STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315064	A. BUILDING _____ B. WING _____	C 12/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBROOK CARE & REHABILITATION CENTER	**1610 RARITAN ROAD SCOTCH PLAINS, NJ 07076**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaints#: NJ00165821, NJ00165614, and NJ00164563 Survey Date: 12/15/23 Census: 98 Sample: 20 (sample) + 3 (Closed Records) + 24= 47 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on the interview and review of medical records, it was determined that the facility failed to consistently treat resident personal finances and resident mail in a respectful and accountable manner. This deficient practice was observed for one (1) of the 20 residents reviewed (Resident #17).	F 557	F557- RESPECT, DIGNITY/RIGHT TO HAVE PERSONAL PROPERTY CORRECTIVE ACTIONS FOR THOSE AFFECTED: Resident # 17 belongings that were purchased for were immediately brought	1/15/24

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

Electronically Signed | 01/05/2024

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

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F 557	Continued From page 1 This was evidenced by the following: On 12/01/23 at 12:00 PM, the surveyor requested a line list of the facility's Personal Needs Account (PNA) and the surety bond account information. On 12/06/23 at 9:07 AM, the surveyor observed Resident #17 in bed getting ready to be washed and bathed by his/her assigned EX Order 26.4B1 aid. The surveyor reviewed the medical records of Resident #17. Resident's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to EX Order 26.4B1 [redacted] The Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate the management of care with assessment reference date (ARD) EX Order 26.4B1 showed that the resident's Brief Interview for Mental Status (BIMS) score was EX Order of 15 which reflected that the resident's EX Order 26.4B1 .	F 557	up to the room. Packages were opened at resident's bedside by social worker. US FOIA (b)(6) and activity staff were inservised immediately about the process of delivering and ensuring that residents orders are delivered to them in a timely manner. ID OTHERS WITH THE POTENTIAL TO BE AFFECTED ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED BY THIS DEFICIENT PRACTICE. 1. All residents that have any item ordered for them were spoken to, to ensure they received their orders in a timely manner 2. All activity staff and US FOIA (b)(6) inserviced on the process of recieving and delivering resident's packages/mail. SYSTEMIC CHANGES 1. All residents orders placed by Social Worker or activity staff will be reviewed during morning meeting. 2. Staff member who ordered for any resident will report during the morning meeting when the order is received and delivered to the resident.	

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F 557	Continued From page 2 A review of the quarterly statement dated [redacted] for Resident #17 revealed an account balance of [redacted]. The surveyor reviewed the PNA line list with balances as of [redacted], provided by the [redacted], and showed that the resident had a balance of [redacted]. A review of the provided documents by the [redacted]) included the resident's most recent account statement which revealed a "clothing" deduction on [redacted] of [redacted]. After the clothing deduction, the account balance was [redacted] for Resident #17. On 12/12/23 at 08:50 AM, the surveyor interviewed the [redacted]) who was responsible for checking if the resident received items purchased for them by the facility. The [redacted] stated, "Everyone can receive a package for them, nursing, central supply, and activities." The surveyor asked if those departments had access to the receipts for the items purchased. The [redacted] stated, no, only I have access. The surveyor asked if any items had been received yet for such a large ([redacted]) purchase. The [redacted] responded, "I am not sure." On 12/12/23 at 9:00 AM the surveyor reviewed an itemized bill, dated [redacted] provided by the [redacted]. The bill included [redacted] items in total. The items consisted of clothing, personal lift chair, and a television. On 12/12/23 at 9:15 AM, the surveyor and the	F 557	MONITORING 1. Social Worker will audit purchasing orders for residents weekly and report findings to the Administrator and Director of Nursing for eight weeks. 2. Trends will be reported by the Social Worker at the monthly Quality Assurance meeting for 2 months and quarterly at the Quality Assurance Performance Improvement (QAPI) meeting for two quarters	

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F 557	Continued From page 3 US FOIA went to the resident's room to check if the product that was ordered worth EX Order 26.4B1 was delivered and received by the resident. Both the surveyor and the US FOIA did not find the item that was purchased for the resident. The surveyor then asked the US FOIA who was responsible and accountable for the resident's mail and order processing, and the US FOIA responded, "I guess I am the one that should check it. " On 12/12/23 at 9:48 AM, the surveyor and the US FOIA (b)(6)) went to the storage to locate Resident #17's . On that same date at 9:52 AM, the surveyor and the US FOIA (b) entered the storage room with the US FOIA (b)(6)). The US FOIA (b) stated the invoice was attached to the box. The US FOIA (b) further stated, "I do not handle personal packages." The US FOIA (b) indicated that the packing slip for personal items was left in the recreation mailbox and they handled the boxes. On that same date and time, the surveyor asked how two large boxes were put in the central supply department. The US FOIA (b) stated," The packing slip said blankets and I thought it was from a supply vendor. When I saw it was for a resident, I brought it to the US FOIA (b)(6 attention. The US FOIA (b)(6)) and/or US FOIA look to check the receipt of the products. I don't know the process of what they do with it. I just know it is not for me to deal with it." The surveyor asked when the packages were delivered and moved to the basement? The US FOIA (b) stated, "he was unsure of the delivery date." The surveyor asked how long the residents' mail was locked up in central	F 557		

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F 557	Continued From page 4 supply. The [redacted] stated he was not sure. On 12/12/23 at 10:18 AM, the surveyor interviewed the [redacted]) who stated, "The process when a package is delivered it is received at the front desk the activities pick up and delivers to the resident. if it is a large package with furniture or something that needs to be built or hung maintenance will build it in the basement, inspect it to see if it is working then install it in the resident's room. The receipt should come with the delivery, follow up in the clinical meeting each dept head would be asked if there has been a delivery for the resident." A review of the policy Personal Privacy-Residential Mail original date 1/2012, Reviewed 11/2017, 9/2022, 9/2023 the Policy indicated, "It is the practice of this facility to respect our 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 the postal service." Under the section "Policy Explanation and Compliance Guidelines" it further indicated. 1. A facility designee will receive the mail, letters, packages, and other materials addressed to current residents in the facility. 2. The facility designee will refer to the resident mail disposition form when sorting resident mail, letters, packages, and other materials delivered to the facility for the resident. a.) All resident mail, letters, and packages will be	F 557		

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F 557	Continued From page 5 distributed promptly by the facility designee to alert the oriented residents. 4. The US FOIA (b)(6) /designee will maintain a US FOIA (b)(6)) of all current residents of the facility. will be reviewed quarterly as needed. On 12/13/23 at 01:00 PM, the survey team discussed their concerns with the US FOIA (b)(6) . The facility management stated they had no new comments or items to provide to the survey team.	F 557		
F 584 SS=E	NJAC 8:39-4.1 (a)(12)(15) Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary,	F 584		1/20/24

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F 584	Continued From page 6 orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to provide the residents with a safe, comfortable, clean, and homelike environment. This deficient practice was identified in 11 out of 17 resident rooms and one (1) of one (1) shower room observed during environmental rounds. This deficient practice was evidenced by the following: On 12/05/23 at 10:39 AM, the surveyor observed the [EX Order 26.4B1] care treatment of Resident # 39 that was done by the [US FOIA (b)(6)]) and was assisted by the [US FOIA (b)(6)] . The [US FOIA (b] performed handwashing inside the toilet room, the toilet	F 584	F584: SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT CORRECTIVE ACTIONS FOR THOSE AFFECTED: 1. The toilet tissue paper holder dispenser for room [EX Orde] and [EX Orde] was replaced 2. Shower room vent with an accumulation of grayish substances was cleaned 3. Room [EX Ord] toilet tissue dispenser was fixed 4. Room [EX Orde] black phone on top of the	

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F 584	Continued From page 7 room was adjoined (a toilet room that is accessed from and used exclusively by the occupants of two adjacent sleeping units) and the toilet tissue paper holder dispenser was broken. The two rooms with the adjoined toilet were for rooms [redacted] and [redacted] Resident #39 was in room [redacted] After the [redacted] treatment, the [redacted] went outside the resident's room to throw the garbage inside the soiled room which was in front of the resident's room. Inside the soiled room was a sink where the [redacted] performed handwashing. Separated by a wall was a shower room with a shower vent that had an accumulation of grayish substances. On 12/06/23 at 9:21 AM, the surveyor and the [redacted] went to 17 resident rooms for environmental rounds of the [redacted] unit and revealed the following concerns for 11 resident rooms: Room [redacted]=toilet room had one of two toilet tissue dispensers broken. The [redacted] stated it should been fixed, not sure when it was broken and she will let housekeeping know about it. Room [redacted]=black phone on top of the overhead light. Resident#6 stated that the black phone was broken. The resident was unable to remember when the broken phone was on top of the overhead light, and the resident claimed that it was been a while. Room [redacted]=with an adjoined toilet room with Room [redacted], the toilet seat had a commode chair (designed to act as a second toilet seat). Both the surveyor and the [redacted] observed the commode chair with brownish substances around the area. The [redacted] stated that the brownish	F 584	overhead light was removed 5. Room [redacted] with adjoined toilet room with room [redacted] commode with brownish substance was removed and replaced with another one. 6. Room [redacted] with adjoined toilet room with room [redacted] the two broken toilet tissue holders were replaced 7. Room [redacted] ceiling with the scattered brownish substances that extended into the residents closet upper door was cleaned 8. Room [redacted] with an adjoined toilet room [redacted] tissue holder dispenser was fixed 9. Room [redacted] which was empty the room was cleaned, scattered papers and tissues in the receptacle was emptied 10. Room [redacted] with an adjoined toilet to room [redacted] toilet tissue dispenser was replaced 11. Inservice all staff on reporting broken materials 12. Inservice housekeeping staff on proper cleaning ID OTHERS WITH THE POTENTIEL TO BE AFFECTED ALL RESIDENTS HAVE THE	

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F 584	Continued From page 8 substance was rust and not feces. Room [EX Ord]=with an adjoined toilet room with Room [EX Ord], the toilet room had two broken toilet tissue holders. Resident#12 in Room [EX Order 26.4b] ceiling had scattered brownish substances that extended into the resident's closet upper door. Resident #12 stated that the broken tissue holder and the brownish substances in the ceiling had been there since the resident moved into the room. The [US FOIA (b)(6)] stated that Resident#12 was [NJ Ex Order 26.4b1]. During an interview with the [US FOIA (b)(6)], the [US FOIA (b)(6)] stated that "I don't know" why the ceiling had brownish substances and was not sure what was that and indicated that it should have been cleaned. Shower Room ([EX Order 26.4] unit)=the exhaust (or vent) in the shower area was observed with an accumulation of grayish substances in the presence of the [US FOIA (b)(6)] and the [US FOIA (b)(6)] This was the second time that the surveyor observed the vent with accumulation of grayish substances. [US FOIA (b)(6)] stated that he was responsible for cleaning the shower room daily including the vent which was noted with grayish substances which he claimed were dust. [US FOIA (b)(6)] further stated that the look of it, it had been there a week. The surveyor asked the [US FOIA (b)(6)] if he was responsible for cleaning the shower room including the vent daily why there was an accumulation of dust for a week and the [US FOIA (b)(6)] had no answer. Room [EX Order] with an adjoined toilet room with Room [EX Order] the tissue holder dispenser was broken. Room [EX Ord]=the [US FOIA (b)(6)] informed the surveyor that the room had been empty (which means that no resident was occupying the room) for a week	F 584	POTENTIAL TO BE AFFECTED BY THIS DEFECIENT PRACTICE 1. All housekeeping staff inservice on proper cleaning of the room 2. All staff inserviced on reporting broken devices SYSTEMIC CHANGES 1. Five rooms will be checked every other day for cleanliness, and broken material by housekeeping director x4 weeks. 2. Maintenance log will be reviewed during morning meeting 3. All staff Inservice on reporting broken equipment, material 4. The Administrator, Maintenance Director, Housekeeping Director will make rounds once a week. IV. MONITORING 1. The housekeeping director will audit 10 rooms and report findings to the Administrator and Director of Nursing weekly for eight weeks. 2. Maintenance director will audit all work orders and report his findings to the Administrator and Director of Nursing for	

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F 584	Continued From page 9 now. The toilet room had scattered papers and tissues and the garbage receptacle with tissues. The surveyor asked the US FOIA (b)(6) if the room had been empty for a week, and why the toilet room was not clean. The US FOIA (b)(6) stated, "I don't know." Room EX Ord =with an adjoined toilet room with Room EX Ord, the toilet tissue dispenser was broken, and the call light system (rectangular box) connected to the call bell string was not properly installed to the wall. The US FOIA (b)(6) stated that it should fixed to the wall and "probably" it was due to too much pulling of the string when it was being used. On 12/11/23 at 9:34 AM, the survey team met with the US FOIA (b)(6)). The US FOIA (b)(6) stated that there were broken toilet tissue dispensers and there was a non-functional toilet tissue dispenser due to the wrong size of toilet paper. The US FOIA (b)(6) further stated that the toilet commode found in one of the residents' adjoined toilet rooms that were rusty was immediately replaced. He also stated that in room EX Order the call bell that was loose from the wall was fixed and now stable. In addition, the US FOIA (b)(6) informed the surveyor that the housekeeping checklist was revised to add the toilet dispenser as part of the responsibility and accountability for checking the environment. On that same date and time, the US FOIA (b)(6) acknowledged that the shower room in the EX Order 26:4B wing unit vent was cleaned after the surveyor's inquiry. The US FOIA (b)(6) and the facility management acknowledged the above findings and concerns of the surveyor.	F 584	eight weeks 3. Administrator will report all findings during the Quality Assurance monthly meeting x3. 4. The Maintenance director and housekeeping director will report all trends to the Quality Assurance Committee during the quarterly meetings for two quarters.	

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F 584	Continued From page 10 At that same time, the surveyor asked the facility management what happened and why the above findings happened if the facility had a checklist on what to do. The US FOIA (b)(6) stated that it was missed, and the US FOIA (b)(6) should have reported all broken equipment and supplies on a day-to-day basis. A review of Resident #12's medical records showed that the resident was moved to Room EX Order 2E on [redacted] and currently remained in the same room. Room EX Order 2E was the room with scattered brownish substances in the ceiling and closet door. A review of the undated facility's Resident Room Cleaning Policy that was provided by the US FOIA (b)(6) included that the purpose was to provide a detailed description of the steps that are to be completed daily in the cleaning of a resident room. Daily cleaning will ensure optimum levels of cleanliness and sanitation, prohibit and control the spread of infection and bacteria, and maintain the outward appearance of the facility. On 12/14/23 at 02:00 PM, the survey team met with the US FOIA (b)(6) [redacted] for an Exit Conference. The facility management did not provide additional information and did not refute findings. NJAC 8:39-31.2 (e), 31.4(a)(f)	F 584		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609		12/16/23

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F 609	Continued From page 11 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #NJ00165614 #NJ00165821 Based on interviews, a review of medical records (MR), and other facility documentation, it was determined that the facility failed to report an NJ Exec Order 26.4b1 to the New Jersey Department of Health (NJDOH) in the required	F 609	F609 REPORTING OF ALLEGED VIOLATIONS CORRECTIVE ACTION FOR THOSE AFFECTED Resident #17 was assessed and NJ Exec Order 26 [redacted] from this deficient	

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F 609	Continued From page 12 timeframe for one (1) of two (2) sampled residents, (Resident #17). This deficient practice was evidenced by the following: On 12/02/23 at 10:00 AM, the surveyor asked the US FOIA (b)(6) for a copy of Resident #17's Incident/Accident and Reportable (I/A & R) reports for the NJ Exec Order 26.4b1 and the US FOIA (b)(6) stated that he will get back to the surveyor. A review of the Complaint/incident investigative report revealed an NJ Exec Order 26.4b1; Complaint # NJ00165614 reflected an alleged event date on NJ Exec Order 26.4 at 01:45 PM and intake receive date of NJ Exec Order 26. at 4:23 PM from the supervising US FOIA (b)(6) listed as source "other healthcare provider." The facility reported an NJ Exec Order 26.4b1 reflected an NJ Exec Order 26. event date of EX Order 26.4B1 and an intake receive date of EX Order 26.4B1 after the resident was readmitted to the facility from the hospital and complaint #NJ00165614 was known to the facility. A review of the reportable event record report provided by the US FOIA (b)(6) on NJ Exec Order 26.4b1 revealed the event date EX Order 26.4B1, called in marked 'NJ Exec O date of EX Order 26.4B1. It also included a fax submission date of EX Order 26.4B1 to the complaint department of NJDOH. Further review of the reportable event record report provided by the US FOIA (b)(6) on EX Order 26.4B1	F 609	practice. All future possible reportable will be reported to Department of Health, while the investigation is being conducted within the required timeframe. US FOIA (b)(6) Inservice on reporting any allegation of abuse/neglect immediately All allegations of abuse/neglect will be reported immediately to the Department of Health ID OTHERS WITH THE POTENTIEL TO BE AFFECTED ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED BY THIS DEFECIENT PRACTICE a. All staff inservice about the importance of reporting any allegation of abuse or neglect in a timely manner. SYSTEMIC CHANGES All reportable will be reported by the Administrator, if the administrator is not available, the Director of Nursing will do the reporting. In the event neither the Administrator or the Director of Nursing are not available the Assistant Director of Nursing will report to the Department of Health. Once reported all investigation	

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F 609	Continued From page 13 revealed an event dated [redacted]. The investigation report revealed that the resident was found to have [redacted] on his/her pillowcase. Upon further inspection by the nurse, the resident was found to have a [redacted] above his/her [redacted] with an [redacted] that occupied the [redacted] The resident had complaints of [redacted]. The resident was taken by a medical transport team with EMTs to an acute care hospital and was admitted from [redacted]. The surveyor reviewed the medical records of Resident #17. Resident's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; [redacted] The Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate the management of care with assessment reference date [redacted] showed that the resident's Brief Interview for Mental Status (BIMS) score was [redacted] out of 15 which reflected that the	F 609	information will be placed in a red folder in the Administrator's office. MONITORING The administrator and Director of Nursing will audit all reportable the day of the event to ensure that its reported on time and review in clinical meeting weekly for four weeks. All findings will be reported at the monthly quality assurance meeting for three months. Trends will be reported by Director of Nursing to the Quality Assurance Performance Improvemnet Committee quarterly for 2 quarters.	

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F 609	Continued From page 14 resident's NJ Exec Order 26.4b1. On 12/12/23 at 11:18 AM, during an interview with the US FOIA (b)(6) about the process of handling I/A & R and grievances the US FOIA (b)(6) stated, "The staff would initiate the incident form and it would be given to the US FOIA (b)(6), the US FOIA (b)(6) or the US FOIA (b)(6) NJ Exec Order 2 and NJ Exec Order 26. would fall under me." He further explained, "An NJ Exec Order 26.4b1 should be reported within two (2) hours to the NJDOH. The investigation should be reported within 24 hours and at the conclusion." At that time, the surveyor asked, why it was not reported within the timeframe per the regulation. The US FOIA (b)(6) stated, "They did not find it to be NJ Exec Order 26.4b but they reported it on EX Order 26.4B1 to air on the side of caution." The surveyor asked, did you know where the EX Order 26.4B1 came from or was it an EX Order 26.4B1 ? The US FOIA (b)(6) stated, "We didn't know where the EX Order 26.4B1 was from, we logically assumed it was a EX Order 26.4B1 from the resident himself." The surveyor proceeded to ask, if it was NJ Exec Order 26.4b1, should it have been called in within the 2-hour time frame? The US FOIA (b)(6) responded, "Yes." The surveyor reviewed the investigation report. The Ombudsman's office was notified of the incident on NJ Executive Orde via fax. On 12/13/23 at 10:21 AM, the survey team met with the new US FOIA (b)(6) The surveyor notified the facility management of the above findings that	F 609		

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F 609	Continued From page 15 the facility did not report the in[NJ Exec Order 26.4b1] [redacted] in a timely manner. A review of the "Incidents/Accident Reporting" policy dated original 01/2012 and REV (reviewed) dates of 2/14, 5/2019, 9/2020, 9/2022, 9/2023, provided by the [US FOIA (b)(6)] [redacted] included that the policy explanation and compliance guidelines revealed #4, "In case of incidents or injury of unknown etiology, an investigative report of injury of unknown origin and investigative report for skin tear/bruise of unknown etiology are completed as needed." A review of the "Abuse, Neglect and Exploitation" policy dated original 01/2012, REV 11/2017, 11/2019, 9/2021, 9/2022, and 9/2023 provided by the [US FOIA (b)(6)] [redacted] included the following: ~The section of the policy labeled "definitions" reads; "Neglect" means failure of the facility, its employees, or service providers to provided goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. ~The section of the policy labeled "policy explanation and compliance guidelines" reads; #2) The administrator/designee is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with the state law. #3) the facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. ~The section of the policy labeled "identification of abuse, neglect and exploitation" reads; B. Possible indicators of abuse include but are not limited to #8) failure to provide care needs	F 609		

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F 609	Continued From page 16 such as feeding, bathing, dressing, turning, and positioning. ~The section of the policy labeled VII "Reporting / Response" reads; A. #1) Reporting of all alleged violations to the administrator, state agency, adult protective services and to all other required agencies within specified timeframes: a.) immediately, but not later than (2) two hours after allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or b.) not later than (24) twenty-four hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. B. The administrator will follow up with government agencies, during business hours to confirm the initial report was received, and to report the results of the investigation when final with in (5) five working day of the incident, as required by state agencies. On 12/14/23 at 02:00 PM, the survey team met with the US FOIA (b)(6) [redacted] for an Exit Conference and there was no additional information provided by the facility management.	F 609		
F 645 SS=D	NJAC 8:39-13.4(c)(2)(v) PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:	F 645		1/20/24

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F 645	Continued From page 17 (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a	F 645		

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F 645	Continued From page 18 hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to accurately complete and update a NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4b1 to include all diagnoses to ensure the resident was referred to the appropriate state-designated authority for NJ Exec Order 26.4b1 evaluation and determination. This deficient practice was identified for one (1) of (2) two residents (Resident #18) reviewed for NJ Exec Order 26.4b1 and was evidenced by the following: On 12/01/23 at 10:41 AM, during the initial tour, the surveyor observed Resident #18 laying in bed, NJ Exec Order 26.4b1 with a bed sheet from NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 that were placed on	F 645	F645 PASARR SCREENING FOR MD AND ID I. CORRECTIVE ACTION FOR THOSE AFFECTED US FOIA (b)(6) reevaluated resident #18 and completed a new NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 [redacted]) Appropriate referrals were made US FOIA (b)(6) [redacted]	

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F 645	Continued From page 19 both sides of the bed. . The surveyor reviewed the medical record for Resident #18. According to Resident #18 Admission Record (or Face Sheet, an admission summary) the resident was admitted to the facility with the diagnoses that included but were not limited to EX Order 26.4B1 [redacted] The quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated EX Order 26.4B1 reflected a Brief Interview for Mental Status (BIMS) score of EX Ord out of 15, which indicated that the resident was EX Order 26.4B1. A review of the admission MDS, dated EX Order 26.4B1, reflected the resident had EX Order 26.4B1 [redacted] The resident had NJ Exec Order 26.4b1 score of EX Orde, which indicated the resident had EX Order 26.4B1. The surveyor reviewed the NJ Exec Order 26.4b1 NJ Exec Order 26 dated EX Order 26.4B1, does the individual have diagnoses or evidence of NJ Executive Order to	F 645	were Inservice immediately Facility wide audit completed II. ID OTHERS WITH THE POTENTIEL TO BE AFFECTED ALL RESIDENTS ADMITTING TO THE FACILITY FOR MORE THAN 100 DAYS HAVE THE POTENTIAL TO BE AFFECTED BY THIS DEFECIENT PRACTICE III. SYSTEMIC CHANGES Admission will ensure that all residents been admitted to the facility will be admitted with a completed and accurate PASARR. All new admission PASSAR will be reviewed by Sacial Worker during the 72 hours admission meeting. If the resident is admitted without a PASARR, facility Social Worker will complete one by reviewing resident's medical records, interviewing the resident if appropriate, or family member. At the time if the PASARR Level I is positive, Social Worker will make appropriate referrals to an independent Psychiatrist to complete PASARR Level II Once both Level I and Level II PASARR	

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F 645	Continued From page 20 the following disorders: EX Order 26.4B1 [redacted]? According to the question asked, the facility US FOIA documented on the form that the resident did not have any EX Order 26.4B1 diagnoses. A review of an office visit progress note dated EX Order 26.4B1, revealed the resident saw a US FOIA (b)(6) and had taken EX Order 26.4B1 (EX Order 26.4B1 EX Order 26.4B1 used to treat EX Order 26.4B1). A review of the US FOIA (b)(6) Progress Note dated EX Order 26.4B1, revealed the resident was diagnosed with the following: EX Order 26.4B1 [redacted] On 12/12/23 at 01:36 PM, the surveyor interviewed the US FOIA (b)(6) [redacted]) who stated that she encouraged hospitals to complete the NJ Exec Order 26.4b1 prior to admission to the facility and in the event, the resident was admitted without it, she then created one for the resident. The US FOIA (b) also stated she never updated the NJ Exec Order 26.4b1 NJ. At that time, the US FOIA (b) explained that she checked the NJ Exec Order 26.4b1 for accuracy of name, social security, date of birth, demographics, and for NJ Exec Order 26.4b1 Based on the answers on section 2, we determine the result	F 645	are completed the Social Worker will then send it to either the Department of Developmental Disabilities (DDD), or Department of Mental Health Services (DMHS). If the Social Worker does not receive a response from the appropriate division, a follow-up inquiry will be made via email, or phone call. IV. MONITORING Social Worker will review all new admission PASARR and report during Clinical meeting on Monday, Wednesday, and Friday x four weeks. Social Worker will report at the monthly Quality Assurance Performance Improvement x 2 months. Trends will be reported quarterly x 2 quarters to the Quality Assurance Performance Improvement Committee.	

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F 645	Continued From page 21 [positive/negative screen]. The [US FOIA (b)] stated that for section [NJ E] she answered the [ ] against the resident's diagnosis. At that time, the [US FOIA (b)] stated that there was no process or flag to update the [NJ Exec Order 26.4b1] The [US FOIA (b)] also stated "I am not sure if there is a process to update the [NJ Exec Order 26.4b1] I do not know when and if I have to update the [NJ Exec Order 26.4b1] On 12/13/23 at 11:26 AM, the surveyor and the new [US FOIA (b)(6)] reviewed the record for the resident. At that time the new [US FOIA (b)] stated that section [NJ] was answered by the [US FOIA (b)] inaccurately and that the resident should have been a [NJ Exec Order 26.4] screen for [EX Orde] as opposed to [NJ Exec Order 26.4b1] screen. At that time, the [US FOIA (b)] could not determine if the resident should have been referred to the appropriate state-designated authority for [NJ Exec Order 26] evaluation and determination. At that time, the new [US FOIA (b)] could not explain if the facility had a process or procedure for the [US FOIA (b)] to follow. The [US FOIA (b)] stated she would get back to the surveyor after investigating the concern. On 12/14/23 at 9:54 AM, in the presence of the survey team, the [US FOIA (b)(6)] stated she sat down with the [US FOIA (b)] and went over the [NJ Exec Order 26.4b1] for the resident. The [US FOIA (b)] stated that the [US FOIA (b)] acknowledged that the [NJ Exec Order 26.4b1] for	F 645		

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F 645	Continued From page 22 Resident #18 was inaccurate. The [redacted] stated the [redacted] did not have a process that she followed and the [redacted] was unable to state why. At that time, the [redacted] stated that they had created a process yesterday for the [redacted] to follow. The [redacted] further stated that I sat with the [redacted] and we updated Resident #18's [redacted] and she referred the resident to the appropriate state-designated authority for [redacted] evaluation and determination. "We initiated a Quality Assurance Performance for Improvement (QAPI) with the objective to follow the correct process and create an accurate [redacted] A review of the facility's Coordination with PASARR Program, dated on 9/20/23 revealed under Policy Explanation and Compliance Guideline 1 All applicants to this facility will be screened for serious mental disorder or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. 6. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority. 9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or related condition will be referred promptly to the state mental health or intellectual disability authority for a level 2 resident review. NJAC 8:39-11.2(i), 27.1(a)	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F 656		1/20/24

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F 656	Continued From page 23 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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	315064	A. BUILDING _____ B. WING _____	C 12/15/2023

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F 656	Continued From page 24 section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of medical records and facility documents, it was determined that the facility failed to update the resident's plan of care with new interventions. This deficient practice was identified for one (1) of 20 residents (Resident #17) reviewed for [redacted] and assistance of daily living (ADL) and was evidenced by the following: On 12/06/23 at 9:07 AM, the surveyor observed Resident #17 in bed getting ready to be [redacted] and [redacted] by his/her assigned [redacted] aid. The surveyor reviewed the medical records of Resident #17. Resident's Admission Record (or face sheet; admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to: [redacted]	F 656	F656 DEVELOP/IMPLEMENT COMPREHENSIVE CARE PLAN I. CORRECTIVE ACTIONS FOR THOSE AFFECTED: 1. The care plans for resident #17 were reviewed and updated immediately to include a plan of care related [redacted] 2. Staff members were in serviced on updating care plans immediately when residents are admitted/readmitted to the facility or any change in conditions. II. ID OTHERS WITH THE POTENTIAL TO BE AFFECTED: ALL RESIDENT CARE PLANS HAVE THE POTENTIAL TO BE AFFECTED. 1. All care plans of residents that were readmitted to the facility were reviewed for complete and accurate documentation of interventions. No missing plans of care were identified. 2. Unit managers were in-service on related assessment, documentation, and care planning.	

