintenance program to ensure compliance. Performance Improve		
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 10/20/23, in the presence of the Maintenance Director (MD), Maintenance Director from another Sister Facility (MDSF), it was determined that the facility failed to ensure that one 1 of 11 electrical outlets located next to a water source (with-in 6 feet) were equipped with Ground-Fault Circuit Interrupter (GFCI) protection.	K 911	K 911 ELECTRICAL SYSTEMS 1 On 10-24-23 maintenance replaced the non-GFCI outlet with a new GFCI outlet in the area where the hydroculator was stored.	12/15/23	

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K 911	Continued From page 11 This deficient practice was evidenced by the following: At 9:45 AM. the surveyor observed in the Physical Therapy room office that a Hydrocollator was plugged into a non-GFCI outlet. The Hydrocollator was filled with water and has an electric heating element and is required to be protected by a GFCI (ground-fault circuit interrupter) to prevent a shock. The MD and MDSF, confirmed the finding at the time of observation. The Administrator and Regional Staff were notified of the finding at the Life Safety Code exit conference on 10/20/23. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911	2- All residents have the potential to be affected by the alleged deficient practice. 3 Maintenance will do weekly round Inspections for one month checking the functioning of the plug then followed by monthly Inspection for a period of three months.Any adverse issues will be immediately addressed. We will also ensure equipment similar to the hydrocollator that contains water will also have a GFI switch as well. 4- Maintenance director will report the results of the assessments to the qapi committee during their monthly meeting for a period of three months.		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36	K 918			1/31/24

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315141	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2023
NAME OF PROVIDER OR SUPPLIER ABINGDON CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 ROCK AVE GREEN BROOK, NJ 08812		
(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 918	Continued From page 12 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/20/23, in the presence of the Maintenance Director (MD) and Maintenance Director from a Sister Facility (MDSF), it was determined that the facility failed to ensure a remote manual stop station for one of one outside diesel generator (60 KW), providing emergency power to approximately 50% of Health Care facility, was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice was evidenced by the following: On 10/20/23 at 1:05 PM, the surveyor, MD, and MDSF, observed the exterior 60 KW (kilowatt) diesel generator. The observation indicated that there was no remote manual stop station observed outside the area of the generator	K 918	K 918 ELECTRICAL SYSTEMS Element 1 -Installation of generator switch was completed on January 31, 2024. Element 2 -Due to this deficient practice All residents have the potential to be affected . Element 3 -Maintenance director and or designee will In- service both maintenance staff and housekeeping staff on how to reset the generator in the event of a malfunction of the equipment.		

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

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NAME OF PROVIDER OR SUPPLIER ABINGDON CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 ROCK AVE GREEN BROOK, NJ 08812		
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K 918	Continued From page 13 location. An interview was conducted during the time of the observation with the MD, who stated and confirmed that the exterior generator did not have a remote manual stop station to prevent inadvertent or unintentional operation that was located outside the area of the enclosure housing the prime mover for the current generator in service. The Administrator and Regional Staff were informed of the findings at the Life Safety Code exit conference on 10/20/23. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	Maintenance will test the remote function weekly during weekly generator testing. Switch will be tested by the vendor during quarterly generator inspection. Element 4- Maintenance director will report the results of the testing, to the quality assurance committee on a monthly basis.		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315141	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	DATE OF REVISIT 2/5/2024
NAME OF FACILITY ABINGDON CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 303 ROCK AVE GREEN BROOK, NJ 08812

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	01/31/2024	LSC K0345	12/15/2023	LSC K0347	12/15/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0521	12/22/2023	LSC K0531	12/23/2023	LSC K0741	12/15/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0911	12/15/2023	LSC K0918	01/31/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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 10/31/2023		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			