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	315091	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE CRANFORD, NJ 07016**

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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 Survey Date: 8/04/22 Census: 187 Sample: 35 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 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult	F 578		9/3/22

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

Electronically Signed | 08/24/2022

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F 578	Continued From page 1 residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on the interview, and review of medical and facility policy, it was determined that the facility failed to provide information in a manner easily understood by the resident or resident representative about the right to formulate an Advanced Directive (AD). This deficient practice was identified in 1 of 3 residents reviewed for AD (Resident #150) and evidenced by the following: During an interview of the surveyor on 7/15/22 at 11:11 AM, Resident #150 stated that he/she does not recall if staff offered them AD information. The surveyor reviewed the electronic Medical	F 578	The Medical Doctor reviewed the Advanced Directive wishes with Resident #150 and resident's daughter on June 8, 2022. Resident #150 remains Full Code Status per resident request. All residents have the potential to be affected. All residents were reassessed for Advanced Directives. Those Residents without Advanced Directives or their representatives were offered the opportunity to formulate Advanced Directives.	

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F 578	Continued From page 2 Record (eMR) for Resident #150. The resident's Admission Record (face sheet; an admission summary) indicated that the resident was admitted to the facility and had diagnoses that included but were not limited to; [redacted], unspecified *Ex Order 26. 4B1* [redacted]. The Admission Minimum Data Set (MDS), an assessment tool used for management of care dated 6/20/2022 revealed that Resident #150 had a Brief Interview for Mental Status (BIMS) score of [redacted] of 15, indicating *Ex Order 26. 4B1* [redacted] A social worker's (SW) Social History and Initial Assessment signed 6/12/2022 for Resident #150 indicated the resident did not have an AD and no AD information was given to the resident. A SW note dated [redacted] reflects the SW met with the resident for the initial assessment. The SW note revealed that the resident was admitted for short term rehab and that the resident appeared to be alert but very difficult to understand due to their [redacted] In addition, the 6/8/22 SW note indicated that the SW spoke with the family representative (FR) to complete the assessment and that a scheduled care conference for Friday at 11:30 to discuss projected plans. Further review of Resident #150's medical record	F 578	Education: Social Services Director and Social Workers were educated regarding Advanced Directives by Regional Nurse. System Change: Information regarding Advanced Directives will be included in the Admission Information Packet. The Social Worker and Physician will follow up with the Resident or their representative during their initial assessment. All new Advanced Directives will be reviewed at morning meeting. Monitor: The corrective actions will be monitored by the Social Services Director or designee with utilization of an Advanced Directive Audit. 5 Residents will be audited weekly for twelve weeks. The Social Services Director will report the audit results at the Quarterly QAPI Committee Meeting. The QAPI Committee reviews, evaluates and makes recommendations to sustain compliance.	

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F 578	Continued From page 3 showed that there was no document evidencing that an AD was offered and the resident or their representative was provided information on formulating an AD. On 7/19/22 at 10:13 AM, the SW for Resident #150 stated [redacted] came into the facility it was difficult to understand the resident with the *Ex Order 26. 4B1*. Furthermore, the SW confirmed that she did not offer the FR information on AD. NJAC 8:39-9.6(e)	F 578		
F 637 SS=E	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that a significant change assessment was completed for Residents #66 and #140 for a total of two quarters. This deficient practice was identified for 2 of 2 residents reviewed, and was evidenced by the following:	F 637	Resident #66 and Resident #140 had new Significant Change MDS completed to accurately capture current status of resident. All residents have the potential to be affected by the deficient practice. All Quarterly/Annual MDS completed in July	9/3/22

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F 637	Continued From page 4 1. On 7/12/22 at 10:42 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM). The LPN/UM informed the surveyor that Resident#66 was *Ex Order 26. 4B1* [redacted]. On that same date at 11:00 AM, the surveyor observed the resident standing in the nursing station with the LPN/UM. The resident was not able to respond appropriately to the surveyor's questions. Later on, the Certified Nursing Aide (CNA) came and accompanied the resident to be toileted by hand-held assistance while walking. The surveyor reviewed the medical records of Resident #66: The resident's Admission Record (admission summary) disclosed that the resident had diagnoses which included, but were not limited to, *Ex Order 26. 4B1* [redacted] *Ex Order 26. 4B1* [redacted] and *Ex Order 26. 4B1* [redacted]. The Comprehensive Minimum Data Set (CMDS) dated 10/29/21, an assessment tool used to facilitate the management of care, indicated cognitive skills for daily decision-making were *Ex Order 26. 4B1* [redacted] Section E Behavior of the CMDS showed that the resident was noted with physical behavioral symptoms directed toward others score of one which indicated that behavior	F 637	and August were audited for possible missed Significant Change Assessments. Education: MDS Coordinator was educated regarding Significant Change Assessments per the RAI Manual by the MDS Director. System Change: During MDS Completion Process, the MDS Coordinator will identify via validation tab if one or more changes are apparent, if so the Interdisciplinary Team will decide if a Significant Change Assessment is warranted. If a Significant Change Assessment is warranted, a Significant Change MDS will be completed. A MDS Note will be created under the progress notes tab to indicate the decision that was made and the reason why such decision was made. MDS Coordinator(s) will continue to identify for any possible Significant changes in condition via morning meeting, family meetings, daily report, observations and interviews. Monitor: The MDS Director or designee will utilize a significant change audit tool. Five residents will be Audited weekly for 12 weeks. The MDS Director will report the results of the audits at the Quarterly QAPI Committee meeting. The QAPI Committee reviews, evaluates and makes	

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F 637	Continued From page 5 of this type occurred one to three days. Section G Functional Status of the CMDS revealed that the resident's bed mobility and transfer were coded 3/3 *Ex Order 26. 4B1* [redacted] eating 4/2 *Ex Order 26. 4B1* [redacted], and toileting 4/3 *Ex Order 26. 4B1* [redacted] The 01/28/2 Quarterly MDS (QMDS), indicated there were no changes in cognitive skills for daily decision-making. Section E Behavior of the 01/28/22 QMDS showed that the resident was noted with *Ex Order 26. 4B1* [redacted] Section G of the QMDS revealed that the resident's bed mobility and transfer were coded 2/2 *Ex Order 26. 4B1* [redacted] eating 2/2, and toileting 3/2 *Ex Order 26. 4B1* [redacted] The 4/25/22 QMDS, indicated there were no changes in cognitive skills for daily decision-making. Section E Behavior of the 4/25/22 QMDS showed that the resident was noted with other *Ex Order 26. 4B1* [redacted] not directed toward others and a *Ex Order 26. 4B1* [redacted] both scores of two which indicated that behavior of this type occurred 4 to 6 days but less than daily. Section G of the QMDS revealed that the resident's bed mobility and transfer were coded 2/2, eating 2/2, and toileting 3/2. Further review of the MDS revealed that there was no Significant Change (SC) MDSs completed when the resident was noted with a significant improvement in functional status and worsening	F 637	recommendations to sustain compliance.	

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F 637	Continued From page 6 of behavior on both QMDS dated 01/28/22 and 4/25/22. The personalized care plan focused on psychotropic medications related to behavior management initiated on 12/02/21 and revised on 6/7/22. The care plan interventions date initiated on 12/02/21 and revised on 6/7/22 included [redacted] The Occupational Therapy (OT) Discharge Summary dated 11/24/21 showed that the resident was discharged (d/c) from Skilled OT and met the goal for maximum assistance for toileting. The Physical Therapy (PT) Discharge Summary dated 11/24/21 revealed that the resident was d/c from Skilled PT and met the goal for the following: Bed mobility=stand by assist [redacted] Transfer=contact guard assist (CGA) [redacted] According to the Therapy Screening Form (TSF) dated 01/26/22 for a Quarterly status revealed a comment that the resident was a minimum assist for safety with self-care and was supervision for transfers.	F 637		

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F 637	Continued From page 7	F 637		

The TSF dated 4/25/22 for a Quarterly status showed a comment that the resident was a minimum assist for safety with self-care and supervision for transfers.

On 7/15/22 at 9:08 AM, the surveyor interviewed the MDS Coordinator/Registered Nurse (MDSC/RN) in the presence of the survey team. The MDSC/RN informed the surveyor that the facility had no specific policy concerning SC MDS and "we follow the RAI (Resident Assessment Instrument) manual." The MDSC/RN stated that if there were two or more areas of a change within adls and a change in mood or behavior of the resident, "we discuss it as a team," and a significant change assessment will be done.

On that same date and time, the surveyor notified the MDSC/RN of the above concerns. The MDSC/RN stated that there were two opportunities that a SC should have been done on 01/28/22 and 4/25/22 where there were more than two areas of improvement with adls and the other one was worsening of behavior, and "it was missed." She further stated that it was the part-time MDS nurse (PT/MDSN) who did the MDS on the above-mentioned MDS on 01/28/22 and 4/25/22.

On 7/18/22 at 11:38 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and was made aware of the above concerns.

On 7/19/22 at 02:22 PM, the surveyors met with the LNHA, Director of Nursing (DON), and the Regional Director of Clinical Services/Registered Nurse (RDCS/RN). The DON stated that SC should have been initiated for residents with

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F 637	Continued From page 8 improvements in ADL (activities of daily living) and worsening mood and behavior. On 7/21/22 at 9:44 AM, the surveyor interviewed the PT/MDSN via phone conference. The PT/MDSN informed the surveyor that the SC was "missed." He further stated "I do agree" that a SC should have been done on two opportunities on two quarterlies on 01/28/22 and 4/25/22. 2. On 7/12/22 at 10:55 am, the surveyor observed Resident #140 lying in bed, awake, alert, and appropriately responded to the surveyor. The resident stated that he/she needed help from staff for care. A review of Resident #140's medical record reflected the following: The resident's Admission Record reflected that Resident #140 had diagnoses that included but were not limited to *Ex Order 26. 4B1* [redacted] *Ex Order 26. 4B1* [redacted] The QMDS with an ARD of 3/9/22 reflected that Resident #140 had a brief interview for mental status (BIMS) score of [redacted] which indicated that the resident had an *Ex Order 26. 4B1*. Section G Functional Status of the QMDS revealed that the resident's bed mobility and transfer were coded 3/3, toilet use 3/2 *Ex Order 26. 4B1* [redacted] and eating 1/1 *Ex Order 26. 4B1*	F 637		

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F 637	Continued From page 9 *Ex Order 26. 4B1* [redacted]. The QMDS also reflected that the resident had a mood interview (PHQ-9©) that reflected Symptom presence of *Ex Order 26. 4B1* [redacted] or *Ex Order 26. 4B1* [redacted] with a Symptom Frequency of 1 *Ex Order 26. 4B1* [redacted], and the resident had 0 *Ex Order 26. 4B1* [redacted] for verbal behavioral symptoms directed toward others. A review of the QMDS with an ARD of 6/9/22 reflected that Resident #140's cognition was the same. In comparison with March 2022 QMDS, there was an improvement in the resident's functional status and now the resident required 2/2 in bed mobility, transfer, and toilet use *Ex Order 26. 4B1* [redacted] and eating 0/1 *Ex Order 26. 4B1* [redacted] Furthermore, there was a decline in mood which reflected that the resident's symptom frequency for *Ex Order 26. 4B1* [redacted] or *Ex Order 26. 4B1* [redacted] was now 2 *Ex Order 26. 4B1* [redacted] There was also a decline in resident's behavior which reflected that the resident's verbal behavior symptoms toward others was now 1 *Ex Order 26. 4B1* [redacted] There was no documented evidence that an SCSA (Significant Change in Status Assessment) was initiated when a significant improvement in functional status and decline in mood and behavior were identified on the June 2022 QMDS. On 7/19/22 at 12:35 PM, MDSC/RN informed the surveyor that SCSA should be done if there were at least two areas of either improvement or decline in ADLs and decline in mood and behavior. The surveyor informed her of the above concerns. The MDSC/RN stated that she will	F 637		

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F 637	Continued From page 10 verify whether SCSA was missed or if there were MDS coding inaccuracies on the 6/9/22 QMDS assessments. On 7/19/22 at 02:22 PM, the survey team met with the LNHA, the RDCS/RN, and the DON. The DON stated that SCSA should have been initiated for residents with improvements in ADLs and worsening mood and behavior. In a follow-up interview with MDSC/RN on 7/20/22 at 8:51 AM, she acknowledged that the coding in 6/9/22 QMDS assessments were accurate and that SCSA should have been done and stated, that it was "missed." On 7/21/22 at 9:52 AM the surveyor interviewed PT/MDSN via telephone. He acknowledged that SCSA should have been done on 6/9/22 MDS assessments and stated, "I should have done a significant change." According to the RAI Manual Version 3.0 of CMS (Centers for Medicare & Medicaid Services) guidelines, updated October 2019, page 2-23 reflected that "An SCSA is appropriate when: - There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; ..." It was also indicated on page 2-25 that an SCSA is appropriate "if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of ADL decline or improvement)." It reflected that	F 637		

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F 637	Continued From page 11 "Decline in two or more of the following: ... - Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-9©), e.g., increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (Behavior); ..." While on page 2-26, it reflected that SCSA MDS is required if there is an "Improvement in two or more of the following: - Any improvement in an ADL physical functioning area (at least 1) where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment and does not reflect normal fluctuations in that individual's functioning;.." On 7/25/22 at 12:45 PM, the survey team met with the administrative team. There was no additional information provided.	F 637		
F 641 SS=D	NJAC 8:39-11.1 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: Based on observation, interview, and record review, it was determined that the facility failed to accurately assess a resident's status in the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care. This deficient practice was identified for 3 of 35 residents reviewed (Resident #66, #149, and #167) as evidenced by the following:	F 641	Residents #66, #149, and #167 were reassessed and MDS corrections were submitted to CMS. All residents have the potential to be affected by the deficient practice.	9/3/22

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F 641	Continued From page 12 1. On 7/12/22 at 10:42 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM). The LPN/UM informed the surveyor that Resident#66 was Ex Order 26. 4B1 and a Ex Order 26. 4B1 On that same date at 11:00 AM, the surveyor observed the resident standing in the nursing station with the LPN/UM. The resident was not able to respond appropriately to the surveyor's questions. During the observation the surveyor could not observe a Ex Order 26. 4B1 on the resident. The surveyor reviewed the medical records of Resident #66: The resident's Admission Record (admission summary) disclosed that the resident had diagnoses which included, but were not limited to, Ex Order 26. 4B1 Ex Order 26. 4B1 in other diseases classified elsewhere with behavioral disturbance Ex Order 26. 4B1 The Order Summary Report showed that there was an order dated 12/6/21 for Ex Order 26. 4B1 The above order for Ex Order 26. 4B1 was transcribed to the electronic Treatment Record	F 641	Most recent MDS of all residents with Wanderguards in place were audited for accuracy of MDS coding. Most recent MDS of all residents with falls in May 2022, June 2022 and July 2022 were audited for accuracy. Education: MDS Coordinators were educated regarding accurate assessment of resident status in the MDS by the MDS Director. System Change: MDS Coordinator will physically assess resident for WanderGuard placement prior to MDS completion. MDS Coordinator will cross-check all coding for falls prior to submitting completed MDS. Monitoring: MDS Director or designee will utilize a MDS Audit tool for Sections J and Section P. Five Audits will be completed weekly for twelve weeks. The MDS Director will report at the Quarterly QAPI Committee Meeting. The QAPI Committee reviews, evaluates and makes recommendations to sustain compliance.	

