STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315104	A. BUILDING _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNELL HALL CARE & REHABILITATION CENTER	234 CHESTNUT STREET UNION, NJ 07083

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint #: NJ#160179, NJ#161019, NJ#162377, NJ#163297, NJ#164216, NJ#166425, NJ#169168, NJ#169272 Survey Date: 01/24/24 Census: 111 Sample: 25 + 3 + 11=39 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 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,	F 607		2/22/24

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

Electronically Signed | 02/15/2024

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 607	Continued From page 1 §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent documentation provided by the facility it was determined that the facility failed to implement the facility's [NJ Ex Order 2] policy to ensure a) licensed staff credentials were verified upon hire (Staff #7 and #8) and b) reference checks were completed (Staff #2, #3, #4, #8 and #9). This deficient practice was identified for seven (7) of nine (9) newly hired staff reviewed, and was evidenced by the following: 1.) The surveyors randomly selected nine new employee files for license verification which revealed the following: Staff #7, a [US FOIA (b)(6)] was transferred to the facility on [NJ Ex Order 26.4], had a New Jersey Division Consumer Affairs (NJCA) license verification printout for license verification (used to verify the status of a RN's license status) which was dated [NJ Exec Order 26.4], after the employee's transfer	F 607	F607- Staff Employment verifications Element I Staff #2, a [US FOIA (b)(6)], with a hire/rehire date of [NJ Ex Order 26.7], did not have a reference check on file although reference checks were obtained on 2/16/2024. Staff #3, a [US FOIA (b)] with a hire/rehire date of [NJ Ex Order 2], had one (1) of two (2) reference checks on file and the second reference was completed on 2/12/2024. Staff #4, a [US FOIA (b)] with a hire/rehire date of [NJ Ex Order 26.4], did not have a reference check on file. Reference checks were requested and obtained on 2/15/2024. Staff #8 a [US FOIA (b)(6)] with a hire date of	

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F 607	Continued From page 2 date of [NJ Ex Order 26.4]. Staff #8, a [US FOIA (b)(6)], with a date of hire of [NJ Ex Order 26.4], did not have a license verification print out. There was no documented evidence that Staff #8's license was verified. 2.) Further review of the employee file for reference check reflected the following : Staff #2, a [US FOIA (b)(6)]), with a hire/rehire date of [NJ Ex Order 26.4], did not have a reference check on file. Staff #3, a [US FOIA (b)] with a hire/rehire date of [NJ Ex Order 26.4], had one (1) of two (2) reference check on file and the other form was not completed. Staff #4, a [US FOIA (b)] with a hire/rehire date of [NJ Ex Order 26.4], did not have a reference check on file. Staff #8 a [US FOIA (b)(6)] with a hire/rehire date of [NJ Ex Order 26.4], did not have a reference check on file. Staff #9, a [US FOIA (b)(6)], with a hire/rehire date of [NJ Ex Order 26.4D], had one (1) of two (2) reference check on file and the other form was not completed. On 1/18/24 at 1:12 PM, during an interview with the surveyors, the [US FOIA (b)(6)] informed that she did not have a check list for newly hired employees; There was an orientation check list. At that time, the [US FOIA (b)] stated "I haven't been doing it because it is repetitive. The facility would prefer me to use the orientation check list".	F 607	[NJ Ex Order 26.], did not have a reference check on file nor was a license verification done and was obtained by 2/15/2024. Staff #9, a [US FOIA (b)(6)], with a hire date of [NJ Ex Order 26.4D], had one (1) of two (2) reference checks completed and the second reference check was completed on 2/14//2024. Onboarding form to include onboarding check list of regulatory requirements of all new hires and transferring employees within the corporate system was initiated. Element II All resdients that are in the facility have the potential to be affected by the deficient practices. Element III Human Resources and/or Designee will provide Onboarding Checklist completions to the Administrator for review to ensure all is completed before the start date of any new hires or transferring employees. Human resources was in-serviced on 2/14/2024 on the importance of regulatory compliance with timely reference checks, license verifications and onboarding paperwork process. Element IV All new hires and /or transferring employees will be discussed at monthly	

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F 607	Continued From page 3 At that time, the US FOIA (b) informed the surveyors that the license verification should be completed as part of the pre-hiring process. At that time, the US FOIA (b) stated that depending on the position, the reference checks were completed by either her, the staffing coordinator or the director can also do the reference checks. The US FOIA (b) informed the surveyor that the facility process required two (2) reference checks per applicant prior to date of hire. At that time, the US FOIA (b) confirmed that the license verification check was not completed for Staff #7 and #8 prior to date of hire. At that time, the US FOIA (b)(6) confirmed the following: Staff #2, the US FOIA (b) stated Staff #2 was recommended by the previous US FOIA (b) but there was no reference check on file. Staff #3 had 1 of 2 reference check. Staff #4 did not have a completed reference check. None was on file. Staff #8 did not have a completed reference check. None was on file. Staff #9 had 1 or 2 reference check. At that time, the US FOIA (b) stated the license verification, and two reference checks should have been completed prior to the hire date. At that time, the US FOIA (b) stated she had no back-up and that she did not know what occurred when	F 607	Quality Assurance and Performance Improvement committee meetings under the direction of the Administrator to ensure that employees have completed reference checks, license verifications, and onboarding paperwork completed in each employee file on a monthly basis. The checklist and said documentation will be audited upon hire and monthly for 2 months by both the human resources director and the administrator. The verification audit will be discussed in Quality Assurance and Performance committee meetings quarterly on the monthly employment records. Completion date: February 22, 2024	

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F 607	Continued From page 4 she was not in the building. On 1/22/24 at 11:06 AM, in the presence of the survey team, the US FOIA (b)(6) [redacted] the surveyor discussed the concerns regarding the license verifications and reference checks prior to the date of hire. On 1/23/23 at 12:04 PM, in the presence of the survey team, the [redacted] and the [redacted] the [redacted] stated the license checks was the responsibility of the [redacted] and the reference checks were the responsibility of the department heads. The license checks and reference checks prior to the date of hire should have been completed. A review of the provided facility policy dated/revised on 7/23, included under Policy Explanation and Compliance Guidelines, the components of the facility abuse prohibition plan .... Under Screening, section A. Potential employees will be screened for a history of abuse neglect exploitation or misappropriation of resident property. Subsection 1. Background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants.	F 607		
F 609 SS=E	N.J.A.C. 8:39- 9.3(b), 43.15(a) Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse,	F 609		2/22/24

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F 609	Continued From page 5 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 NJ#163297, NJ#164216, and NJ#169168 Based on interviews, review of medical records (MR) and other facility documentation, it was determined that the facility failed to report an allegation of [NJ Ex Order 2] / [NJ Ex Order 26.4] to the New Jersey Department of Health (NJ DOH) in the required timeframe for 5 of 10 sampled residents, (Residents #35, #63, #90, #361, #362).	F 609	F609-Reporting of Alleged Violations Element I Resident #63 was assessed and had [NJ Ex] [redacted] from this deficient practice, resident and family feels [NJ Ex Or] at the facility. Resident #90 was assessed and had [NJ Ex]	

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F 609	Continued From page 6 This deficient practice was evidenced by the following: 1.) A review of the reportable event record report (FRE; Facility Reported Event) which was called in on [redacted] at 10:00 AM, with an event date of [redacted] at 7:00 PM. The FRE was reported as an allegation of [redacted] and was described as follows: On [redacted] at 2:00 PM, Resident #362 was admitted to the facility [redacted] and [redacted] at the staff asking for [redacted] medications. The resident was made aware that the orders had to be verified with the [redacted] and that the hospital report reflected the resident received the [redacted] medication at 11:30 AM, before admission. Resident #361 who resided in the adjacent room, [redacted], stayed [redacted], then told Resident #362 to "[redacted]" and to [redacted], and left. Resident #362 [redacted] and told the supervisor that he/she was [redacted]. The surveyor reviewed the closed record for Resident 362. The Admission Record (AR; or face sheet; an admission summary) reflected that the resident had been admitted with diagnoses which included [redacted], and [redacted]. A review of the entry MDS dated [redacted], indicated the resident entered from an [redacted] on [redacted]. No further assessments were completed for the Resident who was discharged on [redacted].	F 609	[redacted] from this deficient practice. Resident feels [redacted] at the facility. Resident #361 was discharged from the facility Resident #362 was discharged from the facility. Resident #35 was reassessed with [redacted] observed. Resident #35 verbalized feeling [redacted] in the facility currently. The aide in question was removed from resdients' care. On February 2, 2024, the licensed [redacted] was in-serviced by the Regional Clinical Nurse on Reporting of all alleged violations to the state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified time frames. a.) Immediately, but no later than two hours after the allegation is made if the events that caused the allegation involve abuse or result in serious bodily injury. Element II All residents have the potential to be affected by the deficient practice. Element III All staff were in-serviced on the requirement to report to administration	

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F 609	Continued From page 7 A review of the active orders for the resident for [NJ Ex Order 2] included an order for [NJ Ex Order 26.4b1], 1 tablet every 4 hours as needed for [NJ Ex Order 26.4b1]. A review of the nursing progress note (PN) for the resident included the following: - On [NJ Ex Order 2] at 3:40 PM, the nurse documented that at 2:00 PM the resident arrived [NJ Ex Order 26.4b1], was [NJ Ex Orde] [NJ Ex Order 26.4b1] and [NJ Ex Order 26.4b1]. The resident was described as [NJ Ex Order 26.4b] - At 3:50 PM, the nurse documented an administration of a [NJ Ex Or] medication, [NJ Ex Order 26.4b1] - At 8:00 PM, the [US FOIA (b)(6)] documented that at about 7:00 PM, the resident was heard [NJ Ex Order 26.4b1] and his/her call light was on. The [US FOIA (b)(6)] and assigned nurse responded to his/her room. The resident reported that a [race and gender redacted] [NJ Ex Order 26.4b1] and was [NJ Ex Order 2]". The [US FOIA (b)(6)] and [US FOIA (b)] assured the resident that he/she was [NJ Ex Or], the call light was kept within reach and frequent resident checks were done. - At 8:46 PM, the [US FOIA (b)] documented an administration of a pain medication, [NJ Ex Order 26.4b1]. A review of the Risk Management report initiated on 4/5/23 at 7:00 PM, indicated that the immediate action included provision of [NJ Ex Order 26.4b1] and [NJ Ex Order 26.4b1] of Resident #362's [NJ Ex Order 2]. The incident was an unwitnessed event. A review of the investigation summary indicated that [NJ Ex Order 26.4b1] occurred between Resident #361 and #362.	F 609	(both the Director of Nursing and the Administrator) immediately at the time the abuse occurs to ensure that the reporting is called in to the Department of Health within the two-hour timeframe. Contact telephone numbers were placed at the three nursing stations and staff made aware that they should call the administration (both Director of Nursing and Administrator) at the time of the potential abuse as well as place on the twenty-four-hour report. Administration will ensure that the call is made timely to the Department of Health (within the two hours) and that an AA-45 is sent with the conclusion within five working days of the occurrence of the abuse. All licensed nursing educated on the facility policy and procedure on incident and accident investigations, use of the resident monitoring tool, and notification of the Director of Nursing or designee of reporting all incidents immediately. Element VI Administrator/Director of Nursing will review all reportables the day of the event to ensure that it is reported on time and review at the clinical meeting weekly for four weeks. Director of Nursing or designee will audit investigations and update care plans for	

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F 609	Continued From page 8 Further review of the summary reflected a documentation by the US FOIA (b)(6), and the US FOIA (b)(6) that Resident #362 had a history of NJ Ex Order 26.4b1 from the previous place of residence. Attached to the investigation summary were three pages of witness statements, documented by the US FOIA (b)(6) and dated NJ Ex Order 2. -The US FOIA (b)(6) documented on an Investigation of Incident, Employee Care Partner Statement form (II/ECPS) that at 7:00 PM, Resident #362 was heard NJ Ex Order 26.4b1 and the resident's call light was on. The US FOIA (b)(6) responded to the call light and was informed by the resident that a person (gender and race redacted) NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. The US FOIA (b)(6) assured the resident that he/she was NJ Ex Or and ensured the call bell was within reach. -On a blank piece of paper, the US FOIA (b)(6) documented on NJ Ex Order 2, which included Resident 362 NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. Two NJ Ex Order responded on the scene. The two NJ Ex Order spoke with the resident for about 10 minutes, then proceeded to the nurses' station. The nurse was questioned if the resident was receiving NJ Ex Or medication. The US FOIA (b)(6) informed the NJ Ex Order 26.4b1 that the resident had an order for NJ Ex Order 26.4b1 every 4 hours. The physician had ordered for a NJ Ex Or management specialist for the resident and the staff were responding to the call light and the resident's NJ Ex Order 26.4b. The NJ Ex Order 26.4b1 departed after speaking with the US FOIA (b)(6).	F 609	completeness and ensure suitable interventions are implemented. This audit will be done weekly times four weeks, bi-weekly times four weeks and then monthly times three months. All abuse occurrences will be reviewed and discussed at Quality Assurance and Performance Improvement monthly meetings by the Administrator for timeliness and will be discussed at the meeting and recorded for review. An Abuse Reporting time audit will be done on the start and end date of the five working day submission to ensure that the information is reported timely. The Abuse Reporting audit log will be audited for timeliness for 2 months and the Quality Assurance and Performance Improvement committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan will be amended when indicated. Adverse findings will be immediately addressed as well as findings and trends will be reported at least quarterly to the Quality Assurance and Performance Improvement committee for 2 quarters. Compliance Date: February 22, 2024	

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-The US FOIA (b)(6) documented on another II/ECPS form dated NJ Ex Order 2, that Resident #361 acknowledged NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 Resident #362 to NJ Ex Order 26.4b1 ...

The surveyor reviewed the closed record for Resident #361.

The Admission Record (AR; or face sheet; an admission summary) reflected that the resident had been admitted on NJ Ex Order 26.4 with diagnoses which included NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 , NJ Ex Order 26.4 (NJ Ex Order 26.4b1) and NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 .

According to the admission Minimum Data Set, an assessment used to facilitate the management of care, dated NJ Ex Order 2, reflected the resident had a brief interview for mental status of NJ Ex out of 15 which indicated the resident was NJ Ex Order 26.4b1 .

The individualized Care Plan (CP) revealed a focus that included, a focus that the resident used NJ Ex Order 26.4b1 medication related to NJ Ex Order 26.4b1 initiated on NJ Ex Order 2. An additional focus was added on NJ Ex Order 2, that indicated the resident was NJ Ex Order and NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 . The interventions initiated on NJ Ex Order 2, was to educate the resident and family regarding the risk, benefit, and the side effects and or toxic symptoms of the NJ Ex Order 26.4b1 medications. The NJ Ex Order 26.4b1 side effects documented included NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 , NJ Ex Ord

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F 609		F 609		

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NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1. NJ Ex Order 26.4b1 side included, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 or NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1.

Further review of the CP revealed an additional intervention initiated on NJ Ex Order 2, that reflected the resident was provided a NJ Ex O on NJ Ex Order 2 until transfer to another room far from Resident 362.

The admission Minimum Data Set, an assessment used to facilitate the management of care, dated NJ Ex Order 2, reflected the resident had a brief interview for mental status of NJ Ex out of 15 which indicated the resident was NJ Ex Order 26.4b1 and had not exhibited NJ Ex Order 26.4b1.

A review of the PN for Resident # 361 included the following:
On 4/5/23 at 7:30 PM, the US FOIA (b) documented that at about 7:00 PM, the resident in [room number redacted] reported that a resident had NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. The supervisor interviewed the resident, who indicated that he/she NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. The resident was offered another room to move into but declined.

No further documentation by a facility staff was noted on the PN on NJ Exec Orde.

On 01/22/24 12:16 PM, the surveyor called a Certified Nursing Assistant (CNA #1) who worked on NJ Ex Order 2, during the 3 to 11 shift. CNA #1 could not recall the residents.

On 01/22/24 12:21 PM, the surveyor called CNA

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#2 who worked on [NJ Ex Order 2], during the 3 to 11 shift. There was no answer, no voice mail option.

On 01/22/24 12:27 PM, the surveyor called CNA #3 who worked on [NJ Ex Order 2] during the 3 to 11 shift. CNA #3 could not recall the residents.

On 01/22/24 01:01 PM, the surveyor called the [US FOIA (b)(6)] who wrote the witness statement. There was no answer, and the surveyor left a message.

On 1/22/24 at 1:16 PM, in the presence of the surveyor and the [US FOIA (b)(6)], the [US FOIA (b)(6)] explained the process for [NJ Exec Order 26.4b] of [NJ Ex Order 2] and stated any department head was able to initiate the process for [NJ Ex Order 26.4b1] or [NJ Ex Order 2].

At that time, the surveyor informed the [US FOIA] and the [US FOIA (b)(6)] of the concern regarding the failure to timely report the FRE to the NJDOH.

At that time, in the presence of the surveyor, and the [US FOIA], the [US FOIA (b)(6)] stated that she was not the [US FOIA (b)(6)] at that time of the FRE, and that the FRE should have been reported to the NJDOH, no later than two (2) hours after the allegation was made.

On 1/23/24 at 12:04 PM, in the presence of the survey team, the [US FOIA (b)] and the [US FOIA (b)(6)] the [US FOIA] confirmed the 2-hour reporting time was unfortunately not followed for this FRE.

2.) A review of the ASE Complaint / Incident Investigation report revealed a receive date of [NJ Ex Order 26.4] at 11:47 AM to the New Jersey Department of Health (NJDOH).

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On 01/11/24 at 10:00 AM, the surveyor asked the US FOIA (b)(6) for a copy of Resident #63 and #90, Incident/Accident and Reportable (I/A & R) reports for the last (8) eight months, and the US FOIA (b)(6) stated that she will get back to the surveyor.

A review of reportable event record report provided by the US FOIA (b)(6) on 01/12/24 at 11:52 AM revealed an "event date" of NJ Ex Order 26.4 and a "today's date" of NJ Ex Order 26.4. The facsimile to NJ Ex Order 26.4b1 of the events was submitted NJ Ex Order 26.4 at 15:12 with summary and conclusion of the NJ Ex Order 2 incident.

A review of reportable event record report provided by the US FOIA (b)(6) on 01/11/23 revealed an event dated NJ Ex Order 26.4 at 08:25 AM. The investigation report revealed that during breakfast staff heard resident #90 NJ Ex Order 26.4b1 that he/she NJ Ex Order 26.4b1 while resident # 63 was found NJ Ex Order 26.4 resident #90 NJ Ex Order 26.4b1 . Resident # 63 was saying " NJ Ex Order 26.4b1 ". Both residents were NJ Ex Order 26.4b1 and resident # 63 was NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 until a NJ Ex Order 26.4b1 could be done. Both residents were assessed for NJ Ex Order 26.4b1 . NJ Ex Order 26.4b1 were noted. When the US FOIA (b)(6) came to consult resident #63 the NJ Ex was removed and resident #63 NJ Ex Order were adjusted.

The surveyor reviewed the medical records of Resident #63.

Resident's Admission Record, (or face sheet; admission summary) (AR), for #63 reflected that

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the resident was admitted to the facility with diagnoses that included but not limited to; NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 .

The quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care with assessment reference date (ARD) NJ Ex Order 2 showed that the resident's Brief Interview for Mental Status (BIMS) score was NJ Ex of 15, showing NJ Exec Order 26.4b1 for NJ Exec O were NJ Ex Order 26.4b1.

A review of the residents Care Plan (CP) revealed the reflected focus "a NJ Ex Order 26.4b1 and NJ Ex Order 26.4 and NJ Ex Order 26.4b1 his /her NJ Ex Order 26.4b1", initiated on NJ Ex Order 26.4. Another focus of "NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 ", initiated on NJ Ex Order 26.4b1. It further revealed a focus for " NJ Ex Order 26.4b1 related to NJ Ex Order 26.4b1", initiated on NJ Ex Order 26.4b1 with a new intervention initiated on NJ Ex Order 26.4.

A review of the physician order set (POS) revealed a new order for NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) NJ Ex Order 26.4b1 by mouth two times daily. (This medication is used to treat NJ Ex Order 26 .)

The surveyor reviewed the medical records of Resident #90.

Resident's AR, for #90 reflected that the resident was admitted to the facility with diagnoses that included but not limited to, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 ,NJ Ex Order 26.4b1, NJ Ex Order , NJ Ex Order 26.4b1, NJ Ex Order 26.

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NJ Ex Order 26.4b.

The Comprehensive Minimum Data Set (cMDS), with an ARD of NJ Ex Order 26.4 showed that the resident's Brief Interview for Mental Status (BIMS) score was NJ of 15, showing NJ Exec Order 26.4b1 for NJ Exec O were NJ Ex Order 26.4b1.

On 01/23/24 at 11:10 AM, during an interview with the US FOIA (b)(6) the process of handling I/A & R and NJ Exec Order 26.4b1 the US FOIA (b)(stated, "the staff would initiate the incident form and it would be given to the US FOIA (b)(6), NJ Ex Order 2 would fall under me." She further explained, an allegation of NJ Ex Order 2 should be reported within (2) two hours to the NJDOH." "I came here to make a difference the community is very nice."

At that time, the Surveyor inquired, why it was not reported with in the timeframe per the regulation. The US FOIA (b)(stated, "I am unable to answer that due to the high turnover of management in this facility. The previous US FOIA (b)(6)) are no longer here. It should have been reported per regulation in the two (2) hour timeframe."

3.) On 01/10/24 at 10:01 AM, the surveyor observed Resident # 35 lying in their bed NJ Ex Order 26.4b1. The resident was NJ Ex Ord but did NJ Exec Order 26.4b1 by the surveyor.

The surveyor reviewed the medical record for Resident #35.

A review of the Admission Record (an admission summary) reflected that the resident was

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admitted to the facility with diagnoses which included but not limited to; NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1), NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1 , and NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1).

A review of the resident's most recent quarterly Minium Data Set (MDS) revealed that the resident had a BIMS score of NJ Ex out of 15 which indicated an NJ Ex Order 26.4b1.

A review of a NJ Ex Order 26.4b1 Report revealed that on NJ Ex Order 26.4b1, Resident #35 filed a NJ Ex Order 26.4b1 regarding an incident that occurred during care with a US FOIA (b)(6)).

A review of a facility incident report revealed that the facility conducted a full investigation into an allegation of NJ Ex Order 2 that was filed by Resident #35 regarding an incident that occurred with a US FOIA (b) who was providing care to the resident. The facility immediately removed the aid and did a NJ Ex assessment of the resident. The facility conducted a full investigation which included interviews. The facility determined that they were NJ Ex Order 26.4b1, but the aid was given a new assignment and the resident's care plan was updated. The facility called the resident's family and notified the physician.

A review of the Reportable Event Record/Report (AAS-45) which revealed that the reportable was submitted on NJ Ex Order 2.

A review of a copy of an email that was part of the facility NJ Ex Order 2 investigation revealed an email that was sent to the Department of Health on NJ Ex Order 26.4b1

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regarding the AAS-45 in which the Licensed Nursing Home Administrator wrote the following: "Did I send you the AAS-45 on [Resident # 35] I cannot find mind ...I need a copy or will have to re-do.

On 1/23/24 at 10:50 AM, the surveyor interviewed the [redacted] who stated that when there is an [redacted] of [redacted] that she will need to submit an [redacted] form within two hours. In regard to Resident #35's [redacted] incident, the [redacted] stated that she filled out the [redacted] form and that she gave it to the US FOIA (b)(6) [redacted] who was at the facility during the investigation. She stated that she gave a copy of the investigation and the [redacted] to the US FOIA (b)(6) She stated the email that she sent was to the US FOIA (b)(6) who sent her an earlier email requesting the [redacted] form. The [redacted] stated that going forward that she will be faxing the [redacted] to the appropriate agency.

A review of the "Abuse, Neglect and Exploitation" policy dated, original 01/2012 and REV (reviewed) date of 11/2017, 9/2021, 9/2020, 9/2022, 7/2023, provided by the [redacted] on 01/21/23 at 01:00 PM. The policy definition of abuse revealed "willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." Under policy explanation section #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 state law." The policy further revealed section IV "Identification of Abuse, Neglect and Exploitation, #6, Physical abuse of a resident observed. #7, Psychological abuse of a resident observed.

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F 609	Continued From page 17 A review of the provided facility policy Abuse, Neglect and Exploitation, dated/revised 7/2023, which included under section VII. Reporting/Response: A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified time frames. a.) Immediately, but no later than two hours after the allegation is made if the events that caused the allegation involve abuse or result in serious bodily injury. NJAC 8:39-4.1(a)(5) NJAC 8:39-13.4(c)(2)(v)	F 609		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		2/22/24

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F 623	Continued From page 18 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;	F 623		

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(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:

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F 623	Continued From page 20 Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to provide written notification of the NJ Ex Order 26.4b1 to the Office of the Long-Term Care Ombudsman (LTCO) for one (1) of two (2) residents (Resident #94), reviewed for hospitalizations. This deficient practice was evidenced by the following: The surveyor reviewed the hybrid (a combination of paper, scanned, and computer-generated records) medical records of Resident #94. The Admission Record (or face sheet, an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4b1 NJ Ex Order 26.4b1), NJ Ex Order 26.4b1 NJ Ex Order 26.4b1), (NJ Ex Order 26.4b1), and NJ Ex Order 26.4b1 (A review of the New Jersey Universal Transfer Form (UTF) showed that the resident was transferred to the hospital on NJ Ex Order 26.4 at 11:50 AM and the reason for the transfer was due to NJ Ex Or . The Physician Discharge Summary that was signed by the physician revealed that the resident was transferred to the hospital on NJ Ex Order 26.4 for NJ Ex Order 26.4b1	F 623	F623-Notice Requirements Before Transfer/Discharge Element I Resident #94 was discharged from the facility and was no longer active during the time of the annual survey conducted by the Department of Health. A full house audit of resident files who have gone to the hospital in 2024 has been reviewed and a bed hold policy has been sent to the resident or the family member as of 2/8/2024. Element II All residents in the facility have the potential to be affected by the deficient practice. Element III On 2/8/2024,the licensed nurses were educated on the regulations and the facility policy and procedures to provide the Resident/Representative with the written emergency transfer notification format at the time of transfer or the responsible party, if the resident is unable to sign at the time of transfer. The Ombudsman form will be sent to the Long-Term Care Complaints office on a weekly basis. Weekly audits will be conducted and reviewed by the Social Worker and/or designee to ensure that all acute transfer	

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F 623	Continued From page 21 On 01/18/24 at 10:57 AM, the survey team met with the US FOIA (b)(6) The surveyor asked for a copy of the notice of transfer sent to the LTCO for the resident's hospital transfer. On 01/22/24 at 8:48 AM, the surveyor interviewed the US FOIA (b) regarding the notifications of transfer sent to LTCO. The US FOIA (b) stated that there was no notification sent to LTCO that was done for the resident. She further stated that it was because the US FOIA (b)(6) did not do the notifications. The US FOIA (b) stated that she thinks it was the US FOIA who was responsible for notification, and that she will get back to the surveyor about it if it was the US FOIA responsible for it. On 01/22/24 at 9:45 AM, the US FOIA (b) stated that the facility had no specific policy regarding notice transfer that was sent to the LTCO, instead, the facility follows the regulation about notice requirements before transfer and discharge. On that same date and time, the US FOIA (b) confirmed that the facility did not have a written notification sent to the LTCO when the resident was transferred to the hospital on NJ Ex Order 26.4. On 01/22/24 at 10:08 AM, the survey team met with the US FOIA (b)(6). The surveyor notified the facility management of the above concern. On 01/24/24 at 12:49 PM, the survey team met with the US FOIA (b)(6), and there was no additional information provided by the	F 623	notifications are completed and faxed to the Ombudsman. Element IV Hospital transfer audit of all hospital transfer notifications to the Ombudsman will be monitored for completion by the Social Worker or designee weekly for one month, every two weeks for two months and monthly for 3 months. Audit findings will be discussed during the monthly Quality Assurance and Performance Improvement committee. The Quality Assurance and Performance Improvement committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan will be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to Quality Assurance and Performance Improvement committee at least quarterly. Completion date: 02/22/2024	

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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 623	Continued From page 22 facility management. NJAC 8:39-4.1(a)(32)	F 623		
F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on the interview, record review, and review of pertinent facility documentation, it was	F 625	F625- Notice of Bed Hold Policy Before/Upon Transfer	2/22/24

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	315104	A. BUILDING _____ B. WING _____	C 01/24/2024

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F 625	Continued From page 23 determined that the facility failed to provide resident and/or their representatives with the facility's written notice of bed hold. This deficient practice was identified for one (1) of two (2) residents, (Resident #94), reviewed for hospitalization. This deficient practice was evidenced by the following: The surveyor reviewed the hybrid (a combination of paper, scanned, and computer-generated records) medical records of Resident #94. The Admission Record (or face sheet, an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1), NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1), (NJ Ex Order 26.4b1), and NJ Ex Order 26.4b1 (A review of the New Jersey Universal Transfer Form (UTF) showed that the resident was transferred to the hospital on NJ Ex Order 26.4 at 11:50 AM and the reason for the transfer was due to NJ Ex Or (NJ Ex Order 26.4b1). The Physician Discharge Summary that was signed by the physician revealed that the resident was transferred to the hospital on NJ Ex Order 26.4 for NJ Ex Order 26.4b1 Further review of the hybrid medical records	F 625	Element I Resident #94 was discharged from the facility and was no longer active during the time of the annual survey conducted by the Department of Health. House wide audit of all residents completed with bed hold policy was initiated. Element II All residents in the facility have the potential to be affected by the deficient practice. Element III Nursing staff, US FOIA (b)(6), Admission, educated on the facility policy and procedures including the process of providing the written bed hold policy to the resident and the residents' representative at the time of transfer. Bed hold policy will be signed and uploaded to the residents' electronic medical records under Miscellaneous. The Unit Managers and Nursing Supervisors were in-serviced on the process of providing the residents and the residents' responsible party with the written bed hold policy at the time of transfer by the Director of Nursing and the Administrator. Weekly audits will be conducted and	

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F 625	Continued From page 24 showed that there was no written notification for a bed hold when the resident was transferred to the hospital on [NJ Ex Order 26.].	F 625	reviewed at the daily Clinical meetings to ensure that all residents transferred to the hospital have received a bed hold notification and/or are mailed to the responsible party and faxed to the Ombudsman by the social worker and/or designee.	
	On 01/18/24 at 10:57 AM, the survey team met with the [US FOIA (b)(6)] The surveyor notified the facility management of the above findings and concerns.		Audits of all hospital transfer notifications to the Ombudsman will be monitored for completion and reviewed during the clinical morning meetings by the Social Worker/Administrator/or designee weekly for four weeks, every two weeks for two months and monthly for three months.	
	On 01/22/24 at 8:48 AM, the surveyor interviewed the [US FOIA (b)] regarding the notifications of bed hold. The [US FOIA (b)] stated that there was no notification of bed hold that was done for the resident. She further stated that it was because the [US FOIA (b)(6)] did not do the notifications. The [US FOIA (b)] stated that she thinks it was the [US FOIA] who was responsible for notification, and that she will get back to the surveyor about it if it was the [US FOIA] responsible for it.		Element IV Audit findings will be discussed during the monthly Quality Assurance and Performance Improvment committee. The Quality Assurance and Performance Improvement committee will determine if continued auditing is necessary, once 100% compliance threshold is met for two consecutive months. This plan will be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will also be reported to Quality Assurance and Performance Improvement Committee at least quarterly.	
	On 01/22/24 at 9:45 AM, the [US FOIA (b)] confirmed that the resident did not have a written bed hold notice upon transfer to the hospital when the resident was transferred to the hospital on [NJ Ex Order 26.]. The [US FOIA (b)] acknowledged that the bed hold notice upon transfer should have been done.			
	A review of the provided Bed Hold Notice Upon Transfer Policy with a reviewed date of 9/2023 included that at the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed.			

