STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315370	A. BUILDING _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARNEGIE POST ACUTE CARE AT PRINCETON LLC	5000 WINDROW DRIVE PRINCETON, NJ 08540

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Survey Date: 1/31/23 Census:131 Sample: 27 + 2 closed records 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 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F 623		3/15/23

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

Electronically Signed | 02/10/2023

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

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F 623	Continued From page 2 the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide written notification of the emergency transfer to the resident, resident representative, and the Office of the Long-Term Care Ombudsman (LTCO) for two (2) of two (2) residents (Resident	F 623	How the corrective action will be accomplished for those residents found to be affected by this practice? ¿ Affecting Resident #88 and Resident #113. The Admission Director & Social Worker were in-serviced on sending out	

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F 623	Continued From page 3 # 88 and Resident # 113), reviewed for hospitalizations. This deficient practice was evidenced by the following: 1. The surveyor reviewed the medical records of Resident # 88. Review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to EX Order 26.4B1 Review of the New Jersey Universal Transfer Form (NJUTF) dated EX Order 26.4B1 indicated the resident was transferred to the hospital for EX Order 26.4B1 Review of the Minimum Data Set (MDS) dated EX Order 26.4B1 indicated the resident had a discharge assessment with return anticipated. Review of the NJUTF dated EX Order 26.4B1, indicated the resident was transferred to the hospital for EX Order 26.4B1 Review of the MDS dated EX Order 26.4B1 indicated the resident had a discharge assessment with return anticipated. Review of the NJUTF dated EX Order 26.4B1 indicated the resident was transferred to the hospital for EX Order 26.4B1 Review of the MDS dated EX Order 26.4B1, indicated the resident had a discharge assessment with return	F 623	the resident□s discharge information to the resident or resident representative and to the Office of the State Long Term Care Ombudsman to ensure a written notification of the emergency transfer is sent to the resident, resident representative, and the Office of the Long-Term Care Ombudsman. How the Facility will identify other residents having the potential to be affected by the same deficient practice? ¿ All Residents who have been transferred or discharged have the ability to be affected by the facility not meeting the requirements of a written notification of the emergency transfer being sent to the resident, resident representative, and the Office of the Long-Term Care Ombudsman. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? ¿ The Admission Director & Social Worker were in-serviced on sending out the Transfer/Discharge information to the resident or resident representative and the Office of the State Long Term Care Ombudsman. ¿ Social Worker/designee will audit Transfer/Discharge notification sheets that they are properly sent and that it matches the discharge/transfer of those residents, monthly for 3 months then quarterly thereafter.	

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F 623	Continued From page 4 anticipated. Review of the NJUTF dated EX Order 26.4B1, indicated the resident was transferred to the hospital for EX Order 26.4B1 ." Review of the MDS dated EX Order 26.4B1 indicated the resident had a discharge assessment with return anticipated. Review of the NJUTF dated EX Order 26.4B1, indicated the resident was transfered to the hospital for EX Order 26.4B1 Review of the MDS dated EX Order 26.4B1 indicated the resident had a discharge assessment with return anticipated. On 1/25/23 at 1:14 PM, the surveyor interviewed the Admissions Director (AD) who stated she was responsible for notifying the residents and resident representatives of the facility's bed-hold policy and notice of transfers. She stated she began her position as the Admission Director on EX Order 26.4B1. She stated she notified the Social Worker of the emergency transfers and discharges who then notified the Ombudsman office monthly. On 1/25/23 at 1:18 PM, the surveyor interviewed the Social Worker (SW) who stated she began her position as the SW the end of September of 2022. She confirmed that she was responsible for notifying the Long-Term Care Ombudsman office of emergency transfer(s) and discharges on a monthly basis. On that same date at 1:20 PM, the Admissions	F 623	How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?) ¿ The Admission Director/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits.	

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F 623	Continued From page 5 Director provided the surveyor with the Notice of Transfer for Resident # 88 dated [redacted]. The Admission Director could not provide any documented evidence of the Notice of Transfer notices to the resident representative for [redacted] On 1/26/23 at 10:54 AM, the SW provided the surveyor with a monthly "Admission/Discharge" report from August to December 2022, sent to the Ombudsman office via email. Resident # 88 was listed on the August 2022 "Admission/Discharge" report. However, review of the October through December 2022 Admissions/Discharge report indicated Resident # 88 was not listed. At that same time, the SW stated, "I ran the discharge report incorrectly that was why Resident # 88 was not on the October, November, and December discharge list that I sent to the Ombudsman office. Now moving forward, I will ensure that the list matches the census and those who are transferred to the hospital and discharged home." On 1/27/23 at 1:35 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) and discussed the above findings. There was no additional information provided. 2. The surveyor reviewed the medical records of Resident #113. Review of the Admission Record reflected that	F 623		

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F 623	Continued From page 6 the resident was admitted to the facility with diagnoses which included but not limited to EX Order 26.4B1 Review of the NJUTF dated EX Order 26.4B1, indicated the resident was transferred to the hospital. Review of the MDS dated EX Order 26.4B1, indicated the resident had a discharge assessment with return anticipated. Review of Resident #113's "Progress Notes" revealed a Ex.Order 26.4(b)(1) Nursing Notes that indicated the physician requested for the resident to be transferred to the emergency room for possible EX Order 26.4B1 EX Order 26.4B1 Review of Resident #113's medical record did not include a notification letter to the Office of the State Long-Term Care Ombudsman of the transfer to the hospital. On 1/26/23 at 11:11 AM, the surveyor interviewed the AD who stated she started working at the facility the week of Thanksgiving 2022. The AD further stated that she was unable to provide the resident's notifications of emergency transfer to the hospital because she was unable to locate her predecessor's documents. The AD added that she attempted to reach out via email but had not received a response. On 1/27/23 at 1:38 PM, the surveyor interviewed the LNHA who stated that he tried to reach out to the previous staff but had not received a	F 623		

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F 623	Continued From page 7 response. The LNHA added that he had no additional information to provide. Review of the facility's undated policy for "Notice Requirements for Transfer/Discharge of a Long-Term Care Resident" include that the notice of transfer or discharge form will be completed by the nursing/social services department. The resident/responsible party will be notified. Resident discharge list will be emailed to the Ombudsman office on a monthly basis.	F 623		
F 625 SS=B	NJAC 8:39-5.3; 5.4 Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.	F 625		3/15/23

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F 625	Continued From page 8 §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide residents and/or their representatives with the facility's notice of bed hold policy. This deficient practice was identified for two (2) of two (2) resident (Resident # 88 and Resident # 113), reviewed for hospitalization. This deficient practice was evidenced by the following: 1. The surveyor reviewed the medical records of Resident # 88. Review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to EX Order 26.4B1 [redacted] Review of the New Jersey Universal Transfer Form (NJUTF) dated [redacted], indicated the resident was transferred to the hospital for [redacted] Review of the Minimum Data Set (MDS) dated [redacted], indicated the resident had a discharge assessment with return anticipated.	F 625	How the corrective action will be accomplished for those residents found to be affected by this practice? ¿ Affecting Resident #88 and Resident #113. The Admission Director were in-serviced on sending out the facility□s bed hold policy to the resident or resident representative to ensure that the resident and resident representative is aware of the facility□s bedhold policy upon a resident□s discharge/transfer. How the Facility will identify other residents having the potential to be affected by the same deficient practice? ¿ All Residents who have been transferred or discharged have the ability to be affected by the facility not meeting the requirements of notifications bed hold policy before/upon transfer.. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? ¿ The Admission Director was in-serviced on sending out the facility□s bed hold policy to the resident or resident representative.	

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F 625	Continued From page 9 Review of the NJUTF dated EX Order 26.4B1, indicated the resident was transferred to the hospital for EX Order 26.4B1 Review of the MDS dated EX Order 26.4B1 indicated the resident had a discharge assessment with return anticipated. Review of the NJUTF dated EX Order 26.4B1 indicated the resident was transferred to the hospital for Ex.Order 26.4(b)(1). Review of the MDS dated EX Order 26.4B1, indicated the resident had a discharge assessment with return anticipated. Review of the NJUTF dated EX Order 26.4B1 indicated the resident was transferred to the hospital for EX Order 26.4B1 ." Review of the MDS dated EX Order 26.4B1, indicated the resident had a discharge assessment with return anticipated. Review of the NJUTF dated EX Order 26.4B1 indicated the resident was transferred to the hospital for ex.Order 26.4(b)(1 Review of the MDS dated EX Order 26.4B1 indicated the resident had a discharge assessment with return anticipated. On 1/25/23 at 1:14 PM, the surveyor interviewed the Admissions Director (AD) who stated she was responsible for notifying the residents and resident representative of the facility's bed-hold policy and notice of transfers. She stated she	F 625	¿ Admissions Director/designee will audit the bed hold policy notification forms that they are properly sent and that it matches the discharge/transfer of those residents, weekly for 1 month then monthly for 3 months, followed by quarterly thereafter. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?) ¿ The Admission Director/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits.	

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F 625	Continued From page 10	F 625		

began her position as the Admission Director on 11/21/22. She stated she notifies the Social Worker of the emergency transfers and discharges who then notifies the Ombudsman office monthly.

On 1/25/23 at 1:18 PM, the surveyor interviewed the Social Worker (SW) who stated she began her position as the SW the end of September of 2022. She confirmed that she was responsible for notifying the Long-Term Care Ombudsman office of emergency transfer(s) and discharges on a monthly basis.

On that same date at 1:20 PM, the Admissions Director provided the surveyor with the Bed-Hold policy form dated 12/16/22. The Admissions Director could not provide any documented evidence of bed-hold notifications from August through November 2022.

On 1/27/23 at 1:35 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) and discussed the above findings.

There was no facility Bed-Hold policy provided. The Admissions Director provided a blank Bed-Hold notification form which indicated that based on Federal regulations, the facility was required to offer the option of holding the bed should a resident be discharged to the hospital for medical necessity. The notification form also included that Medicaid had a ten (10) day Bed-Hold policy and the bed would be held for 10 days at no charge. It further revealed that Medicare and private insurance do not have a Bed-Hold policy.

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F 625	Continued From page 11 There was no additional information provided. 2. The surveyor reviewed the medical records of Resident #113. Review of the Admission Record reflected that the resident was admitted to the facility with diagnoses which included but not limited to [redacted] Review of the NJUTF dated [redacted] indicated the resident was transferred to the hospital. Review of the MDS dated [redacted] indicated the resident had a discharge assessment with return anticipated. Review of Resident #113's "Progress Notes" revealed a 10/08/22 Nursing Notes that indicated the physician requested for the resident to be transferred to the emergency room for possible [redacted] Review of Resident #113's medical record did not include a notification letter to the residents and/or their representatives with the facility's notice of bed-hold policy. On 1/26/23 at 11:11 AM, the surveyor interviewed the AD who stated she started working at the facility the week of Thanksgiving 2022. The AD further stated that she was not able to provide	F 625		

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F 625	Continued From page 12 the resident's notification of bed-hold policy because she was unable to locate her predecessor's documents. The AD added that she attempted to reach out via email but had not received a response. On 1/27/23 at 1:38 PM, the surveyor interviewed the LNHA who stated that he tried to reach out to the previous staff but had not received a response. The LNHA added that he had no additional information to provide.	F 625		
F 656 SS=E	NJAC 8:39-5.3 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		3/15/23

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CARNEGIE POST ACUTE CARE AT PRINCETON LLC	**5000 WINDROW DRIVE PRINCETON, NJ 08540**

(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 656	Continued From page 13 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to a.) develop a comprehensive, person-centered care plan to address EX Order 26.4B1 care for Resident #16, b.) develop a comprehensive, person-centered care plan to address a Ex.Order 26.4(for Resident #83, c.) develop a comprehensive, person-centered care plan to address the use of an EX Order 26.4B1 for Resident #109 and d.) develop a comprehensive, person-centered care plan to address EX Order 2 for Resident #122. This deficient	F 656	How the corrective action will be accomplished for those residents found to be affected by this practice? ¿ Affecting Resident #16, Resident #83, Resident 109, and Resident #122. The MDS Coordinator, and nurses were in-serviced on developing and implementing comprehensive care plans based on resident□s diagnosis and resident□s Care Area Assessment (CAA) Triggers Summary. ¿ Ex.Order 26.4(b)(1) plan was initiated for	