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F 656	Continued From page 25 EX Order 26.4B1). The Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate the management of care with assessment reference date (ARD) EX Order 26.4B1 showed that the resident's Brief Interview for Mental Status (BIMS) score was EX Ord out of 15 which reflected that the resident's EX Order 26.4B1 A review of the reportable event record report provided by the US FOIA (b)(6) on NJ Exec Order 26.4b1 revealed an event dated The investigation report revealed that the resident was found to have EX Order 26.4B1 Upon further inspection by the nurse, the resident was found to have a EX Order 26.4B1 with an EX Order 26.4B1 that EX Order 26.4B1. The resident had complaints of EX Order 26.4B1. The resident was taken by medical transport to an acute care hospital and was admitted from EX Order 26.4B1 The facility's internal investigation concluded that the ADL care plan was updated with a new intervention "involve the family in plan of care, reach out to [family member] via phone call" NJ Exec Order 26.4 by the US FOIA (b)(6)). The investigation also included that the resident had EX Order 26.4B1 A review of the resident's person-centered care plan (CP) revealed that a focus on NJ Exec Order 26.4b1 was initiated on EX Order 26.4B1 for EX Order 26.4B1. The revision dates were EX Order 26.4B1 and EX Order 26.4B1 No new interventions were added. The last dated revision was on EX Order 26.4B1 for interventions, which was "refer to NJ Exec Order	F 656	3. All nurses in-serviced on care planning and updating care plans as changes occurred quarterly and individually on specific issues as areas of necessary improvement are identified. III. SYSTEMIC CHANGES: 1. All care plans will be reviewed quarterly during care plan meetings for complete, thorough and accuracy by the intradisciplinary team. 2. Unit Managers will do care plan audits for residents with special needs weekly and the findings will be reported to the Director of Nursing and Assistant Director of Nursing. 3. Assistant Director of Nursing will audit Care Plan monthly for three months. 4. All nurses and members of the IDCP team will be in-service on care planning and updating care plans as changes occurred quarterly and individually on specific issues as areas of necessary improvement are identified. IV. MONITORING: 1. The Unit Managers will audit 10 care plans of residents weekly and report their findings to the Director of Nursing x4 weeks. 2. The Assistant Director of Nursing will	

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F 656	Continued From page 26 department for proper use of EX Order 26.4B1." There was not a new intervention for EX Order 26.4B1 and EX Order 26.4B1 as stated in the "Reportable Event Record/ Report" investigation from the facility dated EX Order 26.4B1. Further review of the above personalized CP showed that the original CP already had an intervention "involve the family in plan of care" as an intervention written on EX Order 26.4B1. The "Reportable Event Record/ Report" investigation dated EX Order 26.4B1 did not include statements by nursing on why the original plan of care intervention to involve the family in the plan of care was not being followed. Furthermore, the resident's person-centered CP revealed that a focus of ADL: NJ Exec Order 26.4b1 was initiated on EX Order 26.4B1 Goal revealed Resident will have NJ Exec Order 26.4b1 met by staff x NJ Ex days. The revision dates were EX Order 26.4B1 EX Order 26.4B1, EX Order 26.4B1 and EX Order 26.4B1. No new interventions were added to alter the outcome until Ex Order 26.4B1 A review of the resident's person-centered CP revealed that a focus on EX Order 26.4B1 was initiated on EX Order 26.4B1 On 12/07/23 at 10:24 AM, during an interview with the contracted EX Order 26.4B1 nursing aid, she stated that she has a NJ Exec Order 26.4b1 with the resident, and the resident allows her to NJ Exec Orde and NJ Exec Orde the resident's hair. She further stated that the resident was not Ex Order 26.4B1 with her. She indicated that the resident did have a EX Order 26.4B1, but it was NJ Exec Order 26 NJ Exec Order 2	F 656	report the trends noted and related interventions to the Administrator, Director of Nursing and Quality Assurance Committee at the quartley Quality Assurance Performance Improvement (QAPI) meeting x2. 2. The Assistant Director of Nursing and Director of Nursing will audit care plans and the care plan meeting process bi-weekly and report their findings quarterly to the Administrator and Quality Assurance Committee at the quarterly Quality Assurance meetings x3.	

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F 656	Continued From page 27 On 12/07/23 at 11:41 AM, the surveyor interviewed the facility's US FOIA (b)(6) The US FOIA (b) stated, "The resident is okay, he/she has never been Ex Order 26.4B1 and Ex Order 26.4B1. The resident does Ex Order 26.4B1 at times. The US FOIA (b) further stated "You" just have to walk away and leave him/her alone, tell the nurse on duty, and document it on the resident's ADL sheet that the resident Ex Order 26.4B1 Ex Order 26.4B. On 12/14/23 at 12:52 PM, the surveyor interviewed the US FOIA (b)(6) The surveyor asked the US FOIA (b)(6) what was the purpose of updating the CP. The US FOIA (b)(6) stated, "It is to reflect the up-to-date plan of care for a patient, for recurring or new interventions that were identified and possible interventions that were exhausted and not working. The Interdisciplinary Department Team is to ensure all the care needed by the resident is captured and at that point, it should be reflected in the care plan. During that time interventions should be reviewed on the care plan and altered and updated to reflect any identified concerns and new interventions should be put in place. " A review of the Comprehensive Care Plan policy dated, 01/2012, 11/2017, 11/2019, 9/2021, 9/2022, and 9/2023 revealed "Person Centered Care Plan" definition means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives. It is further revealed under the section "Policy Explanation and Compliance Guidelines" ...	F 656		

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F 656	Continued From page 28 #1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the residents' personal and cultural preferences in developing goals of care. Services provided or arranged by the facility as outlined in the comprehensive care plan, shall be culturally and trauma-informed. #5. The comprehensive CP (CCP) will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. #6. The CCP will include measurable objectives and timeframes to meet the residents' needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented as needed. #7. The physician, other practitioner, or professional will inform the resident and /or resident representative of the risks and benefits of proposed care of treatment and treatment alternatives /options. The facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record including discussions with the resident and or resident representative. On 12/14/23 at 02:00 PM, the survey team met with the US FOIA (b)(6) [redacted] for an Exit Conference and there was no additional information provided by the facility management. NJAC 8:39-11.2 (e)	F 656		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		1/20/24

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F 686	Continued From page 29 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Complaint # NJ00164563 Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to a) evaluate and complete an assessment for a newly identified EX Order 26.4B1 (NJ Exec O [redacted] for one (1) of two (2) residents reviewed for [redacted] Ex Order 26.4B1 (Resident #299) according to standards of clinical practice and facility's policy and procedure, b) accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, for one (1) of two (2) residents reviewed for [redacted] (Resident #299), c) update the individualized care plan (CP) for one (1) of two (2) residents reviewed for [redacted] (Resident #299), d) clarify multiple treatments for [redacted] for one (1) of two (2) residents reviewed for [redacted] (Resident #299), e) ensure all incident reports were in the computer system in order to track and trend, and f) maintain infection control practices to reduce the risk of infection during a	F 686	F686 TREATMENT/SVCS TO PREVENT/HEAL PRESSURE ULCER I. CORRECTIVE ACTIONS FOR THOSE AFFECTED: 1. Resident #299 was discharged from the facility; no other residents were affected by this deficient practice. 2. Nurses staff educated on accurate wound assessment and documentation, US FOIA (b)(6) inservive on accurate coding. Nurses inservice on completion of incident report. 3. LPN#2 and US FOIA (b)(6) were Inservice immediately about proper handwashing, donning	

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F 686	Continued From page 30 NJ Exec treatment for one (1) of two (2) residents reviewed for NJ Exec (Resident #39). This deficient practice was evidenced by the following: 1) On 12/01/23 at 12:48 PM, the surveyor reviewed the closed medical record of Resident #299. Resident #299's Admission Record (AR or face sheet; admission summary) indicated that the resident was admitted to the facility with medical diagnoses that included but were not limited to; EX Order 26.4B1 A review of the Universal Transfer Form (UTF) dated EX Order 26.4B1 from the hospital to the facility indicated under NJ Exec O NJ Exec Order 26.4b1 that the resident had a EX Order 26.4B1 and the site was EX Order 26.4B1 EX Order 26. A review of Resident #299's readmission evaluation indicated that the resident had EX Order 26.4B1 here was no documentation to acknowledge that the UTF was reviewed or that the documented EX Order 26.4B1 that was documented on the UTF was not observed by the admission nurse.	F 686	and doffing of personal protective equipment, and storage of gloves 4. Resident # 39 was not affected NJ Exec Order 26.4b1 by the deficient practice of LPN#2 and US FOIA (b)(6). II. ID OTHERS WITH THE POTENTIAL TO BE AFFECTED: ALL RESIDENTS WITH WOUNDS HAVE THE POTENTIAL TO BE AFFECTED BY THIS DEFICIENT PRACTICE. 1. All residents with wounds were assessed and all wounds had treatments order place. 2. All staff Inservice on proper hand washing technique 3. Infection Preventionist to Inservice all nursing staff on treatment pass III. SYSTEMIC CHANGES 1. All admissions/readmissions will be assessed the next day post admission to ensure all wounds are identified and have a treatment order by Unit manager or assign nurse 2. Unit manager/assign nurse will report findings to Director of Nursing, or Assistant Director of Nursing.	

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F 686	Continued From page 31 A review of Resident #299's EX Order 26 Evaluation dated EX Order 26.4B1 indicated the resident had the following EX Order 26.4B1: EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1 A review of the Resident #299's EX Order 26 Evaluation dated EX Order 26.4B1 indicated the resident had the EX Order EX Order 26.4B1 and that the other EX Order 26 issue was EX Order 26.4B1. This assessment included the measurements. Review of the CP included the focus area of at risk for Ex Order 26.4B1 alteration r/t (related to) Ex Order 26.4B1 and refusing care at times with an initiated date of EX Order 26.4B1 1 included the following interventions: EX Order 26.4B1 apply NJ Exec Order 26.4b1 Monitor s/s (signs and symptoms) of such as EX Order 26.4B1 notify US FOIA (b)(6)); NJ Exec O evaluation weekly. There was no update to the CP to include a focus area of EX Order 26.4B1 impairment for the EX Order 26.4B1 and . A review of Resident #299's Discharge Return Anticipated MDS, dated EX Order 26.4B1, indicated the Brief Interview for Mental Status (BIMS) question was left blank. The NJ Exec Order 26.4b1 for NJ Exec Ord was coded NJ Exec Order 26.4b1 . Further review of EX Order 26.4B1	F 686	3. Infection Preventionist will do handwashing inservice to all staff, competency on handwashing for all staff. 4. MDS coordinator will review 5 completed MDS assessment during clinical meeting for accuracy x4 weeks 5. Director of Nursing will audit all incident report weekly x4 weeks IV. MONITORING 1. Unit managers will audit 5 residents with wounds to ensure there is treatment order for each wound weekly x4 weeks 2. Assistant Director of Nursing will audit resident with wounds orders bi-weekly and report findings to Administrator and Director of nursing monthly. 3. Trends will be reported to the Quality Assurance Committee at the quarterly meetings x 2 4. Infection Preventionist will report on treatment pass bi-weekly to the Administrator and Director of Nursing x 4weeks 5. Unit managers will audit 5 care plans of residents to ensure there are care plans in place weekly x4 weeks. 6. MDS coordinator will report all findings at the monthly QAPI x 2	

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F 686	Continued From page 32 Conditions indicated that Resident #299 did not have any [NJ Exec O] A review of Resident #299's Discharge Return Anticipated MDS, dated [EX Order 26.4B1] indicated the resident had two (2) [EX Order 26.4B1] and that one (1) of the two (2) was present upon admission/entry or reentry. The MDS was coded incorrectly. On 12/05/23 at 9:00 AM, the surveyor asked the [US FOIA (b)(6)] for any incidents and investigations that Resident #299 had since the last recertification survey. On 12/05/23 at 10:37 AM, the [US FOIA (b)(6)] provided the surveyor one incident report that was in the facility's risk management section of their computer system. Review of the incident provided was for a [EX Order] An incident report for the [EX Order 26.4B1] and later [EX Order 26.4B1] was not provided. A review of Resident #299's [EX Order 26.4B1] Scale for Predicting Pressure [EX Order 26.4B] Risk" dated [Ex Order 26.4B1] indicated on readmission the score was [EX Order] which indicated the resident was at risk. On 12/11/23 at 10:30 AM, the surveyor asked the [US FOIA (b)(6)] if Resident #299 had any other incidents or investigations. The [US FOIA (b)(6)] stated that she believed that the incident provided for the [Ex Order] was the only one but that she would double check. On 12/11/23 at 10:58 AM, the [US FOIA (b)(6)] confirmed that there were no other incidents or investigation for Resident #299 for the year [redacted]	F 686	7. Director of Nursing will report all finding from incident report audit at the QAPI monthly meeting x2	

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F 686	Continued From page 33 On 12/11/23 at 11:27 AM, the surveyor interviewed, via phone, the US FOIA (b)(6) who performed the readmission assessment. The surveyor asked the if the process was to review the information on the UTF. The stated that she looked at the UTF. The surveyor asked the if a assessment was done for residents that were readmitted. The stated that a EX Order 26.4B1 assessment was done with a US FOIA (b)(6) which included the area. She added that she would document what she saw. The surveyor asked the about the assessment that she performed on Resident #299. The stated that she did not remember. On 12/11/23 at 11:43 AM, the surveyor interviewed Licensed Practical Nurse #1 (LPN #1) regarding the admission assessment. LPN #1 stated that she could do the admission or readmission assessment and that a registered nurse would double check the assessment. She stated that she would perform a head to toe assessment of the and then after that the residents would have a weekly assessment done. On that same date and time, the surveyor asked LPN #1 if she reviewed the UTF. The stated that she would review the UTF and that she would observe the resident for any . She then added that if there was a she would measure it and refer to the physician. The further stated that she could not depend on what was written on the UTF because she had observed a in the past that was not listed on the UTF.	F 686		

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F 686	Continued From page 34	F 686		

At this time, the surveyor asked LPN #1 what the process EX Order 26.4B1 developed, she would notify the US FOIA (b assess the EX Order 26.4B with measurements, find the cause and see what could be done for the EX Order 26.4B1 The surveyor asked if an incident report would be done. The US FOIA (b stated that an incident report would be done since it was a NJ Exec Order 26.4b1 . She added that the EX Order 26.4B would be investigated and the previous shifts would be interviewed. The surveyor asked the US FOIA (b if she had taken care of Resident #299. The US FOIA (b stated that she was not sure.

On 12/11/23 at 12:49 PM, the surveyor interviewed the US FOIA (b)(6) on EX Ord unit regarding the readmission process. The US FOIA stated that the nurse would perform a readmission assessment that included a EX Order 26 check. The surveyor asked if the nurse would review the UTF and verify what was written on the UTF. The US FOIA stated that the nurse would look at the UTF. The surveyor asked the US FOIA what the process was for a new EX Order 26.4B1 or NJ Exec O The US FOIA stated that the EX Order 26.4B or NJ Exec O would be referred to the EX Order 26.4B physician who visited the facility every Monday. She then stated that an incident report and investigation would be done. The surveyor asked the US FOIA if the CP would be updated. The US FOIA stated that the CP would be updated as soon as the incident report was reviewed and that it should be updated within two to three days. She added that the nurse, herself and the EX Order 26.4B1 nurse would update the CP.

On 12/12/23 at 9:28 AM, the surveyor interviewed the US FOIA (b)(6) regarding Resident

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F 686	Continued From page 35 #299's EX Order 26.4B1 and EX Order 26. The US FOIA stated that Resident #299 developed the EX Order 26.4B1 during his/her stay at the facility. She stated that according to the electronic medical record, the resident went to the Ex Order 26.4B1 with EX Order 26.4B1 and returned to the facility a few days later and had EX Order 26.4B1 according to the readmission assessment. On that same date and time, the US FOIA (b)(6) stated that on EX Order 26.4B1 it was noted that the resident had EX Order 26.4B1 discoloration that was a Ex Order 2 and a EX Order 26.4B opening that was caused from the EX Order 26.4B1. The US FOIA stated that on EX Order 26.4B1 the EX Order 26.4B1 physician noted that it was a EX Order 26.4B1 EX Order 26.4B1 The surveyor asked if there was an incident report. The US FOIA stated that there was an investigation that was done on paper and that it was in the nursing office. The surveyor asked the US FOIA the reason why it was not in the risk management section of the facility's computer system like other incident reports. The US FOIA stated that it should have been in the risk management section. At this time, the surveyor asked the RN/UM about the UTF that had listed a EX Order 26.4B1 to EX Order 26.4B1. The US FOIA stated that the nurse should verify the information listed. She added that she did not know what happened that day. The surveyor asked the US FOIA about the MDS and if it was coded correctly. The US FOIA stated that the MDS should have the EX Order 26.4B1 and that none were present on readmission. On 12/12/23 at 9:53 AM, the surveyor asked the acting US FOIA (b)(6)) where incident reports were located. The US FOIA (b)(6) stated	F 686		

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that the incident reports were in the computer system and that everything should be in the computer.

On 12/12/23 at 10:18 AM, the [US FOIA (b)(6)] provided the surveyor a folder with an investigation for Resident #299's [EX Order 26.4B1]. There was no investigation for the [EX Order 26.4B1] or the [EX Order 26.4B1].

On 12/12/23 at 10:19 AM, in the presence of another surveyor, the surveyor asked the [US FOIA (b)(6)]) and the [US FOIA (b)(6)] the reason some of the incident reports were on paper and some were in the computer system. The [US FOIA (b)(6)] stated that the [NJ Exec] ones were hybrid (on paper). The surveyor asked the [US FOIA (b)(6)] how the facility would track and trend the [NJ Exec O] if they were not in the computer system. The [US FOIA (b)(6)] stated that it was something that they needed to look into and improve.

Furthermore, the surveyor asked the [US FOIA (b)(6)] the reason the [NJ Exec] incident report was not provided to the surveyor when the surveyor asked multiple times and that it was only provided after the surveyor inquired about the resident. The [US FOIA (b)(6)] stated that she did not ask the [US FOIA (b)(6)]. The surveyor asked what the purpose of the risk management was. The [US FOIA (b)(6)] stated to monitor and fully investigate to ensure [NJ Exec Order 2] or [NJ Exec Order 26] was ruled out. She added also to track and trend. The [US FOIA (b)(6)] stated that it should be in a central location and easily accessible to all staff.

A review of Resident #299's [Ex Order 26.4B1] MAR/TAR (Medication Administration Record/Treatment Administration Record)

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included the following:
Cleanse with NJ Exec Or EX Order 26.4B1) and apply NJ Exec Order 26.4b1 (EX Order 26.4B1 [redacted]) EX Order 26.4B1 Days which was ordered on Ex Order 26.4B1. The order was discontinued on EX Order 26.4B1 and replaced with the following order:
EX Order 26.4B1 [redacted].

Further review included an order to cleanse EX Order 26.4B opening with NJ Exec Or and apply EX Order 26.4B1 Ex Order 26.4B1 two times a day for NJ Exec Order 26.4b for NJ Exec Order 26.4b that was ordered on EX Order 26.4B1 and was continued until the resident went to the Ex Order 26.4B1. This order should not have been administered at the same time as the order for EX Order 26.4B1 EX Order 26.4B1 were administered.

Lastly there was an order to cleanse EX Order 26.4B1 area with NJ Exec Or and apply EX Order 26.4B1 two times a day for EX Order 26.4B1 for NJ Exec Order 26.4b which was ordered on EX Order 26.4B1 There was no documentation or assessment performed for this new EX Order 2 EX Order 26.4B1

On 12/12/23 at 12:02 PM, the surveyor interviewed the US FOIA (b)(6) regarding Resident #299's CP. The US FOIA (b)(6) stated that the CP should have been updated to reflect the EX Order 26.4B1

On 12/13/23 at 9:49 AM, the surveyor interviewed the US FOIA (b)(6) regarding the EX Order 2 assessment dated EX Order 26.4B1 and if it should include

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measurements. The [US FOIA] stated that it should have had measurements. The surveyor asked if the [EX Order 26.4B1] should have had an incident report. The [US FOIA] stated that it was her understanding the [EX Order 26.4B1] was from [NJ Exec Order 26] and that if we knew the cause then they would not do an incident report. The [US FOIA] added that only if the [NJ Exec Order 26.4b1]. The surveyor asked the [US FOIA] about the [EX Order 26.4B1]. The [US FOIA] confirmed that there was not a [Ex Order 2] assessment done and it should have been. The surveyor asked the [US FOIA] about the multiple orders for the [EX Order 26.4B1] treatment (tx). The [US FOIA] stated that the orders should have been clarified.

On 12/13/23 at 10:01 AM, the surveyor interviewed the [EX Order 26.4B1] Nurse ([US FOIA (b)] regarding the process for a new [EX Order 26.4B1]. The [US FOIA] stated that the primary nurse would perform a [Ex Order 2] evaluation and an incident report. The surveyor asked the [US FOIA] if the [NJ Exec Order 26.4b1] should be filled out on the assessment. The [US FOIA] stated that the [NJ Exec Order 26.4b1] should be filled out. The surveyor asked the [US FOIA] if an assessment should be done for [EX Order 26.4B1]. The [US FOIA] stated that there should be an assessment and incident report. The surveyor asked the [US FOIA] if there should have been multiple orders for the tx of Resident #299's [EX Order 26.4B1]. The [US FOIA] stated that the original tx should have been discontinued (d/c) when the other tx was ordered.

On 12/13/23 at 10:37 AM, in the presence of the survey team, the surveyor notified the [US FOIA (b)(6)] the concerns that Resident #299 had a UTF that indicated the resident had a [EX Order 26] [EX Order 26.4B1], there was no update to the CP, the

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F 686	Continued From page 39 MDS was coded incorrectly, there were two different treatments for the EX Order 26.4B1, the NJ Exec O assessment did not have NJ Exec Order 26.4b1 and there was no NJ Exec O assessment for the EX Order 26.4B1. On 12/13/23 at 10:38 AM, the US FOIA (b)(6) stated that one of the treatments should have been d/c. On 12/14/23 at 11:43 AM, in the presence of the survey team, the US FOIA (b)(6) responded with the following regarding the concerns. US FOIA (b)(6) stated that according to the nurse's assessment there was EX Order 26.4B1. She added that she interviewed that nurse and that nurse stated that she did not "see that." The US FOIA (b)(6) stated that if there was inconsistency that there should have been documentation that it was not noted. The US FOIA (b)(6) stated that the documentation description was poor to determine if an actual incident report was required for the EX Order 26.4B1 and that for NJ Exec Order 2 one was not done. The US FOIA (b)(6) stated that the MDS was coded incorrectly. The US FOIA (b)(6) stated that the assessment should have had measurements whenever there was a NJ Exec O alteration. She added that the entire form should be completed. The US FOIA (b)(6) stated that a NJ Exec O assessment should have been done for the EX Order 26.4B1 and the CP should have been updated. On that same date and time, the US FOIA (b)(6) stated that the incident reports should be in one place and in the computer system. The US FOIA (b)(6) stated that the original order should have been d/c when the new order was written. She added that the	F 686		

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nurses should have questioned the multiple order and gotten clarification.

A review of the facility provided policy titled, "Skin Assessment Policy" with a rev (reviewed) date of 9/2023 included the following:
Policy: It is our policy to perform a full body skin assessment as part of our systematic approach for pressure ulcer prevention and for the promotion of healing of various skin conditions, including pressure ulcers ...
Policy Explanation and Complete Guidelines
1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter. The assessment may also be performed after a change of condition or after newly identified pressure ulcer ...
7. Documentation of skin assessment:
a. Include the date and time of the assessment, your name, and position title.
b., Document observations (i.e. skin conditions, how the resident tolerated the procedure, etc.)
c. Document type of wound.
d. Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain).
e. Document if resident refused assessment and why.
f. Document other information as indicated or appropriate.

A review of the facility provided policy titled, "Comprehensive Care Plan" dated 9/2023, included the following:
Policy: It is the policy of this facility to develop and implement a comprehensive person-centered CP for each resident, consistent with resident rights, that includes measurable

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F 686	Continued From page 41 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines 1. The care planning process will include an assessment of the resident's strengths and needs ... 2 ...Other factors identified by the interdisciplinary team ...will also be addressed in the plan of care ... 3. The comprehensive CP will describe, at a minimum the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being ... 5. The comprehensive CP will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. The policy did not include information regarding updating the CP with a change in a resident's condition. A review of the facility provided policy titled "Incident/Accident Reporting" with a reviewed date of 9/2023, included the following: Policy: The facility shall ensure that systems are in place whereby resident incidents and accidents are reported, their causes identified when possible and timely interventions are established to reduce the probability of a repeated incident. Policy Explanation and Compliance Guidelines: 1. It is the responsibility of the licensed nurse who first witnessed the incident/accident to initiate and complete the Risk Management forms its entirety utilizing input from the staff present at the time of the incident/accident ...	F 686		

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F 686	Continued From page 42 8. The UM brings all completed incident/accident reports to the morning meeting/team huddles for review by the Interdisciplinary Team. Interventions agreed upon are documented. CPs are updated, as needed. 9. A conclusion or summary of the investigation is completed by the IDCP team for all incidents/accidents. 2. On 12/01/23 at 10:48 AM, the surveyor observed Resident #39 seated in a [NJ Exec Order 26.] wheelchair, well dressed, there was an [NJ Exe] [redacted] on the bed, and the [Ex Order 26.4B1] [NJ Exec Orde] on the [NJ Exec O] was off. On 12/04/23 at 8:38 AM, the [US FOIA (b)(6)] provided a list of residents with in-house (facility-acquired) [EX Order 26.4B1] on [Ex Order 26.4B1] that included Resident # 39. The surveyor reviewed the medical records of Resident #39. The AR revealed that the resident was admitted to the facility with medical diagnoses that included but were not limited to; [EX Order 26.4B1] [redacted] The quarterly MDS with an assessment reference date (ARD) of [EX Order 26.4B1], Section [NJ E] [NJ Exec Order 26.4b1] showed skills for [NJ Exec Orde]	F 686		

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NJ Exec Order 26.4b1 were EX Order 26.4B1. Section NJ Ex NJ Exec Or Conditions revealed that the resident had a EX Order 26.4B1, present on admission EX Order 26.4B1 EX Order 26.4

On 12/05/23 at 10:39 AM, the surveyor observed the EX Order 26.4B1 care tx of Resident # 39 that was done by LPN #2 assisted by the US FOIA (b)(6). LPN #2 informed the surveyor that the resident was EX Order 26.4B1, and required NJ Exec O assistance with adls (activities of daily living), the resident was pre-medicated with EX Order 26.4B1 two tablets before EX Order 26.4B1 treatment for NJ Exec O management. The surveyor observed the NJ Exec Order 26.4 NJ Exec O was off and the resident had EX Order 26.4B1 EX Order 26.4B1 in use while in bed. The LPN introduced herself to the resident and informed the resident that the surveyor will observe the EX Order 26.4B1 tx.

LPN #2 then performed handwashing inside the toilet room, went to the tx cart outside the resident's room donned (put on) gloves, took the disinfecting wipes, disinfected the table inside the resident's room, doffed off (removed) gloves, and performed handwashing. US FOIA (b) took the EX Order 26.4B1 EX Order 26 care supplies inside the tx cart, [redacted] and NJ Exec Order 26.4b1, three (NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 one pack NJ Exec Order 26.4b1, two NJ Exe Order 26.4B NJ Exec Order 26.4 medicine cup with NJ Exec Order 26.4b1 EX Order 26.4B1), two tongue depressor and two NJ Exec Order 26.4b1 (or NJ Exec Order 26.4 a kind

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of NJ Exec Order 26.4b1 that are designed to be placed on the top of a bed, wheelchair, or any surface you want to NJ Exec Order 26.4b1

LPN #2 put the NJ Exec Order 26.4b1 on top of the dry table inside the resident's room and placed the gathered supplies from the tx cart in the NJ Exec O . US FOIA (b returned to the tx cart to get the NJ Exec Order 26.4b1 wrote the date signed the NJ Exec Order 26.4b1 , and then placed it on top of the table. The US FOIA (b did not read tx orders before starting the EX Order 26.4B1 care tx and while preparing the EX Order 26.4B1 care supplies. US FOIA (b then donned a new pair of gloves without performing hand hygiene. US FOIA (b removed the to the EX Order 26.4B1 . The surveyor observed an old NJ Exec Order 26.4b1 with brownish discoloration to the , US FOIA (b stated that was a EX Order 26.4B1 EX Order 26.4B1 and the was brownish due to EX Order 26.4B1 medication. There was EX Order 26.4B1 and the EX Order 26.4B1 was observed with EX Order 26.4B1 EX Order 26.4B1). LPN# 2 stated that EX Order 26.4B1 was present in the EX Order 26.4B1 and that the EX Order 26.4B1 was EX Order 26.4B1 . US FOIA (b described the EX Order 26.4B1 bed with areas of EX Order 26.4B1

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or[redacted] and [redacted]. [redacted] also stated that the [redacted] doctor came in yesterday, comes every week [once a week] did some [redacted], and changed the orders.

LPN #2 removed gloves and performed handwashing, donned gloves, cleansed the [redacted] bed with the use[redacted] that the [redacted] soaked inside the [redacted] of [redacted] and used the same gloves that were used in cleaning the [redacted] bed and the same gloves used in getting a [redacted] inside the pack that the gloves touched the surrounding area inside and outside the [redacted]. LPN stated that the [redacted] in the [redacted] was the [redacted] that was d/c by the [redacted] doctor and changed to [redacted]. [redacted] doffed off gloves and performed handwashing, donned new gloves used [redacted] prep to apply to [redacted] x 2, took the tongue depressor to apply the [redacted] to the [redacted] and covered the [redacted] with [redacted] covered with [redacted].

LPN #2 asked the [redacted] get another [redacted]. The [redacted] doffed off gloves and did not perform hand hygiene went to the tx cart. The surveyor observed the [redacted] from a slightly open door, open enough that the surveyor was able to see the [redacted] get another [redacted] by opening the tx cart with keys that were from the [redacted] uniform pocket. [redacted] took a pair of new blue gloves from her uniform pocket and donned gloves without performing hand hygiene, went inside the resident's room, and handed the [redacted] to the [redacted] used the [redacted]

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[redacted] to cover the [redacted] and [redacted] doffed off gloves.

Later on, the [redacted] doffed off gloves, performed handwashing for 28 seconds, and scrubbed both hands under the stream of running water.

Afterward, LPN #2 performed handwashing, took the extra [redacted] and box of gloves outside the resident's room, and returned the used supplies on top of the tx cart. [redacted] then disinfected the table, took the garbage outside the room to the soiled room, and performed hand washing.

At this time, LPN #2 stated that she was done and will sign off on the tx. She indicated that she read the order for [redacted] treatment to the [redacted] area before the surveyor observed the [redacted] tx. The [redacted] then put back the [redacted] inside the tx cart.

On 12/05/23 at 11:20 AM, near the Nursing Station where the medication (med) cart of LPN #2 was parked, the [redacted] read the order for the [redacted] and signed off the electronic TAR. During the interview, the [redacted] informed the surveyor that the [redacted] was deteriorating and that it was an unavoidable [redacted] due to the resident's [redacted], diagnosis, and history of [redacted]. She further stated that the resident was on [redacted] and [redacted] to promote [redacted] and was on preventative tx prior to the [redacted] development.

On that same date and time, the surveyor asked who provided her education for infection control including hand hygiene and personal protective

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equipment (PPE) use, and LPN #2 stated it was the [US FOIA (b)(6)]. The [US FOIA (b)(6)] stated that handwashing should be done before and after donning and doffing and when gloves are visibly soiled. The surveyor notified the [US FOIA (b)(6)] of the above concerns regarding hand hygiene not performed before and after donning doffing off gloves and the concern regarding the [NJ Exec Order 26.4b1]. The [US FOIA (b)(6)] acknowledged that she should have performed hand hygiene before donning and doffing gloves and that the [NJ NJ Exec Order 26.4b1] should have been thrown out.

On 12/05/23 at 11:29 AM, the surveyor interviewed the [US FOIA (b)(6)] and [US FOIA] regarding hand hygiene and infection control. The [US FOIA] stated that it was an expectation that staff when they come out of the resident's room, aftercare, passing tray, before and after donning/doffing PPEs including gloves, hand hygiene should be performed. She further stated that staff should not be stocking gloves inside their pockets and they can not put back the [NJ Exec Order 26.4b1] inside the tx cart due to infection control and contamination. The [US FOIA] indicated that when the staff had multiple back and forth from one area to another, there should be hand hygiene, for example, the [US FOIA (b)(6)] with supplies to the room and then to tx cart with keys in their pocket, hand hygiene should have been done.

On 12/05/23 at 12:36 PM, the surveyor interviewed the [US FOIA (b)(6)]. The [US FOIA (b)(6)] stated that it was that [US FOIA] who does education regarding infection control hand hygiene, and PPE use. The [US FOIA (b)(6)] further stated that hand hygiene should be done before and after gloves use. She stated that hand washing which was scrubbing of

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F 686	Continued From page 48 both hands should be at least 20 seconds and done outside the running water and not under the stream of running water. The surveyor then asked why the US FOIA (b)(6) did not follow the education and practice for hand hygiene if she knew that gloves should not be stored inside the uniform pocket, scrubbing of hands outside the stream of running water, and perform hand hygiene after each glove use that included donning and doffing with direct contact with the resident's environment bed frame, bed, resident's body, privacy curtain when she removed her used gloves 2 x to get supplies from tx cart. the US FOIA (b)(6) stated that because she was hurrying up. On 12/14/23 at 02:00 PM, the survey team met with the US FOIA (b)(6) for an Exit Conference and there was no additional information provided by the facility management. N.J.A.C. 8:39-27.1(a)	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and review of other pertinent facility provided documentation, it was determined that	F 689	F689 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	1/20/24

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F 689	Continued From page 49 the facility failed to ensure residents were appropriately supervised and monitored to ensure safety specifically by failing to ensure a) a resident was properly and accurately assessed for risk of EX Order 26.4B1, b) a EX Order 26.4B1 (a NJ Exec Order 26.4b1 was in place according to risk for EX Order 26.4B1 c) a care plan for wandering was created, and d) the Minimum Data Set (MDS; an assessment tool used to facilitate the management of care) was accurately coded for one (1) of two (2) residents reviewed for EX Order 26.4B1 (Resident #26). This deficient practice was evidenced by the following: On 12/01/23 at 11:40 AM, the surveyor observed Resident #26 NJ Exec Order 26.4b1 the halls of the facility holding a NJ Exec O in his/her hand. The resident went through the double doors at the end of the EX Order 26.4B unit and toward the front entrance of the building. A staff member asked Resident #26 if the resident needed help. The resident went with the staff member through the other set of double doors that led to the EX Order 26.4 unit. On 12/01/23 at 12:20 PM, the surveyor observed Resident #26 with a different staff member walking the hall of the EX Order 26.4B unit. The surveyor reviewed the medical records of Resident #26. Resident #26's Admission Record (or face sheet; admission summary) indicated that the resident	F 689	I. CORRECTIVE ACTION FOR THOSE AFFECTED Resident #26 was reassessed immediately with NJ Exec Order 26.4b1 from this deficient practice. An NJ Exec Order 26.4b1 assessment completed that put at risk for NJ Exec Order 26.4b1 Order obtained, NJ Exec Order 26.4b1 applied, Care plan updated. Inservice done with nurses on following up on interventions from NJ Exec Order 26.4b1 assessment immediately. II. ID OTHERS WITH POTENTIAL TO BE AFFECTED All residents that wander have the potential to be affected by this deficient practice. An audit was completed on all residents that wandered and there were no negative findings. 1. All nurses were Inservice on following up on Elopement assessment interventions. 2. All staff Inservice on monitoring wandering resident and to report to nursing staff immediately if they noticed a wandering resident's wander guard is missing III. SYSTEMIC CHANGES	

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F 689	Continued From page 50 was admitted to the facility with medical diagnoses that included but were not limited to; EX Order 26.4B1 [redacted] A review of Resident #26's Quarterly MDS (QMDS) dated EX Order 26.4B1 indicated a Brief Interview for Mental Status (BIMS) score of EX O out of 15, which reflected that the resident's EX Order 26.4B1 was EX Order 26.4B1. Section NJ E NJ Exec Order 26.4b1 indicated that the resident EX Order 26.4B1 daily. Section NJ Exec Order 26.4b1 indicated that a EX Order 26.4B1 NJ Exec Order was not being used. A review of Resident #26's EX Order 26.4B1 Medication Administration Record and Treatment Administration Record did not include an order related to a EX Order 26.4B1 Resident #26's Progress Notes included the following notes: Effective date: EX Order 26.4B1 [Resident #26] is alert, EX Order 26.4B1, he/she EX Order 26.4B1 EX Order 26.4B1 no history of EX Order 26.4B1, staff continue to monitor NJ Exec Order 26.4b1 EX Order 26.4B1 discontinued. Effective date: NJ Exec Order 26.4b1 12:41 [Resident #26] noted to EX Order 26.4B1, no NJ Exec	F 689	1. Nurses were Inservice on following interventions from Elopement assessment 2. Weekly audit will be done by unit managers to ensure all wandering residents have appropriate intervention IV. MONITORING 1. Unit managers will do audits on Elopement assessments that are completed to ensure appropriate interventions are followed weekly x 4 weeks. 2. Unit Managers will do a weekly audit on residents with wander guard x4 weeks. 3. Assistant Director of nursing will do bi-weekly audit and report findings to the Director of Nursing and Administrator monthly x3 4. The Director of Nursing will report trends to the Quality Assurance Committee at the quarterly meetings x3.	

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NJ Exec Order 26.4 noted for the past quarter, NJ Exec Order 26.4b1 discontinued, NJ Exec Order 26.4b1 like utensils, empty containers, straws, spoons, have he/she carries around with whatever he/she staff continues to monitor for safety.

A review of Resident #26's Discontinued Orders included an order created on EX Order 26.4B1 to check EX Order 26.4B1 function every night shift for protocol which indicated the resident had a EX Order 26.4B1 applied. Further review indicated the order was discontinued on EX Order 26.4B1.

A review of Resident #26's quarterly "NJ Exec Order 26.4b1 Evaluation" dated EX Order 26.4B1 the evaluation performed prior to the removal of the EX Order 26.4B1 EX Order 26.4 device, indicated a score of EX Orde that the resident was not at risk. However, the section for BIMS score EX Order 26.4B1 and the section for NJ Exec Orde was EX Order 26.4B1. Each of those sections if filled out properly could affect the score. Further review indicated that under Clinical Suggestions the following were checked: Apply identification bracelet; Apply personal NJ Exec Order 26.4b1 and Monitor NJ Exec Order 26.4 frequently. The evaluation/assessment was not correctly completed. The evaluation/assessment indicated that the resident should have an NJ Exec Orde device applied based on the answers to the questions listed in the evaluation.

There was no EX Order 26.4B1 evaluation/assessment after EX Order 26.4B1 to indicate a NJ Exec Order 26.4b1 was not needed and that the resident's EX Order 26.4B should have been removed.

Review of Resident #26's previous quarterly

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[redacted] Evaluation" dated [redacted], indicated a score of [redacted] and the sections for BIMS score and [redacted] score were [redacted]. The evaluation/assessment was not correctly completed.

Review of Resident #26's admission '[redacted] Evaluation" indicated a score of [redacted] which meant the resident was at risk for [redacted] Further review indicated that under Clinical Suggestions the following were checked: Apply identification bracelet; Apply [redacted] Monitor [redacted] frequently; Document specific behaviors on the behavior log; and Notify staff of [redacted] risk.

A review of Resident #26's active individualized care plan (CP) did not reflect a focused area that the resident [redacted] or was at risk for [redacted] There was a focused area that the resident was '[redacted]. Dx. (diagnosis) [redacted]." Further review indicated there was a resolved focused area that Resident #26 was [redacted] that was initiated on [redacted] and was resolved/discontinued on [redacted]. The resolved/discontinued interventions included the following: Distract resident from [redacted] by offering pleasant diversions, structured activities, food, conversation, television, book.; Monitor [redacted] every frequently. Document [redacted] behavior and attempted diversional interventions.; Provide structured activities: [redacted]; [redacted]: Apply [redacted] on the [redacted], Check for placement

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F 689	Continued From page 53 every shift and check for function every night. A review of Resident #26's QMDS dated [redacted], indicated that the Resident had a BIMS score of [redacted] out of 15, which indicated that the resident's [redacted] was EX Order 26.4B1. Section [redacted] NJ Exec Order 26.4b1 indicated that a EX Order 26.4B1 [redacted] was not used. The MDS was coded incorrectly. The resident had a EX Order 26.4B1 at the time of this MDS. On 12/04/23 at 11:03 AM, the surveyor, via phone, interviewed Resident #26's representative who stated that Resident #26 was being taken care of at the facility. The resident's representative (RR) stated that Resident #26 was previously at another facility in a [redacted] unit and that the resident was transferred here. The RR stated that Resident #26 had [redacted] but that the resident was able to [redacted]" at this facility and that the staff "[redacted]" on the resident. The surveyor asked the RR if Resident #26 NJ Exec Order 26.4b1 The RR stated that in the beginning Resident #26 wanted to [redacted] his/her [redacted] and that [redacted] he/she thinks that he/she was EX Order 26.4B1. The RR added that when they visit, Resident #26 wanted to go outside for a walk and that they knew that the resident may not want to go back in [the facility]. On 12/05/23 at 10:58 AM, the surveyor interviewed the US FOIA (b)(6) [redacted]) regarding the process for residents that [redacted]. The [redacted] stated that if a resident [redacted], she would check on them to see where they were. She added that sometimes they may [redacted] around the building to the [redacted]	F 689		

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unit and that she would redirect them back to the [redacted] unit. She then stated that she thought that residents that [redacted] EX Order 26.4B1 [redacted]. The surveyor then asked the [redacted] about Resident #26. The [redacted] stated that the resident sometimes went around the building and that when she would look for the resident she would go to the [redacted] unit to find the resident.

On 12/05/23 at 11:02 AM, the surveyor interviewed the [redacted] US FOIA (b)(6) regarding residents that [redacted] or were at risk for [redacted] EX Order 26.4B1. The [redacted] stated that if a resident [redacted] then an [redacted] EX Order 26.4B1 would be applied and it would [redacted] NJ Exec Order 26.4b1. She added that an assessment was done by the [redacted] and the resident was monitored closely, kept in activities and they knew where they were all the time. The surveyor asked about Resident #26. The [redacted] stated that when Resident #26 was admitted that the resident had a [redacted] EX Order 26.4B1 and that it was discontinued because the resident was not an [redacted] EX Order 26.4B1. The [redacted] added that the resident just [redacted] around the building and that the resident did not say that he/she [redacted] NJ Exec Order 26.4b1 The surveyor asked if the resident should have a CP for [redacted] EX Order 26.4B1 and who was responsible for the CP. The [redacted] stated that she was not sure and that the [redacted] would do the CP.

On 12/05/23 at 11:09 AM, the surveyor interviewed the [redacted] of [redacted] unit regarding the process for CP. The [redacted] stated that she and the nurses did the CP and that anyone could update the CP. The surveyor asked if a resident [redacted] EX Order 26.4B1 or was at risk for [redacted] EX Order 26.4B1 if they would have a CP. The [redacted] stated that there

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F 689	Continued From page 55 would be a CP for EX Order 26.4B1 and for NJ Exec Order 26.4b1 The US FOIA stated that they would evaluate if the resident would need a EX Order 26.4B1 if NJ Exec [redacted] On 12/05/23 at 11:14 AM, the surveyor interviewed the US FOIA (b)(6) regarding the process for residents who wandered or were at risk for EX Order 26.4B1 The US FOIA (b)(6) stated that when a resident that had a EX Order 26.4B1 on would come near the NJ Exec Order 26.4b1 would NJ Exec Order [redacted] and the NJ Exec Order 26.4b1. The surveyor asked what would happen if a resident did not have a EX Order 26.4B1 on. The US FOIA (b)(6) stated that from 8 AM to 8 PM there was someone at the desk and that they would see the resident and NJ Exec Order 26.4 them away from the NJ Exec O [redacted] On that same date and time, the surveyor observed that behind the desk were five (5) resident's pictures under a sign which read "Patients with EX Order 26.4B1". Resident #26's picture was listed under the "Patients with EX Order 26.4B1 sign. There were three resident's pictures under a sign which read 'EX Order 26.4B1 EX Order 26.4B1." The US FOIA (b)(6) stated that she had to move Resident #26's picture down to the section that had the EX Order 26.4B1 EX Order 26.4B1 " sign. The surveyor asked why she had to move Resident #26's picture. The US FOIA (b)(6) stated that the staff just tell me what to do and that Resident #26 did not have the EX Order 26.4B1 anymore. She added that she still watched for Resident #26. On 12/05/23 at 11:37 AM, the surveyor interviewed the US FOIA of EX Order 26.4B [redacted] unit regarding	F 689		

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Resident #26 and the reason the EX Order 26.4B1 was removed. The US FOIA stated that Resident #26 NJ Exec Order 26.4b1 but that the resident did not NJ Exec Order 26.4b1 and that the resident did not NJ Exec Order 26.4b1 for the NJ Exec O so they discontinued the EX Order 26.4B1 and the at risk for EX Order 26.4B1 t CP. The surveyor asked if Resident #26 should have a CP for wandering. The US FOIA stated that she did not see a CP for EX Order 26.4B1. She added that she would consult with the interdisciplinary (IDCP) team to determine if the resident needed a CP for EX Order 26.4B1 and that if the resident needed that CP, she would put it.

On 12/05/23 at 01:11 PM, the surveyor interviewed the US FOIA of the EX Order 26.4B unit regarding the process for the EX Order 26.4B1 evaluation/assessment. The US FOIA stated that Resident #26 was due for the quarterly EX Order 26.4B1 evaluation/assessment this month on EX Order 26.4B1 and that the resident would be reassessed then. The surveyor asked who performed the EX Order 26.4B1 evaluation/assessment. The US FOIA stated that she and the nurses did them.

At that same time, the surveyor asked how EX Order 26.4B1 evaluation/assessment was done. The US FOIA stated that she would review with the nurses, interview staff and check the progress notes to see if there were any issues. The surveyor reviewed Resident #26's three EX Order 26.4B1 evaluation/assessments that were done with the US FOIA and asked about the BIMS and NJ Exec Orde sections that were blank. The US FOIA stated that the US FOIA (b)(6) did the BIMS score in a separate assessment. The surveyor asked if the BIMS score should be filled in on the EX Order 26.4B1 evaluation/assessment or should it be

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left blank. The US FOIA stated that if the BIMS score was already done by the US FOIA then it would be available to view in the computer system and that it could be put in the EX Order 26.4B1 evaluation/assessment. She added that if the BIMS score assessment was not done prior then she could not put it in the EX Order 26.4B1 evaluation/assessment.

Furthermore, the surveyor asked the US FOIA how the clinical suggestions were populated on the EX Order 26.4B1 evaluation/assessment. The US FOIA stated that clinical interventions (suggestions) were populated from the questions that were answered. The surveyor then asked about the EX Order 26.4B1 evaluation/assessment that had the clinical suggestion of apply personal NJ Exec Order 26.4b1. The US FOIA stated that the EX Order 26.4B1 was discontinued on EX Order 26.4B1. The surveyor asked the US FOIA if there was another EX Order 26.4B1 evaluation/assessment done before the EX Order 26.4B1 was discontinued and if a EX Order 26.4B1 should be discontinued if the EX Order 26.4B1 evaluation/assessment had the clinical suggestion of apply NJ Exec Order 26.4b1 device. The US FOIA stated that the discontinuation of the EX Order 26.4B1 would be supported by the progress note on Ex Order 26.4B1 that said will continue to monitor for safety.

The US FOIA added that she was going to do the quarterly EX Order 26.4B1 evaluation/assessment in EX Order 26.4B1 and that they would decide then if the EX Order 26.4B1 was needed or not. The surveyor then asked if the BIMS score was put in the EX Order 26.4B1 evaluation/assessment, would the BIMS score affect the at risk score. The US FOIA stated that a NJ Exec BIMS score would make the

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resident at risk because that meant the resident was NJ Exec Order 26.4b1 The surveyor asked what Resident #26's BIMS score was. The US FOIA stated the latest score was Ex Order 26.4B1 Ex Order 26.4B1 .

On 12/05/23 at 01:37 PM, in the presence of the US FOIA (b)(6)), the surveyor interviewed the US FOIA (b)(6) , who was the current acting US FOIA (b)(6) regarding the process for a resident that wandered. The US FOIA (b)(6) stated that an EX Order 26.4B1 assessment would be done and that a EX Order 26.4 would be applied "if fitting." The surveyor asked if the resident would have a CP. The US FOIA (b)(6) stated that if they EX Order 26.4B1 then they would have a CP and that if a EX Order 26.4B1 was applied that would also be on the CP.

At that same time, the surveyor asked how it was determined if a resident needed a EX Order 26.4B1 . The US FOIA (b)(6) stated that if a resident EX Order 26.4B1 and was at risk for EX Order 26.4B1 then a EX Order 26.4B1 EX Order 26.4 would be applied. The US FOIA (b)(6) stated that the evaluation was done on admission and quarterly. The surveyor asked if the BIMS and NJ Exec Ord should be filled out on the EX Order 26.4B1 assessment. The US FOIA (b)(6) stated that ideally they would be put in if they were available. She added that they were a separate assessment. The surveyor asked if the BIMS score would affect the risk of EX Order 26.4B1 score. The US FOIA (b)(6) stated that the BIMS score did affect the at risk for EX Order 26.4B1 score. The surveyor asked how the clinical suggestions were determined on the assessment. The US FOIA (b)(6) stated that the clinical suggestions were triggered by the answers to the questions. The surveyor asked that if the EX Order 26.4B1 assessment had apply

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NJ Exec Order 26.4b1 device (i.e. EX Order 26.4B1) then should the expectation be that a resident would have the NJ Exec Order 26.4b1 on. The US FOIA stated that it was a yes and no. She added that if the resident were NJ Exec Order 26.4b1 they would have the device but that if the resident was not NJ Exec Order 26.4b1 then they would not have a the device. The surveyor asked that if a resident EX Order 26.4B1 should they have a CP. The US FOIA (b)(6) both stated "definitely."

On 12/06/23 at 11:15 AM, the surveyor interviewed the US FOIA (b)(6)) regarding the process for MDS. The US FOIA (b)(6) stated that before the MDS is done, the admission nurse would do their own evaluation and assessments. She added that she would gather information from the different assessments and do the admission MDS. The US FOIA (b)(6) stated that the same process for getting the information for the quarterly MDS was from nursing assessments and whatever documentation that was needed for look back period. The surveyor asked about the section for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 The US FOIA (b)(6) stated that the did that section. The surveyor asked about the section for alarms. The US FOIA (b)(6) stated that she got the information from the MAR/TAR.

On 12/06/23 at 11:21 AM, the surveyor interviewed the US FOIA (b)(6) regarding the process for MDS. The US FOIA (b)(6) stated that for the BIMS assessment she would interview the resident and ask questions like what year it was. She added that the resident could not answer then she would interview the family or get information from staff observation. The US FOIA (b)(6) stated that for the NJ Exec Order 26.4b1 and

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F 689	Continued From page 60 NJ Exec Order 26.4b1 section she would assess the resident and observe if the resident EX Order 26.4B1 or NJ Exec [redacted] She added that she would also ask the family. The surveyor then asked about Resident #26. The US FOIA (b)(6) [redacted] stated that Resident #26 on admission when first arrived the resident was not EX Order 26.4B1 The surveyor then asked about the NJ Exec Ord [redacted] MDS and if it was coded correctly. The US FOIA (b)(6) [redacted] stated that she would have to get back with the answer. On 12/06/23 at 11:28 AM, the US FOIA (b)(6) [redacted] confirmed that Resident #26's MDS's were coded incorrectly in regards to the NJ Exec Orde [redacted] section and that it was an oversight and that it was not accurately captured from the MAR/TAR. She confirmed that she modified the MDS's. On 12/06/23 at 11:33 AM, the US FOIA (b)(6) [redacted] confirmed that Resident #26's MDS's were coded incorrectly for the EX Order 26.4B1 section and were modified. On 12/07/23 11:09 AM, in the presence of the survey team, the surveyor notified the US FOIA (b)(6) [redacted] the concerns that Resident #26 was not properly and accurately assessed for the risk of EX Order 26.4B1, the residents EX Order 26.4B1 was removed without an accurate assessment, the resident did not have a CP for EX Order 26.4B1 and the MDS was not coded accurately. On 12/11/23 at 9:52 AM, in the presence of the survey team, the US FOIA (b)(6) [redacted] stated that	F 689		

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after the surveyor inquiry, the IDCP team reassessed Resident #26 for EX Order 26.4B1 and that Resident #26 scored 3 on the assessment (which meant the resident was at EX Order 26.4B1 EX Order 26.4B1). She added that the IDCP team discussed with the resident's family the reassessment, the resident's history and for the resident's safety the EX Order 26.4B1 was reapplied.

At that same time, the US FOIA (b)(6) stated that the MDS was reviewed and it was not coded correctly and that they modified the MDS on Ex Order 26.4B1. The US FOIA (b)(6) stated that Resident #26 was not assessed properly prior to removal of the EX Order 26.4B1. The surveyor asked if the BIMS and NJ Exec Ord sections of the assessment should have been filled out. The US FOIA (b)(6) stated that assessments done prior to EX Order 26.4B1, should have been filled out. The surveyor asked if the EX Order 26.4B1 should have been removed based on the assessment done before the removal. The US FOIA (b)(6) stated that the EX Order 26.4B1 should not have been removed. The surveyor asked if there should have been a CP for EX Order 26.4B1. The US FOIA (b)(6) stated that the resident should have had a EX Order 26.4B1 CP.

A review of the facility provided policy titled, "Elopements and Wandering Residents" with a reviewed date of 9/2023, included the following: Policy: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.

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F 689	Continued From page 62 Policy Explanation and Compliance Guidelines: 1. "Wandering" is random or repetitive locomotion that may be goal-directed (e.g., the person appears to be searching for something such as an exit) or non-goal directed or aimless. 2. "Elopement" occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. 3. The facility is equipped with door locks/alarms to help avoid elopements. 4. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. 5. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks., implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. 6. Monitoring and Managing Residents at Risk for Elopement and Unsafe Wandering a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. b. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. d. Adequate supervision will be provided to help	F 689		

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F 689	Continued From page 63 prevent accidents or elopements. e. Charge nurses and unit managers or designee will monitor the implementation of interventions, response to interventions, and document accordingly. f. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff. N.J.A.C. 8:39-27.1(a)	F 689		
F 695 SS=E	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, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure that the facility failed to maintain the necessary [redacted] and services of residents who were receiving [redacted] according to the standard of practice, specifically a) that a resident received [redacted] as ordered for three (3) of five (5) residents reviewed for [redacted] care (Resident #11, #56, and #90) and b) [redacted] and [redacted] equipment were stored in accordance with facility policy and infection control measures for three (3) of five (5) residents reviewed for	F 695	F695 RESPIRATORY/TRACHEOSTOMY CARE AND SUCTINING I. CORRECTIVE ACTIONS FOR THOSE AFFECTED Resident #11 was assessed and had no [redacted] was replaced at the correct setting as per doctor□s order, [redacted] was dated. Resident #56 was assessed and had no [redacted]. The [redacted] amount	1/19/24

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F 695	Continued From page 64 NJ Exec Order 26.4b1 care (Resident #11, #65 and #90). This deficient practice was evidenced by the following: According to the National Library of Medicine, Oxygen-induced hypercapnia: physiological mechanism and clinical implications Abstract Oxygen is probably the most commonly prescribed drug in the emergency setting and is a life-saving modality as well. However, like any other drug, oxygen therapy may also lead to various adverse effects. Patients with chronic obstructive pulmonary disease (COPD) may develop hypercapnia during supplemental oxygen therapy, particularly if uncontrolled. 1. On 12/01/23 at 11:40 AM, during the initial tour, the surveyor observed Resident #11 in bed with the Ex Order 26.4B1 (a medical device used for delivering Ex Order 26.4B1 on and set between Ex Order 26.4B1 The Ex Order 26.4B1 was dated, strewn over the garbage can and the NJ Exec Order 26.4b1 an Ex Order delivery system that is placed directly in the resident's NJ Exec Order was inside the resident's Ex Order 26.4B1 The resident was NJ Exec Order 2 and NJ Exec Order 26.4b1 On 12/04/23 at 12:06 PM, the surveyor observed the resident lying in bed asleep. The Ex Order Ex Order 26.4B1 was on and set to NJ Exec Order 26. Ex Order Ex Order 26.4B was strewn over the garbage can and the floor. The NJ Exec was inside the resident's Ex Order 26.4B. The surveyor reviewed the medical record for Resident #11.	F 695	was changed to correct order. NJ Exec Order 26.4 NJ Exec Order 26.4b1 and dated. NJ Exec Order 26.4 NJ Exec Order 2 that was not in use was replaced and put in a plastic bag. Resident #90 was assessed and had no NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 was changed and dated. NJ Exec Order 26.4b was turned on as ordered. Resident #65 was assessed and had no NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 dated and stored appropriately. Nurses were Inservice immediately following doctor□s order for NJ Exec Order 26.4b, proper storage of NJ Exec Order 26.4b1 when not in use, and dating of NJ Exec Order 26.4b1. II. ID OTHERS WITH THE POTENTIAL TO BE AFFECTED All residents with order for Oxygen have potential to be affected by this deficient practice. An audit was completed for all residents on Oxygen and there were no negative findings All nurses were Inservice about ensuring resident□s Oxygen tank/concentrator is set to the correct order. All nurses were Inservice on dating Oxygen tubing and placing them in a plastic bag when not in use.	

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F 695	Continued From page 65 According to the Admission Record (AR; or face sheet, an admission summary), the resident was admitted to the facility with diagnoses that included EX Order 26.4B1 [redacted] The quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated EX Order 26.4B1, reflected a Brief Interview for Mental Status (BIMS) score of EX Orde out of 15, which indicated that the resident was EX Order 26.4B1. The active Order Summary Report (OSR) revealed a physician order (PO) for EX Orde EX Order 26.4B1 EX Order 26.4B1). A review of the ongoing Care Plan (CP) reflected a focus that included, the resident's required related to EX Order 26.4B1 which was initiated on EX Order 26.4B1 Further review of the CP included an intervention dated EX Order 26.4B1, that the resident required an EX Orde EX Order 26.4B1 On 12/04/23 at 01:26 PM, the surveyor in the presence of the US FOIA (b)(6) EX Order 26.4B1 US FOIA (b)(6)) observed the resident lying in bed, asleep, wearing the NJ Exte that was connected to the EX Order 26.4B1. The EX Order 26.4B1 was	F 695	All Certified Nurse's Assistant were Inservice to call the nurse immediately to connect residents to Oxygen as per order. III. SYSTEMIC CHANGES Nurses are inservice on proper storage of Oxygen tubing. Unit managers are to assess residents that are on oxygen to ensure that the oxygen is set at the correct rate, that the tubing are dated, and when oxygen is not in use the tubing is placed in a plastic bag. Unit managers will audit to make sure that Certified Nurse□s Assistant informed nurses when resident need to be connected their oxygen Infection Preventionist will inservice staff IV. MONITORING Unit Managers will audit all residents with an order for Oxygen weekly and report their findings to the Director of Nursing for 4weeks. Assistant Director of Nursing will audit residents with an order for oxygen bi-weekly and report findings to the administrator and to the Quality Assurance Committee monthly x3 and at the quarterly meetings x 2. Infection Preventionist will audit all	

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F 695	Continued From page 66 on and set to [NJ NJ Exec Orde]. The [NJ Exec Order 26.4b1] was over the garbage can and partly on the floor. The surveyor and the [US FOIA (b)(6)] exited the resident's room to discuss the observations and review the electronic Medical Record (eMR). On 12/04/23 at 01:30 PM, during an interview with the surveyor, the [US FOIA (b)(6)] confirmed the resident's EX Order 26.4B1 The [US FOIA (b)(6)] further stated that too much [EX Order] was not good for the [EX Order 26.4B] and acknowledged that it could prove to be [NJ Exec Order 26.4b1] for a resident with [Ex Order 26.4B1]. The [US FOIA (b)(6)] informed the surveyor that she would assess the resident and adjust the [EX Order 26.4B1] [NJ Exec Or] according to the PO. At that time, the [US FOIA (b)(6)] stated that the [EX Order] [EX Order 26.4B1] should not have been over the garbage can and on the floor because of contamination and against infection control. Furthermore, the [US FOIA (b)(6)] informed the surveyor that she would obtain new [NJ Exec Order] for the resident. On 12/05/23 at 11:05 AM, during an interview with the surveyor, and the [US FOIA (b)(6)] [redacted] stated the [EX Order 26.4B1] should not have been on the garbage can and the floor to avoid contamination. The [Ex Order 26.4B1] depending on the length should have been stored in a bag, when either used or not used. A review of the [EX Order 26.4B1] for the resident reflected the following: [EX Order 26.4B1] [redacted]	F 695	residents with order for Oxygen to ensure that the tubing is dated, and place in a plastic bag when not in use weekly x 4 weeks and report findings to the Administrator and the Director of Nursing to the Quality Assurance Committee monthlyx3 and at the quarterly meetings.	

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EX Order 26.4B1 [redacted]

On 12/05/23 at 11:47 AM, the surveyor, in the presence of the US FOIA (b)(6) [redacted] entered the room and observed the resident lying in bed, asleep wearing the NJ Exec [redacted] that was connected to the EX Order 26.4B1. The EX Orde [redacted] was over the garbage can and partly on the floor. The surveyor and the US FOIA (b)(6) [redacted] exited the resident's room to discuss the observations and review the eMR.

At that time, the US FOIA (b)(6) [redacted] confirmed the PO should have been followed and the EX Order 26.4B1 [redacted] should not have been on the garbage can and not touching the floor.

2. On 12/01/23 at 10:32 AM, during the initial tour, the surveyor observed Resident #65's room. The resident had an EX Order 26.4B1 [redacted] in the room switched off, the EX Order 26.4B [redacted] was connected to the EX Orde [redacted] EX Order 26.4B1 [redacted] and strewn over personal care items that included a brush, band-aid, lens wipes, NJ Exec Order 26.4b1 [redacted], and an aerosol deodorant spray. The NJ Exec [redacted] was in the container, not in a storage bag next to the aerosol deodorant spray.

At 10:33 AM, the US FOIA (b)(6) [redacted] was observed walking into the room and

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F 695	Continued From page 68 informed the surveyor the resident was in the [NJ Exec Order 26] room. The surveyor reviewed the medical record for Resident #65. According to the AR, the resident was admitted to the facility with a diagnosis that included, EX Order 26.4B1 [redacted]. The qMDS dated 11/10/23, reflected a BIMS score of [EX Ord] out of 15, which indicated that the resident was EX Order 26.4B1. A review of the active OSR revealed a PO for [EX Orde] EX Order 26.4B1 as needed for [EX Order 26.4] which was initiated on [EX Order 26.4B1] On 12/05/23 at 11:05 AM, during an interview with the surveyor, and the [US FOIA (b)(6)] the [US FOIA] stated the [EX Order 26.4B1] should have been dated and stored in a bag to prevent contamination. On 12/07/23 at 11:00 AM, in the presence of the survey team, the US FOIA (b)(6) [redacted] were made aware of the	F 695		

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F 695	Continued From page 69 concerns regarding the failure to administer the [EX Order] as ordered for Resident #11 and the failure to ensure proper storage of [Ex Order 26.4B1] equipment for Resident #11 and #65. On 12/11/23 at 9:35 AM, in the presence of the survey team, the [US FOIA (b)(6)] on [NJ Exec Order 26.4b1], changed the [NJ Exec Order 26] corrected the [NJ Exec Order 26.4b1] educated the resident, assessed the resident whose [EX Orde] [NJ Exec Order 26.4b1] was between [Ex Order 26.4B1] and learned from the resident that they had adjusted their own [EX Order 26.4B1]. On that same date and time, the [US FOIA (b)(6)] stated that after Resident #11 was assessed yesterday, the [US FOIA (b)(6)] spoke with the physician and obtained an order of [Ex Order 26.4B1] which was to the resident's comfort level. At that time, the [US FOIA (b)(6)] confirmed that the [Ex Order] saturation was monitored every shift but was not identified by staff, "it was missed." The [US FOIA (b)(6)] acknowledged the CP should have been updated. Furthermore, the [US FOIA (b)(6)] stated a facility-wide education was given regarding proper storage of respiratory equipment since all staff on all shifts were responsible to ensure infection control practices were maintained when observed. All staff that entered the resident's rooms (Resident #11 and #65) should have seen it and acted upon identification. 3. On 12/01/23 at 10:28 AM, the surveyor observed Resident #56 in bed with [EX Orde] ongoing at	F 695		

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EX Order 26.4B1 that was attached to an EX Order 26.4B1. Resident #56 stated that he/she had been to the hospital because he/she had not NJ Exec Order 26.4b1. The surveyor asked Resident #56 what setting the EX Order was that he/she used. Resident #56 stated that it was supposed to be EX Order 26.4B1

On 12/04/23 at 12:27 PM, the surveyor observed Resident #56 laying in bed with EX Order 26.4B1 EX Order 26.4

The resident's AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to EX Order 26.4B1

Resident # 56's OSR included the following order:
EX Order 26.4B1 every shift for EX Order 26.4B1) is a measurement of how much EX Order 26.4B1 is carrying as a percentage of the maximum it can carry) at or NJ Exec Order 26.4b1 % with EX Order 26.4B1. The order had a start date of EX Order 26.4B1.

On 12/05/23 at 12:46 PM, the surveyor observed Resident #56 seated in bed eating lunch. Resident #56 has EX Order 26.4B1

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F 695	Continued From page 71 On 12/05/23 at 12:53 PM, the surveyor interviewed the US FOIA (b)(6) regarding the process for [redacted]. The [redacted] stated that upon admission she would get a report if the resident needed [redacted] and then get an order from the physician for how many [redacted] The [redacted] further stated that she would bring the NJ Exec Order 26.4b1 into the resident's room, do an assessment and if the order is [redacted] then the concentrator should be on [redacted]. On that same date and time, the surveyor asked how often the [redacted] was assessed to make sure the NJ Exec Order 26.4b1 was in the correct setting. The [redacted] stated that she would check it every time she went into the room and at least one time per shift. The surveyor asked where the [redacted] was stored went not in use. The [redacted] further stated that it should be in a plastic bag and that it should not be hanging over something. At that same time, the surveyor asked the [redacted] to observe Resident #56's EX Order 26.4B1. The [redacted] confirmed that the setting was under [redacted] and then changed the setting to [redacted]. On 12/06/23 at 01:00 PM, the surveyor interviewed the [redacted] regarding the process for [redacted] The [redacted] stated that each shift the [redacted] should be checked to see that it was set correctly. The [redacted] stated that the EX Order 26.4B1 or tank would be set according to the order. She added that on the EX Order 26.4B1 you would need to bend over to see the ball at eye level. At that time, the surveyor showed the [redacted] the pictures of the setting that was at [redacted]. The	F 695		

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US FOIA (b)(6) stated that she would have maintenance check the NJ Exec Order 26.4b1 that maybe the ball was dropping. The surveyor and US FOIA (b)(6) then went to Resident #56's EX Order 26.4B1 and observed that it was still set at EX Order 26.4B1 from when the US FOIA (b) had changed the setting earlier. The US FOIA (b)(6) then stated that there probably was not something wrong with the EX Order 26.4B1 but that she still would have them look at it.

4. On 12/01/23 at 11:15 AM, the surveyor observed Resident #90 sleeping in bed with EX Orde EX Order 26.4B1 . The EX Order EX Order 26.4B that was attached to the EX Order 26.4B1 was not dated to indicate when it was last changed. The surveyor observed Resident #90's wheelchair which had a NJ Exec Order 26.4B EX Order 26.4B1 on the back. The NJ Exec EX Order 26.4B was not dated and the NJ Exec Order 2 was just hanging over the EX Order 26.4B1 tank, it was not stored in a plastic bag.

The resident's AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to EX Order 26.4B1

Resident # 90's OSR included the following orders:
EX Order 26.4B1 every shift for EX Order 26.4B1 at or NJ Exec Order 26.4b1 with EX Order 26.4B1. The order had a start date of EX Order 26.4B1
EX Order 26.4B1 as needed for

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EX Order 26.4B1 months NJ Exec Order 26.4b EX Order 26.4B at or NJ Exec Order 26.4b1 % with NJ Exec NJ Exec Order 26.4b1 every shift. The order had a start date of EX Order 26.4B1 and an end date of EX Order 26.4B1.

On 12/05/23 at 12:53 PM, the surveyor interviewed the US FOIA (b) regarding the process for NJ Exec O The US FOIA (b) stated that upon admission she would get a report if the resident needed EX Orde and then get an order from the physician for how many EX Order 26. She further stated that she would bring the EX Order 26.4B1 into the resident's room, do an assessment and if the order is EX Order 26.4B1 then the NJ Exec Order 26.4b1 should be on EX Order 26.4B1

On that same date and time, the surveyor asked how often the NJ Exec Or was assessed to make sure the NJ Exec Order 26.4b1 was in the correct setting. The US FOIA (b stated that she would check it every time she went into the room and at least one time per shift. The surveyor asked where the NJ Exec was stored went not in use. The US FOIA (b stated that it should be in a plastic bag and that it should not be hanging over something.

On 12/06/23 at 10:27 AM, the surveyor observed Resident #90 seated in a wheelchair in the hallway. The surveyor then observed the US FOIA push Resident #90 into the resident's room so the US FOIA (b could administer medication to the resident. The surveyor observed Resident #90 had Ex Order 26.4B1 attached to a NJ Exec Order 26.4B Ex Orde NJ Exec O that was on the back of the resident's wheelchair. The surveyor observed the Ex Order NJ Exec Order 26.4b1 and it was NJ Exec Order 26.4b1. The US FOIA and US FOIA (b confirmed that Resident #90's Ex Orde was NJ Exec Order 26.4b1 and that the NJ Exec Order 26.4b1 which meant there was no Ex Order flowing out of the Ex Order tank and through the

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[redacted]

At this time, the [redacted] that she had to check the [redacted] that the [redacted] was on. The surveyor asked who had put the resident in the wheelchair. The [redacted] stated that the [redacted] placed the resident in the wheelchair. The surveyor asked the [redacted] what the [redacted] should have been set on. The [redacted] stated that the order was for [redacted] and then turned the knob on the [redacted]

On 12/06/23 at 01:00 PM, the surveyor interviewed the [redacted] regarding the process for [redacted] The [redacted] stated that the [redacted] was not supposed to touch the [redacted] The [redacted] stated that each shift the [redacted] should be checked to see that it was set correctly. The [redacted] stated that the [redacted] would be set according to the order. She added that on the [redacted] you would need to bend over to see the ball at eye level. The [redacted] stated that the [redacted] was changed weekly and dated and that when it was not in use it should be stored in a plastic bag.

At this time, the surveyor showed the [redacted] the picture of the [redacted] hanging over the [redacted] The [redacted] stated that the [redacted] should not be hanging over and that it should be dated.

On 12/07/23 at 11:11 AM, in the presence of the survey team, the surveyor notified the [redacted] of the concern that Resident #56's [redacted] instead of the ordered [redacted] In addition, the surveyor notified the facility management that Resident #90's [redacted] was not dated, was not in a plastic bag, and that the [redacted] was not

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F 695	Continued From page 75 [redacted] On 12/11/23 at 10:07 AM, in the presence of the survey team, the [redacted] should be checked every shift. The [redacted] further stated that the [redacted] should have been in a plastic bag and the [redacted] should have been on [redacted] The [redacted] stated that the [redacted] should get the nurse to reapply equipment when they got the resident out of bed. A review of the facility's Oxygen Administration policy, revised on 9/12/23, indicated O2 is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and resident's goals and preferences. Under policy explanation and compliance guidelines reflected the resident's CP shall identify the interventions for O2 therapy based upon the resident's assessment and orders. Keep delivery devices covered in plastic bags when not in use. NJAC 8:39-27.1(a)	F 695		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.	F 727		1/20/24

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F 727	Continued From page 76 §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interviews and review of other facility pertinent documents, the facility failed to have a designated licensed US FOIA (b)(6) on a full time basis to oversee the care of all residents in the facility with 114 licensed beds. This failure increased the risk that all residents would not be provided with appropriate and accurate care and assessments from March 1, 2023, through July 10, 2023. This deficient practice was evidenced by the following: On 12/01/23 at 9:33 AM, the surveyor met with the US FOIA (b)(6) stated that the facility had 114 licensed beds. The US FOIA (b)(6) stated that she had been at the facility for . On that same date and time, the US FOIA (b)(6) stated that there was no US FOIA (b)(6)) at the moment and that the new US FOIA (b)(will start on Ex Order 26.4B1. The US FOIA (b)(6) further stated that the previous DON #1 (DON#1) who had not been at the facility NJ Exec Order 26.4b1 had left. The surveyor asked for the timeline after 02/06/23 (the last recertification survey) up to present, and the US FOIA (b)(6) stated that he will get back to the surveyor.	F 727	F727 RN 8 HRS/7 DAYS/WK, FULL TIME DON I. CORRECTIVE ACTIONS FOR THOSE AFFECTED The facility hired a full time Registered Nurse that is the US FOIA (b)(6) and will Work Monday through Friday, eight hours a day. II. ID OTHERS WITH POTENTIAL TO BE AFFECTED All residents and staff have potential to be affected by the deficient practice A. Interim Directors of Nursing were placed in the building while recruiting for a Director of Nursing. III. SYSTEMIC CHANGES a. The administrator of the facility will ensure that there is an appointed Director of Nursing at all times. b. Human Resources will work to recruit a qualified Registered Nurse to act as a Director if Nursing. c. New qualified Director of Nursing is being hired starting Ex Order 26.4B1 IV. MONITORING a. Administrator will ensure that there a qualified Director of Nursing b. Administrator/Human Resources will notify cooperation of resignation,	

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F 727	Continued From page 77 On 12/05/23 at 10:08 AM, the surveyor interviewed the US FOIA (b)(6) The US FOIA (b)(6) stated that she started on [redacted] as the US FOIA (b)(6) She further stated that she was now the acting US FOIA (b) and that the new US FOIA (b) will start on Monday (12/11/23). The surveyor followed up on the timeline of the US FOIA (b)(6) [redacted] On 12/05/23 at 12:36 PM, the surveyor in the presence of the survey team interviewed the US FOIA (b)(6) [redacted] regarding the US FOIA (b) [redacted] at the facility since the last recertification in NJ Exec Order 26.4b1. The US FOIA (b)(6) informed the surveyor that DON #2 was the previous US FOIA (b) for about NJ Exec Order 26.4b1. The US FOIA (b)(6) was unable to remember the timeframe of DON #2 as US FOIA (b) of the facility. She further stated that there was no covering US FOIA (b) for a month until the current US FOIA (b)(6) came. A review of the provided typewritten sequence of US FOIA (b) of the facility for NJ Exec Orde that was provided by the US FOIA (b)(6) [redacted] revealed the following: NJ Exec Order 26.4b1 = US FOIA (b)(6) was the covering US FOIA (b)(6) DON #2 in Training [US FOIA (b)(6) stated that DON #2 was not the US FOIA (b) at this time]. NJ Exec Order 26.4 =DON #2 resigned NJ Exec Order 26.4 = US FOIA (b)(6) was interim US FOIA (b) NJ Exec Order 26.4 = US FOIA (b)(6) interim US FOIA (b)(6) NJ Exec Order 26.4b1 =DON #1. DON #1 was on vacation on [redacted], returned on NJ Exec Order 26.4b1 and was termed on NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 = US FOIA (b)(6) interim US FOIA (b) again. NJ Exec Order 26.4b1 =DON #3, new US FOIA (b) expected start date NJ Exec Order 26.4b1 [redacted] A review of the provided employee file of DON #2	F 727	termination and appoint another qualified Registered Nurse as an interim Director of Nursing immediately	

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F 727	Continued From page 78 revealed the following: -The resume showed that DON #2 had a total of [redacted] of experience in a supervisory position in a Long Term Care Facility prior to assuming the position of [redacted] in the facility from [redacted] to [redacted]. The resume also included that DON #2 assumed the position of [redacted] at the facility on [redacted]. -Letter provided by the [redacted] addressed to the Department of Health (DOH) dated [redacted] included that DON #2 assumed the role of [redacted] and replaced the [redacted]. -Resignation letter of DON #2 dated [redacted] with an effective date after [redacted] On 12/06/23 at 10:47 AM, the surveyor in the presence of the survey team interviewed the [redacted] The surveyor asked the [redacted] how often she stayed at the facility from the last recertification survey (02/06/23) and if the [redacted] was at the facility Monday through Friday. The [redacted] stated "I visit twice a week," depending on what was happening at the facility. The [redacted] confirmed that when she was the covering [redacted] at the facility she was never at the facility Monday through Friday, from [redacted] through [redacted] this year ([redacted] On that same date and time, the surveyor asked the [redacted] if she was the covering [redacted] of the facility and why she was not on-site at the facility to cover for a full-time [redacted] The [redacted] had no response. On 12/07/23 at 11:00 AM, the survey team met with the [redacted] The surveyor	F 727		

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F 727	Continued From page 79 notified the facility management of the above findings and concerns that there was no designated licensed [redacted] on a full time basis to oversee the care of all residents from [redacted] through [redacted] as evidenced by the provided documents for DON #2 and interview of [redacted] A review of the provided Position Title: Director of Nursing Services (job description) included in the position summary that the essential functions of the job for a DON requires, and may be amended from time to time at the sole discretion of [facility's company name], to include, but are not limited to the following: -Must possess a valid RN license, in good standing in accordance with laws of this state, from an approved NJ (New Jersey) Nursing School of Nursing. A minimum of five (5) years of full-time or equivalent clinical experience is required and a minimum of two years of clinical experience in long-term care nursing with one year in a management/administrative or supervisor capacity is preferred. BSN (Bachelor of Science in Nursing) preferred. -Comply with standards of business conduct in accordance with federal, state, and local health and regulatory standards and guidelines, as applicable. Responsibilities/Accountabilities: -Completes daily rounds on the units to observe residents and to determine if nursing needs are being met; -Participates in the assessment of residents to be admitted by evaluating the level and amount of care required by prospective residents in relation to existing nursing capabilities... On 12/11/23 at 9:34 AM, the survey team met	F 727		

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F 727	Continued From page 80 with the US FOIA (b)(6) [redacted]. The [redacted] stated that for the definition of designated fulltime [redacted] yes there was no [redacted] here from NJ Exec Order 26.4b1. On that same date and time, the [redacted] stated that the facility did not have a policy with regard to [redacted] and that the facility followed the [redacted] job description.	F 727		
F 728 SS=E	NJAC 8:39-25.1(a) Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section.	F 728		1/18/24

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F 728	Continued From page 81 §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to ensure a) that Temporary Nurse Aides (TNA) were enrolled in school prior to 5/11/23 and completed their Certified Nurse Aide (CNA) certification by 9/11/23 as mandated by Centers for Medicare and Medicaid Services (CMS) and New Jersey Department of Health (NJDOH) in order to continue to work after 5/11/23 for two (2) of two (2) non-certified NAs reviewed that were previously working as TNAs; and b) verification that the non-certified Nurse Aides were currently enrolled and actively taking classes in a New Jersey state-approved Certified Nursing Aide (CNA) Training Program and validate completion of Module 1 in their CNA Training Program prior to allocating an independent resident assignment, for two (2) of two (2) non-certified NAs that were previously working as TNAs; and c) there was a delineated policy and/or program in place for the hiring, staffing, and assignments of non-certified NAs.	F 728	I. Corrective Actions -The two Nurse aides in question were terminated. - Other Nurse aides that are currently hired are within the approved 120 days. -US FOIA (b)(6) [redacted] were Inservice immediately on hiring requirements on nurse aides (NA). - No resident was affected negatively by this deficient practice. II. ID others with potential to be affected. - All facility Residents having the potential to be affected by the same deficient practice. III. Systemic Changes	

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F 728	Continued From page 82 This deficient practice was evidenced by the following: Reference: CMS Center for Clinical Standards and Quality/Quality, Safety& Oversight Group (QSO) Memorandum (memo) QSO-21-17-NH, with an updated date of 5/10/2021 included the following regarding TNAs: Additionally, CMS waived the requirements that prohibit a nursing home from using any individual working in the facility as a nurse aide for more than four months unless they complete certain requirements (per 42 CFR §483.35(d)(1)). While this waiver has been in effect, many nurse aides have been able to work longer than four months to support facilities' staffing needs. However, nursing homes and nurse aides have raised concerns about what will happen when the waiver ends. For example, CMS has received questions on whether these individuals will need to leave the nursing home immediately when the waiver ends, if they have not completed the requirements for certification in the last four months. Though this waiver is not being terminated at this time, we are advising stakeholders that the four-month regulatory timeframe will be reinstated when the blanket waiver ends and will start at that time. In other words, nurse aides will have the full four month period starting from the end of the blanket waiver to successfully complete the required training and certification, regardless of the amount of time worked during the time the waiver was in effect. However, though nurse aides will have up to four months from the end of the blanket waiver to complete the required training and certification, we strongly encourage states and nurse aides to explore	F 728	- HR/Designee will complete full audit on all employees to ensure completion of all required documentations/orientation paperwork/validation of certification, if any, and to ensure that all newly hired employees complete the facility orientation program. - On hire NA will provide the facility a letter of proof of completion of their Skills test and HR manager will provide a calendar to the NA informing them the last day they can work without completing their written test. - Facility Educator/Designee will ensure that all newly hired nursing staff, including Registered Nurses; RN, License Practical Nurses; LPN, Certified Nurses Assistants; CNA in addition to the general orientation, complete nursing orientation, including clinical validation competencies training immediately. - Facility Educator/Designee will continue to facilitate general orientation for all staff and nursing orientation program for RNs, LPNs, CNAs. - Facility Educator/Designee will continue in-services on the following topics: a. Facility Direct Care providers, their credentials and responsibilities based on job description and facility policies and procedures.	

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F 728	Continued From page 83 ways to complete all the training and certification requirements as soon as possible. Reference: CMS QSO memo QSO-22-15-NH & NLTC & LSC, with an updated date of 8/29/2022 included the following regarding TNAs: CMS waived the requirements which require that a SNF and NF may not employ anyone for longer than four months unless they met the training and certification requirements under §483.35(d). CMS previously provided information related to nurse aides working under this blanket waiver in CMS memorandum QSO-21-17-NH. This memo provides additional information as well on the modification of this waiver below. We remind states that all nurse aides, including those hired under the above blanket waiver at 42 CFR §483.35(d), must complete a state approved Nurse Aide Competency Evaluation Program (NATCEP) to become a certified nurse aide. State approved NATCEPs must have a curriculum that includes training in the areas defined at 42 CFR §483.152(b), such as respecting residents' rights, basic nursing skills, personal care skills, and caring of cognitively impaired residents. Additionally, the requirements at 42 CFR §483.154(b)(i) and (ii) requires these nurse aides pass a written or oral exam, and demonstrate skills learned. Lastly, we note that CMS did not waive the requirement that the individual employed as a nurse aide be competent to provide nursing and nursing related services at 42 CFR §483.35(d)(1)(i), and that requirement must continue to be met. Reference: State of New Jersey Department of Health memo dated April 21, 2023 sent to Nursing Homes included the following:	F 728	b. Facility general orientation/nursing orientation including clinical competency validations completion. c. HR follows facility policy and procedures on hiring, including completion of all required documentations/orientation paperwork/validation of certification, if any. d. Unit Managers/Nursing Supervisors/Charge nurses' responsibilities. e. Facility training program for nursing and non-nursing staff. IV. Monitoring Human Resources manager will audit all Nurse Aide to ensure they are within the approve time frame of days to work weekly x 4 weeks All trends will be reported to the administrator at the Quality assurance performance improvement committee monthly x 3 months, and quarterly x2	

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F 728	Continued From page 84 On February 27, 2023, the Centers for Medicare and Medicaid Services (CMS) announced that all nurse aide emergency training waivers will terminate at the end of the Federal Public Health Emergency (PHE). The PHE is expected to end on May 11, 2023. At that time, all Temporary Nurse Aides (TNAs) hired prior to the end of the PHE and who have enrolled in a NATCEP program and completed the first 16 hours of training prior to May 11, 2023, must complete the NATCEP and pass the nurse aide written exam and the clinical skills competency exam by September 10, 2023. Nurse aides hired after the end of the PHE will have four months to complete a NATCEP program and pass the exams, as required by N.J.A.C. 8:39-43.1. The New Jersey Department of Health issues this memorandum to update facilities on the interpretation of the CMS guidance, P.L. 2021, c. 326, c. 368 and Executive Directive (ED) 20-004 (Revised July 6, 2022). Facilities are advised as follows: I. TNAs A. Individuals who are working as TNAs must pass the nurse-aide written or oral exam and the State-approved clinical skills competency exam by May 11, 2023, or the end of the federal PHE, whichever comes first. B. If a TNA does not pass the exams by the end of the federal PHE, the TNA may not work after May 11, 2023, unless the TNA meets the requirements of Paragraph C below. C. In order to work beyond May 11, 2023, TNAs must, by May 11, 2023: 1. Be enrolled in a NATCEP CNA training program, and 2. Have completed the first 16 hours of training, and	F 728		

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F 728	Continued From page 85 3. Be working in a facility before May 11, 2023. 4. Note that the TNA only has until September 10, 2023 to complete the NATCEP program and pass the exams. II. Nurse Aides Nurse Aides (not TNAs) who are enrolled in a NATCEP program must finish training and pass the nurse-aide written or oral exam and the State approved clinical skills competency exam within the usual 120 days, pursuant to N.J.A.C. 8:39-43.1. After completing the first 16 hours of training, the nurse aide may work in a nursing home while completing the training and testing. On 12/01/23 at 12:52 PM, the surveyor asked the [redacted]) for the facility's NA policy. The [redacted] stated that the facility did not have a specific policy for NAs and that they follow the NJDOH guideline. On 12/04/23 at 10:31 AM, the surveyor reviewed the facility provided list of employees that were NAs. Review of the list indicated the following: NA #1 had a date of hire (doh) of [redacted] NA #2 had a doh of [redacted] Review of the facility provided schedule for 12/02/2023 listed NA #1 and NA #2 scheduled to work the 3-11 shift. The two NAs would be past the 120 day employment and would also be past the TNA waiver that mandated TNAs be certified by [redacted] On 12/04/23 at 11:02 AM, the surveyor requested the [redacted] provide the surveyor the two NAs employee files.	F 728		

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F 728	Continued From page 86 At 11:48 AM, the surveyor requested the two NAs employee files from the US FOIA (b)(6) [redacted] At 12:34 PM, the surveyor requested again the two NAs employee files from the US FOIA (b)(6) [redacted] At 12:40 PM, in the presence of another surveyor, the surveyor interviewed the US FOIA (b)(6) [redacted] US FOIA (b)(6) [redacted]). The US FOIA (b)(6) [redacted] stated that she supported several buildings and that she kept the HR portion of new hire employees in her office. The surveyor asked where the two NA files were that the surveyor had requested. The US FOIA (b)(6) [redacted] stated that she had given them to the nursing office. At 12:48 PM, the US FOIA (b)(6) [redacted] stated that he had dropped a copy of the two NAs files in the conference room. At 12:55 PM, the surveyor reviewed the copies of documents that were provided. The complete employee files that the facility had were not provided. At 12:58 PM, the surveyor requested from the US FOIA (b)(6) [redacted] the documented evidence that the NAs completed Module 1/16 hours of the US FOIA (b [redacted] program and their competencies. On 12/05/23 at 8:50 AM, the surveyor requested the full and complete employee file for the two NAs from the US FOIA (b)(6) [redacted] who was the designee for the US FOIA (b)(6) [redacted] who was not at the facility at the time. The employee files were provided. A review of the facility provided employee files	F 728		

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F 728	Continued From page 87 included the following: NA #1: An application for employment for [US FOIA (b)] dated [Ex Order 26.4B1] TNA 8 hour training certificate of Completion (requirement for someone to work as a TNA during the PHE without the required CNA training) dated [Ex Order 26.4B1] background check with a reported date of [Ex Order 26.4B1]; a payment receipt dated [Ex Order 26.4B1] for [US FOIA (b)] course which did not include when the course started; a job description for NA dated [Ex Order 26.4B1]. There was a personnel change form dated [Ex Order 26.4B1] which indicated the employee was a hospitality aid and changed to a NA with an effective date of change of [Ex Order 26.4B1] There was no documentation that NA #1 was enrolled in the NATCEP program by [Ex Order 26.4B1]. There was no verification that NA #1 had the required Module 1/16 hours of [US FOIA (b)] program completed. NA #2: An application for employment for [US FOIA (b)] dated [Ex Order 26.4B1]; background check with a reported date of [Ex Order 26.4B1] an undated letter that stated that NA #2 was enrolled in a [NJ Exec Order 26.4b1] program that started on [Ex Order 26.4B1] and ended [Ex Order 26.4B1]; a job description for NA dated [Ex Order 26.4B1]. There was no documented evidence that NA #2 had the TNA 8 hour training certificate of Completion in the file. There was a personnel change form dated [Ex Order 26.4B1] which indicated the employee was a hospitality aid and changed to a NA with an effective date of change of [Ex Order 26.4B1]. There was a personnel change form dated [Ex Order 26.4B1] which indicated the employee was a TNA with an effective date of change of [Ex Order 26.4B1] for a rate change. There was no documentation that NA #1 was enrolled in the [NJ Exec Order 26.4b1] program by [Ex Order 26.4B1] There was no verification that NA #1 had the required Module 1/16 hours of [US FOIA (b)]	F 728		

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F 728	Continued From page 88 program completed. On 12/12/23 at 9:56 AM, the surveyor interviewed [US FOIA (b)(6)] regarding hiring TNAs and NAs. The [US FOIA (b)(6)] stated that right now she did not hire TNAs. She stated that to hire a NA the person would have to be enrolled in school when she hired them. She added that she would get documentation that they are in school usually an enrollment letter. The surveyor asked if there was a certain amount of time that they had to pass the exam by. The [US FOIA (b)(6)] stated that she thought it was 120 days from the completion of the course. The surveyor asked what needed to be verified if they were to work with residents if they were in school. The [US FOIA (b)(6)] stated that she would defer that to nursing. She added that she knew they needed to be in school and that they have documentation they are in school. On that same date and time, the surveyor asked about the process for TNAs. The [US FOIA (b)(6)] stated that TNAs were able to work during the PHE after they completed an online course and had a certificate. She added that she did not do much here with TNAs. The surveyor asked what was supposed to be done with the TNAs when the waiver for TNAs was ended. The [US FOIA (b)(6)] stated that TNAs had to go to school and not sure what else. The surveyor asked if there was a time limit. The [US FOIA (b)(6)] stated that she believed there was. She stated that the facility did not have any TNAs anymore. The surveyor asked if the facility had any current employees that were TNAs. The [US FOIA (b)(6)] stated that maybe they did and that she would have to check. She added that the TNAs would have either left the facility or changed to a NA and then on to a [US FOIA (b)(6)]	F 728		

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F 728	Continued From page 89 At this time, the surveyor asked if the files that were provided were complete. The [US FOIA (b)(6)] stated that the HR portion was complete. The surveyor asked if the TNA certificate and the Module 1/16 hours would be in the file. The [US FOIA (b)(6)] stated that it should all be in there. On 12/12/23 at 10:35 AM, in the presence of the [NJ Exec Order 2] and acting [US FOIA (b)(6)]), the surveyor interviewed the [US FOIA (b)(6)] regarding NA #2's TNA certificate. The [US FOIA (b)(6)] stated that there was a separate binder for the TNA certificates to track who needed to switch over. She added that there was a memo in April that facilities could no longer use TNAs and that the facility sent them to school to get their certification but that some did not get their certification. The [US FOIA (b)(6)] provided NA #2's TNA certificate that was dated [NJ Exec Order 26.4b1] The surveyor asked when the TNAs should have been certified by. The [US FOIA (b)(6)] stated that by [NJ Exec Order 26.4b] should have completed the program and passed the exam. The [US FOIA (b)(6)] stated that they had to be enrolled in school and complete 16 hours to continue working here while completing the training and testing. She added that once they finished the skills, they had 120 days to complete the written test. At this time, the surveyor asked about the process for a NA. The [US FOIA (b)(6)] stated that if they hired a NA, they would ask for proof of skills test and enrollment in school and if completed school they have 120 days from when they passed the skills exam. The surveyor asked who was responsible to verify the 16 hours was completed. The [US FOIA (b)(6)] stated that the [US FOIA (b)(6)] and [redacted] would verify and it would be	F 728		

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F 728	Continued From page 90 reviewed by the [US FOIA (b)(6)]. The [US FOIA (b)(6)] stated that she and the US FOIA (b)(6) worked with that. The surveyor asked if the documentation should be in the HR file. The [US FOIA (b)(6)] stated that it should be in the file. On 12/12/23 at 11:00 AM, the [US FOIA (b)(6)] looked in the facility binders for the verification documentation that the TNAs/NAs had Module 1/16 hours. The [US FOIA (b)(6)] confirmed that she could not find the documentation in any of the binders. On 12/12/23 at 12:12 PM, the surveyor reviewed the employee files with the [NJ Exec Order]. The [US FOIA (b)(6)] stated that NA #1 was a TNA and converted to a NA when she went to school in June. She added that she passed the skills test on [NJ Exec Order 26.4b]. The surveyor asked if there should be documentation that the NA completed Module 1/16 hours. The [US FOIA (b)(6)] stated that it should be verified with a document that is dated that she completed 16 hrs. and it should be available in the HR file. On 12/12/23 at 12:22 PM, the [US FOIA (b)(6)] confirmed that NA #2 had an undated form that she went to school from NJ Exec Order 26.4b1 and passed the skills test on [NJ Exec Order 26.4]. The [US FOIA (b)(6)] confirmed that there was no verification documentation for Module 1/16 hours and that she was not certified by [NJ Exec Order 26.4]. On 12/12/23 at 12:28 PM, the surveyor asked the [US FOIA (b)(6)] if the change in title to NA should have been done prior to [NJ Exec Order 26.4]. The [US FOIA (b)(6)] stated yes and that the title given previously to the TNAs was hospitality aid because the [US FOIA (b)(6)] did not understand the correct title.	F 728		

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F 728	Continued From page 91 On 12/12/23 at 02:01 PM, the [US FOIA (b)(6)] stated that the existing TNAs had until [NJ Exec Order 26.4] to complete the [NJ Exec Order 26.4b1] program and pass the exams according to the [NJ Exec Order 26.4] memo. She added that for the two NAs since they belonged to that category as of [NJ Exec Order 26.4b1] and they did not [NJ Exec Order 26.4b1] they were converted to NAs on [redacted]. She added that according to their qualifications they completed the school after [NJ Exec Order 26.4b1] and they are still within the 120 days to pass the written exam. At that time, the surveyor asked that if they were to qualify to be changed to NAs then should they have had written verification of completion of Module 1/16 hours. The [US FOIA (b)(6)] stated yes. The surveyor requested a blank TNA job description. A review of the facility provided TNA job description included the following: ...Must be willing to apply and complete the CNA certification program before expiration of the NJ DOH Nurse Aide Certification waiver program ... NA #1 and NA #2 did not have a signed TNA job description in their file. On 12/13/23 at 10:36 AM, in the presence of the survey team, the surveyor notified the [US FOIA (b)(6)] [redacted] the concerns that the two NAs who were TNAs worked past the [NJ Exec Order 26.] date with out being enrolled in school and that they were not certified by [NJ Exec Order 26.] and that even though they were not allowed to work after [NJ Exec Order 26.] that if they were allowed to be NAs that there was no verification that they completed their Module 1/16 hour. On 12/13/23 at 11:40 AM, the surveyor requested	F 728		

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	315064	A. BUILDING _____ B. WING _____	C 12/15/2023

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F 728	Continued From page 92 the schedules and assignment sheets for the NAs that worked before and after the [NJ Exec Order 26.4] deadline. A review of the schedules and unit assignments from before [NJ Exec Order 26.4] included the following: NA #1 worked [NJ Exec Order 26.4] 3-11 shift on the [Ex Order 26.4B] Wing and had an independent assignment (Assignment [NJ Ex] NA #2 worked [Exec Order 26.4b1] 7-3 shift on the [Ex Order 26.4] Wing and had an independent assignment (Assignment [NJ Ex] NA #1 and NA #2 were working as TNAs. On 12/13/23 at 12:27 PM, the [US FOIA (b)(6)] stated that originally NA #1 and NA #2 were hired as TNAs. She added that when the memo was received they reviewed it and they were transitioned into a school. On 12/14/23 at 10:23 AM, in the presence of the survey team, US FOIA (b)(6) stated that they were waiting for the actual school transcripts. The surveyor asked if the facility should have had that verification and documentation in the HR file. The [US FOIA (b)(6)] stated that it should have been. The surveyor asked that if the NAs were TNAs when the memo was received, did the TNAs do what was required according to the memo to continue to work after [NJ Exec Order 26.] . The [US FOIA (b)(6)] stated that it was not done and that it should have been done. The surveyor asked if the NAs that were TNAs should have been certified by [NJ Exec Order 26.4] The [US FOIA (b)(6)] stated that they should have been. The [US FOIA (b)(6)] stated that moving forward they would review credentials	F 728		

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F 728	Continued From page 93 and ensure verification prior to hire. The facility did not have a policy regarding TNAs or NAs. N.J.A.C. 8:39-43.1	F 728		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to	F 732		12/16/23

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F 732	Continued From page 94 exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that the 24-hour staffing report that was posted was up to date and in a prominent place within the facility readily accessible to the residents and the visitors. This deficient practice was evidenced by the following: On 12/01/23 at 8:50 AM, the survey team entered the facility and observed the Nursing Home Resident Care Staffing Report (NHRCSR) was on a bulletin board outside th [redacted] office which was on the [redacted] unit side of the building. The location of the bulletin board was not visible to residents or their visitors that resided on the [redacted] unit since those residents and/or their visitors would not walk in that direction. The NHRCSR was dated [redacted] The NHRCSR for that day was not posted. On 12/01/23 at 01:46 PM, the surveyor observed that the NHRCSR that was posted was dated [redacted]. The posting was the same posting that was observed that morning. On 12/04/23 at 8:50 AM, the surveyor observed	F 732	F732 POSTED NURSE STAFFING INFORMATION I. CORRECTIVE ACTIONS FOR THOSE AFFCTED a. Facility staffing information was posted at the front desk by the receptionist and on the units. b. Staffing coordination was Inservice immediately II. ID OTHERS WITH POTENTIAL TO BE AFFECTED BY THIS DEFICIENT PRACTICE a. All residents, staff and visitors have potential to be affected by this deficient practice III. SYSTEMIC CHANGES a. The Staffing coordinator will post staffing daily Monday through Friday. b. Staffing coordinator will leave weekend staffing for the weekend supervisor to post. c. When Staffing coordinator if off Assistant Director of Nursing or designee will post staffing IV. Monitoring a. Director of Nursing will audit daily during the week x 10days b. The Manager on Duty will audit on the weekend x4 weekends to ensure staffing	

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F 732	Continued From page 95 the NHRCSR posted was dated [NJ Exec Order 26.4b]. The NHRCSR had not been posted daily on Friday, Saturday or Sunday. The place that the NHRCSR was posted was not visible to any residents or their visitors that resided on the [NJ Exec Order] unit since the bulletin board would not be passed on the way to the [NJ Exec Order] unit. On 12/05/23 at 11:24 AM, the surveyor interviewed the [US FOIA (b)(6)] regarding the process for posting the NHRCSR. The [US FOIA] stated that she posted the NHRCSR every day during the weekdays. She stated that she would post it on Friday and if there were any changes over the weekend that she would change it in the system on Monday. On that same date and time, the surveyor asked the [US FOIA] if anyone posted the NHRCSR on the weekend days. The [US FOIA] stated that nobody posted it on the weekend. The surveyor asked the [US FOIA] what time of the day the NHRCSR was posted. The [US FOIA] stated that tried to post it by 10 AM. At that same time, the surveyor asked the [US FOIA] if she was working on [NJ Exec Order 26.4b] since the NHRCSR that was observed on [NJ Exec Order 26.4b] was dated [NJ Exec Order 26.4b] The [US FOIA] stated that maybe she posted it late because she had callouts and was trying get people to come in. The surveyor then notified the [US FOIA] that when the surveyors entered the facility on Monday 12/04/23 the posting that was observed was dated 11/30/23. The [US FOIA] stated that she was not sure why. On 12/07/23 11:10 AM, in the presence of the survey team, the surveyor notified the [US FOIA (b)(6)]	F 732	is posted. c. The Director of Nursing will report trends to the Administrator and the Quality Assurance Committee monthly x 3, and quarterly x2.	

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F 732	Continued From page 96 US FOIA (b)(6) the concerns that the staff posting was not in a prominent place and not up to date on a daily basis. The surveyor requested a facility policy on posting the staffing report. On 12/11/23 at 9:35 AM, in the presence of the survey team, US FOIA (b)(6) stated that they investigated and put interventions because the posting was only on one side. She added the US FOIA forgot to post the NHRCSR on 12/01/23, 12/02/23, 12/03/23 and 12/04/23. On 12/11/23 at 10:28 AM, the US FOIA (b)(6) stated that the facility did not have a policy regarding posting the NHRCSR and that they followed the state regulation for posting and visible to residents and staff.	F 732		
F 755 SS=E	N.J.A.C. 8:39-41.2 (a)(b)(c) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	F 755		12/20/23

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F 755	Continued From page 97 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility provided documents, it was determined that the facility failed to a) develop and evaluate policy and procedure for the implementation of pharmaceutical services consistent with state and federal requirements and reflect current standards of practice for dispensing; disposing of narcotic medications within the electronic back-up machine (EBM) upon the departure of the previous Medical Director, and b) maintain a system of record keeping of the DEA Form 222 that ensured an accurate inventory and reconciliation of controlled dangerous substance (narcotics medications, with high potential for abuse and are tracked with detail) observed during	F 755	F755 PHARMACY SRVCS/PROCEDURES/PHARMACIST/RECORDS I. CORRECTIVE ACTION FOR THOSE AFFECTED Nurses were Inservice not to use any of the narcotics in the back up Regional Infection Preventionist Nurse contacted Drug Enforcement Administration about what to do with the remaining narcotics from the previous medical director, and where to send the unused 222 forms.	

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F 755	Continued From page 98 medication storage inspection. This deficient practice was evidenced by the following: 21 CFR 1301.52 Termination of registration; transfer of registration; distribution upon discontinuance of business. (a) Except as provided in paragraph (b) of this section, the registration of any person, and any modifications of that registration, shall terminate, without any further action by the Administration, if and when such person dies, ceases legal existence, discontinues business or professional practice, or surrenders a registration. Any registrant who ceases legal existence or discontinues business or professional practice shall notify the Administrator promptly of such fact... (b) No registration or any authority conferred thereby shall be assigned or otherwise transferred except upon such conditions as the Administration may specifically designate and then only pursuant to written consent. Any person seeking authority to transfer a registration shall submit a written request, providing full details regarding the proposed transfer of registration, to the Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration. See the Table of DEA Mailing Addresses in § 1321.01 of this chapter for the current mailing address. 21CFR 1305.18 Return of unused DEA Forms 222. If the registration of any purchaser terminates (because the purchaser dies, ceases legal existence, discontinues business or professional	F 755	A binder was created with the 222 forms put in order, locked in the Director of Nursing Office. II. ID OTHERS WITH POTENTIAL TO BE AFFECTED All residents have the potential to be affected by the deficient practice Nurses were Inservice to call the residents primary doctor to get scripts for any narcotics that were needed. III. SYSTEMIC CHANGES If there is a change in the Medical Director, Administrator and or Director of Nursing will immediately notify Drug Enforcement Administration (DEA) about the change. All unused 222 forms will be mail to the address provided through certified mail 222 forms are place in a locked brawer in the director of nursing office IV. MONITORING Pharmacy account representative will check Medical Director status monthly and report findings to Administration and Director of Nursing x3 months, and at Quality Assurance quarterly meetings. The Pharmacist Consultant will review	

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F 755	Continued From page 99 practice, or changes the name or address as shown on the purchaser's registration) or is suspended or revoked under § 1301.36 of this chapter for all Schedule I and II controlled substances for which the purchaser is registered, the purchaser must return all unused DEA Forms 222 to the Registration Section 1. On 12/07/23 at 11:44 AM, during an interview with the surveyor, the US FOIA (b)(6) [redacted] stated "we do not have narcotic back-up medications." The new DEA Form 222 (a federal requisition form), of the new US FOIA (b)(6)) were just received. "We do not have back up." On 12/11/23 at 12:18 PM, in the presence of the US FOIA (b)(6) [redacted] and the US FOIA (b)(6) [redacted] the surveyor inspected the EBM. During the inspection, the surveyor learned that narcotics were still available in the facility. The cycle count reflected the following narcotics were in stock for dispensing: -Acetaminophen-Codeine (is a combination medicine made up of codeine (an opioid medication) and acetaminophen (a non-opioid medication) and is used to relieve pain) 325 milligram (mg) 30 mg tablet, quantity of 15 -Dilaudid (narcotic analgesics) 2 mg tablet, quantity of 26 -Diazepam (Valium; anxiolytic and sedative that can treat anxiety, muscle spasms, and seizures) 5 mg tablet, quantity of 1 -Fentanyl (narcotic that can treat severe pain) 25 microgram (mcg) patch, quantity of 4 -Fentanyl 50 mcg patch, quantity of 3 -Lyrica (medication that treats nerve pain by calming overactive nerve) 50 mg (Pregabalin)	F 755	222 binders monthly with Director of Nursing and repot findings to Administrator monthly x3 months and at the Quality Assurance quarterly meetings.	

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F 755	Continued From page 100 capsule, quantity of 18 -Oxycodone (It can treat moderate to severe pain) 10 mg tablet, quantity of 24 A review of the facility provided; Controlled Substance Report dated 12/01/23 to 12/12/23 reflected the following: -Oxycodone 10 mg tablet, 1 tablet was removed on 12/04/23 by Facility staff (FS) #1 and FS #2 on 12/04/23 for a resident. -Oxycodone/ Acetaminophen 10 mg /325 mg tablet, 23 tablets were removed on 12/01/23 by the pharmacy provider representative (PPR) and US FOIA (b)(6) [same quantity was reflected on the destruction request form dated 12/06/23]. -Morphine Sulfate 10 mg/0.5 milliliter (ml), two ml was removed on 12/01/23 by the PPR and the US FOIA (b)(6) [quantity of 12 was reflected on the destruction request form dated 12/06/23]. A review of the facility provided; Controlled Substance Report dated 11/01/23 to 11/30/23 reflected the following: -Morphine sulfate 30 mg tablet, one tablet was removed on 11/04/23 by FS #3 and FS #4 for a resident, six tablets were removed on 11/30/23 by FS #5 and FS #6 not for a resident, discrepancy not stated and not resolved [quantity of 26 was reflected on the destruction request form dated 12/06/23]. -Oxycodone immediate release 5 mg tablet, one tablet was removed on 11/04/23, by FS #3 and FS #5 for a resident. Two tablets were removed on 11/11/23 by FS #8 and FS #9 for a resident. -Diazepam 5 mg tablet, one tablet was removed on 11/16/23 by FS #10 and FS #11 for a resident. One tablet was removed on 11/16/23 by FS #12 and FS #5 for a resident.	F 755		

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F 755	Continued From page 101 -Oxycodone 10 mg tablet, one tablet was removed on 11/12/23, by FS #5 and FS #12 for a resident. -Fentanyl 12 mcg, two was removed on 11/29/23 by FS #5 and FS #6 [same quantity was reflected on the destruction request form dated 12/06/23]. Lyrica 50 mg, 18 were removed on 11/30/23 by FS #5 and FS #6 [same quantity was reflected on the destruction request form dated 12/06/23]. A review of the facility provided; Controlled Substance Report dated 10/01/23 to 10/30/23 reflected the following: - Morphine sulfate 30 mg tablet, [did not reflect a removal for return or usage}. -Oxycodone Immediate Release 5 mg one tablet was removed on 10/15/23 by FS #13 and FS #14 for a resident. one tablet was removed on 10/16/23 by FS #14 and FS #13 for a resident. one tablet was removed on 10/20/23 by FS #6 and FS #14 for a resident. one tablet was removed on 10/23/23 by FS #12 and FS #6 for a resident. one tablet was removed on 10/27,23 by FS #1 and FS #7 for a resident. one tablet was removed on 10/29/23 by FS #14 and FS #11 for a resident. one tablet was removed on 10/29/23 by FS #2 and FS #9 for a resident. A review of the Controlled Substance report for December 2023, November 2023, and October 2023, revealed the facility continued to use the narcotic medication located within the EBM after the previous [redacted] resigned. On 12/12/23 at 10:33 AM, during an interview	F 755		

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F 755	Continued From page 102 with the surveyor, the US FOIA (b)(6) [redacted] stated that he had not taken any narcotic orders from the facility for the EBM since the new [redacted] started. They were waiting for the new DEA Form 222 that would reflect the current US FOIA (b) DEA registration number. On 12/13/23 at 10:21 AM, in the presence of the survey team, the US FOIA (b)(6) [redacted] were made aware of the concerns regarding the failure of the facility to develop and evaluate policy and procedures for the implementation of pharmaceutical services consistent with state and federal requirements and reflect current standards of practice for dispensing; and disposing of narcotic medications upon the departure of the previous medical director and the missing DEA -222 Forms. On 12/13/23 at 10:58 AM, during an interview with the surveyor, the US FOIA (b)(6) stated that we have not replenished our narcotic back-up medication for the EBM since the previous US FOIA left in Ex Order 26 Ex Order 26.4b [redacted] On that same date and time, the US FOIA (b)(6) stated that they were told by the provider pharmacy representative verbally that they were able to use the left-over narcotic medication in the EBM that was ordered under the previous US FOIA (b) DEA license. The US FOIA (b)(6) stated that the narcotic medications in the EBM were owned by the facility.	F 755		

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ASHBROOK CARE & REHABILITATION CENTER	**1610 RARITAN ROAD SCOTCH PLAINS, NJ 07076**

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F 755	Continued From page 103 At that time, the [US FOIA (b)(6)] stated we did not inquire with the US FOIA (b)(6) in [NJ Exec Order 26.4b1]. We decided to follow the guidance from the pharmacy provider who dispensed the medication to us. When the [US FOIA (b)(6)] was asked who was ultimately responsible for the narcotic medication in the EBM, the [US FOIA (b)(6)] stated the [US FOIA (b)(6)] At that time, the surveyor asked if the facility had followed their policy and procedures. The [US FOIA (b)(6)] stated that she was unaware of the policy and procedures or if there was a process for the narcotics in the EBM when there was a change of [US FOIA] or when an [US FOIA] resigned. At that time, the [US FOIA (b)(6)] confirmed that the facility did not notify the DEA of the fact that the previous [US FOIA] had left or requested for guidance regarding the narcotics within the EBM prior to surveyor inquiry. Furthermore, the US FOIA (b)(6) stated that stat orders (immediate/emergency) were available for the facility from the provider pharmacy which could be delivered within two to four hours when needed. At that same time, the [US FOIA (b)(6)] informed the surveyor that the DEA Form-222 were mailed back to the DEA but did not have proof that the documents were mailed or when they were mailed. The [US FOIA (b)(6)] stated she was unsure of who the previous [US FOIA (b)(6)] was at that time. On 12/13/23 at 12:01 PM, the [US FOIA (b)(6)] stated that they had reached out to the New Jersey Drug Control Unit (NJDCU) on [NJ Exec Order 26.4b1], by email and	F 755		

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F 755	Continued From page 104 called the Controlled Dangerous Substance department to inquire regarding the event of a change of medical director, can the facility continue to dispense, administer narcotics left in the EBM from the previous [US FOIA] after surveyor inquiry. At that time, the surveyor reviewed the NJDCU auto response email which reflected the facility's inquiry would receive a response in approximately two weeks. A review of the letter sent by the pharmacy provider's Compliance Officer dated 12/12/23, included guidance that reflected " ...the facility can continue to utilize their stock being that they have a valid CDS [Controlled Dangerous Substance, license] and DEA [Drug Enforcement Administration, registration number] under the new MD ..." A review of the previous [US FOIA (b)] resignation letter revealed a date of [Ex Order 26. NJ?] A review of the new [US FOIA (b)] employee file revealed a contract signed on [redacted]. A review of the CDS license revealed the valid dates were from 9/28/23 to 10/31/24. A review of the DEA registration number revealed an issue date of 11/06/23. The review of the previous [US FOIA (b)] resignation against the date of hire of the new [US FOIA (b)] the date of issuance of the CDS and DEA registration, revealed a gap of an authorized practitioner in the facility while the Controlled Dangerous	F 755		

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F 755	Continued From page 105 Substance was maintained in the facility's EBM machine. A review of the standard form contract between the facility and the [US FOIA (b)] under section 11.1 Disclosure of Confidential Information and Reports indicated: All property and supplies used by physician in the performance of its services hereunder; and all patient records charts, Facility equipment and Facility furnishings shall remain the sole property of Facility ... On 12/14/23 at 9:54 AM, in the presence of the survey team, the [US FOIA (b)(6)] stated there was no document of transfer of registration, no Power of Attorney on file, no letter was sent to the DEA for the change of the [US FOIA] by the facility or the previous [US FOIA] prior to surveyor inquiry. The [US FOIA (b)(6)] acknowledged that there should have been communication with the DEA when the previous [US FOIA] had resigned. At that time, the [US FOIA (b)(6)] stated she found the DEA Form 222 that was locked in the previous [US FOIA (b)(6)] office. She further stated that she voided the forms, emailed CDS, and asked CDS where to mail the unused DEA Form 222. At that time, the [US FOIA (b)(6)] stated she failed to account for the DEA Form 222. The [US FOIA (b)(6)] further stated that the policy should have included a process for when there was a change of [US FOIA (b)]. On 12/14/23 at 12:42 PM, the surveyor and [US FOIA (b)(6)] reviewed the recovered DEA Form 222s	F 755		

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F 755	Continued From page 106 together. Upon review the forms, DEA Form number 220289218 could not be located. The [redacted] could not identify if the form was used, lost, or stolen. At that time, the [redacted] stated there was no process to identify, reconcile, account for the DEA Form 222 against diversion. The [redacted] confirmed she was unable to account for the missing DEA Form 222. There is no current process to track, used and received DEA Form 222. A review of the facility provided; Controlled Substance Policy reviewed 8/2022, included the following: Policy: It is the policy of this facility to promote safe high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure. Policy Explanation and Compliance Guidelines 1. The Director of Nursing ("DON") as designated by the facility will be responsible for ensuring that facility's compliance with the terms of the policy. Orders for Back-Up Controlled Substances 4. The DON will maintain a copy of the DEA Form 222. copy will be kept in the backup stock-controlled substance binder. The facility policy did not reflect a policy and procedure regarding a change of MD and a process for the narcotic in the EBM and a process to maintain a system of record keeping of the DEA Form 222 that ensured an accurate inventory and reconciliation of controlled	F 755		

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F 755	Continued From page 107 dangerous substance. NJAC 29.7(c)	F 755		
F 756 SS=F	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and	F 756		1/10/24

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F 756	Continued From page 108 maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interviews and a review of pertinent facility documents, it was determined that the facility failed to provide oversight by a licensed [US FOIA (b)(6)], to review the resident's medication regimen and medical record to identify and report irregularities for 17 out of 20 residents, (Residents #1, #11, #16, #17, #18, #24, #26, #38, #39, #43, #56, #61, #65, #72, #76, #87, and #90) reviewed during Medication Regimen Review (MRR), according to facility's policy and procedure. This deficient practice was evidenced by the following: 1. On 12/01/23 at 9:12 AM, the surveyor observed Resident #1 sitting on edge of bed eating breakfast and dressed appropriately. The surveyor reviewed the hybrid (a combination of paper-based and electronic medical records that primarily involves tracking and storing a patient's health records in several formats and places) medical records of Resident #1. Resident #1's Admission Record (AR; or face sheet, an admission summary) reflected that that resident was a [Ex Order 26.4B1] resident at the facility and had diagnoses which included but were not limited to [EX Order 26.4B1]	F 756	F756 DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON I. CORRECTIVE ACTION FOR THOS AFFECTED Resident # 1 was assessed by [US FOIA] and had [NJ Exec Order 26.4b1] from the deficient practice Resident #11 was assessed by [US FOIA] and had [NJ Exec Order 26.4b1] from the deficient practice Resident #16 was assessed by [US FOIA] and had [NJ Exec Order 26.4b1] from the deficient practice Resident #17 was assessed by [US FOIA] and had [NJ Exec Order 26.4b1] from the deficient practice Resident #18 was assessed by [US FOIA (b)] and had [NJ Exec Order 26.4b1] from the deficient practice Resident #24 was assessed by [US FOIA] and had [NJ Exec Order 26.4b1] from the deficient practice	

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F 756	Continued From page 109 EX Order 26.4B1 [redacted] A review of the resident's US FOIA (b)(6) [redacted] Evaluation (or MRR), a paper month-to-month report of CP #1 revealed that the last MRR date was on Ex Order 26.4B1 . A review of the provided two binders for Pharmacy reviews showed that there were two different companies for CP. CP #1 last MRR was on Ex Order 26.4B1 while CP #2 initial MRR was on Ex Order 26.4B1 . Further review of the hybrid medical records showed that there were no MRRs for Ex Order 26.4B1 [redacted]. 2. On 12/06/23 at 9:03 AM, the surveyor observed Resident #16 in bed, the surveyor noted a EX Order 26.4B1 [redacted]. The resident had an NJ Exec Order 26.4b1 in place and a EX Order 26.4B1 Ex Order 26.4B1 .	F 756	Resident #26 was assessed by US FOIA [redacted] and had NJ Exec Order 26.4b1 from the deficient practice Resident #38 was assessed by US FOIA [redacted] and had NJ Exec Order 26.4b1 from the deficient practice Resident #39 was assessed by US FOIA [redacted] and had NJ Exec Order 26.4b1 from the deficient practice Resident #43 was assessed by US FOIA [redacted] and had NJ Exec Order 26.4b1 from the deficient practice Resident #56 was assessed by US FOIA [redacted] and had NJ Exec Order 26.4b1 from the deficient practice Resident #61 was assessed by US FOIA [redacted] and had NJ Exec Order 26.4b1 from the deficient practice Resident #65 was assessed by US FOIA [redacted] and had NJ Exec Order 26.4b1 from the deficient practice Resident #72 was assessed by US FOIA [redacted] and had NJ Exec Order 26.4b1 from the deficient practice Resident #76 was assessed by US FOIA [redacted] and had NJ Exec Order 26.4b1 from the deficient practice Resident #87 was assessed by US FOIA [redacted] and had NJ Exec Order 26.4b1	

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F 756	Continued From page 110 The surveyor reviewed the hybrid medical records of Resident #16. Resident #16's AR reflected that that resident was a LTC resident at the facility and had diagnoses which included but were not limited to, EX Order 26.4B1 [redacted] A review of the resident's CP Evaluation, a paper month-to-month report of CP #1 revealed that the last MRR date was on NJ Exec Order 26.4b [redacted] A review of the provided two binders for Pharmacy reviews showed that there were two different companies for CP. CP #1 last MRR was on NJ Exec Order 26.4b1 [redacted] while CP #2 initial MRR was on NJ Exec Order 26.4b1 [redacted] Further review of the hybrid medical records showed that there were no MRRs for NJ Exec Order 26.4 [redacted] NJ Exec Order 26.4b1 [redacted] and NJ Exec Order 26.4b1 [redacted] 3. On 12/6/23 at 9:07 AM, the surveyor observed Resident #17 in bed getting ready to be washed and bathed by their assigned EX Order 26.4B1 [redacted] aid. The surveyor reviewed the hybrid medical records of Resident #17. Resident's 17's AR reflected that the resident	F 756	from the deficient practice Resident #90 was assessed by US FOIA [redacted] and had NJ Exec Order 26.4b1 [redacted] from the deficient practice II. ID OTHER WITH POTENTIAL TO BE AFFECTED All residents had the potential to be affected by the deficient practice. All residents were assessed and no negative outcome from the deficient practice III. SYSTEMIC CHANGES New pharmacy consultant group started All resident's medication review were completed IV. MONITORING Director of Nursing to audit residents drug regimen review monthly and report any break or omission to the administrator immediately x3months Trends will be reported monthly x3months and quarterly x3 by the Director of Nursing.	

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was admitted to the facility with diagnoses that included but not limited to; EX Order 26.4B1 [redacted].

A review of the resident's CP Evaluation, a paper month-to-month report of CP #1 revealed that the last MRR date was on EX Order 26.4B1.

A review of the provided two binders for Pharmacy reviews showed that there were two different companies for CP. CP #1 last MRR was on EX Order 26.4B1 while CP #2 initial MRR was on EX Order 26.4B1.

Further review of the hybrid medical records showed that there were no MRRs for EX Order 26.4B1 EX Order 26.4B1.

4. On 12/01/23 at 10:44 AM, the surveyor observed Resident #24 during transfer by two Certified Nursing Assistance (CNA).

The surveyor reviewed the hybrid medical records of Resident #24.

Resident #24's AR reflected that that resident was a [redacted] at the facility and had

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F 756	Continued From page 112 diagnoses which included but were not limited to EX Order 26.4B1 [redacted] A review of the resident's CP Evaluation, a paper month-to-month report of CP #1 revealed that the last MRR date was on EX Order 26.4B1 [redacted]. A review of the provided two binders for Pharmacy reviews showed that there were two different companies for CP. CP #1 last MRR was on EX Order 26.4B1 [redacted] while CP #2 initial MRR was on EX Order 26.4B1 [redacted] Further review of the hybrid medical records showed that there were no MRRs for EX Order 26.4B1 [redacted] EX Order 26.4B1 [redacted]. 5. On 12/01/23 at 10:48 AM, the surveyor observed Resident #38 on edge of bed and during breakfast and there was a wheelchair (w/c) in the room. The surveyor reviewed the hybrid medical records of Resident #38. Resident #38's AR reflected that that resident was a LTC resident at the facility and had diagnoses which included but were not limited to EX Order 26.4B1 [redacted]	F 756		

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F 756	Continued From page 113	F 756		

(EX Order 26.4B1 [redacted]

A review of the resident's CP Evaluation, a paper month-to-month report of CP #1 revealed that the last MRR date was on EX Order 26.4B1.

A review of the provided two binders for Pharmacy reviews showed that there were two different companies for CP. CP #1 last MRR was on EX Order 26.4B1 while CP #2 initial MRR was on EX Order 26.4B1

Further review of the hybrid medical records showed that there were no MRRs for NJ Exec Order 26.4 NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1

6. On 12/01/23 at 10:58 AM, the surveyor observed Resident #43 seated in a w/c inside their room watching tv.

The surveyor reviewed the hybrid medical records of Resident #43.

Resident #43's AR reflected that that resident was a Ex Order 26 resident at the facility and had diagnoses which included but were not limited to EX Order 26.4B1 [redacted]

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EX Order 26.4B1 [redacted]

A review of the resident's CP Evaluation, a paper month-to-month report of CP #1 revealed that the last MRR date was on EX Order 26.4B1 [redacted].

A review of the provided two binders for Pharmacy reviews showed that there were two different companies for CP. CP #1 last MRR was on NJ Exec Order 26.4b1 [redacted] while CP #2 initial MRR was on NJ Exec Order 26.4b1 [redacted].

Further review of the hybrid medical records showed that there were no MRRs for NJ Exec Order 26.4 [redacted] NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1.

7. On 12/01/23 at 10:41 AM, during the initial tour, the surveyor observed Resident #18 lying in bed, NJ Exec Orde NJ Exec Order 26 NJ Exec Order 26.4b with a NJ Exec Order 26.4b1 from NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1 were placed on both sides of the bed.

The surveyor reviewed the hybrid medical records of Resident #18.

According to the resident's AR, Resident #18 was admitted to the facility with the diagnoses that included but were not limited to EX Order 26.4B1 [redacted]

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EX Order 26.4B1 [redacted].

A review of the resident's CP Evaluation, a paper month-to-month report of CP #1 revealed that the last MRR date was on EX Order 26.4B1.

A review of the provided two binders for Pharmacy reviews showed that there were two different companies for CP. CP #1 last MRR was on EX Order 26.4B1 while CP #2 initial MRR was on EX Order 26.4B1.

Further review of the hybrid medical records showed that there were no MRRs for EX Order 26.4B1, EX Order 26.4B1

8. On 12/01/23 at 11:40 AM, during the initial tour, the surveyor observed Resident #11 in bed with the EX Order 26.4B1 NJ Exec Order 26.4b1 on and set between EX Order 26.4B1

The surveyor reviewed the hybrid medical records of Resident #11.

According to the AR, the resident was admitted to the facility with diagnoses that included EX Order 26.4B1 [redacted].

A review of the resident's CP Evaluation, a paper

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F 756	Continued From page 116 month-to-month report of CP #1 revealed that the last MRR date was on EX Order 26.4B1 A review of the provided two binders for Pharmacy reviews showed that there were two different companies for CP. CP #1 last MRR was on EX Order 26.4B1 while CP #2 initial MRR was on EX Order 26.4B1. Further review of the hybrid medical records showed that there were no MRRs for EX Order 26.4B1, EX Order 26.4B1. 9. On 12/01/23 at 11:00 AM, the surveyor observed Resident # 76 wandering up and down the hallways, fitted with NJ Exec Order 26.4b1, and was well dressed. The surveyor reviewed the hybrid records of Resident #76. According to the AR, the resident was admitted to the facility with diagnoses that included, EX Order 26.4B1 A review of the resident's CP Evaluation, a paper month-to-month report of CP #1 revealed that the last MRR date was on EX Order 26.4B1. A review of the provided two binders for Pharmacy reviews showed that there were two different companies for CP. CP #1 last MRR was on EX Order 26.4B1 while CP #2 initial MRR was on EX Order 26.4B1	F 756		

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Further review of the hybrid medical records showed that there were no MRRs for [redacted] and [redacted].

10. On 12/01/23 at 10:32 AM, during the initial tour, the surveyor observed Resident #65's room.

At 10:33 AM, the [redacted] was observed walking into the room and informed the surveyor the resident was in the activity room.

The surveyor reviewed the hybrid medical records of Resident #65.

According to the AR, the resident was admitted to the facility with diagnoses that included, [redacted].

A review of the resident's CP Evaluation, a paper month-to-month report of CP #1 revealed that the last MRR date was on [redacted].

A review of the provided two binders for Pharmacy reviews showed that there were two different companies for CP. CP #1 last MRR was on [redacted] while CP #2 initial MRR was on [redacted]

Further review of the hybrid medical records showed that there were no MRRs for [redacted].

11. On 12/01/23 at 11:19 AM, during initial tour, the surveyor observed the Resident #72's door was closed, [redacted] sign on

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the door, personal protective equipment supply was outside the resident's door with ample supply.

The surveyor reviewed the hybrid medical records of Resident #72.

According to the AR, the resident was admitted to the facility with diagnoses that included, [redacted].

A review of the resident's CP Evaluation, a paper month-to-month report of CP #1 revealed that the last MRR date was on [redacted].

A review of the provided two binders for Pharmacy reviews showed that there were two different companies for CP. CP #1 last MRR was on [redacted] while CP #2 initial MRR was on [redacted].

Further review of the hybrid medical records showed that there were no MRRs for [redacted] and [redacted].

12. On 12/01/23 at 10:15 AM, during initial tour the surveyor observed the Resident #61 lying on a [redacted] bed with a bla[redacted] The resident stated he/she attended [redacted] a week and the schedule were mostly consistent and was accommodated when he/she arrived late. The resident informed the surveyor they were [redacted] and had not experienced [redacted].

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F 756	Continued From page 119 The surveyor reviewed the hybrid medical records of Resident #61. According to the AR, the resident was admitted to the facility with diagnoses that included, [EX Order redacted]. A review of the resident's CP Evaluation, a paper month-to-month report of CP #1 revealed that the last MRR date was on [EX Order 26.4B1 redacted]. A review of the provided two binders for Pharmacy reviews showed that there were two different companies for CP. CP #1 last MRR was on [NJ Exec Order 26.4b1 redacted] while CP #2 initial MRR was on [redacted]. Further review of the hybrid medical records showed that there were no MRRs for [EX Order 26.4B1 redacted] EX Order 26.4B1 [redacted]. 13. On 12/01/23 at 11:40 AM, the surveyor observed Resident #26 Ex Order 26.4B1 of the facility holding a bag in his/her hand. The surveyor reviewed the hybrid medical records of Resident #26. A review of Resident #26's AR indicated that the resident was admitted to the facility with medical diagnoses that included but were not limited to; EX Order 26.4B1 [redacted]. A review of the resident's CP Evaluation, a paper month-to-month report of CP #1 revealed that the EX Order 26.4B1 [redacted] was on [EX Order 26.4B1 redacted]	F 756		

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F 756	Continued From page 120 A review of the provided two binders for Pharmacy reviews showed that there were two different companies for CP. CP #1 last MRR was in [NJ Exec Order 26.4b1] while CP #2 initial MRR was on [NJ Exec Order 26.4b1]. Further review of the hybrid medical records showed that there were no MRRs for [EX Order 26.4B1] [EX Order 26.4B1]. 14. On 12/01/23 at 10:28 AM, the surveyor observed Resident # 56 in bed wit [EX Order 26.4B1] [redacted] The surveyor reviewed the hybrid medical records of Resident #56. A review of Resident #56's AR indicated that the resident was admitted to the facility with diagnoses that included but were not limited to [EX Order 26.4B1] [redacted] A review of the resident's CP Evaluation, a paper month-to-month report of CP #1 revealed that the initial MRR was on [Ex Order 26.4B1] A review of the provided two binders for Pharmacy reviews showed that there were two different companies for CP. CP #1 last MRR was in [NJ Exec Order 26.4b1] while CP #2 initial MRR was on [NJ Exec Order 26.4b1]	F 756		

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F 756	Continued From page 121 Further review of the hybrid medical records showed that there were no MRRs for [redacted] and [redacted]. 15. On 12/01/23 at 10:20 AM, the surveyor observed Resident #87 laying in bed with a [redacted] his/her [redacted]. The surveyor reviewed the hybrid medical records of Resident #87. A review of Resident #87's AR indicated that the resident was admitted to the facility with medical diagnoses that included but were not limited to; [redacted] A review of the resident's CP Evaluation, a paper month-to-month report of CP #1 revealed that the last MRR date was on [redacted]. A review of the provided two binders for Pharmacy reviews showed that there were two different companies for CP. CP #1 last MRR was in [redacted] while CP #2 initial MRR was on [redacted]. Further review of the hybrid medical records showed that there were no MRRs for [redacted]	F 756		

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F 756	Continued From page 122 16. On 12/01/23 11:15 AM, the surveyor observed Resident #90 sleeping in bed with EX Orde EX Order 26.4B1 . The surveyor reviewed the hybrid medical records of Resident #90. A review of Resident #90's AR that the resident was admitted to the facility with diagnoses that included but were not limited to EX Order 26.4B1 [redacted] A review of the resident's CP Evaluation, a paper month-to-month report of CP #1 revealed that the last MRR date was on EX Order 26.4B1 A review of the provided two binders for Pharmacy reviews showed that there were two different companies for CP. CP #1 last MRR was in EX Order 26.4B1 while CP #2 initial MRR was on EX Order 26.4B1 . Further review of the hybrid medical records showed that there were no MRRs for EX Order 26.4B1 EX Order 26.4B1 17. On 12/01/23 at 10:48 AM, the surveyor observed Resident #39 seated in a NJ Exec Order 26. wheelchair and well dressed. The resident's Ex Order 26 Ex Order 26.4B1 Ex Order 26.4B1 . The surveyor reviewed the hybrid medical	F 756		

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F 756	Continued From page 123 records of Resident #39. Resident #39's AR reflected that that resident was a [redacted] resident at the facility and had diagnoses which included but were not limited to [redacted]. A review of the resident's Consultant Pharmacist (CP) Evaluation (or MRR), a paper month-to-month report of CP #1 revealed that the last MRR date was on [redacted]. A review of the provided two binders for Pharmacy reviews showed that there were two different companies for CP. CP #1 last MRR was on [redacted] while CP #2 initial MRR was on [redacted]. Further review of the hybrid medical records showed that there were no MRRs for [redacted]. On 12/06/23 at 9:01 AM, the surveyor interviewed the [redacted] unit [redacted] regarding CPs. The [redacted] informed the surveyor that the previous CP company had stopped service in [redacted]. The [redacted] stated that she was not sure about [redacted] because she was on vacation at that time. She further stated that she was unaware of the reason why the previous company of the previous CP #1 had [redacted]	F 756		

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F 756	Continued From page 124 services in the facility because the facility management did not discuss why. On that same date and time, the [US FOIA (b)(6)] stated that the new company for CP #2 started last month ([EX Order 26.4B1]). Furthermore, the [US FOIA (b)(6)] confirmed that there was no covering CP during [EX Order 26.4B1] [EX Order 26.4B1] to do MRR. On 12/06/23 at 10:05 AM, the surveyor in the presence of the survey team asked the [US FOIA (b)(6)] and the acting [US FOIA (b)(6)]) for the CPs contracts and timeline. At that same time, the [US FOIA (b)(6)] confirmed after he reviewed the two binders for CPs MRRs that the last service of the previous CP was on [NJ Exec Order 26.4] and the new CP's MRR start date was on [NJ Exec Order 26.4b1]. On that same date and time, the surveyor asked the [US FOIA (b)(6)] why there were no CP services in [NJ Exec Order 26.4b1]. The [US FOIA (b)(6)] stated "I don't know" why there was a lapse, it will be the corporate office who knows the answer and coordinates all contracts because all contracts were coordinated by the corporate office. He further stated that he was aware that there was no CP at the facility for the last three months. On 12/06/23 at 10:21 AM, the surveyor in the presence of the survey team called CP #2 for an interview and the surveyor was unable to leave a message because the voicemail was full.	F 756		

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F 756	Continued From page 125 On 12/06/23 at 10:22 AM, the surveyor in the presence of another surveyor called CP #1's company number, and the surveyor was able to speak to the US FOIA (b)(6) [redacted] who informed the surveyor that the CP services were terminated on Ex Order 26.4B1 [redacted] due to NJ Exec Order 26.4b1 of the facility for approximately NJ Exec Order 26.4b1 [redacted]. On 12/06/23 at 10:28 AM, the US FOIA (b)(6) [redacted] provided a copy of the Agreement of the facility between the company of CP #2 that was signed by the US FOIA (b)(6) [redacted] (CP #2 was also known as the owner) and the US FOIA (b)(6) [redacted]) of the facility on NJ Exec Order 26.4b1 [redacted] that stipulated under Fees: Due Date: All payments are to be made in advance on the first of every month. On 12/06/23 at 10:32 AM, CP #2 called back and was interviewed by the surveyor in the presence of the survey team. CP #2 stated that she was also the US FOIA (b)(6) [redacted] of the consulting pharmacy and the US FOIA (b)(6) [redacted] who came to the facility for MRR. She further stated that she started in November this year and per requirement, "we" come to the facility to review residents' medication records, and onsite visit requirements once a month. On 12/06/23 at 11:52 AM, the surveyor called and spoke to the US FOIA (b) [redacted] in the presence of the survey team. The US FOIA (b) [redacted] confirmed that there was no CP for the last NJ NJ Exec Order 26.4b1 [redacted] at the facility and that she was responsible for coordinating US FOIA (b)(6) [redacted] contracts of the facility. The US FOIA (b) [redacted] stated that the previous CP's company provided a three-day notice only to the facility when	F 756		

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services were terminated which was why it took them months to be able to get another CP to be on board. She further stated that she tried multiple companies via phone communication and there was no email documentation of the inquiries to other companies.

On 12/06/23 at 01:27 PM, the surveyor interviewed again CP #2 regarding communication with the facility's US FOIA (b) regarding the start of service at the facility. CP #2 stated that it was the US FOIA (b) who called her in NJ Exec Order 26.4b1 but she was unable to remember the exact date in NJ Exec Order 26.4b1 when she was asked by the US FOIA (b) to be the facility's CP. CP #2 further stated that she informed the US FOIA (b) that she would not be able to start until NJ Exec Order 26.4b1.

At that same time, the surveyor asked CP #2 why was it important that the facility had a CP. CP #2 stated that it was important to have CP at the facility to make sure to review residents' medication records for the safety of the residents and compliance with the regulations.

On 12/06/23 at 02:21 PM, CP #2 called back and stated that she wanted to make sure that the contract was ready and reviewed first prior to accepting the job at the facility. She further stated that she knew that there was a problem with the previous CP at the facility due to late payments.

On 12/11/23 at 9:34 AM, the survey team met with the US FOIA (b)(6) The surveyor asked the facility management if the CP services were part of the care of the residents

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and the [US FOIA (b)(6)] responded "yes" and needed to be met. The [US FOIA (b)(6)] further stated that the new CP started on [NJ Exec Order 26.4b1]. The facility management confirmed that there were no CP services in [NJ Exec Order 26.4b1].

On 12/11/23 at 11:16 AM, the surveyor called and interviewed the [US FOIA (b)] of the previous CP in the presence of the survey team regarding the facility-provided copy of an email dated [NJ Exec Order 26.4] from the [US FOIA (b)] regarding the termination of contract to the facility's company effective [NJ Exec Order 26.] . The [US FOIA (b)] stated that there were prior notifications provided to the company of the facility regarding late payments until final notification of termination of the contract was sent to the facility's regional office.

A review of the previous CP contract with the facility that was provided by the [US FOIA (b)(6)] was signed on [NJ Exec Order 26.4b] by the Facility/Covering Entity and the previous CP company's [US FOIA (b)(6)] signed on [NJ Exec Order 26.4b] included in number 11 that it is agreed that [name of company] has the right to immediately terminate this contract if the facility does not abide by the reimbursement schedule agreed upon in this contract.

On 12/14/23 at 01:37 PM, the [US FOIA (b)(6)] stated that as per [US FOIA (b)(6)] and his decision there was no additional information that the facility could provide and surveyors could proceed with decision-making.

A review of the facility's Medication Regimen Review Policy with an original date of 9/2023 that was provided by the [US FOIA (b)(6)] included that the drug

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F 756	Continued From page 128 regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart. MRR or a Drug Regimen Review, is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes a review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. On 12/14/23 at 02:00 PM, the survey team met with the US FOIA (b)(6) [redacted] an Exit Conference. There was no additional information provided by the facility management.	F 756		
F 849 SS=E	NJAC 8:39-29.3 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 LTC facility through an agreement as specified in	F 849		1/15/24

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F 849	Continued From page 129 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 provided.	F 849		

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F 849	Continued From page 130 (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.	F 849		

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F 849	Continued From page 131 §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.	F 849		

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F 849	Continued From page 132 (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, review of the medical record and other facility documentation, it was determined that the facility failed to ensure a) that a consistent coordination/communication was provided between facility staff and EX Order 26.4B1 staff to meet the resident's needs b) that a recommendation made by EX Order 26.4B1 was acted upon on a timely manner (Resident #11), and c) an order was transcribed in accordance with standards of practice (Resident #65). This deficient practice was identified for two (2) of two (2) residents reviewed for EX Order 26.4B1 and EX Order 26.4B1 EX Order 26.4	F 849	F849 HOSPICE SERVICES CORRECTIVE ACTIONS FOR THOSE AFFECTED Resident # 11 was assessed and ha NJ Exec O [redacted] Resident #65 was assessed and had NJ Exe [redacted]. All nurses were Inservice on the importance of following up on NJ Exec Order 26.4b [redacted]	

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F 849	Continued From page 133 This deficient practice was evidenced by the following: 1. On 12/01/23 at 11:40 AM, during the initial tour, the surveyor observed Resident #11 in bed with the Ex Order 26.4B1 on and set between Ex Order 26.4B1). The resident was NJ Exec Order 2 and NJ Exec Order 26.4b1 The surveyor reviewed the medical record for Resident #11. According to the Admission Record (AR; or face sheet, an admission summary), the resident was admitted to the facility with diagnoses that included EX Order 26.4B1 A review of the quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated EX Order 26.4B1 reflected a Brief Interview for Mental Status (BIMS) score of EX Orde out of 15, which indicated that the resident was EX Order 26.4B1. A review of the active Order Summary Report (OSR) revealed a physician order (PO) for EX Order 26.4B1 evaluation and treatment with [name redacted] with a start date of EX Order 26.4B1 A review of the Care Plan (CP) included a focus	F 849	recommendation NJ Exec Order 26.4b companies were called and a meeting to be held to go over better way of communicating recommendations ID OTHERS WITH POTENTIAL TO BE AFFECTED All residents have the potential to be affected by this deficient practice All nurses were Inservice about following up on recommendations SYSTEMIC CHANGES Hospice representative will report to the nurse on the unit or unit manager before leaving the unit to review any recommendation. Nurse/Unit manager will call resident primary care physician for approval of the order and write a nurses note if the recommendation is approved, denied or change. MONITORING 11-to-7-night supervisor/night nurses will audit all residents' chart to ensure all recommendations have been followed up on every night x30 days and report findings to Unit Managers/Assistant Director of Nursing.	

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F 849	Continued From page 134 that the resident has new order for [name redacted] EX Order 26.4B1 initiated on EX Order 26.4B1. At that time, the CP did not indicate an intervention or goals for the new orders. A review of the resident's NJ Exec Order 26.4b1 assessments reflected the following: EX Order 26.4B1 ; General Note: EX Order 26.4B1 ... EX Order 26.4B1 ; General Note: EX Order 26.4B1 .. -EX Order 26.4B1 A review of the Progress Note (PN) reflected the following: -EX Order 26.4B1 -EX Order 26.4B1 EX Order 26.4B1 . On 12/07/23 at 12:05 PM, the surveyor requested for the communication record from the US FOIA (b)(6) At that time, the US FOIA (b)(6) could not locate the communication record from [name redacted] within the hybrid medical record (a combination of paper-based and electronic health record that primarily involves tracking and storing a patient's health records in several formats and places). The US FOIA (b)(6) stated she would continue to look for it and contact the resident's EX Order 26.4B1	F 849	Unit managers and Assistant Director of Nursing will audit residents' chart bi-weekly and report findings to Director of Nursing x 2 months. Director of Nursing will report trend to the Administrator and the Quality Assurance Committee at the monthly meeting x 2 months and quarterly x3.	

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F 849	Continued From page 135 US FOIA (b)(6) On 12/12/23 at 11:15 AM, during an interview with the surveyor, the US FOIA (b)(6) stated the US FOIA did not leave progress notes but had a communication record (CR) sign in sheet. This CR is where the communication with the nurses were documented. At that time, the US FOIA (b)(6) presented the communication record, [name redacted] EX Order 26.4B1 recommendation sheets that she found in the resident's adjunct medical record. The CR reflected visits from [name redacted] EX Order 26.4B1 on the following dates: NJ Exec Order 26.4b1 . Within this time frame the surveyor received two documents NJ Exec Order 26.4b1 of EX Order 26.4B1 recommendation sheet for the resident. At that time, the US FOIA (b)(6) stated she had a conversation with the US FOIA on NJ Exec Order 26.4b1, and on NJ Exec Order 26.4b1 regarding the missing progress notes/recommendation sheet record. The US FOIA (b)(6) stated that the US FOIA documented on their own proprietary electronic system, which the facility had no access to review. The US FOIA then sent their internal interdisciplinary team notes after surveyor inquiry to the facility. 2. A review of the CR for the resident reflected a recommendation made by EX Order 26.4B1 on EX Order 26.4B1 that indicated the resident had a EX Order 26.4B1.	F 849		

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The specific location was not reflected on the EX Order 26.4B1. Further review of the record reflected that on EX Order 26.4B1 the EX Order 26.4B1 EX Order 26.4B1."

A review of the PN from EX Order 26.4B1 did not reflect a documentation by any nurse regarding the recommendation from EX Order 26.4B1 for the resident's EX Order 26.4B1

At that time, the surveyor and the US FOIA (b)(6) reviewed the EX Order 26.4B1 recommendation (NJ Exec O dated EX Order 26.4B1, which indicated consider start EX Order 26.4B1 NJ Exec Order 26.4 medication to affected NJ Exec Order EX Order 26.4B1. Further review of the NJ Exec revealed the recommendation was reviewed with Licensed Practical Nurse (LPN #1) on the same date.

At that time, the surveyor and the US FOIA (b)(6) reviewed the hybrid medical record for the resident which reflected the order was not transcribed until EX Order 26.4B1

At 11:39 AM, during an interview with the surveyor, in the presence of the US FOIA (b)(6), LPN#1 whose name was reflected on the NJ Exec stated that he receives orders from the US FOIA and is transcribed to an order on the same day. "The EX Order 26.4B1 recommendation should be completed on the same day it is recommended," the NJ Exec is usually given to me but if I am doing something the paper is left here. I can not say why it was not carried out [transcribed] on the same day".

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F 849	Continued From page 137 At 11:56 AM, the [US FOIA (b)(6)] clarified that when a recommendation was made by [EX Order 26.4B1], we contact the physician and obtain an order. The [US FOIA (b)(6)] stated the [EX Order 26.4B1] order was a duplicate since the resident was already on an [EX Order 26.4B1] from [EX Order 26.4B1]. At that time, the [US FOIA (b)(6)] obtained the [EX Order 26.4B1] [EX Order 26.4B1] and reviewed with the surveyor. The bottle reflected an active ingredient of EX Order 26.4B1 The [US FOIA (b)(6)] confirmed the ingredients were not the same as the [EX Order 26.4B1] recommendation of EX Order 26.4B1 [NJ Exec Order 26.4b] [redacted]. At that time, the [US FOIA (b)(6)] stated the communication between the facility and [name redacted] [EX Order 26.4B1] needed improvement. "I will discuss this concern with the [US FOIA] the facility nurses and inform the US FOIA (b)(6) [redacted]" On 12/12/23 at 01:33 PM, during an interview with the surveyor, LPN #2 stated the [EX Order 2] evaluations were conducted weekly and logged in the electronic Medical Record (eMR). The surveyor and LPN#2 reviewed the [EX Order 2] evaluations which were marked as no [EX Order 2] issues. The LPN #2 stated when a resident had a [EX Order 2] the [EX Order 2] evaluation should not have been marked as "EX Order 26.4B1" and should have indicated the resident had a [EX Order 2] issue/a [EX Order 2]. 3. On 12/1/23 at 10:32 AM, during the initial tour, the surveyor observed Resident #65's room. The resident had an EX Order 26.4B1 in the room switched off, the [NJ Exec Order 2] was connected to the [EX Orde] EX Order 26.4B1.	F 849		

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F 849	Continued From page 138 At 10:33 AM, the US FOIA (b)(6) was observed walking into the room and informed the surveyor the resident was in the activity room. The surveyor reviewed the medical record for Resident #65. According to the AR, the resident was admitted to the facility with diagnosis that included, EX Order 26.4B1 A review of the qMDS, dated EX Order 26.4B1, reflected a BIMS score of EX Ord out of 15, which indicated that the resident was EX Order 26.4B1 A review of the active OSR revealed an order for [name redacted] EX Order 26.4B1 care ordered on EX Order 26.4B1 A review of the CP reflected the resident was admitted to the facility under [name redacted] EX Order 26.4B1 #2 care. A review of the resident's weekly EX Order2 assessments reflected the following: EX Order 26.4B1 On 12/07/23 at 12:05 PM, the surveyor and the US FOIA (b)(6) reviewed the [name redacted] EX Order 26.4B1 CR within the resident's hybrid medical chart.	F 849		

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F 849	Continued From page 139 On 12/12/23 at 12:27 PM, during an interview with the surveyor, the US FOIA (b)(6) confirmed the recommendation for the EX Order 26.4B1 was transcribed as EX Order 26.4B1 (a EX Order 26.4B1 EX Order 26.4B1). The surveyor asked the US FOIA (b)(6) if that was the correct drug, the US FOIA (b)(6) stated no, the order should have been clarified with the doctor. A review of the PN did not reflect a documented clarification note for the EX Order 26.4B1 recommendation from the resident's EX Order 26.4B1 provider. The PN did not reflect a communication with the prescriber regarding the EX Order 26.4B1 EX Order 26.4B1 A review of the electronic Treatment Administration Record for EX Order 26.4B1 and EX Order 26.4B1 reflected the resident received administration for the EX Order 26.4B1 from EX Order 26.4B1 At that time, the surveyor and the US FOIA (b)(6) reviewed the order entry for the EX Order 26.4B1 that reflected the order was created on EX Order 26.4B1 revised on EX Order 26.4B1 and discontinued on EX Order 26.4B1 At that time, the US FOIA (b)(6) informed the surveyor that she would assess the resident, inform the doctor, contact EX Order 26.4B1, the family, and the US FOIA (b)(6) "We will have to educate all the nurses." On 12/13/23 at 9:16 AM, during an interview with the surveyor, the US FOIA (b), EX Order 26.4B1 US FOIA (b)(6) was asked regarding the order that she had revised for the resident. The US FOIA (b)(6) stated that	F 849		

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F 849	Continued From page 140 the EX Order 26.4B1 was a house stock medication and that it was an EX Order 26.4B1 medication. The nurse also stated that EX Order 26.4B1 was a classification for a drug and not a name of a medication. The US FOIA (b)(6) acknowledged that the recommendation of the EX Order 26.4B1 should have been clarified since it was a type of medication as opposed to a name of a medication. On 12/13/23 at 10:21 AM, in the presence of the survey team, the US FOIA (b)(6) were made aware of the concerns regarding the failure of the facility to ensure consistent collaboration and communication occurred between EX Order 26.4B1 and the facility staff. The facility EX Order 2 evaluations did not indicate Resident #11 and 65 had a EX Order 2 issue while the EX Order 26.4B1 recommendation identified the NJ Exec Or and recommended a treatment for each resident. The facility did not act upon the recommendation made for Resident #11 on EX Order 26.4B1 in a timely manner and was later acted upon on EX Order 26.4B1. The concern regarding Resident #65's order that was not transcribed in accordance with professional standards of practice. On 12/14/23 at 9:54 AM, in the presence of the survey team, the US FOIA (b)(6) stated a medication incident report form was created for Resident #11 regarding the order that	F 849		

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F 849	Continued From page 141 was not acted upon on a timely manner. At that time, the [US FOIA (b)(6)] stated that she had spoken with LPN#3 who had originally created the order for Resident #65. The [US FOIA (b)(6)] stated that LPN #3 had failed to document that the physician assistant had changed the order from [EX Order 26.4B1] [EX Order 26.4B1] . Furthermore, the [US FOIA (b)(6)] confirmed that there were discrepancies with the [redacted] documented for the residents. The [redacted] further acknowledged that the transcription of Resident #65's order was not in accordance with standards of practice. A review of the facility's Coordination of Hospice Services, revised on 9/2023 included the following: Policy; It is the policy of this facility to provide and or arrange for Hospice services in order to protect resident's rights to a dignified existence, self-determination, and communication with, and access to persons and services inside and outside the facility. Procedure: 2. The facility will utilize A systematic approach for recognition, assessment, treatment, and monitoring of Hospice care. 3. The facility and Hospice will coordinate plan of care and will implement interventions in accordance with the resident's needs, goals and recognize standards of practice in consultation with the resident's attending physician/practitioner and resident's representative, to the extent possible 5. The facility will communicate with Hospice and identify communicate, follow, and document all interventions put into place by Hospice and the	F 849		

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ASHBROOK CARE & REHABILITATION CENTER	1610 RARITAN ROAD SCOTCH PLAINS, NJ 07076

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F 849	Continued From page 142 facility. NJAC 8:39-27.1(a)	F 849		
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP,	F 868		1/22/24

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F 868	Continued From page 143 must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, the facility failed to have: a) the US FOIA (b)(6) present for two (2) of three (3) Quality Assurance and Performance Improvement (QAPI) meetings and b) the US FOIA (b)(6)) present for one (1) of three (3) QAPI meetings. The deficient practice was evidenced by the following: On 12/13/23 at 11:04 AM, the surveyor met with the US FOIA (b)(6) in the presence of the survey team for an interview regarding the facility's QAPI program. The US FOIA (b)(6) informed the survey team that the facility had a quarterly meeting and the key people to attend were the US FOIA (b)(6) On that same date and time, the US FOIA (b)(6) reviewed the last three quarters' sign-in sheets for QAPI and the US FOIA (b)(6) acknowledged that there was no US FOIA who attended that 3rd quarter QAPI meeting on 10/25/23. The US FOIA (b)(6) also acknowledged that there was no US FOIA (b) who attended the 2nd quarter QAPI meeting on 7/26/23. In addition, the US FOIA (b)(6) acknowledged that at the 1st quarter QAPI meeting on 4/26/23, there was no US FOIA (b) who attended the meeting because the previous US FOIA (b) (US FOIA (b)(6) who signed for US FOIA (b) at that time did not	F 868	868 QAA Committee The administrator will ensure that all designated and mandatory clinical and non clinical individuals will attend the quarterly QAPI meetings. This includes the medical director, director of nursing, IP nurse, and administrator. Advance notification of QAPI meetings will be sent out via email 2 weeks prior to the meeting. The facility will monitor the corrective actions by maintaining a complete sign in sheet of all clinical and non clinical specialties for a period of 6 month. Administrator will audit this quarterly x2 quarters.	

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F 868	Continued From page 144 have a qualification for a [US FOIA (b)] and according to the resume, she ([US FOIA (b)(6)] was the [NJ Exec Order 26.4b1] from [NJ Exec Order 26.4b1] through [NJ Exec Order 26.4b1]. On 12/14/23 at 9:54 AM, the survey team met with the US FOIA (b)(6) The [US FOIA (b)(6)] acknowledged the above findings of the surveyor regarding the key people who were not present during the quarterly QAPI meetings which were the [US FOIA (b)] and the [US FOIA (b)] A review of the facility's Quality Assurance and Performance Improvement Policy with a review date of 11/2022 that was provided by the [US FOIA (b)(6)] included that the QAA (Quality Assessment and Assurance) Committee shall be interdisciplinary and shall: a. Consist at a minimum of: i. The Director of Nursing Services; ii. The Medical Director or his/her designee; iii. At least three other members of the facility's staff, at least one of which must be the Administrator, Owner, Board Member, or other individual in a leadership role; and iv. The Infection Preventionist b. Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI Program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects under the QAPI program, are necessary. On 12/14/23 at 02:00 PM, the survey team met	F 868		

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F 868	Continued From page 145 with the US FOIA (b)(6) for an Exit Conference and there was no additional information provided by the facility management.	F 868		
F 880 SS=D	NJAC 8:39-33.1 (a) (b) 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	F 880		1/5/24

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F 880	Continued From page 146 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (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:	F 880		

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F 880	Continued From page 147 Based on observation, interview, and review of the facility provided documents, it was determined that the facility failed to ensure: a) the staff handled, stored, and processed linens and other supplies in a clean manner and to prevent possible contamination according to facility's policy and Centers for Disease Control and Prevention (CDC) guidelines, b) routine, ongoing, and systematic monitoring and tracking of facility's water management, and c) policy was reviewed and updated to reflect and address the need of the facility according to clinical standard of practice and CDC guidelines. This deficient practice was evidenced by the following: According to the CDC, Appendix D - Linen and laundry management, last reviewed May 4, 2023, Best practices for management of clean linen: Sort, package, transport, and store clean linens in a manner that prevents risk of contamination by dust, debris, soiled linens or other soiled items. Each floor/ward should have a designated room for sorting and storing clean linens. Transport clean linens to patient care areas on designated carts or within designated containers that are regularly (e.g., at least once daily) cleaned with a neutral detergent and warm water solution. According to the CDC, What Owners and Managers of Buildings and Healthcare Facilities Need to Know about Legionella Water Management Programs, Page last reviewed: April 30, 2018, included, How to Develop a Legionella Water Management Program Developing and maintaining a water	F 880	F880 Clean linen was observed being stored without a plastic bag on top of a three tier rack Items on folding table mixed with personal items that included a container of Aquaphor. Inside the laundry room, there was a three-tier rack with linen inside and uncovered; above it there was a fan with visible dust Legionella water management plan. Infection Prevention & Control Linens were removed of the rack, bagged, and placed in the soil linen bins to be sent out to be processed by the laundry company. All linens found on top pf the folding table were bagged and placed in the soil linen bin to be sent out to be processed by the outside company. All linen inside the three tier rack was bagged and placed in the soil linen bin to be sent out to be processed by the outside linen company. Laundry room was detail cleaned and dusted including fans, tables, dryers, washers, ceilings and walls. Legionella policy was revised, by LNHA and Director of maintenance and the	

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F 880	Continued From page 148 management program is a multi-step process that requires continuous review. Below are steps to building an effective Legionella water management program: -Establish a water management program team -Identify areas where Legionella could grow and spread Identify where potentially hazardous conditions could occur in your building water systems, such as areas where water temperature could promote Legionella growth or where water flow might be low. -Decide where you need to apply control measures and how to monitor them -Make sure the program is running as designed and is effective Establish procedures, both initially and on an ongoing basis, to verify that your team is implementing the water management program as designed. -Document and communicate all activities on a continual basis. 1. On 12/12/23 at 11:36 AM, the surveyor toured the laundry area in the presence of the US FOIA (b)(6) [redacted]. The US FOIA informed the surveyor that there was no in-house laundry at the facility since he started working [redacted] and that they have an outsourced, third party that provides personal clothing and other laundry needs of the facility. The US FOIA stated that the third-party laundry services' pick-up and return schedules were every Tuesday, Thursday, and Saturday. On that same date and time, the surveyor observed in the basement hallway area a three-tier rack of clean linen and fitted sheets that	F 880	water management plan was added to the policy depicting the process in detail. This was completed on 1-4-24. All residents could have been affected. All housekeeping staff were Inservice immediately All residents could have been affected. Housekeeping and laundry staff were re-educated on the procedures of maintaining clean linen storage room areas always clean and the regulation of not keeping personal items or food in these areas on 12-16-23. Housekeeping and laundry staff were re-educated of maintaining all linens covered at all times to prevent contamination and to follow proper infection control procedures on 12-16-23. US FOIA (b)(6) [redacted] and maintenance workers were re-trained in the water management plan set forth by Windsor management on 1-4-24 by the LNHA and RDEVS. Director of housekeeping develop a Clean linen storage log to check for the proper storage of clean linen, three times a day;	

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F 880	Continued From page 149 were not covered and not stored in a plastic bag. On top of the rack, approximately eight inches away from the ceiling were linens and fitted sheets, not stored in a plastic bag. Inside the three-tier rack, at the bottom part, there were linens and bed sheets not stored in a plastic bag. The [redacted] stated that the linens, fitted sheets, and be sheets were considered clean and should have been covered, stored in a plastic bag, and not exposed. Upon entry to the Laundry room, there was a folding table for clean linens that were mixed with personal items that included a container of [redacted] (a brand of over-the-counter (OTC) skincare ointments), a container of petroleum jelly (that helps skin and can ease inflammation and keep skin moist) and a container of ABHR (alcohol base hand rubbed). The [redacted] stated that they ([redacted] and petroleum jelly) were personal items of the person in charge of the laundry area and the table was considered clean and should not have personal items on top of the table that were being used for sorting out linens that were delivered. He further stated that the facility sorted out linens that were delivered because some of them had holes and were not appropriate sizes that the residents at the facility could use and that they were returned to the third-party vendor. At that time, there was a bin of sorted linens next to the folding table that was full and uncovered. In the same room (Laundry room), there was a three-tier rack of linens, towels, pillowcases, and fitted sheets that were not covered. Just above the three-tier rack of linens was an electric fan that was covered with grayish substances. The	F 880	7am and 2:45pm, to ensure all linens are covered or bagged after delivery times. This log will be utilized for 60 days or until improvement is noticed. This procedure will begin on 1-4-24. Director of Housekeeping will develop a Clean linen log to ensure all storage areas are clean and free of contamination; this is to be followed daily for 60 days or until improvement is noticed. This procedure will begin on 1-4-24. Housekeeping Director will report all inspection results with the Quality Assurance Performance Improvement committee on a monthly x3 months to ensure quality improvement and quarterly x2 Director of maintenance will implement a water temp log to record weekly cold water and hot water temperatures beginning on 1-4-24. This practice will be ongoing as part of company policy. Director of maintenance will present and report all water management related documentation such as: dead leg flushing, low utilization areas, aerator and shower head cleaning to the monthly Quality Assurance Performance Improvement committee for 60 days.	

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F 880	Continued From page 150 fitted sheets were not stored in a plastic bag. The US FOIA stated that the electric fan should have been cleaned and the cover for the clean linens, towels, pillowcases, and fitted sheets should have been dropped down to cover from dust and maintain cleanliness. The US FOIA stated that the grayish substances were accumulation and build-up of dust. He acknowledged that the housekeeper was responsible for making sure the room was clean. He further stated that the linens, towels, pillowcases, and fitted sheets were considered clean. On 12/13/23 at 10:21 AM, the survey team met with the new US FOIA (b)(6) [redacted]). The surveyor notified the facility management of the above findings with the laundry. On 12/14/23 at 9:54 AM, the survey team met with the US FOIA (b)(6) [redacted]. The US FOIA (b)(6) stated that contamination was possible due to the accumulation of dust in the fan that could go to the clean linens inside the laundry room where the three-tier rack for clean linens was left open, some of the linens was not properly stored inside the bag as well as the one in the basement hallway where the linen cart that was left opened and unattended. 2. On 12/13/23 at 01:35 PM, the surveyor interviewed the US FOIA (b)(6) [redacted]) in the presence of the survey team. The US FOIA [redacted]	F 880		

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F 880	Continued From page 151 informed the surveyor that he had been working at the facility since [NJ Exec Order 26.4b1]. The surveyor asked the [NJ Exec O] what was the facility process with regard to water management and Legionella (serious type of pneumonia caused by Legionella bacteria that people can get when they breathe in or swallow water contaminated with Legionella). The surveyor also asked the [US FOIA] who was the designated person in charge of the facility's water management which included the surveillance for Legionella. The [US FOIA] stated that he thought he was in charge of water management. The surveyor then asked the [US FOIA] what was the facility's process, and the [US FOIA] responded that he needed to get the facility's policy first before responding to the surveyor's inquiries, and the [US FOIA] left. On 12/13/23 at 01:50 PM, the [US FOIA] came back and informed the surveyor in the presence of another surveyor that he confirmed with the [US FOIA (b)(6)] first before meeting the surveyor again that "we do not test unless there was a confirmed case of Legionella." The surveyor asked the [US FOIA] how he knew if there were confirmed cases of Legionella, and where to get that information. The [US FOIA] then pulled the Legionella Surveillance Policy [reviewed 5/2023] and read #5 in the policy Primary prevention strategies: "a. Diagnostic testing i. The facility shall use the McGeer criteria (are designed for Surveillance and are used for retrospectively counting true infections) when diagnosing pneumonia." The surveyor also asked where else the information on Legionella be available. The [US FOIA] was not able to identify local health where the risk of Legionella and other opportunistic pathogens in the facility's water systems can be affected by the local water	F 880		

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F 880	Continued From page 152 system. On that same date and time, the US FOIA stated that the water temperature (temp) should be maintained above 140 degrees and circulated by visually checking the water temp gauge. The surveyor asked the US FOIA if there was a log or accountability for monitoring the water temp, and the US FOIA stated that he did not have a log and that there was no regular set scheduled for checking it. The surveyor asked about where in the facility water system he could check and monitor the temp, and US FOIA said he did not know. The surveyor then asked if he did not know what to check and routinely monitor the water temp of the facility, how he knew that the facility complied with the facility's policy and procedure, and regulations with regard to water management, and the US FOIA did not respond. Later on, the US FOIA stated in the presence of another surveyor that he would go to the US FOIA (b)(6 to get the information and education needed in order to comply with the requirement of water management and Legionella surveillance policy. The surveyor also asked the US FOIA about the facility's policy #5 C. Physical Controls iii. nonpotable water systems shall be routinely cleaned and disinfected. The US FOIA stated that the policy for non-potable water systems was not being followed because the facility had no non-potable water system. The surveyor then asked if the facility had no potable water system and why it was in the facility's policy. The US FOIA stated that "probably" the policy was intended for the entire [company name of the facility] and not intended for the facility. The surveyor then asked should the policy be reflective of the facility's	F 880		

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F 880	Continued From page 153 needs and specifications. The [US FOIA] stated that he would get the information from the [US FOIA (b)(6)] and update the policy. On 12/13/23 at 02:05 PM, the surveyor in the presence of another surveyor notified the [US FOIA (b)(6)] of the above findings and concerns with regard to water management and Legionella. The US FOIA (b)(6) was in charge of water management including Legionella. On 12/14/23 at 9:54 AM, the survey team met with the US FOIA (b)(6). The [US FOIA (b)(6)] stated that there was no log for cold temp as part of water management. The [US FOIA (b)(6)] further stated that the facility failed to keep a log, however visuals were done. The US FOIA (b)(6) acknowledged that there was a break in the system for water management, and accountability should have been done. The surveyor asked again about the non-potable water as part of the facility's policy, and the US FOIA (b)(6) both stated that they would review again the policy. The [US FOIA (b)(6)] further stated that "we" failed to include what specific procedure to be done about Legionella and that the facility failed to include it in the water management plan. On 12/14/23 at 12:53 PM, the surveyor notified the [US FOIA (b)(6)] in the presence of the survey team about the review of the provided documents of the [US FOIA (b)(6)] for the timesheets of the maintenance staff and the dead leg (will have more stagnant water having more microbial growth because the water in the dead leg does not circulate) and less frequent area weekly flush records, daily air and	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 154 water temps and aerator logs that showed that the following: A. Deadleg and Less Frequently Area weekly flush log: -was signed by Maintenance Staff (MS) on 8/23/23. The time sheet showed that the MS did not work on 8/23/23. -there was no weekly sheet for 10/25/23 B. Daily Air and Water Temps log: -March 2023-December 2023 =water temp (hot temp) [there was no log for cold temp] A review of the facility's Infection Prevention and Control Program Policy with a reviewed date of 5/19/23 that was provided by the [US FOIA (b)(6)] included the Water Management: a. A water management program has been established as part of the overall infection prevention and control program. b. Control measures and testing protocols are in place to address potential hazards associated with the facility's water systems. c. The Maintenance Director serves as the leader of the water management program. A review of the facility's Legionella Surveillance Policy with a reviewed date of 5/2023 that was provided by the [US FOIA] included primary prevention strategies: c. Physical controls: i. Cooling towers and potable water systems shall be routinely maintained .... iii. Non-potable water systems shall be routinely cleaned and disinfected... d. Temperature controls: i. Cold water shall be stored in distributed below	F 880		

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	315064	A. BUILDING _____ B. WING _____	C 12/15/2023

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F 880	Continued From page 155 68 degrees Fahrenheit. ii. Hot water shall be stored above 140 degrees Fahrenheit and circulated at a minimum return temperature of 124 degrees Fahrenheit. A review of the undated Storing Clean Linen Policy that was provided by the RIPN included that all linen being brought to the floors must be bagged, never stack piles too high on shelves-it may be a hazard when moving, keep storage areas clean, neat, and sanitary at all times, and clean linen bins must be covered at all times and in a clean area upon delivery. On 12/14/23 at 02:00 PM, the survey team met with the US FOIA (b)(6) [redacted] for an Exit Conference and there was no additional information provided by the facility management.	F 880		
F 881 SS=D	NJAC 8:39-19.4 (a), 21.1(d) Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure the	F 881	F881 ANTIBIOTIC STEWARDSHIP PROGRAM	12/20/23

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F 881	Continued From page 156 implementation of a comprehensive antibiotic stewardship program (ASP) in accordance with the facility's policy and procedure and the Centers for Disease Control and Prevention (CDC) guidance. This deficient practice was identified for one (1) of one (1) month antibiotic (ABT) log reviewed. This deficient practice was evidenced by the following: According to CDC, Core Elements of Antibiotic Stewardship for Nursing Homes, Page last reviewed: August 20, 2021, included, ... Improving the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance is a national priority. . .Antibiotic stewardship refers to a set of commitments and actions designed to 'optimize the treatment of infections while reducing the adverse events associated with antibiotic use'. . . CDC also recommends that all nursing homes take steps to improve antibiotic prescribing practices and reduce inappropriate use. . .Nursing homes monitor both antibiotic use practices and outcomes related to antibiotics to guide practice changes and track the impact of new interventions. Data on adherence to antibiotic prescribing policies and antibiotic use are shared with clinicians and nurses to maintain awareness about the progress being made in antibiotic stewardship. Clinician response to antibiotic use feedback (e.g., acceptance) may help determine whether feedback is effective in changing prescribing behaviors. Below are examples of antibiotic use and outcome measures. . .Process measures: Tracking how and why antibiotics are prescribed. . .Antibiotic	F 881	CORRECTIVE ACTION FOR THOSE AFFECTED Resident #22 was assessed and NJ Exec Order 26 [redacted] outcome from this deficient practice. Resident #22 Ex Order 26.4B1 [redacted] contacted who wanted resident to continue on the Ex Order 26.4B1. US FOIA (b)(6) [redacted] was Inservice immediately Resident #22 was added on the Ex Order 26.4B1 [redacted] line list ID OTHERS WITH POTENTIAL TO BE AFFECTED All residents on antibiotics have potential to be affected by this deficient practice. All residents on antibiotics were assessed and there were no negative findings All nurses were Inservice on antibiotic stewardship program SYSTEMIC CHANGE US FOIA (b)(6) [redacted] and Unit Managers are Inservice on antibiotic stewardship Infection preventionist to keep an active list of residents on antibiotic use even if its use for prophylaxis	

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F 881	Continued From page 157 use measures. . .Tracking how often and how many antibiotics are prescribed. . .Antibiotic outcome measures. . .Tracking the adverse outcomes ... The surveyor reviewed the hybrid medical records (a combination of paper-based and electronic records that primarily involve tracking and storing a patient's health records in several formats and places) of Resident #22. A review of [NJ Exec Order 26.4b1] current physician orders included an order dated [Ex Order 26.4B1] for a [Ex Order 26.4B1]) to give [Ex Order 26.4B1] capsule orally one time a day for [Ex Order 26.4B1] [Ex Order 26.4B1] A review of the ABT Log for [NJ Exec Order 26.4b1] revealed Resident #22 was not included in the list of residents who received [Ex Order 26.4B1] and there was no tracking that the criteria was met for [Ex Order 26.4B1] use. A review of the Physician Progress Notes (PPN) showed that on [Ex Order 26.4B1] Medicine Annual History and Physical of Physician #1 included in the documentation for a follow-up [Ex Order 26.4B1]) consult and follow-up use of [Ex Order 26.4B1] In addition, the [Ex Order 26.4B1] PPN also included the documentation of Physician #1 to follow up on [Ex Order 26.4B1] Further review of the hybrid medical records of Resident #22 revealed that there was [NJ Exec Order 26] that was done and no documentation to justify the continued use of [Ex Order 26.4B1].	F 881	Infection preventionist or unit managers will ensure that all follow up MONITORING Assistant Director of Nursing will audit residents on antibiotic bi-weekly x 3 and report findings to Director of Nursing. Infection preventionist will audit antibiotic line list and report findings to the quality assurance committee monthly x3 months and quarterly. Director of Nursing will report trends to the administrator and quality assurance committee x3 months and quaterly x 3.	

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F 881	Continued From page 158 On 12/11/23 at 01:03 PM, the surveyor asked the US FOIA (b)(6)) for a copy of the most recent Ex Order 26.4B1, NJ Exec Order 26.4 of Resident # 22 and he stated that he will get back to the surveyor. On 12/12/23 at 9:27 AM, the surveyor reviewed the provided Ex Order 26.4B1 office visit reports that were provided by the US FOIA (b)(6) and revealed that the most recent Ex Order 26.4B1 visit notes from the Ex Order 26.4B1 was on 1 NJ Exec Order 26.4b1. On 12/12/23 at 9:37 AM, the surveyor called the primary physician's (Physician #2) office and the surveyor was informed by the receptionist that it was Physician #1 who was responsible for Physician #2's residents in the facility and that she would notify Physician #1 to call the surveyor for an interview regarding Resident #22. On 12/12/23 at 10:07 AM, Physician #1 informed the surveyor that she was responsible for the residents of Physician #2 at the facility including Resident #22. Physician #1 stated that she had been working with Physician #2 and had been going to the facility for about NJ Exec Order 26.4b1 now. During an interview of the surveyor with Physician #1 concerning Resident #22's Ex Order 26 Ex Order 26.4B1 Physician #1 stated that she did include in her PPN that the resident needed a Ex Order 26.4B1 with regard to the use of Ex Order 26.4B1 She further stated that she documented that she spoke to the assigned nurse at that time about the Ex Order 26.4B1 needed.	F 881		

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F 881	Continued From page 159 On that same date and time, Physician #1 stated that she was not aware that the last Ex Order 26.4B1 consult was back on NJ Exec Order 26.4b1 and that the resident did not return to the Ex Order 26.4B1 The surveyor asked Physician #1 if she was aware that it was after the surveyor's inquiry that the facility had contacted the previous Ex Order 26.4B1 and the resident's Responsible Party (RP) regarding the follow-up Ex Order 26.4B1, and Physician #1 responded that she was not aware and was not notified by the facility. On 12/12/23 at 11:06 AM, Physician #1 called back and stated that the resident should be followed up with the Ex Order 26.4B1 regarding the continued use of Ex Order 26.4B1, and that was why she documented it in her PPN. On 12/12/23 at 11:47 AM, the surveyor interviewed the US FOIA (b)(6) in the presence of another surveyor in the Ex Order 26.4B unit nursing station. The US FOIA (b)(6) informed the surveyor that she knew Resident # 22 who was on Ex Order 26.4B1 for a long period for Ex Order 26. The US FOIA (b)(6) stated that according to the resident's RP, the resident should be on an NJ Exec Order 26.4b1 for Ex Order 26 for NJ Exec to prevent Ex Order 2 as per the Ex Order 26.4B1. She further stated that the information of RP was a verbal communication from the Ex Order 26.4B1 and there was no documentation about it. At that same time, the US FOIA (b)(6) acknowledged that the last Ex Order 26 consult was on NJ Exec Order 26.4b and that per facility practice and standard of practice, she should have called the Ex Order 26.4B1 to verify the resident's RP information that the resident should be on Ex Order 26.4B1 NJ Exe NJ Exec since there was no	F 881		

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F 881	Continued From page 160	F 881		

documentation from Ex Order 26.4B1 about what the RP had said. The US FOIA (b)(6) further stated that she did not recall that she had called the Ex Order 26.4B1 about it.

Furthermore, the US FOIA (b)(6) stated that she was not aware that Physician #1 had documented in her PPN about follow-up NJ Exec Order 26.4b1 regarding continued use of Ex Order 26.4B1. The surveyor asked the US FOIA (b)(6) why it is important that the resident with NJ Exec Or should be monitored, have a stopped date, and have justification for its use. The US FOIA (b)(6) stated that it was important because of the possible resistance to the NJ Exec O according to NJ Exec Order 26.4b1. The surveyor asked the US FOIA (b)(6) then why the physician's notes for NJ Exec O follow-up for continued use of NJ Exec Or were not followed if she knew the importance of the NJ Exec Or stewardship program and policy, and why the facility did not follow up with the RP about the NJ Exec Order 26.4b1 not until surveyor's inquiry, the US FOIA (b)(6) had no answer.

On 12/12/23 at 12:37 PM, the surveyor in the presence of the survey team interviewed the US FOIA (b)(6)). The US FOIA (b)(6) verified the NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 and acknowledged that Resident #22 was not included in the list of residents on Ex Order 26.4B1 even though the resident was using Ex Order 26.4B1 for Ex Order 26.4B1.

On 12/12/23 at 12:40 PM, the surveyor interviewed the facility's US FOIA (b)(6) stated that she was in charge of the NJ Exec Or stewardship program of the facility. She further stated that she generated reports for NJ Exec Or from the nurses' notes about

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F 881	Continued From page 161	F 881		

signs and symptoms, physician progress notes about the diagnosis for use of [NJ Exec Orde] and [NJ Exec Order 26.4b1] results to follow criteria for the use of [redacted] which were considered justification for continued use of [NJ Exec O] according to the facility's policy and procedure.

On that same date and time, the surveyor asked the [US FOIA] if residents who were in [NJ Exec O] for [Ex Order 26.4B1] were included on the [NJ Exec O] log, and the [US FOIA] responded yes. The [US FOIA] acknowledged that Resident #22 was on [NJ Exec O] for [Ex Order] [Ex Order 26.4B1] The surveyor then asked the [US FOIA] why the resident was not included on the [NJ Exec Order 26.4b1] [NJ Exec O] Log and that the resident was not monitored and tracked, the [US FOIA] stated that it was overlooked. She further stated that the facility should have seen Physician #1's documentation about follow-up [Ex Order 26.4B1] and [Ex Order 26.4B1] use and that the facility should have followed up with the RP.

On 12/14/23 at 9:54 AM, the survey team met with th [US FOIA (b)(6)] [redacted]. The [US FOIA (b)(6)] acknowledged that the [US FOIA (b)(6)] had documented the resident's justification for continued use of [Ex Order 26.4B1] (also known as [Ex Order 26.4B1]) after the surveyor's inquiry.

At this time, the surveyor asked the facility management why was it important that all residents were reviewed for [NJ Exec O] stewardship. The [US FOIA (b)(6)] stated that to ensure that the resident was not prescribed unnecessary medication, monitor possible side effects of chronic use of

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F 881	Continued From page 162 medications, and follow regulations for [NJ Exec O] stewardship. The [US FOIA (b)(6)] also acknowledged that there was no tracking and monitoring as part of [NJ Exec O] stewardship for Resident #22 in the NJ Exec Order 26.4b1 Log. On 12/14/23 at 02:00 PM, the survey team met with the US FOIA (b)(6) for an Exit Conference and there was no additional information provided by the facility management. NJAC 8:39-19.1(a), 19.4(d)	F 881		
F 882 SS=D	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on the interview and review of pertinent facility documents, it was determined that the	F 882	F882 INFECTION PREVENTIONIST QUALIFICATIONS/ROLE	12/18/23

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F 882	Continued From page 163 facility failed to ensure that the designated US FOIA (b)(6) dedicated solely to the infection prevention and control program (IPCP), and physically worked onsite in the facility for one (1) of two (2) staff and b) must have time necessary and participate in required Quality Assessment and Assurance (QAA) committee for one (1) of three (3) QAPI quarters in accordance with the facility policy and Centers for Medicare and Medicaid Services (CMS) and New Jersey (NJ) guidelines. This deficient practice was evidenced by the following: According to the NJ Executive Directive 21-012 (revised 12/22/22) included "ii. The facility's designated individual(s) with training in infection prevention and control shall assess the facility's IPCP by establishing or revising the infection control plan, annual infection prevention and control program risk assessment, and conducting internal quality improvement audits." According to the CMS QSO-22-19-NH Memo dated 6/29/22 and Fact Sheet, Updated Guidance for Nursing Home Resident Health and Safety dated 6/29/22, effective date on October 24, 2022 Overview of New and Updated Guidance, Summary of Significant Changes, included that in Infection Control, requires the facilities to have a part-time IP. While the requirement is to have at least a part-time IP, the IP must meet the needs of the facility. The IP must physically work onsite and cannot be an off-site consultant or work at a separate location. IP's role is critical to mitigating infectious diseases through an effective infection	F 882	I. CORRECTIVE ACTION FOR THOSE AFFECTED Facility has since hired a full-time qualified Infection Preventionist II. ID OTHERS WITH POTENTIAL TO BE AFFECTED a. All residents and staff have potential to be affected by this deficient practice. III. SYSTEMIC CHANGES a. The Director of Nursing and or the Administrator of the facility will ensure that there is a dedicated Infection Preventionist. b. Human Resources will work on getting a qualified interim Infection preventionist if there is a vacancy in the position. c. Train a backup Infection preventionist IV. MONITORING a. Administrator will ensure that there is a qualified Infection Preventionist daily b. Administrator and or Director of Nursing will notify Human Resources of vacancy of the infection preventionist position immediately	

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F 882	Continued From page 164 prevention and control program. IP specialized training is required and available. On 12/01/23 at 9:33 AM, the surveyor met with the US FOIA (b)(6) [redacted] during the Entrance Conference. The US FOIA informed the surveyor that she had been working at the facility for NJ Exec Order 26.4b1 and assumed the position of an US FOIA in NJ Exec Order 26.4b1. On that same date and time, the facility management confirmed that the facility was not in a NJ Exec Order 26.4b1 and currently did not have an NJ Exec Order 26.4b1 residents and staff. The surveyor reviewed the employee file of the US FOIA and showed the following: -Nursing Home Infection Preventionist Training Course (web-based) completed on NJ Exec Order 26.4 -The US FOIA (b)(6) Job Description was signed on [redacted]. Included major duties and responsibilities to participate in the facility's QAA committee (required to meet at least quarterly to identify issues and to develop and implement plans of action to correct identified deficiencies). A review of the last three-quarters QAPI (Quality Assurance and Performance Improvement (QAPI) is a data-driven and proactive approach to quality improvement where the QAA committee expected to attend) sign-in sheets showed that on the 3rd quarter, NJ Exec Order 26.4b1, the US FOIA did not attend the meeting. On 12/07/23 at 9:12 AM, the surveyor interviewed the US FOIA (b)(6)	F 882		

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F 882	Continued From page 165 US FOIA (b)(6)) in the presence of the survey team regarding US FD requirements. The surveyor asked who was the designated US FD of the facility since the last recertification (02/06/23). The surveyor also asked for the timeline of the designated US FD The US FOIA (b)(6) stated that she was the covering IP and the covering US FOIA (b) of the facility from NJ Exec Order 26.4b1 until the facility was able to hire a new US FOIA (b) and the US FOIA completed the training and examination for an US FD position. The US FOIA (b)(6) confirmed that the US FOIA assumed the position of US FD on NJ Exec Order 26.4b1 She further stated that the designated US FD from FNJ Exec Order 26.4b1 was the US FOIA (b)(6) and the US FOIA assumed the position of an US FD from NJ Exec Order 26.4b1 through the present, and that there was no other designated US FD except the US FOIA (b)(6) and the US FOIA (b) At that same time, the surveyor asked the US FOIA (b)(6) if she was aware of the regulation regarding US FD hours and the requirement for an US FD and that the US FD should be on-site, the US FOIA (b)(6) stated "yes." The surveyor then asked the US FOIA (b)(6) if the facility complied with the US FD requirements according to the facility's policy and regulations, and the US FOIA (b)(6) stated "no, and unfortunately, we tried to hire and no one fits the position," and that no applicants. She further stated that the US FOIA was required to attend the QAPI quarterly meetings. On 12/07/23 at 11:00 AM, the surveyors met with the US FOIA (b)(6) The surveyor notified the facility management of the above concerns regarding the designated US FD role that the requirement was not met from NJ Exec Order 26.4b1 through NJ Exec Order 26.4b1 the US FOIA (b)(6) had confirmed.	F 882		

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	315064	A. BUILDING _____ B. WING _____	C 12/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBROOK CARE & REHABILITATION CENTER	1610 RARITAN ROAD SCOTCH PLAINS, NJ 07076

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F 882	Continued From page 166 On 12/11/23 at 9:34 AM, the survey team met with the US FOIA (b)(6) [redacted]. The US FOIA (b)(6) stated that around NJ Exec Order 26.4b1 [redacted], she asked the US FOIA to do the training for US FO and the US FOIA completed it on NJ Exec Order 26.4b1. The US FOIA (b)(6) further stated that the facility was trying to get a replacement because the US FOIA was still a full-time nurse in the subacute unit and wanted to have a replacement first before the US FOIA assumed the position on NJ Exec Order 26.4. In addition, the US FOIA (b)(6) stated that the facility did not have a designated US FO in-house at the facility from NJ Exec Order 26.4b1 [redacted] On 12/14/23 at 9:54 AM, the survey team met with the US FOIA (b)(6) [redacted]. The US FOIA (b)(6) stated that he acknowledged the concern of the surveyor regarding the US FOIA did not attend the quarterly meeting on NJ Exec Order 26.4b1 [redacted] A review of the facility's Infection Preventionist Policy with an original date of 9/2023 that was provided by the US FOIA (b)(6) included the facility will designate a qualified individual as Infection Preventionist (IP) whose primary role is to coordinate and be actively accountable for the facility's infection prevention and control program to include the antibiotic stewardship program. The IP must be employed at least part-time and the amount of time should be determined by the facility assessment, to determine the resources it needs for its IPCP. The facility, based upon the facility assessment, will determine if the individual functioning as the IP should be dedicated solely to the IPCP. The IP must have	F 882		

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F 882	Continued From page 167 the time necessary to properly assess, develop, implement, monitor, and manage the IPCP for the facility, address training requirements, and participate in required committees such as QAA. The IP will physically work onsite in the facility. On 12/14/23 at 02:00 PM, the survey team met with the L[redacted] for an Exit Conference and there was no additional information provided by the facility management. NJAC 8:39-19.1(b)	F 882		

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift, evening shift, and overnight shift as mandated by the State of New Jersey. The facility was deficient in CNA (Certified Nursing Aide) staffing for the following weeks as follows: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	S560 MANDATORY ACCESS TO CARE I. CORRECTIVE ACTION FOR THOSE AFFECTED - Facility immediately ensure that there are enough staff at the center to provide care to the residents. - Facility evaluate staff salaries and increases were given, staff were inservice and made aware of the changes - Facility opened separate facility account to advertise all nursing openings in-house,	1/14/24

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

Electronically Signed | 01/05/24

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S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the 2 weeks of staffing from 11/12/2023 to 11/25/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 3 of 14 evening shifts, deficient in CNAs to total staff on 2 of 14 evening shifts, and deficient in total staff for residents on 12 of 14 overnight shifts as follows: -11/12/23 had 7 CNAs for 95 residents on the day shift, required at least 12 CNAs. -11/12/23 had 6 total staff for 95 residents on the overnight shift, required at least 7 total staff. -11/13/23 had 8 CNAs for 95 residents on the day shift, required at least 12 CNAs. -11/13/23 had 4 total staff for 95 residents on the overnight shift, required at least 7 total staff. -11/14/23 had 9 CNAs for 95 residents on the	S 560	including Certified Nursing Assistant (CNA) position. - Facility implemented weekly fixed bonus incentive to increase overall CNA's rate to the competitive market level. - Facility implemented aggressive advertisement of the open nursing positions, including CNAs, in the community. - Facility implemented signed-on bonuses for the CNAs to attract and retain candidates. - Facility implemented referral bonuses for staff. II. ID OTHERS WITH POTENTIAL TO BE AFFECTED - All residents have the potential to be affected by the deficient practice. III. SYSTEMIC CHANGES - Facility Master Schedule is in place and is matching with payroll system; each CNA has payroll app on the phone to be aware and to comply with scheduled working hours. - Administrator, Director of Nursing and Staffing Coordinator are meeting every morning to discuss staffing schedule for	

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S 560	Continued From page 2 day shift, required at least 12 CNAs. -11/14/23 had 8 total staff for 95 residents on the evening shift, required at least 9 total staff. -11/14/23 had 3 CNAs to 8 total staff on the evening shift, required at least 74 CNAs. -11/14/23 had 6 total staff for 95 residents on the overnight shift, required at least 7 total staff. -11/15/23 had 7 CNAs for 95 residents on the day shift, required at least 12 CNAs. -11/16/23 had 8 CNAs for 95 residents on the day shift, required at least 12 CNAs. -11/16/23 had 6 total staff for 95 residents on the overnight shift, required at least 7 total staff. -11/17/23 had 7 CNAs for 95 residents on the day shift, required at least 12 CNAs. -11/17/23 had 6 total staff for 95 residents on the overnight shift, required at least 7 total staff. -11/18/23 had 8 CNAs for 94 residents on the day shift, required at least 12 CNAs. -11/18/23 had 8 total staff for 94 residents on the evening shift, required at least 9 total staff. -11/18/23 had 3 CNAs to 8 total staff on the evening shift, required at least 4 CNAs. -11/18/23 had 6 total staff for 94 residents on the overnight shift, required at least 7 total staff. -11/19/23 had 6 CNAs for 94 residents on the day shift, required at least 12 CNAs. -11/19/23 had 6 total staff for 94 residents on the overnight shift, required at least 7 total staff. -11/20/23 had 8 CNAs for 94 residents on the day shift, required at least 12 CNAs. -11/20/23 had 6 total staff for 94 residents on the day shift, required at least 7 total staff. -11/21/23 had 9 CNAs for 93 residents on the day shift, required at least 12 CNAs. -11/21/23 had 6 total staff for 93 residents on the overnight shift, required at least 7 total staff. -11/22/23 had 9 CNAs for 92 residents on the	S 560	the day and following 3-5 days. - Facility has 24-hour nursing management on-call rotation in case of any call outs and/or to cover the floor if needed. - Facility utilizes reinforcement steps for excessive call outs if any. IV. MONITORING - The Human Resources Director will report recruitment and retention trends, outcomes, and recommendations to the Quality Assurance and Performance Improvement Committee meetings monthly x 3 months, then quarterly x 9 months for review and revision as deemed appropriate.	

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S 560	Continued From page 3 day shift, required at least 11 CNAs. -11/22/23 had 6 total staff for 92 residents on the overnight shift, required at least 7 total staff. -11/23/23 had 9 CNAs for 92 residents on the day shift, required at least 11 CNAs. -11/23/23 had 7 total staff for 92 residents on the evening shift, required at least 9 total staff. -11/23/23 had 6 total staff for 92 residents on the overnight shift, required at least 7 total staff. -11/24/23 had 8 CNAs for 92 residents on the day shift, required at least 11 CNAs. -11/25/23 had 7 CNAs for 92 residents on the day shift, required at least 11 CNAs. -11/25/23 had 5 total staff for 92 residents on the overnight shift, required at least 7 total staff. On 12/05/23 at 11:24 AM, the surveyor interviewed the Staffing Coordinator (SC) regarding the process for staffing. The SC stated that if someone called out or was on vacation that she would ask the facility's staff to cover and that she was not using agency staff. She added that since she had been hired NJ Ex Order 26.4b1 [redacted] she had not used agency staff. On that same date and time, the SC confirmed that she was aware of the required ratios for CNAs and amount depended on the resident census. The surveyor asked if the facility was meeting the mandated ratios. The SC stated that sometimes they met the ratio, sometimes they were over and sometimes when there were so many callouts they were short. On 12/13/23 at 10:39 AM, the survey team was provided a policy titled "Emergency Staffing." The surveyor asked the Regional Infection Preventionist Nurse (RIPN) if the facility had a policy for staffing other than the policy for	S 560		

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S 560	Continued From page 4 emergency staffing. The RIPN stated that there was no staffing policy and that they staffed the facility according to the New Jersey mandated staffing ratio law. She added that they try they best to meet that guideline. On 12/13/23 at 11:42 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding staffing. The LNHA stated that he was aware there was a shortage and that they were not meeting the ratios. The LNHA stated that they were trying to attract new staff. A review of the "Facility Assessment" did not include information about staffing. On 12/13/23 at 12:15 PM, the surveyor interviewed the LNHA regarding the "Facility Assessment." The LNHA stated that staffing should be the "Facility Assessment" and that the facility did not use agency staff because he personally thought that agency staff were not committed. A review of the facility provided policy titled "Emergency Staffing" did not include information regarding regular staffing schedule or the mandated CNA ratios.	S 560		
S2905	8:39-43.1(a)(2) Certification of Nurse Aides (a) An individual who meets any of the following criteria shall be considered by the Department to be competent to work as a nurse aide in a licensed long-term care facility in New Jersey: 2. Has been employed for less than 120 days and is currently enrolled in an approved nurse	S2905		12/20/23

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S2905	Continued From page 5 aide in long term care facilities training course and scheduled to complete the competency evaluation program (skills and written/oral examination) within 120 days of employment; or This REQUIREMENT is not met as evidenced by: Based on a review of facility documentation and interview with facility staff, it was determined that the facility failed to ensure that one (1) of one (1) newly hired Nurse Aides (NA) were enrolled in an approved nurse aide training course during their employment with the facility. This deficient practice was evidenced by: On 12/01/23 at 9:30 AM, the surveyor interviewed the [Ex Order 26.4] Wing Unit Manager regarding the staffing of the unit. The surveyor observed that NA #3 was listed on the schedule as a NA. On 12/01/23 at 9:43 AM, observed NA #3 performing care for an unsampled resident. NA #3 wore an identification badge that listed her name and title that she was a CNA. The surveyor asked NA #3 what her title was and she stated that she was a CNA. On 12/01/23 at 11:01 AM, the surveyor interviewed NA #3. NA #3 confirmed that she had an identification badge with the wrong title and that her new badge had her listed as a NA. The surveyor asked NA #3 about her schooling and exams. NA #3 stated that she had started school the last weekend of [NJ Ex Order 26.4b1] and had finished	S2905	F2905 CERTIFICATION OF NURSE AIDES CORRECTIVE ACTION TAKEN FOR THOSE AFFECTED Nurse aide #3 was terminated [US FOIA (b)(6)] were Inservice immediately about requirements. ID OTHERS WITH POTENTIAL TO BE AFFECTED All residents have the potential to be affected by this deficient practice SYSTEMIC CHANGES Upon hire Human Resources or designee will ensure that Nurse Aide that are hired have applied to take their test within 120day of completing their skilled test. Nurse Aide who does not pass the test and are nearing their 120days will be removed from the schedule until they successfully pass the test.	

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S2905	Continued From page 6 school the second week in September and that she passed the skills test. The surveyor asked when she was taking the written exam. NA #3 stated that she took the written exam on EX Order 26.4B1 and that NJ Exec Order 26.4b1. On 12/01/23 12:52 PM, in the presence of the Licensed Nursing Home Administrator (LNHA), the surveyor interviewed the Regional Infection Preventionist Nurse (RIPN) regarding a NA policy. The RIPN stated that the facility did not have a specific policy for NAs and that they follow the department of health guidelines. The surveyor asked where NA #3's employee file was that was previously asked for by the survey team coordinator during entrance conference. The LNHA stated that stated that the person that had the files was not in the facility that day and would be in on Monday (EX Order 26.4B1. On 12/04/23 at 10:31 AM, the surveyor reviewed the facility provided list of employees that were NAs. Review of the list indicated the following: NA #3 had a date of hire of EX Order 26.4B1 On 12/04/23 at 11:02 AM, the surveyor requested the RIPN provide NA #3's employee file. At 11:48 AM, the surveyor requested NA #3's employee file from the LNHA. At 12:34 PM, the surveyor requested again NA #3's employee file from the LNHA. At 12:40 PM, in the presence of another surveyor, the surveyor interviewed the Regional Director of Human Resources (RDHR). The RDHR stated that she supported several buildings and that she kept the HR portion of new	S2905	MONITORING Human Resources will report on all nurse-aide status monthly to the quality assurance committee for 3 months. Assistant Director of Nursing will audit nurse aides to ensure compliance weekly x4. Administrator/Director of Nursing will report on trends during the quarterly meeting x3.	

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S2905	Continued From page 7 hire employees in her office. The surveyor asked where NA #3 file was that the surveyor had requested. The RDHR stated that she had given the file to the nursing office. At 12:48 PM, the LNHA stated that he had dropped a copy of NA #3's file in the conference room. At 12:55 PM, the surveyor reviewed the copies of documents that were provided. The complete employee file that the facility had were not provided. On 12/05/23 at 8:50 AM, the surveyor requested the full and complete employee file for NA #3's from the Director of Operations who was the designee for the LNHA who was not at the facility at the time. The employee file was provided. A review of the facility provided employee file included the following: NA #3: An application for employment for NA dated [redacted]; background check with a reported date of [redacted]; a certificate of completion of the CNA program dated [redacted]; a job description for NA undated but signed; skills evaluation test dated [redacted] which NA passed. On 12/12/23 at 9:56 AM, the surveyor interviewed RDHR regarding hiring NAs. The RDHR stated that to hire a NA the person would have to be enrolled in school when she hired them. She added that she would get documentation that they are in school usually an enrollment letter. The surveyor asked if there was a certain amount of time that they had to pass the exam by. The RDHR stated that she thought it	S2905		

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S2905	Continued From page 8 was 120 days from the completion of the course. The surveyor asked what needed to be verified if they were to work with residents if they were in school. The RDHR stated that she would defer that to nursing. She added that she knew they needed to be in school and that they have documentation they are in school. The surveyor asked if the files that were provided were complete. The RDHR stated that the HR portion was complete. On 12/12/23 at 10:35 AM, in the presence of the acting Director of Nursing (acDON) and LNHA, the RIPN stated that if there is a new hire NA that they ask for proof of skills test and enrollment in school or if they completed school then they have 120 days from when they passed the skills exam. . At 12:21 PM, the RIPN stated that NA #3 was hired as a NA on EX Order 26.4B1 and that she had finished school EX Order 26.4B1 and passed her skills test on EX Order 26.4B1 The surveyor asked if NA #3 had worked at another facility prior to this facility. The RIPN was not sure. On 12/13/23 at 10:35 AM, in the presence of the survey team, the surveyor notified the LNHA, new Director of Nursing (nDON), acDON, RIPN and IPN the concern that NA #3 was not enrolled in school while she was working at the facility. At 02:18 PM, in the presence of another surveyor, nDON and LNHA, the RIPN stated that NA #3 had finished her schooling and did the skills part. On 12/14/23 at 10:26 AM, in the presence of the survey team, LNHA, new DON, IPN, Director of Maintenance and Regional Director of	S2905		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S2905	Continued From page 9 Environmental Services, the RIPN stated that NA #3 was hired after she finished her schooling. The RIPN stated that she had finished school in August. The surveyor asked if NA #3 was scheduled to take the written exam. The RIPN was not sure and that they told her verbally to schedule the test. The RIPN stated that the nDON would call and verify that she is taking the tests. The facility did not have a policy regarding NAs.	S2905		

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
315064 Y1	A. Building B. Wing Y2	1/29/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBROOK CARE & REHABILITATION CENTER	1610 RARITAN ROAD SCOTCH PLAINS, NJ 07076

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 F0557	Correction	ID Prefix F0584	Correction	ID Prefix F0609	Correction
Reg. # 483.10(e)(2)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed
LSC	01/15/2024	LSC	01/20/2024	LSC	12/16/2023
ID Prefix F0645	Correction	ID Prefix F0656	Correction	ID Prefix F0686	Correction
Reg. # 483.20(k)(1)-(3)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed
LSC	01/20/2024	LSC	01/20/2024	LSC	01/20/2024
ID Prefix F0689	Correction	ID Prefix F0695	Correction	ID Prefix F0727	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.35(b)(1)-(3)	Completed
LSC	01/20/2024	LSC	01/19/2024	LSC	01/20/2024
ID Prefix F0728	Correction	ID Prefix F0732	Correction	ID Prefix F0755	Correction
Reg. # 483.35(d)(1)-(3)	Completed	Reg. # 483.35(g)(1)-(4)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	01/18/2024	LSC	12/16/2023	LSC	12/20/2023
ID Prefix F0756	Correction	ID Prefix F0849	Correction	ID Prefix F0868	Correction
Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.70(o)(1)-(4)	Completed	Reg. # 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	Completed
LSC	01/10/2024	LSC	01/15/2024	LSC	01/22/2024

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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315064 Y1	A. Building B. Wing Y2	1/29/2024 Y3

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0880	Correction	ID Prefix F0881	Correction	ID Prefix F0882	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80(a)(3)	Completed	Reg. # 483.80(b)(1)-(4)	Completed
LSC	01/05/2024	LSC	12/20/2023	LSC	12/18/2023

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?
12/15/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
062002 Y1	A. Building B. Wing Y2	1/29/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S2905	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-43.1(a)(2)	Completed	Reg. #	Completed
LSC	01/14/2024	LSC	12/20/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/15/2023	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315064	A. BUILDING **02** B. WING _____	C **12/15/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBROOK CARE & REHABILITATION CENTER	**1610 RARITAN ROAD** **SCOTCH PLAINS, NJ 07076**

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 12/15/23. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/15/23 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Ashbrook Care and Rehabilitation Center is a one-story building with a basement that was built in 1967. It is composed of Type II protected construction. The facility is divided into six - smoke zones. The generator does approximately 80 % of the building per the Maintenance Director. The current occupied beds are 99 of 112.	K 000		
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall	K 271		2/20/24

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

Electronically Signed | 01/04/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 271	Continued From page 1 be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the exit discharge in accordance with NFPA 101 Life Safety Code (2012 edition) 7.2.2.2.4.4.2. The facility's exterior ramp handrails near the front entrance were in need of repair. This deficient practice had the potential to affect all 99 residents who resided at the facility. Findings include: Observation on 12/15/23 at 10:35 AM revealed that the exterior ramp handrails were rusted and had broken away from the concrete base. Continued observation revealed the top of the exterior ramp handrail spindle, the handrail had pulled away from the concrete. During an interview on 12/15/23 at 12:30 PM, the US FOIA (b)(6) verified that the handrail was rusted and broken from the concrete. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e)	K 271	K271 □ Discharge from exits Corrective Action: On December 15, 2023 all exterior handrails were checked by facility maintenance director for safety, railings were found to be rusted at some point. Staff, visitors, vendors and residents were advised to use stairs. Other Residents: All residents, staff and guests who use the front ramps have the potential to be affected by this deficient practice. Measures: Contractor contacted and will be instatlling new handrails. Materials ordered and in place. The work has been sucessfully completed within our window of 70 days. I can confirm the front hand railings were copleted on 2/20/24. See photos attached of project completion. Monitoring: Maintenance will inspect all exterior handrails monthly and finding will be reported at the monthly quality assurance performance improvement meeting (monthly QAPI) x 6months Any issues identified during the inspection, will be rectified immediately.	
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101	K 311		4/12/24

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K 311	Continued From page 2 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire rated door assemblies for stairway exit doors were equipped with approved labels indicating the fire rating of the fire doors in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.3.1. This deficient practice had the potential to affect all 99 residents who resided at the facility. Findings include: Observation on 12/15/23 at 11:34 AM revealed two of two stairway doors, located on the first floor near room [redacted] and in the basement across from the laundry. Neither of the doors had the required labels to indicate the fire rating of the doors. During an interview at the time of observation, the [redacted] confirmed the stairway doors did not have labels indicating the fire ratings on either door. NJAC 8:39-31.2(c)	K 311	K311- Vertical Openings - Enclosure Corrective Action: All other fire doors in the facility were checked on December 15, 2023 to ensure the fire rating tags were in place and no other issues were found. Other Residents: All residents in the facility have the potential to be affected by this deficient practice. Measures: New fire rated doors were ordered and will be delivered in seven weeks, April 12th 2024, upon delivery the doors will be affixed by certified contractor. The reason for seven weeks is they are custom fit doors made to opening specifications. Please see copy of invoice attached. Additional measures undertaken: We have installed new fire exstinguishers at base and top of stairwell as an additional measure of protection	

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K 311	Continued From page 3	K 311	maintained at all times. Our fire detection vendor inspected all smoke detectors in the facility on 2/2/24 to insure all are functioning as designed, especially the ones located nearest the stairwell. Facility is requesting for a time-limited waiver for the fire rated door, this cannot be completed within the specified time frame due to the fact that it is a custom order. Monitoring: A monthly audit of the fire doors will be conducted and findings will be recorded on the fire door audit tool and reported to the monthly QA meeting for a period of 6 months.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96	K 324		1/22/24

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K 324	Continued From page 4 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on document review, observation, and interview, the facility failed to ensure the kitchen hood assembly was free of holes and penetrations in accordance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011 edition) section 5.1. The deficient practice had the potential to affect all 99 residents who resided at the facility. Findings include: Observation on 12/15/23 at 11:15 AM revealed the kitchen hood assembly had two 2" sprinkler pipes going into the hood assembly and the holes for which the sprinkler pipes entered the hood were 3" x 3" in diameter and were not sealed. During an interview at the time of the observation, the US FOIA (b)(6) confirmed the holes in the hood assembly. REF: NFPA 96	K 324	K324- Cooking Facilities Corrective Action: The cooking facility was checked on December 15, 2023 for proper fire protection and no other issues were found. Other Residents: All residents in the facility have the potential to be affected by this deficient practice. Measures: Certified contractor has been approved and is schedule to make the necessary repairs to the kitchen hood assembly, schedule for completion 1/22/2024. The completion date was done on 1/22/24 Monitoring: The maintenance staff will monitor any construction in the facility and report any issues immediately. Maintenance director/designee will inspect kitchen hood monthly x3months to ensure integrity is maintained at times. Mainenance director or designee will report trend at the Quality assurance	

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K 324	Continued From page 5	K 324	performnce improvement commitee x 3 months. Work completed. see attached	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review, observation, and interview, the facility failed to ensure the fire doors were inspected annually in accordance with NFPA 101 Life Safety Code (2012 edition) 7.2.1.15. This deficient practice had the potential to affect all 99 residents who resided at the facility. Findings include: Review of the facility's untitled fire door inspection binder dated for the years of 2022 and 2023, provided by the US FOIA (b)(6) , did not reveal any inspections on the facilities fire door assemblies.	K 761	K761 □ Maintenance, Testing and Inspection □ Doors Corrective Action: An annual fire door inspection was conducted on January 4, 2024. US FOIA (b)(6) inservice on ensuring that fire doors are checked annually Other Residents: All residents in the facility have the potential to be affected by this deficient practice. Measures: The maintenance staff have been educated on how to properly	1/4/24

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K 761	Continued From page 6 During an interview on 12/15/23 at 1:00 PM, the US FOIA (b)(6) confirmed the only fire doors were not inspected. NJAC 8:39-31.2(e) NFPA 80	K 761	conduct the yearly door inspections in accordance with NFPA 80. All fire doors have been inspected and found to be in compliance with NFPA 80. Monitoring: Maintenance Director or designee will inspect all fire doors monthly and report finding at the monthly quality assurance meeting x3months.	
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 transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and	K 918		1/4/24

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K 918	Continued From page 7 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 record review and interview, the facility failed to ensure the three-year load bank test was completed on the emergency generator in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 4.9.1. This deficient practice had the potential to affect all 99 residents who resided at the facility. Findings include: Document review of the generator reports for 2022 and 2023 provided by the US FOIA (b)(6) [redacted] revealed a three-year load bank test had not been completed for the emergency generator. During an interview on 12/15/23 at 12:55 PM, the US FOIA (b)(6) [redacted] confirmed the three-year load bank test had not been completed on the emergency generator. NJAC 8:39-31.2(e)(g) NFPA 99, 101	K 918	5. K918 □ Electrical Systems □ Essential Electric Systems Corrective Action: The maintenance director or designee will review the life safety binder monthly to ensure that all inspections and tests are completed timely. Other Residents: All residents in the facility have the potential to be affected by this deficient practice. Measures: Maintenance director will ensure that all required inspections and testing is done as required. A load bank test was conducted on both generators by contracted company on Jan 4, 2024. Monitoring: The binder will be reviewed monthly by the administrator for 3 months and any missing tests or inspections will be discussed with the monthly QA meeting and corrected immediately.	

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315064 Y1	A. Building 02 - BUILDING B. Wing Y2	2/20/2024 Y3

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ASHBROOK CARE & REHABILITATION CENTER	1610 RARITAN ROAD SCOTCH PLAINS, NJ 07076

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 K0271	02/20/2024	LSC K0311	02/20/2024	LSC K0324	01/22/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0761	01/04/2024	LSC K0918	01/04/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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?
12/15/2023	☐ YES ☐ NO