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F 625	Continued From page 25 On 01/24/24 at 12:49 PM, the survey team met with the[redacted], and there was no additional information provided by the facility management.	F 625		
F 640 SS=D	NJAC 8:39-5.1 Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit	F 640		2/18/24

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F 640	Continued From page 26 encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on the interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to complete and transmit a Minimum Data Set (MDS) - Discharge Assessment in accordance with federal guidelines. This deficient practice was identified for two (2) of 28 residents, (Residents #21 and #94), reviewed for resident assessments. This deficient practice was evidenced by: According to the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.18.11, updated October 2023, the MDS is a comprehensive tool that is a federal mandated process for clinical assessment of all residents that must be completed and transmitted	F 640	F640-Encoding/Transmitting Resident Assessments Element I Resident #21 was discharged from the facility at the time of the Department of Health annual survey. Discharged/Returned/Not Anticipated assessment was completed and submitted on [redacted]. Resident #94 was discharged from the facility at the time of the Department of Health annual survey. Discharge/Returned/Anticipated assessment was completed and	

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F 640	Continued From page 27 to the Quality Measure System. The facility must electronically transmit the MDS within 14 days of the assessment being completed. After the transition of the MDS, a quality measure will be transmitted to enable a facility to monitor the residents decline or progress. page 2-11 "Discharge refers to the date a resident leaves the facility..." There are two types of OBRA (Omnibus Budget Reconciliation Act) required discharges: return anticipated and return not anticipated. A Discharge assessment is required with all types of discharges. The manual on Page 2-17 "A Discharge Assessment - return not anticipated MDS must be completed not later than discharge date + 14 days. The assessment must also be transmitted to the QIES (Quality Improvement and Evaluation System) ASAP (Assessment Submission and Processing) system not later than the MDS completion + 14 days. 1. The surveyor reviewed the hybrid (a combination of paper, scanned, and computer-generated records) medical records of Resident #21. The Admission Record (AR, an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4b1 NJ Ex Order 26.4b1), NJ Ex Order 26.4b1 NJ Ex Order 26.4b1), NJ Ex Orde (NJ Ex Order 26.4b1), NJ Ex Order 26. , and NJ Ex Order 26.4b1 . The Physician Discharge Summary (PDS) that	F 640	submitted on NJ Exec Order 26.4b1 . US FOIA (b)(6) was re-educated on 1/18/2024 by the Regional Reimbursement Coordinator on accurate coding based on documentation, demonstration, staff interviews, and discharge plans. Element II All residents with a discharge plan in place have the potential to be affected by the deficient practice. Element III The US FOIA (b)(6) was in-serviced by the Regional Reimbursement on 2/8/2024 on the Accuracy of Assessments to reflect the resident's status based on the interview, record review, and review of pertinent facility documentation. The Regional MDS will run the 3.0 Missing OBRA Assessment Report monthly and as needed to review accuracy of Encoding/Transmitting Resident Assessments. The Minimum Data Set Coordinator and /or designee will review the daily census and conduct a weekly Action Summary report for any discharges prior to submitting the Minimum Data Discharge	

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F 640	Continued From page 28 was signed by the physician revealed that the resident NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. A review of the Progress Notes showed that on NJ Ex Order 26.4 at 9:37 AM, the US FOIA (b)(6) who was also the US FOIA (b)(6) documented that the resident was discharged (d/c) NJ Exec Order 26.4b1 The surveyor reviewed the resident's MDS 3.0 Assessment History assessment tool, including all the completed MDS. The MDS assessment history revealed that there was no Discharge Assessment MDS completed for the resident's d/c date of NJ Ex Order 26.4. 2. The surveyor reviewed the hybrid medical records of Resident #94. The AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 NJ Ex Order 26.4b1), NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1), and NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1 A review of the Universal Transfer Form (UTF) showed that the resident was transferred to the hospital on NJ Ex Order 26.4 at 11:50 AM and the reason for the transfer was due to NJ Ex Order 26.4b1 . The PDS that was signed by the physician	F 640	Not Anticipated assessment to CMS. Element IV The discharge assessment review by the Minimum Data Set Coordinator will be discussed at the clinical meetings but will also be logged and brought to the attention of the Interdisciplinary team on a weekly basis to be reviewed prior to the fourteen day window for completion and then reported at the monthly Quality Assurance and Performance Improvement committee meetings on a monthly basis for two months. Compliance for a 100% threshold will be reported for three months and reviewed weekly by the Minimum Data Set Coordinator each month.	

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F 640	Continued From page 29	F 640		

revealed that the resident was transferred to the hospital on [NJ Ex Order 26.] for [NJ Ex Order 26.4b1].

A review of Resident #94's MDS, an assessment tool used to facilitate the management of care showed that there were no d/c MDS that was done.

On 01/18/24 at 9:51 AM, the surveyor interviewed the [US FOIA (b)(6)] in the presence of the survey team. The [US FOIA (b)(6)] stated that she was responsible for the MDS schedule and make sure that MDS was completed and done on time. She further stated that the facility did not have a separate policy about MDS completion, instead, the facility follows the RAI Manual. The [US FOIA (b)(6)] stated that the [NJ Exec Order 26.4b1]) and the [NJ Exec Order 26.4b1]) should be completed within 14 days and transmitted within 21 days, and she was not sure if that was the exact date, but should be within that period.

On that same date and time, the surveyor notified the [US FOIA (b)(6)] of the above findings regarding [NJ Exec Order 26.4b1] that was not done for Resident #94 when the resident was transferred to the hospital and the [NJ Exec Order 26.4b1] that was not done for Resident #21. The [US FOIA (b)(6)] stated that there should be a [NJ Exec O] done for Resident #94 and [NJ Exec Orde] for Resident #21, and that she will get back to the surveyor to check what happened, and why the MDS assessments were not done.

On 01/22/24 at 10:08 AM, the survey team met with the [US FOIA (b)(6)]. The surveyor notified the facility

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F 640	Continued From page 30 management of the concern regarding Resident #21 and #94's MDS. The US FOIA (b) confirmed that the d/c MDS of Residents #21 and #94 were not done. The US FOIA (b) further stated that the US FOIA (b)(6) completed the d/c MDS after the surveyor's inquiry. On 01/24/24 at 12:49 PM, the survey team met with the US FOIA (b)(6) , and there was no additional information provided by the facility management. NJAC 8:39 - 11.1	F 640		
F 641 SS=C	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on the interview, record review, and review of pertinent facility documentation it was determined that the facility failed to accurately code the Minimum Data Set (MDS) for one (1) of the 28 residents reviewed, Resident #105. This deficient practice was evidenced by the following: According to the Admission Record (admission summary), Resident #105 was admitted to the facility with a diagnosis that included but was not limited to NJ Ex Order 26.4b1 NJ Ex Order 26.4b1	F 641	F641-Accuracy of Assessments Element 1 Resident #105 was discharged from the facility at the time of the Department of Health annual survey. MDS assessments were modified in Section A2105 which was modified and submitted on NJ Exec Order 26.4b1 to reflect the accuracy of assessments. US FOIA (b)(6) was re-educated on 1/18/2024 by the Regional Reimbursement Coordinator on accurate coding based on documentation, demonstration, staff interviews, and	2/22/24

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F 641	Continued From page 31 NJ Ex Order), NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1 . A review of the resident's Progress Notes under Health Status Note (HSN) dated, NJ Ex Order 26.4b1 at 02:51 PM, revealed that the assisted living staff came, assessed the resident, will be discharged in the afternoon, and that the responsible party (RP) was made aware. Further review of the HSN dated NJ Ex Order 26.4b1 at 5:45 PM showed that the resident's RP was present when the resident was picked up by the transportation via wheelchair when discharged from the facility. A review of the resident's discharge MDS dated NJ Ex Order 26.4b1 revealed that the MDS section NJ Exec Order 2 Discharge Status was coded NJ Exec NJ Exec Order 26.4b1 instead of NJ Ex Or which was discharge NJ Exec Order 26.4b1 . On 01/18/24 at 9:51 AM, the surveyor interviewed the US FOIA (b)(6) in the presence of the survey team. The US FOIA (b)(6) informed the surveyor that she was responsible for answering all sections in the MDS except for sections C, D, E, F, and Q. The US FOIA (b)(6) confirmed that she was responsible for answering section A Identification Information that included section NJ Exec Order 2 Discharge Status. She further stated that section NJ Exec Order 2 should have been coded as 'NJ Ex because the resident was discharged to an NJ Exec Order 26.4b1 and	F 641	discharge plans. Element II All residents in the facility have the potential to be affected by the deficient practice. Element III Minimum Data Set Coordinator or designee will conduct weeklyreview. The Minimum Data Set Coordinator and /or designee will review the daily census and conduct a weekly Action Summary report for any discharges prior to submitting the Minimum Data Discharge Not Anticipated assessment to CMS. The Director of Nursing and the Interdisciplinary Care Plan Team including the Minimum Data Set department will continue to discuss these residents during the length of stay until assessment is submitted successfully. Element VI The completion of the Discharge Assessment audit log will be monitored by the Administrator, Director of Nursing, or designee weekly for four weeks, every two weeks for two months and monthly for 3 months. Audit findings will be discussed during the monthly Quality Assurance and	

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F 641	Continued From page 32 not in the hospital. The US FOIA (b)(6) stated that she will get back to the surveyor on what had happened and why the MDS was not coded accurately. On 01/18/24 at 10:57 AM, the survey team met with the US FOIA (b)(6) The surveyor notified the facility management of the above findings regarding the resident's MDS was not accurately coded to reflect the discharge to the community. On 01/22/24 at 10:08 AM, the survey team met with the US FOIA (b)(6). The US FOIA (b) confirmed that the resident's discharge MDS was not coded accurately to reflect the discharge to NJ Ex Order 26.4b1. On 01/24/24 at 12:49 PM, the survey team met with the US FOIA (b)(6), and there was no additional information provided by the facility management. NJAC 8:39-11.1, 11.2(e)(1)	F 641	Performance Improvement committee meetings. The Quality Assurance and Performance Improvement committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan will be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to Quality Assurance and Performance Improvement Committee at least quarterly.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		2/9/24

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F 657	Continued From page 33 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined that the facility failed to revise comprehensive care plans for 2 of 28 residents reviewed (Resident #41 and #75). This deficient practice was identified by the following: 1. On 01/10/24 at 11:08 AM, the surveyor observed Resident #41 in bed [redacted]. The resident was [redacted] and [redacted]. The surveyor reviewed Resident #41's hybrid medical records. The Admission Record (AR) (an admission summary), reflected that Resident #41 was	F 657	F657- Care Plan Timing and Revision Element I Resident #41 Care plan was revised to reflect the physician orders and the residents [redacted] Status to be a [redacted] on January 12, 2024. Resident #75 Care plan was revised on January 18, 2024, to reflect the resident refusal for [redacted]. Primary Physician made aware with no new orders. A full house audit was conducted of physician□s orders for residents with advance directives and was completed on	

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	315104	A. BUILDING ______ B. WING ______	C 01/24/2024

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admitted to the facility with medical diagnoses which included but was not limited to: [redacted] ([redacted]), [redacted] [redacted], [redacted] [redacted]) and [redacted] ([redacted].

According to Resident #41's Comprehensive Minimum Data Set (C/MDS), an assessment tool used to facilitate the management of care, the Brief Interview for Mental Status (BIMS) was not conducted due to the resident's [redacted] which revealed that the resident had [redacted] with both [redacted] and [redacted].

A review of the [redacted] Order Summary Report (OSR) revealed a physician order (PO), for a [redacted] ([redacted]) status.

The surveyor reviewed the residents comprehensive care plan (CP) which reflected a CP for Resident #41 titled, "[Resident's name] is a [redacted] ([redacted]), [redacted] ([redacted]), and [redacted] ([redacted]) [redacted] as part of Advanced Care Planning.

On 1/12/24 at 11:20 AM, the surveyor interviewed the [redacted] unit Registered Nurse (RN #1) who reviewed Resident #41's medical records, in the presence of the surveyor, which revealed that the resident had a [redacted] status. RN#1 stated that

January 21,2024.

Element II

All residents that reside in the facility have the potential to be affected by the deficit practice.

Element III

All licensed nursing staff were educated on the facility policy and procedure for initiating and revising Care Plans to reflect the residents□ plan of care on 2/9/2024.

The Director of Nursing in-serviced the [redacted]) on 2/9/2024 on the facility policy and procedure on Revision of Care Plan. Care plans will immediately be addressed both quarterly, annually, and upon changes to ensure that all behaviors and refusal of treatments are recorded and part of the care planning process. Any changes in resident care will be addressed in the clinical meetings under the direction of the Director of Nursing to allow for revision needed to the care plan in a timely manner.
Audits will be monitored by the Director of Nursing or designee for initiating and revisions of care plans weekly for four weeks and then every two weeks for two months and then monthly for three months.

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F 657	Continued From page 35 the NJ Ex Order 26.4b1 should have been updated in the comprehensive care plan and that it was the unit manager's responsibility to update the care plan. On 1/12/24 at 11:30 AM, the NJ Exec Order 26.4 Unit US FOIA (b)(6) reviewed Resident #41's medical record, in the presence of the surveyor, which revealed that the resident had a NJ Ex Order 26.4b status. The US FOIA (b)(6) stated that the resident's comprehensive care plan should have been updated. On 1/18/24 at 1:10 PM, the surveyor met with the facility's US FOIA (b)(6) and the US FOIA (b)(6) regarding the above concerns. There was no additional information provided. A review of the facility's policy for "Resident's Rights Regarding Treatment and Advanced Directives" dated 09/30/23, which was provided by the US FOIA (b) revealed the following: "8. Decisions regarding advance directives and treatment will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions and weather the resident wishes to change or continue these instructions." 2. On 01/11/24 at 11:36 AM, the surveyor interviewed Resident #75 who was in bed NJ Ex Order 26.4b1. The resident stated that they "did NJ Ex Order 26.4b1 today." The surveyor reviewed Resident #75's electronic medical record (eMR).	F 657	Element IV The Administrator will determine if there is a 100% compliance threshold met for three months and the plan will be amended. All audits will be discussed at the monthly Quality Assurance Performance Improvement meetings by the Administrator. Adverse findings will be addressed immediately, and trends will be reported to the Quality assurance and Performance Improvement committee at least quarterly. Completion date: February 22, 2024	

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According to the AR, Resident#75 was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26.4b1 , NJ Ex Order 26.4b (NJ Ex Order 26.4b1), NJ Ex Order 26.4 (NJ Ex Order 26.4b1), and NJ Ex Order 26.4b1 NJ Ex Order 26.4b1).

A review of the Quarterly Minimum Data Set (MDS) indicated that the resident had a BIMS score of NJ Ex out of 15, which indicated that the resident was NJ Ex Order 26.4b1. Further review of the MDS, revealed the resident had NJ Ex Order 26.4b1

A review of Resident #75's CP, revised on NJ Ex Order 26.4, revealed a" Focus: ... NJ Ex Order 26.4b1 ." Further review of the CP did not reveal that the resident NJ Ex Order 26.4 treatment/care.

A Review of the eMar (electronic Medication Administration Record) -Medication Administration notes for NJ Ex Order 26.4b1 revealed the resident refused treatments on 1 NJ Ex Order 26.4b1 at 14:25, NJ Ex Order 26.4b1 at 15:45, NJ Ex Order 26.4b1 at 13:20, NJ Ex Order 26.4b1 at 21:53, NJ Ex Order 26.4b1 at 15:07, NJ Ex Order 26.4b1 at 15:48, NJ Ex Order 26.4b1 at 15:53, and NJ Ex Order 26.4b1 at 14:16.

Review of the eMar notes for NJ Ex Order 26.4b1 revealed the resident refused treatments NJ Ex Order 26.4b1 at 15:40 NJ Ex Order 26.4b1 at 14:08, NJ Ex Order 26.4b1 at 14:12, NJ Ex Order 26.4b1 at15:40, NJ Ex Order 26.4b1 at 15:02, NJ Ex Order 26.4b1 at 22:51, and NJ Ex Order 26.4b1 at 15:15,

On 01/11/24 at 11:40 AM, the surveyor

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interviewed the [redacted] who stated that Resident #75 '[redacted] and [redacted]. You need to [redacted] with [him/her]. [He/She] sometimes [redacted]." She further stated that the resident "always [redacted] to [redacted]" and that once he/she gets '[redacted]" the resident '[redacted]."

On 01/16/24 at 01:23 PM, the surveyor interviewed the [redacted] who stated that Resident #75 was '[redacted] and [redacted] and needs help with ADLS (activities of daily living)." She then stated that sometimes he/she '[redacted] care or to [redacted]." The [redacted] stated that if the resident [redacted] she would try again later.

On 01/18/24 at 12:40 PM, the surveyor interviewed the [redacted], who stated that Resident #75 had [redacted] She stated she knew that the resident [redacted]. She further stated that in regard to [redacted] care, that the resident would "sometime [redacted]." The [redacted] stated that if a resident [redacted] care or treatment that it should be on the care plan.

On 01/18/24 at 12:54 PM, the [redacted] reviewed the eMR, in the presence of the surveyor. She reviewed the eMAR notes and confirmed that the resident [redacted] several times in [redacted]) and [redacted]). She stated that the CP should include that the resident [redacted]. She then reviewed the residents CP and confirmed that it did not include that the resident [redacted]. She stated that anyone can update the CP. The [redacted] stated, "now that I am the [redacted], I am aware CP reviews need to be done." She

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F 657	Continued From page 38 stated that the purpose of the CP was "to know how to take care of the resident." On 01/22/24 at 10:30 AM, the US FOIA (b)(6) [redacted] were made aware of the above findings, during a meeting with the survey team. The US FOIA (b) stated that "nurses were responsible for the CP." She then stated that the purpose of the CP was to "direct the care of the patient." A review of the facility policy "Comprehensive Care Plans" with a revised date 9/2023, revealed Policy: It is the policy of this facility to develop and implement comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Definition: "Person-Centered care" means to focus on the resident as the focus of control and support the resident in making their own choices and having control over their daily lives. 3. b. Any services that would otherwise be furnished but are not provided due to the resident's exercise of his or her right to refuse treatment. 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. NJAC 8:39-11.2 (e)(2)(i)	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		2/22/24

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F 684	Continued From page 39 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of pertinent facility documentation it was determined that the facility failed to follow the Physician's Order (PO) for a.) NJ Ex Order 26.4b1, b.) NJ Ex Order 26.4b1 and c.) NJ Ex Order 26.4b1. This deficient practice was identified for one (1) of twenty-eight (28) residents, (Resident #1) reviewed for quality of care. This deficient practice was evidenced by the following: On 01/12/24 at 11:12 AM, the surveyor observed resident #1 in their room, in bed, there were NJ Ex. The resident presents with NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. The resident did not have any NJ Ex Order 26.4b1 or NJ Ex Order 26. present. The resident was NJ Ex Order 26.4b1 on the NJ Ex Order 26.4b1 with a pillow. The resident can NJ Ex Order 26.4b1 straight into the air. There was an NJ Exec on the bed and the resident head of bed (HOB) was at 30 degrees. The resident had NJ Ex Ord in use NJ Ex Order 26.4b1 for 8 hours. NJ Ex Order 26.4b1 were observed on the NJ Ex Orde in the corner. On 01/16/24 at 12:21 PM, the surveyor observed the resident NJ Exec Order 26.4b1) in NJ Ex Order 26.4b1.	F 684	Element I Resident #1 had the NJ Ex Order 26.4b1 removed on NJ Exec Order 26.4b1. Resident # 1 was assessed with NJ E observed due to the deficit practice. On 1/23/2024 the US FOIA (b)(6) initiated an evaluation to re-assess the use of the NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1. Physician made aware and resident will continue with NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 and NJ Ex Orde daily during the day. NJ Ex Order 26.4b1 were discontinued. The Director of Nursing and the Director of Rehabilitation provided education to the who performed the deficient practice on the facility policy and procedure on Splinting and Floor mats. Element II All residents that reside in the facility have the potential to be affected by the deficient practice. Element III	

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F 684	Continued From page 40 There was a NJ Ex Order 26.4b1 present, there were no NJ Ex Order 26.4b1 or NJ Ex Order 26.4b1 for NJ Ex Order 26.4b1 in use. NJ Ex Order 26.4b1 were not present in the room or around bed. NJ Ex Order 26.4b1 observed on the NJ Ex Ord in the corner. On 01/22/24 at 06:45 AM, the surveyor observed the resident while touring with the scheduled night shift US FOIA (b)(6)). The US FO and the surveyor entered Resident #1's room. NJ Ex Order 26.4b1 was not present on either side of the bed, the resident did not have his/her NJ Ex Order 26.4b1 on, and they were still located on the NJ Ex Ord in the corner as observed previously. The resident had NJ Ex Order 26.4 [redacted]. On 01/23/24 at 10:06 AM the surveyor toured and observed in the presence of the US FOIA (b)(6) [redacted] the resident did not have NJ Ex Order 26.4b1 present in the room. The resident did not have his/her NJ Ex Order 26.4b1 or NJ Ex Order 26.4, there was no application of NJ Ex Order 26.4b1 present. The residents NJ Ex Order 26.4b1 were in the NJ Ex Ord in the corner. A review of the Admission Record (an Admission Summary) reflected that that resident was a long-term care resident at the facility and had diagnoses which included but were not limited to NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1), NJ Ex Order 26.4b1 [redacted]	F 684	Therapy will review all splint/floor mat orders of those residents requiring splints and floor mats to ensure that a splint is done correctly or in the case of floor mats, that a resident requires said floor mat, according to therapy orders or if changes are needed. Meetings will be held weekly, by the Director of Rehab, Unit Managers and Director of Nursing discussing all patients who require floor mats or splints. If changes have been made and if new additions have been added to the list of individuals who require floor mats or splinting, a review will be conducted and addressed with the unit manager and discussed with therapy at the Clinical meeting prior to any changes. Occupational Therapist will complete weekly splinting rounds/floor mat audits weekly to make sure that the residents' splints and or floor mats are in their room and remain appropriate for each resident. Deficient practice findings from the audit will be discussed at daily Clinical meetings with nursing and therapy administration. Element IV Floor mats and Heel booty audits will be monitored for completion by the Administrator and Director of Nursing weekly times four weeks and bi weekly times four weeks and monthly times three months. Splint Audits from the Therapy department will be done weekly and reviewed and	

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F 684	Continued From page 41 NJ Ex Order 26.4b1 [redacted] NJ Ex Order 26.4b1) ((NJ Ex Order 26.4b1 [redacted]) The resident's Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4b1, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident was NJ Ex Order 26.4b1 [redacted]. A review of the resident's Care Plan (CP) initiated on NJ Ex Order 26.4b1 and revised on NJ Ex Order 26.4b1, revealed a focus area that the resident has NJ Ex Order 26.4b1 [redacted] of NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. The goal of the resident's CP was that the resident will NJ Ex Order 26.4b1 [redacted] NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1 initiated NJ Ex Order 26.4b1. The interventions in the resident's CP indicated application of NJ Ex Order 26.4b1 [redacted] NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1 to be applied on in the AM and off in the PM care. NJ Ex Order 26.4b1 with each donning and doffing, dated NJ Ex Order 26.4b1. A review of the resident's treatment administration record (TAR), dated NJ Ex Order 26.4b1 - NJ Ex Order 26.4b1 revealed treatment prescribed... ~NJ Ex Order 26.4b1 every shift for NJ Ex Order 26.4b1. ~NJ Ex Order 26.4b1 every shift ~NJ Ex Order 26.4b1 to NJ Ex Order 26.4b1 while in bed ~NJ Ex Order 26.4b1; NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 [redacted]. ON after AM care and OFF before PM care. NJ Ex Order 26.4b1 with each donning and doffing every shift for NJ Ex Order 26.4b1	F 684	tracked and trended by the Quality Assurance Performance Improvement team on a monthly basis. The Administrator will review and track compliance for 100% compliance for auditing to be discontinued if met after two months. This plan is amended when indicated by the Quality Assurance and Performance Improvement committee and reported to the committee at least quarterly times two quarters. Completion date: February 22, 2024	

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management.

Further review of the TAR revealed that nursing documented completion of the above treatments and NJ Ex Order 26.4b1 on the TAR for every day, evening, and night shift for the dates of NJ Ex Ord, NJ Ex Ord, NJ Ex Ord, and day shift NJ Ex Orde The dates listed coincide with the observation dates of the surveyor on 1/12, 1/16, 1/23 Day (7am-3 pm) shift and 1/22/24 Night (11 pm-7am) shift. Those observations revealed the resident did not have NJ Ex Order 26.4b1 in the room, NJ Ex Order 26.4b applied and that the NJ Ex Order 2 and NJ Ex Order 26.4b1 were in a NJ Ex Orde in the corner of the resident's room.