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F 656	Continued From page 14 practice was identified for 4 of 29 residents reviewed for comprehensive care plans and was evidenced by the following: 1. On 1/20/23 at 12:25 PM, the surveyor observed Resident #16 in the dining room in a recliner. The resident was Ex.Order 26.4(b)(1) [redacted]. A review of the resident's medical record reflected the following: Review of the residents Admission Record (an admission summary) reflected that he/she was admitted with diagnoses that included but not limited to EX Order 26.4B1. Review of the residents Admission Minimum Data Set (MDS), a tool to facilitate the management of care, dated EX Order 26.4B1 reflected that he/she had a diagnosis of EX Order 26.4B1 with a Brief Interview for Mental Status (BIMS) score of EX Orde which indicated a EX Order 26.4B1. In addition, in the Care Area Assessment (CAA) of the MDS, it reflected that EX Order 26.4B1 loss was coded as an actual problem and indicated goals for the resident to maintain his/her current level of functioning and to minimize risks related EX Order 26.4B1. Review of the residents Comprehensive Care Plan (CCP) did not reflect or address EX Order 26.4B1 EX Order 26.4B1 for Resident #16. On 1/25/23 at 10:48 AM, the surveyor interviewed the Registered Nurse (RN) MDS Coordinator (RN MDS) in the presence of the survey team. He stated that it was the	F 656	resident #16. Ex.Order 26.4(b)(1) was initiated for Resident #83. Ex.Order 26.4(b)(1) therapy initiated for Resident #109. Pain care plan initiated for Resident #122 How the Facility will identify other residents having the potential to be affected by the same deficient practice? ¿ All Residents have the ability to be affected by the facility not meeting the requirements of developing/implementing comprehensive care plans. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? ¿ The MDS Coordinator, Nursing Managers, Activity Director, Social Services, Director of Rehabilitation, and Dietician were in-serviced on the development and implementation of comprehensive care plans based on the resident□s diagnosis, and Care Area Assessment (CAA) Triggers Summary. ¿ MDS Coordinator/designee will audit new admissions and OBRA assessments(including quarterly,annual and significant change assessments) to ensure comprehensive care plans are in line with the resident□s diagnosis and care that is being provided for the resident, weekly for 1 month then monthly for 3 months, followed by quarterly thereafter. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality	

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F 656	Continued From page 15 interdisciplinary team members who were responsible to ensure that the residents needs were addressed in the comprehensive care plan. He further stated that he was responsible to coordinate and oversee that each discipline accurately and comprehensively developed the residents care plan to address his/her individual needs. The RN MDS also stated that if an area was triggered in the CAA's, it should have been addressed in the resident's comprehensive care plan. On 1/25/23 at 11:11 AM, the surveyor and the RN MDS reviewed the electronic medical record for Resident #16 in the presence of the survey team. He acknowledged that the Admission MDS indicated that the resident had a diagnosis of EX Order 26.4B1 He stated that the person who completed that section (section I) should have initiated and ensured there was a care plan for EX Order 26.4B1 . He further acknowledged that EX Order 26.4B1 was not addressed in Resident #16's comprehensive care plan. The RN MDS stated that "this is a problem." On 1/26/23 at 12:28 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the survey team. He stated that it was the nurses responsibility to develop the resident's comprehensive care plan and that he was ultimately responsible, "that would be me" to oversee and ensure that the resident care plans are complete and comprehensive. On 1/27/23 at 1:34 PM, the surveyors met with the DON and the Licensed Nursing Home Administrator (LNHA) for responses to previously	F 656	assurance program will be put into place?) ¿ The MDS Coordinator/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits.	

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F 656	Continued From page 16	F 656		

shared surveyor concerns. At that time, the DON stated that a care plan for EX Order 26.4B1 loss should have been initiated on the baseline care plan and then the personalized comprehensive care plan for Resident #16.

Review of the facility policy "Dementia Care" dated 3/2022, included that "It is the policy of this facility to provide appropriate care for those residents with dementia or similar cognitive impairments." It also reflected that "Staff should follow the resident's plan of care."

2. On 1/18/23 at 12:07 PM, the surveyor observed Resident #83 in bed awake lying comfortably watching tv.

Review of Resident #83's medical record revealed the following information:

Review of the resident's Admission Record revealed that Resident #83 had diagnoses that included but were not limited to EX Order 26.4B1 [redacted]

Review of the resident's Quarterly MDS dated 11/17/22 revealed the resident had a BIMS score of [redacted] out of [redacted] which indicated that the resident had EX Order 26.4B1 [redacted]

Review of electronic Order Summary Report (OSR) included a physician's order (PO) for EX Order 26.4B1 [redacted] daily every day shift."

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F 656	Continued From page 17 Review of the January 2023 electronic Treatment Administration Record (eTAR) reflected the above corresponding PO's. Review of resident's Ex.Order 26.4(b)(1) [redacted] t Summary report's from the [redacted] management company on 1/19/23, 1/12/23, and 1/05/23 revealed under Focused Exam (Site 1): "Non - EX Order 26.4B1 [redacted] " and Ex.Order 26.4(b)(1) [redacted] Review of the resident's CCP did not reflect the treatment to EX Order 26.4B1 for Resident #83. On 1/26/23 at 10:26 AM, the surveyor discussed the concern with the DON who acknowledged that there was no care plan initiated for the [redacted]. The DON stated that the care plan should have been added. No further information was provided. On 01/26/23 at 10:34 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that the care plan should have been initiated by the nurse who entered the physician's order and as soon as the resident started the treatment. The RN/UM further stated that in the event he/she could not do so they would be responsible to notify the nurse supervisor. Review of undated facility policy "Wound Care", reflected in the procedure that: "19. Update skin breakdown care plan with skin impairment." 3. On 1/18/23 at 11:18 AM, the surveyor	F 656		

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F 656	Continued From page 18 observed Resident #109 lying in bed, alert and oriented watching tv, with a call bell within reach. Review of Resident #109's medical record revealed the following information: Review of the resident's Admission Record revealed that Resident #109 had diagnoses that included but were not limited to EX Order 26.4B1 [redacted] Review of the resident's Quarterly MDS dated EX Order 26.4B1 revealed the resident had a BIMS score of [redacted] out of EX Ord, which indicated that the resident had an EX Order 26.4B1. Review of the OSR indicated a PO dated EX Order 26.4B1, for EX Order 26.4B1 [redacted] EX Order [redacted]). Review of the January 2023 electronic Medication Administration Record (eMAR) reflected the above corresponding PO's. Review of the resident's CCP did not reflect the use of EX Order 26.4B1 for Resident #109 On 1/26/23 at 10:23 AM, the surveyor discussed the concern with the DON who acknowledged that there was no care plan initiated for the resident upon receiving EX Order 26.4B1. No further information was provided.	F 656		

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F 656	Continued From page 19	F 656		

4. On 1/18/23 at 10:45 AM, the surveyor observed Resident #122 sitting in wheelchair next to bed. The resident was stated they had a history o[EX Order 26] and had been on [EX Order 26] medication prior to being admitted. Resident #122 added that the facility had to "figure everything out." During the interview, the resident denied having [Ex.Order 26] and shows Ex.Order 26.4(b)(1) .

A review of the resident's medical record reflected the following:

Review of the Admission Record reflected that the resident was admitted to the facility with diagnoses which included but not limited to EX Order 26.4B1 EX Order 26.4B1

Review of Resident #122's Admission MDS, dated [EX Order 26.4B], reflected that the resident was EX Order 26.4B1 and had received as needed Ex.Order 26.4(b)(1) in the last five days. The MDS revealed that the resident had frequent [EX Order 26] which made it hard to sleep at night and had to limit his/her day-to-day activities because o[Ex.Order 26.4]

Review of Resident #122's 1/8/23 CAA Triggers Summary (Care Area Assessment) (care areas triggered by MDS response) revealed Ex.Order 26.4(b)(1) was triggered and that it was addressed in the CP.

Review of the residents OSR revealed a PO, dated [EX Order 26.4B1] for EX Order 26.4B1 and to

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F 656	Continued From page 20 administer EX Order tablet every EX Order 2 hours as needed for EX Order 26.4B1 This order was discontinued on EX Order 26.4B1 The OSR revealed additional POs, dated 1/8/23, 1/11/23 and 1/12/23 for EX Order 26.4B1 and to administer EX Order tablet every EX Order 26 hours as needed for EX Order 26.4B1. Review of Resident #122's EX Order 26.4B1 Medication Administration Record revealed the resident was administered EX Order 26.4B1 on: EX Order 26.4B1	F 656		

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F 656	Continued From page 21	F 656		

EX Order 26.4B1 [redacted]

Review of the residents CCP did not reflect or address [redacted] for Resident #122.

On 01/25/23 at 10:48 AM, the surveyor interviewed the RN MDS who stated the completion of the CCP was an interdisciplinary team effort. The RN MDS added that CPs were entered by the discipline of each department and the care areas triggered by the MDS should be addressed in the CCP. The RN MDS reviewed Resident #122's MDS and CCP, in the presence of the surveyor, and confirmed that [redacted] was not addressed. The RN MDS added that [redacted] should have been addressed in the resident's CCP.

On 01/25/23 at 11:02 AM, the surveyor interviewed the Registered Nurse Unit Manager (RN UM) who stated that the UM's reviewed and revised the CCP as needed. The RN UM added that it was the responsibility of the interdisciplinary team to make sure the CCP addressed all of the resident's needs.

On 01/26/23 at 12:27 PM, the surveyor

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F 656	Continued From page 22 interviewed the DON who stated that he expected Resident #122's CCP to address the resident's [EX Order 26] Review of the facility's "Comprehensive Care Plan" policy, revised 02/2022, included that the CCP would be resident centered having the individual resident as the focus of control. Each discipline would be responsible for the initiation and ongoing follow up for the care plans as related to their area of expertise. The policy indicated the CCP would address resident goals, actual and potential problems, needs, strengths, and preferences.	F 656		
F 658 SS=E	NJAC 8:39-11.2 (e)(2) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) follow physician orders for [EX Order 26.4B1] [EX Order 26.4B1] [EX Order 26.4B1] levels every three months since [EX Order 26.4B1] for Resident #13. This deficient practice was identified for 1 of 28 residents (Resident # 13) reviewed for physician orders; b.) act upon the [EX Order 26.4B1] Consultation's recommnedation according to professional standards of clinical practice for Resident #90. This deficient practice	F 658	How the corrective action will be accomplished for those residents found to be affected by this practice? ¿ Affecting Resident #13 and Resident #90. Doctor was called and labs were drawn for Resident #13. The [EX Order 26.4B1] was called and order was clarified regarding Resident #90. ¿ All Nurses were in-serviced on following physician orders and consultation recommendations to ensure	3/15/23

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F 658	Continued From page 23 was evidenced for 1 of 2 residents (Resident #90) reviewed for EX Order 26.4B1 This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 1/18/23 at 12:46 PM, the surveyor observed Resident # 13 in bed awake watching television. The surveyor reviewed the medical records of	F 658	they meet the professional standards of care. How the Facility will identify other residents having the potential to be affected by the same deficient practice? ¿ All Residents have the ability to be affected by the facility not meeting the professional standards of care. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? ¿ All Nurses were in-serviced on the importance of following physician orders and consultation recommendations. ¿ Unit Managers/designee will audit new physician□s orders and consultation recommendations for accuracy and follow thru, weekly for 1 month then monthly for 3 months, followed by quarterly thereafter. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?) ¿ TheDON/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits.	

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F 658	Continued From page 24 Resident #13. Review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to EX Order 26.4B1. Review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated EX Order 26.4B1, reflected the resident had a brief interview for mental status (BIMS) score of EX Order Further review of the MDS indicated that the resident's EX Order 26.4B1 for daily decision making was EX Order 26.4B1 EX Order 26.4B1 Review of the electronic Order Summary Report indicated a physician's order (PO) dated EX Order 26.4B1 level's every EX Order 26.4B1 Further review of the electronic Order Summary Report reflected a PO dated EX Order 26.4B1, for EX Order 26.4B1 EX Order 26.4B1), give EX Order 26.4B1 tablets by mouth in the afternoon for Ex.Order 26.4(b)(1) EX Order 26.4B1), and a PO dated EX Order 26.4B1 capsule EX Order 26.4B1 give Ex.Order 26.4( ) capsules by mouth at bedtime for , and a PO dated EX Order 26.4B1 for EX Order 26.4B1, give Ex.Order tablet by mouth every EX Orde hours for EX Order 26.4B1. Review of the January 2023 electronic Medication Administration Record (eMAR) reflected the above corresponding PO's. Review of the resident's comprehensive care plans reflected a focus area for actual EX Order 26.4B1 risk related to EX Order 26.4B1	F 658		

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F 658	Continued From page 25 Interventions implemented on 1/18/23 reflected to obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Give medications as ordered by doctor. Review of the electronic and paper chart for Resident # 13 revealed a EX Order 26.4B1 level dated EX Order 26.4B1, which indicated a Ex.Order 26.4(b)(1) value of EX Order 26.4B1 The normal value for EX Order 26.4B1 level is EX Order 26.4B1 Further review of the electronic and paper chart revealed a EX Order 26.4B1 level dated EX Order 26.4B1, which indicated a Ex.Order 26.4(b)(1) There were no EX Order 26.4B1 levels obtained as ordered by the physician and the EX Order 26.4B1 levels were not obtained every three months as ordered by the physician on EX Order 26.4B1. On 1/24/23 at 9:34 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the EX Order 26.4B1 levels were not done because "we changed labs and didn't get done." He stated the EX Order 26.4B1 levels were done "yesterday" EX Order 26.4B1 and the nurse practitioner (NP) discontinued the order for labs every three months for the EX Order 26.4B1. Review of the EX Order 26.4B1 level indicated a level of EX Order 26.4B1 which was Ex.Order 26.4(b)(1) level. A normal EX Order 26.4B1 level is EX Order 26.4B1. Review of the EX Order 26.4B1 level indicated a level of EX Order 26.4B1 which was Ex.Order 26.4(b)(1) limits.	F 658		

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	315370	A. BUILDING _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 26 Review of the electronic Progress Notes (ePN) dated 1/24/23 timed at 8:30 AM and documented by the Nurse Practitioner (NP). The ePN indicated that the NP spoke with the resident's primary care physician (PCP) and discussed the EX Order 26.4B1 levels for every three months. The PCP ordered to discontinue the EX Order 26.4B1 levels every three months. There was no additional information provided. NJAC 8:39-11.2(b) 2. On 1/20/23 at 12:14 PM, the surveyor observed Resident #90 lying in bed awake. He/she was Ex.Order 26.4(b)(1) with the surveyor. On the left side of the resident's bed, the surveyor observed a EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1 in a privacy bag that was hung on the left side of the bed. The surveyor reviewed the medical record for Resident #90 which revealed the following: A review of the Admission Record (an admission summary) reflected diagnoses that included but not limited to EX Order 26.4B1). A review of the 11/10/22, Significant Change in Status Assessment Minimum Data Set (SCSA/MDS), an assessment tool used to	F 658		

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F 658	Continued From page 27 facilitate the management of care, indicated that the resident's EX Order 26.4B1 . It also reflected that the resident had an EX Order 26.4B1 EX Order 26.4B1 A review of EX Order 26.4B1 Report of Consultation form dated EX Order 26.4B1 reflected a diagnosis of EX Order 26.4B1 Retention (EX Order 26.4B1) with a recommendation to Ex.Order 26. the EX Order 26.4B1 tube daily with EX Order 26.4 (cubic centimeter) of EX Order 26.4B1 A review of the Order Summary Report with an order date of EX Order 26.4B1 and the resident's January 2022 electronic medication administration record (eMAR), reflected a physician's order to Ex.Order 26 EX Order 26.4B1 with EX Order 26.4B1 daily to keep patent every day shift for Ex.Order 26.4(b)(1) On 1/25/23 at 1:14 PM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) who stated that when a resident returned to the facility from a consultation, he would review the consultation report form for the procedure that was done during resident's consultation and "any orders or recommendations." He also stated that after reviewing the consultation form, he would call the resident's Attending Physician (AP) to communicate the consult's recommendation. The UM/LPN stated that if the AP agreed with the recommendations, he would carry out and transcribe the AP orders into the EMAR via the orders tab on the resident's electronic medical records (EMR). Furthermore, he stated that he would document his conversation with the AP	F 658		

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F 658	Continued From page 28 and include their responses and orders in the resident's EMR in the Progress Notes section. During the interview, the surveyor inquired to the UM/LPN about Resident #90's EX Order 26.4B1 appointment. The UM/LPN stated that the resident's last EX Order 26.4B1 appointment was on Ex.Order 26.4(b)(1). The UM/LPN reviewed and read the resident's EX Order 26.4B1 Report of Consultation dated EX Order 26.4B1 in the presence of the surveyor. He acknowledged that the EX Order 26.4B1 consult's recommendation was to Ex.Order 26. the EX Order 26.4B1 daily with EX Order 26.4B1. He informed the surveyor that after he reviewed the consult form, he called the resident's AP and communicated to him the above recommendations. He stated that the AP gave him an order and "ok" to follow the EX Order 26.4B1 consultant's recommendation. The surveyor asked the UM/LPN why the EX Order 26.4B1 consult's recommendation and the AP order for the EX Order 26.4B1 were different and inconsistent. The UM/LPN acknowledged the discrepancies. On the same day at 1:29 PM, the UM/LPN called the EX Order 26.4B1 office and spoke to the LPN staff in the EX Order 26.4B1 office, in the presence of the surveyor. The UM/LPN asked the LPN to clarify the EX Order 26.4B1 recommendations on Ex.Order 26.4(b)(1) for Resident #90. The LPN acknowledged to the UM/LPN and the surveyor that the recommendation was to Ex.Order 26. the EX Order EX Order 26.4B1 On the same day at 1:33 PM, the UM/LPN acknowledged that the way he carried out and transcribed the AP's order was "wrong." He	F 658		

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F 658	Continued From page 29 acknowledged that he entered EX Order 26.4 instead of Ex.Order 26.4(b)(1), not according to EX Order 26.4B1 recommendation and AP's order, stating "It was a mistake." On 1/26/23 at 11:19 AM, the surveyor interviewed the LPN in the EX Order 26.4B1 office via phone call, in the presence of the survey team. The LPN acknowledged that she spoke to the UM/LPN and the surveyor in which she clarified the EX Order 26.4B1 consult recommendation to Ex.Order 26.4(b)(1) tube with EX Order 26.4B1 was clarified. When the surveyor asked the LPN when the EX Order 26.4B1 was clarified, she acknowledged that it was clarified on 1/25/23, after the surveyor's inquiry. On the same day at 12:59 PM, the surveyor informed the DON and LNHA of the above concerns, in the presence of the survey team. The surveyor showed the 1/17/23 EX Order 26.4B1 Report of Consultation form. The DON read the written EX Order 26.4B1 recommendation and confirmed that the recommendation was to Ex.Order 26 the EX Order 26.4B1 with EX Order 26.4B1 . On 1/30/23 at 1:08 PM, the DON and LNHA met with the survey team. The DON stated that when the resident returned from a consultation with recommendations, the receiving nurse in the facility should call the resident's AP to communicate the recommendations. He further stated that the nurse should document in the resident's electronic progress notes and include whether the AP agreed or disagreed with the recommendations. During the interview, the DON stated that if the nurse was in doubt and had questions about the recommendations, the nurse	F 658		

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F 658	Continued From page 30 should have called the consultant for clarification and document this in the progress notes. On 1/31/23 at 1:50 PM, the survey team met with the LNHA and DON. There was no further information provided. The facility's policy "Consult and Order" with a revised date of 3/2022, included "to follow through and carry out all consults and orders as needed a nd deemed necessary by the residents primary care physician."	F 658		
F 698 SS=E	NJAC 8:39-11.2(b) Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to a.) consistently monitor Ex.Order 26.4(b)(1) instructions in accordance with the physician's order and professional standards of care and b.) carry out a dietitian recommendation for 1 of 2 residents (Resident #71) reviewed for EX Order 26.4B1. This deficient practice was evidenced by the following:	F 698	How the corrective action will be accomplished for those residents found to be affected by this practice? ¿ Affecting Resident #71. Nurse immediately called the doctor and carried out proper recommendation for resident #71. Doctor was also notified about the fluids that were Ex.Order 26.4(b)(1) [redacted] parameters. ¿ The orders regarding Ex.Order 26.4(b)(1)	3/15/23

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F 698	Continued From page 31 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 01/19/23 01:35 PM, the surveyor observed Resident #71 in bed asleep wearing his/her own clothes. According to the Admission Record (an admission summary), the resident was readmitted with diagnoses that included but were not limited to EX Order 26.4B1 [redacted]	F 698	for resident #71 were rewritten to avoid confusion ¿ The Registered Dietician and nurses were in-serviced on consistently monitoring Ex.Order 26.4(b)(1) instructions and to properly carry out Dietician recommendations to ensure the facility is consistently monitoring Ex.Order 26.4(b)(1) instructions in accordance with the physician□s order and professional standards of care, and carry out dietitian recommendations. How the Facility will identify other residents having the potential to be affected by the same deficient practice? ¿ All Residents that are on Ex.Order 26.4(b)(1) and have an order for Ex.Order 26.4(b)(1) have the ability to be affected by the facility not meeting the requirements of consistently monitoring Ex.Order 26.4(b)(1) instructions in accordance with the physician□s order and professional standards of care, and carry out dietitian recommendations. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? ¿ The Registered Dietician and nurses were in-serviced on consistently monitoring Ex.Order 26.4(b)(1) instructions and to properly carry out Dietician recommendations ¿ The Registered Dietitian/designee will audit the new recommendation for Ex.Order 26.4 Ex.Order 26.4(b)(1) to ensure they are properly carried out, weekly for 1 month then monthly for 3 months, followed by	

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F 698	Continued From page 32 EX Order 26.4B1 Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated EX Order 26.4B1, Resident #71 revealed a BIMS score of EX Order out of EX Order, which indicated that the resident had EX Order 26.4B1 EX Order 26.4B1 and had Ex.Order EX Order 26.4B1 issues. Review of Resident #71's Care Plan (CP) initiated on 9/18/19, revealed that Resident #71 was at risk for Ex.Order 26.4(b)(1) related to EX Order 26.4B1 The CP further revealed an intervention that was initiated on EX Order 26.4B1, for EX Order 26.4B1. Review of Resident #71's EX Order 26.4B1 "Order Summary Report", revealed a physician's order dated EX Order 26.4B1, for EX Order 26.4B1 per day. The order indicated that nursing had EX Order ml per day and dietary had EX Order 26 ml per day. The order further instructed: Ex.Order 26.4(b)(1) EX Order 26.4B1 (EX Order 26.4B1) every shift for Ex.Order 26.4(b)(1) for Nursing 360 (1 EX Order 26.4B1); Dietary EX Order 26.4B1 Review of Resident #71's EX Order 26.4B1 Electronic Medication Administration Record (eMAR) reflected the above EX Order 26.4B1 order for EX Order 26.4B1 Ex.Order 26.4(b)(1) per day. The order was also specified on the MAR EX Order 26.4B1 per shift for nursing (180 7-3; 120 3-11; 60 11-7). The November 2022 MAR reflected that nurse administered fluids outside the physician ordered Ex.Order 26.4(b)(1) parameters as follows:	F 698	quarterly thereafter. ¿ The Registered Dietitian/designee will audit the MAR to ensure accurate fluid amounts are being given weekly for 1 month then monthly for 3 months, followed by quarterly thereafter. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?) ¿ The Registered Dietitian/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits.	

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F 698	Continued From page 33	F 698		

11/02/22: the nurse administered EX Order 26.4B1 on night shift.
11/05/22: the nurse administered EX Order 26.4B1 on evening shift.
11/09/22: the nurse administered EX Order 26.4B1 on night shift.
11/12/22: the nurse administered EX Order 26.4B1 on evening shift.
11/14/22: the nurse administered EX Order 26.4B1 on evening shift.
11/15/22: the nurse administered EX Order 26.4B1 on evening shift.
11/16/22: the nurse administered EX Order 26.4B1 on night shift.
11/17/22: the nurse administered EX Order 26.4B1 on evening shift.
11/20/22: the nurse administered EX Order 26.4B1 on evening shift.
11/22/22: the nurse administered EX Order 26.4B1 on day shift.
11/23/22: the nurse administered EX Order 26.4B1 on evening shift and 180 ml on night shift.
11/30/22: the nurse administered EX Order 26.4B1 on night shift.

The EX Order 26.4B1 MAR reflected that nurse administered fluids outside the physician ordered Ex.Order 26.4(b)(1) parameters as follows:

12/01/22: the nurse administered EX Order 26.4B1 on day shift.
12/03/22: the nurse administered EX Order 26.4B1 on day shift and 240 ml on evening shift.
12/08/22: the nurse administered EX Order 26.4B1 on evening shift.
12/10/22: the nurse administered EX Order 26.4B1 on evening shift.

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F 698	Continued From page 34 12/13/22: the nurse administered [EX Order 26.4B1] on day shift. 12/15/22: the nurse administered [EX Order 26.4B1] on day shift. 12/18/22: the nurse administered [EX Order 26.4B1] on day shift. 12/19/22: the nurse administered [EX Order 26.4B1] on evening shift. 12/21/22: the nurse administered [EX Order 26.4B1] on evening shift and 180 ml on night shift. 12/23/22: the nurse administered [EX Order 26.4B1] on evening shift. 12/24/22: the nurse administered [EX Order 26.4B1] on evening shift. 12/29/22: the nurse administered [EX Order 26.4B1] on night shift. The January 2023 MAR reflected that nurse administered fluids outside the physician ordered [Ex.Order 26.4(b)(1)] parameters as follows: 1/01/23: the nurse administered [EX Order 26.4B1] on evening shift. 1/05/23: the nurse administered [EX Order 26.4B1] on day shift and 280 ml on evening shift. 1/07/23: the nurse administered [EX Order 26.4B1] on evening shift. 1/14/23: the nurse administered [EX Order 26.4B1] on night shift. 1/15/23: the nurse administered [EX Order 26.4B1] on evening shift. 1/16/23: the nurse administered [EX Order 26.4B1] on night shift. 1/20/23: the nurse administered [EX Order 26.4B1] on day shift. Nursing was to administer [EX Order 26.4B1] per day.	F 698		

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F 698	Continued From page 35 During an interview with the Licensed Practical Nurse (LPN) on 1/25/23 at 1:18 PM, the LPN stated Resident #71 was on a EX Order 26.4B1 of EX Order 26.4B1, and it was broken down every shift and it was documented in the MAR at the end of each nurse's shift. The LPN further stated that the resident was unable get Ex.Order 26.4(b)(1) because the resident was [redacted] and that Ex.Order 26.4 were given by nursing. During an interview with the Director of Nursing (DON) on 1/26/23 at 10:13 AM, the DON stated that the staff were inconsistent with giving Ex.Order 26.4(to the resident and the staff should follow the physician order correctly. The DON further stated that the dietitian should be involved with the EX Order 26.4B1 so that the nurse would not give Ex.Order 26.4(more than the amount recommended by the physician. Review of Resident #71's 12/29/22 Dietitian Alert Sheet (DAS) revealed under Description of Problem: EX Order 26.4B1 with handwritten notation of Ex.Order 26.4(b)(1) " and on Recommendation with handwritten notations of: "1. change EX Order 26.4B1 ml/day: Nursing = EX Order 26.4B1 " Review of Resident #71's December 2022 "Order Summary Report" revealed that the Ex.Order 26 recommendations were not addressed to EX Order 26.4B1 per day. During an interview with the Registered Nurse/Unit Manager (RN/UM) on 01/23/23 at 11:58 AM, the RN/UM stated that if there' was a flagged up recommendation in a residents chart it	F 698		

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F 698	Continued From page 36 meant that there was an order recommendation and the physician needed to be called, and if the physician approved the recommendation, she would carry out the order. The RN/UM further stated that the dietitian recommendation was not carried out until today after surveyor inquiry. During an interview with the Dietitian on 01/23/23 at 12:16 PM, she stated that the resident had Ex.Order 26.4(b)(1) of within 6 months. The dietitian further stated that she wrote a recommendation to change the EX Order 26.4B1 to EX Order 26.4B1 per day then flagged it in the chart but failed to follow up with the nurses. During an interview with the Licensed Nursing Home Administrator on 01/27/23 at 01:42 PM, who stated that the expectation was that the nutritional recommendation should have been carried out. Review of the facility's undated policy "Fluid Restriction" included that "Guidelines 4. Nursing will document fluid given during med pass and residents compliance with Ex.Order 26.4(b)(1) ." Review of the facility's undated policy "Nutrition Documentation", included under Follow-Up: "Any changes to resident nutritional and dietary needs will be conducted through the RD."	F 698		
F 755 SS=E	NJAC 8:39-27.1(a) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency	F 755		3/15/23

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F 755	Continued From page 37 drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures 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 a.)accurately document the administration of a Ex.Order 26.4(b)(1) [redacted] for Resident #11; and b.) ensure that a resident was administered all their medications	F 755	How the corrective action will be accomplished for those residents found to be affected by this practice? ¿ Affecting Resident #11. LPN #1 was counseled on proper receipt and disposition of all Ex.Order 26.4(b)(1) sufficient detail to enable accurate	

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	315370	A. BUILDING _____ B. WING _____	01/31/2023

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CARNEGIE POST ACUTE CARE AT PRINCETON LLC	**5000 WINDROW DRIVE PRINCETON, NJ 08540**

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F 755	Continued From page 38 for Resident #11. This deficient practice was identified for one (1) of three (3) residents, Resident #11 and one (1) of two (2) nurses during medication observation pass; and failed to c.) maintain the availability of two [EX Order 26.4B1] medications ([EX Order 26.4B1] for (1) one of (6) six residents interviewed during resident council, Resident #103. 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	F 755	reconciliation. ¿ Affecting Resident #11. LPN #1 was counseled on ensuring residents complete the medication before discarding cup to ensure an accurate administering of all drugs to meet the needs of the resident. ¿ Affecting Resident #103. The unavailable [Ex.Order 26.4(b)(1)] medication for Resident #103, was located in the facility□s supply closet and given to residents nurse to administer when appropriate to ensure an accurate administering of all drugs to meet the needs of the resident. How the Facility will identify other residents having the potential to be affected by the same deficient practice? ¿ All Residents have the ability to be affected by the facility not meeting the requirements of providing pharmaceutical services in accordance with professional standards What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? ¿ All nurses were in-serviced on accurately documenting the administration of controlled medication, ¿ All nurses were in serviced to ensure that the resident completed the medication before discarding cup to ensure an accurate administering of all drugs to meet the needs of the resident. ¿ The Unit Managers/designee will	

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F 755	Continued From page 39 authorized physician or dentist." 1. On 1/26/22 at 9:05 AM, during the medication administration observation, the surveyor observed the Licensed Practical Nurse (LPN #1) in the room of Resident #11. The surveyor observed LPN #1 checking the resident's identification bracelet and informing Resident #11 that she will be administering the resident's medications. The surveyor observed that the resident just finished eating breakfast. On 1/26/23 at 9:05 AM, the surveyor observed the LPN #1 preparing to administer Ex.Order 26.4(b)(1) medications to Resident #11 which included EX Order 26.4B1 The surveyor observed LPN #1 remove a bingo card (medication administration system) from the Ex.Order 26.4(b)(1) that contained a card for EX Order 26.4B1 . The surveyor observed the card containing EX Orde tablets and after LPN #1 removed one tablet the card there were EX Orde remaining tablets. The surveyor then observed LPN #1 sign off the Ex.Order 26.4(b)(1) count down sheet which then indicated that they were only EX tablets remaining in the bingo card. After administering Resident #11's medications the surveyor asked LPN #1 if she can show him the resident's EX Order 26.4B1 bingo card and count down sheet. It was revealed that Resident #11 had two bingo cards of EX Order 26.4B1 tablets. LPN #1 removed one tablet from a new card that was received from the pharmacy and signed off on a count down sheet for a bingo card that contained EX remaining tablets.	F 755	audit narcotic logs to ensure accurate reconciliation weekly for 1 month then monthly for 3 months, followed by quarterly thereafter. ¿ The Unit Managers/designee will audit 3 nurses to ensure an accurate administering of all drugs weekly for 1 month then monthly for 3 months, followed by quarterly thereafter. ¿ Central Supply was in-serviced on maintaining proper par level of OTC topical analgesic medications on the units at all times. ¿ The Unit Managers/designee will audit the med carts to ensure all medication is available weekly for 1 month then monthly for 3 months, followed by quarterly thereafter. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?) ¿ The Unit Manager/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits.	

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F 755	Continued From page 40	F 755		

After realizing that she logged off the wrong count down sheet, LPN #1 called over the unit manager and explained to her that she logged off the wrong count down sheet. The surveyor observed both LPN #1 and the unit manager correct the count down sheets and checked the count on both cards which revealed that they were no missing tablets.

The surveyor reviewed the medical record for Resident #11.

A review of the Admission Record (an admission summary) revealed diagnoses which included but were not limited to EX Order 26.4B1 EX Order 26.4B1

A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated EX Order 26.4B, reflected the resident had a brief interview for mental status (BIMS) score of EX Ord out of EX Ord indicating that the resident had an EX Order 26.4B1.

A review of the EX Order 26.4B1 Order Summary Report (OSR) reflected a physician's order (PO) with a start date of EX Order 26.4B1 for EX Order 26.4B1 EX Order 26.4B1 give EX tablet by mouth every EX Ord hours for EX Order 26.4B1

A review of the January 2023 Electronic Medication Administration Record (EMAR) revealed a PO with an order date of EX Order 26.4B for EX Order 26.4B1 " The EMAR

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	315370	A. BUILDING _____ B. WING _____	01/31/2023

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F 755	Continued From page 41 indicated that EX Order 26.4B1 was to be administered at 8:00 AM (0800) and 8:00 PM (2000). On 1/26/23 at 11:45 AM, the surveyor interviewed LPN#1 in the presence of the surveyor team. LPN #1 stated that it was her responsibility to log on the correct count down sheet when she removed any Ex.Order 26.4(b)(1) to ensure that the counts match. She acknowledged that she failed to do so prior to administering the medication to Resident #11. 2. On 1/26/23 at 9:05 AM, the surveyor observed the LPN #1 preparing to administer Ex.Order 26.4(b)(1) medications to Resident #11 which included EX Order 26.4B1 The surveyor observed LPN #1 measure a Ex.Order 26.4(b)(1) that was equivalent to EX Order grams, the surveyor then observed LPN #1 add the Ex.Order 26.4(b) r into a cup and then added eight (8) ounces of water. LPN#1 was then observed mixing the contents with a straw. The surveyor observed LPN #1 administer Resident #11's medications. After the resident took all their medications the surveyor observed LPN#1 discard the cup that contained the EX Order 26.4B1 Ex.Order 26.4(b)(1) into the resident's garbage with around of solution remaining in the cup. The surveyor did not observe LPN#1 encourage the resident to drink the remaining contents of their medication. A review of the EX Order 26.4B1 OSR reflected a PO with a start date of 7/1/22 for " EX Order 26.4B1 EX Order 26.4B1) give EX Order EX Order 26.4B1 one time a day for EX Order 26.4B1 EX Order 26.4B1	F 755		

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F 755	Continued From page 42 A review of the January 2023 EMAR revealed a PO dated [redacted] for [redacted] r ([redacted] grams by [redacted] oz of water." The EMAR indicated that [redacted] r was to be administered at 9:00 AM (0900). On 1/26/23 at 11:45 AM, the surveyor interviewed LPN #1 in the presence of the surveyor team. LPN #1 stated that she thought that the resident took all their medication and that she "never bothered checking the cup" to make sure the resident consumed all their medication. On 1/27/23 at 1:30 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) and discussed the surveyors concerns from medication administration. No further information was provided. 3. On 1/23/23 at 10:26 AM, the surveyor conducted the Resident Council meeting with six alert and oriented residents. Resident # 103 stated that "two or three weeks ago" the nurse was unable to apply an [redacted] due to the medication was unavailable. On 1/26/23 at 11:49 AM, the surveyor in the presence of the second floor Licensed Practice Nurse (LPN #2) assigned to care for Resident # 103 inspected the second-floor medication cart and the treatment cart assigned to LPN #2. LPN #2 was unable to locate the as needed [redacted] ordered for Resident # 103.	F 755		

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F 755	Continued From page 43	F 755		

At that same time, LPN #1 stated, "I can order it from the pharmacy. Anyway, the resident doesn't ask for it."

On that same date and time, the surveyor interviewed the second floor Registered Nurse Unit Manager (RN/UM) who stated that both as needed Ex.Order 26.4(b)(1) should be available and could not speak to why they weren't available. She further stated that the primary nurse was responsible for ensuring all active ordered medications were available.

On that same date at 12:03 PM, the surveyor interviewed Resident # 103. The resident stated that his/her [redacted] was under control and they were [redacted]

The surveyor reviewed the medical records for Resident # 103.

Review of the Admission Record reflected that the resident was admitted to the facility with diagnoses which included but were not limited to EX Order 26.4B1 [redacted]

Review of the quarterly MDS dated [redacted], reflected the resident had a BIMS score of [redacted] which indicated that the resident had an [redacted]. Review of section J for [redacted] management reflected that the resident occasionally experienced [redacted] and that the resident had experienced a numeric scale [redacted] the last five days of the assessment.

Review of the electronic Order Summary Report indicated a PO dated [redacted], for [redacted]

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F 755	Continued From page 44 EX Order 26.4B1) apply to EX Order 26.4B1 topically every Ex.O hours as needed for EX Order 26 management and a PO dated 11/28/22, for EX Order 26.4B1 apply to EX Order 26.4B1 topically every EX Orde hours as needed for Ex.Order 26. apply EX Order 26.4B1 to each EX Order 26.4B Review of the EX Order 26.4B1 electronic Medication Administration Record (eMAR) reflected the above corresponding PO's. Further review of the EX Order 26.4B1 eMAR indicated that the EX Order 26.4B1 was administered on EX Order 26.4B1 for a EX Order 2 level of Ex.Order 26.4(b)(1 Further review of the EX Order 26.4B1 and EX Order 26.4B1 eMAR indicated that the EX Order 26.4B1 EX Order 26.4B1 was not administered. On 1/27/23 at 1:35 PM, the survey team met with the LNHA and the DON and discussed the above observations and findings. The LNHA stated that both Ex.Order 26.4(b)(medications were over the counter (OTC) and should be available. He further stated that the medications were "probably" available from central supply but the nurse did not follow up with central supply and should have followed up with the doctor. On that same date and time, the DON stated, that both Ex.Order 26.4(b) medications were "house stock" and should have been items available in central supply but weren't. A review of the central supply inventory list provided on EX Order 26.4B1, by the LNHA revealed that EX Order 26.4B1 was indicated on the central	F 755		

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F 755	Continued From page 45 supply inventory list. EX Order 26.4B1 was not indicated on the inventory list. At that same time, the DON further stated that the Ex.Order 26.4(b)(1) medications "came from the pharmacy at one point." The LNHA explained the process that the nurse(s) order from central supply and then central supply has to order from the company that the facility utilizes for all OTC medications. The LNHA could not speak to name of the company who provided the facility with the OTC medications. The DON and the LNHA stated that the provider pharmacy did not provide the facility with OTC medications. The DON further stated that it was "ultimately" his responsibility to ensure that all medications were available. There was no additional information provided to dispute the above findings. A review of the facility's policy for "Controlled Substances Accountability" dated 9/2022, and provided by the LNHA included to double check the count of the controlled medication whenever administering the drug; if there is a discrepancy, it should be investigated immediately. A review of the facility's policy for "Medication Administration" dated 3/2022, and provided by the LNHA included Medication Administration (General)...All medications administered.	F 755		
F 759 SS=E	NJAC 8:39-11.2(b), 27.1(a), 29.2(d), 29.4(g)(h) Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors.	F 759		3/15/23

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	315370	A. BUILDING _____ B. WING _____	01/31/2023

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F 759	Continued From page 46 The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; 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 all medications were administered without error of 5% or more. During the medication observation performed on 1/26/23, the surveyor observed three (3) nurses administer medications to three (3) residents. There were 29 opportunities, and three (3) errors were observed, which calculated to a medication administration error rate of 10.34 %. This deficient practice was identified for two (2) of three (3) residents, (Resident #11 and #73), that were administered medications by two (2) of three (3) nurses. The deficient practice was evidenced by the following: On 1/26/22 at 9:05 AM, during the medication administration observation, the surveyor observed the Licensed Practical Nurse (LPN #1) in the room of Resident #11. The surveyor observed LPN #1 checking the resident's identification bracelet and informing Resident #11 that she will be administering the resident's medications. The surveyor observed that the resident just finished eating breakfast. On 1/26/23 at 9:05 AM, the surveyor observed the LPN #1 preparing to administer EX Order 26.4B1EX Order) medications to Resident #11 which included EX Order 26.4B1 EX Order 26.4B1	F 759	How the corrective action will be accomplished for those residents found to be affected by this practice? ¿ Affecting Resident #11 Medication Error form was filled out for Resident #11 and doctor was notified and LPN #1 counseled.. ¿ Affecting Resident #11. The primary care physician was notified for clarification on the residents order. ¿ LPN #1 was counseled on proper medication administration and to clarify any orders when needed to ensure all medications are administered without error. ¿ Affecting Resident #73. The physician was notified and LPN#2 was counceled to clarify if medication can be crushed prior to crushing to ensure all medications are administered without error. How the Facility will identify other residents having the potential to be affected by the same deficient practice? ¿ All Residents have the ability to be affected by the facility not meeting the requirements of ensuring administering medications without error of 5% or more. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur?	

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	315370	A. BUILDING _____ B. WING _____	01/31/2023

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F 759	Continued From page 47 EX Order 26.4B1) and EX Order 26.4B1 (EX Order 26.4B1). The surveyor observed LPN #1 moving quickly, pulling out cards, indicating the medication name and it's use to the surveyor. The surveyor observed LPN #1 administer Ex.Order 26.4(b)(1) medications to Resident #11 including EX Order 26.4B1 (Error #1) and EX Order 26.4B1 (Error #2). The surveyor reviewed the medical record for Resident #11. A review of the Admission Record (an admission summary) revealed diagnoses which included EX Order 26.4B1 (EX Order 26.4B1 EX Order 26.4B1), EX Order 26.4B1) and EX Order 26.4B1 (condition with a Ex.Order 26.4(b)(1) . A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated EX Order 26.4B, reflected the resident had a brief interview for mental status (BIMS) score of EX Ord out of EX Ord, indicating that the resident had an EX Order 26.4B1. 1.A review of the January 2023 Order Summary Report (OSR) reflected a physician's order (PO) with a start date of 7/1/22 for EX Order 26.4B1 EX Order 26.4B1 hours for EX Order 26.4B1" A review of the EX Order 26.4B1 Electronic Medication Administration Record (EMAR) revealed a PO with an order date of EX Order 26.4B for "EX Order 26.4B1 Give EX capsule by mouth every EX O hours for EX Order 26.4B1." The EMAR	F 759	¿ The Unit Managers, and nurses were in-serviced on proper medication procedures. ¿ The DON/designee will audit 1 nurse during medication administration, to ensure that all medications are being administered without error of 5% or more, weekly for 1 month then monthly for 3 months, followed by quarterly thereafter. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?) ¿ The DON/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits.	

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F 759	Continued From page 48 indicated that EX Order 26.4B1 was to be administered at 6:00 AM (0600), 2:00 PM (1400) and 10:00 PM (2200). A further review of the EX Order 26.4B1 EMAR revealed that LPN #1 did not sign off that EX Order 26.4B1 was administered. The surveyor observed that the 6:00 AM dose was signed off by the overnight nurse (11-7). On 1/26/23 at 11:45 AM, the surveyor interviewed LPN #1 in the presence of the survey team who stated that she was told by the overnight nurse to administer, Resident #11's EX Order 26.4B1. She further stated that it was not a normal practice to give a medication three hours after the recommended time and stated that she should have not administered the EX Order 26.4B1 with the [redacted] medications 2. A review of the EX Order 26.4B1 OSR reflected a PO with a start date of [redacted] for '[redacted] EX Order 26.4B1) Give [redacted] tablet by mouth one time a day for Ex.Order 26.4(b)(1) A further review of the PO revealed no strength for EX Order 26.4B1 A review of the January 2023 EMAR revealed a PO dated of 7/1/22 for EX Order 26.4B1 (EX Order 26.4B1) Give [redacted] tablet by mouth one time a day for Ex.Order 26.4(b)(1) The EMAR indicated no strength for [redacted] On 1/26/23 at 11:45 AM, the surveyor interviewed LPN #1 in the presence of the survey team regarding the fact that there was no strength documented for EX Order 26.4B1 on the PO or EMAR. LPN #1 stated that she gave the EX Order 26.4B1 because it was the standard strength despite EX Order 26.4B1 being available in multiple strengths. LPN #1 further stated that she should have	F 759		

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	315370	A. BUILDING _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 759	Continued From page 49 clarified the order with the physician to make sure that the resident received the proper strength. 3. On 1/26/23 at 9:35 AM, during the medication administration observation, the surveyor observed LPN #2 in the room of Resident #73. The surveyor observed an empty food tray next to the resident. LPN #2 asked Resident #73 if the resident was ready to receive their medications. LPN #2 then identified the resident and checked their identification bracelet. The surveyor observed LPN #2 prepare to administer nine medications [redacted] to Resident #73 which included [redacted] prepare the medications for administration. The LPN #2 stated that the resident medications were crushed and administered with apple sauce. The surveyor observed LPN #2 crush Resident #73's medication and added apple sauce to the crushed medications which included [redacted] (ERROR #3). The surveyor then observed LPN #2 administer the medications to Resident #73. The surveyor observed Resident #73 express a look of displeasure after consumption of the crushed medications in apple sauce. The resident asked LPN #2, what he/she just ate. LPN #2 stated it was apple sauce. The surveyor reviewed the medical records for Resident #73. A review of the Admission Record revealed diagnoses which included [redacted]	F 759		

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	315370	A. BUILDING _____ B. WING _____	01/31/2023

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F 759	Continued From page 50 EX Order 26.4B1 and EX Order 26.4B1 (EX Order 26.4B1).	F 759		

A review of the annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated EX Order 26.4B1, reflected the resident had a BIMS score of [redacted] out of [redacted] indicating that the resident was EX Order 26.4B1.

A review of the EX Order 26.4B1 OSR reflected a PO with a start date of EX Order 26.4B1 for "EX Order 26.4B1 Give [redacted] tablet by mouth one time a day for EX Order 26.4B1

A review of the EX Order 26.4B1 OSR reflected a PO with a start date of [redacted] which revealed the following: Ex.Order 26.4(b)(1) [redacted] "

A review of the EX Order 26.4B1 EMAR revealed a PO with an order date of EX Order 26.4B1 for "EX Order 26.4B1 Give [redacted] tablet by mouth one time a day for EX Order 26.4B1." The EMAR indicated that EX Order 26.4B1 was to be administered at 9:00 AM.

A review of the Manufacturer's specifications revealed the following: "Take EX Order 26.4B1 EX Order 26.4B1 whole. Ex.Order 26.4(b)(1) [redacted]

On 1/26/23 at 11:10 AM, the surveyor interviewed LPN #2 regarding EX Order 26.4B1. LPN #2 looked up EX Order 26.4B1 on the computer and pointed out to the surveyor that EX Order 26.4B1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315370	A. BUILDING _____ B. WING _____	01/31/2023

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F 759	Continued From page 51	F 759		

should not be crush and that a sprinkle formulation was available.

On 1/27/23 at 1:30 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) and discussed the surveyors concerns from medication administration.

On 1/30/23 at 1:30 PM, the survey team met with the LNHA and DON who then responded to the surveyors concerns from 1/27/23. The LNHA stated that he spoke to LPN#1 who stated that she accidently administered Resident #11's EX Order 26.4B1. The LNHA also stated that he spoke with the 11-7 nurse who stated that she administered Resident #11's EX Order 26.4B1 dose.

The DON also stated that LPN #1 should have clarified the order for the EX Order 26.4B1 strength with the physician.

The facility also acknowledged that the manufacturer's specifications for EX Order 26.4B1 revealed that the medication should have been taken whole and not crushed.

A review of the facility's policy for Medication Administration, dated EX Order 26.4B1 and was provided by the LNHA included the following:

"Medication Timing 1. General Rule: For medications scheduled at the times designated by facility policy (i.e., BID at 9AM and 5PM), there is a two-hour window for administration. This is one hour before up to one hour after scheduled administration time."

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	315370	A. BUILDING _____ B. WING _____	01/31/2023

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F 759	Continued From page 52 "Medication Preparation Under 3 Crushing revealed the following: "b. Refer to "Do Not Crush" list or drug reference if clarification needed." "c. If a medication states "do not crush"-it should not be crushed unless physician order states that crushing the medication will not adversely affect the resident. Nursing should also monitor for adverse effects." "d. If resident cannot swallow the medication-request the physician to change the order to alternative dosage form of the medication." "Medication Administration (General) 1. Medication checked against MAR/eMAR before administering." NJAC 8:39-11.2(b), 29.2(d)	F 759		
F 761 SS=E	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 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.	F 761		3/15/23

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	315370	A. BUILDING _____ B. WING _____	01/31/2023

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F 761	Continued From page 53 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to properly label, store and dispose of medications in 4 of 5 medication carts inspected. This deficient practice was evidenced by the following: On 1/27/23 at 11:25 AM, the surveyor inspected the 3rd floor medication cart #1 in the presence of a Licensed Practical Nurse (LPN#1). The surveyor observed an opened and undated bottle of Morphine 20 mg/ml solution (medication for pain). The surveyor interviewed LPN #1 who stated that once a bottle of Morphine solution was opened that it should be dated because once opened it only had a 90-day expiration date. On 1/27/23 at 11:30 AM, the surveyor inspected the 3rd floor medication cart #2 in the presence of LPN #2. The surveyor observed an opened bottle of blood Glucose test strips (a product to test the blood sugar levels) that was not dated. The surveyor interviewed LPN #2 who stated that an opened bottle of blood Glucose test strips should have been dated.	F 761	How the corrective action will be accomplished for those residents found to be affected by this practice? ¿ Affecting 4 of 5 medication carts. Improperly labeled medications were either immediately discarded or labeled to ensure all drugs in the facility are labeled with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date when necessary ¿ All nurses were in-serviced on proper labeling, storing and disposing of medications in medication carts to ensure all drugs in the facility are labeled with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date when necessary How the Facility will identify other residents having the potential to be affected by the same deficient practice? ¿ All Residents have the ability to be affected by the facility not meeting the requirements of proper labeling, storing	

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	315370	A. BUILDING _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 54 On 1/27/23 at 11:45 AM, the surveyor inspected the 2nd floor medication cart #2 in the presence of LPN #3. The surveyor observed an opened bottle of blood Glucose test strips that was opened and not dated. The surveyor interviewed LPN #3 who stated that an opened bottle of blood Glucose test strips should have been dated. On 1/27/23 at 12:00 PM, the surveyor inspected the 2nd floor medication cart #1 in the presence of LPN #4. The surveyor observed an unopened and undated vial of Lantus insulin (medication that controls blood sugar) inside the medication cart. The surveyor interviewed LPN #4 who stated that an unopened vial of Lantus insulin should have been stored in the medication refrigerator. A review of the Manufacturer's Specifications for the following medications revealed the following: 1. Morphine 20 mg/ml oral solution once opened had an expiration date of 90-days. 2. Blood Glucose Test strips once opened had an expiration date of 90-days. 3. Lantus Insulin once stored at room temperature had an expiration date of 28-days. 4. Unopened Lantus Insulin Vial should have been stored in a refrigerator. On 1/27/23 at 1:35 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). There was no further information provided by the facility.	F 761	and disposing of medications in medication carts. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? ¿ All nurses were in-serviced on proper labeling, storing, and disposing of medications in medication carts. ¿ The Unit Managers/designee will audit all medication carts for proper labeling, storing, and disposing of medications, weekly for 1 month then monthly for 3 months, followed by quarterly thereafter. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?) ¿ The Unit Manager/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits.	

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	315370	A. BUILDING _____ B. WING _____	01/31/2023

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F 761	Continued From page 55	F 761		

2. On 1/26/23 at 11:49 AM, in the presence of the Licensed Practical Nurse (LPN #5), the surveyor inspected the Treatment Cart #2 on the second floor. In the top drawer the surveyor observed an unlabeled and undated 100 gram tube of Diclofenac (Voltaren) 1% gel (a medication used for arthritic pain) inside a clear plastic bag.

At that same time, LPN #5 stated that she did not know who the Diclofenac 1% gel belonged to or where it came from. She further stated that it should have a label on it.

On that same date and time, the surveyor interviewed the second floor Registered Nurse Unit Manager (RN/UM) who stated that the undated and unlabeled Diclofenac 1% gel should have a label on it. The RN/UM could not speak to who the gel belonged to or how long it has been in the treatment cart.

On 1/27/23 at 1:35 PM, the surveyor discussed the above observation and findings with the LNHA and the DON.

There was no additional information provided.

A review of the facility's policy for Medication Labeling that was dated 3/2022 and provided by the LNHA included that the labels for individual drug containers must include the residents name and the expiration dates.

A review of the facility's policy for Medication Storage dated 3/2022 and provided by the LNHA

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	315370	A. BUILDING _____ B. WING _____	01/31/2023

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F 761	Continued From page 56 included that medications requiring refrigeration must be stored in the refrigerator located in the drug room at the nurses' station. Medication must be stored separately from food and must be labeled. A review of the facility's policy for Medication Administration dated 3/2022 and provided by the LNHA included that the Organization of the Medication Cart...items that expire sooner than the printed expiration date after being opened or removed from refrigeration are dated (on the product itself, not just the outer container). NJAC: 8:39-29.4 (a) (h) (d)	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to ensure the safe and appetizing temperatures of food and drink served to the residents. This deficient practice was identified by 6 of 6 residents, who during the 1/23/23 Resident Council group meeting stated that hot foods were received cold, and confirmed during the lunch time meal service on 1/27/23 on	F 804	How the corrective action will be accomplished for those residents found to be affected by this practice? ¿ Affecting all residents. Food Service Director and dietary staff were in-serviced on proper methods to maintain appropriate temperature on all food to ensure safe and appetizing temperatures of food and drink served to residents.	3/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315370	A. BUILDING _____ B. WING _____	01/31/2023

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F 804	Continued From page 57 1 of 3 nursing units (third floor) tested for food temperatures by two surveyors, and was evidenced by the following: On 1/23/23 at 10:26 AM, the surveyor conducted a group meeting with six residents who were alert and oriented and selected by the facility to attend the group meeting. All six residents stated that hot foods were received cold at meals. On 1/27/23 at 11:44 AM in the presence of the survey team, the surveyor ensured that a state issued digital thermometer was calibrated (Calibration ensures that the thermometer is accurate and precise for the measurement of food temperatures) to the reading of 32 degrees Fahrenheit (F) via the ice bath method. On 1/27/23 at 12:21 PM, two surveyors observed the arrival of a closed food truck to the second floor. The surveyor and a Registered Nurse identified a regular consistency lunch tray that would be used for temperature testing. At 12:25 PM, the Director of Nursing (DON) closed the food truck door and stated that it belonged to the third floor. Both surveyors followed the DON who transported the food truck to the third floor. At 12:30 PM, the last food tray from the food truck was passed. At 12:31 PM, the surveyor obtained food and fluid temperatures in the presence of a second surveyor and the third floor Licensed Practical Nurse and Unit Manager (LPN/UM). The temperatures were as follows: Fish patty: 114.1 degrees F Broccoli: 104 degrees F White rice: 107 degrees F Black coffee: 144.6 degrees F	F 804	¿ The pelette warmer and plate warmer were sent for repair, the plate warmer has been returned repaired. Pellets are being warmed in the oven prior to meal time while the facility waits for the pellet warmer to be fixed. How the Facility will identify other residents having the potential to be affected by the same deficient practice? ¿ All Residents have the ability to be affected by the facility not meeting the requirements of ensuring safe and appetizing temperatures of food and drink served to residents. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? ¿ The Food Service Director and dietary staff were in-serviced on ensuring safe and appetizing temperatures of food and drink served to residents. ¿ The Food Service Director/designee will audit one tray daily for a week , weekly for 1 month then monthly for 3 months, followed by quarterly thereafter to ensure safe and appetizing temperatures of food and drink served to residents. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?)	

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	315370	A. BUILDING _____ B. WING _____	01/31/2023

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F 804	Continued From page 58 Vanilla Health Shake 4 oz: 51 degrees F 4 oz Chocolate Ice Cream: 16.5 degrees F and the ice cream was soft to touch. Both the ceramic plate and the metal pellet (a metal plate that should be heated and placed below a ceramic plate to help retain heat in an effort to maintain hot food temperatures at meals) were not warm to the touch. This was acknowledged LPN/UM who touched both and stated that they were "not even warm." On 1/18/23 at 10:52 AM, during the initial kitchen tour the Food Service Director (FSD) stated that the plate warmer was not working. On 1/27/23 at 10:15 AM, the survey team met with the facility's Volunteer Advocate who stated that he attended the resident council meetings on resident invitation and that lately there have been "a lot of complaints related to food service", which included food temperatures. On 1/27/23 at 1:27 PM, the surveyor interviewed the FSD in the presence of the survey team. He acknowledged that the plate warmer was still not working and that the pellet warmer broke last night. He stated the kitchen was maintaining food temperatures by keeping hot foods in the steam table and that cold foods were "iced down" before the tray line service. The FSD further stated that test trays were conducted once a week. On 1/27/23 at 1:34 PM, the survey team met with the DON and Licensed Nursing Home Administrator (LNHA), at which time the surveyor reviewed the lunch test tray results. The LNHA stated that the facility was waiting for parts to fix	F 804	¿ The Food Service Director/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits.	

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	315370	A. BUILDING _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 804	Continued From page 59	F 804		

the plate warmer and that the pellet warmer broke the night before.

On 1/30/23 at 1:37 PM, the survey team met with the DON and LNHA, at which time the LNHA acknowledged that both the plate and pellet warmers had not yet been fixed and could not speak to how the FSD was able to ensure hot food temperatures would be maintained upon meal delivery to the residents.

On 1/31/23 at 1:50 PM, the survey team met with the DON and LNHA, at which time no additional information was provided to the surveyor.

The surveyor reviewed the 10/25/22, 11/29/22, and 12/29/22 Resident Council meeting minutes. The minutes did not address food temperatures.

Review of the FS form "Daily Food Temperature Log" with a revised date of 3/2017, reflected that "All hot food must be above 135 degrees F before service. All cold food must be below 41 degrees F before service ...Danger zone - above 41 degrees F and below 135 degrees F."

The FSD provided completed "Test Tray" forms for 12/6/22, 12/21/22 and 1/4/23. As previously indicated, the FSD stated that test trays were conducted once a week on interview. Review of the form indicated that soups, hot beverages, hot entrees, starch, vegetables and eggs should be above 135 degrees F and dessert, fruit, milk, cold beverages and potentially hazardous foods should be below 41 degrees F.

The completed Test Tray form for 12/6/22, revealed a recorded temperature of 128 degrees

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	315370	A. BUILDING _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 804	Continued From page 60 F for Lasagna and 130 degrees F for coffee. Excellent was marked as the assessed overall quality. The completed Test Tray form for 12/21/22, revealed a recorded temperature of 120 degrees F for coffee. Excellent was marked as the assessed overall quality. The completed Test Tray form for 1/4/23, revealed a recorded temperature of 130 degrees F for pasta. Excellent was marked as the assessed overall quality. Review of the facility policy "Test Meal/Tray Audit" dated 4/2022, included that "A test meal or tray audit will be conducted a minimum of once a quarter or more often as deemed necessary to ensure timely delivery, appetizing temperatures, and acceptable quality of all foods served." It also indicated that findings should be summarized, and a plan of correction should be developed for each problem noted. NJAC 8:39-17.4 (a)	F 804		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a	F 809		3/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315370	A. BUILDING _____ B. WING _____	01/31/2023

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F 809	Continued From page 61 nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to consistently serve residents a nourishing snack when there was more than a 14-hour span of time between the dinner and breakfast mealtimes. This deficient practice was identified for 6 of 6 residents (Resident's #2, #27, #30, #46, #63 and #103) during resident council meeting and was evidenced by the following: On 1/23/23 at 10:26 AM, the surveyor conducted a group meeting with six residents who were alert and oriented and selected by the facility to attend the group meeting. Four of six residents stated that they did not receive a bedtime snack even when they asked. One resident stated that "I didn't know they had snacks, so I didn't know to ask for it." On 1/25/23 at 9:31 AM, in the presence of the survey team the Licensed Nursing Home Administrator (LNHA) stated that he reviewed and provided copies to the surveyor of the snack accountabilities logs from the electronic medical record for Resident's #2, #27, #30, #46, #63 and #103. He acknowledged that there were "holes in	F 809	How the corrective action will be accomplished for those residents found to be affected by this practice? ¿ Affecting Resident #2, Resident #27, Resident #30, Resident #46, Resident #63, and Resident #106. Food Service Director, dietary staff, and nursing staff were in-serviced on consistently serving residents a nourishing snack when there was more than a 14-hour span of time between the dinner and breakfast mealtimes. How the Facility will identify other residents having the potential to be affected by the same deficient practice? ¿ All Residents have the ability to be affected by the facility not meeting the requirements of consistently serving residents a nourishing snack when there was more than a 14-hour span of time between the dinner and breakfast mealtimes. What measures will be put in place or what systemic changes will be made to	

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F 809	Continued From page 62 the documentation" and that the facility started in services about documentation. On 1/27/23 at 10:03 AM, the surveyor interviewed the Food Service Director (FSD) who stated that the kitchen provided the three floors with bedtime snacks. He could not speak to an accountability system nursing used to document and ensure residents were served bedtime snacks. The FSD stated that he was aware that there could not be more than 16 hours between dinner and the breakfast meals, and that the facility was required to offer resident's a substantial snack at bedtime. The FSD stated that when he or his supervisor inspected the unit pantries in the morning that they have not found left over snacks, so he "assumed" they were distributed. On 1/27/23 at 10:09 AM, the surveyor interviewed the Registered Dietitian (RD) in the presence of the survey team. She stated that the facility-maintained snack logs but could not speak to where they were located or if she referred to them when conducting resident nutrition assessments. The RD could not speak to the allowable gap of time between the dinner and breakfast meals, whether or not snacks should have been served verse offered and/or if resident consumption should be accounted for. She then stated that by 8 PM residents should be offered a snack. On 1/31/23 at 1:50 PM, the survey team met with the DON and the LNHA and at that time no additional information was provided by the facility.	F 809	ensure that the deficient practice will not recur? ¿ Food Service Director, dietary staff, and nursing staff were in-serviced on consistently serving residents a nourishing snack when there was more than a 14-hour span of time between the dinner and breakfast mealtimes. ¿ Nursing staff was in-serviced on proper documentation of offering HS snack in pcc. ¿ The Unit Manager/designee will audit documentation of snacks being offered in PCC, weekly for 1 month then monthly for 3 months, followed by quarterly thereafter. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?) ¿ The Unit Manager/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits.	

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F 809	Continued From page 63	F 809		

The surveyor reviewed the 10/25/22, 11/29/22, and 12/29/22 Resident Council meeting minutes. The minutes did not address food bedtime snacks.

Review of the undated facility "Meal Times" list reflected the following:

First floor dinner was scheduled to arrive at 4:30 PM and breakfast at 7:45 AM, which yielded a 15 hour and 15-minute gap of time.

Second floor dinner was scheduled to arrive at 5:10 PM and breakfast at 8:30 AM, which yielded a 15 hour and 20-minute gap of time.

Third floor dinner was scheduled to arrive at 4:40 PM and breakfast at 8:00 AM, which yielded a 15 hour and 20-minute gap of time.

Review of the "Nutrition - Snacks" logs with a 30 day look back period that was provided by the LNHA from the electronic medical record for Resident's #2, #27, #30, #46, #63 and #103 reflected the following:

Resident #2 received a snack on 9 of 30 days, refused a snack on 2 of 30 days and on 1 of 30 days it reflected "Resident Not Available."
Resident #27 received a snack on 4 of 30 days and indicated "No" did not receive a snack on 10 of 30 days.
Resident #30 received a snack on 4 of 30 days and indicated "No" did not receive a snack on 10 of 30 days.
Resident #46 received a snack on 1 of 30 days, indicated "No" did not receive a snack on 10 of 30 days and on 1 of 30 days it reflected "Not

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F 809	Continued From page 64 Applicable." Resident #63 received a snack on 1 of 30 days, refused a snack on 5 of 30 days and on 5 of 30 days it reflected "Not Applicable." Resident #103 received a snack on 11 of 30 days, refused a snack on 1 of 30 days and on 1 of 30 days it reflected "Not Applicable." Review of the facility policy "Snacks" with a review date of 2/2022, included the following: "It is the policy and procedure of this facility to offer each resident an HS [bedtime] snack if applicable." "If there are more than 14 hours between evening meal and breakfast the following day, a nourishing snack will be offered at bedtime." "Ask the resident if they wish to have a snack. If not, document that the resident refused the snack. If yes, ...Document that the resident was offered a snack and if the resident accepted the snack." NJAC 8:39-17.2 (f); 17.2 (f) 1	F 809		
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist.	F 868		3/15/23

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F 868	Continued From page 65 §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to provide documentation to account for the Infection Control Preventionist attendance for 2 of 3 Quarterly Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (QAPI) meetings. This deficient practice was evidenced by the following: On 1/24/23 at 9:42 AM, the surveyor interviewed the Interim Infection Control Preventionist (ICP) in the presence of the survey team. The Interim ICP stated that she was responsible for the	F 868	How the corrective action will be accomplished for those residents found to be affected by this practice? ¿ Affecting all residents. Infection Control Preventionist was in-serviced on attending Quarterly Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (Qapi) meetings. How the Facility will identify other residents having the potential to be affected by the same deficient practice? ¿ All Residents have the ability to be	

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F 868	Continued From page 66 facility's infection prevention control program. She also stated that she had been "coming in and out of the facility." However, she stated that she had been working full time in the facility, 50 hours per week for "the past 3 weeks." She informed the surveyor that prior to her, the facility hired an ICP on 2 separate occasion and neither of which remained in the facility. During the interview, the surveyor asked the Interim ICP if she attended the Quarterly QAPI committee meetings. She stated that she had not attended the QAA meetings at the facility but was aware that the attendance of the ICP was a requirement. On 1/30/23 at 12:29 PM, the survey team met with the LNHA and DON. The DON stated that the QAA/QAPI team met weekly and quarterly. During the interview, the DON further stated that the ICP is supposed to attend the QAPI meetings. The DON and LNHA could not speak to whether an ICP had attended the QAPI meetings. The LNHA stated that the Interim ICP was at the facility "on and off" and they had "some people in between." However, the LNHA and DON acknowledged that there was no documented evidence that the ICP attended the quarterly QAPI committee meetings on the three quarterly sign in sheets they provided to the surveyor. Review of the facility's "QAPI Committee sign in sheets indicated that the Infection Control Coordinator as a member of the meeting as well as the LNHA, DON, and Medical Director in addition to other members which included	F 868	affected by the facility not meeting the requirements of providing documentation for the Infection Control Preventionist attendance for Quarterly Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (QAPI) meetings. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? ¿ The Infection Control Preventionist was in-serviced on attending Quarterly Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (Qapi) meetings . ¿ DON/Designee will audit the QA/QAPI sign in sheets quarterly to ensure all required members are in attendance. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?) ¿ The DON/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits.	

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F 868	Continued From page 67 department heads. Review of the completed QAPI Committee sign in sheets provided to the surveyor reflected that an ICP attended the 4/21/22 quarterly meeting, however there was no documented evidence that an ICP attended the quarterly meetings dated 7/21/22 and 11/17/22. Review of the facility policy "Quality Assurance and Performance Improvement" with a reviewed date of 2/2022, included "Our leadership team, which consists of the administrator, director of nursing, and key department managers, is responsible for creating and sharing the focus of QAPI." NJAC 8:39-33.1 (b)	F 868		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable	F 880		3/15/23

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F 880	Continued From page 68 diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (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	F 880		

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	315370	A. BUILDING _____ B. WING _____	01/31/2023

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F 880	Continued From page 69 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other pertinent documentation, it was determined that the facility failed to ensure a.) staff adhered to standards of infection control practices for the appropriate disposal of a soiled incontinence brief and b.) practiced appropriate hand hygiene in accordance with the Centers for Disease Control (CDC). This deficient practice was identified for (1) one staff member on one (1) of three (3) units. This deficient practice was evidenced by the following: According to the U.S. CDC guidelines, Hand Hygiene Recommendations, Guidance for Healthcare Providers for Hand Hygiene and COVID-19, page last reviewed 01/18/2021 included, "Hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom. Immediately after glove removal." It further specified the procedure for hand hygiene which included, "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by	F 880	How will the corrective action be accomplished for those residents found to be affected by this practice? ¿ Affecting Resident #32. Agency CNA involved was counseled regarding proper hand hygiene and disposal of soiled incontinence in the proper manner. ¿ Infection Preventionist in-serviced with the staff regarding ensuring that all soiled incontinence care items are disposed of properly in accordance with the facility□s Incontinent Care and Waste Bin policy and procedure. ¿ Infection Preventionist in-service with the staff of proper performance of hand hygiene in accordance with the U.S. CDC guidelines, Hand Hygiene Recommendations, Guidance for Healthcare Providers for Hand Hygiene and COVID-19 and the facility□s Hand Hygiene policy and procedure. How the Facility will identify other residents having the potential to be affected by the same deficient practice? ¿ All residents have the ability to be affected by not meeting the requirements	

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F 880	Continued From page 70 the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds." On 1/23/23 at 12:26 PM, the surveyor observed an agency Certified Nursing Assistant (CNA) rendering EX Order 26.4B1 to Resident # 32. The CNA placed the EX Order 26.4B1 onto the floor. She then picked up the EX Order 26.4B1 from the floor and placed it into an unlined open trash bin. The CNA then removed a clear plastic bag from her pocket and placed it over the unlined open trash bin and flipped the trash bin upside down and emptied the contents into the clear plastic bag. She then tied the plastic bag, removed gloves and walked into the bathroom. At that same time, the surveyor observed the CNA perform hand. She turned the facet on, wet her hands, applied soap and lathered for 20 seconds. She then proceeded to dry her hands but was unable due to the automatic paper towel dispenser was jammed. She then walked over to the roommate of Resident # 32 and removed one absorbent wipe from the package and dried her hands. She then picked up the plastic bag which contained the EX Order 26.4B1 from the floor and left the room. She did not perform hand hygiene after leaving Resident # 32's room. At that same time, the surveyor interviewed the CNA who did not wish to speak to the surveyor.	F 880	to ensure staff are not properly disposing of soiled incontinent care items and not performing proper hand hygiene. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? ¿ The facility will review/develop and implement a disposal of soiled incontinent care items process to ensure this procedure adheres to the facility Incontinent Care and Waste Bin policy and procedure, ¿ Infection Control Preventionist/designee will audit staff disposing of soiled incontinent care items related to the facility□s Incontinent Care and Waste Bin policy, weekly for a month then monthly thereafter for 3 months then quarterly thereafter. ¿ All staff are receiving ongoing in-service education by Infection Preventionist/designee regarding the proper disposal of soiled incontinent care processes related to our Incontinent Care and Waste Bin policy. ¿ Increase signage throughout the facility to remind staff of proper hand hygiene practice. ¿ Infection Preventionist (IP) /designee will conduct an audit based on observation of the staff performance of hand hygiene daily for 1 week, then weekly for 1 month, monthly for 3 months then quarterly thereafter. ¿ Topline Staff/ Infection Preventionist we trained in Infection Preventionist	

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F 880	Continued From page 71 On 1/24/23 at 10:36 AM, the surveyor interviewed the Infection Control Preventionist who stated that the EX Order 26.4B1 should never have been placed on the floor. She explained the process that the EX Order 26.4B1 should have been placed into a lined trash bin and then tied and placed into the proper disposable receptacle bin outside of the room. Review of the facility's "Incontinent Care" policy with a review date of 2/2022, included to remove all soiled items and place them in plastic bags. Soiled linen or briefs are to be properly disposed of in the waste bin. Review of the facility's "Waste Bins" policy with a review date of 3/2022, included that it is the policy and procedure of the facility to provide proper waste bins to discard trash in a sanitary manner in the resident rooms .... Doff [remove] gloves appropriately and conduct proper hand hygiene. Review of the facility's "Handwashing/Hand Hygiene" policy dated 1/2/23, included that the purpose of this policy procedure is to provide guidelines for effective handwashing and hand hygiene techniques that will aid in the prevention of the transmission of infections ...dry hands with a paper towel and discard. On 1/26/23 at 12:53 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) and discussed the above observations and findings. On 1/27/23 at 1:35 PM, the LNHA stated that one to one counseling was done with the agency	F 880	Training Course: Training Program Module 1-Infection Prevention & Control Program; Module 5 Outbreaks; Module 4 Infection Surveillance. ¿ All staff were trained on the following topics: Nursing Home Infection Preventionist Training Course: Module 5 - Outbreaks; Module 7 - Hand Hygiene; Module 6A Principles of Standard Precautions; Module 6B - Principles of Transmission Based Precautions. ¿ Frontline staff will be trained on: CDC Covid-19 Prevention Messages for Front Line Long-Term Care Staff: Keep Covid-19 Out!; Clean Hands; Closely Monitor Residents How the Facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place? ¿ The DON/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine frequency of future audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315370	A. BUILDING _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARNEGIE POST ACUTE CARE AT PRINCETON LLC	**5000 WINDROW DRIVE PRINCETON, NJ 08540**

(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 72 CNA and he began a building wide hand washing in-service audit to ensure all paper towels dispenser are full in the building. NJAC 8:39-19.4 (a)(1)	F 880		

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
	62202	A. BUILDING: _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARNEGIE POST ACUTE CARE AT PRINCETO	5000 WINDROW DRIVE PRINCETON, NJ 08540

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews, and review of pertinent facility documentation, it was determined that the facility failed to have all remaining staff to be trained for LGBTQ+ program by an outside training company within the required time frames for the LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Queer/questioning [one's sexual or gender identity], Intersex [person is born with a combination of male and female biological traits] positive) and HIV+ (Human Immunodeficiency Virus [a virus that attacks cells that help the body fight infection] positive) program. This deficient practice was evidenced by the following: Findings include:	S 560	How the corrective action will be accomplished for those residents found to be affected by this practice? ¿ Affecting all residents. Email was sent to outside training company to initiate the training process for LGBTQ+ to ensure all remaining staff are trained for LGBTQI+ program by an outside training company within the required time frames How the Facility will identify other residents having the potential to be affected by the same deficient practice? ¿ All Residents have the ability to be affected by the facility not meeting the	3/15/23

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

Electronically Signed | 02/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	62202	A. BUILDING: _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARNEGIE POST ACUTE CARE AT PRINCETO	5000 WINDROW DRIVE PRINCETON, NJ 08540

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S 560	Continued From page 1 Reference: New Jersey Department of Health (NJDOH) memo, dated 04/19/22, "Statutory Amendments Regarding the Rights of LGBTQI+ and HIV+ Residents of Long-Term Care Facilities Pursuant to N.J.S.A. 26:2H-12.101-10 7." The memorandum concerned the rights of LGBTQI+ and HIV+ residents of long-term care facilities; N.J.S.A. 26:2G-12, 101-107 ("LGBTQI+ Law"), and a facility's responsibilities under the LGBTQI+ Law. The LGBTQI+ Law was signed on March 3, 2021 and took effect on August 30, 2021. The requirements of the LGBTQI+ Law will be included in N.J.A.C 8:39 in future rulemaking. Specifically, the LGBTQI+ Law establishes specific rights and protections for lesbian, gay, bisexual, transgender, undesignated/non-binary, questioning, queer, and intersex ("LGBTQI+) older adults and people living with HIV ("HIV+) in long-term care facilities ("Facilities"). The LGBTQI+ Law ensures that LGBTQI+ and HIV+ residents in facilities have equitable access to health care and provides the same legal protections as everyone else regardless of their sexual orientation or health status. Prohibited Actions The LGBTQI+ Law prohibits facilities from taking any of the following actions based on a person's sexual orientation, gender identity, gender expression, intersex status, or HIV status: 1. Denying admission to a facility, transferring or refusing to transfer a resident within a facility or to another facility, or discharging, or evicting a resident from a facility; 2. Denying a request by residents to share a room;	S 560	requirements of ensuring all remaining staff to be trained for LGBTQI+ program by an outside training company within the required time frames for the LGTBQI+. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? ¿ All remaining staff to be trained for LGBTQI+ program by an outside training company within the required time frames for the LGTBQI+ ¿ The Social Worker/designee will audit in-serviced staff to ensure all current employees are in-serviced within the required timeframe, monthly for 3 months, followed by quarterly thereafter. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?) ¿ The Social Worker/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits.	

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S 560	Continued From page 2 3. Where rooms are assigned by gender, assigning or reassigning a room based on gender, subject to the provisions of 42 C.F.R. 483.10 (e) (5); 4. Forbidding a resident from, or harassing a resident who seeks to use or does use, a restroom available to other residents of the same gender identity, regardless of whether the resident is making a gender transition, has taken or is taking hormones, has undergone gender affirmation surgery, or presents as gender-nonconforming. For the purposes of this paragraph, harassment includes, but is not limited to, requiring a resident to show identity documents in order to gain entrance to a restroom available to other persons of the same gender identity; 5. Repeatedly failing to use a resident's chosen pronouns or the name the resident chooses to be called, despite being clearly informed of the resident's choice; 6. Denying a resident from wearing preferred clothing, accessories, or cosmetics, or participating in grooming practices; 7. Restricting a resident's right to visit and have conversations with other resident's or with visitors including the right to have consensual sexual relations; 8. Denying, restricting, or providing unequal medical or non-medical care, which is appropriate to the resident's bodily needs and organs, or providing medical or nonmedical care that, to a similarly-situated resident, causes avoidable discomfort or unfairly demeans the resident's dignity; and 9. Declining to provide any service, care, or reasonable accommodation requested by the resident, subject to the provisions of 42 C.F.R. 483.10(c)(6).	S 560		

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S 560	Continued From page 3 Resident Records Additionally, facilities are required to ensure that resident records include the resident's gender identity and the resident's chosen name and pronouns, as indicated by the resident. Confidentiality The LGBTQI+ Law also requires facilities to maintain the confidentiality of certain resident information. Unless required by state or federal law, personal identifying information regarding a resident's sexual orientation, whether a resident is transgender or undesignated/non-binary, a resident's gender transition status, a resident's intersex status, or a resident's HIV status shall not be disclosed. Further, facilities are required to take appropriate steps to minimize the likelihood of inadvertent or accidental disclosure of such information to other residents, visitors, or facility staff, except to the minimum extent necessary for facility staff to perform their duties. Unless expressly authorized, facility staff not directly involved in providing direct care to a transgender, undesignated/non-binary, intersex, or gender-nonconforming resident, shall not be present during a physical examination of, or the provision of personal care to, that resident if the resident is partially or fully unclothed. Doors, curtains, screens, or other effective visual barriers to providing bodily privacy, when partially or fully unclothed, shall be used. Informed consent is required in relation to any non-therapeutic examination or observation of, or treatment provided to, a resident of the facility. Facilities shall also provide transgender residents with access to transition-related assessments, therapy, and treatments as having been	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	62202	A. BUILDING: _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARNEGIE POST ACUTE CARE AT PRINCETO	5000 WINDROW DRIVE PRINCETON, NJ 08540

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S 560	Continued From page 4 recommended by the resident's health care provider, including, but not limited to, transgender-related medical care, including hormone therapy and supportive counseling Violations A facility or an employee of a facility that violates the requirements of the LGBTQI+ Law is subject to civil or administrative action. Training Facilities shall designate two employees, including on employee representing management at the facility and one employee representing direct care staff at the facility, to receive in-person training within six months after the effective date of the LGBTQI+ Law. The required training shall be provided by an entity that has demonstrated expertise in identifying the legal, social, and medical challenges faced by, and in creating safe and affirming environments for LGBTQI+ and HIV+ seniors who reside in long-term care facilities in New Jersey. The required training shall address: 1. Caring for LGBTQI+ seniors and seniors living with HIV; 2. Preventing discrimination based on sexual orientation, gender identity or expression of intersex status, and HIV status; 3. The definition of terms commonly associated with sexual orientation, gender identity and expression, intersex status, and HIV; 4. Best practices for communicating with or about LGBTQI+ and HIV+ seniors, including the use of a resident's chosen name and pronouns; 5. A description of the health and social challenges historically experienced by LGBTQI+ and HIV+ seniors, including discrimination when seeking or receiving care at long-term care facilities, and the demonstrated physical and mental health effects within the LGBTQ	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	62202	A. BUILDING: _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 5 community; 6. Strategies to create a safe and affirming environment for LGBTQI+ and HIV+ seniors, including suggested changes to facility policies and procedures, forms, signage, communication between residents and their families, activities, and staff training and in-services; and 7. An overview of the provisions of LGBTQI+ Law. Facilities are responsible for maintaining records documenting the completion of the training, as well as the cost of providing the training. Reference: New Jersey Department of Health (NJDOH), "Clarification Regarding LGBTQI / HIV+ Training for LTC Facilities" dated 06/10/22 reflected the following: The NJ Department of Health, Office of Long-Term Care Resiliency, and the NJ Office of the Long-Term Care Ombudsman want to ensure that long term care (LTC) providers understand the training requirements in the LGBTQ / HIV+ Bill of Rights legislation passed last year, specifically that all staff are required to be trained by September 2022, and that the facility's first two designees to receive training cannot, in turn, train all other staff. Under the law, two designated staff members from each LTC facility were required to receive LGBTQI / HIV+ training by March 2022, and all remaining staff must be trained by September 2022. The trainer must be "an entity that has demonstrated expertise in identifying the legal, social, and medical challenges faced by, and in creating safe and affirming environments for, LGBTQI seniors and seniors living with HIV who reside in long-term care facilities in New Jersey." (6)(c). This level of expertise applies to "the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 6	S 560		

training required pursuant to this section," which includes all of the facility's training - both of the first two designees and of all other staff.
In recent weeks, some providers have asked the LTCO if the first two designated staff members may in turn train all other staff, using a "train the trainer" model. As explained above, this is not legally sufficient. And, as a practical matter, two staff members who have just trained on this sensitive, challenging and new (for many people) material cannot adequately train their peers.

Confusion may come from language in the law stating that the first two designees "shall serve as points of contact for the facility regarding compliance with the provisions of this act and shall develop a general training plan for the facility." (6)(d)(1)(emphasis added). However, it is clear from the entire section that the "training plan" is about logistics and timing of training; the training itself must still be provided by experienced educators.

On 1/19/23 at 3:34 PM, the surveyors met with the LNHA and DON. The LNHA stated that there were two staff members that received training and were certified for the LGBTQI+ program. However, he was "not sure" if the rest of the staff were trained for the program.

On 1/20/23 at 9:33 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The LNHA acknowledged that they did not have an outside company to train all remaining staff at the facility for LGBTQI+ program within the required time frames.

On 1/31/23 at 1:50 PM, the survey team met with

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	62202	A. BUILDING: _____ B. WING _____	01/31/2023

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S 560	Continued From page 7 the LNHA and DON. There was no additional information provided. Review of the facility LGBTQI Policy revised 12/2022 included "Facilities shall ensure that administrators and staff receive training, on at least every other year basis"	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
62202 Y1	A. Building B. Wing Y2	3/16/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CARNEGIE POST ACUTE CARE AT PRINCETON LLC	5000 WINDROW DRIVE PRINCETON, NJ 08540

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 03/15/2023	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 1/31/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

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
315370 Y1	A. Building B. Wing Y2	3/16/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CARNEGIE POST ACUTE CARE AT PRINCETON LLC	5000 WINDROW DRIVE PRINCETON, NJ 08540

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 F0623 Reg. # 483.15(c)(3)-(6)(8) LSC	Correction Completed 03/15/2023	ID Prefix F0625 Reg. # 483.15(d)(1)(2) LSC	Correction Completed 03/15/2023	ID Prefix F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 03/15/2023
ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 03/15/2023	ID Prefix F0698 Reg. # 483.25(l) LSC	Correction Completed 03/15/2023	ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 03/15/2023
ID Prefix F0759 Reg. # 483.45(f)(1) LSC	Correction Completed 03/15/2023	ID Prefix F0761 Reg. # 483.45(g)(h)(1)(2) LSC	Correction Completed 03/15/2023	ID Prefix F0804 Reg. # 483.60(d)(1)(2) LSC	Correction Completed 03/15/2023
ID Prefix F0809 Reg. # 483.60(f)(1)-(3) LSC	Correction Completed 03/15/2023	ID Prefix F0868 Reg. # 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) LSC	Correction Completed 03/15/2023	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 03/15/2023
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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/31/2023	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315370	A. BUILDING **01** B. WING _____	**01/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARNEGIE POST ACUTE CARE AT PRINCETON LLC	**5000 WINDROW DRIVE** **PRINCETON, NJ 08540**

(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
E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 01/26/23. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/26/23 and was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Springhills Post-Acute Care of Princeton is a three story - building that was built in the 1980's. It is composed of Type II protected construction. The facility is divided into 9 - smoke zones. The generator does approximately 100 % of the building as per the Director of Facilities. The current occupied beds are 131 of 180. .	K 000		

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

Electronically Signed | 02/10/2023

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.