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F 641	Continued From page 13 (eTAR) and signed by nurses every shift from December 2021 through July 2022. The Comprehensive Minimum Data Set (CMDS) dated 10/29/21, indicated cognitive skills for daily decision-making were *Ex Order 26. 4B1* . Section P: Restraints and Alarms of 10/29/21 CMDS revealed that it was coded as 0 which means that there was no restraint or alarms used for the resident. The 01/28/2 and 4/25/222 Quarterly MDS (QMDS), indicated there were no changes in cognitive skills for daily decision-making. Section P was coded 0. Further review of the MDS revealed that the *Ex Order 26. 4B1* used for the resident was not coded in the MDS. On 7/15/22 at 11:18 AM, the surveyor observed the resident walking in the rotunda (is a round building or room) with handheld assistance from the Certified Nursing Aide (CNA). The surveyor asked the LPN/UM while approaching the resident and the CNA to check if the resident had a *Ex Order 26. 4B1* in use. Then, the LPN/UM showed the resident's left ankle with a *Ex Order 26. 4B1* Afterward, the surveyor and the LPN/UM went to wing one nursing station. The surveyor asked the LPN/UM why the order in the eTAR was to check the *Ex Order 26. 4B1* on the *Ex Order 26. 4B1* when the *Ex Order 26. 4B1* at that time was on the *Ex Order 26. 4B1* The LPN/UM stated that the *Ex Order 26. 4B1* was probably loose and had to change it to the *Ex Order 26. 4B1* and forgot to change the order.	F 641		

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F 641	Continued From page 14 On 7/18/22 at 11:38 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and was made aware of the above concerns. On 7/18/22 at 12:11 PM, the surveyor informed the MDS Coordinator/Registered Nurse (MDSC/RN) regarding the above concern with the wander guard. The MDSC/RN stated that the wander guard was not coded on the MDS and it should have been coded for accuracy. On 7/19/22 at 02:22 PM, the surveyors met with the LNHA, Director of Nursing (DON), and the Regional Director of Clinical Services/Registered Nurse (RDCS/RN). The facility team both acknowledged that there was a concern with MDS accuracy for not capturing the wander guard alarms in all MDS and the DON stated that it should have been documented. On 7/21/22 at 9:44 AM, the surveyor interviewed the PT/MDSN via phone call. The PT/MDSN informed the surveyor that the coding for the wander guard was "missed." He further stated that the wander alarm should have been coded in the MDS. 2. On 7/13/22 at 11:40 AM, Resident #149 was observed in the activities area of the facility sitting in a wheelchair. During the observation the surveyor could not observe a *Ex Order 26. 4B1* on the resident. On 7/13/22 at 11:50 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) regarding a *Ex Order 26. 4B1*. The LPN said, "let's go see if one is on, we check for placement". The LPN checked the medication administration	F 641		

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F 641	Continued From page 15 record in the presence of the surveyor which said the resident should have a Ex Order 26. 4B1 on the right ankle. The LPN approached Resident #149, identified the resident, and checked the [redacted] where there was a Ex Order 26. 4B1 in place. The surveyor reviewed Resident #149's Admission Record from the electronic medical record which indicated the resident admitted to the facility with diagnoses included, but not limited to Ex Order 26. 4B1 [redacted] The most recent QMDS dated 6/13/22 showed that Resident #149 had a Brief Interview of Mental Status (BIMS) score of [redacted], meaning the resident had Ex Order 26. 4B1. The QMDS, Section P, titled Restraints and Alarms indicated that Ex Order 26. 4B1 was coded 0. On 7/14/22 at 12:36 PM, the surveyor reviewed the physician orders, which showed an active order that was initially ordered on 3/17/22 for checking Ex Order 26. 4B1 placement to the right ankle. On 7/14/22 at 01:00 PM, the surveyor reviewed the June and July 2022 eTAR, which showed that the staff were signing that placement of the Ex Order 26. 4B1 was checked every shift. On 7/14/22 at 01:15 PM, the surveyor reviewed Resident #149's care plan which included a focus for Ex Order 26. 4B1 which included Ex Order 26. 4B1 placement, education and follow Ex Order 26. 4B1 guidelines.	F 641		

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F 641	Continued From page 16	F 641		

On 7/19/22 at 02:22 PM, the surveyors met with the LNHA, the RDCS/RN, and the DON for responses. Both the LNHA and DON acknowledged that there was a concern with MDS accuracy for not capturing the wander guard alarms in all MDS and the DON stated that it should have been documented.

3. On 7/14/22 at 10:00 AM, the surveyor observed Resident #167 in the atrium sitting in their wheelchair listening to music.

The surveyor reviewed the medical records for the resident.

The Admission Record which reflected Resident # 167 was admitted to the facility with diagnoses which included but were not limited to: *Ex Order 26. 4B1* [redacted] and *Ex Order 26. 4B1* [redacted]

The Electronic Medical Record (EMR) in the Risk Management Assessment dated 5/04/21 at 11:00 PM, reflected that Resident #167 had a [redacted] with minor injury.

According to the QMDS dated 6/21/22 revealed that Resident's #167 cognitive skills for daily decision making were *Ex Order 26. 4B1* [redacted]. Further review of the resident's MDS, Section - J1800 - "Any falls since Admission/Entry or Reentry or Prior Assessment (OBRA or

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F 641	Continued From page 17 Scheduled PPS), whichever is more recent", indicated that that Resident #167 had two [redacted] during the assessment review period. This MDS was not accurately coded to reflect one [redacted] with minor injury. On 7/20/22 at 12:02 PM, the surveyor interviewed the MDSC/RN. The MDSC/RN stated that she "does not check for accuracy of my MDS Coordinator." Then the surveyor asked the MDSC/RN what was her process for doing MDS, the MDSC/RN stated, "For quarterly, we open the record and based on the section we are entering, we do a look back for [redacted] in the Risk Manager, interview staff and family, check the actual chart and different areas in the EMR, then, we document our findings based on all those factors." During an interview, the MDSC/RN acknowledged that the quarterly MDS was inaccurately coded for falls. NJAC 8:39-11.2(e)1; 27.1(a), 33.2(d)	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, it was determined that the facility failed to clarify a physician order for 1 of 3 residents (Resident #63) reviewed for code status according to professional standards of clinical practice.	F 658	Resident #63's code status was immediately verified with residents daughter who is the power of attorney for the resident and clarified by the physician. Residents chart and careplan were updated to reflect correct code status.	9/3/22

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F 658	Continued From page 18 The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, 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." On 7/12/22 at 11:02 AM, the surveyor observed Resident #63 sitting in a wheelchair at a table with other residents in a small area across from the nurse's station. Resident #63 was awake, alert, and speaking in another language to other residents. Resident #63 was unable to answer any questions from the surveyor.	F 658	All residents have the potential to be affected by the same deficient practice. Education: All nursing staff was immediately in-serviced by the facility educator upon receipt of the code status order to verify if there is previous order that needs to be discontinued. System Change: A system was initiated that when 11-7 supervisor does a 24-hour chart check, she will verify if code status is correct and update for any new orders. All new orders will be reviewed at the morning meeting by the unit managers and care plans will be updated/implemented immediately at the morning meeting. Monitoring: The ADON or designee will utilize a code status audit tool. To check for accuracy. Random audits of 6 Residents will be completed each week for twelve weeks. THE DON will present the Audit Results at the Quarterly QAPI Meeting. The QAPI Committee reviews, evaluates and makes recommendations to sustain compliance.	

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F 658	Continued From page 19 The surveyor reviewed Resident #63's electronic Medical Record (eMR). The Admission Record (admission summary) showed that the resident had a diagnosis that included, but was not limited to, *Ex Order 26. 4B1* [redacted] The quarterly Minimum Data Set (MDS), an assessment tool used for management of care, dated 6/30/22 indicated Resident #63's cognition was *Ex Order 26. 4B1* . A review of the current Order Summary Report (OSR) indicated a physician order (PO) on 12/28/2017 for Full code (Full code means that if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive), and another physician order dated 4/14/2022 for DNR (Do not Resuscitate-indicating that a person should not receive cardiopulmonary resuscitation if that person's heart stops beating), and DNI (Do Not Intubate-meaning no breathing tube would be placed). The Nurses Notes dated 4/14/2022 at 4:22 PM indicated a hospice nurse visited Resident #63 and a new POLST (Physician Orders for Life Sustaining Treatment) of DNR, DNI was placed. During an interview with the surveyor on 7/14/22 at 12:58 PM, Resident #63's assigned LPN (Licensed Practical Nurse), stated that a	F 658		

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F 658	Continued From page 20 resident's code status was documented in a resident's paper chart and a resident's eMR. The surveyor asked the LPN to show the surveyor where the code status was documented in the eMR for Resident #63. Then, the LPN showed and stated that the resident was Full Code as documented below Resident #63's photo in the eMR. On that same date and time, the surveyor asked the LPN to review Resident #63's PO. The LPN stated that Resident #63 had two PO for code status. The LPN stated that one PO dated 12/28/2017 indicated the resident was a Full code, and another PO dated 4/14/2022 indicated DNR/DNI. The LPN stated that the two PO for code status should have been clarified and corrected. The LPN also added that he/she had entered the PO of DNR/DNI on 4/14/22 in Resident #63's eMR. The LPN stated that he/she should have discontinued the 12/28/2017 Full Code PO after entering the DNR/DNI PO on 4/14/2022. During an interview with the surveyor on 7/15/22 at 9:42 AM, the facility's Social Worker (SW) stated that each resident's code status is documented in their eMR below the resident's photo on the profile screen. The SW stated that if there is a change in the code status, then the nurses would have to enter the change in the resident's eMR. The SW stated that nursing is responsible to update a resident's code status in the eMR and a resident's paper chart. The SW added that the facility team would be informed of any resident code status changes during morning clinical meetings. During an interview with the surveyor on 7/15/22	F 658		

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F 658	Continued From page 21 at 9:50 AM, the Regional Nurse stated that a resident's code status is in the PO and would populate on top of the dashboard below a resident's photo in their eMR. The Regional Nurse added that each resident's code status was reviewed during the 24-hour clinical meetings. On 7/19/22 at 02:24 PM, with the survey team in attendance, the DON (Director of Nursing) stated that there were two physician orders for code status for Resident #63. One PO for full code, and a second order for DNR/DNI. The DON stated that the nurse that put in the DNR/DNI order did not discontinue the previous order of Full Code. The DON stated that the nurse should have discontinued the previous Full Code order after entering the DNR/DNI physician order. NJAC 8:39-35.2 (d)6 N.J.A.C 8:39-27.1(a)	F 658		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility 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	F 688		9/3/22

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F 688	Continued From page 22 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 follow a physician's order (PO) for a Ex Order 26. 4B1 This deficient practice was identified for 1 of 3 residents (Resident #73) reviewed for limited range of motion (ROM). This deficient practice was evidenced by the following: On 7/12/22 at 11:30 AM, the surveyor observed the resident awake, dressed, and seated in a wheelchair in the rotunda area. The resident's Ex Order 26. 4B1 was observed contracted with no device in use. The resident was alert, and able to answer questions appropriately. Later that same day at 01:00 PM, the surveyor observed the resident out of bed seated in a wheelchair in their room with no device in use. On 7/13/22 at 11:50 PM, the surveyor observed the resident awake, out of bed and seated in a wheelchair. The resident was self-propelling back to their room. There was no Ex Order 26. 4B1 in use. At that same time, the surveyor interviewed the resident's assigned Certified Nursing Assistant (CNA) who stated that Resident #73 was able to make their needs known, and required extensive assistance of one person with activities of daily living (ADLs). The CNA could not speak to any	F 688	Resident # 73's Ex Order 26. 4B1 was placed immediately on the resident□s Ex Order 26. 4B1 as per the physician□s order All residents with splints have the potential to be affected by the same deficient practice. Education: All nursing staff was immediately in-serviced to follow splints orders as per physician orders by the Facility Educator. System Change: A system was initiated that Unit Manager or Designee will check on Residents with Splints to make sure they have their splints on as per order as part of their daily unit rounds and update for any new orders. All new splints orders will be reviewed at the morning meeting by the unit managers and care plans will be updated/implemented immediately at the morning meeting. Monitoring: The ADON or designee will utilize a splints audit tool. A random audit of 6 Residents will be audited each week. for 12 weeks.	

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F 688	Continued From page 23 devices or orthotics the resident wore. Later that same day at 01:15 PM, the surveyor observed the resident in his/her room with no device in use. On 7/18/22 at 10:49 AM, the surveyor observed the resident awake, out of bed seated in a wheelchair working on a word puzzle at a table in the main rotunda area. There was no *Ex Order 26. 4B1* [redacted] in use. On 7/18/22 at 12:40 PM, the surveyor observed the resident awake out of bed seated in a wheelchair with no *Ex Order 26. 4B1* [redacted] in use. On 7/19/22 at 12:20 PM, the surveyor observed the resident out of bed seated in a wheelchair with no *Ex Order 26. 4B1* [redacted] in use. The surveyor interviewed the resident who stated, "no body wants to be bothered. I haven't worn the [redacted] in three weeks." On that same date at 12:22 PM, the surveyor interviewed the resident's assigned Licensed Practical Nurse (LPN) who stated that he works per diem but was facility hired. He further stated, "its late. I didn't see the order." He acknowledged that it was the nurse's responsibility to make sure the *Ex Order 26. 4B1* [redacted] was applied according to the PO. He couldn't speak to why the resident hasn't been wearing his/her *Ex Order 26. 4B1* [redacted]. On 7/19/22 at 12:34 PM, the surveyor interviewed the Director of Rehab (DOR) who stated that the nurses are responsible for applying the [redacted]. The DOR could not speak to why the [redacted] has not been applied by nursing and stated that the resident will be "re-evaluated."	F 688	Results of these audits will be reported by the DON to the quarterly Quality Control Committee. The QAPI Committee reviews, evaluates and makes recommendations to sustain compliance.	

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F 688	Continued From page 24 The surveyor reviewed the medical record for Resident #73. The resident's Admission Record reflected that the resident had diagnoses which included but were not limited to Ex Order 26. 4B1 and Ex Order 26. 4B1 following Ex Order 26. 4B1 not elsewhere classified, multiple sites. The resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 6/28/22, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of Ex.Order out of 15 which indicated Ex Order 26. 4B1. Further review of the MDS reflected that the resident had no behaviors for section E for Behavior, section G for Functional Status reflected that the resident required Ex Order 26. 4B1 with one person for bed mobility, transfers, dressing, toileting, personal hygiene, and bathing and section O for Special Treatment, Procedures, and Programs reflected that Ex Order 26. 4B1 was not checked. A review of the electronic Order Summary Report (OSR) reflected a PO dated 7/20/20, to "Don [put on] Ex Order 26. 4B1 with Ex Order 26. 4B1; keep Ex Order 26. on for four hours (or more if tolerated), on after AM [morning] care and off before 3:00 PM with Ex Order 26. 4B1 performed. One time a day and remove per schedule." The July 2022 electronic Treatment	F 688		

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	315091	A. BUILDING _____ B. WING _____	08/04/2022

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F 688	Continued From page 25 Administration Record (eTAR) reflected the above corresponding PO. Further review of the eTAR indicated that the Ex Order 26. 4B1 was plotted to be applied at 10:00 AM and remove at 1359 [1:59 PM]. The eTAR further indicated that the nurses signed as applied for each day. According to the resident's Care Plan (CP) date initiated 3/22/22, reflected a focus area that the resident has Ex Order 26. 4B1 to prevent further Ex Order 26. 4B1. The goal of the resident's CP was that the resident will not have any [redacted] by the review date of 9/21/22. The interventions for the resident's CP indicated 'Ex Order 26. 4B1 to be placed as per dr order." Further review of the resident's CP did not reflect that the resident refused to wear or removed the Ex Order 26. 4B1. Review of the electronic Progress Notes from April 2022 through July 2022 did not reflect documentation that the resident refused to wear or removed the Ex Order 26. 4B1. The Occupational Therapy (OT) Discharge Summary dated 5/5/22, reflected "patient will safely wear least restrictive Ex Order 26. 4B1 4 hrs [hours] on/4 hrs [hours] off without Ex Order 26. 4B1 and Ex Order 26. 4B1 in order to reduce pain caused by Ex Order 26. 4B1 .. Ex Order 26. 4B1 ...excellent with consistent staff support ...discharge recommendations: Ex Order 26. 4B1 [redacted] The OT Evaluation and Plan of Treatment dated 7/19/22, reflected that the resident is able to tolerate the Ex Order 26. 4B1 for four hours without complaints of Ex Order 26. 4B1 and the resident would benefit from skilled OT services for further	F 688		

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F 688	Continued From page 26 assessment of [redacted] and potential of more hours of tolerance of [redacted] to prevent [redacted] and [redacted]. On 7/21/22 at 11:46 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the resident puts the [redacted] on him/herself. The DON could not speak to why the PO reflected to "Don [put on] [redacted] with maxA [redacted]." The DON did not provide additional information. On 7/21/22 at 12:45 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON and discussed the above observations and concerns. There was no additional information provided. Review of the facility's Splinting policy revised 7/1/22, provided by the LNHA included that Certified Nursing Assistants (CNAs) may apply splints under the supervision of the nursing department, a physician's order will be obtained for the use of a splint, an assessment and treatment plan must be completed by OT prior to referral to nursing for splint management, the nurse is responsible for splint application and will document and initial on the TAR/eTAR each time [redacted] is applied and removed. A review of the facility's Splinting and Orthotics policy dated 9/5/17, provided by the LNHA included that the facility is responsible for maintaining cleanliness of devices and cleanliness of the extremity of the resident, and implementing the wearing schedule to include applying and removing devices as ordered by the physician.	F 688		

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F 688	Continued From page 27 NJAC 8:39-27.2(m)	F 688		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to: a.) follow a Physician's Order (PO) for the use of Ex Order 26. 4B1 for 2 of 4 residents (Resident#150 and #678), b.) develop a care plan for the use of Ex Orde for 2 of 4 residents (Resident#93 and #678), and c.) date and store the Ex Order 26. 4B1 for 1 of 4 residents (Resident #93) reviewed for Ex Order 26. 4B1 The deficient practice was evidenced by the following: 1. On 7/12/22 at 10:59 AM, the surveyor observed resident #150 in their bed with an Ex Order 26. 4B1 in place. The Ex Order 26. 4B1 reflected the Ex Order 26. 4B1 was set at Ex Order 26. 4B1 The surveyor reviewed the medical records of	F 695	Resident(s) #150, and #678 were placed in the correct Ex.Order 26.4(b)(1) as per the physician's order and care plans were added immediately. Resident #93 was placed on the Ex Order 26. 4B1 setting, all Ex Order 26. 4B was changed and dated and the careplan was updated. All residents with a Physician Order for use of Oxygen have the potential to be affected by the same deficient practice. The DON audited all residents on oxygen for correct settings and to ensure that tubing was stored correctly in a protective bag while not in use. Education: All nursing staff was immediately in-serviced by Facility Educator to follow Oxygen orders with the correct setting as per physician orders and to care plan resident. All nursing staff were educated	9/3/22

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F 695	Continued From page 28 Resident #150. The resident's Admission Record (face sheet; an admission summary) indicated that the resident was admitted to the facility and had diagnoses that included but were not limited to; [redacted] unspecified protein-calorie *Ex Order 26. 4B1* [redacted] The Admission Minimum Data Set (AMDS), an assessment tool used to facilitate the management of care dated 6/07/22 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated that the resident's cognitive status was *Ex Order 26. 4B1* [redacted]. The resident's MDS, Section O - Special Treatments, Procedures, and Programs revealed that the resident received [redacted] The July 2022 Order Summary Report (OSR) did not show an Ex.Order 26.4(b)(1) for Resident #150. The July 2022 electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) lacked evidence of oxygen administration. On 7/14/22 at 9:54 AM, the surveyor observed Resident #150 sitting upright in bed watching television. The resident's *Ex Order 26. 4B1* was set at 5 L via [redacted] The resident stated that he/she was not aware of their *Ex Order 26. 4B1*. The resident indicated that it was the nurse who check	F 695	by the facility educator to properly store tubing in a protective bag while not in use. System Change: A system was initiated that UM Managers/ Weekend Sup 7-3 will check the Residents on Oxygen for the proper setting, tubing storage and that a care plan is in place. All Residents found with an incorrect Oxygen setting shall have the oxygen adjusted to the correct setting immediately. All residents with tubing not stored properly will have tubing replaced immediately. Care plans to be updated as needed. Monitoring: The ADON or designee will utilize an audit tool to check that the Nursing staff is following the Orders for Oxygen setting, have tubing stored properly and have Care Plans for oxygen use. 8 Residents on Oxygen will be checked for appropriate settings, tubing storage and that they all have care plans. The audit will be on a weekly basis for twelve weeks. Results of these audits will be reported by the DON to the Quarterly QAPI Committee. The QAPI Committee reviews, evaluates	

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F 695	Continued From page 29 and operates the O2 concentrator. On 7/15/22 at 11:11 AM, the surveyor observed Resident #150 in their room with Ex Order 26. 4B1 in place and the Ex Order 26. 4B1 was set at 2 (two) L. On 7/21/22 at 10:18 AM, the surveyor interviewed Certified Nursing Aide#1 (CNA#1). CNA#1 confirmed that Resident #150 was on Ex Order 26. 4B1, but stated it was up to the nurse how much the resident is on and for monitoring the Ex Order CNA#1 stated that she removes the Ex Order 26. 4B1 to wash the resident's face, but never touches the Ex Order 26. 4B1 . On 7/21/22 at 10:23 AM, the surveyor interviewed Licensed Practical Nurse#1 (LPN#1) regarding Resident #150's Ex Order 26. 4B1 administration. LPN#1 explained that the resident was receiving Ex Orde at 2L. LPN#1 checked the electronic Medical Record (eMR), reviewed the physician orders, and confirmed there was an order dated 7/15/22 for Ex Order 26. 4B1 continuously every shift. On that same date and time, the surveyor asked LPN#1 if there was a previous order prior to 7/15/22 for Ex Orde. LPN#1 checked the eMAR, electronic eTAR, and OSR for July 2022 and stated that no order could be found prior to 7/15/22. LPN#1 further stated that there should be an order for Ex Orde prior to 7/15/22 because the resident was admitted to the facility with a Ex Order 26. 4B1 on 5/20/22. At that time, the surveyor informed LPN#1 that the surveyor observed the resident on 7/12 and 7/14/22 with Ex Order 26. 4B1 On 7/21/22 at 10:41 AM, the surveyor informed	F 695	and makes recommendations to sustain compliance.	

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F 695	Continued From page 30 the MDS Coordinator who was also the acting Manager of unit 5 that the surveyor observed the resident on 7/12 and 7/14/22 with Ex Order 26. 4B1. The surveyor notified the MDS Coordinator of LPN#2's review of OSR, eTAR, and eMAR that did not show an [redacted] order prior to 7/15/22. The MDS Coordinator confirmed that the expectation is that if a resident is on [redacted], there should be a physician's order and the assigned nurse is responsible for monitoring the flow rate. 2. On 7/12/22 at 11:25 AM, the surveyor observed Resident #678 lying in bed. CNA#2 was in the room at that time providing incontinence care to the resident. The surveyor waited till the CNA was done performing care and attempted to interview the resident. The resident had a thick accent and responded with yes and no answers. The surveyor observed the Ex Order 26. 4B1 and identified that [redacted] was being administered to the resident at Ex Order 26. 4B1 Per Minute (LPM) via [redacted]. The Ex Order 26. 4B1 was attached to the [redacted] Ex Order 26. 4B1 in the resident's room. On 7/14/22 at 10:26 AM, the surveyor observed the resident in their room watching television. The resident was observed wearing the [redacted] in their nares. The surveyor observed that the [redacted] Ex Order 26. 4B1 in the resident's room was set at four (4) LMP. The surveyor asked the resident if he/she ever touched the Ex Order 26. 4B1 and the resident stated, "No." The surveyor reviewed the medical record for Resident #678. The resident's Admission Record reflected that the resident had diagnoses which included but were not limited to Ex Order 26. 4B1	F 695		

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F 695	Continued From page 31 Ex Order 26. 4B1 with personal care. The resident's AMDS dated 6/01/22 reflected that the resident had a BIMS score of Ex.Order out of 15 which indicated the resident was Ex Order 26. 4B1. The resident's MDS, Section O - Special Treatments, Procedures, and Programs revealed that the resident received Ex Order 26. 4B1. The resident's July 2022 OSR reflected a PO dated 7/05/22 for Ex Orde at three Ex Order 26. 4B1 continuous for Ex.Order 26.4(b)(1). A review of the Resident #678's July 2022 eMAR revealed that the nurses were signing on the day, evening, and night shifts that the resident was administered Ex Orde at three Ex Order 26. 4B1 continuous for Ex.Order 26.4(b)(1). A review of the resident Care Plan did not reflect a focus area for the care of and the Ex Order 26. 4B1. On 7/14/22 at 11:52 AM, the surveyor interviewed the resident's CNA#2 who stated that the resident required Ex Orde and received the administration of the Ex Orde by way of the Ex Order 26. 4B1. The CNA told the surveyor that she did not touch the Ex Orde, and it was the nurses job to monitor the flow rate of Ex Orde from the Ex Order 26. 4B1. On 7/14/22 at 11:59 AM, the surveyor interviewed the resident's Licensed Practical Nurse#1 (LPN#1) who stated that the resident received Ex Orde via the Ex Order 26. 4B1 and had a PO for the administration of Ex Orde at three Ex Order 26. 4B1. LPN#1 further stated that the resident would touch his/her Ex Order 26. 4B1, but never the Ex Order 26. 4B1. LPN#1 told the	F 695		

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F 695	Continued From page 32 surveyor that if a resident had a PO for the use of [redacted], the [redacted] should be reflected in the resident's Care Plan. The surveyor asked who was responsible for creating the resident's Care Plan and the LPN told the surveyor that the Nursing Supervisor was responsible for creating the resident's Care Plan. On 7/18/22 at 9:20 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the resident's Licensed Practical Nurse/Unit Manager#1 (LPN/UM#1) was unavailable for an interview. The DON told the surveyor that if a resident had a PO for the administration of [redacted], the expectation was that the PO would be followed. The DON further stated that if a resident had a PO for the use of [redacted], it should be reflected in a focus area in the resident's Care Plan. The DON stated that the Unit Mangers were responsible for creating the Care Plans for the residents. 3. On 7/12/22 at 10:48 AM, the surveyor observed Resident#93 seated on their bed with [redacted] in use at [redacted] with a long [redacted] attached to an [redacted]. The [redacted] was not dated. The resident informed the surveyor that the resident had been using [redacted] for a long time and was aware of the [redacted] order of [redacted]. The resident further stated that it was the respiratory therapist who changes the [redacted] once a week. The surveyor reviewed Resident #93's medical records. The resident's Admission Record reflected that the resident was admitted to the facility with diagnoses that included [redacted]	F 695		

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F 695	Continued From page 33	F 695		

Ex Order 26. 4B1

Ex Order 26. 4B1 and Ex Order 26. 4B1

The July 2022 OSR showed an order dated 8/23/21 for Ex Order 26. 4B1 for Ex Order 26. 4B1 every shift. The order for Ex Order 26. 4B1 was transcribed in the eMAR and nurses were signing on the day, evening, and night shifts that the resident was administered Ex Orde at three Ex Order 26. 4B1

A review of the resident's Care Plan did not reflect a focus area for the care of and the Ex Order 26. 4B1.

According to the 5/6/22 Quarterly MDS (QMDS), with a BIMS score of 15 out of 15, which indicated that the resident's cognition was Ex Order 26. 4. The QMDS indicated that the resident was on Ex Order

On 7/13/22 at 11:14 AM, the surveyor and LPN#2 both went inside Resident #93's room and observed Ex Order 26. 4B1 on top of the resident's bed not stored in a bag. The resident was not in the room. LPN#2 stated to the surveyor that the Ex Orde should have been stored in a plastic bag when not in use.

On that same date and time, LPN#2 looked around the resident's room and found a plastic bag, and immediately placed the Ex Order 26. 4B1 that was found on top of the resident's bed.

At that time, the surveyor and LPN#2 observed a Ex Order 2 wrapped around the portable Ex Order 26. 4B1 inside the resident's room. The Ex Order 2 was not stored inside a plastic bag and was not dated. LPN#2

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F 695	Continued From page 34 then discarded the [Ex Order 2] and stated that it should have been stored in a plastic bag when not in use. Then the surveyor asked LPN#2 why she placed the [Ex Order 26. 4B1] that was found on top of the bed inside a plastic bag and did not discard it. LPN#2 stated that the surveyor was right and, "Maybe I should throw that." On 7/13/22 at 11:46 AM, the surveyor interviewed LPN/UM#2 and was made aware of the above concerns. LPN/UM#2 stated that "we have a clear baggy that we suppose to put in the [Ex Order 26. 4B1] when not in use." LPN/UM#2 further stated that the nurse should throw the [Ex Order 26. 4B1] because "you don't know what was on the bed." At that same time, the surveyor asked LPN/UM#2 why is it important to store the [Ex Order 26. 4B1] and [Ex Order 26. 4B] inside a plastic bag when not in use and to date the [Ex Order 26. 4B1], and LPN/UM#2 replied "for infection control." On 7/18/22 at 11:38 AM, the survey team met with the LNHA and was made aware of the above concerns. On 7/19/22 at 02:22 PM, the surveyors met with the LNHA, Regional Director of Clinical Services/Registered Nurse (RDCS/RN), and the Director of Nursing (DON) and were made aware of the above concerns. The DON stated that [Ex.Orde] should be stored if not in use and dated. The DON further stated that the nurse should discard the [Ex.Order 26.4(b)(1)] when found on top of the bed for infection control. A review of the facility Oxygen Administration Policy that was provided by the LNHA with a revised date of December 2021, included "Policy	F 695		

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F 695	Continued From page 35 I. Initiation of Oxygen A. A physician's order is required to initiate oxygen therapy, except in an emergency situation. The order shall include: i. Oxygen flow rate ii. Method of administration (e.g. nasal cannula) iii. Usage of therapy (continuous or prn) iv. Titration instructions (if indicated) v. Indication for use ...III. Infection Control. A. All oxygen tubing, humidifiers, masks, and cannulas used to deliver oxygen: i. Are for single resident use only. ii. Will be changed weekly and when visibly soiled, or as indicated by state regulation. B. Oxygen items will be stored in a plastic bag at the resident's bedside to protect the equipment form dust and dirt when not in use....IX. Turn off oxygen when not in use." A review of the facility's Oxygen Administration Policy and Procedure revised December 2021 indicated that a PO was required to initiate O2 therapy, except in an emergency and the PO should include the O2 flow rate, method of administration, usage of therapy, and indication for use. The facility's Oxygen Policy and Procedure further revealed to, "Turn on the oxygen at the prescribed rate." NJAC 8:39-27.1(a)(b)	F 695		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		9/3/22

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	205 BIRCHWOOD AVE CRANFORD, NJ 07016

(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 755	Continued From page 36 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to assure that a.) a medications were available for administration during the medication administration observation for one (1) of four (4) residents (Resident #98) observed, b.) medications that were ordered by the physician were available for administration during the months of May, June and July 2022 for two (2) of five (5) residents, (Resident #12 and #93) who attended the resident council meeting and c.) a medication was removed from active inventory after being discontinued in March 2022	F 755	Resident # 98 Residents received the medication as per the physician□s order, Nurse got the medications from the backup supply and ordered the missing medication STAT from the pharmacy. The discontinued medication for #98 and #38 were removed from the medication carts. Physicians for Resident #12 and Resident #93 were informed of previous medications not being available with no new orders. All residents have the potential to be affected by the same deficient practice.	

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F 755	Continued From page 37 until surveyor inquiry for one (1) of five (5) medication carts inspected. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, 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." The evidence was as follows: 1. On 7/14/22 at 9:06 AM, the surveyor observed Licensed Practical Nurse#1 (LPN #1) during medication pass observation for Resident #98. LPN #1 attempted to prepare the medications (meds) for Resident #98 which included the following meds:	F 755	Education: All nursing staff was immediately educated by the facility educator to order medications from the pharmacy on time and if the medication is not available follow the facility protocol, document, and not borrow from a different Resident. All nursing staff were educated by the Facility Educator to immediately remove discontinued medications from the cart upon receiving the physician order to discontinue that medication. system change: A system was initiated that UM Managers/Supervisors on 7-3/3-11/11-7 will check with nurses if they are any unavailable medications and make sure that the medication was ordered from the pharmacy and that nurse called MD and got an order for an alternative or hold order. All Residents with unavailable medications will be discussed at the morning meeting by the unit managers and the issue should be resolved immediately after the morning meeting. A system was initiated that UM Managers/Supervisors on 7-3/3-11/11-7 will check the EMAR for discontinued medications and make sure that the medication was removed from the cart. Monitor: The Assistant Director of Nursing or	

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F 755	Continued From page 38 Ex Order 26. 4B1 [redacted]  At the same time, LPN #1 stated Ex Order 26. 4B was not available for Resident #98 and presented an empty Ex Order 26. 4B1 [redacted] to the surveyor. The surveyor observed LPN #1 access the electronic Medical Record (eMR) and re-ordered Ex Order 26. 4B. The surveyor and LPN #1 reviewed the eMR together which reflected that Ex Order 26. 4B was last ordered on 6/14/22. LPN #1 stated that she will get the medication (med) from the electronic back up supply machine (EBSM). During the same medication pass observation on 7/14/22 for Resident #98, LPN #1 stated Ex Order 26. 4B1 was also not available. LPN #1 showed the surveyor a bingo card for Ex Order 26. 4B1 [redacted]. LPN #1 informed the surveyor that Ex Order 26. 4B1 was changed from Ex Order 26. 4B1 on 7/11/22 and that Ex Order 26. 4B1 was not yet delivered. LPN #1 stated she will follow up on the med order for Ex Order 26. 4B1 and will get the med from the EBSM . On 7/14/22 at 9:36 AM, the surveyor and LPN/Unit Manager#1 (LPN/UM #1) went to the	F 755	designee will utilize an audit tool to audit for Medications that are not available. The audit will be on a weekly basis for twelve weeks. The Assistant Director of Nursing or designee will utilize an audit tool to audit for Discontinued Medications being removed from the cart. The audit will be on a weekly basis for twelve weeks. Results of these audits will be reported by the DON to the quarterly Quality Control Committee. The QAPI Committee reviews, evaluates and makes recommendations to sustain compliance.	

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F 755	Continued From page 39 EBSM located in wing 5. In the presence of the surveyor, LPN/UM #1 and LPN/UM #2 removed one tablet of Ex Order 26. 4B1 and one tablet of Ex Order 26. 4B1 from the EBSM. LPN/UM#1 and LPN/UM#2 reviewed the EBSM remaining quantity for Ex Order 26. 4B1. The EBSM revealed a back-up quantity remaining of seven for Ex Order 26. 4B and a back-up remaining quantity of five for Ex Order 26. 4B1. On 7/14/22 at 11:45 AM, the Director of Nursing (DON) provided a copy of Transactions Item: 85158020100320 for Plavix 75 mg tab page 1 of 1 with the following transactions: 7/14/22 09:36:21 AM 6/22/22 02:11:50 PM 6/22/22 02:11:50 PM 5/27/22 02:38:48 PM On 7/14/22 at 11:45 AM, the DON provided a copy of Transactions Item: 33200030100305 for Lopressor (Metoprolol) 25 mg T page 1 of 1 with the following transactions: 7/14/22 09:36:04 AM 6/22/22 02:00:16 PM 5/27/22 02:33:25 PM On 7/14/22 at 12:09 PM, the surveyor interviewed LPN #2 who signed the electronic Medication Administration Record (eMAR) on 7/13/22 at 0800 (8 AM) as administered for Ex Order 26. 4B1. LPN #2 acknowledged that she administered the meds to Resident #98. LPN #2 also stated, she recalled that Ex Order 26. 4B1 was not available on that day and that she had to borrow meds from Resident # 378. She further stated that "I don't remember about Ex Order 26. 4B," if it was available but she recalled signing the eMAR as administered.	F 755		

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F 755	Continued From page 40	F 755		

At the same time, the surveyor asked LPN #2 why Ex Order 26. 4B1 was not available, LPN #1 stated "I don't know." LPN #2 stated that she attempted to call the pharmacy about the missing med but the phone was "busy." The surveyor asked if she was allowed to borrow meds, and LPN #2 did not respond.

During an interview of the surveyor on 7/14/22 at 12:12 PM, the DON stated "I know the regulations does not allow facility to borrow meds", and the nurses have been borrowing meds for Resident #98. The DON also stated that the facility did not have a policy on borrowing meds.

A review of the Pharmacy Delivery Manifest dated 6/15/22 reflected a delivery for Resident 98's Ex Order 26. 4B. A review of the Pharmacy delivery packing slip dated 6/23/22 included a delivery for Resident #98's Ex Order 26. 4B1 . No additional information was provided for Ex Order 26. 4B1 delivery prior to 7/14/22.

On 7/15/22, the Licensed Nursing Home Administrator (LNHA) provided the surveyor an electronic mail (email) from the pharmacy provider.

A review of the email from the Pharmacist in Charge of the pharmacy provider dated 7/14/22 at 12:47 PM revealed an acknowledgement of an order received from the facility on 7/11/22. The same email contained an admission of a dispensing error by the pharmacy which resulted in not sending the Ex Order 26. 4B1 until 7/14/22, after surveyor inquiry.

A review of the eMAR revealed Ex Order 26. 4B1

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F 755	Continued From page 41 was administered on the following dates from 7/11/22: 7/11/22 at 1700 (5:00 PM) 7/12/22 at 1700 (5:00 PM) 7/13/22 at 0800 (8:00 AM) 7/13/22 at 0800 (8:00 AM) A review of an investigation conducted by the DON on 7/14/22, revealed that LPN #2, LPN #3 and LPN #4 admitted to borrowing Ex.Order 26.4(b)(1) mg from another resident from 7/11/22 to 7/13/22 which reflected the 4 doses administered on the eMAR. 2. On 7/18/22 at 10:30 AM, during the resident council meeting, the surveyor interviewed five (5) residents who all acknowledged that they had experienced a time when they were told by nursing that their meds were not available. Three (3) of the five (5) residents were unable to identify a specific time or med but acknowledged that it had happened in the past. Two (2) of the five (5) residents were able to identify specific meds that they had been told were unavailable. Resident #12 stated that he/she routinely takes Ex Order 26. 4B1 *Ex Order 26. 4B1* at night and was told that the pharmacy had not delivered the med. The surveyor reviewed the eMAR for five (5) of the five (5) residents who attended the resident council meeting and identified meds that were not administered for two (2) of the five (5) residents due to not being available. The surveyor reviewed the medical record for Resident #12. The quarterly Minimum Data Set (qMDS), an	F 755		

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F 755	Continued From page 42 assessment tool used to facilitate the management of care dated 7/1/22, reflected the resident had a brief interview for mental status (BIMS) score of Ex.Order out of 15, indicating that the resident had an *Ex Order 26. 4B1*. The June 2022 eMAR revealed a physician's order (PO) dated 4/4/2019 for *Ex Order 26. 4B1*, give one tablet by mouth at bedtime for *Ex Order 26. 4B1*" On 6/11/22 and 6/13/22 at 9 PM the *Ex Order 26. 4B1* had a medication administration entry "9" by LPN#5 which corresponded to the chart code of "other/see nurses notes." Further review of the eMAR revealed a PO dated 12/15/21 for *Ex Order 26. 4B1*, give one tablet by mouth two times a day for Ex Order 26." On 6/14/22 at 5 PM the *Ex Order 26. 4B1* had a med administration entry "9" by LPN#5 which corresponded to the chart code of "other/see nurses notes." A review of the corresponding nursing progress notes dated 6/11/22 at 9:49 PM, 6/13/22 at 9:19 PM and 6/14/22 at 5:05 PM revealed that the meds were not administered because there was documentation "awaiting for pharmacy to deliver." According to the resident's Individual Patient's Controlled Drug Record (IPCDR) for *Ex Order 26. 4B1* tablets with a received date of 5/29/22 for 10 tablets revealed that the last date that the med was removed from inventory was on 6/10/22 and the inventory was zero. A review of the resident's IPCDR for *Ex Order 26. 4B1* with a received date of 6/14/22 for 10 tablets had the first date that the med was removed from inventory was on 6/14/22.	F 755		

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F 755	Continued From page 43 There were no entries on the IPCDR for the dates of 6/11, 6/12 and 6/13. Further review of the June 2022 eMAR revealed that on 6/12/22 the [redacted] had a med administration entry of a checkmark which corresponded to mean that the med was administered at 9 PM which was inconsistent with the IPCDR entries. On 7/20/22 at 10:47 AM, the surveyor further interviewed Resident #12 who stated that he/she felt there were no repercussions from not getting the meds but could not understand why this would happen. On 7/20/22 at 11:28 AM, the surveyor interviewed LPN#5 via telephone. LPN#5 stated that she usually worked the 3 PM to 11 PM shift and that she had remembered meds not being available for Resident #12. LPN#5 stated that the meds were not in the facility back up supply, so she called the pharmacy and was told that the pharmacy had not delivered the meds because they were waiting for a prescription from the physician. LPN#5 then stated that she called the physician to let them know a prescription was needed and spoke to the resident to let them know. Then, LPN#5 added that the resident was "okay" when she explained the situation to the resident. LPN#5 stated that she had not discussed with the physician an alternative for the meds, but she told the next shift if the med came in that they can administer it. LPN#5 added that she had not documented what she had done and acknowledged the documentation "awaiting for pharmacy to deliver."	F 755		

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F 755	Continued From page 44 A review of the list of meds stored in the electronic back up supply machine provided by the DON revealed that Ex Order 26. 4B1 and Ex Order 26. 4B1 were not available in the back up supply. On 7/22/22 at 12:08 PM, the surveyor interviewed the Consultant Pharmacist (CP) via the telephone. The CP stated that she had done inservices with the nurses regarding proper procedures for med administration and documentation. The CP added that she has instructed the nurses that the proper procedure if a med was not available in the med cart was to check if the med was available in the back up supply, then call the provider pharmacy to see why the med was not delivered to rectify the problem. The CP also stated that if the med was not in the back up supply, then the physician was to be called to notify them and get PO as to what to do until the med could be obtained. On 7/22/22 at 1:47 PM, the survey team met with the LNHA and DON. The DON stated that she was able to speak with the nurse who signed for the administration of Ex Order 26. 4B1 on 6/12/22 when there was no entry for removal of Ex Order 26. 4B1 on the IPCDR. The DON explained that the nurse had mistakenly signed that the med was administered when she had no supply of the med. The DON further stated that a med error report was completed for the nurse. The LNHA and the DON acknowledged that the nurses had not administered the identified meds because they were not available. The DON also stated that the nurses who had not administered meds because they were not available had not followed the proper procedure and were inserviced on the	F 755		

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F 755	Continued From page 45 correct procedure. 3. On 7/18/22 at 10:30 AM, the surveyor reviewed the eMAR for five (5) of the five (5) residents who attended the resident council meeting and identified meds that were not administered for two (2) of the five (5) residents due to not being available. The surveyor reviewed the medical record for Resident #93. The qMDS dated 5/6/22, reflected the resident had a BIMS score of Ex.Ord out of 15, indicating that the resident had an *Ex Order 26. 4B1*. The May 2022 eMAR revealed PO for the following: *Ex Order 26. 4B1* give one tablet by mouth every 12 hours for *Ex Order 26. 4B1*" with a start date of 6/16/22. '*Ex Order 26. 4B1* , give one tablet by mouth at bedtime for *Ex Order 26. 4B1* give with *Ex Order 26. 4B1* " with a start date of 8/23/21. '*Ex Order 26. 4B1* , give one tablet by mouth in the evening every Monday, Wednesday, Friday for *Ex Order 26. 4B1* (URI)" dated 10/18/21. '*Ex Order 26. 4B1* give one tablet by mouth in the evening for *Ex Order 26. 4B1*. Check apical pulse before administering medication. Hold for heart rate less than Ex Order with a start date of 11/1/21. The following meds with times of administration had a med administration entry "9" by LPN#3 which corresponded to the chart code of "other/see nurses notes" for:	F 755		

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Ex Order 26. 4B1 on 5/5/22 at 9 PM.
Ex Order 26. 4B1 on 5/6/22 and 5/9/22 at 5 PM.
Ex Order 26. 4B1 on 5/13/22 at 9 PM, 5/14/22 at 9 AM and 5/19/22 at 9 PM.
Ex Order 26. 4B1 on 5/19/22 at 5 PM.

The following were the corresponding nursing progress notes completed by LPN#3 with the dates and times:

for Ex Order 26. 4B1 on 5/5/22 9:02 PM was "waiting for the pharmacy."
for Ex Order 26. 4B1 on 5/6/22 at 5 PM was "waiting for the pharmacy."
for Ex Order 26. 4B1 on 5/9/22/at 6:58 PM was "awaiting for the pharmacy."
for Ex Order 26. 4B1 on 5/13/22 at 8:55 PM "waiting for the pharmacy."
for Ex Order 26. 4B1 on 514/22 at 10:03 AM "waiting for the pharmacy."
for Ex Order 26. 4B1 on 5/19/22 at 8:59 PM "awaiting for the pharmacy."
for Ex Order 26. 4B1 on 5/19/22 at 7:42 PM "waiting for pharmacy."

The June 2022 eMAR revealed a med administration entry "9" by LPN #3 which corresponded to the chart code of "other/see nurses notes" for Ex Order 26. 4B1 on 6/17/22 at 5 PM.

A review of the corresponding nursing progress notes dated 6/17/22 at 6:12 PM revealed that the Azithromycin was not administered because there was documentation "waiting for the pharmacy."

The July 2022 eMAR revealed a med

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F 755	Continued From page 47 administration entry "9" by LPN#6 which corresponded to the chart code of "other/see nurses notes" for *Ex Order 26. 4B1* on 7/3/22 and 7/9/22. In addition, for the *Ex Order 26. 4B1* there was the same "entry" 9 by LPN #4 on 7/17/22 at 9 PM with the same corresponding chart code. A review of the corresponding nursing progress notes by LPN #6 dated 7/3/22 at 9:14 PM and 7/9/22 at 8:24 PM revealed an administration note for the *Ex Order 26. 4B1* but there was no reason or documentation as to whether the Lidocaine was administered. The corresponding nursing progress notes by LPN #4 dated 7/17/22 at 8:42 AM revealed that the Lidocaine gel was not administered because there was documentation "not available." On 7/20/22 at 10:56 AM, the surveyor interviewed Resident #93 who stated that he/she was told by the nurses that the meds were not available, and he/she would not receive the meds. The resident also stated that there were no repercussions from not receiving the meds but does not understand why this would happen. On 7/20/22 at 11:10, the surveyor interviewed the Staffing Coordinator who stated that LPN #3 was on vacation. On 7/20/22 at 11:35 AM, the surveyor attempted to contact LPN #6 but was unable to leave a voicemail. On 7/21/22 at 9:52 AM, the surveyor interviewed LPN #4 who stated that he remembered on 7/17/22 that he worked and was administering meds that day to Resident #93. The surveyor with	F 755		

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F 755	Continued From page 48 LPN#4 reviewed the eMAR for 7/17/22 and LPN#4 stated that he had not administered the Ex Order 26. 4B1 because the med was not in the treatment cart. LPN#4 stated that if he did not have a med then he would usually borrow from another resident, but he was recently instructed that he was no longer allowed to do that. LPN #4 stated that if he did not have the med then he could not administer it. LPN #4 was unable to speak to the procedure to follow when a med was not available. A review of the list of meds stored in the electronic back up supply machine provided by the DON revealed that Ex Order 26. 4B1 tablets were in the back up supply machine. Further review revealed that Ex Order 26. 4B1 tablets were in the back up supply machine, but Ex Order 26. 4B1 tablets were not. In addition, Ex Order 26. 4B1 tablets and Ex Order 26. 4B1 were not in the back up supply machine. On 7/22/22 at 12:08 PM, the surveyor interviewed the CP via the telephone. The CP stated that she had done inservices with the nurses regarding proper procedures for med administration and documentation. The CP added that she has instructed the nurses that the proper procedure if a med was not available in the med cart was to check if the med was available in the back up supply, then call the provider pharmacy to see why the med was not delivered to rectify the problem. The CP also stated that if the med was not in the back up supply, then the physician was to be called to notify them and get PO as to what to do until the med could be obtained. On 7/22/22 at 01:47 PM, the survey team met with the LNHA and DON. The DON stated that	F 755		

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F 755	Continued From page 49 she spoke with LPN #3 who had been on vacation but was called in. The DON stated that LPN #3 had said she had called the physician but had not documented what she had done. On that same date and time, the DON also stated that LPN #6 had said that the resident refused the med but had not documented properly. Furthermore, the DON stated that LPN#4 was a per diem nurse and was unaware of the procedure. The LNHA and the DON acknowledged that the nurses had not administered the identified meds because they were not available. The DON also stated that the nurses who had not administered meds because they were not available had not followed the proper procedure and were inserviced on the correct procedure. 4. On 7/18/22 at 11:47 AM, the surveyor inspected wing four (4) South med cart in the presence of LPN#7. The surveyor found [redacted] of *Ex Order 26. 4B1* of Resident #38. Each bingo card was dated 3/15/22, labeled 1 of 3 and 3 of 3. Both bingo cards found were opened with *Ex Order 26. 4B1* remaining. At the same time, LPN#7 informed the surveyor that the *Ex Order 26. 4B1* order for Resident #38 was discontinued. LPN#7 acknowledged that the *Ex Order 26. 4B1* should have been removed from the med cart to prevent a med error. She stated that the nurse who received the order to discontinue the med, should have removed the med from the med cart. LPN#7 added that the med was placed in the over stock section of the med cart which	F 755		

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F 755	Continued From page 50 was the reason she did not notice it was there. A review of the March 2022 eMAR for Resident #38 revealed that *Ex Order 26. 4B1* was discontinued on 3/28/22. The PO for Resident #38 revealed *Ex Order 26. 4B1* was discontinued on 03/28/22. A review of Resident #38's eMAR from 7/1/22 to 7/19/22, did not reveal a current order for *Ex Order 26. 4B1* . The CP unit inspection report in the past three months for 4 (four) South Medication cart revealed the following: June 2022 All expired and discontinued meds out of cart, N-not in compliance May 2022 All expired and discontinued meds out of cart, N-not in compliance April 2022 All expired and discontinued meds out of cart, Y-in compliance On 7/19/22 at 01:57 PM, during an interview with the surveyor, the DON stated that all nurses on all shifts, on the med carts were responsible to ensure all items in the med carts were current, expired meds and discontinued meds were removed. During a follow up interview on 7/20/22 at 01:05 PM, in the presence of the survey team and LNHA, the DON stated that the nurse who received the order to discontinue Resident #38's *Ex Order 26. 4B1* should have removed the med from	F 755		

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F 755	Continued From page 51	F 755		

the med cart. The DON also stated that the Unit Manager should have doubled checked that the med was removed from the med cart. She added that the Assistant Director of Nursing also covered the units, to ensure that discontinued meds were removed from med carts. The DON acknowledged removal of discontinued med should have occurred to avoid med errors. The DON confirmed that the discontinued med for Resident #38 dated 3/15/22 should have been destroyed.

A review of the facility's "Administering Medications" policy revised on April 2021, under section "Policy heading" revealed "Medications are administered in a safe and timely manner and as prescribed." In addition, "Policy Interpretation and Implementation" number 26, reflected "Medications ordered for a particular resident may not be administered to another resident, unless permitted by state law and facility policy and approved by the director of nursing services." "Medications are administered in accordance with prescriber orders, including any required time frame."

A review of facility policy titled "Discontinued Medications" revised April 2021 revealed under "Policy Heading, Staff shall destroy discontinued medications or shall return them to the dispensing pharmacy in accordance with facility policy. The policy also reflected under "Policy Interpretation and Implementation" section 3. "Discontinued medications must be destroyed or returned to the issuing pharmacy in accordance with established policies."

A review of facility policy received from DON titled "3.0 Medication Disposal/Destruction" under

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F 755	Continued From page 52 "Procedure" section 5. Indicated "Discontinued medications shall be disposed of within 60 days of the date the drug was discontinued." Section 6 reflected "The Consultant Pharmacist and Registered Nurse or two (2) nurses (one of who is a Registered Nurse) shall periodically destroy medications .... subsection b. Tablets, capsules and liquids will be disposed if according to local, state, and federal regulations. A review of facility policy received from the DON titled "6.0 Medication Storage" under "Procedure" section F revealed "Expired, discontinued/or contaminated medications will be removed form [from] the medication storage areas and disposed of in accordance with facility policy." A review of the inservice procedure provided by the DON reflected that the back up supply was to be checked and then the pharmacy contacted to make sure of the delivery time and if the medication could be delivered "STAT (immediately)." If the medication would not be available within an hour of the scheduled time, then the physician must be notified and receive a hold order for the medication or a new PO or a PO for an alternate medication that was available. NJAC 8:39-11.2(b), 29.2(d), 29.4(g)	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		9/3/22

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F 761	Continued From page 53 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) properly label an opened Blood Glucose test strip, b.) identify, and dispose of an expired biological in 1 of 5 medication carts and 1 of 2 medication rooms inspected. This deficient practice was evidenced by the following: On 7/18/22 at 9:41 AM, the surveyor inspected wing three (3) medication (med) room in the presence of a Licensed Practical Nurse (LPN#1). The surveyor observed one box of Sterile 0.9% NaCl (Sodium Chloride) solution for inhalation dated 4/4/2022. The surveyor interviewed LPN #1 who stated that the med room is inspected by	F 761	No residents were found to be affected by the deficient practice. The expired medication and unlabeled items were discarded immediately as per facility protocol. All residents have the potential to be affected by the same deficient practice. Education: All nursing staff was immediately in-serviced by facility educator to store and label medications/Biological items properly and to discard expired /discontinued medication and biological items as per facility protocol. System Change:	

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F 761	Continued From page 54 the Unit Manager (UM) who is away on vacation. LPN #1 also acknowledged the expired Sterile Sodium Chloride for inhalation should not have been in the med room. He further stated that he would remove the expired item from the med room and give it to a UM. On 7/18/22 at 11:47 AM, the surveyor inspected wing four (4) South med cart in the presence of LPN #2. The surveyor observed an opened bottle of Blood Glucose (BG) test strips that did not contain an open date label. During an interview with surveyor, LPN #2 stated that she would discard the opened bottle of test strip. LPN #2 also stated that she does not know how long the BG test strips has been opened. She added that the opened date of a BG test strip determined the expiration. The surveyor and LPN #2 reviewed the package insert of the BG test strip marketed as [name redacted]. The insert indicated under "Storage and Handling" section 5. "Use within 6 months of first opening or the expiration date in the label whichever comes first." A record review of the Consultant Pharmacist (CP) unit inspection report in the past three months for Unit 3 med room revealed the following: June 2022 All expired and discontinued medications (meds) removed, Y- in compliance May 2022 All expired and discontinued meds removed, Y- in compliance April 2022 All expired and discontinued meds removed, Y- in compliance	F 761	A system was initiated that UM Managers/Supervisors on 7-3 will check med carts/Treatment carts/med-rooms for unlabeled/expired discontinued medication and biological items and discard them as per facility protocol. All Discontinued meds will be given by UM/Sup to ADON to return to the pharmacy. Monitoring: The ADON or designee will utilize an audit tool to check that Nursing staff are following the facility protocol to label, store, and discard medications/Biological Items as per facility protocol. 2 carts/2 med rooms to be checked. weekly. The audit will be on a weekly basis for twelve weeks. Results of these audits will be reported by the DON to the quarterly QAPI Meeting. The QAPI Committee reviews, evaluates and makes recommendations to sustain compliance.	

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F 761	Continued From page 55 A record review of the CP unit inspection report in the past three months for 4 South Medication cart revealed the following: June 2022 All expired and discontinued meds out of cart, N-not in compliance All drugs are properly labeled, N- not in compliance May 2022 All expired and discontinued meds out of cart, N-not in compliance All drugs are properly labeled, N- not in compliance April 2022 All expired and discontinued meds out of cart, Y-in compliance All drugs are properly labeled, N- not in compliance On 7/18/22 at 10:59 AM, during an interview with surveyor, LPN/UM stated expired meds are given to the Assistant Director of Nursing (ADON). LPN/UM also stated expired items are to be discarded to prevent usage with a patient resulting in errors. On 7/18/22 at 11:27, during an interview with surveyor, the ADON stated that expired and discontinued meds are given to him for disposal. ADON further added that expired and discontinued meds are either returned to the pharmacy or discarded. On 7/19/22 at 1:57 PM, during an interview with the surveyor, the Director of Nursing (DON) stated all nurses on all shifts, on the med carts were responsible to ensure all items in the med carts were current, expired meds and	F 761		

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F 761	Continued From page 56	F 761		

discontinued meds were removed. The DON also stated that the UMs were responsible for ensuring that expired meds and discontinued med were removed from the med rooms. She further added that in the absence of a UM, that she and the ADON were responsible to conduct a spot check. The DON added that spot checks were conducted randomly and that currently, at that time had no tracking forms for the spot checks completed.

Furthermore, the DON stated that the CP conducted all med carts and rooms inspections monthly. The DON stated she expected all expired items and discontinued meds to be removed immediately.

On 7/22/22 at 12:15 PM during an interview with surveyor, CP stated med carts and med room inspections were completed monthly and expired meds are pulled and she exits with UM.

On 7/20/22 at 01:05 PM, during a follow up interview with the surveyor, the DON acknowledged that an open BG test strip should have been dated once opened because not knowing when it is opened means not knowing when it expired.

On 07/22/22 at 01:47 PM in the presence of the survey team, the DON stated she was unable to determine if the Sterile 0.9% NaCl (Sodium Chloride) solution for inhalation was used for inhalation or wound. She acknowledged that the expired item should have been removed from the med room.

A review of facility policy for "Blood Glucose Monitoring" under "Procedure" section VI

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F 761	Continued From page 57 subsection A. revealed "Check the date on the test strip prior to using the strip. Discard the strip and the remainder of the vial if the strip is past the expiration date. A review of facility policy received from the DON titled "6.0 Medication Storage" under "Procedure" section F revealed "Expired, discontinued/or contaminated medications will be removed form [from] the medication storage areas and disposed of in accordance with facility policy. NJAC 8:39-29.4 (c) (g)	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 812	No residents were found to be affected by	9/3/22

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F 812	Continued From page 58 and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices and properly store potentially hazardous and dry foods in a safe and sanitary environment to prevent the development of food borne illness. This deficient practice was observed during multiple kitchen tours and was evidenced by the following: On 7/12/2022 at 9:45 AM, the surveyor conducted an initial tour with the Food Service Director (FSD) and observed the following: A large ice machine with a brown and black substance along the entire baffle (device used to restrain the flow of ice or to prevent the spreading of ice in a particular direction) along with dripping condensation into the ice below. The FSD wiped the baffle with a paper towel which removed most of the substance. The FSD acknowledged it was not clean. FSD stated "It should not be there, and I will shut it down." The shelf above the stove burners with crusted on drippings. When the surveyor asked what the shelf was used for? The FSD stated "it is where the cook places the utensils and dirty pots while cooking." There were 4 of 4 crumb trays under the multi range stove top which were soiled with a black grease like substance and food debris on aluminum foil that covered the crumb tray. When the FSD removed the foil there was another layer of black sticky debris under the foil. One crumb tray had multiple burnt bowtie pasta on it. The FSD could not state when the last time the crumb	F 812	the deficient practice. Food storage and cleaning issues that were identified as non-compliant were addressed immediately. All residents who eat food prepared in the kitchen are at risk from the alleged deficient practices. 1. The ice machine was cleaned, descaled and sanitized per manufacturer manual instructions. 2. The shelf above the stove burners was cleaned. 3. The crumb trays under the multirange stove top were cleaned. 4. The meat slicer was cleaned and sanitized. 5. The double stack oven was cleaned. 6. The freezer door was fixed to close tightly and eliminate ice condensation. 7. Refrigerator #1 and #2 were thoroughly cleaned including shelving units and fans. 8. The juice machine including the nozzle was cleaned per manufacturer recommendations. 9. The steam table was cleaned. 10.The small trash can in the dishwasher room was replaced with a trash can with a lid. 11. The dishes were rewashed as per the Food Service Director Instruction. Education Culinary Service Manager and/or Registered Dietitian provided education to Dietary staff members on:	

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F 812	Continued From page 59 trays were cleaned. The FSD could not provide a cleaning schedule for the stove or crumb trays. The commercial meat slicer covered with plastic. The FSD director removed the plastic and the surveyor observed brown particles on the shield and on and under the blade. The FSD stated, "When a piece of equipment was covered with plastic that indicated the equipment was cleaned and sanitized". The FSD acknowledged the meat slicer was not cleaned and sanitized. The double stack oven with baked on debris on the interior surfaces and door on each unit. When asked what the FSD thought the sediment was? The FSD stated, "Sweet and oily residue from splatter." The double stack steamer unit with black debris on bottom shelf and door of each unit. The Freezer had ice condensation build-up on 1 of 3 interior unit fans and ice deposits on the interior floor. The FSD stated "she was having the service company come out again to look at it and fix it." Refrigerator Box #1, which had black debris on the ceiling, door frame, in between shelving unit holes and hanging off the fan in the unit. Refrigerator box #2 had black, crusted debris within the openings on the shelves in the unit. The juice dispenser tap placed in a metal holder with copious amounts of sticky red liquid and a white disposable cup lid in the metal holder with black debris on it. The FSD stated, "The evening shift was responsible to clean it daily". The FSD stated, "The purpose of the cleaning schedule is	F 812	-Refrigeration, Freezer and dry food storage, including labeling/dating of food items for storage in the kitchen and discarding items by the use-by date. -Cleaning schedules -Procedures for cleaning each piece of equipment System Change Cleaning schedules with accountability signatures were posted. Culinary Services Manager or designee will utilize the Culinary Services Manager Checklist to monitor kitchen & food labeling & dating, and cleaning schedule compliance . Monitor: Culinary Services Manager or designee will audit Foodservice sanitation utilizing the Sanitation Audit weekly for 12 weeks, then monthly thereafter. The Sanitation Audit results will be presented by the Culinary Services Director at the Quarterly QAPI Committee meeting. The QAPI Committee reviews, evaluates and makes recommendations to sustain compliance. Date Compliance- September 3, 2022	

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F 812	Continued From page 60 to prevent fruit flies and cross contamination." No cleaning schedule or check off list could be provided at the time of our tour. Steamer table had 10 of 10 steamer water pans. They were all filled with very dark discolored water with food debris. It was noted and agreed upon by two surveyors, FSD and Kitchen Supervisor, that the breakfast pancakes were served while being warmed by these steamer pans. The surveyor asked the FSD what the cleaning process was? The FSD stated, "The steam table is to be broken down and cleaned nightly which clearly has not been done." At that time the FSD stated, "Take your picture then I will have all the steam water replaced." A cleaning schedule and/or check off list couldn't be provided. The small trash bin under a sink located in the dishwasher room next to a rack of clean small brown bowls. The FSD asked the food service worker to remove the trash can and rewash the square tray of brown dishes. When asked why she gave that instruction? The FSD stated, "The trash can should have a lid, and it is next to the clean dishes." During an interview with the FSD on 07/12/2022 at 10:34 AM, the FSD stated, "There was no formal process for scheduled cleaning." "There is no accountability, sign off log or checklists available at this time." On 7/25/22 at 11:17 AM, the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA) acknowledged the kitchen concerns. A review of an undated [name redacted] cleaning	F 812		

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F 812	Continued From page 61 and sanitizing instruction manual under the section "cleaning the nozzle" indicated, "this means our dispenser can be soaked in lukewarm or cold water, which we recommend to be done, when necessary, without being damaged. " A review of the [name redacted] Ice Machine cleaning and sanitizing instruction manual, section 4; Maintenance, dated 5/21/08 part # 000014141, "General" indicated, "Descale and sanitize the ice machine every 6 months for efficient operation." "An extremely dirty ice machine must be taken apart for descaling and sanitizing. NJAC 8:39-17.2 (g)	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		9/3/22

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F 880	Continued From page 62 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 (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	F 880		

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F 880	Continued From page 63 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was identified that the facility failed to: a.) appropriately perform hand hygiene during the medication pass observation for 1 of 5 nurses, and during incontinence care for 1 of 3 residents (Resident #158), b.) appropriately don (put on) Personal Protective Equipment (PPE) prior to entering and while providing care to residents on Transmission Based Precautions (TBP), c.) appropriate clean multi-use resident equipment, d.) follow appropriate sequential infection control practices when providing care to residents on TBP, and e.) follow the Center for Disease Control (CDC) guidelines and facility policies and procedures to prevent the spread of infection to residents. This deficient practice was identified for, (Resident #93, #158, #678) and on two out of five nursing units (unit three and five). This deficient practice was evidenced by the following: 1. On 7/14/22 at 9:06 AM, the surveyor observed Licensed Practical Nurse#1 (LPN#1) assisting Resident#149 to be wheeled outside the room after administering medications. On the same date and time, LPN#1 assisted Resident#98 inside the room by propelling the resident's wheelchair. LPN#1 did not perform	F 880	Resident #158, #93, #678, #149 and #98 were evaluated for signs and symptoms of Ex.Order 26.4(b)(1) All residents have the potential to be affected by this deficient practice. The facility performed a root cause analysis for the Staff's incorrect use of PPE it was determined that they lacked a full understanding of transmission based precautions and proper use of PPE. The facility performed a root cause analysis for hand hygiene and staff did not wash hands per policy because they were nervous. The facility performed a root cause analysis regarding correct use multiuse equipment versus single use equipment and transmission based precautions and staff did not use the single use equipment because they lacked a full understanding of transmission based precautions. Education: Staff identified in this deficiency for	

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F 880	Continued From page 64 hand hygiene in between direct contact with Resident #149 and #98, then LPN#1 immediately applied a new pair of gloves when the LPN started to disinfect the blood pressure (bp) cuff. The surveyor asked LPN#1 if she should be performing hand hygiene and the LPN stated "I will do it later after I remove my gloves." Afterward, the surveyor observed LPN#1 after disinfecting the bp apparatus, removed gloves, performed handwashing for 7 seconds, and then scrubbed hands under running water. The LPN then checked the resident's vital signs, perform hand hygiene with the use of ABHR, and prepared and administered medications. On 7/14/22 at 9:46 AM, the surveyor interviewed LPN#1 in the presence of the Licensed Practical Nurse/Unit Manager#1 (LPN/UM#1). LPN#1 stated that she received education and competency for hand hygiene that was provided by the facility Infection Preventionist Nurse (IPN). LPN#1 further stated that handwashing should be at least 20 seconds and scrubbing is done under running water. On that same date and time, the surveyor asked LPN#1 when to perform hand hygiene. LPN#1 stated that hand hygiene should be performed in between direct contact with residents with the use of alcohol-based hand rub (ABHR) and then on the 3rd or 4th resident, handwashing should be performed. She further stated that hand hygiene should be done after gloves removal. The surveyor then asked LPN#1 if she perform hand hygiene in between direct contact with Resident #98 and #149, LPN#1 responded "I can not remember."	F 880	incorrect hand hygiene (LPN #1 and CNA in 500 Unit)received immediate education and competency testing by the infection prevention nurse. Staff identified in this deficiency for incorrect PPE Use (Maintenance and TNA) received immediate education regarding PPE, including N95 use from the infection prevention nurse. LPN #2 was educated regarding transmission based precautions, reading isolation precaution signs, and multi- use equipment disinfection by the infection prevention nurse. All staff were educated for and completed hand hygiene competency by the infection prevention nurse. All staff were educated for proper PPE use, including wearing N95 masks by the infection prevention nurse. Module 1: Infection Prevention and Control Program was viewed by Topline staff and Infection Preventionist on or before September 3, 2022. Keep Covid Out! was viewed by all frontline Staff on or before September 3, 2022. Sparkling Surfaces was viewed by all frontline staff on or before September 3, 2022. Closely Monitor Residents was viewed by	

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F 880	Continued From page 65 Furthermore, the surveyor asked LPN#1 if she should perform hand hygiene after direct contact with Resident #98 and #149, before donning (putting on) gloves and disinfecting the bp apparatus, and she stated "I think I should have," performed hand hygiene. On 7/19/22 at 02:22 PM, the surveyors met with the Licensed Nursing Home Administrator (LNHA), and Regional Director of Clinical Services/Registered Nurse (RDCS/RN). The Director of Nursing (DON) informed the surveyors that LPN#1 acknowledged that she washed her hounds under a stream of running water and did not perform hand hygiene in between direct contact with residents. The DON further stated that LPN#1 should have performed hand hygiene. 2. On 7/19/22 at 6:37 AM, the surveyor observed the Certified Nursing Aide (CNA) on the 500 unit perform incontinence care for Resident #158. After performing care, the surveyor observed the CNA place the soiled linen and garbage in a garbage bag, walk out into the hallway and put the linen and the garbage in the appropriate receptacles. The surveyor further observed the CNA walk into Resident #158's bathroom, wet her hands, apply soap, and wash her hands under running water for 12 seconds. On 7/18/22 at 10:21 AM, the surveyor interviewed the IPN who stated that the appropriate procedure for hand hygiene was to turn on the water to a comfortable temperature, wet hands, apply soap, rub hands together with friction for at least 20 seconds. The IPN further stated that staff had to rub hands outside the stream of water, otherwise the soap would wash off the persons hands and not clean them. The IPN told the	F 880	Frontline Staff on or before September 3, 2022. Use PPE Correctly for Covid-19 was viewed by all frontline staff on or before September 3, 2022. Module 5-Outbreaks was viewed by all Topline Staff and Infection Preventionist on or before September 3, 2022. Module 11B-Environmental Cleaning and Disinfection was viewed by ALL staff including topline staff and infection preventionist. Module 4- Infection Surveillance was viewed by Topline staff and infection preventionist on or before September 3, 2022. Module 7- Hand Hygiene was viewed by ALL Staff including Topline staff and infection preventionist on or before September 3, 2022. Module 6A- Principles of Standard Precautions was viewed by ALL Staff including Topline Staff and Infection Preventionist on or before September 3, 2022. Module 6B- Principles of Transmission Based Precautions was viewed by ALL Staff including Topline staff and Infection Preventionist on or before September 3, 2022. Module 11A- Reprocessing Reusable	

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F 880	Continued From page 66 surveyor that after lathering hands together for at least 20 seconds, staff were to rinse hands with fingers down, making sure their hands did not touch the sink. Then grab a paper towel, drying hands fingers to wrist, throw away that paper towel, grab a new paper towel, and turn off the water. A review of the CNA's Clinical Competency Validation revised 11/2017 titled, "Hand Hygiene" indicated that the CNA correctly washed her hands in the presence of the IPN on 6/14/22. 3. On 7/12/22 at 11:23 AM, the surveyor observed on the 500 unit a red sign attached to a plastic tarp with a zipper in the center of Resident #678's bedroom door. The zipper was zipped down to the floor and the resident's bedroom door was shut. The red sign indicated to, "STOP" that the resident was on droplet and contact precautions, staff were to clean their hands before entering and upon leaving the resident's room, doors were to remain closed, staff were to don gloves, gowns, eye protection, a fit-tested N95 mask, and use dedicated or disposable equipment prior to entering the resident's room. The surveyor donned the appropriate PPE and entered the resident's room. At 11:25 AM, the surveyor observed the resident's Temporary Nursing Aide (TNA) in the resident's room providing care, leaning over, and touching the resident. The TNA was observed wearing a surgical mask with her N95 mask over it. The surveyor reviewed the medical record for resident #678. A review of the resident's Admission Record	F 880	Resident Care Equipment was viewed by Topline Staff and infection Preventionist on or before September 3, 2022. System change: Single use equipment will be added to the isolation carts for Red Zone patients. Red Zone Isolation Carts will be labeled as such. Unit Manager/Supervisor will hold shift huddles with staff working in the Yellow and Red Zones to review PPE and transmission based precautions. Monitor: IPN will complete PPE use audits of 5 staff members weekly for twelve weeks. IPN will complete hand hygiene audit of 5 staff weekly for twelve weeks. IPN will complete multi- use equipment disinfection audit of 3 staff weekly for twelve weeks. IPN will present audit results at Quarterly QAPI meeting. The QAPI Committee reviews, evaluates and makes recommendations to sustain compliance.	

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F 880	Continued From page 67 reflected that the resident had resided at the facility for a few months and had diagnoses which included but were not limited to *Ex Order 26. 4B1* [redacted] and need for assistance with personal care. The resident's July 2022 Order Summary Report (OSR) reflected a Physician's Order (PO) dated 07/05/22 for contact and droplet precautions. The resident's July 2022 Medication Administration Record (MAR) revealed that nurses were signing on the day, evening, and night shifts that the resident was on contact and droplet isolation and nurses were to sign every shift for monitoring. On 7/18/22 at 10:02 AM, the surveyor interviewed the resident's TNA who stated that she would don a gown, gloves, face shield, surgical mask and N95 mask prior to entering a resident's room who was on contact and droplet precautions due to COVID-19. The TNA stated that she would put on a surgical mask and then the N95 mask over the surgical mask. The surveyor asked the TNA if she had received education on how to appropriately don PPE prior to entering a resident's room who was on TBP related to being COVID-19 positive. The TNA told the surveyor that she was educated by the Administrator on how to don PPE. On 7/14/22 at 10:38 AM, the surveyor interviewed the resident's LPN#2 who stated while providing care to a COVID-19 positive resident staff were required to wear a N95, face shield, gloves, and a gown. On 7/18/22 at 10:11 AM, the surveyor interviewed the IPN who stated that prior to entering a	F 880		

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F 880	Continued From page 68 resident's room who was COVID-19 positive and while proving care staff were to first perform hand hygiene and don a N95 mask, face shield, gown, and gloves. The surveyor asked the IPN if it was appropriate for staff to wear a surgical mask under their N95 mask in a COVID-19 positive resident room. The IPN stated, "No" and explained that the purpose of wearing a fit tested N95 mask was to create a seal that was better at preventing the transmission and spread of the COVID-19 virus. A review of the the TNA's Clinical Competency Validation revised 11/2017 titled, "Putting on Personal Protective Equipment (PPE)/Taking Off PPE" competency dated 05/26/22 indicated that she passed. A further review of the facility's Clinical Competency Validation Form did not reflect N95 masking procedures. 4. On 7/14/22 at 10:02 AM, the surveyor observed LPN#2 on the 500 unit enter a COVID-19 positive room with a mobile blood pressure machine. Upon entering the COVID-19 positive room, LPN#2 shut the door behind her. The surveyor observed a red sign which indicated to "STOP" that the resident was on droplet and contact precautions, staff were to clean their hands before entering and upon leaving the resident's room, doors were to remain closed, staff were to don gloves, gowns, eye protection, a fit-tested N95 mask, and use dedicated or disposable equipment prior to entering the resident's room. On 7/14/22 at 10:05 AM, the surveyor observed LPN#2 exit the COVID-19 positive room with the mobile blood pressure machine. The bottom of the mobile blood pressure machine was observed	F 880		

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F 880	Continued From page 69	F 880		

to have brown spillage throughout and the wheels were observed to have grey, blackish debris stuck to them. The surveyor observed LPN#2 wipe the blood pressure cuff with a bleach wipe. The surveyor did not observe LPN#2 disinfect any other part of the mobile blood pressure machine.

On 7/14/22 at 10:10 AM, the surveyor observe LPN#2 push the mobile blood pressure machine in front of a resident's room who was on TBP. The surveyor observed LPN#2 perform hand hygiene, appropriately don PPE, enter the resident's room, and shut the door behind her. The mobile blood pressure machine remained in the hallway outside of the resident's room who was on TBP. At that time, the surveyor observed a yellow sign on the resident's bedroom door. The yellow sign indicated that the resident was on contact and droplet precautions related to being a Person Under Investigation (PUI) who was newly admitted to the facility and not fully vaccinated for COVID-19.

On 7/14/22 at 10:33 AM, the surveyor observed LPN#2 push the mobile blood pressure machine into the resident's room who was on TBP related to being a PUI.

On 7/14/22 at 10:38 AM, the surveyor interviewed #LPN2 who stated that there was no single use equipment for the COVID-19 positive or PUI residents who were on TBP and that was why she used the mobile blood pressure machine. LPN#2 told the surveyor that prior to taking the resident's blood pressure she would wipe down the top of the blood pressure machine and the blood pressure cuff. The surveyor observed the bottom of the blood pressure machine in the presence of LPN#2 who stated that she did not clean the

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F 880	Continued From page 70	F 880		

bottom of the machine, only the top. LPN#2 explained that the residents who resided in the room with the yellow signs on the door just came from the hospital and were on observation. The LPN confirmed that she used the same blood pressure machine when going from the COVID-19 positive room to the PUI room and she did not wipe down the entire machine. The LPN acknowledged that the sign on the Covid-19 positive room indicated that equipment was designated to that room.

On 7/14/22 at 12:35 PM, the surveyor interviewed LPN/UM#2 who stated that the COVID-19 positive resident's had disposable stethoscopes and blood pressure cuffs in their rooms to prevent cross contamination and the spread of infection. This interview with LPN/UM#2 contradicted the surveyor's observation.

On 7/14/22 at 12:44 PM, the surveyor interviewed the IPN who stated that if a resident was COVID-19 positive the expectation would be that the multi-use equipment was disinfected between residents. The IPN told the surveyor that if the mobile blood pressure machine or multi-use equipment was appropriately disinfected, it could be used between resident rooms. The surveyor asked the IPN what part of the multi-use equipment should be disinfected? The IPN stated the staff was expected to disinfect the part of the equipment that came in contact with the resident. The IPN further stated that the signs outside the resident rooms indicated the type of precautions the staff should follow.

At that time, the surveyor further asked the IPN if it mattered if the resident was COVID-19 positive and if the multi-use equipment could be used

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE CRANFORD, NJ 07016**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 71	F 880		

between resident rooms? The IPN stated that the staff would be expected to provide care from clean to dirty. The IPN explained that "for example, the staff would provide care from non-ill, to PUI/TBP to COVID-19 positive." The IPN stated that LPN#2 brought it to her attention that there was no single use equipment provided for the COVID-19 resident, so she gave LPN#2 a single use stethoscope, blood pressure cuff, and thermometer.

5. On 7/14/22 at 10:38 A.M., the surveyor observed a Maintenance Staff (MS) going into PUI room with a surgical mask, gloves, and gown. A sign posted on the door of PUI room directs to wear a fit-tested N95 and face-shield. The MS did not have a N95 or a face-shield donned.

On that same date and time during an interview of the surveyor, the MS stated that he has worked at the facility for a year. He further stated that he uses surgical mask all the time.

On 7/14/22 at 10:38 AM, the surveyor interviewed LPN#2 who stated that when a staff member entered a residents who was PUI and on TBP staff must wear a N95 mask, gown, face shield, gloves, surgical mask over N95. LPN#2 explained that she observed the MS entered the PUI room and he should have donned a N95 mask prior to entry to protect himself and the residents from infection.

On 7/18/22 at 10:32 AM, the surveyor interviewed the IPN who stated that when a staff member entered a resident's room who was on TBP related to being a PUI, the appropriate PPE to wear were gloves, gown, N95, face shield or

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	315091	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE CRANFORD, NJ 07016**

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F 880	Continued From page 72 goggles. A review of the MS Clinical Competency Validation revised 11/2017 titled, "Putting on Personal Protective Equipment (PPE)/Taking Off PPE" dated 03/23/22 indicated that he passed. A further review of the facility's Clinical Competency Validation Form did not reflect N95 masking procedures. A review of the facility's Cohorting COVID-19 Policy and Procedure revised April 2022 indicated that Cohort 1 - (Red Zone) included residents who were symptomatic or asymptomatic and tested positive for the COVID-19 virus regardless of vaccination status. The facility's Cohorting COVID-19 Policy and Procedure indicated that COVID-19 positive residents, "should be placed in quarantine and cared for using full PPE (gowns, gloves, eye protection that covers the front and sides of face, and NIOSH approved N95 or equivalent or higher-level respirator." The Cohorting COVID-19 Policy and Procedure further indicated that Cohort 5 - (Yellow Zone) consisted of new or re-admitted asymptomatic residents who were not up to date with COVID-19 vaccinations and tested negative for COVID-19 upon admission or re-admission to the facility. The facility's Cohorting COVID-19 Policy and Procedure indicated, "These residents should be placed in quarantine and cared for using full PPE (gowns, gloves, eye protection that covers the front and sides of the face, and NIOSH approved N-95 or equivalent or higher-level respirator), even if they have a negative test upon admission." A review of the facility's Coronavirus Disease	F 880		

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	315091	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	205 BIRCHWOOD AVE CRANFORD, NJ 07016

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F 880	Continued From page 73 (COVID-19) - Infection Prevention and Control Measures Policy and Procedure revised 03/2022 revealed, "Dedicated or disposable noncritical resident-care equipment (e.g., blood pressure cuffs, blood glucose monitoring equipment) are used, or if not available, then equipment is cleaned and disinfected according to manufacturer's instructions using EPA-registered disinfectant for healthcare setting prior to use on another resident. A further review of the facility's Coronavirus Disease (COVID-19) - Infection Prevention and Control Measures Policy and Procedure did not indicate the sequence for care such as going from non-ill to ill with the usage of multi-use resident care equipment. A review of the facility's Hand Hygiene Policy and Procedure revised 03/2021 indicated that hand hygiene was always the final step after removing and disposing of PPE. The facility's Hand Hygiene Policy and Procedure reflected that the correct procedure when washing hands was to, "vigorously lather hands with soap and rub them together, creating friction to all surfaces, for at least twenty (20) seconds."	F 880		
F 921 SS=D	NJAC 8:39-19.4; 27.1(a) Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was identified	F 921	No resident was affected by the deficient practice. The Oxygen Tank was	9/3/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE CRANFORD, NJ 07016**

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F 921	Continued From page 74 that the facility failed to safety store Oxygen (O2) equipment in a resident's private room. This deficient practice was identified for one of six resident's reviewed, (Resident #678) for *Ex Order 26. 4B1* and was evidenced by the following: On 7/12/22 at 11:25 AM, the surveyor observed Resident #678 laying in bed in their room. At that time, the surveyor attempted to interview the resident and the resident responded with yes or no answers. The surveyor observed a free standing, *Ex Order 26. 4B1* in the upright position in the resident's room to the left of the resident's nightstand while facing the head of the resident's bed. The *Ex Order 26. 4B1* was not observed to be stored in a container. The surveyor further observed that the gauge on the *Ex Order 26. 4B1* read that it was full. On 7/14/22 at 10:26 AM, the surveyor observed the resident in their room lying in bed watching television. The surveyor observed the *Ex Order 26. 4B1* in the upright position in the same location as the previous observation in the resident's room. The *Ex Order 26. 4B1* was observed free standing in the upright position, full, and was not stored in a container. On 7/14/22 at 11:52 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that the resident received his/her *Ex Orde* via an *Ex Order 26. 4B1* and not the *Ex Order 26. 4B1* *Ex Order 26*. The CNA further stated that the *Ex Order 26. 4B1* were not supposed to be stored in a resident's room because it was not safe. On 7/14/22 at 11:59 AM the surveyor interviewed the resident's Licensed Practical Nurse (LPN)	F 921	immediately placed in a cart and safely stored. All residents have the potential to be affected by the same deficient practice. Education: All staff was immediately in-serviced to store Oxygen Tanks safely by the Director of Environmental Services. A system was initiated that UM Managers/Supervisors will do shift rounds in the units/Oxygen rooms to check if All Oxygen Tanks are stored safely. All Oxygen Tanks that were found to be stored unsafely will be immediately corrected and discussed by UM/SUP in the Morning meeting. Monitor: The Assistant Director of Nursing or designee will utilize an audit tool to check that oxygen is stored safely. A random audit of 8 Residents on Oxygen and 1 Oxygen room will be completed weekly for 12 weeks. Results of these audits will be reported by the Director of Nursing to the quarterly QAPI meeting. The QAPI Committee reviews, evaluates and makes recommendations to sustain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE CRANFORD, NJ 07016**

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F 921	Continued From page 75 who stated that the Ex Order 26. 4B1 should be stored in a container because if the resident had to move around the room freely, the Ex Order could move with the resident. On 7/14/22 at 12:10 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manger (LPN/UM) who stated that all portable Ex.Order should be stored in a container in the upright position, especially if it was full because it posed a potential hazard to the resident's environment. On 7/14/22 at 12:17 PM, the surveyor interviewed the facility's Maintenance Director (MD) who stated that it was necessary and very important for Ex.Order 26.4(b)(1) to be stored in a container for safety purposes. The surveyor reviewed the facility's Oxygen Administration Policy and Procedure revised December 2021 which indicated in the section titled, "Safe Handling of Oxygen/Equipment" that, "Oxygen cylinders are to be secured in a cylinder cart or bracket at all times." NJAC 8:39-31.2(d)	F 921		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062006	A. BUILDING: _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHC	205 BIRCHWOOD AVE CRANFORD, NJ 07016

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on the interview, and record review, 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. The facility was deficient in CNA staffing for 14 of 14 day shifts reviewed and this deficient practice had the potential to affect all residents. Findings included: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance	S 560	No residents were found to be affected by the deficient practice. All residents have potential to be affected the deficient practice. Education: The Staffing Coordinator was educated by the Administrator regarding staffing requirements. System Change:	9/3/22

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

Electronically Signed | 08/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062006	A. BUILDING: _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHC	205 BIRCHWOOD AVE CRANFORD, NJ 07016

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S 560	Continued From page 1 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....." As per the "Nurse Staffing Report" completed by the facility for the weeks of 6/26/22 and 7/9/22, the staffing to resident ratios did not meet the minimum requirement of 1 CNA to 8 residents for 14 of 14 day shifts as documented below: The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -06/26/22 had 11 CNAs for 184 residents on the day shift, required 23 CNAs. (16.72 residents per CNA) -06/27/22 had 16 CNAs for 184 residents on the day shift, required 23 CNAs. (11.50 residents per CNA) -06/28/22 had 19 CNAs for 184 residents on the day shift, required 23 CNAs. (09.68 residents per CNA) -06/29/22 had 18 CNAs for 184 residents on the day shift, required 23 CNAs. (10.22 residents per CNA) -06/30/22 had 17 CNAs for 184 residents on the day shift, required 23 CNAs. (10.82 residents per CNA) -07/01/22 had 19 CNAs for 183 residents on the day shift, required 23 CNAs. (09.63 residents per CNA) -07/02/22 had 18 CNAs for 179 residents on the	S 560	A daily staffing report has been created and will be completed daily by the Staffing Coordinator and Reviewed by the Director of Nursing for compliance. Monitoring: The DON will Audit 5 staffing reports per week for twelve weeks. The DON will report at the Quarterly QAPI Committee Meeting. The QAPI Committee reviews, evaluates and makes recommendations to sustain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062006	A. BUILDING: _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHC	205 BIRCHWOOD AVE CRANFORD, NJ 07016

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S 560	Continued From page 2	S 560		

day shift, required 22 CNAs. (09.94 residents per CNA)
-07/03/22 had 19 CNAs for 178 residents on the day shift, required 22 CNAs. (09.36 residents per CNA)
-07/04/22 had 17 CNAs for 178 residents on the day shift, required 22 CNAs. (10.47 residents per CNA)
-07/05/22 had 18 CNAs for 178 residents on the day shift, required 22 CNAs. (09.88 residents per CNA)
-07/06/22 had 16 CNAs for 178 residents on the day shift, required 22 CNAs. (11.12 residents per CNA)
-07/07/22 had 18 CNAs for 178 residents on the day shift, required 22 CNAs. (09.98 residents per CNA)
-07/08/22 had 18 CNAs for 177 residents on the day shift, required 22 CNAs. (09.83 residents per CNA)
-07/09/22 had 14 CNAs for 177 residents on the day shift, required 22 CNAs. (12.64 residents per CNA)

On 7/25/22 at 9:40 AM, the surveyor interviewed the staffing coordinator (SC) regarding staffing and ratios. The SC acknowledged that the ratio should have been one CNA to every eight residents. The SC told the surveyor, "We use agency, but the problem is the call outs all the time".

A review of the facility Nursing Department-Staffing, Scheduling and Postings policy dated December 1, 2021 included "Under the procedures section of the policy, Number VI, it read that the facility will put forth every effort to comply with the minimum staffing requirements/ratios set for by The State of New Jersey (Bill s2712) in a 24-hour period as follows:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062006	A. BUILDING: _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHC	205 BIRCHWOOD AVE CRANFORD, NJ 07016

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S 560	Continued From page 3 -One Certified Nursing Assistant to every eight residents for the day shift..."	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
315091 Y1	A. Building B. Wing Y2	10/19/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	205 BIRCHWOOD AVE CRANFORD, NJ 07016

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 F0578	Correction	ID Prefix F0637	Correction	ID Prefix F0641	Correction
Reg. # 483.10(c)(6)(8)(g)(12)(i)-(v)	Completed	Reg. # 483.20(b)(2)(ii)	Completed	Reg. # 483.20(g)	Completed
LSC	09/03/2022	LSC	09/03/2022	LSC	09/03/2022
ID Prefix F0658	Correction	ID Prefix F0688	Correction	ID Prefix F0695	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(c)(1)-(3)	Completed	Reg. # 483.25(i)	Completed
LSC	09/03/2022	LSC	09/03/2022	LSC	09/03/2022
ID Prefix F0755	Correction	ID Prefix F0761	Correction	ID Prefix F0812	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	09/03/2022	LSC	09/03/2022	LSC	09/03/2022
ID Prefix F0880	Correction	ID Prefix F0921	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(i)	Completed	Reg. #	Completed
LSC	09/03/2022	LSC	09/03/2022	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
8/4/2022	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
062006	A. Building B. Wing	10/19/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	205 BIRCHWOOD AVE CRANFORD, NJ 07016

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/03/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 8/4/2022	☐ 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
	315091	A. BUILDING **01** B. WING _____	**08/04/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE** **CRANFORD, NJ 07016**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/03/2022 and 08/04/2022 and Cranford Rehabilitation and Nursing Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Bayshore Healthcare Center is a two story, Type II Protected building that was built in January 1970. The facility is divided into 10 smoke zones.	K 000		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/03/2022 in the presence of facility management, it was determined that the facility failed to provide a fully functioning battery backup emergency light above 1 of 1 emergency generator's transfer switch, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following:	K 291	No residents were found to be affected by the deficient practice. The battery backup emergency light above the emergency generator transfer switch was fixed immediately. All residents in the facility have the potential to be affected by the deficient practice. Education: The Maintenance Director educated all Maintenance Staff fully functioning battery	9/3/22

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

Electronically Signed | 08/24/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. BUILDING **01** B. WING _____	**08/04/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE** **CRANFORD, NJ 07016**

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K 291	Continued From page 1 During the survey entrance on 08/03/2022 at 10:25 AM, a request was made to the facility's Administrator and Maintenance Director (MD) if the facility had an emergency generator. The MD said, yes we have one. Later during the building tour with the facility MD at 01:50 PM, an inspection inside the mechanical room where the emergency generator and Automatic Transfer Switch (ATS) are located was performed. During a test of the battery backup emergency light for the ATS, the light did not function properly. This finding was verified by the facility's MD at the time of inspection. The Administrator was notified of the finding at the Life Safety Code exit conference on 08/04/2022 at 1:22 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	backup emergency light above emergency generators. System Change: The battery backup light will be tested daily as part of the maintenance checklist. Monitor: The maintenance director or designee will utilize an audit to check the function of the battery backup emergency up weekly for twelve weeks. The Maintenance Director will present the audit at the quarterly QAPI meeting. The QAPI Committee reviews, evaluates and makes recommendations to sustain compliance.	
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced	K 293		9/3/22

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	315091	A. BUILDING **01** B. WING _____	**08/04/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE** **CRANFORD, NJ 07016**

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K 293	Continued From page 2 by: Based on observation and review of facility provided documentation on 8/03/2022, it was determined that the facility failed to ensure that illuminated exit signs were in two (2) locations to clearly identify the exit access path for one of one enclosed center courtyards in the facility. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 On 8/03/2022 (day one of the survey) during the survey entrance at 10:25 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility layout which identifies the various rooms and smoke compartments. A review of the facility provided layout identified that there is one (1) enclosed center courtyard in the facility. Starting at 10:53 AM, in the presence of the facility MD a tour of the building was conducted. During the tour the surveyor observed the following locations that failed to have illuminated exit signs to clearly identify the exit access route:	K 293	No residents were found to be affected by the deficient practice. All residents have the potential to be affected by the deficient practice. Education: The Maintenance Director educated all Maintenance Staff fully functioning Exit and directional signs . Systems Change: Two locations identified as needing an illuminated exit sign in the courtyard had the illuminated exit signs installed on August 22, 2022. Monitoring: The Maintenance Director will tour the entire building monthly to complete a standardized audit of the physical environment. The Maintenance Director will report the results at the Quarterly QAPI meeting. The QAPI Committee reviews, evaluates and makes recommendations to sustain compliance	

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	315091	A. BUILDING **01** B. WING _____	**08/04/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE** **CRANFORD, NJ 07016**

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K 293	Continued From page 3 1. At 12:08 PM, the surveyor observed in the outside enclosed center courtyard (located between Wing #3 and Wing #4) failed to have two (2) illuminated exit signs. One illuminated exit sign above each of the two (2) exit access doors leading you out of the enclosed center courtyard. This finding was verified by the facility's Maintenance Director at the time of inspection. The Administrator was notified of the finding at the Life Safety Code exit conference on 8/04/2022 at 1:22 PM. Fire Safety Hazard. NJAC 8:39 -31.1 (c) NFPA Life Safety Code 101	K 293		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.	K 351		9/3/22

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	315091	A. BUILDING **01** B. WING _____	**08/04/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE** **CRANFORD, NJ 07016**

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K 351	Continued From page 4 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 8/03/2022, it was determined the facility failed to provide proper fire sprinkler coverage to all areas of the facility, as required by National Fire Protection Association (NFPA) 13 for Installation of Sprinkler Systems. The New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. The evidence includes the following: On 8/03/2022 (day one of the survey) during the survey entrance at 10:25 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility layout which identifies the various rooms and smoke compartments in the facility. Starting at approximately 10:50 AM, in the presence of facility's MD a tour of the building was conducted. Along the tour the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following location: 1. At 12:15 PM, on Wing 3 next to the double smoke doors by Resident room #301 the surveyor observed no evidence of fire sprinkler protection inside the four (4) feet six (6) inch deep by two (2) feet six (6) inch wide alcove area. At this time the surveyor asked the MD, do you see a fire sprinkler in the alcove. The MD looked inside and said, no. This finding was verified by the facility's	K 351	No residents were found to be affected by the deficient practice. All residents in the area of W301 have the potential to be affected. Education: The Maintenance Director educated all Maintenance Staff regarding approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. . System change: The identified alcove area was removed from the facility. Monitoring: The Maintenance Director will tour the entire building monthly to complete a standardized audit of the physical environment. The Maintenance Director will report the audit findings at the Quarterly QAPI meeting. The QAPI Committee reviews, evaluates and makes recommendations to sustain compliance	

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K 351	Continued From page 5 Maintenance Director at the time of inspection. The Administrator was notified of the finding at the Life Safety Code exit conference on 08/04/2022 at 1:22 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351		
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations on 8/03/2022 and 8/04/2022 in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 2 of 12 resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: During the survey entrance on 8/03/2022 at 10:25 AM, a request was made to the facility's Administrator and Maintenance Director (MD) to provide a copy of the facility layout which	K 521	No residents were found to be affected by the deficient practice. Residents in odd numbered rooms in Wing One have the potential to be affected by the deficient practice. Education: The Maintenance Director educated all maintenance staff regarding resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. System change:	9/3/22

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K 521	Continued From page 6 identified the various rooms in the facility. Starting at 10:53 AM, in the presence of the facility's MD, an inspection of 12 Resident rooms was performed. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 2 of 12 resident bathrooms in the following locations: On 08/03/2022, 1. At 11:04 AM, inside Resident room #113 bathroom, when tested the exhaust system did not function properly. At this time, the surveyor informed the MD that the exhaust system did not function properly. 2. At 11:11 AM, inside Resident room #107 bathroom, when tested the exhaust system did not function properly. All the bathrooms had no windows with an area that would open. The bathrooms would rely on mechanical ventilation. This finding was verified by the facility's Maintenance Director at the time of inspection. The Administrator was notified of the finding at the Life Safety Code exit conference on 08/04/2022 at 1:22 PM. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521	The exhaust system was repaired on August 22, 2022. The maintenance checklist was modified to include bathroom exhaust system tests. Monitor: The Maintenance Director or designee will complete the Exhaust Systems Audit weekly of at least 2 rooms on each wing. The audits will be weekly for twelve weeks. The Maintenance Director will present the Exhaust Systems Audit results at the quarterly QAPI meeting. The QAPI Committee reviews, evaluates and makes recommendations to sustain compliance.	

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K 912	Continued From page 7	K 912		
K 912 SS=D	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 8/03/2022, in the presence of facility management, it was determined that the facility failed to ensure that 1 of 6 electrical outlets located next to a water source was equipped with proper working Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: During the survey entrance on 8/03/2022 at 10:25 AM, a request was made to the facility's Administrator and Maintenance Director (MD) to provide a copy of the facility layout which identified the various rooms in the facility. Starting at 10:53 AM, in the presence of the facility's MD, a tour of the building was conducted. Along the tour, the surveyor tested six (6) Ground-Fault Circuit Interrupter (GFCI) outlets located in wet locations with a GFCI tester to de-energize the outlets.	K 912	No residents were found to be affected by the deficient practice. All residents utilizing the soiled utility room on Wing 4 had the potential to be affected by the deficient practice. The GCFI outlet was replaced on August 4, 2022. Education: The Maintenance Director educated all Maintenance staff. Systems Change: The GCFI outlet was replaced on August 4, 2022. GCFI checks will be added to the Maintenance checklist. The Maintenance Director will complete an audit of 5 GCFI outlets weekly for twelve weeks. The Maintenance Director will present the audit at the Quarterly QAPI Committee Meeting.	9/3/22

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BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER	**205 BIRCHWOOD AVE** **CRANFORD, NJ 07016**

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K 912	Continued From page 8 At 1:33 PM, one GFCI electrical outlet inside Wing four (4) Soiled utility room when tested did not de-energize as required by code. The GFCI tester identified the GFCI outlet as having the Ground and Hot wires reversed. This finding was verified by the facility's Maintenance Director at the time of inspection. The Administrator was notified of the finding at the Life Safety Code exit conference on 8/04/2022 at 1:22 PM. NJAC 8:39 -31.2 (e) NFPA 99	K 912	The QAPI Committee reviews, evaluates and makes recommendations to sustain compliance.	
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by	K 918		9/3/22

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K 918	Continued From page 9 competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/03/2022 , in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 emergency generator was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents and was evidenced by the following: During the survey entrance on 8/03/2022 at 10:25 AM, a request was made to the facility's Administrator and Maintenance Director (MD) if the facility had an emergency generator. The MD said, yes we have one. Later during the building tour with the facility MD 1:50 PM, an inspection inside the mechanical room where the emergency generator is located was performed.	K 918	No residents were found to be affected by the deficient practice. All residents have the potential to be affected by the deficient practice. The remote manual stop station was relocated on August 4, 2022. Education: The Maintenance Director educated all Maintenance Staff regarding remote manual stop stations. System Changes: The stop station was relocated to a remote area on August 4, 2022. Monitor: The Maintenance Director will tour entire building monthly to complete a	

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K 918	Continued From page 10 The surveyor observed that the generator's emergency stop button was located on the front of the generator control panel At this time the surveyor asked the MD, do you have a remote stop button somewhere else for the generator. The MD said, no that is the emergency stop button. This finding was verified by the facility's Maintenance Director at the time of inspection. The Administrator was notified of the finding at the Life Safety Code exit conference on 8/04/2022 at 1:22 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	standardized audit of the physical environment. The Maintenance Director will present the audit at the Quarterly QAPI Meeting. The QAPI Committee reviews, evaluates and makes recommendations to sustain compliance	

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{K 000}	INITIAL COMMENTS	{K 000}		

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

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.