On 01/22/24 at 06:45 AM, the surveyor interviewed the US FOIA (b)(6). The surveyor inquired about the NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 and why they were NJ Ex Order 26.4b1. She stated, "that the resident NJ Ex Order 26.4b1 , so they did not apply them and that there have not been NJ Ex Order 26.4b1 in a long time for the resident as the resident is NJ Ex Order 26.4b1. The NJ Ex Order 2 get put on during the daytime and removed before bed."

On 01/23/24 at 10:10 AM, the surveyor interviewed the US FOIA (b)(6), who stated, "the treatments that are ordered and entered on the TAR for resident #1 are to help prevent more NJ Ex Order 26.4b1 and NJ Ex Order 2 for the resident. The US FOIA (b)(6)) and nursing staff should be NJ Ex Order 26.4b1 to the resident. The US FOIA (b) should initiate the application of the durable medical equipment (DME) during care and the nurse should check that it is done prior to signing it off on the TAR."

On 11/23/24 at 10:30 AM, the surveyor in the

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F 684	Continued From page 43 presence of the survey team discussed the above findings with the US FOIA (b)(6) [redacted] On 01/22/23 at 12:40 PM, the surveyor asked the US FOIA (b)(6) for a facility policy for durable medical equipment (DME). On 01/24/24 at 01:15 PM, the survey team met with the US FOIA (b)(6) for the Exit Conference. There was no additional information provided by the facility. The surveyor reviewed the "Use of Assistive Device" policy, dated 1/2012 original, 11/2017, 2019, 9/2021, 9/2023 revision. Policy: The purpose of this policy is to provide a reliable process for the proper and consistent use of assistive devices for those residents requiring equipment to maintain or improve function and /or dignity. Policy Explanation: #5. Direct care staff will be trained on the use of the devices as needed to carry out their roles and responsibilities regarding the devices. Training will also include when to refer to other departments for changes in condition or problems with the device. #6. A nurse with responsibility for the resident will monitor for the consistent use of the device and the safety in the use of the device. Refusals of use, problems with the device will be documented in the medical records. Modifications to the plan of care will be as needed. NJAC 8:39-27.1(a)	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility	F 688		2/22/24

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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 688	Continued From page 44 CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to apply a NJ Ex Order 26.4b1 ([redacted]) for the care and management of the [redacted]. This practice was observed for 1 of 5 (Resident #30) residents reviewed for [redacted]. This deficient practice was evidenced by the following: On 01/10/24 at 11:25 AM, the surveyor observed Resident #30 in the great room sitting in the wheelchair and participating in a group activity.	F 688	F688-Increase/Prevent Decrease in ROM/Mobility Element I Resident #30 was re-assessed with [redacted] observed. [redacted] aware and the resident is to maintain [redacted] with the use of [redacted] recommended as per orders. The [redacted] assessed the resident, and the [redacted] were applied. On February 14,2024 full house splint audit was conducted by the Director of Rehab on all residents that require use of	

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F 688	Continued From page 45 The surveyor observed the resident had on an NJ Ex Order 26.4b1 to the NJ Ex Order 26.4b1 and a NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) to the NJ Ex Order 26.4b1. The NJ Ex Order 26.4b1 was observed to be in a NJ Ex Order 26.4b1 and the NJ Ex Order 2 was NJ Ex Order 26.4b1 . The surveyor reviewed the electronic health record (EHR) of Resident #30 which revealed the following: According to the Admission Record, (an admission summary) the resident was admitted with diagnoses that included but were not limited to: NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1)following a NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) affecting the NJ Ex O ; NJ Ex Order 26.4b1 of the NJ Ex Order 26.4b1 ; NJ Ex Order 26.4b1 of the NJ Ex Order 26.4b1 ; and NJ Ex Order 26.4b1 of the NJ Ex Order 26.4b1 The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, was reviewed and revealed the following: The resident had a Brief Interview Mental Status (BIMS), (a tool used to identify the resident's NJ Exec Order 26.4b1) score of NJ out of 15, which indicated the resident was NJ Ex Order 26.4b1 . The assessment also revealed that the resident is usually NJ Ex Order 26.4b1 and usually NJ Ex Order 26.4b1. Further review of the MDS revealed the resident required assistance with activities of daily living (ADL'S), NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 ,	F 688	orthotics with no other findings. Element II All residents in the facility with splinting devices have the potential to be affected by the deficient practice. Element III The Director of Nursing /Director of Rehabilitation provided education to the US FOIA (b)(6) on the facility policy and procedures on donning and doffing Splintings as per the physician's orders on February 9,2024. The Director of Nursing provided education to the US FOIA (b)(6) on following the Physician orders and signing orders in the electronic records with specifics, and detailed instructions for scheduling Donning and Doffing splitting devices, documentation of refusal, and who is responsible for applying the splints in accordance with the physician order. . The Director of Rehab or designee will in-serve and provide on-going education with the Nursing, Dietary, MDS, and Therapy department to ensure availability of assisted devices, such as for ordering and/or replacement, a nurse with responsibility for the resident will monitor for the consistent use of the device and safety in the use of the device. Refusal of use or problems with the device will be documented in the electronic medical	

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F 688	Continued From page 46 NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1. In section NJ Ex Order 26.4b1) Resident #30 was coded as NJ Ex Order 26.4b1 NJ Ex Order . Review of the physician orders revealed physician orders as follows: -NJ Ex Order 26.4b: NJ Ex Order 26.4b1 to be worn 6-8 hours(hrs.) for NJ Ex Order 26.4b1 management, perform NJ Ex Order 26.4b1 after doffing (removal); NJ Ex Order 26.4b1 recommended to NJ Ex Order 26.4b1 for 6-8 hours(hrs.). He/she will NJ Ex Order 26.4b1. Every day and evening shift for NJ Ex Order 26.4b1 management related to NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 following NJ Ex Order 26.4b affecting NJ Ex Order 26.4b1. Donn (put on) after AM care and doff (take off) before pm care." dated NJ Ex Order 26.4b1 , A review of the NJ Ex Order 26.4b1 eTAR revealed the licensed nurse signed that Resident #30 had on both NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1 . A review of the NJ Ex Order 26.4b1 progress notes revealed no documentation indicating the reason that the devices (NJ Ex Order 26.4b1) were not NJ Ex Order 26.4b as ordered. A review of care plan (CP) revealed a "Focus:"[name redacted] demonstrated NJ Ex Order 26.4b : Goal [name redacted] will NJ Ex Order 26.4b1 " and "Interventions: Use of NJ Ex Order 26.4b1 recommended to NJ Ex Order 26.4b1 for 6-8 hrs. [name redacted] will use it NJ Ex Order 26.4b1 ."	F 688	record. Modifications to the plan of care will be made as needed. Therapy Occupational Therapist will complete splint rounds/audits weekly times four weeks, bi-weekly times four weeks, then monthly times three months to make sure that the residents' splints are available as per orders and remain appropriate for each resident. Element IV -Audits will be monitored for completion by the Administrator and Director of Nursing weekly times four weeks, bi-weekly times four weeks, monthly times three months. Audits performed by the Director of Rehab will be discussed and reviewed by the Quality Assurance and Performance Improvement committee for tracking and trending purposes. The Quality Assurance and Performance Improvement committee will determine if continued auditing is necessary once 100% threshold is met for two consecutive months. This plan will be amended when indicated. Adverse findings will be immediately addressed and report to the Quality Assurance and Performance Improvement committee at least quarterly. Completion Date: February 22, 2024	

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Further review of the CP revealed a "Focus read, "[name redacted] has ADL NJ Ex Order 26.4b1 related to NJ Ex Order 26.4b1; Goal: [name redacted] will maintain current level of function in NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, NJ Ex Order 2, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 through the review date; Interventions: ... NJ Ex Order 26.4b1 recommended to NJ Ex Order 26.4b1 for 6-8 hrs. [name redacted] will use it NJ Ex Order 26.4b1."

On 1/11/24 at 09:54AM, the surveyor observed Resident #30 lying in bed. The surveyor interviewed Resident #30 in reference to the care of the NJ Ex Order 26.4b1. The resident stated, "I have something for it," and pointed to the wheelchair. The surveyor observed an NJ Ex Order and NJ Ex Order 26.4b1 on the wheelchair. The surveyor did not observe a NJ Ex Order 26.4b1.

On 01/11/24 at 11:40 AM, the surveyor observed Resident #30 in the great room NJ Ex Order 26.4b1 and playing bingo. The surveyor observed that the resident had on an NJ Ex Order 26.4b1 to the NJ Ex Order 26.4b1 and a NJ Ex Order 26.4b1 to the NJ Ex Order 26.4b1. The surveyor did not observe a NJ Ex Order 26.4b1.

0n 01/11/24 at 12:16 PM, the surveyor interviewed the US FOIA (b)(6) in reference to the plan of care for the NJ Ex Order 26.4b1 for Resident #30. The US FOIA (b) explained that she provided care for the resident and that the resident had an NJ Ex Order 26.4b1 which was applied to the NJ Ex Order 26.4b1. The US FOIA (b) also stated that "NJ Ex Order 26.4 gave the resident NJ Ex Order 2" for the NJ Ex Order 26.4b1. The US FOIA (b) was asked by the surveyor to NJ Ex Order 26.4b1. The surveyor did not observe NJ Ex Order 2 in the resident's NJ Ex Order

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On 01/11/24 at 12:22 PM, the surveyor interviewed the US FOIA (b)(6) in reference to the plan of care for the NJ Ex Order 26.4b1 [redacted]. The US FOIA explained that the US FOIA (b)(6) do NJ Ex Order 26.4b1 to the NJ Ex Order 26.4b1 [redacted] during morning care and that the resident had a NJ Ex Order 26.4b1 and a NJ Ex Order 2 [redacted]. The US FOI stated that the resident did not have any devices for the NJ Ex Order 26.4b1.

On 01/12/24 at 10:28 AM, the surveyor observed Resident #30 in the great room doing a puzzle. He/she had on an NJ Ex Order 26.4b1 to the NJ Ex Order 26.4b1 [redacted] and a NJ Ex Order 26.4b1 to the NJ Ex Order 26.4b1 [redacted]. The surveyor asked the resident if a NJ Ex Order [redacted] was provided for her NJ Ex Order 26.4b1. The resident stated, "NJ Ex Order 26.4b1" and pointed to the NJ Ex Order 26.4b1.

On 01/12/24 at 10:40 AM, the US FOIA reviewed the physician order for "NJ Ex Order 26.4b1: NJ Ex Order 26.4b1 [redacted] to be worn 6-8 hours(hrs.) for NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 after doffing (removal) NJ Ex Order 26.4b1 recommended to NJ Ex Order 26.4b1 for 6-8 hours(hrs.). He/she will NJ Ex Order 26.4b1. Every day and evening shift for NJ Ex Order 26.4b1 management related to NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 following NJ Ex Order 26.4b1 affecting NJ Ex Order 26.4b1. Donn (put on) after AM care and doff (take off) before pm care." dated NJ Ex Order 26.4b1, on the eTAR, in the presence of the surveyor. The US FOI was made aware by the surveyor that the resident only had on the NJ Ex Order 2 [redacted] during observations. The US FOIA then acknowledged that when signing off the physician order on the eTAR for the NJ Ex Order 2 to NJ Ex Order 26.4b1

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NJ Ex Order 26.4b1 that the resident should be wearing the NJ Ex Order 26.4b1 and the NJ Ex Order 26.4b1. She acknowledged at that time the resident did not have a NJ Ex Order 26.4b1.

On 01/12/24 at 11:06 AM, the surveyor interviewed the US FOIA (b)(6) in reference to the protocol for NJ Ex Order 26.4b1 documentation of refusal, and who is responsible for NJ Ex Order 26.4b1 in accordance with the physician order. The US FOIA (b)(6) explained that the use of NJ Ex Order 2 was a physician order. She further explained that the US FOIA (b)(6) enters the order into the medical record then the nurses verify the order with the Physician. The US FOIA (b)(6) then stated, "the nurses are responsible for applying the NJ Exec Order because they sign off the order." The US FOIA (b)(6) explained that if a resident NJ Ex Order 26.4 to wear or NJ Ex Order 26.4b1 it should be documented in the resident's chart. She stated, "the physician would be notified of the NJ Ex Order 26 or inability to NJ Ex Order 26.4 the NJ Ex Order 2 and US FO would be made aware to give a different NJ Ex Order 26

At that time, the US FOIA (b)(6) reviewed the eTARs, in the presence of the surveyor, and acknowledged that the nurse was signing off that the resident had on both NJ Ex Order 2 NJ Ex Order 26.4b1 . The US FOIA (b)(6) was made aware by the surveyor that the resident only had on the NJ Ex Order during the above observations. She then stated, "if the resident is not NJ Ex Order 26.4b1 it should be documented in the progress note the reason the resident NJ Ex Order 26.4b1 ."

On 01/22/24 at 11:19 AM, the surveyor interviewed the US FOIA (b)(6))regarding the concern for the care and

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management of the NJ Ex Order 26.4b1 for Resident #30. The US FOIA (b) stated the purpose of NJ Ex Order 2 were to prevent NJ Ex Order 26.4b1 and NJ Ex Order 26. The US FOIA (b) also stated, "if there is an order for NJ Ex Order 2, it is the nurse's responsibility to apply the NJ Ex Order 2 because it is the nurse who signs off the order."

The US FOIA (b) reviewed the order dated NJ Ex Order 26.4 on the eTAR and stated, "there are two orders in one and it should be separated." She stated according to the order they are signing that the resident has on NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1).

A review of the facility's policy, "PHYSICIAN ORDERS", originally dated 01/2012 and revised on 10/2019;11/2021 and 09/2023 under policy Physician orders may be received by telephone, by a licensed nurse or other licensed or registered health care specialist in their own area of specialty.
In the section titled Policy Explanation and Compliance Guidelines, under explanation number 2 letter C states "use clarification questions to avoid misunderstandings."

A review of the facility's policy, "Use of Assistive Devices," originally dated 1/2012 and revised on 11/2017; 9/2021; and 9/2022 under policy statement read, "the purpose of this policy is to provide a reliable process for the proper and consistent use of assistive devices for those residents requiring equipment to maintain or improve function and/or dignity.
In the section titled Policy Explanation and compliance guidelines states the following: (a) the use of assistive devices will be based on the resident's comprehensive assessment, in accordance with the residents' plan of care,

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F 688	Continued From page 51 (b)the facility will provide assistive devices for residents who need them. Nursing, dietary, social services and therapy departments will work together to ensure availability of devices, such as for ordering and/or replacement, (c)a nurse with responsibility for the resident will monitor for the consistent use of the device and safety in the use of the device. Refusal of use or problems with the device will be documented in the medical record. Modifications to the plan of care will be made as needed. N.J.A.C 8:39-27.1 (a) N.J.A.C 8:39-27.2 (m)	F 688		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F 692		2/22/24

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F 692	Continued From page 52 This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY C # NJ166425 Based on interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to prevent, identify and address an unintended NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) NJ Ex Order 26.4b1 in less than a NJ Exec Order 26.4b1 period (NJ Ex Order 26.4 to NJ Ex Order 2) in a timely manner for a resident who was identified as NJ Ex Order 26.4b1 with NJ Ex Order 26.4b1 and at NJ Ex Order 26.4b1 on admission. The facility failed to: a.) obtain, record and monitor NJ Ex Order 26.4b1 for 4 weeks after admission, and b.) implement a NJ Ex Order 26.4b1 care plan in a timely manner. This deficient practice was identified for 1 of 2 resident's reviewed for NJ Ex Order 26.4b (Resident #358). The evidence was as follows: The surveyor reviewed the medical record for Resident # 358. Review of the resident's Admission Record (an admission summary) reflected the resident was admitted with diagnoses that included but were not limited to; NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 , and NJ Ex Order 26.4b1 . Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated NJ Ex Order 26.2, reflected a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, which indicated the resident's NJ Exec Order 26.4b was NJ Ex Order 26.4b1. It further reflected that the resident required extensive	F 692	F 692 Assisted nutrition and hydration Element I Resident # 358 was discharged and is is no longer at the facility. The registerered dietician who was deficient in the montioring and documentation no longer is employed at the facility. The Regional Dietician provided education to the facility dieticians. The registered dietician will complete a full house audit ensuring nutrition care plans arein place for all residents by 2/22/2024. Monthly notes are present for high risk and all significant weight losses have been addressed and updated to the care plan. Element II All residents have the potential to be affected by the deficient practice. Element III The current registered dietician was made aaaware of the deficient prior practice on JanuaryThe dietician will conduct weekly audits on admissions to ensure care plans are in place by 2/22/2024. High risk residents are followed monthly and significant weight losses have interventions in place and/or are updated to the care plan by the dietician.	

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F 692	Continued From page 53 assistance of NJ Ex Order 26.4b1 for the task of NJ Ex Order 2. In addition, it reflected that the resident had an active diagnosis of NJ Ex Order 26.4b1 or was at risk for NJ Ex Order 26.4b1 and received a NJ Ex Order 26.4b1 . Review of the Care Area Assessment (CAA) Summary reflected the decision to care plan for NJ Ex Order 26.4b1 status. Review of the Physician's Orders (POs) from both the electronic medical record (EMR) and the paper chart for NJ Ex Ord, NJ Ex Or, and NJ Ex Ord of NJ Ex Orde, included a NJ Ex O order dated NJ Ex Order 26.4 for "NJ Ex Orde NJ Ex Order 2 ," which was advanced to a NJ Ex O dated NJ Ex Order 26.4, NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 [for NJ Ex Order 26.4b1." In addition, there was a PO dated NJ Ex Order 26.4 for "Resident is At Risk for NJ Ex Order 26.4b1 (Refer to US FOIA (b)(6) and/or US FOIA [physician] documentation." There was also a PO dated NJ Ex Order 2 for a NJ Ex Order 26.4b1 two times a day which would "provide NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1." Upon further review, there was a PO for "NJ Ex Order 26.4b1 ... NJ Ex Ord to be administered." There was no PO to obtain NJ Ex Order 26.4 for Resident #358. Review of the NJ Ex Orde NJ Ex Ord and NJ Ex Order 26.4b1 electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) did not include documented evidence that NJ Ex Order 26.4 were obtained and recorded for Resident #358. In addition, the NJ Ex Ord eMAR reflected that the NJ Ex Order 26.4b1 was NJ Ex Order 26.4b1 by the resident twice a day from NJ Ex Order 26.4 through NJ Ex Order 26.4. The surveyor reviewed the NJ Ex Order 2 record in the EMR. NJ Ex Order 26.4b documented were as follows:	F 692	The Dietician will conduct weekly audits and educate licensed nursing staff on the importance of adhering to orders requiring weekly weights, including admission weight orders and having the certified nursing aides obtain post admission weekly weights. Docmentation will be based upon actual weights completed. The Director of Nursing will provide oversight as to documentation of monthly weights being done for completion. Element IV Weight and documentation audits will be monitored for completion by the Dietician on a weekly basis times four, bi-weekly times two and monthly times three months and quarterly times two. These findings will be reported to the Quality Assurance and Performance improvement commttee monthly and then quarterly.The Administrator and the Quality Assurance and Performance committee will review and determine compliance for the three months and quarterly.	

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NJ Ex Order 26.4b1: NJ Ex Order 26.4b1

Review of the US FOIA (b)(6) US FOIA (b)(6)'s (US FOIA #1 Admission 'NJ Ex Order 26.4b1 Evaluation V2" dated NJ Ex Order 26.4b1, reflected that the resident was NJ Ex Order 26.4b1 on admission. The US FOIA identified the residents NJ Ex Order 26.4b1) as NJ Ex Order 26.4b1 for age." The US FOIA did not obtain the residents usual NJ Ex Order 26.4b1 or NJ Ex Order 26.4b1 or NJ Ex Order 26.4b1. The US FOIA identified that the resident required assistance NJ Ex Order 26.4b1. The US FOIA further documented that the resident would need to NJ Ex Order 26.4b1 of NJ Ex Order 26.4b1 to meet his/her estimated NJ Ex Order 26.4b1 needs yet in summary documented that the resident NJ Ex Order 26.4b1 of his/her NJ Ex Order 26.4b1. The US FOIA documented that the resident had a NJ Ex Order 26.4b1 ... NJ Ex Order 26.4b1 ...consistent with NJ Ex Order 26.4b1 ... current NJ Ex Order 26.4b1 appears NJ Exec Order 26.4b1 to meet [his/her] needs ... [he/she] is at NJ Ex Order 26.4b1 risk for NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 due to NJ Ex Order 26.4b1." She further documented to NJ Ex Order 26.4b1 by removing the NJ Ex Order 26.4b1, however added no other interventions that would NJ Ex Order 26.4b1. US FOIA #1 documented to "evaluate NJ Ex Order 26.4b1, labs, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1" and ..."proceed with care plan."

Review of RD #1's "NJ Ex Order 26.4b1: Follow up" note dated NJ Ex Order 26.4b1, included the following NJ Ex Order 26.4b1: (NJ Ex Order 26.4b1, (NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1 , (NJ Ex Order 26.4b1. The US FOIA documented the NJ Ex Order 26.4b1 reflected a NJ Ex Order 26.4b1. / NJ Ex Order 26.4b1 % NJ Ex Order 26.4b1 in NJ Exec Order 26.4b1 and a NJ Ex Order 26.4b1 / NJ Ex Order 26.4b1 % NJ Ex Order 26.4b1 in NJ Exec Order 26.4b1. She acknowledged that the resident had not received NJ Ex Order 26.4b1 yet received NJ Ex Order 26.4b1 twice a day (there was no

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documented evidence of NJ Ex Order 26.4b1). RD #1 documented that the resident experienced "NJ Ex Order 26.4b1" due to NJ Ex Order 26.4b1. She further documented that she "observed" the resident only NJ Ex Order 26.4b1 of NJ Ex Order that day. At this time the US FOA documented that she would start the resident on a NJ Ex Order twice a day NJ Ex Order 26.4b1 and NJ Ex Order 26.4b with NJ Ex Order, would "continue" to monitor the resident's NJ Ex Order t and would start "NJ Ex Order 26.4b1 x 3 days start (NJ Ex Order 26.4) for better evaluation of NJ Ex Order." Review of the EMR and paper chart did not reveal documented evidence that NJ Ex Orde monitoring was conducted or evaluated. In addition, there was no other US FOA documentation.

Review of the EMR and paper chart did not reveal documented evidence that physician services were aware of the resident's NJ Ex Order 26.4b1. In addition,
review of the EMR and paper chart did not reveal documented evidence of NJ Ex Order 26 or NJ Ex Or.

Review of the EMR "Progress notes" reflected IDCP (interdisciplinary care plan) team meeting's dated NJ Ex Order 26.4 and NJ Ex Order 26.4b, which did not include the resident's NJ Ex Order 26.4b1. In addition, there was an IDCP meeting note dated NJ Ex Order 2, which reflected the team met with the resident's NJ Ex Order 26.4b1 to discuss discharge plans. There was no documented evidence that the residents NJ Ex Order 26.4b1 were discussed with the resident's NJ Ex Order 26.4b1 Further review of the progress notes included a "Health status note" dated NJ Ex Order 26.4, reflected that the resident's NJ Ex Order 26.4b1 discharged the NJ Exec Order 26.4b1

Review of the resident's Care Plan initiated on

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NJ Ex Order 26.4, included a NJ Ex Order 26.4b care plan which was created on NJ Ex Order 2 (NJ Ex days after admission) by the US FOIA The "focus" area included that the resident had "NJ Ex Order 26.4b1" and a NJ Ex Or of NJ Ex Or. It did not reflect the resident's NJ Ex Order 26.4 NJ Ex Order 26.4b1 since admission as was reflected in the US FO note dated NJ Ex Order 2. The US FOIA (b goals for the resident reflected to "maintain adequate NJ Ex Order 26.4b1 status as evidenced by NJ Ex Order 26.4b1 within NJ Ex Order 26. plus or minus NJ Ex Order 2 no signs or symptoms of NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 at least NJ Ex Ord of at least NJ Ex Order 26.4b1 ..." The US FOIA (b interventions included "US FOIA to evaluate and make NJ Ex Order 26.4b1 recommendations PRN [as needed]" and "NJ Ex Order 2 per facility protocol." The care plan did not reflect the resident's actual status on NJ Ex Order 2 nor was it updated as the resident's status changed to reflect a NJ Ex Order 26.4b1, NJ Ex Order 2 and NJ Ex Order 26.4b1 as indicated in the US FOIA (b NJ Ex Order 2 progress note.

On 1/18/24 at 1:20 PM, the surveyor interviewed the US FOIA (b)(6)) for the NJ Exec Order 26.4 unit where Resident #358 resided. She stated that the US FOIA (b)(6) obtained NJ Ex Order 26.4 which the nurse recorded in the EMR. The US FOIA stated that the NJ Ex Order 26.4 are initially recorded on paper but once entered into the EMR the paper documentation was shredded. She stated that if a resident required weekly NJ Ex Order 26.4 there should be a PO. She stated that it was facility policy to obtain an admission NJ Ex Order 2 and then weekly NJ Ex Order 26.4 for four (4) weeks when a resident was newly admitted. She stated that the NJ Ex Order 26.4 should be recorded in the NJ Ex Order 26.4 and vitals section and/or in the eMAR or eTAR section of the EMR. The US FO further stated that residents were NJ Ex Order 26.4b weekly if they experienced a

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significant or unplanned NJ Ex Order 26.4b1. She stated that the US FOIA reviewed the NJ Ex Order 26.4 and would notify the physician if there was a NJ Ex Order 26.4b1. In addition, the US FOI stated that if a resident experienced an unplanned NJ Ex Order 26.4b1, she would expect the US FOI to request a reweight to verify the NJ Ex Order 2, implement and review weekly NJ Ex Order 26.4b reassess the resident's NJ Ex Order 26.4b1 needs and put interventions into place. She stated that she would expect the US FOI to document this and communicate the same to the nursing staff team. The US FOIA stated that she would expect the US FOIA (b and US FOIA to monitor the resident's NJ Ex Order 26.4b1 and that the US FOIA would intervene timely.

On 1/23/24 at 10:16 AM, the surveyor interviewed RD #2. She stated that US FOIA (b)(6 obtained NJ Ex Order 26.4 and they are recorded in the NJ Ex Order 26.4 and vitals section of the EMR. She stated that if a resident experienced an unplanned NJ Ex Order 26.4b1, she would implement weekly NJ Ex Order 26.4 for further monitoring. She stated that newly admitted residents were NJ Ex Order 26.4b on admission and then weekly for four (4) weeks after. The US FOIA stated that weekly NJ Ex Order 26.4 were monitored by the team which included the US FOIA (b) the nurse and the US FOIA She stated that the US FOI would oversee the process and monitor the weekly NJ Ex Order 26.4b The US FOI stated that she would review hospital records as part of the NJ Ex Order 26.4b1 process. She stated that if a resident had an unplanned NJ Ex Order 26.4b1, she would have requested a NJ Ex Order 26.4b1 to verify the NJ Ex Order 26.4b1, assess the resident's NJ Ex Order 2 update NJ Ex Order 26.4b1 and if there was no improvement, she would implement weekly NJ Ex Order 26.4 and notify the physician. The US FOI stated that if a resident was assessed to have NJ Ex Order 26.4b1 on admission, she would NJ Ex Order 26.4b1 and if the resident experienced

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NJ Ex Order 26.4b1 she would add NJ Ex Order 26.4b1 and/or NJ Ex Order 26.4b1. She added that if that did not abate the NJ Ex Order 26.4b1 she would continue to reassess and change interventions. The surveyor reviewed the EMR for Resident #358 with RD #2. She acknowledged the surveyors' concerns.

On 1/23/24 at 11:25 AM, the surveyor interviewed RD #2 who stated that RD #1's initial intervention to NJ Ex Order 26.4b1 the resident's NJ Ex O was NJ Exec Order 26.4b1. She acknowledged that weekly NJ Ex Order 26.4 were not done per facility policy. At this time, she acknowledged that RD #1's progress note dated NJ Ex Order 2 identified unplanned NJ Ex Order 26.4b1 and that was the first-time NJ Ex Order 26.4b1 was addressed.

On 1/23/24 at 12:04 PM, the survey team met with the US FOIA (b)(6) to discuss concerns related to Resident #358.

On 1/23/24 at 12:49 PM, the NJ Exec O and US FOIA acknowledged that NJ Ex Order 26.4 should have been obtained and recorded initially on admission and for weekly for the next NJ Exec Order 26.4b1. They stated that the US FOIA should have addressed the resident's unplanned NJ Ex Order 26.4b1. The US FOIA (b)(6 stated and acknowledged "that was too long" for the US FOIA to wait to reassess and implement interventions. The US FOIA (b)(6) acknowledged that based on US FOI #1's NJ Ex Order 26 note, the US FOI had knowledge of the resident's NJ Ex Order 26.4b1 on NJ Ex Order 2, NJ Ex Order 26.4 and NJ Ex Order 2 and did not intervene timely. The US FOIA acknowledged that since the US FOIA identified Resident #358 at NJ Ex Order 26.4b1 on admission, and with a NJ Ex Order 26.4b1, the US FOI should have intervened from admission and should not

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have just NJ Ex Order 26.4b1 which did not provide additional NJ Ex Order 26.4.

On 1/24/24 10:09 AM, the surveyor interviewed the US FOIA (b)(6)) in the presence of the survey team. She stated that care plans should be implemented on admission and if there are any problems or changes it should be updated "immediately." She stated that if a resident experienced a NJ Ex Order 26.4b1 a care plan should be implemented. The US FOIA (b)(6) stated that the facility conducted monthly NJ Ex Order 2 meetings which the US FOIA (b)(6), herself and the clinical team attended. She stated that the US FOIA or nurse would update the care plan, the family and physician would be called, and weekly NJ Ex Order 26.4 and NJ Ex Order 26.4b1 would be implemented. She stated that if a CAA was triggered for an MDS that would indicate an area of concern which should be care planned. She further stated that this should have been discussed at the resident's care plan meeting. Review of the EMR for Resident #358, the US FOIA (b)(6) acknowledged that the resident's initial care plan meeting was held on NJ Ex Order 26.4, and the US FOIA did not attend. She stated all disciplines should attend the initial care plan. The US FOIA (b)(6) acknowledged that the RD #1's initial evaluation was completed on NJ Ex Order 26.4, the NJ Ex Order 26.4b care plan was initiated on NJ Ex Order 2, and a follow up NJ Ex Order 26.4b note was not done until NJ Ex Order 2. She stated baseline care plans should be initiated on admission and the comprehensive care plan needed to be completed 21 days after admission.

On 1/24/24 at 10:55 AM, the surveyor interviewed RD #3 in the presence of the survey team. She stated that the facility conducted NJ Ex Order 2 meetings but could not speak to documentation. She stated she was not sure if this would have been

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documented in the EMR. She stated that if she identified that a resident had a NJ Ex Order 26.4b1, she would obtain a NJ Ex Order 26.4b1 to verify the NJ Ex Order 26.4b1 and would assess for possible causes. RD #3 stated she would add interventions to the care plan which would have included weekly NJ Ex Order 26.4 and NJ Exec Order 26.4b1. In addition, she stated that she would have discussed concerns and interventions with the team, the US FOIA (b)(6) and the physician. RD #3 stated she would have documented in the EMR as well. She stated this would be her process whether a resident had a significant NJ Ex Order 26.4b1 or an unplanned NJ Ex Order 26.4b1 .

On 1/24/24 at 11:22 AM, the survey team met with the US FOIA (b)(6) . At that time, the US FOIA acknowledged that prior to NJ Ex Order 26.4b1, there were concerns related to missing NJ Ex Order 26.4 for new admissions and NJ Ex Order 2 .

Review of the facility policy "Weight Monitoring" dated 8/2023, included the following:

- "Based on the resident's comprehensive assessment, the facility will ensure that all resident's maintain acceptable parameters of nutritional status, such as usual body weight ..."
- "Weight can be a useful indicator of nutritional status. Significant unintended changes in weight ...or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem ... Suggested weight schedule: Newly admitted residents - weekly for 4 weeks."
- Significant weight change is defined as 5% within one month, 7.5% within three months and

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10% within six months. It also included that the physician should be notified and who may order nutritional interventions.
- The physician should be encouraged to document a diagnosis or clinical condition that could have contributed to the weight loss.
- Meal consumption may be recorded for the team to reference and the RD should be consulted to assist with interventions and actions should be recorded in the nutrition progress notes.

Review of the policy provided by the facility "Medical Nutrition Therapy: Assessment and Care Planning" dated 9/2017, included the following:

- The RD is responsible for the completion of a comprehensive nutrition assessment for all residents for the purpose of identifying and planning nutrition care based on the needs, goals, and preferences of each resident.
- The RD contributes to the comprehensive care plan within 21 days of admission and reviews/revises the plan of care as indicted by the clinical condition of the resident.
- The RD recommendations will be communicated via the "summary recommendation sheet."
- The RD will be responsible for ensuring the plan of care for each resident is in concert with the residents expressed wished for care and services.

Review of the undated facility policy "Fortified Food Program," included the following:

- "The goal of the fortified food program is to be able to provide higher calorie and/or higher

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protein food items to a resident if the intake of regular foods or beverages are not able to meet estimated nutritional needs."
- These are nutrient dense items and do not increase food volume.
- Fortified food program may be used for "nutritional rehabilitation."
- "... if the intake of regular and/or fortified foods becomes limited, a commercial supplement can be offered in between meals to help increase overall calorie and protein intake."

Review of the facility policy "Clinical practice: Therapeutic Snacks and Nutritional Supplements" dated 7/2016, included the following:

- "Food preference interviews with the resident, resident's family, or through observation should be completed for all residents."
- "Nutrition interventions should be discussed with the resident or resident's family."
- "Inadequate intake may be related to medical, functional, and psychosocial factors associated with the resident's condition. A root cause analysis must be completed to identify the causative factors that will direct the plan of care."
- Between meal snacks can contribute to an increase in total nutrient intake.
- An indication to modify a resident's meal plan included insufficient intake through meals and an evening snack "evidenced by unintended weight loss (significant and insidious)."
- The resident's care plan should be updated to include additional food items.
- Indications for use of supplements include a resident's inability to consume adequately through meals and snacks.
- "The nutrition plan of care is developed

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F 692	Continued From page 63 through the RAI [Resident Assessment Instrument] process: MDS, CAA's, and assessment to develop the plan of care." Review of the signed job description for RD #1 titled "Registered Dietitian" dated 4/3/23, included the following: - "Responsibilities include planning, organizing, developing and directing the nutritional care of the resident in accordance with current federal, state, and local standards, guidelines, and regulations that govern the facility." - "Completes comprehensive nutrition assessments, including MDS, CAA, assessment, and care plan development, in accordance with federal and state regulatory guidance." - "Consults with resident's, family, or interdisciplinary team as needed regarding the plan of care for residents." - "Participates in care plan and quality assurance committee meeting as needed, including weight and wound meetings." NJAC 8:39 - 11.2(d)(e)(1)(f), 17.1(c), 17.2(d), 27.1(a)	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences,	F 695		2/22/24

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F 695	Continued From page 64 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 maintain the necessary NJ Ex Order 26.4b1 care and services of residents in accordance with standard of practice for two (2) of four (4) residents, (Resident #42 and #85) reviewed for NJ Ex Order 26.4b1 care. 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 1/10/24 at 11:05 AM, the surveyor observed Resident #42 in bed with the NJ Ex Order 26.4 ([redacted] NJ Ex Order 26.4b1) was set to NJ Ex Order 26.4b1 [redacted]. The resident was NJ Ex Order 26 and NJ Ex Order 26.4b1 On 1/11/24 at 12:08 AM, the surveyor observed the resident lying in bed NJ Ex Order 26. NJ Ex Ord and informed the surveyor that he/she NJ Ex Order 26.4b1 [redacted] that his/her NJ Ex Order 26.4b1 provided. The NJ Ex Order 26.4b1 was NJ Ex and set to NJ Ex Order 26.4b.	F 695	F695-Respiratory/Tracheostomy Care and Suctioning Element I Resident #42 was re-assessed with NJ Ex [redacted] noted. Primary physician was notified, and physician orders were reviewed and will continue with the active NJ Ex Order 26.4 treatments ordered. NJ Ex Order 26.4 [redacted] was assessed and replaced on January 18,2024. Resident #85 was re-assessed with NJ Ex [redacted] noted. January 17, 2024, Care plan was initiated to reflect the residents plan of care for NJ Ex Order 26.4b1 Care and NJ Ex Order 26.4b1 [redacted] An in-service was initiated on respiratory care for all licensed nurses by the Director of Nursing on the facility policy and procedures for Oxygen Administration. This includes assessing oxygen equipment, physician orders, respiratory care, tracheostomy care and which is consistent with professional standards of practice for residents who require oxygen use. On January 18,2024 the facility conducted a full house audit on all residents who require Respiratory/Oxygen	

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F 695	Continued From page 65 On 1/18/24 at 9:55 AM, the surveyor observed the NJ Ex Order 26.4b1 at NJ Ex Order 26.4b. The surveyor reviewed the medical record for Resident #42. According to the Admission Record (AR; or face sheet, an admission summary), the resident was admitted to the facility with diagnoses that included NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) or NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) and NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 . The quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4b1, reflected a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, which indicated that the resident was NJ Ex Order 26.4b1. A review of the active Physician's Orders included an order for NJ Ex Order 26.4b1 via NJ Ex Order with a start date of NJ Ex Order 2. A review of the ongoing Care Plan (CP) reflected a focus that included, the resident's required NJ Ex related to NJ Ex Order 26.4b1 and NJ Ex Order 2 which was initiated on NJ Ex Order 26.4. Further review of the CP included an intervention dated NJ Ex Order 26.4, that the resident required an NJ Ex O	F 695	Administration. Identifies the oxygen flow rate, physician order, tubing supplies, humidifier changes, signage, and care plan review. Element II All residents have the potential to be affected by the deficient practice. Element III An in-service was initiated on respiratory care for all licensed nurses by the Director of Nursing on the facility policy and procedures for Oxygen Administration. This includes assessing oxygen equipment, physician orders, respiratory care, tracheostomy care and which is consistent with professional standards of practice for residents who require oxygen use. On January 18,2024 the facility conducted a full house audit on all residents who require Respiratory/Oxygen Administration. Identifies the oxygen flow rate, physician order, tubing supplies, humidifier changes, signage, and care plan review. The Director of Nursing/Facility Educator/ Designee will conduct weekly audits of residents who require respiratory administration to ensure orders and care plans are present and accurately recorded in the electronic medication administration record.	

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F 695	Continued From page 66 NJ Ex Order 26.4b1. A review of the electronic Treatment Administration (eTAR) reflected an order for NJ Ex [redacted] via NJ Ex Order 26.4b1 every shift for NJ Ex Order 26.4b1. Maintain NJ Ex Order 26. [redacted] at or greater than NJ Ex Orde with NJ Ex [redacted]. The eTAR reflected the nurses were signing the eTAR at every shift and documented the resident's NJ Ex Order 26.4b1 [redacted]. On 1/18/23 at 9:56 AM, the surveyor and the US FOIA (b)(6) [redacted] entered Resident #42's room to observe the resident's NJ Ex Order 26.4b1, greeted the resident and walked out of the resident's room. At that time, the US FOIA (b)(6) confirmed with the surveyor that the NJ Ex Order 26.4b1 was set to NJ Ex [redacted]. The US FOIA (b)(6) stated that the order [NJ Ex Order 26.4b1 [redacted]] should have been followed, was last checked during the 11 to 7AM shift, should have been checked at every shift, and that she should have checked at the beginning of her shift that day. The US FOIA (b)(6) stated the order for the NJ Ex [redacted] should have been followed as standard of practice. At that time, the US FOIA (b)(6) stated she would check the NJ Ex Order 26.4b1 of the resident, call the physician, educate the staff, and inform her US FOIA (b)(6) [redacted]), inform the resident and the family. At 10:13 AM, the surveyor observed the US FOIA (b)(6) use the NJ Exec Order 26.4b1 to measure the resident's NJ Exec Order 26.4 which reflected an NJ Exec Order 26.4b1 of NJ Exec Order 2 [redacted]	F 695	The Unit Managers will conduct Care plan review of any admissions will be discussed for accuracy during the clinical review meeting. The Director of Nursing and Unit managers will also review the care plans quarterly and comprehensives annually. Element IV Ten residents with oxygen will be audited weekly. Audits and results will be monitored for compliance by the Administrator and Director of Nursing weekly for 4 weeks, bi-weekly X 2 months and monthly for 3 months. Audits will reflect need, change in condition orders are reflected properly, verify equipment meets standards, changed according to policy on a weekly basis. - Audits will be discussed quarterly during Quality Assurance Performance Improvement Committee meeting for two months. Quality Assurance and Performance Improvement Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to Quality Assurance and Perfromance Improvment Committee at least quarterly times two. Completion date:	

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F 695	Continued From page 67 On 1/18/23 at 10:58 AM, in the presence of the survey team, the US FOIA (b)(6) [redacted], the surveyor discussed the concern regarding the failure to follow the physician's order for the NJ Ex [redacted] and to maintain the NJ Ex Order 26.4b1 services for the resident. On 1/22/23 at 10:09 AM, in the presence of the survey team, the US FOIA (b)(6) [redacted] stated an audit was conducted for residents who had NJ Ex [redacted] orders, all were correct, and education was given to the staff. The US FOIA (b) [redacted] informed the surveyors that the machine was replaced since it was not able to hold the NJ Ex Order 26.4b1 consistently, it fluctuated. The US FOIA (b) [redacted] acknowledged that the NJ Ex Order 26.4b1 for the resident should have been checked, to ensure detection of the incorrect level. The US FOIA (b) [redacted] stated the reporting between the nurses will be reviewed by the facility. A review of the provided facility policy Oxygen Administration, dated/revised 9/23 included the following: Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Policy Explanation and Compliance Guideline: 1. Oxygen is administered under orders of a physician ... 2.) According to the Admission Record, Resident #85 was re-admitted to the facility in NJ Ex Order 26.4b1 [redacted], with diagnoses that included but were not	F 695	February 22, 2024	

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limited to: NJ Ex Order 26.4b1 [redacted], NJ Ex Order 26.4b1 [redacted]), NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 [redacted] NJ Ex Order 26.4b1 [redacted]), NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1 [redacted]), and NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1 [redacted]).

A review of the Significant change Minimum Data Set (MDS), as assessment tool dated NJ Ex Order 26.4b1, revealed a Brief Interview for Mental Status of "NJ Ex" indicating NJ Ex Order 26.4b1. Further review of the MDS revealed that the resident required substantial/maximum assistance with activities of daily living (ADLs)., had an Active Diagnoses of NJ Ex Order 26.4b1 [redacted]) with NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 [redacted]) and NJ Ex Order 26.4b1.

A review of the physician order summary report for NJ Ex Order 26.4b1 revealed a physician's order for NJ Ex Order 26.4b1 and via NJ Ex Order as needed; NJ Ex Order 26.4 and via NJ Ex Orde every shift for to remove NJ Ex Order 26.4b1 Continuous NJ Ex Order 26.4 with NJ Ex Order 26.4b1 every shift; Change NJ Ex Order 26.4b1 with NJ Ex Order 26.4b1 daily and NJ Ex Orde every day shift for care; Change NJ Ex Order 26.4b1 set up every night shift every Wed; NJ Ex Order 26.4b1

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- every shift for care; Change NJ Ex Order 26.4b1 daily every day shift for care, NJ Ex to maintain NJ Ex Order 26.4b1 every shift.

A review of the facility provided CP initiated NJ Ex Order 26.4, revealed a "Focus" for Resident # 85:.. NJ Ex Order 26.4b1, Discharge Plan, NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, potential for NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, at risk for NJ Ex Order 26.4b1 NJ Ex Ord, NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 problem of NJ Ex Order 26.4b1 in hospital, NJ Ex Order 26.4b1 problem NJ Ex Order 26.4 ....Date initiated: NJ Ex Order 26.4. Further review of the CP did not reveal a Focus for NJ Ex Order 26.4b1 and or NJ Ex Order 26. and NJ Ex Order 26.4b1

On 01/17/24 at 1:30 PM, during an interview with the surveyor, the US FOIA (b)(6) stated that the purpose of the CP is like "telling you about the resident" and gave an example if the resident has a wound, at fall risk, trach or is on tube feeds, then you include all these diagnoses in the care plan. The US FOIA stated the CP are initiated on admission and also with any significant changes. The US FOIA further stated, "US FOIA (b)(6)) should be doing the care plans now since manager left."

On 01/17/24 at 1:38 PM, during an interview with the surveyor, the US FOIA (b)(6)) stated that the purpose of the CP was to "provide the appropriate care to the patients." The US FOIA (b) further stated, "CP are done on admission and then with changes in condition, example anything new with patients like UTI (urinary tract infection) or if the residents start antibiotics." The US FOIA (b) informed the surveyor that usually she put the CP because "nurses don't know how to do it." The

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F 695	Continued From page 70 surveyor asked the US FOIA (b) to review the facility provided CP, for resident # 85, for NJ Ex Order 26.4b1 The US FOIA (b) viewed the CP in front of the surveyor and acknowledged "it's missing the CP for NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1." The US FOIA (b) further stated, "Yes, CP should've been initiated for NJ Ex Order 26.4b1 and I should've picked up that he/she came with NJ Ex Order 26.4b1 It's my fault." A review of the facility's policy "Comprehensive Care Plans" with a last review date of 9/2023, revealed: Policy explanation and compliance guidelines: 2. The comprehensive care plan will be developed within seven (7) days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record. 3. The comprehensive care plan 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. 4. The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to: b. A registered nurse with responsibility for the resident. f. Other appropriate staff or professionals or disciplines as determined by the resident's needs or as requested by the resident. Examples include, but are not limited to:	F 695		

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F 695	Continued From page 71 i. The RAI Coordinator. iii. Social Services Director/ Social Worker. iv. Licensed therapists. 8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. NJAC 8:39-27.1(a)	F 695		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must	F 725		2/22/24

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F 725	Continued From page 72 designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Complaint # NJ169272 Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to: a) maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey and b) provide sufficient nursing staff for three (3) of three (3) units of the facility according to facility policy. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) 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	F 725	F725-Sufficient Nursing Staff Element I The Director of Nursing educated the US FOIA (b)(6) on the importance of staffing to the state requirement of correct ratio of staff to resdient per disignated shift (1/8, 1/10 and 1/14). The Administrator and the Director of Nursing are responsible for oversight that the required staffing is met. Both reviewed the staffing ratio requirements with the Staffing Coordinator to ensure the minimum state required staffing of One Certified Nurse Aide (CNA) to every eight residents for the day shift. One certified nurisng aide to every ten residents for the evening shift, One certified nursing aide to every fourteen residents for the night shift are met. Nursing staff were in-serviced by the Administator and / or designee on the state requirements about the staffing ratio. Open House scheduled for February 20, 2024 for this quarter and thereafter with the facility recruiter in efforts to recruit license LPN/RN/CNA. The facility has initiated a sign-on and employee referral bonuses to attract qualified staff. Element II	

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F 725	Continued From page 73 One (1) 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. 1. For the week of Complaint staffing from 11/12/2023 to 11/18/2023, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -11/12/23 had 11 CNAs for 114 residents on the day shift, required at least 14 CNAs. -11/13/23 had 11 CNAs for 112 residents on the day shift, required at least 14 CNAs. -11/15/23 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -11/16/23 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. -11/17/23 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs. -11/18/23 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. For the 2 weeks of staffing prior to survey from 12/24/2023 to 01/06/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -12/24/23 had 9 CNAs for 102 residents on the day shift, required at least 13 CNAs. -12/25/23 had 11 CNAs for 10 residents on the day shift, required at least 13 CNAs. -12/26/23 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs. -12/27/23 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs. -12/28/23 had 9 CNAs for 97 residents on the day shift, required at least 12 CNAs. -12/29/23 had 9 CNAs for 97 residents on the day	F 725	All residents that reside in the facility have the potential to be affected by the deficient practice. Element III The Administrator and/or Director of Nursing will review the Retention and Recruitment program monthly to ensure staff turnover is at minimum and recruitment is improving. The Administrator and /or Director of Nursing will initiate the emergency staffing which requires department heads to Report to work to ensure the staffing challenge is met in providing care or services to the residents. Element IV Administrator and Director of Nursing to review staffing schedule on a continuous basis with the staffing coordinator weekly. Director of Nursing or designee to audit weekend staffing twice weekly for four weeks and then twice monthly for two months. Results of the audits will be presented to monthly Quality Assurance and Performance Improvement committee meetings for review and revision as deemed appropriate. Completion Date: February 22, 2024	

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shift, required at least 12 CNAs.
-12/30/23 had 9 CNAs for 97 residents on the day shift, required at least 12 CNAs.

-12/31/23 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs.
-01/01/24 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs.
-01/02/24 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs.
-01/03/24 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs.
-01/04/24 had 11 CNAs for 105 residents on the day shift, required at least 13 CNAs.
-01/05/24 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs.
-01/06/24 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs.

2. On 01/11/24 at 9:42 AM, Surveyor #1 (S#1) called and left a message to Emergency Contact #1 (EC#1) of Resident #72 for an interview.

On 01/11/24 at 10:03 AM, EC#1 called back and informed the surveyor that EC#1 visits the resident routinely and usually in the afternoon at around 4:30 PM. EC#1 stated that the nursing staff was very nice and did not complain about the care provided to the resident. EC#1 further stated that the only concern was the weekend and holiday short-staff. EC#1 indicated that the facility was short-handed, unable to specify how many staff "but it felt different from regular weekday when there's a lot of staff."

3. On 01/12/24 at 11:02 AM, during the Resident Council Meeting, there were two (2) of three (3) residents stated that they had to wait a long time for the call bell response and had to wait a long

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time for ice. There were also two (2) of three (3) residents who stated that the facility was short of nursing staff which was two (2) CNAs for the whole unit and at night sometimes only one (1) CNA and it varies shifts all the time.

On that same date and time, Resident #34 informed S#2 that the resident had to [NJ Ex Order 26.4b1] [redacted].

On 01/18/24 at 10:58 AM, the survey team met with the [US FOIA (b)(6)] [redacted] and the facility management was made aware of the above findings and concerns.

4. On 01/22/24 at 6:32 AM, S#1 met with Registered Nurse #1 (RN#1) from the [NJ Exec Ord] unit (subacute) during an [NJ Ex Order 26.4b1] round. The [US FOIA] informed the surveyor that she was one of the two nurses assigned to the unit for the 11-7 shift. The [US FOIA] stated that the unit census was 32 and there was one resident at the ER (emergency department at the hospital) with no disposition yet. She further stated that "technically" the unit had a total of 33 residents.

On that same date and time, RN#1 informed the surveyor that there were two Certified Nursing Aides (CNAs) and two RNs (RN#1 and RN#2) including her with no call-out. The [US FOI] stated that the usual staffing for the [NJ Exec Ord] unit was two CNAs and two nurses.

At that same time, the [US FOIA (b)(6)] [redacted] joined the interview. The surveyor asked both the [US FOIA (b)] and RN#1 if they were aware of the nurse staffing law and ratio.

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RN#1 stated "I don't know. " The [US FOIA (b)] stated that, "I think" it was 1:15 (1 CNA to 15 residents) or 1:20 to the subacute unit for the 11-7 shift. The surveyor then notified both nurses about the staffing law of 1:14 CNA for 11-7.

Furthermore, S#1 asked both the [US FOIA (b)] and RN#1 if the facility complied with the staffing law. Both [US FOIA (b)] and RN#1 stated "no" but they were trying their best to provide care and nurses were helping with care. Both [US FOIA (b)] and RN#1 confirmed that they were not assigned to certain residents and they still do their nursing tasks of giving medications while helping with residents' care. Both confirmed that this had been ongoing for months. RN#1 indicated that it was a struggle due to staffing but they tried their best to work it out.

The [US FOIA (b)] also provided a copy of the 11-7 [NJ Exec Ord] CNA Post (3) Assignment Sheet for 01/21/24 (Sunday) with the following information:
Nurse (Low): RN#1 16 residents
Nurse (High): RN#2 17 residents
Post 1 and 2: CNA#1 16 residents
Post 3: CNA#2 17 residents
Census: 33

On 01/22/24 at 6:41 AM, S#1 met with the [US FOIA (b)] in the nursing station of [NJ Exec Order 26.4] unit, a long-term care unit. The surveyor asked the [US FOIA (b)] about the unit's census and staffing, and she stated that she will get back to the surveyor.

On 01/22/24 at 7:05 AM, S#1 interviewed CNA#3 from the [NJ Exec Order 26.4] unit, in the nursing station. The [US FOIA (b)] informed the surveyor that she had been working in the facility for [NJ Ex Order 26.4b1] as a regular 3-11 shift CNA, and worked OT (overtime) today for the 11-7 shift (Sunday). She further stated that

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she just finished her assignments.

On that same date and time, CNA#3 informed S#1 that she had a total of 20 residents in her assignment for the 11-7 shift. She stated that there were a total of three CNAs assigned to the [redacted] unit last night for the 11-7 shift, there was no call-out, and that was the usual staffing for the 11-7 shift for the [redacted] unit. She further stated that she was unaware of the NJ staffing law and ratio. She indicated that care was provided to her assigned residents and since she had been working for a long time, she was able to manage time wisely and take care of all residents. CNA#3 stated that even though it was hard, she got used to it.

On 01/22/24 at 8:48 AM, S#1 notified the [redacted] regarding the above concerns and findings.

On 01/22/24 at 10:08 AM, the survey team met with the [redacted]. S#1 notified the facility management of the findings above and regarding the weekend staffing concerns for Sunday 01/21/24 for the 11-7 shift for three units that did not comply with the mandated staffing law of 1:14 as follows:

[redacted] unit=census 32 with two CNAS. CNA#1 had a total of 16 residents and CNA#2 had a total of 17 residents.
[redacted] unit=53 census with three CNAs. CNA#3 had a total of 20 residents in her assignment.
[redacted] unit=census 20 with one CNA. CNA#4 had a total of 20 residents.

On 01/23/24 at 12:02 PM, in the presence of the survey team, the [redacted] stated "we are aware of the shortage.

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At that time, the [redacted] confirmed that the facility did not use agency because they were not reliable.

At that time, the [redacted] informed the surveyors that they try to fill the open shifts with a staff that was not on schedule. The [redacted] also stated that they have hired more people but was unable to retain the new staff. The [redacted] also stated that they will make every effort to enhance our staffing and will do what we need to do to increase their staffing.

A review of the provided staffing policy that was provided by the [redacted] on 01/23/24 at 12:08 PM showed a NJ staffing law Section 30:13-18-Minimum staffing requirements for a nursing home that included that the minimum direct care staff-to-resident ratios:
one CNA to every eight residents for the day shift;
one direct care staff member to every 10 residents for the evening shift; and
one direct care staff member to every 14 residents for the night shift.

A review of the facility provided policy, Nursing Services and Sufficient Staff dated/revised on 9/23, included the following.
Policy: It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical mental and psychosocial well-being of each resident.
The facility's census acuity and diagnoses of the resident population will be considered based on the facility assessment.

On 01/24/24 at 12:49 PM, the survey team met

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F 725	Continued From page 79 with the US FOIA (b)(6) for an Exit Conference. There was no additional information provided by the facility management. NJAC 8:39 - 5.1 (a); 27.1 (a)	F 725		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to conduct yearly performance reviews of Certified Nursing Aides (CNA) in order to provide specific education based on the outcomes of the reviews. This deficient practice was identified for 5 of 5 CNAs whose personnel records were reviewed, and was evidenced by the following: On 1/23/24 at 11:22 AM PM, the surveyor requested from the US FOIA (b)(6) to provide the most recent performance evaluation for five randomly selected Certified Nursing Aides (CNA #1; #2; #3; #4; and #5). On 1/24/24 at 9:31 AM, in the presence of the survey team, the US FOIA confirmed that there were no performance evaluations for the two (2) of the	F 730	F730 Performance Evaluations Element I Staff #2 had evaluation reviwed on NJ Exec Order 26.4b1 Staff #3 had evaluation reviwed on NJ Exec Order 26.4b1. Staff #5 had evaluation reviewed on NJ Exec Order 26.4b1. Staff #4 with a hire date of NJ Ex Order 26.4b1 had no performance evaluation for NJ Exec Or and it was provided to employee on NJ Exec Order 26.4b1. Staff #1 with a hire date of NJ Ex Order 26.4b1 had no performance evaluation for NJ Exec Or and it was provided to employee on NJ Exec Order 26.4b1. Element II	2/22/24

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F 730	Continued From page 80 five (5) CNAs who had completed more than a year of service. CNA#1 with a date of hire on [NJ Ex Order 26.], had no performance evaluation. CNA #4 with a date of hire on [NJ Ex Order 26.4b], had no performance evaluations. On 1/24/24 at 11:23 AM, in the presence of the survey team, the [US FOIA (b)(6)], the [US FOIA (b)(6)], and the [US FOIA (b)(6)], the [US FOIA] stated moving forward they will conduct audits on whom did not have a performance evaluation and do a "QAPI" (Quality Assurance and Performance Improvement, a data driven and proactive approach to quality improvement) for performance evaluations. A review of the provided facility policy, Nurse Aide Training Program dated/revised on 10/22, included Policy Explanation and Compliance Guideline, section 5. Reflected, Additional training will be provided to each nurse aid based on any areas of weakness as determined in the nurses aide's performance reviews. N.J.A.C. 8:39-43.17(b)	F 730	All residdents have the potential to be affected by this deficient practice. Element III All employees are being provided with performance evaluations upon their hire date for the year 2024 and being done monthly respective of their anniversary date by the Department Head and/or Designee. Human resources and Administrator are repsonsible for noting that said evaluations have been completed timely Department Heads are provided Dates of Hire of all employees within their departments to ensure that monthly, we are responding to needed performance evaluations that are do for that month. Human Resources and Administrator will be receiving the completed evaluations and check them off to ensure completion. Element IV Said evaluations will be reviewed for completion in the Quality Assurance and Performance Improvement committee meetings monthly to ensure evaluations are current and up to date by the specific Department Head, Human Resources and/or designee. Human Resources will be providing a monthly audit to	

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F 730	Continued From page 81	F 730	administrator to ensure that all evaluations for the month prior have completed performance evaluations. The Quality Assurrance and Performance Improvement committee will be reviewing the audit results for three months to ensure performance evaluation completions for the prior month on a onthly basis. All performance evaluations for the month prior will be completed. Completion date: February 22, 2024	
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.	F 732		2/22/24

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F 732	Continued From page 82 (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 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 for three (3) of nine (9) days. This deficient practice was evidenced by the following: On 01/22/24 at 7:18 AM, the surveyor in the presence of the US FOIA (b)(6) confirmed that the Nursing Home Resident Care Staffing Report (NHRCSR) that was posted in the reception area was dated 01/19/24 and not for 01/22/24. On that same date and time, the surveyor asked the US FOIA (b) why the NHRCSR posted was from Friday (01/19/24) and there were no posted staffing report for Saturday (01/20/24), Sunday (01/21/24), and Monday (01/22/24). The US FOIA (b) stated that because there were no admission people during weekends that was why the	F 732	F732-Posted Nurse Staffing Information Element I The weekend staffing was posted on Monday, January 22, 2024 after it was noted by the Department of Health surveyor that it was not posted. US FOIA (b)(6) was in-serviced on the importance of posting the staffing daily for both weekdays and weekends in the main lobby for each shift. Element II All residents have the potential to be affected by the deficient practice. Element III Both US FOIA (b)(6) and US FOIA (b)(6)	

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F 732	Continued From page 83 NHRCSR was not updated. She further stated that she was not responsible for posting the NHRCSR and she did not know about NHRCSR posting. The posted NHRCSR revealed the following information: 01/19/24-Day Shift Shift Hours: 7 AM-3 PM Census 103 Staff to Resident Ratio: 1 RN:20.6 Residents, 1 LPN:34.3 Residents, 1 CNA:10.3 Residents 01/19/24-Evening Shift Shift Hours: 3 PM-11 PM Census 103 Staff to Resident Ratio: 1 RN:51.5 Residents, 1 LPN:25.8 Residents, 1 CNA:10.3 Residents 01/19/24-Night Shift Shift Hours: 11 PM-7 AM Census 103 Staff to Resident Ratio: 1 RN:25.8 Residents, 1 CNA:17.2 Residents On 01/22/24 at 10:08 AM, the survey team met with the US FOIA (b)(6) and the surveyor notified the facility management of the above findings. On that same date and time, the US FOIA (b)(stated that it was the responsibility of the US FOIA (b)(6)) to provide the updated NHRCSR every day including the weekends and holidays. The US FOIA (b)(further stated that the US FO can send it via email to nursing supervisors including the US FOIA (b) and that should be updated daily even on weekends and holidays.	F 732	were in-serviced on need to be able to post staffing hours and will be the back up for the staffing coordinator when the posting does not occur. The administrator will be responsible for ensuring that the staffing is posted in the front lobby in front of the Receptionist desk for all to see. It will be clarified on the weekends by the weekend receptionist and reported to the Administrator if not available. Element IV Daily staffing posting will be adited once weekly audit and will be monitored and discussed at the AM meetings for adherence and provided to the Quality Assurance and Performance Improvement Committee, monthly for two months and then quarterly times two. Complete date: February 22, 2024	

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F 732	Continued From page 84 At that time, the surveyor asked the facility management if the nursing supervisor should be aware of what should have been done and why the [redacted] not aware of it. The facility management did not respond. The surveyor then asked for the policy regarding the posting of the NHRCSR, and the US FOIA (b)(6) stated that she would provide the policy. A review of the Facility Required Postings Policy that was provided by the [redacted] included that the facility will post required postings in an area that is accessible to all staff and residents. Policy explanation and compliance guidelines: 1. facility postings include the following but are not limited to staffing information and other state-specific postings. On 01/24/24 at 12:49 PM, the survey team met with the US FOIA (b)(6) [redacted] for an Exit Conference. There was no additional information provided by the facility management. N.J.A.C. 8:39-41.2 (a)(b)(c)(d)	F 732		
F 756 SS=E	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	F 756		2/22/24

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F 756	Continued From page 85 facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and a review of pertinent facility documents, it was determined that the facility failed to a.) provide oversight by a US FOIA (b)(6)) in the entire month of NJ Ex Order 26.4b1, for 4 of 5 residents reviewed for NJ Ex Order 26.4b1 (Resident #46, #68, #80, and #87) and b.) act upon a recommendation made by a US FO in a timely manner for 1 of 28 residents (Resident #92) reviewed for NJ Ex Order 26.4b1 management .	F 756	F 756 Drug Regimen Element I Resident #92 was assessed and is having the NJ Ex Order 26.4b1 parameter held, if the NJ Ex Order 26.4b1 is NJ Ex Order 26.4b1 , as required by the physician on 1/24/24. There was NJ Ex Order 26.4b1 to resident due to the deficinet practice. Resident #46, was assessed with NJ Ex	

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F 756	Continued From page 86 This deficient practice was evidenced by the following: 1. On 01/11/24 11:45 AM, the surveyor observed Resident #46 in bed. The resident was [redacted]. The resident's eyes were closed. The surveyor reviewed Resident #46's electronic medical record (eMR). According to the Admission Record (AR), (an admission summary) Resident #46's was admitted to the facility with diagnoses that included but were not limited to: [redacted]. A review of the [redacted] Monthly Regiment Review (MRR) did not reveal a review of Resident #46's medications for the month of [redacted]. On 01/22/24 at 11:16 AM, the [redacted] in the presence of the survey team, were made aware of the above concern. The [redacted] confirmed that the facility did not have a [redacted] for the month of [redacted] therefor the MRR was not done for [redacted]. 2. On 1/10/24 at 10:49 AM, the surveyor	F 756	[redacted] due to the deficient practice. Resident #68, was assessed with [redacted] due to the deficient practice. Resident #80, was assessed with [redacted] due to the deficient practice. Resident #87, was assessed with [redacted] due to the deficient practice. Element II All residents have the potential to be affected by the deficient practice. Element III The facility has developed policies and procedures for the monthly drug regimen review that included but are not limited to the steps the pharmacist must take when identifying irregularities that require urgent actions to protect active residents. The Director of Nursing provided [redacted] on 1/11/2024 to the [redacted] regarding holding parameters and medication administration as per physicians orders. The Director of Nursing/Designee in-serviced licensed nurses on the policy and procedures of medication administration according to the manufacturer recommendations and physicians orders of holdng parameters	

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F 756	Continued From page 87 observed Resident #68 NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 and the NJ Ex Order 26 appeared to be NJ Ex Order 26.4b1 The call bell was observed to be within reach. On 1/11/24 at 12:21 PM, the surveyor observed the resident sitting on a wheelchair, NJ Exec Order 26.4b1, and NJ Ex Order 26.4b1. The resident was NJ Ex Order 26.4b1 The surveyor reviewed the hybrid medical record for Resident #68. A review of Resident #68 reflected the resident was admitted to the facility with diagnoses that included but was not limited to; NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1), NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1), NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) and NJ Ex Orde . A review of the resident's US FO Evaluation, a paper month-to-month report log revealed that the last MRR was conducted on NJ Ex Order 26.4. A review of the eMR under progress notes revealed that the initial electronic MRR was conducted on NJ Ex Order 26.4. The hybrid medical record for the resident did not show an MRR was conducted by a US FO for the entire month of NJ Ex Order 26.4b1. On 1/22/24 at 1:09 the surveyor discussed the concern with the US FOIA (b)(6) regarding the missing MRR for Resident #62, for the entire month of NJ Ex Order 26.4b1.	F 756	on 2/8/2024,2/9/2024 and 2/10/2024. On 1/19/2024 the Director of Nursing in-serviced licensed nurses on the facility policy and procedure for completing the Pharmacy Consultant recommendations and/ or therapeutic suggestions. 1/24/2024 the Regional Clinical Nurse provided 1:1 education to the US FOIA (b)(6) on the facility policy and procedures on completing the pharmacy consultant recommendations and therapeutic suggestions. The Director of Nursing or designee will audit weekly completion of all new admissions, monthly reports, or residents with change in condition for pharmacy consultant reviews and recommendations. Pharmacy recommendations will be reviewed and completed within the ten days of receiving the initial report. The Director of Nursing and /or designee will provide on-going education to maintain compliance with the facility policy and procedures for pharmacy consultation and recommendations. Five residents with blood pressure medications with parameters will be audited weekly by Director of Nursing or desgnee. Element IV The Director of Nursing or designee will audit the Pharmacy consultant Recommendations/Therapeutic	

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F 756	Continued From page 88 At that time, the [US FOIA] informed the surveyor that the contract with the previous [US FO] provider was terminated, and the facility was able to secure a different [US FO] provider in [NJ Ex Order 26.4b1] however the services stated on [NJ Ex Order 26.4b1]. At that time, the [US FOIA] confirmed there should not have been a lapse of service of the [US FO] that provided MRR for all the residents. 3. On 1/10/24 at 10:00 AM, the surveyor observed Resident #80 sitting in their wheelchair in the [NJ Exec Order 26.4] unit activity room. The resident was observed participating in a group activity. The surveyor reviewed the hybrid medical record for Resident #80. A review of Resident #80's AR reflected the resident was admitted to the facility with diagnoses that included but was not limited to; [NJ Ex Order 26.4b1] [NJ Ex Order 26.4b1]), [NJ Ex Order 26.4b1] [NJ Ex Order 26.4b1] , [NJ Ex Order 2] [NJ Ex Order 26.4b1]) and [NJ Ex Order 26.4b1] [NJ Ex Order 26.4b1])([NJ Ex Order 26.4b1] . A review of the resident's [US FO] Evaluation, a paper month-to-month report log revealed that the last medication regiment review (MRR) was conducted on [NJ Ex Order 26.4]. A review of the electronic Medical Record (eMR)	F 756	suggestions report monthly for completion by the licensed nurse and the physician. Parameter audits will be monitored for completion by the Administrator and/or Director of Nursing weekly for four weeks,bi-weekly times two months, monthly times three months and quarterly times two months. Audits on antihypertensive medication with parameters will be discussed during the Quality Assurance Performance Improvement Committee meeting for tracking and trending. The Quality Assurance and Performance Improvement committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to Quality Assurance and Performance Improvement committee at least quarterly. Completion date: February 22, 2024	

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under progress notes revealed that the initial electronic MRR was conducted on [NJ Ex Order 26.4].

The hybrid medical record for the resident did not show an MRR was conducted by a [US FO] for the entire month of [NJ Ex Order 26.4b1].

4. On 01/10/24 at 11:30 AM, during the initial tour, Resident #87 was observed in bed, with [NJ Ex Order 26.4b1], and [NJ Ex Order 26.4b1].

According to the AR, Resident# 87 was admitted to the facility with diagnoses that included but were not limited to: [NJ Ex Order 26.4b1], [NJ Ex Order 26.4b1] and [NJ Ex Order 26.4b1] not due to a [NJ Ex Order 26.4b1] or [NJ Ex Order 2].

A review of the [US FO] Monthly Regiment Review (MRR) did not reveal a review of Resident #87's medications for the month of [NJ Ex Order 26.4].

On 01/22/24 at 11:16 AM, the [US FOIA (b)(6)], in the presence of the survey team, were made aware of the above concern. The [US FOIA (b)] confirmed that the facility did not have a [US FOIA (b)(6)] for the month of [NJ Ex Order 26.4] therefor the MRR was not done for [NJ Ex Order 26.4].

5.) On 01/10/24 at 11:10 AM, the surveyor observed Resident #92 in bed [NJ Ex Order 26.4b1] and [NJ Ex Order 26.4b1].

The surveyor reviewed Resident #92's medical records.

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A review of the AR reflected that the resident was admitted to the facility with diagnoses which included but not limited to; NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1), NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) and NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1).

A review of the Quarterly Minimum Data Set, an assessment tool used to facilitate the management of care, reflected that the resident's NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 score was NJ out of 15, which indicated that the resident's NJ Exec Order 26.4b1 was NJ Ex Order 26.4b1.

A review of the NJ Ex Order 26.4b1 Order Summary Report (physician's order sheet) revealed a physician's order (PO) dated NJ Ex Order 26.4b1, for NJ Ex Order 26.4b1 oral tablet NJ Ex Order 26.4b1, give 1 tablet by mouth twice daily for NJ Ex Order 26.4b1 for a total of NJ Ex Order 2. Hold for NJ Ex Order 26.4b1 or NJ Ex Order 26.4b1 and administer with NJ Exec Ord

A review of the NJ Ex Order 26.4b1 and the NJ Ex Order 26.4b electronic medication administration record (eMAR) revealed an order dated NJ Ex Order 26.4b1, for NJ Ex Order 26.4b1 oral tablet NJ Ex Order 2, give 1 tablet by mouth twice daily for NJ Ex Order 26.4b1 Hold for NJ Ex Ord , NJ Ex Ord and NJ Ex Order 26.4b1 and administer with NJ Exec Or Take with or immediately following meals with a scheduled time of 0900 (9:00AM) and 1700 (5:00PM). The eMAR revealed that the NJ Ex Order 26.4b1 oral tablet was signed as administered when the NJ Ex O was NJ Ex Order 26.4b1.

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A review of the NJ Ex Order 26.4b1, eMAR showed that the medication was administered ten (10) times when the [redacted] was NJ Ex Order 26.4b1. The following dates and times:

- [redacted] at 9AM
- [redacted] at 5PM
- [redacted] at 5PM
- [redacted] at 5PM
- [redacted] at 9AM
- [redacted] at 9AM
- [redacted] at 9AM
- [redacted] at 9AM
- [redacted] at 9 AM
- [redacted] at 5PM

A review of the NJ Ex Order 26.4b1, eMAR showed that the medication was administered seven (7) times when the [redacted] was NJ Ex Order 26.4b1. The following dates and times:

- [redacted] at 9AM
- [redacted] at 5PM
- [redacted] at 5PM
- [redacted] at 5PM
- [redacted] at 9AM
- [redacted] at 9AM
- [redacted] at 9AM

A review of the Consultant Pharmacist (CP)-Medication Regimen Review dated [redacted] revealed the following:
"Medication error (s) noted NJ Ex Order 26.4b1 is not always held as required by the physicians hold order. Please review and follow physician's order. See [redacted], at 0900. See [redacted], at 1700."

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F 756	Continued From page 92 On 1/12/24 at 11:00AM, the surveyor interviewed the US FOIA (b)(6) who in the presence of the surveyor, reviewed the eMAR for Resident #92. The US FOI acknowledge that on multiple occasions in both NJ Ex Order 26.4b1 and NJ Ex Order 26.4b that NJ Ex Order 26.4b1 was signed as being given when the resident's NJ Ex O was NJ Ex Order 26.4b1. The US FOIA further stated that on those occasions the nurse should have held the medication. On 1/12/24 at 11:20 AM, the surveyor in the presence of the US FOIA (b)(6) reviewed Resident #92's electronic medical record. At that time, the US FOIA (b)(6) acknowledge that on multiple occasions in NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 that nurses signed the emar that the resident's medication were administered when the NJ Ex Order 26.4b1 was NJ Ex Ord. She further acknowledges that a nurse should have held the medication when the NJ Ex O was NJ Ex Order 26.4b1. On 01/18/24 at 1:10 PM, the surveyor discussed the above observations and findings with the US FOIA (b)(6). On 1/23/24 at 11:05 AM, the surveyor interviewed the facility's US FOIA (b)(6) who told the surveyor that the facility was notified about not following the perimeters back in NJ Ex Order 26.4b1. She further stated that when a US FO recommendation had been made that the nurses should follow those recommendations. There was no additional information provided. A review of the facility's policy for "Consultant Pharmacy" dated 09/30/23, which was provided	F 756		

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F 756	Continued From page 93 by the [redacted] included the following: "Under Policy explanation: The facility will utilize a systemic approach for reviewing each resident's medication regimen which included preventing, identifying, reporting, and resolving medication-related problems, medication errors or other irregularities, and collaborating with other members of the interdisciplinary team." "Under policy explanation: The medication regimen of each resident must be reviewed by a licensed pharmacist at least once a month (or more frequent, as indicated by the resident's condition). The review must include a review of the resident's medical chart." A review of the facility's policy for "Medication Administration" dated 09/30/23, which was provided by the [redacted] included the following: "Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters."	F 756		
F 758 SS=D	NJAC 8:39-29.3 (a) Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F 758		2/22/24

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F 758	Continued From page 94 (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 758		

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F 758	Continued From page 95 Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to monitor NJ Ex Order 26.4b1 for the use of a NJ Ex Order 26.4b1 medication, NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 [redacted]). This was identified for one of five residents, (Resident #87) reviewed for unnecessary medications. This deficient practice was identified by the following: On 01/10/24 at 11:30 AM, during the initial tour, Resident #87 was observed in bed, with NJ Ex Ord [redacted], and NJ Ex Order 26.4b1. The surveyor reviewed the electronic medical record (eMR) for resident #87. According to the Admission Record, (an admission summary) Resident #87's was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26.4b1 [redacted], NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 [redacted] NJ Ex Order 26.4b1 [redacted] A review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, idicated that the resident's had a Brief Interview for Mental Status (BIMS) of NJ Ex [redacted] out of 15, which indicated that the resident was NJ Ex Order 26.4b1. Further review of the MDS, revealed that the resident was receiving NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1	F 758	F758-Free from Unnecessary Psychotropic Meds Resident #87 was immediately assessed for any adverse reaction; NJ Ex Order 26.4b1 [redacted] observed. Primary physician was informed with orders for NJ Ex Order 26.4b1 monitoring for receiving NJ Ex Order 26.4b1 medication and document in the residents electronic records. Element II All residents on antipsychotics that reside in the facility have the potential to be affected by this deficient practice. Element III Director of Nursing and or designee is in-servicing all License nurses on the facility policy and procedures on use of psychotropic drugs to ensuring the residents are free from unnecessary drugs and behavior managment. Director of Nursing and or designee will randomly audit 5 medical charts for behavioral psychotropic monitoring for residents with psychotropic medications, weekly times four, bi- weekly times four, monthly times three and quarterly times two. Element VI The Administrator and or Director of Nursing will audit completion for behavior psychotropic monitoring for residents with	

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F 758	Continued From page 96 medications. A review of the Order Summary Report (OSR) revealed physician orders (PO) as follows: -[redacted] Oral Tablet [redacted] Give 1 tablet by mouth two times a day for [redacted] order dated [redacted] at 17:00, discontinued [redacted]. -[redacted] Oral Tablet [redacted] Give 1 tablet by mouth two times a day for [redacted] with a start date of [redacted] at 09:00. Further review of the OSR, from [redacted] to [redacted], did not reveal an order to monitor [redacted] for a resident who was on [redacted] A review of the Care Plan (CP) initiated: [redacted], revealed a "Focus: Resident uses [redacted] medications [redacted], ... [redacted]." A review of [redacted] Medications Administration Records (MARs) and Treatment Administration Records (TARs) revealed the following: -[redacted] was signed as administered as ordered. -Resident is on [redacted]. [redacted] every shift for [redacted] AND every shift Monitor for side effects: [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted] and [redacted] *Document in progress notes and Notify [redacted] AND every shift every 1 month(s) starting on the 4th for 1 day(s) Monthly [redacted] Summary to evaluate effectiveness of [redacted] medication. *Document summary	F 758	psychotropic medications, weekly times four, bi-weekly times two, monthly times three and quarterly times two. Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to Quality Assurance and Perfromance Improvement Committee at least quarterly. Completion date; February 22,2024	

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in Progress Notes*-D/C Date- NJ Ex Order 26.4b1 at 1531.

A review of NJ Ex Order 26.4b1 MARs and TARs revealed that the NJ Ex Order 26.4b1 was signed as administered as ordered. Further review did not reveal NJ Ex Order 26.4b1 and monitoring for a resident receiving NJ Ex Order 26.4b1

On 01/17/24 at 11:46 AM, the surveyor interviewed the US FOIA (b)(6) , who stated that the purpose of NJ Ex Order 26.4b1 monitoring was to know what was normal, to identify a change in the resident, if they become "more or less" NJ Ex Order 26.4b1 Also, to know if the medication was "helping or not."

On 01/18/24 at 12:54 PM, during a follow up interview with the surveyor, the US FOIA (b)(6) stated that the resident did have NJ Ex Order 26.4b1 monitoring for receiving NJ Ex Order 26.4b1 She then reviewed the eMR in the presence of the surveyor. She reviewed the NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 MARs and TARs and confirmed that when the resident was readmitted to the facility, NJ Ex Order 26.4b1 monitoring for the resident receiving NJ Ex Order 26.4b1 was not done.

On 01/22/24 at 11:16 AM, the US FOIA (b)(6) , in the presence of the survey team, were made aware of the above concern.

A review of the facility's policy, " Use of Psychotropic Drugs" with a review date of 9/2023 revealed Policy: Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical

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F 758	Continued From page 98 records, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medications. Policy Explanation and Compliance Guidelines: 1. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics. 4.... II. Non-pharmacological interventions that have been attempted, and the target symptoms for monitoring shall be included in the documentation. 10. The resident's response to the medication(s), including progress towards goals and presence /absence of adverse consequences, shall be documented in the resident's medical record. NJAC 8:39-27.1(a)	F 758		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure the safe and appetizing temperatures of hot foods served to	F 804	F804 Food Temperatures ELement I Food for those resietns who had cold food were provided with new trays of food at	2/22/24

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CORNELL HALL CARE & REHABILITATION CENTER	234 CHESTNUT STREET UNION, NJ 07083

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F 804	Continued From page 99 the residents. This deficient practice was identified for two (2) of three (3) residents interviewed during the Resident Council meeting and confirmed during the lunchtime meal service on 1/18/24 for 1 of 3 nursing units tested for food temperatures by two surveyors and was evidenced by the following: On 1/11/24 at 11:02 AM, the surveyor met with three residents for council meeting. Two out of three residents who resided on the [NJ Exec Order 26.] unit stated that hot food temperatures were unacceptable. On 1/18/24 at 11:48 AM, the surveyor calibrated a state issued digital thermometer via the ice bath method to 32 degrees Fahrenheit (F) in the presence of the survey team. At 11:57 AM, the first food truck arrived at the [NJ Exec Order 26.] unit. A regular diet consistency tray was identified by the surveyor and [US FOIA (b)(6)]. This tray was removed from the food truck and placed at the nurse's station in the presence of two surveyors. The [US FOIA] replaced the resident's tray from the kitchen. At 12:01 PM, the nursing staff began delivering the resident's food trays. At 12:13 PM, the last tray was delivered to the residents' and the surveyor tested the food temperatures with the reserved tray in the presence of the [US FOIA (b)] The temperatures were as follows: Italian sausage: 104 degrees F Pasta Parmigiana: 98.5 degrees F Spinach: 109.5 degrees F	F 804	the proper temperature. Food Service Director or designee will ensure all food is placed on the steam table to remain its temperature. Food temperatures will be randomly documented and audited prior to the tray leaving the dietary department to ensure that temperatures are being maintained. [US FOIA (b)(6)] was inserviced by the District Manager of the contracted food service and the Food Service Director in-serviced the dietary staff on 2/15/2024. Element II All residents have the potential to be affected by this deficient practice. Element III Food Service Director or designee will ensure all plates will be placed in the hotbox prior to meal distribution. Food Service Director or designee will conduct one test tray daily for thirty days and will edcuate the dietary staff on the importance of tray temperatures. Critcal control points and check points have been implemented at various stages of the meal service. ELement IV Food Service Director will be providng daily audits of food temperatures leaving the kitchen and the temperature of food once given to the resdeint randomly on the unit which will be done once a day and	

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F 804	Continued From page 100 At 12:25 PM, the surveyor interviewed the US FOIA (b)(6) in the presence of a second surveyor. She stated that their kitchen equipment to maintain meal temperatures were working adequately. The surveyor reviewed the "Service Line Checklist" food temperatures for lunch which reflected that at the time of service the Italian sausage was 188 degrees F, the pasta was 186 degrees F, and the spinach was 193 degrees F. The US FOIA stated that she had not conducted test trays and could not speak to whether the previous US FOIA had. At that same time, the US FOIA (b)(6) was present and stated that the purpose of a test tray was to be able to identify the cause of cold food. He could also not speak to whether the previous US FOIA conducted test trays and acknowledged that there were no logs to verify that the staff calibrated their thermometers. He further stated that test trays should be conducted to ensure resident satisfaction. At 1:40 PM, the surveyor interviewed the US FOIA in the presence of the survey team and US FOIA (b) The US FOIA stated that he was unable to provide evidence that test trays conducted by the previous US FOIA (b) In addition, he stated that if hot food temperatures were tested on the unit via the test tray method and were recorded at 120 degrees F, that would not be palatable. The US FOIA acknowledged that the facility did not have a plate warmer. On 1/24/24 at 11:35 AM, the survey team met with the US FOIA (b)(6) They were unable to provide	F 804	will be an on-going audit. This will be done by the Director of Food Service and / or designee and they will discuss findings either monthly or quarterly to the Quality Performance committee . Audit findings will be discussed at the Quality Assurance and Performance Improvement committee meetings and will continue until the goal is met of 100% compliance and then on-going. If any areas are identified as concerns, the issues will be addressed immediately and resolutions will be presented to the Quality Assurance and Performance Improvement committee meeting. Completion date: February 22, 2024	

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F 804	Continued From page 101 additional information. At 12:03 PM, the US FOIA requested to meet with the survey team in the presence of the US FOIA (b)(6) . He was unable to provide additional information. Review of the facility policy "Food: Quality and Palatability" dated 9/2017, included "Food will be palatable, attractive and served at a safe and appetizing temperature." Review of a blank facility provided "Thermometer Calibration Log" dated 1/2021, included thermometers should be checked for accuracy "at least once a week." Review of the blank facility provided document "Resident Tray Assessment Report" dated 10/02, included a blank "Test Tray Audit" form which included temperature parameters for hot foods to be above 120 degrees F. NJAC 8:39-17.2(g), 17.4(e)	F 804		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.	F 851		2/22/24

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F 851	Continued From page 102 §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format.	F 851		

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F 851	Continued From page 103 The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to submit their Payroll Based Journal (PBJ) Report to the Centers for Medicare and Medicaid Services (CMS) within a timely manner. This deficient practice was identified for one of three PBJ Report submissions reviewed, (Fiscal Year Quarter 4 2023, July 1 - September 30) and was evidenced by the following: A review of the PBJ Staffing Data Report CASPER Report 1705D reflected a triggered area that the facility failed to submit data for the fourth fiscal year quarter to CMS. The dates of the fourth quarter included July 1, 2023, through September 30, 2023. On 1/12/24 at 12:01 PM, during an interview with the surveyor, the US FOIA (b)(6) [redacted] stated that the US FOIA (b)(6) [redacted] submitted staffing to CMS on a quarterly basis. At that time, the US FOIA informed the surveyor that the US FOIA (b) was no logger employed with the facility. At that time, the US FOIA stated that on 11/14/23, the same date as the due date for submission of the fourth quarter PBJ report to CMS, the US FOIA (b)	F 851	F851-Payroll Based Journal Element I The Facility will maintain compliance with Centers for Medicare and Medicaid Services regulations which required nursing facilities to collect and report staffing level data through payroll-based journal reporting. This requirement allows Center for Medicare and Medicaid Services to track the quality of care our facility delivers and ensure the accuracy of our staffing data. Proof of Payroll Based Journal timely submissions will be submitted to the Administator. Element II All residents that reside in the facility have the potential to be affected by the alleged deficit practice. Element III The facility has secured and educated the two persons with access (US FOIA (b)(6) [redacted]	

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F 851	Continued From page 104 attempted to log in and was not able to access the site. At that time, the US FOIA was made aware of the issue and proceeded to open a ticket request for PBJ submission of the report on 11/14/23. The US FOIA provided the surveyor copies of the correspondence to CMS that reflected the following: -On 11/14/23 at 9:34 AM, the US FOIA opened a ticket to request PBJ submission of the report. -On 11/14/23 at 9:44 AM, the US FOIA received a response from CMS which reflected that CMS was unable to reset the US FOIA (b)(6) password and was referred to another phone number for resolution. -On 11/15/23 at 9:06 AM, the US FOIA opened a ticket that stated the RCM was unable to log in to submit the PBJ report. -On 11/15/23 at 10:44 AM, the US FOIA received correspondence from CMS that indicated that it was not possible to correct the PBJ data once the submission data had passed. -On 1/3/24 at 2:58 PM, the US FOIA received correspondence from CMS that the ticket opened had been resolved and that the US FOIA (b)(6) was provided a temporary password. The US FOIA was able to log in successfully. At that time, the US FOIA (b) informed the surveyor that as of 1/3/23, she had access to the CMS website and that the facility team had a tentative meeting on 1/15/23. The meeting was to review the PBJ data in order to submit the PBJ staffing data	F 851	US FOIA (b)(6)) to submit/report the Payroll Based Journal Nurse Staffing and Non-Nurse Staffing data, including Physician and Rehabilitation services on a quarterly basis. Element IV The US FOIA (b)(6) were educated on submission and will conduct a monthly audit of the payroll based journal submission data to review for accuracy, reporting hours and completion, as well as timeliness It will be audited times three months and then quarterly times two for the payroll based journal data subission. If errors are found, immediate corrections will be updated to the data prior to the final quarterly submission deadline. Results of the audit will be presented to the quarterly Quality Assurance and Performance Improvement committee meeting. Comletion Date: February 22, 2024	

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F 851	Continued From page 105 weeks before the deadline. On 1/12/23 at 1:34 AM, the US FOIA informed the surveyor that there was no written protocol for the quarterly PBJ submission. As a result of the missed submission for the fourth quarter the facility obtained additional access for the Vice President of Human Resources and Regional Clinical Nurse. On 1/18/23 at 10:58 AM, in the presence of the survey team, the US FOIA (b)(6) the surveyor discussed the concern regarding the missed submission for the fourth quarter of 7/1/23 to 9/30/23 to CMS as required. On 1/22/23 at 10:09 AM, in the presence of the survey team, the US FOIA (b)(6) stated they acknowledge their error, learned from their error and initiated a "QAPI" (Quality Assurance and Performance Improvement, a data driven and proactive approach to quality improvement) for performance evaluations.	F 851		
F 868 SS=D	N.J.A.C. 8:39-41.3(a) 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	F 868		2/22/24

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F 868	Continued From page 106 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, 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 one (1) of three (3) Quality Assurance and Performance Improvement (QAPI) meetings and b) the Medical Director (MD) present for one (1) of three (3) quarterly QAPI meetings. The deficient practice was evidenced by the	F 868	F868 QAA Committee Element I The facility Administrator present on the date in question, last quarter of January 2023, is no longer the licensed NUrsing home administrator for the faciliity. The US FOIA (b)(6) was educated on the Quality Assurance and Perfromance Improvement participation requirements.	

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F 868	Continued From page 107 following: On 01/11/24 at 01:06 PM, the surveyor reviewed the provided last three quarters sign-in sheets for QAPI meetings that were provided by the US FOIA (b)(6) The QAPI committee was attended and included the required minimum members except the following who did not attend and were required to attend: 01/27/23=The US FOIA was not in the meeting. 4/26/23=The US FOIA (b)(6) was not in the meeting. On 01/18/24 at 10:57 AM, the survey team met with the US FOIA (b)(6) The surveyor notified the facility management of the above findings. On that same date and time, the US FOIA (b)(6) provided a copy of the US FOIA (b)(6) Timeline for 2023 and showed that the prior US FOIA was MD#1 who ended up service in NJ Exec Or and MD#2 started on NJ Ex Order 26.4b1. The surveyor asked when in NJ Exec Or MD#1 ended service as US FOIA (b)(6) and the US FOIA (b)(6) stated it was on NJ Ex Order 26.4. The US FOIA (b)(6) confirmed that there was no MD from NJ Ex Order 26.4 through NJ Ex Order 26.4b1. At this time, the facility management acknowledged that the reason why there was no US FOIA attended the 01/27/23 quarterly QAPI meeting was because there was no US FOIA at that time. A review of the provided facility's Assessment and Improvement Plan that was provided by the US FOIA (b)(6) with the developed date of 8/09/23 and approved on 8/16/23 included that the QAPIC (QAPI Committee) functions under the authority of the	F 868	Element II All residents have the potential to be affected by this deficit practice. Element III All required Quality aAssurance and Performance Improvement Committee Members have been educated on Quality Assurance and Performance Improvement regulations and requirements for participation. Quality Assurance andPerformance Imporvement committee meetings will be scheduled monthly, to ensure all required members are available and present. Quality Assurance and Performance Improvement committee meetings will be re-scheduled if required members are unavailable. ELement IV The facility Administrator and/or designee will present Quality Assurance and Performance Improvement committee meeting minutes and signatures to the Quality Assurance and Performance Improvement Committee for review monthly for three consecutive months to ensure compliance. Completion Date: February 22, 2024	

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F 868	Continued From page 108 Administrator and is composed of the following individuals: Administrator Medical Director or designee Director of Nursing or designee Infection Preventionist or designee Department Head (Social Services, Dietary, Recreation, Business Office, Environmental, Maintenance, Human Resources, Rehabilitation, Staffing, and or Central Supply depending on the nature of the issue). Other representatives such as pharmacy, consultant pharmacist, home health, lab, x-ray, physicians, and or divisional support leaders as appropriate or defined by state regulation to provide further insight and resource management. The QAPIC will review and analyze trends and identify potential improvement opportunities for the following, based on the analysis and action plan process completed prior to QAPIC: Lab/Pharmacy/Medical Director performance data (quarterly) Systems/reports for contracted services at a minimum but not limited to just quarterly. On 01/24/24 at 12:49 PM, the survey team met with the US FOIA (b)(6) [redacted], and there was no additional information provided by the facility management.	F 868		
F 880 SS=E	NJAC 8:39-33.1 (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	F 880		2/22/24

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F 880	Continued From page 109	F 880		

infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

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F 880	Continued From page 110 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain [redacted] control standards and procedures to address the risk of NJ Ex Order 26.4b1 by failing to: a) follow [redacted] precautions for a resident who was on NJ Ex Order 26.4b1 Precautions ([redacted]) by two (2) of two (2) medical staff US FOIA (b)(6) [redacted] for Residents #210, #9, and #45, b) follow appropriate hand hygiene practices during an NJ Ex Order 26.4b1 rounds observation by two (2) of three (3) staff observed (US FOIA (b)(6) [redacted]) according to the facility's policy and	F 880	F880-Infection Prevention & Control Element I Resident #9 was assessed with [redacted] due to the deficient practice. Resident $45 was assessed with [redacted] due to the deficient practice. Resident #210 was assessed with [redacted] due to the deficient practice. Resident #47 was assessed with [redacted]	

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F 880	Continued From page 111 Centers for Disease Control and Prevention (CDC) guidelines, and c) follow facility policy and standard of practice regarding not wearing personal protective equipment (PPE) in the hallway by one (1) of three (3) staff (US FOIA (b)(6) [redacted]. This deficient practice was evidenced by the following: According to the CDC Hand Hygiene in Healthcare Settings, Hand Hygiene Guidance, last reviewed on January 30, 2020, included that Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices Before moving from work on a soiled body site to a clean body site on the same patient After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal This deficient practice was evidenced by the following: 1. On 01/10/24 at 11:20 AM, during the initial tour, the surveyor observed multiple signage on Resident #210's door. The signs were as follow: yellow STOP sign, NJ Ex Order 26 precautions, NJ Ex Order 26.4 precautions and sequence for putting on PPE (CDC). The surveyor observed that the NJ Ex Order 26.4 NJ Exec Order 26.4b1 indicated "Everyone must: Make sure their eyes, nose and mouth are fully covered	F 880	NJ Ex Order 26.4b1 due to the deficient practice. Primary physician, licensed nurses, certified nurse assistants were in-serviced by the Infection Preventionist on the facility policy and procedure for infection control standards and procedures to address the risk of infection transmission, proper hand hygiene, and requirement to follow isolation precautions with Proper Personal Equipment for a resident who is on Transmission Based Precautions. January 18, 2024 and January 22, 2024, the Infection Preventionist conducted a facility wide in-service on the importance of proper hand hygiene techniques, proper donning and doffing of personal protective equipment, and need to safely discard PPE prior to leaving an isolated room in preventing the transmission of healthcare-associated infections. Any medical respiratory equipment such as nebulizer mask or oxygen tubing would be placed in clean, dry, plastic bag and dated to prevent infection as it will be discarded if contaminated or touched an uncleaned surfaces. Element II All residents have the potential to be affected by the deficient practice. Element III Infection Preventionist will conduct ten employees hand washing competencies	

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F 880	Continued From page 112 before room entry." At 11:37 AM, the surveyor observed a female doctor ([redacted] wearing a N95 mask, gown, and gloves before entering into Resident #210's room and was not observed wearing an eye protection as the sign on the resident's door indicated was to be worn while inside the room. At 11:40 PM The surveyor conducted an interview with the [redacted] upon exiting Resident #210's room. The [redacted] acknowledged that she did not have goggles on when entering into Resident's room and [redacted] stated, "the resident# 210 has been [redacted] since [redacted] and should not be here on [redacted]." The surveyor reviewed the medical records for Resident #210 which revealed the following: The Admission Record (AR, admission summary) reflected that the resident was admitted to the facility, had diagnoses which included but were not limited to [redacted]. Review of a laboratory result dated [redacted], at 11:01 AM, indicated that the resident was [redacted]. The [redacted] Physician Order Summary	F 880	weekly for four weeks, bi-weekly times two months, monthly times three months and quarterly times two. Infection Preventionist will conduct ten employee donning and doffing proper personal equipment competencies weekly for four weeks, bi-weekly times two months, monthly times three months and quarterly times two. Infection Prevenitonist will conduct an on-going mandatory infection control prevention and management in-service with all licensed and non-licensed staff on proper handwashing techniques and donning and doffing of personal protective equipment. "Center for Disease Control-Droplet Precautions Sign image of a person wearing a mask with face shield or wearing a mask with an eye protection will continue to be visible prior to entering the room as well as other signage for infection cotnrol. Element IV The facility will provide on-going education on proper hand hygiene, PPE and transmission-based infection protocols on a monthly basis in the form of signage and hands on in-services with return of demonstration for compliance. Audits will be monitored for completion by the Administrator or Director of Nursing weekly for four weeks, bi-weekly times two months, monthly times three months and quarterly times two. Audits will be	

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F 880	Continued From page 113 (POS) Report indicated a physician order, dated [redacted] for [redacted] ([redacted]) [redacted] and Single Room [redacted] for 10 days. On 01/17/24 at 01:10 PM The surveyor observed multiple signages on Resident #9 and Resident# 45's room door. The signs were as follow: STOP sign, [redacted] precautions, [redacted] Precautions, Sequence for putting on Personal Protective Equipment (PPE) and How to safely remove PPE (CDC). The surveyor observed the [redacted] did not have an eye protection upon exiting Resident #9 and Resident #45's room. The surveyor conducted an interview with the [redacted] and the [redacted] acknowledged, "I did not have an eye protection/goggles or face shield, when I went into and came out of the [redacted] room." The surveyor reviewed the medical records for Resident #9 which revealed the following: The AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted]. Review of a laboratory result dated [redacted], at 12:34 PM, indicated that the resident was [redacted] for [redacted]. The [redacted] POS report indicated a physician order, dated [redacted] for [redacted]	F 880	discussed during Quality Assurance and Performance Improvement Committee meetings. Quality Assurance and Performance Improvement committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to Quality Assurance and Performance Improvement Committee at least quarterly. Completion Date: February 22, 2024	

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(NJ Ex Order 26.4b and NJ Ex Order 26.4b Precautions for 10 (ten) days due to NJ Ex Order 26.4b1.

The surveyor reviewed the medical records for Resident #45 which revealed the following:

The AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) and NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) NJ Ex Order 26.4b1 NJ Ex Order 26.4b1)NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1), NJ Ex Order 26.4b1 NJ Ex Order 26.4b1), NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1).

Review of a laboratory result dated NJ Ex Order 26.4b1, at 12:35 PM, indicated that the resident was NJ Ex Order 26.4 for NJ Ex Order 26.4b1.

The NJ Ex Order 26.4b1 POS report indicated a physician order, dated NJ Ex Order 26.4b1 for NJ Ex Order 26.4b (NJ Ex Order 26.4b and NJ Ex Order 26.4b Precautions for 10 (ten) days due to NJ Ex Order 26.4b1

Review of the facility's COVID-19 Outbreak management and response revised on 6/5/23 indicated, "Implement standard and transmission-based precautions including use of a N95 respirator or higher (or facemask if unavailable), gown, gloves, and eye protection.

Review of the facility provided "CDC- Droplet

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Precautions Sign" had an image of a person wearing a mask with face shield or wearing a mask with an eye protection.

2. On 01/22/24 at 6:45 AM, the surveyor observed US FOIA (b)(6)) came out of room NJ Ex with full PPE that included an eye protection, N95 mask, gown, and gloves, and continued to walk in the hallway until she reached the covered three compartment bins outside that was in between rooms NJ Ex and NJ Ex to discard a plastic bag.

At that time, the surveyor, the US FOIA (b)(6)) in the presence of another surveyor observed the US FOIA (in the hallway wearing a full PPE. The surveyor interviewed the US FOIA (b) and the US FOIA stated that the US FOIA (should remove PPE before exiting the resident's room and not wear PPE while in the hallway according to the facility's practice and policy. She further stated that the US FOIA (should have removed her gloves and performed hand hygiene before exiting the resident's room.

Afterward, both the surveyor and the US FOIA went to the US FOIA (b) The surveyor then interviewed the US FOIA (in the presence of the US FOIA and US FOIA (b)(6) . The US FOIA (confirmed that she came out of room NJ Ex with full PPE after morning care was provided to the resident. The US FOIA (further stated that Resident #33 in room NJ Ex Ord was NJ Exec Order 26.4b1 and it was the US FOIA (b)(6 preference to wear full PPE when providing care to residents. The surveyor asked the US FOIA (when she should doff off (remove) her PPE and the US FOIA (did not respond. The US FOIA then informed the US FOIA (that she should doff off her PPE before exiting the resident's room. The US FOIA (informed the surveyor

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that she will educate the [redacted] about it.

3. On 01/22/24 at 6:54 AM, during the incontinence tour at the [redacted] unit, both the surveyor and the [redacted] went to room [redacted], and observed Resident #72 laying on the bed, and the NJ Ex Order 26.4b1 on the [redacted] not [redacted]. The [redacted] with gloves picked up the [redacted] then washed the mask with soap and water, dried it with a paper towel, and put the [redacted] inside a [redacted] inside the nightstand table. With the same gloves, the [redacted] went to the resident and checked the resident for [redacted] The [redacted] did not perform hand hygiene after cleaning the [redacted] and did not change gloves prior to checking the resident for [redacted]

After the [redacted] checked the resident, she removed gloves and performed handwashing. The [redacted] stated that Resident #72 had a behavior of [redacted] the [redacted].

On 01/22/24 at 7:00 AM, the surveyor and the [redacted] went to room [redacted] and observed Resident #43 laying on the bed. The [redacted] turned on the switch light, drew the privacy curtain, and donned (put on) a new pair of gloves without performing hand hygiene. The [redacted] then checked the resident for [redacted]

On 01/22/24 at 7:09 AM, the surveyor interviewed the [redacted] in the nursing station of [redacted] unit regarding Residents #72 and #43. The [redacted] informed the surveyor that it was appropriate to wash the [redacted] of Resident #72 with soap and water and she did not need to change gloves after picking up the [redacted] on the floor before touching the resident to check for [redacted]

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because when she washed the [NJ Ex Order 26.4b1] with soap and water, she "actually" washed her gloves already.

On that same date and time, the [US FOIA (b)] further stated that she did not consider the resident's environment of Resident #43 dirty which was why she did not need to wash her hands.

On 01/22/24 at 8:48 AM, the surveyor interviewed the [US FOIA (b)(6)]) in the presence of another surveyor. The surveyor notified the [US FOIA (b)] regarding the above concerns and findings. The [US FOIA (b)] stated the PPE in the hallway should be a "no," and any PPE used for one resident should be removed from the exit door, inside the resident's room before exiting the room, so that any bacteria/germs in PPE contained in the garbage can.

At that same time, the [US FOIA (b)] stated that the [US FOIA (b)] should removed the gloves when she picked up the [NJ Ex Order 26.4b1] and washed her hands. The [US FOIA (b)] further stated that it was okay to wash the [NJ Ex O] with soap and water but the nurse should have removed gloves and wash hands prior to touching the resident.

Furthermore, the [US FOIA (b)] stated that the surrounding area of the resident can be considered [NJ Exec Order 26.4b1] and that the nurse should have washed her hands after she touched the resident's environment.

On 01/22/24 at 10:08 AM, the survey team met with the [US FOIA (b)(6)] The [US FOIA (b)] informed the surveyors that the facility's [NJ Ex Order 26.4b1] started in [NJ Ex Order 26.4]

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F 880	Continued From page 118 NJ Ex Orde. The surveyor notified the facility management of the above findings and concerns. A review of the facility's Hand Hygiene Policy that was provided by the US FOIA (b) with a revised date of 9/2023 included that staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The use of gloves does not replace handwashing. Wash hands after removing gloves. A review of the facility's COVID-19 Outbreak Management and Response Policy that was provided by the US FOIA (b)(6) with a revised date of 6/05/23 included: make adequate waste receptacles available for used PPE. Position these near the exit inside the room to make it easy for staff to discard PPE prior to exiting, or before providing care for another patient/resident in the same room. On 01/24/24 at 12:49 PM, the survey team met with the US FOIA (b)(6) for an Exit Conference. There was no additional information provided by the facility management.	F 880		
F 882 SS=D	NJAC 8:39-19.4(1,2), 27.1(a) 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:	F 882		2/22/24

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F 882	Continued From page 119 §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 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. According to the NJ Executive Directive 21-012 (revised 12/22/22) included "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	F 882	F882-Infection Preventionist Qualifications/Role Element I The facility has one or more individual(s) as the infection preventionist(s) (IP) who are responsible for the facility's IPCP. The primary role would be 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 Regional Infection Preventionist is repsonisble for training and educating the facility Administrataor, director of nursing and infection preventionist at the facility level. Element II All residents that reside in the facility have the potential to be affected by the deficit	

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F 882	Continued From page 120 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 prevention and control program. IP specialized training is required and available. On 01/10/24 at 10:15 AM During the entrance conference, the US FOIA (b)(6) informed the Team Coordinator (TC) that "when I didn't have a US FOIA (b)(6)) here, he/she was our US FOIA (b) and he/she does US FOIA (b)(6) the company." The US FOIA (b)(6) further stated, "since NJ Exec Order 26.4b1, US FOIA (b)(6)) was the US F and the US FOIA (b) until NJ Ex Order 26.4b1 when the new US FOIA (b) started." The TC requested the US FOIA (b)(6) for US FOIA (b) and US F timeline since last recertification survey. During the review of provided Cornell [name redacted] US FOIA (b)(6) Timeline, the timeline revealed that the US FOIA (b) resigned on NJ Ex Order 2 and the US F resigned on NJ Ex Order 2. From NJ Exec Order 26.4b1, the US FOIA (b) was working as a US FOIA (b) and US F for the facility. The surveyor notified the facility management of the above concerns regarding the designated US F or US FOIA (b) role that the requirement was not met from NJ Exec Order 26.4b1 through NJ Exec Order 26.4b1 that the US FOIA (b) and US FOIA (b)(6) had confirmed. On 01/18/24 at 10:57 AM, the survey team met with the US FOIA (b)(6) . During an interview, US FOIA (b) and US FOIA (b)(6) stated that there is no designated US FO In addition, the US FOIA (b) admitted that there's a concern with US F position.	F 882	practice. Element III The Regional Infection Preventionist, the director of nursing and the administrator will ensure that the facility infection preventionist will receive the training that is required. The Infection Preventionist will assess, establish, or revise the infection control plan, annual infection prevention and control program risk assessment, and conduct internal quality improvement audits. The Infection Preventionist attends Qualiity Assurance and Performrance Improvement committee meetings. Element IV The Regional Infection Preventionist educated the US FOIA (b)(6) on the requirement to ensure that this indiviual meets the state regulations and provides infection control to the facility. Results of infection control audits will be presented by the Infection Preventionist at the quarterly Quality Assurance and Performance Improvement committee meetings. Completion date: February 22, 2024	

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F 882	Continued From page 121 On 01/22/23 at 10:09 AM, the survey team met with the US FOIA (b)(6) 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 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. NJAC 8:39-19.1(b)	F 882		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management	F 947		2/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315104	A. BUILDING _____ B. WING _____	C 01/24/2024

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F 947	Continued From page 122 training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility failed to ensure 2 of 5 Certified Nursing Assistants (CNA #1 and CNA #4) received 12 hours of education annually. This deficient practice was evidenced by the following: The surveyor requested five (5) random CNA education files for the year [NJ Exec Orde A review of a facility form titled Individual Mandatory In-services revealed the following: CNA #1 with a date of hire on [NJ Ex Order 26. , had 8.5 education hours from the date of hire, to the anniversary date. CNA #4 with a date of hire on [NJ Ex Order 26.4b] , had no education hours on file. On 1/23/24 at 12:04 PM, in the presence of the survey team, the[US FOIA (b)(6)), and the[US FOIA (b)(6) confirmed that CNA #4 and CNA #5 did not have their 12 hours of in-services training for	F 947	F947-Required In-Service Training for Nurse Aides Element I Certfied nursing aide #1 was provided in-service training to meet the 12-hour education state regulation. Certifed nursing aide #4 was provided in-service trainng to meet the the 12 hour education regulation. The Diretor of Nursing and/or Human Resources reviews the active certified nursing aides to ensure the nurse aides are provided at least 12 hours of in-service training annually based on the employment date, not calendar year. Element II All residents have the potential to be affected by the same deficient practice. Element III	

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F 947	Continued From page 123 NJ Exec Orde On 1/24/24 at 11:23 AM, in the presence of the survey team, the US FOIA (b)(6) stated we will be following-up to ensure the 12-hour mandatory in-services are completed. At that time, the US FOIA stated a QAPI (Quality Assurance and Performance Improvement, a data driven and proactive approach to quality improvement) was initiated, after surveyor inquiry to evaluate everyone's (CNA's) 12-hour mandatory education. A review of the provided facility policy, Nurse Aide Training Program dated/revised on 10/22, included Policy Explanation and Compliance Guideline, section 2. Each nurse aid shall be provided at least 12 hours of in-service training annually based on his or her employment date, not calendar year. N.J.A.C. 8:39-43.17(b)	F 947	The Director of Nursing/Designee will conduct random education audits on a monthly basis for the required in-service training for the certified nurse aides employed by the facility to include dementia management training and resident abuse prevention training. The US FOIA (b)(6) was in-serviced by the Regional Clinical Nurse on the twelve hour required training and continuing education required for nurse aides. There will be two inservices provided monthly (two hours per month) based upon the regulatory twelve hour education requirement which will be audited for completion of the required hours. The Director of Nursing / Designee will continue to conduct five audits for the active certified nursing assistants to ensure completion of all required twelve hour education bi-weekly times four weeks and then monthly for next three months. Element IV The monthly education series will be reviewed by the Administrator and Director of Nursing at the Quaility Assurance and Performance Improvement committee monthly to ensure that all who are due for training have been provided the in-service within that timeframe, and then quarterly which will allow for corrective measures. Completion date:	

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F 947	Continued From page 124	F 947	February 22, 2024	

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	062004	A. BUILDING: _____ B. WING _____	C 01/24/2024

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S 000	Initial Comments Complaint # NJ169272 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: REPEAT DEFICIENCY Complaint # NJ169272 Based on interview and review of other facility documents, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day and overnight shifts as mandated by the State of New Jersey for: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey	S 560	S560- Mandatory Access to Care(staffing) Element I The facility initiated the Tuition Reimbursement program , which pays full school fees for staff interested in continuing their education in the certified nursing assistance training program. The facility will provide adequate staffing by initiating an emergency staffing plan which requires licensed staff and management to assist to meet the needs and care of the residents. There were no negative adverse effects to the residents that resides in the facility due to the deficient practice. The facility to hold a career open	2/22/24

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

Electronically Signed | 02/15/24

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S 560	Continued From page 1 Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) 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 (1) 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. 1.) For the week of Complaint staffing from 11/12/2023 to 11/18/2023, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -11/12/23 had 11 CNAs for 114 residents on the day shift, required at least 14 CNAs. -11/13/23 had 11 CNAs for 112 residents on the day shift, required at least 14 CNAs. -11/15/23 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs. -11/16/23 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. -11/17/23 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs. -11/18/23 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. 2.) For the 2 weeks of staffing prior to survey	S 560	house meeting this quarter on February 20, 2024, for the following open positions, which included Licensed nurses and Certified nursing aides with effective results. The Administrator and Director of Nursing provided on-going education to license staff and the staffing coordinator on the minimum state regulations for staffing ratio. Element II All residents that reside in the facility have the potential to be affected by deficient practice. Element III The facility Recruiter along with the Director of Nursing and Administrator will conduct a career open house to be held at least every quarter to include a sign on and employee referral bonus. The administrator/designee will review the Retention program along with the staffing scheduler daily to assure staff turnover is at minimum and address immediately. Administrator or designee to review staffing schedule daily on continuous basis. Director of Nursing/or designee to audit nursing staffing twice weekly for 4 weeks and then twice monthly for two months to ensure the minimum state required staffing are met daily. Element IV Audits will be monitored for completion by the Administrator or Director of Nursing weekly for four weeks, bi-weekly for two months and monthly and quarterly times two. Audits will be discussed during Quality Assurance Performance	

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S 560	Continued From page 2 from 12/24/2023 to 01/06/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -12/24/23 had 9 CNAs for 102 residents on the day shift, required at least 13 CNAs. -12/25/23 had 11 CNAs for 10 residents on the day shift, required at least 13 CNAs. -12/26/23 had 11 CNAs for 99 residents on the day shift, required at least 12 CNAs. -12/27/23 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs. -12/28/23 had 9 CNAs for 97 residents on the day shift, required at least 12 CNAs. -12/29/23 had 9 CNAs for 97 residents on the day shift, required at least 12 CNAs. -12/30/23 had 9 CNAs for 97 residents on the day shift, required at least 12 CNAs. -12/31/23 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs. -01/01/24 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs. -01/02/24 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs. -01/03/24 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs. -01/04/24 had 11 CNAs for 105 residents on the day shift, required at least 13 CNAs. -01/05/24 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. -01/06/24 had 12 CNAs for 105 residents on the day shift, required at least 13 CNAs. On 1/22/24 at 6:36 AM the surveyor interviewed a CNA working 11 PM-7 AM shift. She stated that the ratio she had this shift was a 20:1 ratio. The surveyor asked if she was aware of the state regulations. The CNA was able to recite the state regulations for every , Day shift 8:1, Evening shift	S 560	Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to Quality Assurance and Performance Improvement Committee at least quarterly.	

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S 560	Continued From page 3 10:1, Night shift 14:1. She then stated, "this is normal for staffing on the weekend, I am alone with 20:1 for the weekend. They hire people then they leave and they cant find replacements." On 1/22/24 at 11:06 AM, in the presence of the survey team, the Infection Preventionist/Regional (IP/R), the Director of Nursing (DON), the Licensed Nursing Home Administrator (LNHA), and the Registered Nurse/Regional, the surveyor discussed the concerns regarding short staffing. On 1/23/23 at 12:04 PM, in the presence of the survey team, the IP/R, and the LNHA, the DON stated "we are aware of the shortage". At that time, the IP/R confirmed that the facility did not use agency because they were not reliable. At that time, the LNHA informed the surveyors that they try to fill the open shifts with a staff that was not on schedule. The LNHA also stated that they have hired more people but was unable to retain the new staff. The LNHA also stated that they will make every effort to enhance their staffing and will do what they need to do to increase their staffing shortage. A review of the facility provided policy, Nursing Services and Sufficient Staff dated/revised on 9/23, included the following. Policy: It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical mental and psychosocial well-being of each resident. The facility's census acuity and diagnoses of the resident population will be considered based on the facility assessment.	S 560		

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{E 000}	Initial Comments An onsite revisit was conducted on 3/18/2024 to verify the facility's POC from the 01/24/2024 Recertification survey. The facility was found to be in compliance.	{E 000}		
{F 000}	INITIAL COMMENTS Survey Date: 01/24/24, Revisit for Survey Date 3/18/24 Census:115 Sample: 2 An onsite revisit survey was conducted to determine compliance with 42 CFR Part 483, Requirnments for Long Term Care facitlities. Deficiencies were cited for this survey.	{F 000}		
{F 692} SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	{F 692}		4/11/24

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

Electronically Signed | 04/03/2024

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 692}	Continued From page 1 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to: a) obtain and follow the order for weekly [NJ Ex Order 2] upon admission or readmission, b) ensure staff education was provided with regard to [NJ Ex Order 2] monitoring and [NJ Ex Order 2] changes, c) ensure that all staff involved in the care of the residents were aware of the facility's practice and procedure with regard to residents' [NJ Ex Order 2] and reflected in the resident's plan of care, and d) ensure routine monitoring of [NJ Ex Order 2] was followed according to plan of correction, standard of clinical practice, and facility's procedure in order to identify, prevent, and address an unintended [NJ Ex Order 2] changes in a timely manner. This deficient practice was identified in two (2) of two (2) residents, Residents #1 and #2 reviewed for [NJ Ex Order 26.4b] This was an uncorrected deficiency, cited during the standard survey of 01/24/24. A plan of correction (POC) submitted by the facility failed to correct the deficient practice. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care	{F 692}	I. Resident #1: [NJ Ex Order 2] was obtained with [NJ Ex] [redacted] due to the deficient practice. Resident # 2: [NJ Ex Order 2] was obtained with [NJ Ex] [redacted] due to the deficient practice. - Regional Clinician in-serviced the US FOIA (b)(6) on the facility Weight Monitoring Policy and Procedures. - Regional Clinician/Designee provided in-service on the facility's Weight Monitoring Policy and Procedures for the license nursing staff and the certified nursing assistant to ensure timely completion of the weights are recorded and monitored as per physicians orders. The weights will be obtained for newly admitted/re-admitted residents weekly for 4 weeks, if clinically indicated daily or weekly and all others monthly. Weights will be recorded and reviewed by the Registered Dietician to identify high risk of weight gain and / or weight loss as part of the facility's plan of correction. - The facility Administrator -initiated on-going Quality Assurance and Performance Improvement (QAPI) on	

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{F 692}	Continued From page 2 supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1) The surveyor reviewed the medical record for Resident #1. Resident #1's Admission Record (AR, an admission summary) reflected the resident was admitted with diagnoses that included but were not limited to; NJ Ex Order 26.4b1 NJ Ex Order 26.4b1), NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1), and (NJ Ex Order 26.4b1). A review of Resident #1's most recent comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care dated NJ Exec Order 2, reflected a Brief Interview for Mental Status (BIMS) score of NJ E out of 15, which indicated the resident's	{F 692}	Weight Monitoring. Dietitian/Designee completed the initial audits of all facility residents that were triggered for weight change as per facility policy and procedures on Weight Monitoring; all data were recorded into the Weight Audit tool sheet provided by the registered dietician with appropriate intervention in place and reviewed during the weekly weight meeting. II. All residents that reside in the facility with significant weight changes have the potential to be affected by the deficient practice. III. -Admission/readmission weights will be reviewed and discussed during weekly weight meeting and care plans will be updated accordingly. - Dietician/Designee will in-service all staff on facility weight policy and procedure. -The Director of Nursing and/or designee will provide continued education for the licensed nurses and certified nursing assistance upon hire, annually and as needed, on monitoring and completion of weights as per physicians orders and the facility's policy and procedures. - The Director of Nursing and the Clinical Unit Managers will oversee the completion and documentation for the admission weights or re-weights to include post hemodialysis weights as per physicians'	

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{F 692}	Continued From page 3 cognition was NJ Ex Order 26.4b1. It further reflected that the resident required NJ Ex Order or NJ Ex Order 26.4b1 assistance for the task of NJ Ex Order 26 In addition, it reflected that the resident had an active diagnosis of NJ Ex Order 26.4b1 or was at risk for NJ Ex Order 26.4b1 and received a NJ Ex Order 26.4b1. A review of Resident #1's comprehensive care plan (CP) included a focus area related to NJ Ex Order 26.4b1 and included an intervention of "Monitor NJ Ex Order 26.4 as ordered." A review of Resident #1's NJ Ex Order 26.4b1 Evaluation dated NJ Ex Order 26.4 included the following: ...Will continue to monitor NJ Ex Order 2 weekly .... A review of Resident #1's Order Summary Report (OSR) included the following orders: Admission and re-admission routine NJ Ex Order 2 every day shift every 1 month(s) starting on the last day of month for 1 day(s) Monthly NJ Ex Order 2 with an order date of NJ Ex Order 26.4b1 and a start date of NJ Ex Order 26.4; Admission and re-admission routine NJ Ex Order 2 every day shift every Wed (Wednesday) for 1 Month until finished Weekly NJ Ex Order 2 x NJ Exec Order 26.4 with an order date of NJ Ex Order 26.4b1, a start date of NJ Ex Order 26.4b1 and an end date of NJ Ex Order 26.4. A review of Resident #1's NJ Ex Order 26.4b1 and NJ Ex Order 2 electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) did not include the order to NJ Ex Order 2 resident weekly. A review of the NJ Ex Order 2 section of Resident #1's electronic medical record (eMR) included the following: NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 (wheelchair) NJ Ex Order 26.4 NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1)	{F 692}	orders and provided to the Registered Dietitian for review. - Registered Dietitian/Designee will review the weekly audits for weight changes if any; The administrator, registered Dietitian, and clinical team will meet weekly to identify root-cause for all weight changes if any. All results will be recorded onto the Weight tool audit and addressed accordingly as per facility Weight Policy and Procedures. Primary physicians will be made aware of the weight loss or weight gain and the residents care plans will be reviewed and updated. IV. - Registered Dietitian/Designee will continue to conduct audits for all residents that have triggered for weight change to ensure that all residents with significant weight change are followed, updated care plans, and all proper interventions and recommendations are in place; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly. - Results of the audits will be presented and discussed during our monthly QAPI meeting; QAPI committee will determine if continued auditing is necessary. Once 100% compliance threshold is achieved for two consecutive months. This plan can be amended when indicated. The Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315104	A. BUILDING _____ B. WING _____	R-C 03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNELL HALL CARE & REHABILITATION CENTER	234 CHESTNUT STREET UNION, NJ 07083

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{F 692}	Continued From page 4 There was no documented evidence that weekly NJ Ex Order 26.4 were done. A review of the facility provided binder that contained NJ Exec Ord Unit NJ Exec Order 26 reflected that Resident #1 did not have any NJ Ex Order 26.4 written. There were no weekly NJ Ex Order 26.4 documented as ordered. A review of the facility provided audit reflected the following: Weekly NJ Ex Order 26.4b1 Report Week NJ Ex Ord - NJ Ex Ord Missing weekly NJ Ex Order 26.4b1 Resident #1 (resident's name was listed under missing weekly NJ Ex Order 26.4) The facility did not provide any prior weekly audits of NJ Ex Order 26.4b The facility did not follow the physician's order for weekly NJ Ex Order 26.4b 2. On NJ Ex Order 26.4 at 11:25 AM, the surveyor reviewed the list of 12 residents that were identified for high risk of NJ Ex Order 26.4b1 and/or NJ Ex Order 26.4b1 as part of the facility's POC. Resident #2 was identified as a NJ Ex Order 26.4b1 resident, readmitted to the facility on NJ Ex Order 26.4, which the US FOIA (b)(6) US FOIA (b)(6) assessed on NJ Ex Order 26.4b. The surveyor reviewed the hybrid (combination of both paper and electronic) medical record for Resident #2. The resident's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) with NJ Ex Order 26.4b1	{F 692}		

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NJ Ex Order 26.4 (NJ Ex Order 26.4b1), NJ Ex Order 2 (NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1) and NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1 .

The resident's most recent quarterly MDS dated NJ Ex Order 26.4b1, reflected that the resident had a BIMS score of NJ Ex out of 15, which indicated the resident was NJ Ex Order 26.4b1. Additionally, the MDS revealed that while a resident a NJ Ex Order 26.4b1 such as NJ Ex Order 26.4, NJ Ex Order 26.4 and NJ Ex Order 26.4b1 was required.

A review of the resident's CP included the resident a NJ Ex Order 26.4b focus that indicated the resident had an NJ Ex Order 26.4b1 with a diagnosis of NJ Ex Order 26.4b1 which could impact the residents NJ Ex Order 26.4b1, dated/revised on NJ Ex Order 26.4.

Further review of the CP reflected the resident was at risk for complications related to NJ Ex Order 26.4b1 for the diagnosis of NJ Ex Order 26.4b1, dated/revised on NJ Ex Order 26.4b1.
The CP intervention included: Monitor resident NJ Ex Order 26. as per protocol dated NJ Ex Order 26.4b1.

A review of the OSR did not reflect an order for NJ Ex Order 2 monitoring.

A review of the eMAR did not reflect an order for NJ Ex Order 2 monitoring.

A review of the eTAR did not reflect an order for NJ Ex Order 2 monitoring.

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{F 692}	Continued From page 6	{F 692}		

A review of the [redacted] record reflected the following:
-On [redacted], the resident [redacted] ([redacted])
-On [redacted], the resident [redacted].
-On [redacted], the resident [redacted].

A review of the US FOIA (b)(6) Progress Note (PN) dated [redacted], included the resident was readmitted to the facility after hospitalization from [redacted] to [redacted]. The resident was on a [redacted] due to medical needs, and that the resident was at times [redacted] despite education.

Additionally, the [redacted] documented that the Resident's post [redacted] was [redacted] an [redacted] in [redacted] and [redacted] in [redacted]. The [redacted] was attributed to [redacted] and [redacted].

A review of the Physician PN from [redacted] to [redacted], did not reflect documentation from the physician awareness of the resident's significant [redacted] of an [redacted] in [redacted] on [redacted].

A review of the [redacted] Communication Record reflected the following:
-On [redacted] the resident's [redacted] and [redacted] were blank/ not recorded.
-On [redacted] the resident's [redacted] was blank/ not recorded.

On 3/18/24 at 11:25 AM, during a meeting with

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the survey team, the US FOIA (b)(6) stated her company was contracted with the facility since NJ Ex Order 26.4, she was assigned to provide a fee for service three times a week.

At that time, the US FOIA (b) stated she was aware of the POC. The facility had asked her company to help ensure the resident's NJ Ex Order 2 monitoring were done but was not asked to provide in-services. The US FOIA (b) also stated that the weekly NJ Exec Order 2 were for residents who were newly admitted, readmitted residents, and residents with a NJ Ex O or NJ Ex Order 26.4b1 in NJ Ex Order 2 NJ Ex Order 26.4b1).

At that time, the US FOIA (b) stated that she posted the weekly NJ Ex Order 26.4 that needed to be obtained in the unit which was then entered into the eMR.

At that time, the US FOIA (b) stated that a physician's order (PO) was not required for NJ Ex Order 2 monitoring. However, should the physician initiate a NJ Ex Order 2 monitoring order, the licensed nurse would then input the NJ Ex Order 2 monitoring order (eMR).

At that time, the US FOIA (b) stated that she did not sign a job description with the facility (a formal account of an employee's responsibilities).

At 01:14 PM, during a follow-up interview with the survey team, the US FOIA (b) stated that for the NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 or NJ Ex Order 26.4b1, on NJ Ex (, Resident #2, the CP she placed was to "monitor NJ Ex Order 26.4 as per protocol."

At that time, the surveyor and the US FOIA (b) reviewed the NJ Ex (communication book together and was

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{F 692}	Continued From page 8 asked about the following missing NJ Ex Order 26.4b -NJ Ex Order 26.4b1 were missing. The nursing PN indicated the resident attended NJ Ex Order 26.4b -NJ Ex Order 26.4 NJ Ex Order 26.4b1 was missing. The nursing PN indicated the resident attended NJ Ex Order 26.4b At that time, the US FOIA (b) stated that in the event NJ Ex Order 26.4 were missing, she would call the NJ Ex (provider to obtain the missing NJ Ex Order 26. At that time, the US FOIA (b) stated that she was a contracted NJ Ex Order 26.4b and followed her company's protocol of not needing a PO for NJ Ex Order 2 monitoring. The US FOIA (b) acknowledged the discrepancy regarding her statements about the CP and the PO against the facility's POC that required the nursing staff to obtain an order for weekly NJ Ex Order 26.4 upon admission and readmission. At that time, the US FOIA (b)(6)) stated that the facility would then incorporate the US FOIA (b)(6) contracted company's protocol for NJ Ex Order 2 monitoring. At 01:20 PM, in the presence of the survey team, the US FOIA (b)(6) the surveyor discussed the concerns regarding the failure to individualize the resident's CP, show evidence that the physician was contacted when the NJ Ex Order 26.4b1 in a month occurred, ensure that all staff were following the same policy and procedures for NJ Ex Order 2 monitoring and the missing NJ Ex Order 26.4 for the resident's NJ Ex Order 26.4 communication book from the date of	{F 692}		

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{F 692}	Continued From page 9 readmission. No further information was provided. 3) On 3/18/24 at 10:45 AM, surveyor reviewed the POC binder provided by the US FOIA (b)(6) The POC provided read as: Element 1 - ~Regional Dietician provided education to facilities three (3) Registered Dietician (RD). Two (2), (RD#1 and RD#2) of three (3) signatures were on the documentation provided. The facility could not provide evidence that this was completed. ~The RD will completed a full house audit for nutritional care plans are in place for all residents by 02/22/24. One of two sampled residents care plan did not reflect this POC. The facility could not provide evidence that this was completed. Element 3- ~The dietician will conduct weekly audits. The facility could not provide evidence that this was completed. ~The dietician will educate licensed nursing staff of the importance of adhering to the orders requiring weekly weights, including admission weight orders, and obtaining weekly weights as ordered. The facility could not provide evidence that this was completed. ~ The Director of Nursing (DON) will provide oversight as to documentation of monthly weights being done for completion. The facility could not provide evidence that this was completed. Element 4- ~Weight and documentation audits will be monitored for completion by the Dietician on a weekly basis times four, bi-weekly times two, monthly times three months, and quarterly times	{F 692}		

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two. These findings will be reported to the Quality Assurance and Performance improvement committee monthly and then quarterly. The Administrator and the Quality Assurance and Performance (QAPI) committee will review and determine compliance for the three months and quarterly.

The facility could not provide evidence to the survey team that the weekly and continued monitoring was being done and findings will be reported in the QAPI and determine compliance for three months according to the POC.

On 3/18/24 at 11:19 AM, the surveyor interviewed the US FOIA (b)(6) The US FOIA (b)(6) stated, "administration is responsible to oversee the POC." She confirmed after surveyor inquiry that the weekly monitoring was not dated. She also was unsure what week was provided or missing because it was not dated.

On 3/18/24 at 11:23 AM, the surveyor interviewed the US FOIA (b) The US FOIA (b) stated, "she works for a contracted NJ Ex Order 26.4 company and was retained starting on NJ Ex Order 26.4. When we were hired, we were told to do the weekly monitoring. The education for nursing staff was to be completed by the facility management."

On that same date and time, the US FOIA (b) stated that "Our company weekly audits for the facility are emailed to the US FOIA (b) the US FOIA (b) and US FOIA (b)(6)

On 3/18/24 at 11:50 AM, the surveyor interviewed the US FOIA (b) The US FOIA (b) stated, "There was no audit list for weekly or monthly from the previous NJ Ex Order 26.4 prior to us starting on NJ Ex Order 26.4. Our first weekly monitoring started on NJ Ex Order 26.4." The US FOIA (b)

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{F 692}	Continued From page 11	{F 692}		

further stated that the US FOIA (b) provided "us" with an email list that was started but it was not complete.

On that same date and time, the surveyor interviewed the US FOIA (b)(6). The US FOIA (b)(6 stated that the previous US FOIA (b) last day of employment was on NJ Ex Order 26.4b1. She further stated that "we" had two dieticians that were employed and then we hired contractor dieticians who started on NJ Ex Order 26.4. The US FOIA (b)(6 also stated that the NJ Ex Order 26.4 of the residents should be in the eMR under the NJ Ex Order 26.4 tab. She further stated that there was also a NJ Ex Order 26 paper in the certified nursing assistant (CNA) book.

Furthermore, the US FOIA (b)(6 informed the surveyor in the presence of the survey team that "If you can not find them in eMR they probably did them but did not log them." The surveyor asked the US FOIA (b)(6 if they were not log, how it was being monitored for weekly NJ Ex Order 26.4 or monthly NJ Ex Order 26.4b. The US FOIA (b)(6 did not have a response or new information to provide to the survey team.

On 3/18/24 at 3:01 PM, the US FOIA (b)(6 provided a copy of the NJ Ex Order 26 Change Audit via email that included the following:
NJ Ex Order 26 Change Audit
Review date: Week 1 (NJ Ex Order 26.4b1)
Reviewed by: RD#1
Review date: Week 2 (NJ Ex Order 26.4b1)
Reviewed by: RD#1

A review of US FOIA (b)(6 weekly monitoring for NJ Ex Order 2 showed that it was for week of NJ Ex Order 26.4 through NJ Ex Order 26.4.

Furthermore, the provided NJ Ex Order 26 Change Audit revealed that there was no further weekly

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{F 692}	Continued From page 12 monitoring done for week 3 ([redacted]) and week 4 ([redacted]) that was provided by the [redacted] The facility management was not able to provide QAPI information regarding the concern above as part of POC. A review of the facility provided policy dated/revised 9/22, under Policy Explanation and Compliance Guidelines included the following: 3. Documentation a. The physician should be informed of a significant change in weight and may order nutritional interventions ... g. The interdisciplinary plan of care communicates care instructions to staff. NJAC 8:39-11.2(d)(e)(1)(f), 17.1(c), 17.2(d), 27.1(a)	{F 692}		

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
315104 Y1	A. Building B. Wing Y2	3/18/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNELL HALL CARE & REHABILITATION CENTER	234 CHESTNUT STREET UNION, NJ 07083

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	F0607	Correction	ID Prefix	F0609	Correction	ID Prefix	F0623	Correction
Reg. #	483.12(b)(1)-(5)(ii)(iii)	Completed	Reg. #	483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. #	483.15(c)(3)-(6)(8)	Completed
LSC		02/22/2024	LSC		02/22/2024	LSC		02/22/2024
ID Prefix	F0625	Correction	ID Prefix	F0640	Correction	ID Prefix	F0641	Correction
Reg. #	483.15(d)(1)(2)	Completed	Reg. #	483.20(f)(1)-(4)	Completed	Reg. #	483.20(g)	Completed
LSC		02/22/2024	LSC		02/18/2024	LSC		02/22/2024
ID Prefix	F0657	Correction	ID Prefix	F0684	Correction	ID Prefix	F0688	Correction
Reg. #	483.21(b)(2)(i)-(iii)	Completed	Reg. #	483.25	Completed	Reg. #	483.25(c)(1)-(3)	Completed
LSC		02/09/2024	LSC		02/22/2024	LSC		02/22/2024
ID Prefix	F0695	Correction	ID Prefix	F0725	Correction	ID Prefix	F0730	Correction
Reg. #	483.25(i)	Completed	Reg. #	483.35(a)(1)(2)	Completed	Reg. #	483.35(d)(7)	Completed
LSC		02/22/2024	LSC		02/22/2024	LSC		02/22/2024
ID Prefix	F0732	Correction	ID Prefix	F0756	Correction	ID Prefix	F0758	Correction
Reg. #	483.35(g)(1)-(4)	Completed	Reg. #	483.45(c)(1)(2)(4)(5)	Completed	Reg. #	483.45(c)(3)(e)(1)-(5)	Completed
LSC		02/22/2024	LSC		02/22/2024	LSC		02/22/2024

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
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315104 Y1	A. Building B. Wing Y2	3/18/2024 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 F0804	Correction	ID Prefix F0851	Correction	ID Prefix F0868	Correction
Reg. # 483.60(d)(1)(2)	Completed	Reg. # 483.70(q)(1)-(5)	Completed	Reg. # 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	Completed
LSC	02/22/2024	LSC	02/22/2024	LSC	02/22/2024
ID Prefix F0880	Correction	ID Prefix F0882	Correction	ID Prefix F0947	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80(b)(1)-(4)	Completed	Reg. # 483.95(g)(1)-(4)	Completed
LSC	02/22/2024	LSC	02/22/2024	LSC	02/22/2024

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	
1/24/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062004	A. BUILDING: _____ B. WING _____	R-C 03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNELL HALL CARE & REHABILITATION CENTER	234 CHESTNUT STREET UNION, NJ 07083

(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
{S 000}	Initial Comments An onsite revisit was conducted on 3/18/2024 to verify the facility's Plan of Correction associated with the 01/24/2024 Recertification survey. The facility was not in compliance with the standards in the New Jersey Administrative code, 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 the 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 as mandated by the State of New Jersey. This was an uncorrected deficiency, cited during the standard survey of 01/24/24. A POC submitted by the facility failed to correct the deficient practice. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health	{S 560}	Element I. The residents were assessed with no adverse effect noted. On March 18, 2024, Administrator, Director of Nursing (DON), Human Resource Director (HR) and Staffing Coordinator reviewed nurse staffing and determined the facility is averaging approximately 8 hours (one shift) under required ppd (per patient day) certified nursing aides (CNA) ratio, either on	4/11/24

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

Electronically Signed | 04/03/24

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{S 560}	Continued From page 1 (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the 2 weeks of staffing prior to survey from 03/03/2024 to 03/16/2024 for the 03/18/2024 Revisit survey, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: - 03/03/24 had 11 CNAs for 115 residents on the day shift, required at least 14 CNAs. - 03/05/24 had 12 CNAs for 115 residents on the day shift, required at least 14 CNAs. - 03/06/24 had 12 CNAs for 115 residents on the day shift, required at least 14 CNAs. - 03/07/24 had 11 CNAs for 115 residents on the day shift, required at least 14 CNAs.	{S 560}	7am-3pm shift or 11pm to 7am shift. The team reviewed staffing for March 19, 2024, and ensured staffing ppd met state regulations moving forward. Element II. All residents have the potential to be affected by this deficit practice. Element III. Nurse staffing will be reviewed daily, via yesterday, today and tomorrow model. LNHA, DON, and SC will review staffing from previous day, current day, and following day to ensure all nurse shifts have met or will meet daily staffing ppd requirement. Weekend staffing will be reviewed on or before every Friday to ensure weekend staffing meets daily ppd state requirement. The Administrator, DON and/or their designee shall complete weekly audits for four weeks, then monthly audits for an additional two months to review and document staffing patterns. Nurse staff meetings held with each shift, 7-3, 3-11 and 11-7 to discuss recruitment, retention and call out process, as well as call out impact on resident care and services. Administrator also spoke with facility LPNs, educating them on the option to sign up as CNA, should they be available. Bonus program reviewed with nursing department and Staffing Coordinator is posting a needs list (open shifts) to enable all nursing staff, full time, part time and per diem to sign up for open positions as per their availability. The facility, working with facility HR Director, have hired NA's (nursing assistants) who have recently graduated from a certified aide course to work as NAs for a maximum of 120 days while he or she	

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{S 560}	Continued From page 2 - 03/08/24 had 11 CNAs for 115 residents on the day shift, required at least 14 CNAs. - 03/09/24 had 12 CNAs for 115 residents on the day shift, required at least 14 CNAs. - 03/10/24 had 10 CNAs for 115 residents on the day shift, required at least 14 CNAs. - 03/11/24 had 11 CNAs for 117 residents on the day shift, required at least 15 CNAs. - 03/12/24 had 10 CNAs for 116 residents on the day shift, required at least 14 CNAs. - 03/13/24 had 10 CNAs for 116 residents on the day shift, required at least 16 CNAs. - 03/14/24 had 13 CNAs for 116 residents on the day shift, required at least 14 CNAs. - 03/15/24 had 11 CNAs for 116 residents on the day shift, required at least 14 CNAs. - 03/16/24 had 11 CNAs for 116 residents on the day shift, required at least 14 CNAs. On 3/18/24 at 9:02 AM, during a facility revisit, the surveyor requested for a copy of the posted 24-hour staffing report which was dated 3/18/24, which reflected the following: -The resident census (total number of residents) indicated there were 115 residents. -Three (3) RNs were scheduled for the 7:00 AM to 3:00 PM shift. -Four (4) LPNs were scheduled for the 7:00 AM to 3:00 PM shift. -13 CNAs were scheduled for the 7:00 AM to 3:00 PM shift. The posted schedule reflected was 1.375 CNA short of the mandated staffing ratio for that shift. On 3/18/24 at 9:20 AM, the surveyor interviewed the Staffing Coordinator (SC). The SC stated she scheduled the CNAs based on the mandatory staffing ratios. The SC also stated that there were times, the facility was short staffed because of staff call outs.	{S 560}	prepares to take their final exam. The facility immediately implemented an aggressive recruitment plan for all nursing positions and has hired a total of 16 nursing employees for the last two months and the facility will continue with on-going recruitment for licensed nursing staff along with the staffing bonuses incentives which offers a financial incentive to nursing staff that agree to accept aditional shiftes. We also innitiated a finacial incentive to nursing staff to reduce call outs for a period of 30 days, which automatically renews every 30 days. In addition, the HR Director and/or designee shall review turnover monthly, for three consecutive months to track/trend retention numbers to ensure recruitment efforts are successful. Element IV: Staffing weekly audits will be completed by the Administrator, DON, and/or their designee for four consecutive weeks for one month; then monthly for an additional two months to review, document and monitor nurse staffing levels. HR director will present monthly turnover audit to the QAPI committee for three consecutive months. All audit results will be presented to the facility QAPI committee monthly for three months to ensure staffing levels meet or exceed the State required ppd ratios, and recruitment efforts have proved successful.	

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{S 560}	Continued From page 3 At that time, the SC stated their efforts to secure staffing included posting job on a web site [site name redacted], and job fairs. At 10:03 AM, during an interview with the surveyor, Licensed Practical Nurse #1 (LPN #1) stated she worked in the [NJ Ex Order] Unit, the unit had 35 residents and five (5) CNAs assigned to the residents in the Subacute unit that day. At 10:10 AM, during an interview with the surveyor, CNA #1 stated that she started [NJ Ex Order 26.4b] , worked the 7:00 AM to 3:00 PM shift and was assigned seven residents that day. The CNA also stated that at times on her weekend shift of 7:00 AM to 3:00 PM, she was assigned 10 residents because of the shortage. The CNA stated the shortage did not affect the care given to the residents. At 10:15 AM, during an interview with the surveyor, CNA #2 stated that she received an in-service about the mandatory staffing ratios, a couple of weeks ago. At that time, the CNA #2 informed the surveyor that she worked the 7:00 AM to 3:00 PM shift and was assigned seven residents that day. CNA #2 stated that sometimes the staffing ratios were met. At that time, CNA #2 stated that the weekends she worked during the 7:00 AM to 3:00 PM shift were hard when they were short staffed because she was assigned 10 to 14 residents. The licensed nurse (Licensed Practical Nurse (LPN) or Registered Nurse (RN)) on duty was aware of the staff shortage, and the ratio not being met since they made the assignments for the CNAs.	{S 560}		

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{S 560}	Continued From page 4 At 10:24 AM, during an interview with the surveyor, LPN #2 stated she worked in the [NJ Ex Order 26.4b1] unit, the unit had 59 residents, and six CNAs assigned to the residents. At that time, LPN#2 stated the weekends were the worst with short staffing but tried their best to help the CNAs to meet the needs of the residents. "We try to manage." At 10 :32 AM, during an interview with the surveyor, CNA #3 stated she worked the 7:00 AM to 3:00 PM shift and was assigned 10 residents that day. The CNA also stated, "It's okay for me because two are independent". At that time, CNA #3 informed the surveyor that she received education on the staffing ratio but could not recall when. At 10:46 AM, during an interview with the surveyor, LPN #3 stated she worked in the [NJ Ex Order 26.4b1] unit, the unit had 19 residents and two CNAs assigned to the residents. At that time, the LPN informed the surveyor that she received education for the staffing ratio a couple of weeks ago and admitted that the staffing ratios were not always met. The SC was aware of the shortage and was told that the facility was continuously trying to hire more people. "It is very hard when short staffed, but we do our best to satisfy the needs of our patients" [residents]. At 11:00 AM, during a meeting with the survey team, the Regional Infection Preventionist Nurse (RIPN) and the Floating Licensed Nursing Home Administrator (FLNHA), the Regional Clinical	{S 560}		

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{S 560}	Continued From page 5 Operations Nurse (RCON) stated that as part of their plan of correction, they had conducted in-services for the staff, the SC, the LNHA and the DON. The job fair was conducted and would be continued quarterly. At that time, the surveyor asked the RCON where the audit for the nurse staffing was documented with its results. The RCON stated "it should have been there" and acknowledged that it was not. At that time, the surveyor asked the RCON where the audit for the Retention program was. The RCON stated that there was no documentation that the retention program audit was conducted. At that time, the RCON stated that on some days the staffing ratios are met and some not. "We continue to recruit, offer incentives, hold job fairs". At that time, the surveyor asked the RCON for the QAPI (Quality Assurance and Performance Improvement, a data driven and proactive approach to quality improvement) associated with nurse staffing. At 01:20 PM, in the presence of the facility team, the FLNHA, the RIPN, the RCON, the Regional Director of Operations and the Regional Registered Dietician, the LNHA stated that they still did not have a QAPI for the Nursing Services and Sufficient Staffing. A review of the facility provided policy, Nursing Services and Sufficient Staff dated/revised on 9/23, included the following. Policy: It is the policy of this facility to provide sufficient staff with appropriate competencies and	{S 560}		

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{S 560}	Continued From page 6 skill sets to assure resident safety and attain or maintain the highest practicable physical mental and psychosocial well-being of each resident. The facility's census acuity and diagnoses of the resident population will be considered based on the facility assessment. No further information was provided.	{S 560}		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315104 Y1	A. Building B. Wing Y2	4/23/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNELL HALL CARE & REHABILITATION CENTER	234 CHESTNUT STREET UNION, NJ 07083

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 F0692	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.25(g)(1)-(3)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/11/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
1/24/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/11/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

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	315104	A. BUILDING **01** B. WING _____	**01/24/2024**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health. Health Facility Survey and Field Operations on 01/18/2024 and 01/22/2024, and was found to be in noncompliance with the requirements for participation in Madicare/ Medicaid at 42 CFR483,90 (a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA). Chapter 19 EXISTING Health Care Occupancy. The facility is a 1-story building that was built in the 60's. It is composed of Type II protected construction. The facility is divided into 6- smoke zones. The generator is natuiral gas and supplies power to approximately 40% of the facility. The building: 55,715 sq. ft. single story, wood truss roof, concrete slab floor and two (2) basements.	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of	K 321		2/22/24

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

Electronically Signed | 02/15/2024

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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K 321	Continued From page 1 hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 1/18/2024 and 1/22/2024, in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following: On 01/18/2024 (day one of survey) during the survey entrance at approximately 9:12 AM, a request was made to the US FOIA (b)(6) [redacted] to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility.	K 321	K321 Enclosures Element I Medical records room door closure was replaced by the maintenance director on January 25, 2024, allowing closures and self latching of the specified door. All rooms measuring 50 square feet or larger were inspected by the maintenance director, ensuring the proper closure and latching of the doors. All other doors were found in compliance. Element II All residents could have been affected by this practice. Element III Facility staff was in-serviced by the facility Administrator on 2-14-24 on the importance of maintaining fire doors clear, unobstructed and to not be held open by	

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K 321	Continued From page 2 A review of the facility provided lay-out identified the facility is a single-story (1) building with two (2) basements. Starting at approximately 9:21 AM on 01/18/2024 and continued on 1/22/2024 in the presence of the facility's US FOIA (b)(6) and US FOIA a tour of the building was conducted. During the two (2) day building tour the surveyor observed the following hazardous area that failed to have smoke resisting doors, On 1/18/2024: 1) At approximately 11:42 AM, during an inspection of the Medical Records room the surveyor observed the corridor door was propped in the open position with a rubber wedge type door hold open device. When the US FOIA (b)(6) removed the rubber door wedge and opened the door to a 90 degree angle to the frame and allowed to self-close, the door did not close into its frame. With this corridor door not closing into its frame, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. A review of an emergency evacuation diagram posted on the corridor wall identified the room is in the primary and/ or secondary exit access path to reach an exit. The US FOIA (b)(6) and US FOIA confirmed the findings at the times of observations. The US FOIA (b)(6) was informed of the Life Safety Code deficiency on 01/22/2024 at approximately 12:35 PM. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321	any device. Rubber wedge was removed by the maintenance director and disposed of on 1-25-24. ELement IV All fire doors and smoke doors throughout the facility were inspected by the maintenance director on 2-14-24 for compliance and recorded on the facility fire and smoke inspection audit log. These inspections will continue to be completed on a monthly basis for three months and yearly thereafter. Facility fire and smoke door inspections will be presented by the maintenance director to the monthly Quality Assurance and Performance Committee meetings for a period of 90 days. Comletion date: February 22, 2024	

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	315104	A. BUILDING **01** B. WING _____	**01/24/2024**

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K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on interview and documentation review on 01/18/2024 and 01/22/2024 in the presence of the facility management, it was determined that the facility failed to 1) conduct a Semi-annual (every 6 months) inspection of the buildings Fire Alarm and Detection system inspection and 2) ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors, in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition Section 14.4.5.3.2. This deficient practice was identified for 1 of 1 fire alarm systems and was evidenced by the following: Reference: Fire Protection Association (NFPA) 72. National Fire Alarm and Signaling Code: - Table 10.3.1 (3) Batteries (d) Sealed Lead-Acid inspection frequency: semi-annual inspections. - 10.4.3.2.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 10.4.3.2.3 1) On 01/18/2024 (day one of survey) during the	K 345	K345 Fire alarm system Testing and Maintenance Element I The residents were assessed and thre wereno adverse affects form the defienct practice. Fire alarm and Detection system had not been inspected and was deficient The Maintenance director contacted the fire alarm and dection system company and the vendor agreed to provide service Fire and detection inspection was conducted and completed on 1-24-24 by facility contracted fire and alarm detection system vendor. Facility fire and alarm vendor was contacted by the maintenance director to conduct the alarm Sensitivity and it was completed on 2-15-24. Element II All residents could have been affected by this practice. ELement III The US FOIA (b)(6) was re-trained	2/15/24

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K 345	Continued From page 4 survey entrance at approximately 9:12 AM, a request was made to the US FOIA (b)(6) [redacted] to provide all mandatory inspections that had been conducted from 01/01/2022 through 01/18/2024 for review later. The surveyor also requested the facility to provide a copy of the last smoke detectors sensitivity testing. Later that same day at approximately 12:05 PM, during the documentation review of the mandatory inspections of the facility's Fire Alarm and Detection system semi-annual (every 6 months) inspections for the previous 24 months identified the system had the following semi-annual fire alarm and detection system inspection reports, The surveyor reviewed the following Fire Alarm and Detection system semi-annual inspections that were provided. - 07/28/2022 and 07/29/2023 semi-annual inspections. This review of the testing reports revealed no reference to a smoke detection sensitivity testing. Later at approximately 12:35 PM, the surveyor asked the US FOIA (b)(6) and US FOIA (b)(6) if they can call the fire alarm and detection vendor and request to get copies of the last smoke detector sensitivity testing and any semi-annual fire alarm and detection system inspections that had been conducted between 07/28/2022 and 07/29/2023 and to provide them to the surveyor by day two of survey. On 01/22/2024 (day two of survey) at	K 345	by Regional Director of Environmental Services on 2-14-24 on the requirements of having the Fire alarm detection system inspected semi-annually (every six months) and the alarm sensitivity testingfor the every two year period. The maintenance director will be reviewing inspections to be completed every two weeks basistimes four weeks and then monthly times two months. ELement IV Administrator will ensure the fire alarm detection systems are inspected by a review quarterly at the Quality Assurance and Performance Improvement meetings. The life safety book will be reviewed by the maintenance director weekly and the administrator on a quarterly basis, to ensure that the fire alarm and detection system sensitivity test will be conducted as required by code as well as any ohter inspections due.	

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K 345	Continued From page 5 approximately 11:15 AM, the [redacted] told the surveyor that the smoke detector sensitivity testing and semi-annual fire alarm and detection system inspection between 07/28/2022 and 07/29/2023 had not been performed. The [redacted] confirmed the findings at the times of review and interview. The [redacted] was informed of the Life Safety Code deficiency on 01/22/2024 at approximately 12:35 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 353		2/14/24

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K 353	Continued From page 6 Based on observation and documentation review, the facility failed to ensure 1) Sprinkler gauges were calibrated or replaced every five years, and 2) conduct quarterly sprinkler inspection in accordance with NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems (2011 edition) sections 26.1. Findings include: On 01/18/2024 (day one of survey) during the survey entrance at approximately 9:12 AM, a request was made to the US FOIA (b)(6) [redacted] to provide all mandatory inspections that had been conducted from 01/01/2022 through 01/18/2024 for review later. Later on 01/18/2024 at approximately 12:05 PM, during the documentation review of the facility's mandatory inspections book was performed. The surveyor reviewed the facility's quarterly (every 3 months) fire sprinkler system system inspections for the previous 24 months identified the system had the following quarterly sprinkler system inspection reports: - 3/20/2022, 6/20/2022, 9/16/2022, - 1/12/2023, 4/27/2023, 7/31/2023 and 10/27/2023. At approximately 12:35 PM, the surveyor asked the US FOIA (b)(6) and US FOI[redacted] if they could provide and additional quarterly sprinkler system inspections for the year 2022 and to provide them to the surveyor on day two (2) of survey. On 01/22/2024 (day two of survey) at	K 353	K353 Sprinkler system Maintenance and testing ELement I Sprinkler quarterly inspections were up to date in 2023 and up to date in 2024. The director of maintenance contacted the facility fire vendor, to replace and to assess and inspect all sprinkler system gauges throughout the facility. The basement sprinkler gauges were inspected and replaced by the facility fire vendor on 2-14-24. All other gauges were in compliance. See attached K353 Sprinkler gauge replacement completed receipt. Element II All residents could have been affected by this practice. ELement III US FOIA (b)(6) was re-trained by the regional director of Environmental Services on the quarterly sprinkler system inspections and the five year expiration requirement of the sprinkler systems on 2-14-24. Maintenance Director or designee, will continue to follow quarterly sprinkler inspections as required. Element IV Sprinkler system quarterly inspections will be presented by the director of maintenance at the monthly Quality Assurancece and Performance Improvement committee meetings for a period of 90 days. Administrator will ensure sprinkler system quarterly	

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K 353	Continued From page 7 approximately 8:40 AM, the surveyor made a request to the [US FOIA] if they had any additional quarterly inspections for the sprinkler system. The [US FOIA] could not provide any quarterly inspections. The facility did not conduct a quarterly fire sprinkler system inspection between 09/16/2023 and 1/12/2023. The facility failed to conducted quarterly (every three months) sprinkler inspections for the year 2022 as required per NFPA 25. During the building tour on 01/22/2024 at approximately 9:55 AM an inspection in the basement of the sprinkler system control valves was performed. The surveyor observed that the gauges on the system had a manufacture date of 2016 with the year 2017 written on the clear plastic cover. There was no tag or sticker which indicated when the last time the sprinkler gauge was calibrated or replaced. The systems gauges were over 5 years old. The [US FOIA (b)(6)] confirmed the findings at the times of review and interview. The [US FOIA (b)(6)] was informed of the Life Safety Code deficiency on 01/22/2024 at approximately 12:35 PM. NJAC 8:39-31.2(e) NFPA 25	K 353	inspections are completed and that the results are reported at the time of the inspection and reviewed by the Quality Assurance and Improvment committee, quarterly.	
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed,	K 355		2/22/24

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K 355	Continued From page 8 inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation on 01/18/2024 and 01/22/2024 in the presence of facility management, it was determined that the facility failed to 1) perform an annual inspection for 6 of 39 portable fire extinguishers observed and inspected, and 2) install portable fire extinguishers with-in the required height for 2 of 39 fire extinguishers observed, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and there after at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected	K 355	K355 Portable Fire extinguishers Element I All fire extinguishers were inspected by the maintenance director on 1-25-24 to ensure the height requirement of five feet was met and all annual inspections were up to date. All fire extinguishers were found in compliance, meeting the height requirement and the annual inspection. The fire extinguishers not meeting the height requirements were re-adjusted to meet the 5 feet height requirement by the maintenance director on 1-25-24. Facility vendor NJ Ex Order 26.4b1 came to re-inspect the four spare extinguishers, the one in the boiler room and the one in the employee lounge on 1-22-24. Vendor NJ Ex Order 26.4b1 supervisor was contacted by the Regional Director of Environmental Services on 1-22-24, to make them aware that for no reason can extra tags be given to the facilities. Extra tags were destroyed by the Regional Director of Environmental Services on 1-22-24. Element II All residents have the potential to be affected by the deficient practicebeen affected by this practice. ELement III	

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K 355	Continued From page 9 to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Reference #2 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 6.1.3.8 Installation Height. - 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb shall be installed so that the top of type fire extinguisher is not more than 5 feet above the floor. - 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 inches. The findings include the following, On 01/18/2024 (day one of survey) during the survey entrance at approximately 9:12 AM, a request was made to the US FOIA (b)(6) [redacted] to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story (1) building and two (2) basements. . Starting at approximately 9:21 AM on 01/18/2024 and continued on 1/22/2024, in the presence of the facility's US FOIA (b)(6) and US FOIA [redacted] an inspection of the building was conducted. During the two (2) day tour of the facility the surveyor observed and inspected thirty-nine (39) portable fire extinguishers in various locations. The surveyor also observed that 33 fire	K 355	US FOIA (b)(6) was re-educated by the Regional Director of Environmental Services on 2-14-24, on the fire extinguisher regulation, annual fire extinguisher inspections and the 5 feet height requirements. A map of all fire extinguishers was made by the maintenance director showing the locations of all the fire extinguishers throughout the facility on 2-14-24. This will ensure the vendor, NJ Ex Order 26.4b1 [redacted] inspects all of the fire extinguishers in the building. The facility implemented a fire extinguisher audit log on 2-14-24 to be conducted monthly by the maintenance director or designee for a period of 90 days. This log will ensure theheight requirement and monthly fire extinguisher inspections are in compliance. Element IV Maintenance director will review the Fire extinguisher log audits at the Monthly Quality assurance and Performance Improvement meetings for 60 days or until regulatory compliance has been met. The facility Administrator will ensure the compliance of the Fire extinguisher audit logs for a period of 90 days. Administrator will also ensure annual inspections are conducted on an annual basis by reviewing the annual inspection checklist. Completino date; February 22, 2024	

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K 355	Continued From page 10 extinguishers had annual inspection tags attached to the extinguishers that identified they were annually inspected January 2024. The surveyor observed the following issues that were identified along the two (2) day tour: On 01/18/2024: 1) At approximately 9:26 AM, the surveyor observed in the basement maintenance area four (4) portable fire extinguishers on the floor. At this time the surveyor asked the [redacted] Are these spare fire extinguishers. The [redacted] said, yes they are. Further inspection identified on the tags attached to the extinguishers they were last annually inspected January 2023. When the surveyor pointed this out to the [redacted] the [redacted] told the surveyor that the fire extinguisher vendor had left 4 extra inspection tags dated January 2024. The [redacted] then opened a desk draw and showed the tags to the surveyor. 2) At approximately 9:41 AM, the surveyor observed in the basement elevator mechanical area one (1) ABC-Type fire extinguisher that was last annually inspected January 2023. 3) At approximately 9:50 AM, the surveyor observed one (1) ABC-Type fire extinguisher in the boiler room that appeared to be mounted too high. At this time the surveyor measured and recorded the fire extinguisher to be 5'-5" to the center of the pressure indicating needle gauge. 4) At approximately 11:10 AM, the surveyor observed one (1) ABC-Type fire extinguishers in the employee lounge room that was last annually inspected January 2023.	K 355		

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K 355	Continued From page 11 On 01/22/2024: 5) At approximately 11:00 AM, the surveyor observed one (1) ABC-Type fire extinguisher in the Physical Therapy room that appeared to be mounted too high. At this time the surveyor measured and recorded the fire extinguisher to be 5'-4" to the center of the pressure indicating needle gauge. The US FOIA (b)(6) confirmed the findings at the times of observations. The US FOIA (b)(6) was informed of the Life Safety Code deficiency on 01/22/2024 at approximately 12:35 PM. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided	K 363		3/28/24

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K 363	Continued From page 12 with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Repeat Deficiency from 11/10/2022 re-certification survey. Based on observation on 01/18/2024 and 01/22/2024, in the presence of facility management it was determined that the facility failed to ensure that 3 of 36 corridor doors inspected and tested, were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. The evidence includes the following, On 01/18/2024 (day one of survey) during the survey entrance at approximately 9:12 AM, a	K 363	K363 Corridor □ Doors Element I Maintenance Director conducted thorough inspections throughout the facility assessing all corridor doors on 1-25-24. All other corridor doors closed, latched into its frame, showed no signs of wear, did not have missing door knobs, veneers were in good condition, and not attached by screws. Results were documented on the fire and smoke door audit log. Director of maintenance contacted facility vendor, NJ Ex Order 26.4b1, to provide a quote and replace corridor doors in room NJ Ex O and NJ Ex Or Measurements were taken by vendor on 2-8-24. Corridor room doors NJ Ex O and NJ Ex O had the vendor NJ Ex Order 26.4b1	

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K 363	Continued From page 13 request was made to the US FOIA (b)(6) [redacted] to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story (1) building with 96 Resident sleeping rooms and two basements. Starting at approximately 9:21 AM on 01/18/2024 and continued on 1/22/2024, in the presence of the facility's US FOIA (b)(6) a tour of the building was conducted. During the two (2) day tour of the facility the surveyor performed closure tests of the thirty-six (36) doors in the corridors with the following results, On 1/22/2024: 1) At approximately 10:38 AM, during a closure test of Resident room NJ Ex O the door did not latch into its frame the door opened to an approximately 5 inch opening. This test was repeated two additional times with the same results. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 2) At approximately 10:46 AM, during a closure test of Resident room NJ Ex O the door sticks into its frame and will not latch. The surveyor also observed that the 1/4 inch veneer on the door was breaking apart and had screws to hold the door together. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire.	K 363	provided a measurement quote on February 8, 2024 and a depsoit was made for siad doors on 2/1/2024. The facility is waiting on the date of the manufacturer to create and deliver the said doors as they are being custom made. NJ Ex Order 26.4b1 has an estimated timeframe of six to eight weeks. Room NJ Ex O had a doorknob which was installed by the maintenance director on 1-25-24. Element II All residents could have been affected by this practice. ELement III US FOIA (b)(6) was re-trained by the Regional Director of Environmental Services on 2-14-24 on the importance of conducting the yearly fire door inspection log that was in place. Under this log, all fire doors were checked for compliance. Element IV All fire doors and smoke doors throughout the facility were inspected by the maintenance director on 2-14-24 for compliance and recorded on the facility fire and smoke inspection audit log. These inspections will continue to be completed on a monthly basis for 90 days and yearly thereafter. Facility fire and smoke door inspections will be presented by the maintenance director to the monthly Quality Assurance and Performance Improvement meeting for a period of 90 days. Completion date:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315104	A. BUILDING **01** B. WING _____	**01/24/2024**

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K 363	Continued From page 14 3) At approximately 11:53 AM, the surveyor observed that Resident room NJ Ex O fire rated corridor door had no evidence of a door knob. This left an approximately 2-1/2 inch hole through the door. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. The facility failed to follow their Plan of Correction for the 11/10/2022 survey which identified Resident rooms NJ Ex O, NJ Ex O and NJ Ex O corridor doors with a completion date of April 26, 2023. The US FOIA (b)(6) confirmed the findings at the times of observations. The US FOIA (b)(6) was informed of the Life Safety Code deficiency on 01/22/2024 at approximately 12:35 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	March 28, 2024	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of	K 374		2/22/24

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K 374	Continued From page 15 egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 01/18/2024 and 01/22/2024, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire and smoke protection. This deficient practice was identified for 1 of 5 sets of corridor smoke barrier doors tested and was evidenced by the following: Reference 1: Life Safety Code 101, 2012 Edition, - 8.5.4.1, Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the bottom of a new door shall be a maximum of 3/4 of an inch. On 01/18/2024 (day one of survey) during the survey entrance at approximately 9:12 AM, a request was made to the US FOIA (b)(6) [redacted]) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story (1) building that has five (5) smoke barrier walls to divide the building into six (6) smoke compartments and two (2) basements. .	K 374	K374 Subdivision of building spaces – smoke barriers ELement I All fire doors were inspected throughout the facility by the maintenance director on 1-25-24 to ensure all fire doors are in compliance with the clearance of a maximum of ¾ inch at the bottom of the fire door. All fire doors were found in compliance. Metal plates were installed on 1-25-24 at the bottom of the door by the maintenance director eliminating the 1 1/8 inch gap and meeting the regulation of a maximum of ¾ inch clearance. Element II All residents could have been affected by this practice. ELement III US FOIA (b)(6) was re-trained by the Regional Director of Enivronmental Services on 2-14-24, on the importance of following the yearly fire door inspection on the audit log that was in place. Under this log, all fire doors are checked for compliance yearly. Element IV All fire doors and smoke doors throughout the facility were inspected by the maintenance director on 2-14-24 for	

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K 374	Continued From page 16 Starting at approximately 9:21 AM on 01/18/2024 and continued on 1/22/2024, in the presence of the facility's US FOIA (b)(6) a tour of the building was conducted. During the two (2) day building tour the surveyor observed and tested five (5) sets of corridor double smoke doors with the following results, On 01/18/2024: 1) At approximately 10:54 AM, during a closure test of the double smoke doors leading into the "Kean Unit" and next to the Physical Therapy area, when the doors were release from the magnetic hold open device and allowed to self close into their frame. The surveyor observed and measure a 1-1/8 inch gap along the doors bottom edge. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The US FOIA (b)(6) confirmed the findings at the time of observations. The US FOIA (b)(6) was informed of the Life Safety Code deficiency on 01/22/2024 at approximately 12:35 PM. Life Safety Code 101, 2012 Edition. N.J.A.C. 8:39-31.1(c), 31.2(e)	K 374	compliance and recorded on the facility fire and smoke inspection audit log. These inspections will continue to be completed on a monthly basis for 90 days and yearly thereafter. Facility fire and smoke door inspections will be presented by the maintenance director to the monthly Quality Assurance and Performance Improvement committee meeting for a period of 90 days.The administrator will review all audit logs for completion with the maintenance director on a monthlly basis for completion and present to the Quality Assurance and Performance committee. Completion date; February 22, 2024	
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing	K 918		2/22/24

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K 918	Continued From page 17 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 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 interview and document review on 01/19/2024 and 01/22/2024, it was determined the facility failed to a.) Exercise the one (1) emergency generator for at least 30 minutes in 20- to 40-day intervals; and b.) Document the	K 918	K918 Electrical systems – Essential electrical systems Element I The generator load test is being	

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K 918	Continued From page 18 time needed by the generator to transfer power to the building was within the 10-second time frame, accordance National Fire Protection Association (NFPA) 99 and 110. Findings included: On 01/18/2024 (day one of survey) during the survey entrance at approximately 9:12 AM, a request was made to the US FOIA (b)(6) [redacted] if the facility had an emergency generator, what type of fuel and how often does the facility run the emergency generator. The [redacted] told the surveyor, "yes we have a Natural Gas Emergency Generator, we run it weekly and we run under a load monthly and keep a logbook." The surveyor asked the [redacted] to provide the logs for the last 12 months (January, February, March, April, May, June, July, August, September, October, November and December 2023) for review later. Later at approximately 12:15 PM, a review of the "Emergency Generator Monthly Log" for the previous 12 months identified the following documented monthly load dates, 01/30/2023, Transfer Time to Emergency Power: 3 seconds. 02/28/2023, Transfer Time to Emergency Power: 3 seconds. 03/27/2023, Transfer Time to Emergency Power: 3 seconds. 04/24/2023, Transfer Time to Emergency Power: 3 seconds. 05/29/2023, Transfer Time to Emergency Power:	K 918	conducted by the maintenance director and meeting the requirements to exercise it every 20 to 40 days under load for 30 minutes. Element II All residents could have been affected by this practice. Element III Regional Direct of Environmental Services re-trained facility US FOIA (b)(6) on 2-14-24 on the proper procedures to conduct a load test every 20 to 40 days under load for 30 minutes and to document the results on the generator audit log on a monthly basis. Element IV The generator load test audit log will be presented by the maintenance director in the monthly Quality Assurance and Performance Improvement committee meetings for a period of 90 days. The Administrator will ensure the generator load test audit log is being completed every 20 to 40 days for a period of 90 days and presents the findings at the monthly Quality Assurance and Performance Improvement committee on a monthly basis Completion Date: February 22, 2024	

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K 918	Continued From page 19 3 seconds. 06/26/2023, Transfer Time to Emergency Power: 3 seconds. 07/31/2023, Transfer Time to Emergency Power: 3 seconds. 08/28/2023, Transfer Time to Emergency Power: 3 seconds. 09/13/2023, Transfer Time to Emergency Power: 3 seconds. 10/30/2023, Transfer Time to Emergency Power: 3 seconds. 11/27/2023, Transfer Time to Emergency Power: 3 seconds. There was no document December 2023 monthly load test. On 01/22/2024 at approximately 11:30 AM, the surveyor made a request to the US FOIA if he could provide any additional emergency generator monthly log for December 2023 and January 2024. The US FOIA could not provide any monthly load test for December 2023 and January 2024. There was no documented certification that the generator would start and transfer power to the building within ten seconds, since no load tests were conducted every 20 to 40 days under load for 30 minutes for December 2023 and January 2024. The US FOIA (b)(6) confirmed the finding at the time of observation. The US FOIA (b)(6) was informed of the Life Safety Code deficiency on 01/22/2024 at approximately 12:35 PM. NFPA 110. NJAC 8:39-31.2(g)	K 918		

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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
315104 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	4/2/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNELL HALL CARE & REHABILITATION CENTER	234 CHESTNUT STREET UNION, NJ 07083

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0321	02/22/2024	LSC	K0345	02/15/2024	LSC	K0353	02/14/2024
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0355	02/22/2024	LSC	K0363	03/28/2024	LSC	K0374	02/22/2024
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0918	02/22/2024	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

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	
1/24/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO