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	315137	A. BUILDING _____ B. WING _____	03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARN HILL CARE AND REHAB CENTER	249 HIGH STREET NEWTON, NJ 07860

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F 000	INITIAL COMMENTS Standard Survey: 3/10/22 Census: 123 Sample Size: 28 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities. Deficiencies were cited for this survey.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records.	F 583		4/21/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/30/2022

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 583	Continued From page 1 (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to provide full visual privacy and maintain confidentiality when discussing the resident's pain during medication administration and a physical assessment, for 1 of 24 residents reviewed, Resident #116. The deficient practice was evidenced by the following: On 3/3/22 at 8:40 AM, the surveyor observed the Licensed Practical Nurse (LPN) prepare to administer medication to Resident #116. The surveyor observed the LPN speaking to the resident from outside the doorway of the resident's room. The LPN entered the room of Resident #116 to administer medication and examine the resident's abdomen. The door to the room was open and the resident could be seen from the hallway lying in the bed. During the physical exam, the resident's abdomen was exposed, the resident's gown raised, and blankets were below the resident's waist. The LPN returned to the medication cart outside of the resident's doorway to prepare pain medication for the resident. The LPN spoke to Resident #116 from outside the doorway of the resident's room	F 583	1. Nurse for resident #116 was educated regarding residents' rights, dignity, and privacy policy and procedure. 2. All residents have the potential to be affected by the same deficient practice. 3. All Nurses were educated on the policy and procedure related to quality of life and dignity. 4. The ADON and / or designee will conduct a weekly random walking rounds to monitor for privacy quality of life - dignity issues for 3 months. Audits will be reviewed through the monthly QAPI process for the next three months.	

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F 583	Continued From page 2	F 583		

and asked about the resident's level of pain. The LPN repeated back the resident's answers from the doorway in a loud voice.

On 3/3/22 at 8:50 AM, the surveyor spoke with the LPN about the observations of speaking to Resident #116 from outside doorway of the resident's room, examining the resident with the door open and the resident being visible from the hallway. The LPN acknowledged she should have closed the door when examining the resident and should have not asked questions from outside the room's doorway for resident privacy.

The surveyor reviewed the medical record of Resident #116 which revealed the following:

The Minimum Data Set assessment dated 2/27/22, revealed the resident scored Ex.Orde out of a possible 15 when the Brief Interview for Mental Status was done which indicated the resident was Ex.Order 26.4(b)(1).

On 3/3/22 at 12:53 PM, the surveyor spoke with the Administrator, the Director of Nursing (DON), the Regional Clinical Specialist and Regional Administrator about the above concerns. The DON provided the surveyor with policies as requested.

On 3/4/22 at 9:50 AM, the surveyor reviewed the facility's policy and procedure dated 10/2021, titled "Quality of Life-Dignity". Under "Policy Interpretation and Implementation" it read, "9. Staff shall maintain an environment in which confidential clinical information is protected ...10. Staff shall promote, maintain and protect resident privacy, including bodily privacy during

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F 583	Continued From page 3 assistance with personal care and during treatment procedures.". The surveyor also reviewed the facility's policy and procedure, dated 10/2021, titled "Administering Medications", but it did not address the need to provide privacy. NJAC 8:39-4.1(a)12,16	F 583		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;	F 623		4/21/22

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(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and

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F 623	Continued From page 5 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to notify resident families or resdient representatives (RR), and the Ombudsman's office in writing for a facility-initiated transfer to the hospital for 6 of 6 residents (Resident #81, #15, #18, #167, #105, and #106) reviewed for hospitalization. The deficient practice was evidenced by the following: The surveyors reviewed the hybrid medical	F 623	1. Residents #81, #15, #18, #167, #105 and #106 notices of transfer were provided to the residents and notifications of transfer were faxed to the Ombudsman’s Office. 2. All residents have the potential to be affected by the same deficient practice. 3. The Business office conducted an audit to ensure all residents or RR that were affected by the deficient practice were	

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F 623	Continued From page 6 records (paper and electronic) that revealed facility-initiated hospital transfers had occurred without written notification to the families and Ombudsman's office for the following residents: 1. According to the Discharge Minimum Data Set (MDS) an assessment tool dated 11/16/21, Resident #81 was transferred to the hospital with anticipated return to the facility. There was no documentation that the facility had notified the resident's family or RR in writing regarding the reason for transfer and bed hold policy. In addition, the Ombudsman's office was not notified. 2. According to the Discharge MDSs dated 9/29/21, 11/5/21 and 1/25/22, Resident #15 was transferred to the hospital with anticipated return to the facility. There was no documentation that the facility had notified the resident's family or RR in writing regarding the reason for transfer and bed hold policy. In addition, the Ombudsman's office was not notified. 3. According to the Discharge MDSs dated 11/16/21 and 1/18/22, Resident #18 was transferred to the hospital with anticipated return to the facility. There was no documentation that the facility had notified the resident's family or RR in writing regarding the reason for transfer and bed hold policy. In addition, the Ombudsman's office was not notified. 4. The 2/2/22 MDS indicated the Resident #167 was discharged from the facility on Ex.Order 26.4(and anticipated to return to the facility. The Census tab indicated the resident was discharged to the hospital on Ex.Order 26.4(and readmitted to the facility on Ex.Order 26.4(.	F 623	notified. Additionally, the Ombudsman's office was sent the notifications of transfer. The Business office staff were educated on the policy and procedure for notification of transfer of residents and family, as well as notifying the Ombudsman's Office. 4. The ADON / Designee will conduct a weekly random audit x 3 months, to ensure that the business office submits notification of transfer to family, residents and the Ombudsman's Office. Audits will be reviewed through the monthly QAPI process for the next three months.	

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The surveyor interviewed Resident #167's resident representative (RR) on 3/2/22 at 11:30 AM. The RR stated the facility provided notification of the transfer by phone. The reason for emergency transfer and a review of the facility bed hold policy was not provided to the RR in writing.

5. The 1/18/22 MDS indicated the Resident #105 was discharged from the facility on [redacted] and anticipated to return to the facility. The Census tab indicated the resident was transferred to the hospital on 1[redacted] and returned to the facility on [redacted]. There was no documentation that the family or RR, and Ombudsman's office were notified in writing for the reason of the transfer.

6. The 1/19/22 MDS indicated the Resident #106 was discharged from the facility on [redacted] and anticipated to return to the facility. The Census tab indicated the resident was transferred to the hospital on 1[redacted] and readmitted to the facility on [redacted]. There was no documentation that the family or RR, and Ombudsman's office were notified in writing for the reason of the transfer.

On 3/1/22 at 1:13 PM, the surveyor interviewed the Director of Nursing (DON). The DON stated families or RRs had not been provided with written notification of emergency transfer or provided with the facility's bed hold policy at the time of transfer. Additionally, the facility had not provided notification of resident emergency transfers to the New Jersey Long-Term Care Ombudsman (LTCO) office.

On 3/3/22 the DON provided the surveyor with the facility policy titled "Transfers-Bed Hold,"

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F 623	Continued From page 8 revised 5/2021. The policy indicated before transfer the resident or RR is to be provided with written information of the bed hold policy. The policy did not address written notification of the reason for emergency transfer to the resident or RR or written notification to the LTCO office. NJAC 8:39-5.3	F 623		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow physician's orders and failed to handle medication appropriately. This was found with 2 of 24 residents reviewed, Resident # 115 and Resident # 81. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing,	F 658	1. LPN #1 for resident #81 was educated on medication administration policy and procedure, and completed a medication administration competency. 2. All residents have the potential to be affected by the same deficient practice. 3. Nursing staff were reeducated on policy and procedure for Medication Administration. 4. The unit managers / designee will randomly observe a nurse weekly to ensure they are following the policy and procedure for medication administration x 3 months. Any re-education needs will be submitted to the Nurse Educator. Audits will be reviewed through the monthly QAPI process for the next three	4/21/22

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F 658	Continued From page 9 and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 2/24/22 at 11:19 AM, the surveyor observed Resident #81 seated in the wheelchair in the activity room. During an interview with the resident, the resident informed the surveyor that he/she doesn't always get their medications and many times not on time. The surveyor asked the resident if they had received their medications today. The resident replied "no." After completing the interview with the resident, the surveyor interviewed Licensed Practice Nurse #1 (LPN #1) who was assigned to the resident. The surveyor asked the nurse if she had given the resident the 9 AM medications. LPN #1 replied "yes." Resident #81 had come up behind the surveyor and quickly stated "no you didn't." LPN #1 stated she would check. LPN #1 opened the medication cart and went into the locked narcotic box and took out an unlabeled medicine up with pills inside and stated that these were the medications for the resident. LPN #1 stated she had poured the medications and realized the	F 658	months. 1. Resident #115's orders were updated to reflect plan of care regarding turning and repositioning schedule. 2. All residents have the potential to be affected by the same deficient practice. 3. Nursing staff were inserviced on following proper plan of care on turning and repositioning schedule. 4. The Assistant Director of Nursing / designee will conduct random audits on residents with turning and repositioning orders weekly x 3 months to ensure orders reflect appropriate plan of care for the resident. Audits will be reviewed through the monthly QAPI process for the next three months.	

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resident wasn't in the resident's room. She stated she put the medicine cup with the resident's prescribed medication in the narcotic box.

LPN #1 agreed it was not best practice to store the medications in the narcotic box. The surveyor asked what time the medications are scheduled to be administered and LPN #1 stated 9 AM. She agreed that the medications should be administered at the time they are scheduled.

The surveyor reviewed Resident #81's the electronic medical records (EMR) that revealed the following:

According to the Admission Record, Resident #81 was admitted to the facility with diagnoses that included EX Order 26 § 4b1 [redacted]

The Quarterly Minimum Data Set (MDS) an assessment tool dated 1/23/22, the facility performed a Brief Interview for Mental Status that revealed a score of Ex.Ord out of 15 indicating the resident was Ex.Order 26.4(b)(1) .

The February 2022 Electronic Medication Administration Record (EMAR) revealed the following medications were scheduled to be administered at 9 AM: EX Order 26 § 4b1 [redacted]

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The EMAR Resident Details form showed an administration history for all the medications listed above that were due at 9 AM were given between 11:47 AM and 11:55 AM.

On 2/24/22 at 12:54 PM, the surveyor discussed the above concern with the Administrator, Director of Nursing (DON), Regional Clinical Specialist and Regional Administrator. The DON provided the surveyor with the Administering Medication policy.

The surveyor reviewed the policy titled Administering Medication with an update dated 10/2021. Under Policy Interpretation and Implementation #3 and #4 revealed the following, "Medications must be administered in accordance with the orders, including any required time frame. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders)."
Surveyor: Ex.Order 26.4(b)(1)

2. On 2/24/22 at 11:45 AM, the surveyor observed Resident #115 in bed. The resident was on their back asleep.

On 2/28/22 at 11:35 AM, the surveyor observed Resident #115 on their back in bed asleep.

On 3/1/22 at 9:41 AM, the surveyor observed Resident #115 asleep in bed on their back.

On 3/1/22 at 12:34 PM, the surveyor observed Resident #115 asleep in bed on their back.

On 3/2/22 at 1:21 PM, the surveyor observed Resident #115 asleep in bed on their back.

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F 658	Continued From page 12 The surveyor reviewed the Resident #115's medical record which revealed the following: According to the Admission Record, Resident #115 was admitted to the facility with diagnoses which included EX Order 26 § 4b1 [redacted] A Treatment Administration Record (TAR) with a physician's order that read "Ensure resident is turned and reposition side to side q 2 hrs (every 2 hours). Resident should only be on [the] back during meals." The order date was 1/4/22. The order was initialed by a nurse every day to indicate that the order was being followed. A quarterly MDS dated 2/2/22 that indicated the resident had Ex.Order 26.4(b)(1) and was understood. On 3/7/22 at 11:28 AM, the surveyor asked the LPN #2 about the resident being observed multiple times on the back when there was a physician's order for the resident to only be on the back during meal time. LPN #2 said the resident stayed on their back for about 15 minutes after eating. The surveyor informed LPN #2 that there were multiple observations of the resident on their back long after meal time. LPN #2 stated she was not aware. On 3/7/22 at 11:41 AM, the surveyor asked LPN #2 who was responsible for repositioning the resident. LPN #2 said the Certified Nursing Assistant (CNA) but that she signed for it. LPN #2 said the order should have read, turn and reposition every two hours and not that the	F 658		

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F 658	Continued From page 13 resident should only be on their back during meals. She said she would call the doctor and have it changed. The Unit Manager/LPN was present and stated "yeah, it's a funky order." She agreed that if the nurse was signing for it she was signing for the order as it was written. On 3/7/22 at 12:41 PM, the surveyor discussed the above concern with the Administrator, DON, the Regional Clinical Specialist, and Regional Administrator. The DON agreed that the nurse should have clarified the physician's order and not signed for it if it was not an accurate order. she would get NJAC 8:39-27.1 (a)	F 658		
F 695 SS=D	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 by: Based on observation, interview, and record review, it was determined that the facility failed to provide the necessary respiratory care and services in accordance with professional standards of practice for 1 of 1 resident (Resident #15) reviewed for respiratory services. The deficient practice was evidenced by the	F 695	1. Resident #15 Received New CPAP mask and tubing. New mask and tubing were labeled and placed in a plastic bag at her bedside. Resident #15's orders were corrected to reflect the cleaning process for the mask and tubing and storage.	4/21/22

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F 695	Continued From page 14 following: On 2/25/22 at 8:22 AM, the surveyor observed Resident #15 in bed awake and alert receiving Ex.Order 26.4(b)(1) mask on the nightstand not secured in a plastic bag. During the interview with resident, the resident stated that the nurses do not clean the mask. On 3/4/22 at 10:38 AM, the surveyor observed the resident in bed awake and alert with EX Order 26 § EX Order 26 § 4b1 The surveyor asked the resident if the tubing gets changed and she replied "yes, they change it weekly, but they still haven't cleaned my mask." On 3/4/22 at 12:12 PM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPNUM) who stated that the night shift nurse takes off the EX Order 26 § EX Order 26 and they should wash it with soap and water. The surveyor reviewed Resident #15's hybrid medical records (paper and electronic) that revealed the following: According to the Admission Record, Resident #15 was admitted to the facility with diagnoses that included, EX Order 26 § 4b1 The Annual Minimum Data Set an assessment tool dated 2/14/22, indicated that the facility performed a Brief Interview for Mental Status	F 695	2. All residents utilizing a BPAP or CPAP are at risk for the same deficient practice. 3. All residents utilizing a BPAP or CPAP were reviewed. Orders were put in place to clean the mask and tubing, and on their proper storage. Nursing staff were re-educated on the policy and procedure for cleaning and storing of BPAP and CPAP masks and tubing. 4. The Unit Managers / Designee will conduct random audits weekly x 3 months for residents with a BPAP or CPAP to ensure that orders were put in place to clean the mask, tubing, and on their proper storage. Audits will be reviewed through the monthly QAPI process for the next three months.	

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which the resident scored a [redacted] out of 15. The score of 14 indicated that the resident was Ex.Order 26.4(b)(1).

The March 2022 Physician's Order Summary Sheet revealed the following order Ex.Order 26.4(b)(1) [redacted] and remove in AM. Interface type: Ex.Order 26.4(b)(1) [redacted]. every evening and night shift." This order was initiated on 2/3/22.

The March 2022 Electronic Treatment Administration Record (ETAR) reveal the above order was initiated on 2/3/22 and the nurses signed the ETAR 12 AM - 8 AM and 4 PM - 12 AM daily.

The care plan titled [the resident] has Ex.Order 26.4(b) [redacted]. The interventions do not include how to care for the CPAP equipment.

According to the manufacturer's specifications the CPAP mask should be cleaned every day. The mask can be cleaned with mild soap where it touches face or nose to clean the facial oils from the seal. Then rinse the mask with warm water and sit the mask on a paper towel or hang to let air dry.

On 3/7/22 at 11:22 AM, the surveyor observed the resident in bed awake and alert, and the CPAP mask lying on the nightstand not secured in a plastic bag. The surveyor asked the resident if

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F 695	Continued From page 16	F 695		

the CPAP mask was being cleaned in the morning when removed. The resident stated, "they still don't clean the mask."

The surveyor asked the LPNUM to come to the resident's room. The LPNUM looked at the nightstand and stated, "the mask should be in a plastic bag." The LPNUM restated to the surveyor that the nurse who removes the CPAP mask should wash it with soap and water.

The surveyor and LPNUM reviewed the physician's orders. There was no physician's order for the care of the CPAP equipment. There was no documentation in the Electronic Medication Administration Record and no documentation in the ETAR that the nurses were cleaning the CPAP equipment.

On 3/7/22 at 12:13 PM, the surveyor returned to the resident's room and observed the CPAP mask was still on the nightstand not secured in a plastic bag.

On 3/7/22 at 1:00 PM, the surveyor discussed with the Administrator, Director of Nursing, Regional Clinical Specialist and Regional Administrator the above concern and that the mask was still on the nightstand not secured in a plastic bag even after the LPNUM had observed it.

The surveyor reviewed the facility's policy titled BiPAP CPAP dated 5/2021, under Procedure #8 "The machine, tubing and masks must all be cleaned according to manufacturer's instructions and facility policy."

A review of the facility's policy titled B-PAP/C-PAP

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F 695	Continued From page 17 Cleaning Policy indicated the following "Mask and filter should be cleaned weekly in warm soapy water and rinsed in warm water." NJAC 8:39-27.1(a)	F 695		
F 711 SS=F	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the residents' primary physician signed and dated monthly physician orders to ensure that the residents' current medical regimen was appropriate. This deficient practice was observed for 16 of 24 residents (Resident #81, #15, #74, #18, #70, #167, #68, #12 #57, #106, #366, #98, #7, #115, #83, and #19) reviewed and occurred over several months. This deficient practice was evidenced by the	F 711	1. Resident # 81, #15, #74, #18, #70, #167, #68, #12, #57, #106, #366, #98, #7, #115, #83 and #19's medical records were reviewed by the Primary Physician. The primary physician reviewed the monthly orders and signed and dated them. 2. All residents and patients are at risk for the same deficient practice. 3. Patients' monthly orders were	4/21/22

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F 711	Continued From page 18 following: The surveyors reviewed the hybrid medical records (paper and electronic) for the residents listed above that revealed the resident's primary physician had not hand signed the Order Summary Reports (monthly physician's orders) located in the residents' chart. In addition, there were no electronic signatures under the physician's orders for the following residents 1. Resident #81's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for November 2021, January 2022 and February 2022. December 2021's physician's orders was not on the chart. 2. Resident #15's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for November 2021, January 2022 and February 2022. The physician's orders for December 2021 were not in the chart. 3. Resident #74's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for January 2022 and February 2022. 4. Resident #18's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for December 2021, January 2022 and February 2022. 5. Resident #70's hybrid medical records revealed the resident's physician had not hand	F 711	reviewed, signed, and dated by the Primary Physician. Physicians were re-educated on how to review and electronically sign their monthly orders timely. 4. The Assistant director of Nursing / designee will randomly audit 3 charts a week x 3 months to ensure the physician signed and dated the monthly orders. Audits will be reviewed through the monthly QAPI process for the next three months.	

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F 711	Continued From page 19	F 711		

signed or electronically signed the monthly physician's orders for November 2021, December 2021, January 2022 and February 2022.

On 3/03/22 at 12:17 PM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) who stated it was her understanding that the physicians come monthly. The LPNUM stated she was not aware of the process of who checks to make sure the physicians are signing their orders.

6. Resident #167's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for December 2021, January 2022, and February 2022.

7. Resident #68's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for December 2021, January 2022, and February 2022.

8. Resident #12's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for December 2021, January 2022, and February 2022.

9. Resident #57's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for December 2021, January 2022, and February 2022.

10. Resident #106's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly

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F 711	Continued From page 20	F 711		

physician's orders for December 2021, January 2022, and February 2022.

On 3/03/22 at 12:12 PM the surveyor interviewed LPN #1 regarding the process for doctors signing their resident's monthly orders. LPN #1 stated the physicians sign orders electronically, however, LPN #1 was unable to show the surveyor that physicians had signed orders in the electronic record.

11. Resident #366's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for December 2021, January 2022, or February 2022.

12. Resident #98's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for December 2021, January 2022, or February 2022.

13. Resident #7's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for December 2021, January 2022, and February 2022.

14. Resident #115's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for December 2021, January 2022, and February 2022.

On 3/4/22 at 11:30 AM, the surveyor asked LPN #2, where the physician's signed their orders. LPN #3 said they sign the medical record electronically.

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F 711	Continued From page 21 15. The hybrid medical records of Resident #83 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for December 2021, January 2022, and February 2022. On 3/3/22 at 12:22 PM, the surveyor interviewed LPN #2 about where the physicians sign the orders for residents. LPN #2 stated the physicians sign in the resident's electronic chart. 16. Resident #19's hybrid medical records revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for December 2021, January 2022 and February 2022. On 3/4/22 at 1:05 PM, the surveyors discussed the above concern with the Administrator, Director of Nursing (DON), Regional Clinical Specialist and Regional Administrator. On 3/8/22 at 12 PM, the DON provided the surveyor with the facility's policy titled Physician Orders. Under Process #5 indicated the following: "All orders must be signed by an authorized, credentialed physician or other authorized practitioner in accordance with state regulations regarding prescriptive privileges." NJAC 8:39-23.2	F 711		
F 761 SS=D	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	F 761		4/21/22

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F 761	Continued From page 22 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to properly label and date medications in 1 of 8 medication carts and 1 of 3 medication storage rooms inspected. The deficient practice was evidenced by the following: 1. On 2/28/22 at 12:26 PM, the surveyor inspected the medication cart on the Franklin unit in the presence of the Licensed Practical Nurse (LPN) who was assigned to the cart. There was a Lispro insulin vial box with a resident's last name written with a marker on the box. The	F 761	1. All improperly labeled or unlabeled medications in the refrigerator and medication drawers were discarded. 2. All residents and patients are at risk for the same deficient practice. 3. Licensed Nursing staff were reeducated on policy and procedure for labeling and storage of medication. 4. The Unit Managers / designee will conduct a weekly audit x 3 months of the refrigerator and medication cart, to ensure all medications are labeled and stored per	

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F 761	Continued From page 23 lispro insulin vial removed from inside the box, had written in marker a different resident's last name. There was a second lispro insulin vial box with a pharmacy label. The lispro insulin vial removed from inside the box, had written in marker, the resident's last name which was smeared and only partially visible. There was no pharmacy label on the vial. An Ozempic insulin pen (A device used to inject insulin. It contains a cartridge, a dial to measure dosage, and a disposable needle), had a resident's first name written in marker on it and there was no pharmacy label. At that time, the surveyor asked the LPN about the insulin vials and pens with resident's name written in marker, she stated "the pharmacy labels come off". On 2/28/22 at 12:40 PM, the surveyor inspected the medication room refrigerator on the Franklin unit with the LPN. Inside the refrigerator was a Glargine insulin pen. There was a pharmacy label with the date of 2/19/22. The plastic bag containing the insulin pen read "Refrigerate until opened". The LPN acknowledged unopened insulin pens should have been stored in the refrigerator and said she didn't know if the pen was unused as she was not the nurse who wrote the date on the medication. On 3/1/22 at 1:40 PM, the surveyor spoke with the Administrator, the DON, the Regional Clinical Specialist and Regional Administrator of the above concerns. On 3/2/22 at 9:55 AM, the surveyor reviewed the facility's policy and procedure titled, "Storage of	F 761	policy. Audits will be reviewed through the monthly QAPI process for the next three months.	

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F 761	Continued From page 24 Medications", with the revised date of November 2021. Under Policy Interpretation and Implementation it read, "4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing" and "7. Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured location". The surveyor reviewed the facility's policy and procedure, titled "Administering Medications", updated on 10/2021. Under Policy Interpretation and Implementation it read, "14. Insulin pens will be clearly labeled with the resident's name or other identifying information. Prior to administering insulin with an insulin pen, the Nurse will verify that the correct pen is used for that resident". NJAC 8:39-29.4(a)	F 761		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an	F 849		4/21/22

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LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services

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provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

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§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.

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F 849	Continued From page 28 (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to consistently provide coordination between facility staff and hospice agency staff to meet the resident's nursing needs. The deficient practice was identified for 1 of 2 residents (Resident #366) reviewed for hospice/end of life care and was evidenced by the following. On 2/24/22 at 11:18 AM, the surveyor observed Resident #366 in bed. The resident's family member was at the resident's bedside. The resident's family member said the resident was on hospice. The resident appeared weak, looked	F 849	1. Resident #366's Hospice documentation was retrieved from the hospice agency and placed in residents chart. 2. All residents on Hospice services are at risk for the same deficient practice. 3. Nursing and hospice staff were re-educated on the policy and procedure for hospice programs including coordinating resident care between the facility and hospice staff to meet the residents nursing needs.	

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F 849	Continued From page 29 at the surveyor and mouthed words but did not speak. The resident's family member said the resident could no longer hear or see very well. The resident's family member said the hospice aide went to the facility to see the resident every day at 7 AM. On 3/1/22 at 10:12 AM, the surveyor reviewed the resident's hybrid medical record which revealed the following: According to the Admission Record, Resident #366 was admitted with diagnoses which included, EX Order 26 § 4b1 [redacted] A 1/26/22 Significant Change Minimum Data Set assessment tool, indicated the resident was cognitively intact as evidenced by a Brief Interview for Mental Status score of [redacted] and was enrolled in a hospice program. The 1/25/22 facility hospice care plan included interventions to provide personal care, pureed diet with pleasure foods, emotional and spiritual support, and notify hospice of any changes in condition or medication changes. Inside of the front cover of the resident's paper chart contained a sheet that read "This patient is under the care of [Name of Hospice Provider] as of 1/21/22." The first page in the resident's chart was a sheet of paper that read "Nursing Home-Nursing Visit." The top line had the resident's name and it read "On 1/27/22 a nursing visit was made by the [hospice providers name] nurse.....Computer generated nursing notes to be put in patient chart at next planned visit. If this nursing note should be required before next visit,	F 849	4. Unit Managers / designee will conduct weekly audits of the charts of residents on Hospice x 3 months, to ensure documentation and coordination of care is in place. Audits will be reviewed through the monthly QAPI process for the next three months.	

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please feel free to call us." That visit sheet was signed by the nurse. There was no other paper work from the hospice provider in the chart.

On 3/1/22 at 10:12 AM, the surveyor asked the Unit Clerk for the hospice documentation that wasn't in the paper chart. She looked in the chart and agreed that there was no hospice documentation. She said she would find out where it was.

On 3/1/22 at 1:10 PM, the Director of Nursing (DON) provided documentation that she stated was just sent over from the Hospice provider. The DON said she didn't know why the hospice provider was not leaving any documentation on the chart but she would call the hospice provider and ask.

On 3/1/22 at 1:45 PM, the surveyor spoke with the DON, Administrator, the Regional Clinical Specialist and Regional Administrator and mentioned the concern with there being no documentation in the resident's record by the hospice provider. They agreed that the hospice provider should have documented each time they saw the resident and it should be part of the record. On the last day of the survey the surveyor asked the DON if she was able to find out from the hospice provider why there was no documentation left in the facility. The DON said she had not heard from the hospice provider about it.

On 3/7/22 at 11:44 AM, the surveyor called the hospice provider and spoke with a Registered Nurse Supervisor (RNS). The surveyor asked the RNS what paperwork was required to be left in the resident's chart at the facility. The RNS stated

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"the plan of care and any orders we recommend, we have an IDT (Interdisciplinary Team) note, that is the note by the hospice nurse, and when we have our meetings every two weeks those notes are sent over after being reviewed by the team. Non skilled care notes by the hospice aide should be kept in the chart after every visit. The Hospice Nurse sees the resident 1-2 times per week minimum, depending on the need. The notes are available for the facility to request at any time between the IDT meetings."

On 3/7/22 at 12:00 PM, the surveyor reviewed the facility's policy and procedure titled "Hospice Program" with a review date of 3/2021. Under "Policy Interpretation and Implementation" 10 d. read "Communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day." Number 12 read " Our facility has elected the Director of Nursing or Designee to coordinate care provided to the resident by our facility staff and the hospice staff.....He or she is responsible for the following: d. Obtaining the following information from the hospice:

1) The most recent hospice plan of care specific to each resident
2) Hospice election form
3) Physician certification and recertification of the terminal illness specific to each resident
4) Names and contact information for hospice personnel involved in hospice care of each resident
5) Instructions of how to access the hospice's 24 hour on-call system
6)Hospice medication information specific to each resident; and

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F 849	Continued From page 32 7) Hospice physician and attending physician (if any) orders specific to each resident. NJAC 8:39-27.1 (a)	F 849		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		4/21/22

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F 880	Continued From page 33 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to implement infection control procedures in a manner that would decrease the possibility of spreading infection. This was found with: 1 of 2	F 880	1. Resident #83's Ex.Order 26.4(b)(1) was replaced by the unit manager immediately. The nurses aide for resident #83 was	

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F 880	Continued From page 34 certified nursing assistants (CNA) during urinary drainage bag changes, 1 of 5 nurses during medication administration and 1 of 3 nurses during wound care observation. The deficient practice was evidenced by the following: 1. On 3/1/22 at 10:12 AM, the surveyor observed the CNA who was assigned to Resident #83 change their large urinary drainage bag to a urinary leg bag. The resident had a urinary catheter (A flexible tube used to empty the bladder and collect urine in a drainage bag). The CNA, with gloved hands, pulled a garbage can towards her, removed her gloves, and put on a new pair of gloves. The CNA did not perform hand hygiene and continued the task of changing the urinary drainage bags. The CNA disconnected the large drainage bag from the catheter and laid the urinary catheter tubing on the inside of the resident's soiled incontinent brief. The CNA then cleansed the leg bag connection tip with an alcohol swab and connected the tube to the catheter. The CNA placed the large drainage bag on the foot of the resident's bed while she retrieved a clear plastic bag for storage. The tube attached to the large drainage bag was not capped and was touching the bed. The CNA placed the large drainage bag with uncapped tubing in a clear plastic bag and placed it in the resident's bed side table. The CNA went to the resident's bathroom, removed her gloves, and washed her hands. The CNA lathered her hands outside of running water for 9 seconds. On 3/2/22 at 1:05 PM, the surveyor interviewed	F 880	reeducated on handwashing and changing urinary bag policy and procedure. Aide was competencied on hand washing and Ex.Order 26.4(b)(1) care. 2. All residents are at risk for the same deficient practice. 3. Nursing staff were re-educated on the Ex.Order 26.4(b)(1) changing policy and procedure and appropriate hand washing techniques. 4. Unit managers / designees will conduct random audits of 3 CNAs weekly x 3 months to ensure they are following the policy and procedure for urinary bag replacement and handwashing. Audits will be reviewed through the monthly QAPI process for the next three months. 1. LPN for resident #116 was educated on the medication administration policy and procedure for eye drops, and completed a Medication administration competency. 2. All residents with an eye drop order are at risk for the same deficient practice. 3. Licensed nurses were re-educated and competencied on the policy and procedure for eyedrop administration. 4. Unit Managers / designee will randomly observe a nurse weekly x 3 months to ensure they are following the policy and procedure for eyedrop administration.	

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F 880	Continued From page 35 the CNA, about the techniques used and observations during the change of the drainage bags for Resident #83. T he CNA stated, "I should have connected the new bag immediately". The surveyor asked the CNA about the storing of the drainage bag and if there was a cap for the drainage bag. The CNA acknowledged there should have been a cap for the drainage bag and said, "they go missing and there are times a new drainage bag is used or bags are stored without a cap". The CNA acknowledged the drainage bag should be stored with a cap on and said she had not reported to nurse or unit manager when a cap was missing. The surveyor asked the CNA about the facility's hand hygiene policy. The CNA stated hand hygiene should be performed "at least 30 seconds or you can sing the happy birthday song". The surveyor reviewed the Resident #83's hybrid medical records (paper and electronic) which revealed the following: According to the Admission Record, Resident #83 was admitted to the facility with diagnoses that included EX Order 26 § 4b1 [redacted] A physician order which read EX Order 26 § 4b1 [redacted] A Quarterly Minimum Data Set assessment tool, dated 1/25/22, indicated the resident was cognitively intact as evidenced by a Brief Interview for Mental Status score of [redacted]	F 880	Audits will be reviewed through the monthly QAPI process for the next three months. 1. The Nurses for resident #115 was reeducated on aseptic wound care technique, hand hygiene and wound dressing care policy and procedure. Nurse was competencied on aseptic wound care and hand hygiene. 2. All residents are at risk for the same deficient practice. 3. Licensed Nurses were reeducated and competencied on aseptic wound care technique and proper hand hygiene policy and procedure. 4. The Unit Managers/Designee will randomly observe a nurse weekly for 3 months to ensure they are following the policy and procedure for aseptic wound care technique and proper hand washing. Audits will be reviewed through the monthly QAPI process for the next three months. A DPOC was imposed upon the facility and an RCA was completed. In-service videos and modules were viewed by staff as follows: Module 1 □ Infection Prevention & Control Program https://www.train.org/main/course/1081350/ All topline staff completed this training.	

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F 880	Continued From page 36 On 3/2/22 at 1:37 PM, the surveyor informed the Administrator, the Director of Nursing (DON), Regional Clinical Specialist and Regional Administrator of the concerns during the urinary drainage bag change observation. On 3/3/22 at 10:50 AM, the DON provided the policies and procedures for hand hygiene and changing of urinary bags. The surveyor reviewed the facility's policy and procedure revised on 12/21, titled, Policy and Procedure for Changing of Urinary Bags. Under Policy, it read "It is the policy of the facility to decrease the incidences of nosocomial infections by utilizing clean techniques when a drainage bag or leg bag is disconnected." Under Procedure, it read "8. Carefully remove sterile cap over the connection tip on leg bag or bedside drainage bag being switched to. 10. Carefully apply sterile cap to drainage system being switched from". The surveyor reviewed the facility's policy and procedure updated on 3/2021, titled, Handwashing/Hand Hygiene. Under Policy Interpretation and Implementation, it read: "7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ...m. After removing gloves ..." and "9. The use of gloves does not replace handwashing/hand hygiene.". Under Washing Hands, it read "1. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds." 2. On 3/3/22 at 8:40 AM, the surveyor observed the Licensed Practical Nurse #1 (LPN #1) administer medication to Resident #116. LPN #1	F 880	CDC COVID-19 - Keep COVID-19 Out! https://youtu.be/7srwrF9MGdw All frontline staff completed this training. CDC COVID-19 □ Sparkling Surfaces https://youtu.be/t7OH8ORr5IG All frontline staff completed this training. CDC COVID-19 □ Clean Hands https://youtu.be/xmYMUly7qiE All frontline staff completed this training. Module 5 □ Outbreaks https://www.train.org/cdctrain/course/1081803/ All topline staff completed this training. Module 11B □ Environmental Cleaning and Disinfection https://www.train.org/main/course/1081815/ All staff completed this training. Module 7 □ Hand Hygiene https://www.train.org/main/course/1081806/ All staff completed this training. Module 6A □ Principles of Standard Precautions https://www.train.org/main/course/1081804/ All staff completed this training. Module 6B □ Principles of Transmission	

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administered an eye drop medication to each eye to Resident #116. The surveyor observed LPN #1 use the same tissue for each eye when giving eye drops.

On 3/3/22 at 8:50 AM, the surveyor spoke with LPN #1 about observation of using same tissue for both eyes. LPN #1 said she used different corners of tissue for each eye.

On 3/3/22 at 12:53 PM, the surveyor informed the Administrator, the DON, and two regional directors of the above concerns.

On 3/4/22 at 9:50 AM, the DON provided policy and procedure for eye drop administration. The surveyor reviewed the facility's policy and procedure reviewed on 11/21, titled "Eye-Drop Administration". Under Procedure, it read "8. Gently dry the eyelid with a tissue if dripping occurs. (Note: Use only one tissue per eye.)".

3. On 3/4/22 at 10:32 AM, the surveyor observed LPN #2 perform a Ex.Order 26.4(b) treatment to the Ex.Order 26.4(b)(of Resident #115. After washing her hands LPN #2 removed a wet paper towel that had fallen in the sink. The LPN then donned gloves without performing any hand hygeine after removing the wet paper towel from inside of the sink.

LPN #2 prepared supplies on the overbed table after sanitizing it and establishing a clean field, removed the old dressing from the resident's Ex.Order 26.4(b)(1 and sprayed the Ex.Order 26.4(b on the Ex.Order 26.4(b)(with Ex.Order 26.4(b)(1) wash. LPN #2 then squeezed Ex.Order 26.4(b)(1) ointment) onto a tongue blade and wiped it into the Ex.Order 26.4(b) while LPN #2 was wiping the Ex.Order 26.4(into the Ex.Order 26.4(b, the can of Ex.Order 26.4 Ex.Order 26.4(b)(1) fell on the floor. LPN #2 picked up

Based Precautions
https://www.train.org/main/course/1081805/
All staff completed this training.

Module 11A □ Reprocessing Reusable Resident Care Equipment
https://www.train.org/main/course/1081814/
All topline staff completed this training.

Why

A) CNA stated she was aware of the hand hygiene policy; however she had become anxious and nervous due to the observation. LPN stated she used a separate dry paper towel to pick up the wet paper towel from the sink and thought this was sufficient practice.
B) The CNA acknowledged there should have been a cap for the drainage bag and said, "they go missing and there are times a new drainage bag is used or bags are stored without a cap". She felt rushed due to the presence of the surveyor.
C) The Director of Nursing interviewed the LPN #1 about using the same tissue after administering the eye drops and the LPN #1 said she used different corners of tissue for each eye and thought this was sufficient practice.
D) LPN stated that during the treatment she felt she followed appropriate practice however upon review when questioned by the surveyor she acknowledged the breakdown in proper procedure.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315137	A. BUILDING _____ B. WING _____	03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARN HILL CARE AND REHAB CENTER	249 HIGH STREET NEWTON, NJ 07860

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 38	F 880		

the can of Ex.Order 26.4(b)(1) with her gloved hand and placed it back onto the overbed table. Without changing gloves or performing any hand hygeine, LPN #2 picked up the Ex.Order 26.4(b)(1)) and placed it into the Ex.Order 26.4(b , she then pressed it into the Ex.Order 26.4(b with a cotton swab. LPN #2 covered the Ex.Order 26.4(b with foam gauze and returned the can of Ex.Order 26.4(b)(1) wash to an opened zip lock bag and placed it into the treatment cart. She did not sanitize the over bed table when she was done.

On 3/4/22 at 12:02 PM, the surveyor spoke to LPN #2 and asked her about the observation of her removing the wet paper towel from the sink and not performing any hand hygeine. LPN #2 said she recognized that she dropped the paper towel in the wet sink but she used another paper towel to remove it. The surveyor then asked her about the can of Ex.Order 26.4(b)(1) that she picked up from the floor. LPN #2 said that she should not have picked up the can of Ex.Order 26.4 Ex.Order 26.4(b)(1) from the floor and continued with the treatment without any hand hygiene. The surveyor then asked about spraying the Ex.Order 26.4(b with the Ex.Order 26.4(b)(1) and then returning the can back to the treatment cart in an open ziplock bag. LPN #2 agreed with the risk of splash back onto the spray can. LPN #2 showed the surveyor the can in the treatment cart that was in an open zip lock bag. LPN #2 showed the surveyor that the zip lock bag could be closed with the can inside and that it was labeled for and dedicated to resident # 115. She said she could have used a disinfectant wipe before putting the can of Ex.Order 26.4(b)(1) back in the treatment cart.

On 3/4/22 at 1:00 PM, the surveyor discussed the

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F 880	Continued From page 39 wound treatment concerns with the Director of Nursing, (DON), the Administrator, Regional Clinical Specialist and Regional Administrator. They were in agreement that the concerns were infection control issues. On 3/7/22 at 11 AM, the surveyor reviewed the facility's policy and procedure titled "Dressings, Dry/Clean" and updated 10/2021. Under "Preparation" number 4 read " Wipe nozzles of wound [cleanser] with alcohol pledget or facility disinfectant wipe. (Note: this may be performed at the treatment cart). Number 22 read "Clean the bedside stand." NJAC 8:39-19.4 (a)	F 880		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061903	A. BUILDING: _____ B. WING _____	03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARN HILL CARE AND REHAB CENTER	249 HIGH STREET NEWTON, NJ 07860

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General	S 560	1. No Residents were affected by this deficient practice 2. All Residents have the potential to be affected by this deficient practice. 3. DON / Designee to in-service Staffing Coordinator on appropriate staffing levels. Facility has advertised open jobs through online recruitment platforms as well as traditional recruitment firms. The facility has conducted job fairs and has contracts with nursing staffing agencies.	4/21/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.	S 560	4. DON / Designee to conduct a weekly audit x 2 months to determine effectiveness of staffing levels.	

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S 560	Continued From page 2 (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 11/28/21 and 12/5/21 revealed the following: The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: - 02/06/22 had 11 CNAs for 110 residents on the day shift, required 14 CNAs. - 02/07/22 had 9 CNAs for 110 residents on the day shift, required 14 CNAs. - 02/08/22 had 13 CNAs for 110 residents on the day shift, required 14 CNAs. - 02/09/22 had 11 CNAs for 110 residents on the day shift, required 14 CNAs. - 02/10/22 had 13 CNAs for 112 residents on the day shift, required 14 CNAs. - 02/11/22 had 12 CNAs for 109 residents on the day shift, required 14 CNAs. - 02/12/22 had 11 CNAs for 108 residents on the day shift, required 14 CNAs. - 02/13/22 had 10 CNAs for 107 residents on the day shift, required 14 CNAs. - 02/14/22 had 10 CNAs for 104 residents on the day shift, required 13 CNAs. - 02/15/22 had 9 CNAs for 104 residents on the day shift, required 13 CNAs.	S 560		

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S 560	Continued From page 3 - 02/16/22 had 11 CNAs for 104 residents on the day shift, required 13 CNAs. - 02/17/22 had 11 CNAs for 104 residents on the day shift, required 13 CNAs. - 02/18/22 had 12 CNAs for 114 residents on the day shift, required 15 CNAs. - 02/19/22 had 13 CNAs for 114 residents on the day shift, required 15 CNAs. On 3/8/22 at 1:00 PM, the surveyor discussed the staffing ratios concerns with the Administrator and Director of Nursing, who stated they were aware of the staffing ratio criteria and they are attempting to hire new CNAs and offer incentives.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315137 Y1	A. Building B. Wing Y2	5/31/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BARN HILL CARE AND REHAB CENTER	249 HIGH STREET NEWTON, NJ 07860

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 F0583	Correction	ID Prefix F0623	Correction	ID Prefix F0658	Correction
Reg. # 483.10(h)(1)-(3)(i)(ii)	Completed	Reg. # 483.15(c)(3)-(6)(8)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	04/21/2022	LSC	04/21/2022	LSC	04/21/2022
ID Prefix F0695	Correction	ID Prefix F0711	Correction	ID Prefix F0761	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.30(b)(1)-(3)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	04/21/2022	LSC	04/21/2022	LSC	04/21/2022
ID Prefix F0849	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.70(o)(1)-(4)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	04/21/2022	LSC	04/21/2022	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/10/2022	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061903 Y1	A. Building B. Wing Y2	5/31/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BARN HILL CARE AND REHAB CENTER	249 HIGH STREET NEWTON, NJ 07860

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/21/2022	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/10/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315137	A. BUILDING **01** B. WING _____	**03/10/2022**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 3/9/22 and 3/10/22, 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 The facility is a 1- story building that was built in 70's, It is composed of Type III unprotected construction. The facility is divided into 8-smoke zones. The generator does approximately 80% of the building. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the	K 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/30/2022

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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K 000	Continued From page 1 following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 154 certified beds. At the time of the survey the census was 138.	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/10/22, it was determined that the facility failed to provide an operational battery backup emergency light above A. The emergency generator's transfer switch, B. The electric fire pump transfer switch independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was observed for 2 of 2 transfer switches and was evidenced by the following: A. At 1:10 PM, the Surveyor and Maintenance Director, observed in the basement fire pump transfer switch room, that no emergency lighting was provided. B. At 1:30 PM, the Surveyor and Maintenance	K 291	1. The backup light for the fire pump transfer switch room was installed on 3/30/22. The backup light for the emergency generator and transfer switch will be installed. 2. All residents have the potential to be affected by this deficient practice. 3. The maintenance director was in-serviced on ensuring there is sufficient backup lighting in the fire pump transfer switch room and above the emergency generator and transfer switch. 4. Maintenance director / designee will conduct weekly audits x 3 months to ensure there is sufficient working emergency lighting. Audits will be	3/30/22

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K 291	Continued From page 2 Director, observed outside the facility where the emergency generator and transfer switch was located, that no emergency lighting was provided where the transfer switch was located. This finding was verified by the Maintenance Director and Administrator at the time of the observation's. The Administrator was notified of the above findings at the Life Safety Code exit conference on 3/10/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	reviewed through the monthly QAPI process for the next three months.	
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility-provided documentation on 3/9/22, it was determined the facility failed to provide illuminated exit signs, that were readily visible for 2 of 2 exit access doors in the enclosed courtyard. This deficient practice was evidenced by the following: During the Life Safety Code tour with the Maintenance Director, an inspection of the	K 293	1. Illuminated exit signs were installed at the two exit access doors of the Franklin Hall enclosed courtyard leading into the building on 3/30/22. 2. All residents had the potential to be affected by this deficient practice. 3. Maintenance director was in-serviced on ensuring there are sufficient illuminated exit signs at exit access doors.	3/30/22

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K 293	Continued From page 3 Franklin Hall enclosed courtyard revealed that there was no illuminated exit sign to identify the access door's (2 of 2) out of the courtyard into the building. The Maintenance Director confirmed the finding during the observation. The Administrator was informed of the finding at the Life Safety Code exit conference on 3/10/22. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.2.10.1	K 293	4. Maintenance director / designee will conduct weekly audits x 3 months to ensure there are sufficient illuminated exit signs at exit access doors. Audits will be reviewed through the monthly QAPI process for the next three months.	
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on	K 341	1. A fire alarm notification (horn/strobe)	3/16/22

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	315137	A. BUILDING **01** B. WING _____	**03/10/2022**

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K 341	Continued From page 4 3/10/2022, in the presence of the Maintenance Director, it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 1 of 1 enclosed courtyards in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9 The deficient practice was evidenced by the following: During the building tour, in the presence of the Maintenance Director at 11:32 AM, an inspection of the outside area (Franklin Hall) enclosed courtyard was performed. The surveyor observed no evidence of a fire alarm notification (horn/strobe) in the above area. At that time, the surveyor asked the Maintenance Director if there was a horn/strobe in the above enclosed courtyard tied into the fire alarm system. The Maintenance Director said "no." The findings were verified and confirmed by the Maintenance Director during the observations. The Administrator was notified of the finding's at the Life Safety Code exit conference on 3/10/2022. NJAC 8:39-31.2(a) NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9	K 341	system was installed in the enclosed courtyard on 3/16/22. 2. All residents had the potential to be affected by this deficient practice. 3. Maintenance director was in-serviced on ensuring there is a sufficient fire alarm notification (horn/strobe) system in the enclosed courtyard. 4. Maintenance director / designee will conduct weekly audits x 3 months to ensure the fire alarm notification (horn/strobe) system in the enclosed courtyard is in working condition. Audits will be reviewed through the monthly QAPI process for the next three months.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing	K 353		3/28/22

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K 353	Continued From page 5 Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other facility documentation from 3/9/22 to 3/10/22, A. the facility failed to maintain the sprinkler system by not performing an electric fire pump monthly test in accordance with NFPA 101, 2012 Edition, Section 19.3.5.1, 4.6.12 and 9.7.5 and NFPA 25, complete sprinkler system inspection and testing is out of compliance. B. Based on record review and interview conducted on 3/9/21, in the presence of the Maintenance Director, it was determined that the facility failed to ensure that their automatic sprinkler system was inspected/tested at the required five-year interval in accordance with the National Fire Protection Association (NFPA) 25. These deficiencies were determined by the following: A. At approximately 10:40 AM, the surveyor requested the fire pump Churn test log from the	K 353	1. The fire pump monthly churn test was conducted on 3/23/22. 2. All residents have the potential to be affected by this deficient practice. 3. Maintenance director was in-serviced on ensuring that all the fire pump monthly tests are performed in a timely manner. 4. Maintenance director / designee will conduct a monthly audit x 3 months to ensure the monthly fire pump tests are being performed. Audits will be reviewed through the monthly QAPI process for the next three months. 1. The five-year internal obstruction investigation was completed on 3/28/22. 2. All residents have the potential to be affected by this deficient practice.	

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K 353	Continued From page 6 Maintenance Director. The Maintenance Director member currently could not provide any documentation indicating a monthly churn test was done. The Maintenance Director stated that he did not test the electric fire pump and relied on the quarterly and annual testing from the facility vendor. The Maintenance Director stated that he did not know a monthly test of the electric fire pump was required. The annual test for the electric fire pump was conducted on 10/12/21 by the facility fire sprinkler vendor. B. The surveyor interviewed the Maintenance Director at 11:30 AM, who acknowledged that he was unsure why the system was not inspected. The Maintenance Director could not provide documentation on when the five-year internal obstruction investigation of the fire sprinkler pipe was last conducted. The Maintenance Director called the facility fire sprinkler vendor, and they did not have any records as to when the inspection was last conducted by the end of the survey. NFPA 25 requires an internal inspection of the fire sprinkler system piping every five years; this needs to be conducted to inspect for the presence of foreign organic material that can cause obstructions to pipe and sprinklers. The Administrator was informed of the findings at the Life Safety Code exit conference on 3/10/22. NJAC 8:39-312(e) NFPA 101, 2012 Edition, Section 19.3.5.1, 4.6.12 and 9.7.5 NFPA 25,	K 353	3. Maintenance director was in-serviced on ensuring that the five-year internal obstruction investigation is performed in a timely manner. 4. Maintenance director / designee will conduct a monthly audit x 3 months to ensure the five-year internal obstruction investigation is performed in a timely manner. Audits will be reviewed through the monthly QAPI process for the next three months.	

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K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363		5/9/22

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K 363	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/10/22, the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring that room doors will close and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was observed in 7 of 50 resident room door's and was evidenced by the following: On 3/10/22, during the building tour from 9:00 AM to 2:00 PM, the Surveyor and Maintenance Director, observed that the doors to resident rooms, did not latch into the door frame in the following room numbers: # 28- hardware malfunction. # 25- missing latch # 23- door does not completely close into the frame assembly leaving a 1/2" to 3/4" gap # 21- 1/4" gap at the to of the door # 19- five door hooks installed on the top of the door (preventing the door from closing into its frame) # 18- door sticks into the frame # 60- door will not latch into the frame (hardware issue) An interview was conducted with the Maintenance Director, who stated and confirmed that the above resident room doors, had hardware issues and door frames that prevented the doors from	K 363	1. Doors # 28, 25, 23, 21, 19, 18 and 60 were fixed by 5/9/22. 2. All residents have the potential to be affected by this deficient practice. 3. Maintenance director was in-serviced on ensuring doors in the facility are able to resist the passage of smoke by closing and latching appropriately. 4. Maintenance director / designee will conduct weekly audits x 3 months to ensure doors in the facility are able to resist the passage of smoke by closing and latching appropriately. Audits will be reviewed through the monthly QAPI process for the next three months.	

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K 363	Continued From page 9 latching properly. The Administrator was informed of the finding at the Life Safety Code exit conference on 3/10/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 521 SS=E	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: Based on observation and interview on 3/10/22, in the presence of the facility Maintenance Director, it was determined that the facility failed to ensure resident bathroom ventilation systems for 34 of 47 units were adequately maintained, in accordance with the National Fire Protection Association (NFPA) 90 A, B. This deficient practice was evidenced by the following: The Surveyor and Maintenance Director observed that the ventilation in the following resident room bathrooms did not function: # 20, 21, 23, 24, 25, 26, 27, 28, 29, 30, 31, 61, 62, 102, 103, 104, 105, 106, 107, 108, 109, 110,	K 521	1. The ventilation systems for the bathrooms in rooms: 20, 21, 23, 24, 25, 26, 27, 28, 29, 30, 31, 61, 62, 102, 103, 104, 105, 106, 107, 108, 109 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, and 122 were fixed and are in working order. 2. All residents have the potential to be affected by this deficient practice. 3. Maintenance director was in-serviced on ensuring there are working ventilation systems in place for bathrooms in the facility. 4. Maintenance director / designee will conduct weekly audits x 3 months to	5/21/22

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K 521	Continued From page 10 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121 and 122. The surveyor requested that the Maintenance Director, confirm if the units were functioning by placing a piece of single-ply toilet tissue paper across the ceiling grills to confirm ventilation. When tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. At that time, the surveyor interviewed the Maintenance Director who confirmed that the exhaust vents in the above resident room bathrooms, were not functioning when tested. The Administrator was informed of this deficiency at the Life Safety Code exit conference on 3/10/22. NFPA 90 A NFPA 101-2012 -19.5.2.1 section 9.2.2 NFPA 101-2012- 19.5.2.1 Chapter 9.1 Utilities 9.2.1 NJAC 8:39-31.2(e)	K 521	ensure the bathroom ventilation systems are in working order. Audits will be reviewed through the monthly QAPI process for the next three months.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted	K 712		3/22/22

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K 712	Continued From page 11 between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview on 3/9/22, it was determined that the facility failed to ensure that fire drills were conducted at varied/unexpected times as evidenced by the following: A review of the facility's fire drill reports at 10:00 AM from 2/24/22 to 3/26/21 (12-months), revealed that fire drills were conducted to close to each other on 3 of 3 shifts as follows: Fire Drills SHIFT's DATE 7-3 3-11 11-7 2/24/22 *5:55 PM 1/27/22 *12:30 PM 12/8/21 *1:40 AM 11/18/21 *5:50 PM 10/12/21 10:55 AM 9/26/21 *12:50 AM 8/22/21 7:45 PM 7/23/21 *11:50 AM 6/30/21 *12:50 AM 5/26/21 *5:50 PM 4/29/21 *12:45 PM 3/26/21	K 712	1. A fire drill was conducted on 3/22/22 at a varied / unexpected time. 2. All residents have the potential to be affected by this deficient practice. 3. Maintenance department and the fire drill company were educated on the need to ensure that the fire drills are conducted at varied / unexpected times. 4. Maintenance director / designee will conduct monthly audits x 3 months to ensure the fire drills are conducted at varied / unexpected times. Audits will be reviewed through the monthly QAPI process for the next three months.	

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K 712	Continued From page 12 2:15 AM * indicates drills must be conducted at varied/unexpected times. The facility's Maintenance Director acknowledged this finding in an interview, during the fire drill record review on 3/9/22. The facility's Administrator was verbally informed of this finding during the Life Safety Code exit conference on 3/10/22. This deficiency was also cited on 11/14/2019. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.7.1.4 through 19.7.1.7	K 712		
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 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual	K 918		5/21/22

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K 918	Continued From page 13 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 the facility did not ensure a remote manual stop station for the generator was provided in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents. On 3/10/22, the Surveyor, Maintenance Director and Administrator observed that the facility generator was outside and encased. Further observation revealed that there was no remote manual stop station to prevent inadvertent or unintentional operation. An interview was conducted during the observation with the Maintenance Director and Administrator, where they both stated that at the time of observation, the area was observed not to have a remote manual stop station.	K 918	1. A remote manual stop station for the generator will be installed. 2. All residents have the potential to be affected by this deficient practice. 3. Maintenance director was in-serviced on ensuring there is working remote manual stop station for the generator. 4. Maintenance director / designee will conduct weekly audits x 3 months to ensure the remote manual stop station on the generator is in working condition. Audits will be reviewed through the monthly QAPI process for the next three months.	

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K 918	Continued From page 14 The Administrator was informed of the finding at the Life Safety Code exit conference on 3/10/22. 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		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315137 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/31/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BARN HILL CARE AND REHAB CENTER	249 HIGH STREET NEWTON, NJ 07860

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 K0291	03/30/2022	LSC K0293	03/30/2022	LSC K0341	03/16/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	03/28/2022	LSC K0363	05/09/2022	LSC K0521	05/21/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0712	03/22/2022	LSC K0918	05/21/2022	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	
3/10/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO