STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING _____ B. WING _____	03/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	633 ROUTE 28 RARITAN, NJ 08869

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Standard Survey Date:03/10/2022 Census:126 Sample:28 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence.	F 636		5/3/22

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

Electronically Signed | 04/08/2022

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

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F 636	Continued From page 1 (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interviews, review of medical records an other facility documentation, it was determined that the facility failed to complete the	F 636	F636 - Comprehensive Assessments & Timing 1. Residents [redacted] have had their	

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F 636	Continued From page 2 Comprehensive Minimum Data Set assessment in a timely manner for 3 of 16 residents reviewed (Residents # [redacted] and [redacted]) for system selected MDS over 120 days for late submissions. This deficient practice was evidenced by: During an interview with the surveyor on 03/04/22 at 11:50 AM, the Licensed Nursing Home Administrator (LNHA) stated that the MDS Coordinator left the facility a few months ago and he was unable to fill the position despite posting it. He stated that a Regional MDS Coordinator completed them in the interim and provided the surveyor with her contact information and an additional preferred contact. During a phone interview on 03/04/22 at 12:03 PM, the surveyor phoned the LNHA's preferred contact who identified herself as an MDS Consultant. She stated that when the previous MDS Coordinator left, it became apparent that the MDS were backed up and they had been working weekly to resolve the issue and tried to catch up. She stated that the facility was very aware of the issue and put a tremendous amount of money out to help fix the problem. She stated that employees were good at covering up what they were not doing, and they thought that they could do things tomorrow. She further stated that the staffing shortage and the pandemic was the reason why the MDS's were late. The MDS Consultant agreed to e-mail the surveyor documented rationale for each resident whose MDS was not completed within 14 days of the Assessment Reference Date (ARD, the date that signifies the end of the look back period) and transmitted within 14 days of the completion date as required. The Regional MDS Coordinator was	F 636	comprehensive Minimum Data Set assessments (MDS) completed and these residents were not adversely affected by the identified deficient practice. 2. All residents have the potential to be affected by the same deficient practice and can be identified on the resident roster. The Regional MDS Coordinator conducted a 90 day look back to ensure comprehensive MDS assessments were completed timely, all overdue comprehensive MDS assessments have been completed on or before 4/30/2022. No other deficient practice identified. 3. A new MDS coordinator has been hired for the facility. The MDS coordinator and MDS consultants were in serviced on or before 4/15/2022 by the Regional MDS coordinator on the federal regulation for completing comprehensive MDS assessments within 14 days of the Assessment Reference Date (ARD.) Census changes will be reviewed in the facility daily meeting to ensure that comprehensive MDS assessments are completed timely. 4. The Regional MDS Coordinator or facility MDS coordinator will conduct weekly audits x 3 months, then monthly audits X 3 months of comprehensive MDS assessments to ensure they are completed within 14 days the ARD. The results of these audits will be presented at the monthly Quality Assurance meeting to ensure compliance and reassessed for further action if needed.	

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F 636	Continued From page 3 not available for interview. On 03/07/22 at 08:09 AM, the surveyor received an e-mail correspondence from the MDS Consultant who provided the surveyor with documented evidence that the facility entered into contract with the Consultant on 12/15/21 and she provided rationale for each resident's late MDS submission: 1. Resident [redacted] s ARD was [redacted] and the assessment was not completed until [redacted], 41 days later, and was submitted on [redacted] The MDS Consultant noted that staffing shortages had been and continued to be a challenge. 2. Resident #[redacted] s ARD was [redacted] and the assessment was not completed until [redacted], 43 days later. The MDS Consultant indicated that the assessment would be submitted on [redacted]. She also noted that staffing shortages had been and continued to be a challenge. 3. Resident [redacted] s ARD was [redacted] and the assessment was not completed unti[redacted], 47 days later. The MDS Consultant indicated that the assessment would be submitted on [redacted] She also noted that staffing shortages had been and continued to be a challenge. She further noted that her company worked with the resources available to clean up the in-progress list and get the facility to full compliance. During an interview with the surveyor on 03/08/22 at 03:38 PM, the LNHA stated that he was informed by the MDS Consultant that they were backed up but would get to it. He stated that they hoped to get caught up as soon as possible with the resources that they had.	F 636		

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F 636	Continued From page 4 Review of the facility policy, "Electronic Transmission of the MDS" (Revised 03/2021) revealed the following: All MDS assessments (e.g., admission, annual, significant change, quarterly review, etc.) and discharge reentry records are completed and electronically encoded into our facility's MDS information system and transmitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current OBRA regulations governing the transmission of MDS data... Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes... Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual... The surveyor reviewed the Resident Assessment Instrument (RAI) 3.0 manual (updated October 2019), Chapter 5: Submission and Correction of MDS Assessments, which indicated that the Annual MDS assessment has a completion date "No Later Than" the ARD +14 calendar days.	F 636		
F 640 SS=E	NJAC 8:39 - 11.2 Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after	F 640		5/3/22

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F 640	Continued From page 5	F 640		

a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

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F 640	Continued From page 6 §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interviews, review of medical records and other facility documentation, it was determined that the facility failed to electronically transmit the Minimum Data Set (MDS, an assessment tool), within 14 days of completing the resident's assessment. This deficient practice was identified for 13 of 16 residents reviewed (Residents # [redacted]), from system selected for MDS over 120 days for late submissions and for 2 of 28 residents reviewed (Residents [redacted] for MDS completion and transmission. This deficient practice was evidenced by the following: During an interview with the surveyor on 03/04/22 at 11:50 AM, the Licensed Nursing Home Administrator (LNHA) stated that the MDS Coordinator left the facility a few months ago and he was unable to fill the position despite posting it. He stated that a Regional MDS Coordinator completed them in the interim and provided the surveyor with her contact information and an additional preferred contact. During a phone interview on 03/04/22 at 12:03 PM, the surveyor phoned the LNHA's preferred contact who identified herself as an MDS Consultant. She stated that when the previous MDS Coordinator left, it became apparent that the	F 640	F640 □ Encoding/Transmitting Resident Assessments 1. Residents # [redacted] Minimum Data Set assessments have been electronically transmitted, and these residents were reviewed by the Regional MDS Coordinator, and none were found to have a decline in functional status or a delay in care and, were not adversely affected by the identified deficient practice. 2. All residents have the potential to be affected by the same deficient practice and can be identified on the resident roster. The Regional MDS Coordinator conducted a 90 day look back to ensure MDS assessments were completed timely. No other deficient practice identified. 3. A new MDS Coordinator has been hired for the facility. The facility MDS Coordinator and MDS consultants were reeducated by the Regional MDS Coordinator on the federal regulation regarding Encoding/Transmitting Resident Assessments within 14 days of completing the resident assessment. The MDS coordinator or MDS Consultant will review the MDS Submission Batches weekly to ensure they have all been	

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F 640	Continued From page 7 MDS were backed up and they had been working weekly to resolve the issue and tried to catch up. She stated that the facility was very aware of the issue and put a tremendous amount of money out to help fix the problem. She stated that employees were good at covering up what they were not doing, and that they thought that they could do things tomorrow. She further stated that the staffing shortage and the pandemic were the reasons why the MDS's were late. The MDS Consultant agreed to e-mail the surveyor documented rationale for each resident whose MDS was not completed within 14 days of the Assessment Reference Date (ARD, the date that signifies the end of the look back period) and transmitted within 14 days of the completion date as required. The Regional MDS Coordinator was not available for interview. On 03/07/22 at 08:09 AM, the surveyor received an e-mail correspondence from the MDS Consultant who provided the surveyor with documented evidence that the facility entered into contract with the Consultant on 12/15/21 and she provided rationale for each resident's late MDS submission: 1. Resident [redacted]'s ARD was [redacted] and the assessment was not completed until [redacted], 41 days later. The MDS Consultant documented that the MDS would be submitted on [redacted] and noted that staffing shortages had been and continued to be the challenge. 2. Resident [redacted]'s ARD was [redacted] and the assessment was not completed until [redacted], 44 days later. The MDS consultant documented that the MDS would be submitted on [redacted] and noted that staffing shortages had been and	F 640	submitted timely. 4. The Regional MDS Coordinator or facility MDS Coordinator will conduct weekly audits x 3 months, then monthly audits X 3 months to ensure MDS assessments are electronically transmitted within 14 days of completion. The results of these audits will be presented at the monthly Quality Assurance meeting to ensure compliance and reassessed for further action if needed.	

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continued to be a challenge.

3. Resident # [redacted] 's ARD was [redacted] and the assessment was not completed until [redacted], 46 days later. The MDS Consultant documented that the MDS would be submitted on [redacted] and noted that staffing shortages had been and continued to be a challenge.

4. The surveyor received a second e-mail from the MDS Consultant on 03/07/22 at 12:44 PM, which demonstrated that Resident [redacted] 's ARD was [redacted] and the assessment was not completed and submitted until [redacted], 50 days later. She noted that staffing shortages had been and continued to be a challenge.

5. Resident [redacted] 's ARD was [redacted] and the assessment was not completed until [redacted], 42 days later, and was submitted on [redacted] The MDS Consultant noted that staffing shortages had been and continued to be a challenge.

6. Resident # [redacted] ARD was [redacted] and the assessment was not completed until [redacted], 46 days later. The MDS Consultant documented that the MDS would be submitted on [redacted] and noted that staffing shortages had been and continued to be a challenge.

7. Resident [redacted] 's ARD was [redacted] and the assessment was not completed until [redacted], 41 days later. The MDS Consultant documented that the MDS was submitted on [redacted] and noted that staffing shortages had been and continued to be a challenge.

8. Resident [redacted] 's ARD was [redacted] and the assessment was not completed and submitted

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until [redacted], 51 days later. The MDS Consultant noted that staffing shortages had been and continued to be a challenge.

9. Resident [redacted]'s ARD was [redacted] and the assessment was not completed until [redacted], 41 days later. The MDS Consultant documented that the MDS was submitted on [redacted] and noted that staffing shortages had been and continued to be a challenge.

10. Resident [redacted]'s ARD was [redacted] and the assessment was not completed until [redacted], 46 days later. The MDS Consultant documented that the MDS was submitted on [redacted] and noted that staffing shortages had been and continued to be a challenge.

11. Resident [redacted]'s ARD was [redacted] and the assessment was not completed and submitted until [redacted], 49 days later. The MDS Consultant noted that staffing shortages had been and continued to be a challenge.

12. Resident [redacted]'s ARD was [redacted] and the assessment was not completed and submitted until [redacted] 46 days later. The MDS Consultant noted that staffing shortages had been and continued to be a challenge.

13. Resident [redacted]'s ARD was [redacted] and the assessment was not completed until [redacted], 41 days later. The MDS Consultant documented that the MDS was submitted on [redacted] and noted that staffing shortages had been and continued to be a challenge.

14. Resident [redacted]'s ARD was [redacted] and the assessment was not completed until [redacted], 23

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days later. The MDS Consultant documented that the resident's MDS was submitted over the weekend, date not specified.

15. Resident [redacted]'s ARD was [redacted] and remained incomplete according to the MDS Consultant who documented that she would ensure that the assessment was completed on [redacted] The MDS Consultant failed to specify when the MDS would be submitted.

During an interview with the surveyor on 03/07/212 at 12:13 PM, the MDS Consultant stated that her company had staffing issues and had more coverage since mid-February and that was when most of the work was done.

During an interview with the surveyor on 03/08/22 at 03:38 PM, the LNHA stated that he was informed by the MDS Consultant that they were backed up but would get to it. He stated that they hoped to get caught up as soon as possible with the resources that they had.

Review of the facility policy, "Electronic Transmission of the MDS" (Revised 03/2021) revealed the following:

All MDS assessments (e.g., admission, annual, significant change, quarterly review, etc.) and discharge reentry records are completed and electronically encoded into our facility's MDS information system and transmitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current OBRA regulations governing the transmission of MDS data...

Our facility will conduct and submit resident

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F 640	Continued From page 11 assessments in accordance with current federal and state submission timeframes... Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual... Review of the Resident Assessment Instrument (RAI) 3.0 manual (updated October 2019), Chapter 5: Submission and Correction of MDS Assessments, which indicated that the MDS assessments must be submitted within 14 days of the MDS Completion Date. NJAC 8:39-11.2	F 640		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		5/3/22

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F 656	Continued From page 12 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to develop a comprehensive care plan for the use of [redacted] for 1 of 2 residents reviewed for [redacted] therapy, Resident # [redacted]. This deficient practice was evidenced by the following: On 02/24/22 at 01:20 PM, during the initial tour of the facility, the surveyor observed Resident # [redacted],in bed. [redacted] was being delivered to the resident through a [redacted] ([redacted]) that was attached to an [redacted] that was set at [redacted] ([redacted]).	F 656	F656 □ Develop /Implement Comprehensive Care Plan 1. A comprehensive care plan for [redacted] therapy was developed for resident [redacted] to include the [redacted] of the [redacted] and the method of delivery. Resident [redacted] was not adversely affected by the identified deficient practice. 2. All residents who use [redacted] have the potential to be affected by the same deficient practice. A facility wide audit was completed for all residents who use [redacted] therapy and that they have a comprehensive care plan in place for [redacted] use. No other deficient practice identified.	

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F 656	Continued From page 13 On 03/01/22 at 12:50 PM the surveyor observed Resident [redacted] in bed with [redacted] delivered through a [redacted]. A review of the Admission Records (an admission summary) indicated Resident [redacted] was admitted to the facility [redacted] and had diagnoses, which included but were not limited to; [redacted] ([redacted]). A review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate resident care, dated [redacted] revealed that the resident had a Brief Interview for Mental Status score of [redacted] which indicated the resident had [redacted]. Further review revealed in section O special treatments indicated the resident used [redacted] while a resident at the facility. A review of the resident's care plan revealed no care plan for [redacted] use. During an interview with the surveyor on 03/08/2022 at 02:10 PM, the Registered Nurse Unit Manager of Long-Term Care (RN/UM/TLC) stated care plans were initiated for residents upon admission by any nurse and is based on specifics for the residents. She stated the nurses who were involved in the care of a resident can an update the care plans. She stated the unit managers and the Director of Nursing should update the care plans quarterly. She stated all residents who received [redacted] should have a care plan. During a meeting with the survey team on 03/08/22 at 03:32 PM, the administrator was	F 656	3. All current licensed staff will be reeducated on or before 4/30/2022 by the Director of Nursing (DON) or Assistant Director of Nursing (ADON) on following the policy for developing a comprehensive care plan for residents who use [redacted] 4. The ADON or Unit Managers will conduct weekly audits x 3 months, then monthly audits X 3 months to ensure that residents who use [redacted] have a comprehensive care plan in place. The results of these audits will be presented at the monthly Quality Assurance meeting to ensure compliance and reassessed for further action if needed.	

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F 656	Continued From page 14 made aware of the surveyor's findings. A review of the Document labeled "Care Planning Nursing Manual-Nursing Administration" with a revision date of 11/01/2021 revealed that a licensed nurse will initiate the care plan. Further review revealed the baseline care plan to include initial goals based on admission orders, physician order, and therapy services. A review of the document labeled [redacted] Administration level III" with a revised date of 12/21/2021 revealed when the staff is to prepare a resident for [redacted] administration, the staff review the resident's care plan to assess for any special needs of the resident. NJAC 8:39-27.1(a)	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility documents, it was determined that the facility failed to obtain physician orders to provide [redacted] for 2 of 2 residents, Resident #[redacted] and [redacted], reviewed for [redacted] in accordance with nursing professional standards of clinical practice. This deficient practice was evidenced by the following:	F 658	F658 □ Services Provided Meet Professional Standards 1. A physician's order for [redacted] was obtained and placed on the Medication Administration Record (MAR) for resident [redacted] A physician's order for [redacted] via [redacted] was obtained and placed on the Medication	5/3/22

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F 658	Continued From page 15 Reference: New Jersey Statutes, Annotated Title45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing a medical regimen as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 02/24/22 at 01:20 PM, during the initial tour of the facility, the surveyor observed Resident # [redacted] in bed. [redacted] was being delivered to the resident through a [redacted]) that was attached to an [redacted] that was set at [redacted] ([redacted]). On 03/01/22 at 12:50 PM the surveyor observed Resident [redacted] in bed with [redacted] delivered through a [redacted].	F 658	Administration Record (MAR) for resident [redacted]. All residents who require [redacted] supplementation have the potential to be affected by the same deficient practice. Residents [redacted] were not adversely affected by the identified deficient practice. 2. All residents who require [redacted] have the potential to be affected by the identified deficient practice. All current residents were reviewed to ensure those who require [redacted] supplementation have a physician's order in place. No other residents who use [redacted] supplementation were identified. Newly admitted or re-admitted residents will have a chart review conducted by the Interdisciplinary Care Team (IDCT) within 24 hours to ensure physician's orders for [redacted] supplementation are in place. 3. All current licensed staff will be reeducated by the Director of Nursing (DON) or the Assistant Director of Nursing (ADON) on the policy for obtaining a physician's order for residents who require [redacted] supplementation. 4. The DON or ADON will conduct weekly audits x 3 months, then monthly audits X 3 months of residents who require [redacted] supplementation to ensure a physician's order is in place. The results of these audits will be presented at the monthly Quality Assurance meeting to ensure compliance and reassessed for further action if needed.	

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F 658	Continued From page 16 A review of the Admission Records (an admission summary) indicated Resident [redacted] was admitted to the faciity [redacted] and had diagnoses, which included but were not limited to; [redacted]). A review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate resident care, dated [redacted], revealed that the resident had a Brief Interview for Mental Status score of [redacted] which indicated the resident had [redacted] Further review revealed in section O special treatments indicated the resident used [redacted] while a resident at the facility. A Review of the Order Summary for Active orders as of [redacted], revealed no order for [redacted] therapy. Further review revealed an order dated [redacted], to change and date [redacted] and [redacted]r every night shift every Sunday for infection control. On 03/02/22 at 11:00 AM, in the presence of the Licensed Practical Nurse (LPN) who was assigned to the resident, the surveyor reviewed the electronic medical record. The LPN was unable to find an [redacted] order. She stated that the resident went to the hospital and returned to the facility and the order was not there. During an interview with the surveyor on 03/02/2022 at 03:02 PM, the Director of Nursing (DON) stated that there was no order for the [redacted]. The last [redacted] order was [redacted]. She stated when the resident was hospitalized,	F 658		

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the order must have been dropped off. She stated it was a "slip through" and the nurses should have seen that and made sure they had an order.

During a meeting with the survey team on 03/08/22 at 03:32 PM, the administrator was made aware of the surveyor's findings.

During a meeting with the survey team on 03/09/2021 at 02:38 PM, the DON stated orders are checked by the admitting nurse and Sunday nights the nurses check the [redacted] She stated there should absolutely be a physician order for [redacted] and it is important to make sure things are being followed.

2. On 03/07/22 at 10:53 AM, the surveyor observed Resident [redacted] seated in a wheelchair in his/her room wearing a [redacted] connected to a [redacted] of [redacted]

On 03/08/22 at 1:25 PM, the surveyor observed Resident [redacted] seated in a wheelchair in his/her room wearing a [redacted] connected to a [redacted] delivering [redacted].

A review of the Admission Record revealed the resident was admitted to the facility with diagnoses that included, but were not limited to; [redacted]).

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F 658	Continued From page 18 A review of the Quarterly MDS, dated [redacted] revealed that the resident had a BIMs score of [redacted], which indicated that the resident had [redacted]. Further review revealed in section O special treatments indicated the resident used [redacted] while a resident at the facility. A review of the Order Summary Report, with active orders as of [redacted], revealed no order for [redacted] administration. A review of the Care Plan, with a revision date of [redacted], revealed [redacted] settings: [redacted] On 03/08/22 at 2:42 PM, in the presence of the Registered Nurse/Unit Manager (RN/UM), the surveyor reviewed the electronic medical record. The RN/UM was unable to find an [redacted] order and acknowledged there should be an [redacted] order. During a meeting with the survey team on 03/09/22 at 02:20 PM, the administrator and DON were made aware of the surveyor's findings. During an interview with the surveyor on 03/09/22 at 2:32 PM, the DON stated that the admission nurse and the next shift nurse were responsible for checking orders and that the UM reviewed all new admission orders for accuracy and that it was important to follow correct orders. The DON acknowledged that the resident should have had an [redacted] order. A review of the facility policy, [redacted] Administration," with a revision date of December 2021, revealed Policy: I. Initiation of [redacted], A. A	F 658		

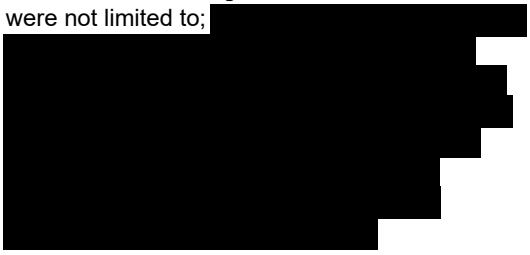
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F 658	Continued From page 19 physician's order is required to initiate [redacted] therapy ... NJAC 8:39-11.2(b); 27.1(a)	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of facility policy, it was determined the facility failed to implement a physician's order for [redacted] care to prevent the worsening of a [redacted] and [redacted] for 1 of 1 residents reviewed for [redacted], Resident #[redacted] This deficient practice was evidenced by the following: According the Admission Record, Resident #1[redacted] was admitted to the facility in [redacted] for rehabilitation. On [redacted] the resident was sent to an acute hospital and was readmitted on [redacted].	F 686	F686 □ Treatment/Services to Prevent/Heal [redacted] 1. Resident [redacted] treatment orders obtained and implemented for [redacted] to the [redacted] and preventative [redacted] to [redacted] which has remained healed. Resident [redacted] was not adversely affected by the identified deficient practice. 2. All current residents with pressure [redacted] injuries have the potential to be affected by the same deficient practice. All current residents with [redacted] have been reviewed to ensure	5/3/22

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F 686	Continued From page 20 The resident had diagnoses that included, but were not limited to; [redacted]  A review of the admission Minimum Data Set (MDS), an assessment tool, dated [redacted], revealed resident [redacted] had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident was [redacted]. Further review of the MDS revealed the resident required extensive assistance with activities of daily living including bed mobility, transfers, dressing, and toileting and had one [redacted] hich was present on admission. A review of the resident's Care Plan (CP) initiated [redacted], revealed the resident was at risk for [redacted] medical condition/diagnosis, and [redacted]. A review of the [redacted] care consultant visit report dated [redacted], revealed the resident had an unhealed [redacted] with [redacted] order treatment recommendations to apply single-layer [redacted] cover with a bordered gauze/Island dressing, change dressing daily. The resident had an unhealed [redacted] with [redacted] order treatment recommendations to apply [redacted] barrier to the [redacted] and surrounding skin every shift. The Plan of Care was discussed with facility staff.	F 686	physician□s orders for treatments are in place. No other deficient practice identified. 3. All current licensed staff will be reeducated by the Director of Nursing (DON) or Assistant Director of Nursing (ADON) to follow the policy for obtaining and implementing physician□s orders for treatments for residents with [redacted]. 4. The ADON or Unit Managers will conduct weekly audits x 3 months, then monthly audits X 3 months of residents with [redacted] to ensure physician□s orders for treatments are in place. The results of these audits will be presented at the monthly Quality Assurance meeting to ensure compliance and reassessed for further action if needed.	

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A review of the [redacted] care consultant visit report dated [redacted], revealed that [redacted] was not healed with [redacted] order treatment recommendations to discontinue prior treatments and to apply [redacted] to the [redacted] and surrounding skin daily and [redacted] was not healed with [redacted] order treatment recommendations to apply [redacted] to the [redacted] and surrounding skin every shift. The Plan of Care was discussed with facility staff.

A review of the [redacted] care consultant visit report dated [redacted] revealed that [redacted] was not healed with [redacted] order treatment recommendations to apply [redacted] wipes [redacted] to the [redacted] and surrounding skin daily and [redacted] was not healed with wound order treatment recommendations to discontinue prior treatments, cleanse the [redacted], do not scrub or use excessive force, pat dry, apply [redacted] cut to size to the [redacted], cover with a bordered gauze/Island dressing, change dressing daily and when soiled. The Plan of Care was discussed with facility staff.

A review of the [redacted] care consultant visit report dated [redacted], revealed that [redacted] was not healed with [redacted] order treatment recommendations to cleanse the [redacted] with [redacted], do not scrub or use excessive force, pat dry, apply [redacted] cut to size to the [redacted] base, cover with a bordered gauze/Island dressing, change dressing daily and when soiled and [redacted] was not healed with [redacted] order treatment recommendations to cleanse the [redacted] with [redacted], do not scrub or use excessive force, pat dry, apply [redacted] cut to size to the [redacted] base,

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cover with a bordered gauze/Island dressing, change dressing daily and when soiled.

A review of the Treatment Administration Record (TAR), dated [redacted], indicated an order for the [redacted] was to be cleansed with [redacted] ([redacted]), pat dry, apply [redacted] and cover with DSD (dry sterile dressing) daily every day shift for [redacted] care, start date [redacted] d/c date [redacted]. The TAR was signed as administered [redacted]. An order for [redacted] apply to [redacted] topically every shift for prevention for 7 days, start date [redacted]. The TAR was signed as administered every shift from night shift [redacted] until evening shift [redacted]. No [redacted] orders appeared on the TAR.

A review of the Order Summary Report with active orders as of [redacted], revealed no [redacted] care orders.

A review of the TAR, dated [redacted] revealed no [redacted] orders for [redacted] and no [redacted] orders for [redacted].

During an interview with the surveyor on 03/03/22 at 12:06 PM, the Licensed Practical Nurse/Supervisor (LPN/S) on [redacted] acknowledged the resident had a [redacted] and stated that the [redacted] was almost healed and that she was putting cream barrier on the [redacted] every time personal care was performed. The LPN/S further stated that she had applied [redacted] to both [redacted] every shift.

During an interview with the surveyor on 03/08/22 at 2:50 PM, the LPN/Unit Manager (LPN/UM) on

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[redacted] stated that the resident was admitted to the facility with [redacted] on his/her [redacted] and his/her [redacted]. The LPN/UM stated that as per the [redacted] rounds, that [redacted] was healed and the treatment was [redacted] and that [redacted] was healed and the treatment was [redacted]. The LPN/UM stated that weekly [redacted] rounds were done with the UM and the [redacted] doctor consultant on all the residents on the unit, the [redacted] doctor uploaded their reports with recommendations to the electronic medical record system, then the nurse inputted the orders for the treatments and the staff nurse would implement them on a daily basis. The LPN further stated that the orders came from the wound physician and not the house physician. The LPN/UM acknowledged complete [redacted] orders for the [redacted] and the [redacted] were not on the TAR and stated that if the order was not on the TAR that the treatment was not administered.

During an interview with the surveyor on 03/08/22 at 3:09 PM, the Director of Nursing (DON) stated that if there were [redacted] care orders that they would be found on the TAR.

During an interview with the surveyor on 03/09/22 at 08:59 AM, the DON stated she reviewed resident [redacted]'s physician orders and that she did not observe an order for [redacted] treatment and was unsure about any [redacted] orders.

During an interview with the surveyor on 03/10/22 at 3:10 PM, the DON acknowledged the [redacted] doctor consultant recommended [redacted] treatment to the resident's [redacted]. The DON stated the [redacted] doctor consultant recommendations were put in the computer system as an order by the DON or UM and that

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F 686	Continued From page 24 once inputted it would show on the TAR. The DON acknowledged there was no order for [redacted] care to the [redacted] and the [redacted] and had no explanation as to how staff would know what [redacted] care to perform. A review of the facility policy, Physician Orders, with a revision date of January 2022, revealed Procedure: VIII. Whenever possible, the Licensed Nurse receiving the order will be responsible for documenting and implementing the order. IX. Medication/treatment orders will be transcribed onto the appropriate resident administration record. A review of the facility policy, [redacted] Management, with a revision date of June 2021, revealed Policy: A resident who has a [redacted] will receive necessary treatment ...Procedure: II. [redacted] Management, G. Per attending physician order, the nursing staff will initiate treatment and utilize interventions for pressure redistribution and [redacted] management. NJAC 8:39-27.1(e)	F 686		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		5/3/22

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F 812	Continued From page 25 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of other facility documentation, it was determined that the facility failed to a.) properly label and date food products stored in the walk-in refrigerator/freezer and b.) ensure that kitchen staff wore a hair restraint that fully covered their hair during food preparation in the kitchen in order to prevent foodborne illness for 1 of 1 staff member observed with improper hair restraint usage. This deficient practice was evidenced by: On 02/24/22 from 09:39 AM until 10:16 AM, the surveyor observed the following in the presence of the Director of Dining (DOD): 1. In the walk-in freezer: a. On the second shelf from the top of a four-tiered wired rack, the clear plastic outer packaging of a block of Swiss cheese was not secured and the cheese was opened and exposed to the air within the freezer. The DOD stated that he would re-wrap it correctly. b. On the second shelf from the top of a three-tiered wired rack, a previously opened	F 812	1. The cook removed the Swiss cheese from freezer cut off the exposed end and discarded it, the cheese was then properly wrapped and labeled & dated. The Director of Dietary (DOD) discarded the open package of hamburger patties and tater tots from the freezer. The DOD discarded the open container of sauerkraut. The cook immediately properly applied a hair restraint covering all hair. No residents were found to have any signs or symptoms of food borne illness because of the identified deficient practice. 2. All residents have the potential to be affected from food items not properly stored, labeled, and dated and from the improper wearing of hair restraints. All dietary staff was in-serviced by the DOD on the policy of proper storage, labeling & dating of food items which includes when to discard foods. All dietary staff was in-serviced by the DOD on the use of the labeling guns and single use food labels and when to use them. The cook was in-serviced by the DOD on how to wear hair restraints. All dietary staff was	

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F 812	Continued From page 26 package of frozen hamburger patties was wrapped in clear plastic, and was not dated. c. On the bottom shelf of a three-tiered wired rack, an unopened 2.5 lbs. bag of tater tots was not dated. The DOD stated that both the frozen hamburger patties and the tater tots should have been marked with an orange sticker that identified the received by date, the date opened and the use by date. He stated that he would discard them. 2. In the walk-in refrigerator: a. On the top shelf of a five-tiered wired rack, there was an opened jar of sauerkraut that was marked with an opened date of 02/02/22. The DOD stated that it should have been discarded within three days after it was opened. He stated that he would discard it. On 03/02/22 from 11:58 AM until 12:10 PM, during a follow-up visit to the kitchen, the surveyor observed the following in the presence of the DOD: The surveyor observed the Cook who was in the galley of the kitchen as she plated food for the lunch service. The surveyor noted that the Cook's hair restraint did not fully cover her hair and the hair that covered her forehead and bordered the sides of her face was left exposed bilaterally. She stated that she intentionally wore bangs and left the hair that bordered the sides of her face outside of the hair restraint as a matter of preference. She stated that she always wore it like that. She further stated that her hair could fall into the food.	F 812	in-serviced by the DOD on the policy of hair and beard restraints and how to properly wear them. 3. The DOD (Director of Dietary) or Licensed Nursing Home Administrator (LNHA) will use an audit tool to conduct weekly audits X 3 months of the storage, labeling & dating of food items in the refrigerators and freezers. The DOD or LNHA will use an audit tool to conduct daily audits X 3 months on the proper wearing of hair and beard restraints. 4. The findings of the audits during the monthly Quality Assurance Performance Improvement (QAPI) X 3 months. The LHNA will make recommendations as appropriate.	

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F 812	Continued From page 27	F 812		

The DOD stated that all kitchen staff were required to wear hair restraints. He stated that if the Cook's hair were not pulled back into the hair net, it could have fallen into the food and contaminated it.

The surveyor reviewed the facility policies Food Storage (Revised 12/01/11) (Policy number 03.03.003) and Employee Sanitation (Revised 12/01/11) which revealed the following:

All frozen foods will be labeled and dated when received. Refrigerated foods are labeled and dated upon receipt from the vendor. Product is then stored in a manner it was received in order to preserve product integrity.

Refrigerated foods are labeled and dated upon receipt from the vendor...Items will be dated upon receipt. They will then be dated upon opening of the product for use. Only a portion of the product will be divided for use. The portion not to be used will be wrapped or covered, dated and refrigerated immediately to prevent any compromise of the product. The used portion will be labeled and dated using the "Labeling of Prepared Foods" Policy The items will be used or discarded after five (5) days of being opened or the product use by date, whichever comes first.

Employee Cleanliness Requirements: ...Hair restraints, such as hats, hair coverings or nets, caps and beard/moustache restraints (snoods) or other effective hair restraints are worn to keep hair from contacting food and food-contact surfaces.

NJAC 17.2(g)

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F 880 SS=D	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		5/3/22

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F 880	Continued From page 29 (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 observations, interviews, record review, and review of facility documents, it was determined that the facility failed to maintain appropriate infection control practices for a.) maintaining the cleanliness of an [redacted] and a [redacted] pole, for 1 of 2 residents reviewed for [redacted], Resident [redacted] and b.) the use of required personal protective equipment (PPE) on 1 of 5 units. This deficient practice was evidenced by the	F 880	F880 – Infection Prevention and Control 1. The [redacted]/base and [redacted] for resident [redacted] were cleaned and disinfected per current Centers for Disease Control (CDC) recommendations for disinfection and the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard. Resident [redacted] was not adversely affected by the identified deficient practice. The staff member who	

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F 880	Continued From page 30 following: 1. On 02/24/22 at 01:20 PM, during the initial tour of the facility, the surveyor observed Resident # [redacted] in bed. [redacted] was being delivered to the resident through a [redacted] that was attached to an [redacted] that was set at [redacted] ([redacted]). There was a [redacted] pole next to the [redacted]. The resident was receiving [redacted] via a [redacted]. The [redacted] display showed the [redacted] was being delivered at [redacted]). There was a large amount of [redacted] substance on the [redacted] and on the base of the [redacted]. On 03/01/22 at 12:50 PM, the surveyor observed Resident [redacted] in bed with [redacted] delivered through a [redacted] and the [redacted] connected and delivering [redacted]. There was [redacted] substance on the [redacted] and on the base of the [redacted]. A review of the Admission Records (an admission summary) dated [redacted], which indicated Resident [redacted] had diagnoses, which included but not limited to; [redacted]. A review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate resident care, dated [redacted], revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the	F 880	was observed exiting room [redacted] wearing a yellow gown, eyeglasses, and N95 mask with a surgical mask under it, and no gloves, placed a clipboard on the floor, and dropped a cell phone on the floor, then proceeded to remove the disposable gown and enter room [redacted] to dispose of it was immediately reeducated by the Interim Infection Preventionist (IIP) on the correct procedure for donning and doffing personal protective equipment (PPE) and hand hygiene when entering and exiting a room that is on droplet and contact precautions to prevent the spread of disease and the possibility of cross contamination. 2. All residents receiving a [redacted] or who use an [redacted] have the potential to be affected by the same deficient practice. All residents with [redacted] or who use an [redacted] were evaluated by their attending physician, and none were found to have any adverse consequence because of the identified deficient practice. All residents on the Persons Under Investigation (PUI) Unit have the potential to be affected by the identified deficient practice of improper PPE donning and doffing. All residents were and continue to be monitored at a minimum of daily by Licensed Nursing staff for signs and symptoms (s/s) of COVID-19 illness and none have been identified or have tested positive for COVID-19. 3. The Director of Environmental Services (DEVS) will reeducate the	

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F 880	Continued From page 31 resident had [redacted]. Further review revealed in section K that the resident had a feeding tube while at the facility. Further review revealed in section O special treatments indicated the resident used [redacted] while a resident at the facility. During an interview with the surveyor on 03/01/2022 at 12:55 PM, the Licensed Practical Nurse (LPN) who was assigned to the resident, stated that she was not aware the [redacted] and the [redacted] was dirty and was not aware of who would keep the equipment clean. During an interview with the surveyor on 03/01/2022 at 01:00 PM, the housekeeper stated she was not responsible to clean the [redacted] and that maintenance is responsible to clean the equipment. During an interview with the surveyor on 03/01/2022 at 01:05 PM, the Director of Environmental Services stated normally in the evenings he had a maintenance man who made rounds and checked the equipment. This happened usually on Tuesdays and if the maintenance man felt the equipment needed to be cleaned, he would clean the equipment. He stated there are no logs for checking and cleaning the equipment. During a follow up interview with the surveyor on 03/07/2022 at 12:40 PM, the Director of Environmental Services stated he had no documentation that the equipment is being cleaned and did not have a cleaning schedule for the rooms. He stated he did not date the medical equipment as to when the equipment was	F 880	housekeeping staff on the policy and procedure of cleaning resident [redacted] and [redacted] equipment per current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. The housekeeping staff will sign off on the Resident Equipment Cleaning log when completed at a minimum of weekly and as needed when visibly soiled. All current staff will be reeducated by the Interim Infection Preventionist (IIP) on the correct PPE to wear and the correct procedure for donning and doffing PPE, and when to perform hand hygiene when entering and exiting resident rooms that require droplet and contact precautions. Root cause analysis was conducted, Business office manager (BOM) verbalized noticing that there was no trash can with a lid in the room she was in to dispose of the PPE she was wearing. She exited the room and entered the room next door that had a bin with a lid and was unoccupied to dispose of the PPE. The BOM stated that she did recall an in-service in that moment that she learned that it's better to dispose of the PPE in the room then to wear out of the room. She was immediately in serviced on by the interim infection preventionist on 3/25/2022 on the proper donning and doffing PPE. A LTC Self-Assessment was completed by the IP on 4/12/2022. Module 1: infection prevention & control program was reviewed by topline staff and Infection Preventionist. Keep Covid Out was viewed by frontline staff. Sparkling Surfaces was viewed by Front Line Staff.	

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F 880	Continued From page 32 cleaned. He stated that he and his staff just clean the equipment when the equipment needed to be cleaned. He further stated that the only cleaning schedule he had was for the cleaning of the wheelchairs. During a meeting with the survey team on 03/08/22 at 03:32 PM, the administrator was made aware of the surveyor's findings. A review of the policy labeled "Cleaning and Disinfection of Resident Care Equipment" with a revised date of 08/01/2021, revealed resident-care equipment, including reusable items and durable medical equipment is cleaned and disinfected per current CDC, recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. A review of the policy labeled "Stationary [redacted] Policy and Procedure" dated 03/07/2022, Cleaning heading #2. clean the exterior of the [redacted] with soapy water solution or commercial cleaner to remove any debris. 2. On 02/25/22 at 11:44 AM, during the initial tour on [redacted] the surveyor observed a plastic barrier in the hallway with posted signage which stated Observation unit (OU), Yellow Zone, PPE:N95, Faceshield/Goggles, Gowns, Gloves. DON (put on) PPE before entering the resident's room, DOFF (remove) PPE before leaving the resident's room and posted signage which stated stop, contact precautions, everyone must clean their hands including before entering and when leaving the room, all providers and staff must also	F 880	Clean Hands was viewed by Front Line staff. Use PPE Correctly for Covid-19 was viewed by Front Line staff. Module 5: Outbreaks was viewed by Topline Staff and Infection Preventionist. Module 6A: Principles of Standard Precautions was viewed by all staff including Topline Staff and Infection Preventionist. Module 6B: Principles of Transmission Based Precaution was viewed by all staff including Topline Staff and Infection Preventionist. All residents will continue to be monitored at a minimum of daily by Licensed Nursing staff for signs and symptoms (s/s) of COVID-19 illness. The Assistant Director of Nursing (ADON) and the IIP also conducted a facility wide audit of the COVID-19 screenings performed at a minimum of daily by the licensed nursing staff and no residents were identified to have s/s of COVID-19 illness. 4. The Director of Environmental Services or Licensed Nursing Home Administrator (LNHA) will conduct weekly audits x 3 months, then monthly X 3 months to ensure all resident [redacted] and [redacted] equipment is cleaned and disinfected per CDC recommendations and OSHA Bloodborne Pathogens Standard. The Infection Preventionist (IP) or Interim Director of Nursing will conduct weekly observations x 3 months, then monthly observations X 3 months of staff entering and exiting resident rooms that require contact and droplet precautions to ensure that the correct procedure is followed to prevent the spread of disease and	

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F 880	Continued From page 33 put on gloves before room entry, remove gloves before room exit, put on gown before room entry, discard gown before room exit, use dedicated or disposable equipment. There was posted signage next to room [redacted] with instructions on donning and doffing PPE. In the hallway outside of same room the surveyor observed a three drawer plastic bin containing gloves, surgical masks, face shields, N95 masks, and disposable yellow gowns. The surveyor observed a staff member in room [redacted] on the OU wearing an untied yellow gown. On 02/25/22 at 11:48 AM, the staff member exited room [redacted] wearing a yellow gown, eyeglasses, an N95 mask with a surgical mask under it, and no gloves. The staff member placed her clipboard on the floor, her cell phone fell to the floor, and she removed the disposable gown in room [redacted] and placed it in the trash can in the room. The staff member then returned to the hall where the surveyor interview took place. The Business Office Manager (BOM) stated she was in room [redacted] obtaining information for billing purposes. The BOM acknowledged she was in the OU and that once on the unit that gowns and N95 masks were to be worn and that before leaving the hall the gown and N95 mask were to be removed. The BOM stated that the posted signage reinforced that gowns, masks and goggles were to be worn on the unit. The BOM acknowledged she wore a gown in the hallway and that she was not wearing goggles. The BOM stated that she should not have removed her gown in room [redacted] and that she should have taken off her gown in the resident's room before leaving and should have used hand sanitizer before entering a room and after leaving a room to prevent cross contamination. The BOM further stated she should not have placed her belongings	F 880	possibility of cross contamination. The results of these audits will be presented at the monthly Quality Assurance meeting to ensure compliance and reassessed for further action if needed.	

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F 880	Continued From page 34 on the floor and that she would wipe them down. During an interview with the surveyor on 03/03/22 at 12:06 PM, the Licensed Practical Nurse/Supervisor (LPN/S) on [redacted] stated that [redacted] is for quarantining persons under investigation (PUI), that the plastic barrier was for protection, and that PPE signage was posted. The LPN/S stated that when entering the plastic barrier that the required PPE in resident rooms were goggles, face shield, N95, gown and gloves. The LPN/S stated that PPE should be donned prior to entering the room and doffed before exiting the room and that once gloves were removed that handwashing should be performed in the bathroom then upon exit of the room that hand sanitizer was used. When informed of the BOM observation that took place on 2/25/22, the LPN/S stated that the BOM should not have worn her gown in the hallway and that she should have removed her PPE in the doorway and washed her hands then used hand sanitizer for everyone's protection. During an interview with the surveyor on 03/03/22 at 12:38 PM, the Director of Nursing (DON) stated that the required PPE on the OU consists of a gown, N95 mask, goggles or faceshield, and gloves and that all PPE was available on the unit. The DON stated that prior to entering a resident's room the PPE was donned and prior to exiting the room the PPE was doffed then handwashing should be performed. When informed of the BOM observation that took place on 2/25/22, the DON acknowledged the BOM did not follow proper PPE instructions and that it was important to wear proper PPE for protection. During an interview with the surveyor on 03/03/22	F 880		

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F 880	Continued From page 35	F 880		

at 1:08 PM, the Interim Infection Preventionist (IIP) stated that the plastic barrier indicated a PUI zone and that the required PPE in that area was an N95 mask, faceshield or goggles, gown and gloves in the room and that PPE should be donned prior to entering the room and doffed prior to exiting the room. When informed of the BOM observation that took place on 2/25/22, the IIP acknowledged the BOM did not follow proper PPE instructions and that it was important to wear proper PPE for protection.

During an interview with the surveyor on 03/09/22 at 10:44 AM, the BOM acknowledged that the required PPE in the PUI unit was goggles, N95 mask, gown and gloves and that she was not wearing the proper PPE during the surveyor observation on 2/25/22. The BOM demonstrated how to correctly wear an N95 mask and acknowledged there should not be a surgical mask underneath the N95 mask. The BOM stated she was inserviced on PPE and that it was important to wear PPE correctly to stay safe and to prevent cross contamination.

Review of facility policy, "Resident Isolation-Categories of Transmission-Based Precautions," with a revision date of 1/2022, revealed Purpose: To ensure that transmission based precautions are used when caring for residents with communicable diseases or transmittable infections. Policy: Transmission based precautions are used accordingly when caring for residents who are documented or are suspected of having communicable diseases or infections that can be transmitted to others. III. Contact precautions, C. Gloves and Handwashing, i. Gloves are worn when entering the room, iii. Gloves are removed before leaving

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	315140	A. BUILDING _____ B. WING _____	03/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	633 ROUTE 28 RARITAN, NJ 08869

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F 880	Continued From page 36 the room and hands are washed immediately with an antimicrobial agent or a waterless antiseptic agent. D. Gown, ii. The gown is removed, and hand hygiene is performed before leaving the resident's environment. IV. Droplet precautions, C. a mask is worn when working within 3 feet of the resident.	F 880		
F 888 SS=D	NJAC 8:39-19.4(k) COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.	F 888		5/3/22

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§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

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

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F 888	Continued From page 38	F 888		

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

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F 888	Continued From page 39 individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of other facility documentation, it was determined that the facility failed to ensure that mitigation measures were followed to prevent the potential spread of COVID-19, a contagious respiratory infection. This deficient practice was identified for 3 of 3 partially vaccinated staff, and 1 of 2 unvaccinated staff, and was evidenced by the following: On 03/07/22 at 11:33 AM, the surveyor observed a Licensed Practical Nurse (LPN) working on [redacted] wearing a surgical mask and goggles. During an interview at that time, the LPN stated that she believed she was scheduled to receive her second dose of the vaccine on 3/18/22. On 03/07/22 at 11:46 AM, the surveyor observed a Certified Nursing Assistant (CNA), working on [redacted] wearing a surgical mask and goggles.	F 888	F888 □ COVID-19 Vaccination of Facility Staff 1. The Licensed Practical Nurse (LPN) on [redacted], the Certified Nursing Assistant (CNA), the Activity Aid (AA), and the receptionist who were not up to date with all recommended COVID-19 vaccinations were immediately reeducated by the Interim Infection Preventionist (IIP) and applied a NIOSH approved N95 mask and eye protection. 2. All residents have the potential to be affected by this identified deficient practice. All residents were and continue to be monitored at a minimum of daily by Licensed Nursing staff for signs and symptoms (s/s) of COVID-19 illness and none have been identified or have tested positive for COVID-19. The Assistant Director of Nursing (ADON) and the IIP	

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F 888	Continued From page 40 During an interview at that time, the CNA stated that she was scheduled to receive her second dose of the vaccine on 03/20/22. On 03/08/22 09:42 AM, the surveyor observed the receptionist, sitting behind the plastic barrier at the desk, wearing a surgical mask, no goggles/face shield. She was speaking to a resident sitting in front of the desk, who was also wearing a surgical mask. During an interview on 03/08/22 at 10:16 AM with the surveyor, the Interim Infection Preventionist (IIP) stated that you are not fully vaccinated if you only received the 1st dose of a 2-dose vaccine. You are not fully vaccinated until the second dose and booster vaccines are completed. On 03/08/22 at 10:31 AM, the surveyor observed the LPN on [redacted] wearing a surgical mask and eye goggles. She was carrying a medication cup and entered a resident's room. On 03/08/22 at 10:49 AM, the surveyor observed the CNA on [redacted] wearing a surgical mask and eye goggles. On 03/08/22 at 11:13 AM, the surveyor observed an Activity Aid (AA) in the activities room with the administrator and another staff member. The AA was wearing a surgical mask and glasses. During an interview at that time, the AA stated that he had received his second dose of the vaccine on 3/1/22. During an interview with the surveyor on 03/08/22 at 11:17 AM, the Director of Nursing (DON) stated that you are fully vaccinated once the first, second and booster vaccine was received. She	F 888	also conducted a facility wide audit of the COVID-19 screenings performed at a minimum of daily by the licensed nursing staff and no residents were identified to have s/s of COVID-19 illness. 3. The IIP or ADON will reeducate all staff who are not vaccinated or partially vaccinated on or before 4/30/2022 on the policy and procedure for wearing the required eye protection and NIOSH approved N95 or equivalent or higher-level respirator for source control regardless of whether they are providing direct care or otherwise interacting with patients. 4. The IIP or ADON will conduct weekly audits X 3 months, then monthly audits X 3 months of all unvaccinated staff or partially vaccinated staff to ensure compliance with wearing the required NIOSH approved N95 or equivalent or higher-level respirator for source control regardless of whether they are providing direct care or otherwise interacting with patients. The results of these audits will be presented at the monthly Quality Assurance meeting to ensure compliance and reassessed for further action if needed.	

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stated that a first dose meant that you are only partially vaccinated. The DON stated that the LPN and CNA were to wear a N95 mask if they go off their assigned unit and/or on [redacted] and [redacted]

During an interview with the surveyor on 03/08/22 at 11:30 AM, the IIP stated that the staff that received the first dose was not considered vaccinated and that they should wear a N95 mask and shield/goggle, at all times regardless of what they are doing in the facility.

During an interview with the surveyor on 03/08/22 at 11:33 AM, in the presence of the IIP, the LPN stated "I should have on an N95 mask." She stated the purpose of wearing a N95 mask was to protect myself and others from COVID. The IIP stated that the N95 mask was to be worn at work at all times.

During an observation by the surveyor and the IIP on 03/08/22 at 11:34 AM, the CNA was observed with a coworker at the linen cart, in the hallway of [redacted] wearing a surgical mask. The IIP stated that the CNA should have had on a N95 mask and that she should remain social distanced while on lunch.

During an interview with the surveyor on 03/08/22 at 11:36 AM, in the presence of the IIP, the AA stated that he wears a surgical mask outside of the office or when around others. The IIP stated that the AA should wear a N95 mask and goggles at all times, everywhere in the building unless on break, then he must remain socially distant. The IIP confirmed that he was not fully vaccinated [redacted] weeks after receiving the last dose of the vaccine.

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During an interview with the surveyor on 03/08/22 at 11:38 AM, in the presence of the IIP, the receptionist stated that she had not received any doses of the vaccine. She was wearing a surgical mask. The IIP confirmed that she should be wearing a N95 and a shield.

During an interview with the surveyors on 03/09/22 at 02:25 PM, the Licensed Nursing Home Administrator, the Vice President of Operations, the DON, the IIP, and the Regional Clinical all agreed that partially vaccinated staff were unvaccinated staff and that the policy for unvaccinated staff should have been followed.

A review of the facility's "Employee Education Attendance Record" dated 3/1/2022, Topic of In-service: Vaccine policy/Procedures; Objectives Inservice-noted wearing surgical mask; needs N95/Shield, revealed the LPN had Participated in discussion and Verbalization of content to meet objective.

A review of the facility's policy, "Atlas COVID-19 Policies and Procedures" updated 1/28/2022, revealed Additional Precautions and Contingency Plans for Unvaccinated Staff: Adhering to universal source control and physical distancing measures even if the facility is located in a county with low-to-moderate community COVID transmission. Require use of a NIOSH-approved N95 or equivalent or higher-level respirator for sources control, regardless of whether they are providing direct care to or otherwise interacting with patients.

NJAC 8:39-5.1(a)

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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: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 13 of 14 day shifts and one of 14 evening shifts reviewed. This deficient practice was evidenced by the following: 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	S 560	S560 □ Mandatory Access to Care 1. All residents who were in the facility on the dates identified below the required staffing ratios were reviewed by their attending physician and none were determined to have had a negative outcome due to facility staffing below the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey on 02/06/2022 day shift, 02/06/2022 overnight shift, 02/08/2022 day shift, 02/09/2022 day shift, 02/10/2022 day shift, 02/11/2022 day shift, 02/12/2022 day shift, 02/13/2022 day shift, 02/14/2022 day shift, 02/15/2022 day shift, 02/16/2022 day shift, 02/17/2022 day shift, 02/18/2022 day shift, 02/19/2022 day shift.	5/3/22

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

Electronically Signed | 04/08/22

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S 560	Continued From page 1 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 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The surveyor requested staffing for the weeks of 2/06/22 and 2/13/22. Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on 13 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows: 02/06/22 had 14 CNAs for 127 residents on the day shift, required 16 CNAs. 02/06/22 had 8 total staff for 127 residents on the overnight shift, required 10 total staff. 02/08/22 had 15 CNAs for 127 residents on the day shift, required 16 CNAs. 02/09/22 had 13 CNAs for 127 residents on the day shift, required 16 CNAs. 02/10/22 had 13 CNAs for 127 residents on the day shift, required 16 CNAs.	S 560	Nursing management, administrative staff and contracted agency were also in the facility to ensure resident needs were being met. The staffing coordinator was immediately reeducated by the Licensed Nursing Home Administrator (LHNA) on the State of New Jersey required minimum direct care staff-to-resident ratios. 2. All residents have the potential to be affected by the identified deficient practice. The LHNA conducted an audit of current direct care staffing schedules that do not meet the required minimum staffing ratios and requests have been sent to all available staffing agencies and monetary bonuses have been offered to the current facility staff pool to ensure that the minimum direct care staff-to-resident ratios are met in the facility. 3. The staffing coordinator and the Human Resource Director (HRD) were educated by the Licensed Nursing Home Administrator (LHNA) on the State of New Jersey required minimum direct care staff-to-resident ratios. The LHNA or Assistant Director of Nursing (ADON) will review the staffing schedule daily to ensure that the minimum direct care staff-to-resident ratios are being met per the census of the facility. The facility will utilize all available contracted staffing agencies to supplement staffing shortages. The staffing coordinator will also prepare a rolling staffing schedule two weeks in advance, updated weekly and forward to the agency the vacancies that require filling to meet or exceed the	

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S 560	Continued From page 2 02/11/22 had 13 CNAs for 129 residents on the day shift, required 17 CNAs. 02/12/22 had 11 CNAs for 129 residents on the day shift, required 17 CNAs. 02/13/22 had 9 CNAs for 129 residents on the day shift, required 17 CNAs. 02/14/22 had 14 CNAs for 128 residents on the day shift, required 16 CNAs. 02/15/22 had 13 CNAs for 126 residents on the day shift, required 16 CNAs. 02/16/22 had 14 CNAs for 126 residents on the day shift, required 16 CNAs. 02/17/22 had 11 CNAs for 126 residents on the day shift, required 16 CNAs. 02/18/22 had 11 CNAs for 126 residents on the day shift, required 16 CNAs. 02/19/22 had 12 CNAs for 126 residents on the day shift, required 16 CNAs. During an interview with the surveyor on 3/07/22 at 10:01 AM, the Staffing Supervisor stated that she was not aware of the staffing ratio requirement. She further stated that due to the pandemic the facility had begun to utilize agency staff for the first time in order to supplement staffing needs. During an interview with the surveyor on 3/07/22 at 10:56 AM, the Director of Nursing (DON) stated that she was aware of the staffing ratio requirement and was unable to recruit and retain enough CNAs to meet the requirement.	S 560	minimum staffing ratios. The staffing coordinator will update the contracted agency daily of any changes in the number of vacant shifts that cannot be filled by the facility□s current staffing pool. The facility is continuously and actively seeking and hiring nursing staff via recruiting agencies, mailings, and social media posts. 4. The LHNA or ADON will conduct weekly audits X 3 months, then monthly of direct care staff schedules to ensure the required minimum direct care staff-to-resident ratios are being met as mandated by the State of New Jersey. The results of these audits will be presented at the monthly Quality Assurance meeting to ensure compliance and reassessed for further action if needed.	