STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315352	A. BUILDING _____ B. WING _____	C 09/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT ST MARY'S	**135 SOUTH CENTER STREET ORANGE, NJ 07050**

(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 Complaint #: NJ00157227, NJ00162992, NJ00154342, NJ00157017, NJ00157068, NJ00158490, NJ00158829, NJ00154628, NJ00158423 Survey Date: 9/18/2023 Census: 148 Sample: 36 + 3 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 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 578		9/20/23

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

Electronically Signed | 10/07/2023

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.

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F 578	Continued From page 1 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to address a Full code status (code status that indicates a patient wants all resuscitation procedures to be provided to keep them alive in case of a medical emergency) order signed by the resident's family with no follow up from the Physician. This deficient practice was identified for 1 of 32 residents, Resident #15 reviewed for advanced directives. This deficient practice was evidenced by the following: On 9/5/23 at 11:14 AM, the resident was observed in the day room seated in a reclining	F 578	The facility failed to address a full code status, request from family, no follow up with physician. The corrective action for the residents affected by deficient practice will be accomplished as follows: Sampled resident 15 showed no negative outcome from the deficient process. Interviewed Licensed Practical Nurse, Unit Manager and Social Worker identified and were in-serviced on current Practitioner Orders for Life Sustaining Treatment policy and procedure on	

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F 578	Continued From page 2 EX Order 26 chair watching TV. The surveyor reviewed Resident #15's hybrid medical record. Resident #15 was admitted to the facility with diagnoses that included but were not limited to EX Order 26.4B1 [redacted] A review of the Social Services progress notes revealed documentation on EX Order 26.4B1 and EX Order 26.4B1 that the resident's family member (listed in the Admission Record as one of the emergency contacts) requested that Resident #15's advance directive status would be as a full code status. On 9/8/23, the surveyor reviewed the POLST (Practitioner Orders for Life Sustaining Treatment) form (medical form signed by a patient's physician, advance practice nurse or physician's assistant, provides instructions for health care personnel to follow for range of life-prolonging interventions) which documented "FULL CODE" status, signed by Resident #15's family member but was not completed due to the lack of the Physician's signature. This POLST could not be implemented because of this. Continued review of the resident's chart, revealed another POLST form dated EX Order 26.4B, which indicated a EX Order 26.4B1 [redacted] that was signed by the Advanced Practice Nurse. A review of the POLST form Section F directions stated that the POLST must be signed by a practitioner, a Physician or Advance Practice Nurse, to be valid.	F 578	9/8/23. Audit done by unit manager and social workers on all units and all charts to verify Practitioner Orders for Life Sustaining Treatment form on chart are signed by family and Primary Care Physician and matches current order and care plan completed on 9/8/23. All residents have the potential to be affected. Director of Nursing, Administrator, Social worker reviewed current policy on code status and Practitioner Orders for Life Sustaining Treatment. Social Worker will maintain monthly audit of all current Practitioner Orders for Life Sustaining Treatment status and provide to Interdisciplinary Team monthly. Any requests to change Practitioner Orders for Life Sustaining Treatment, Social Worker to notify Unit Manager, Administrator and Director of Nursing to facilitate notification to physician for updated order. All Practitioner Orders for Life Sustaining Treatment, charts and orders will be reviewed as part of the quarterly Interdisciplinary Team review and documentation. Unit Managers will conduct audits to monitor Practitioner Orders for Life	

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F 578	Continued From page 3 On 9/8/23 at 11:35 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to Resident #15 who stated that in case of any emergency, she would verify the code status of any resident via the electronic medical record and if there's none indicated, she would proceed to check the paper chart for the POLST form whether resuscitation should be started. The LPN could not provide any information for Resident #15's code status in the electronic medical record when reviewed with the surveyor, it was blank. On 9/8/23 at 12:22 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who showed the POLST form indicating a full code status for Resident #15 signed by the resident's family member. Further review of the POLST form revealed that it was not signed by the physician nor an advance practice nurse. The RN/UM could not explain why there was another POLST form which indicated a EX Order 26.4 status. The RN/UM could not explain how she would proceed in an emergency situation involving Resident #15. On 9/8/23 at 1:38 PM, the surveyor spoke with the facility's Licensed Nursing Home Administrator and the Director of Nursing (DON). The DON stated to the surveyor that if the POLST was not signed by the physician or advance practice nurse, it was invalid. The DON stated that the EX Order 26.4B POLST was the only valid document, and this designated Resident #15, EX Order 26.4 There was no additional information provided to explain why Resident #15's family's EX Order 26.4B1 was never validated by the physician.	F 578	Sustaining Treatment compliance. Audits will be done on 5 residents per week for 3 months and then 2 residents per week for 3 months. Unit Manager will audit chart Practitioner Orders for Life Sustaining Treatment on file matches order and care plan. Unit Managers will review audits biweekly with Director of Nursing to review findings and ensure education and or corrective action is taken or being given as needed. Audits will be reviewed quarterly with Quality Assurance Committee for next 3 quarters	

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F 578	Continued From page 4	F 578		
F 641 SS=D	NJAC 8:39-4.1(a)2 Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for 2 of 32 residents (Resident # 147, and #15) reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: 1. On 9/12/23 at 1:18 PM, the surveyor reviewed the closed medical chart for Resident #147 who was MDS coded for hospitalization. The surveyor reviewed the Discharge Summary (DS) created on EX Order 26.4B1 by the Social Worker (SW) for Resident #147. The DS documented that Resident #147 was EX Order 26.4B1 per their family's request. Review of the EX Order 26.4B1 Nursing Progress Note (PN), indicated that Resident #147 "was EX Order 26.4B1 M with their family member, without any distress or discomfort, all discharge papers ready and signed by the resident." Review of Resident #147's Face Sheet (FS) (a one-page summary of important information	F 641	The facility failed to accurately code the Minimum Data Set, an assessment tool used to facilitate management of care The corrective action for the residents affected by deficient practice will be accomplished as follows: Sampled residents 15 and 147 showed no negative outcome from the deficient process. Part-time Minimum Data Set Coordinator was in-serviced on proper coding of Minimum Data Set by Nurse Educator and Minimum Data Set was immediately corrected on 9/13/23. All residents have the potential to be affected. Director of Nursing will in-service all Minimum Data Set Coordinators on how to accurately code resident discharge status and functional range of motion in extremities The Director of Nursing will do monthly	9/20/23

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F 641	Continued From page 5 about the patient) reflected that the resident was admitted to the facility on [redacted] with diagnosis that included but were not limited to [redacted] Review of the [redacted] of the [redacted] MDS for Resident #147 revealed that section [redacted] documented, [redacted] hospital." There was another option "01. Community (private home/apt., board/care, assisted living, group home)" which identified the correct discharge for Resident #147 which was not specified. On 9/13/23 at 9:55 AM, the surveyor interviewed the part time MDS coordinator. The MDS coordinator explained, "I incorrectly coded where the resident was discharged to. The resident should have been coded discharge to community not to acute hospital" when the MDS was completed for Resident #147. 2. On 9/5/23 at 11:14 AM, Resident #15 was observed in the day room seated in a reclining [redacted]-chair watching TV. The surveyor also observed that Resident #15's [redacted] were [redacted]. The surveyor reviewed Resident #15's hybrid medical record. Resident #15 was admitted to the facility with diagnoses that included but not limited to [redacted] A review of the [redacted] Order Summary	F 641	audit of Minimum Data Set Section A and section G on 5 residents per month for 3 months and then 2 residents per month for 3 months and review with Minimum Data Set Coordinators. Audits will be reviewed quarterly with Quality Assurance Committee for next 3 quarters	

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F 641	Continued From page 6 Report showed an order to, "Provide R. EX Order 26.4B1 to be worn as per schedule: 10:00 AM-2:00 PM." A review of the resident's Annual MDS, dated EX Order 26.4B1 reflected under EX Order 26.4B1 (used to assess functional limitation in EX Order 26.4B1 to EX Order 26.4B1 during a seven-day look-back period from EX Order 26.4B1), the assessment showed that Resident #15 had an EX Order 26.4B1 the EX Order 26.4B1. On 9/12/23 at 10:51 AM, the surveyor interviewed the Certified Nursing Assistant assigned to the resident who confirmed that the resident required assistance with EX Order 26.4B1 EX Order 26.4B1 due to the limitation of EX Order 26.4B1 On 9/13/23 at 10:30 AM, the surveyor interviewed the facility's RN(Registered Nurse)/MDS Coordinator who was responsible for completing the MDS assessments and confirmed that she had verified with the facility's Rehab Director that Resident #15 had limitation to EX Order 26.4B1. The RN/MDS Coordinator acknowledged the MDS assessment dated EX Order 26.4B1 was inaccurately coded in Section EX Order 26.4B1 The surveyor reviewed the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual updated October 2019. The manual indicated, "Functional Limitation in Range of Motion. Limited ability to move a joint that interferes with daily functioning (particularly with activities of	F 641		

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F 641	Continued From page 7 daily living) or places the resident at risk of injury ...Steps for Assessment: 6 .... Upper Extremity - includes shoulder, elbow wrist and fingers.. For each hand, instruct the resident to make a fist and then open the hand. With resident seated in a chair, instruct him or her to reach with both hands and touch palms to back of head. Then ask resident to touch each shoulder with the opposite hand. Alternatively, observe the resident donning or removing a shirt over the head. If assessing upper extremity ROM by observing the resident, making a fist mimics useful actions for grasping and letting go of utensils. When an individual reaches both hands to the back of the head, this mimics the action needed to comb hair." On 9/14/23 at 1:35 PM, the above concerns were discussed with the facility's Licensed Nursing Home Administrator and Director of Nursing. No further information was provided. NJAC 8:39-11.1, 11.2(e)(1)	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657		9/21/23

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F 657	Continued From page 8 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to revise a resident's comprehensive care plan (CCP) for 2 of 32 residents reviewed, Resident #127 and Resident #106. This deficient practice was identified by the following: 1. On 9/5/23 at 11:00 AM, the surveyor observed Resident #127 in the day room seated in their wheelchair. The resident was [redacted] and [redacted] The surveyor reviewed Resident #127's hybrid medical records. The Admission Record (AR) reflected that Resident #127 was admitted to the facility with medical diagnoses which included but not limited to EX Order 26.4B1 [redacted]	F 657	he facility failed to revise a resident comprehensive care plan for 2 of 32 residents reviewed. The corrective action for the residents affected by deficient practice will be accomplished as follows: Sampled residents 106 and 127 showed no negative outcome from the deficient process Care plan for Resident 106 was updated by Unit Manager on 9/13/23. Care Plan for Resident 127 was updated by Unit Manager on 9/13/23. All residents have potential to be affected.	

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F 657	Continued From page 9 A review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 7/10/23 reflected that the resident had a Brief Interview for Mental Status (BIMS) of EX Ord indicating that the resident was EX Order 26.4B1 A review of the form titled; "Wound Evaluation & Management Summary" dated 8/17/23 revealed that Resident #127 had a EX Order 26.4B1 EX Order 26.4B1 that was reported as healed on EX Order 26.4B1 The surveyor reviewed the resident's CCP which reflected a care plan for Resident #127 indicating that the resident had a EX Order 26.4B1. On 9/13/23 at 11:30 AM, the Registered Nurse/Unit stated that the care plan was not updated to reflect the resident's EX Order 26.4B1 EX Order 26.4B1. 2. On 9/5/23 at 11:02 AM, the surveyor observed Resident #106 in their room laying on the bed with eyes closed. The surveyor reviewed Resident #106's hybrid medical records. The AR reflected that Resident #106 was admitted to the facility with medical diagnoses which included but not limited to EX Order 26.4B1. A review of the Annual MDS, an assessment tool used to facilitate the management of care, dated EX Order 26.4B reflected that the resident had a BIMS score of EX Ord indicating that the resident had EX Order 26.4B1.	F 657	Nurse Educator will in-service all Unit Managers, Supervisors and Interdisciplinary team members on importance of immediately updating a resident□s plan of care as indicated by 10/13/23. Unit managers will meet weekly with Assistant Directors of Nursing to review all residents with wounds. At weekly wound meeting, wound reports and care plans will be reviewed to ensure that all care plans accurately reflect current plan of care. Unit Managers will do weekly audits of residents with wounds on their units 5 residents per month for 3 months and then 2 residents per month for 3 month to verify wound reports, orders and care plans are accurate. Dietician will audit NPO residents 5 residents per month for 3 months and then 2 residents per month for 3 months to verify accuracy of care plan and interventions. Unit Managers will review audits biweekly with Director of Nursing to review findings and ensure education and or corrective action is taken or being given as needed Dietician will review audits biweekly with Director of Nursing and Regional Dietician to review findings and ensure education	

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F 657	Continued From page 10 A review of the EX Order 26.4B1 Order Summary Report revealed a physician's order dated EX Order 26.4B1 for NPO (EX Order 26.4B1) EX Order 2 The surveyor reviewed the resident's CCP which reflected a care plan for Resident #106 titled, "[Resident's Name] ...has nutritional problem or potential EX Order 26.4B1 [redacted] On 9/12/23 at 11:45 AM, the Licensed Practical Nurse assigned to Resident #106 confirmed that the resident was EX Order 26.4 On 9/13/23 at 2:05 PM, the surveyor met with the facility's Licensed Nursing Home Administrator and Director of Nursing (DON), to discuss the above concerns. The DON stated to the surveyor that the care plan was not updated to reflect the current resident's status. There was no additional information provided. NJAC 8:39-11.2(i)	F 657	and or corrective action is taken or being given as needed Audits will be reviewed quarterly with Quality Assurance Committee for next 3 quarters.	
F 658 SS=E	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-	F 658		10/2/23

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F 658	Continued From page 11 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow acceptable standards of clinical practice with regards to 1. accurately following a physician's order (PO) in administering pain medication to treat varying EX Order 26.4B1 (Resident #15, Resident #108); 2. ensure the positioning mobility to prevent NJ Exec. Order 26:4.b.1 was applied prior to signing the administration record (Resident #15); 3. accurately documenting the EX Order 26.4B1 EX Order 26.4B for residents with a EX Order 26.4B1 (Resident #39, Resident #78). 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	F 658	1.The facility failed to follow acceptable standards of clinical practice with regards to accurately following a physician□s order in administering NJ Exec. Orde medication to treat varying EX Order 26.4B1 for Resident 15 and 108. All sampled residents showed no negative outcome from the deficient process. Resident 15 was immediately referred to rehab per doctor order to address complaints of NJ Exec. Order 26:4.b.1. Rehabilitation staff started treating resident ongoing since EX Order 26.4B1 Resident 108 was referred to and seen by EX Order 26.4B1 for ongoing EX Order 26.4B1 evaluation on EX Order 26.4B1 Resident 15 was immediately referred to rehabilitation department per doctor order to address use of EX Order 26.4B1 and was picked up for ongoing EX Order 26.4B1 on EX Order 26.4B1 NJ Exec. Order 26:4.b.1 was discontinued per doctor order pending outcome rehab evaluation. Nurse Educator will in-service all licensed nurses on importance of documenting at end of each shift EX Order 26.4B1 output from EX Order 26.4B1	

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	315352	A. BUILDING _____ B. WING _____	C 09/18/2023

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ALARIS HEALTH AT ST MARY'S	**135 SOUTH CENTER STREET ORANGE, NJ 07050**

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F 658	Continued From page 12 counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." The deficient practice was evidenced by the following: 1. On 9/5/23 at 11:14 AM, Resident #15 was observed in the day room seated in a reclining EX Order2 -chair watching TV. The surveyor reviewed Resident #15's hybrid medical record. Review of the facility Face sheet (an admission summary sheet) revealed that Resident #15 was admitted to the facility with diagnoses that included but was not limited to EX Order 26.4B1 [redacted] 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 that the resident had a Brief Interview for Mental Status (BIMS) of EX Ord out of EX Orde indicating that the resident had moderately EX Order 26.4B1. On 9/8/23 at 11:26 AM, the surveyor reviewed the resident's EX Order 26.4B1 Order Summary Report (OSR) which revealed a PO for EX Order 26.4B1 EX Order 26.4B1) EX Order 26.4B1) with an order date of EX Order 26.4B1 "Give EX Order 26.4B1 by mouth every EX O hours as needed for EX Order 26.4B1 (EX Order2 ." There was another PO dated EX Order 26.4B1 for EX Order 26.4	F 658	2.The facility failed to follow acceptable standards of clinical practice with regards to ensuring positioning devices to prevent NJ Exec. Order 26:4.b.1 are applied prior to signing administration record for resident 15. The corrective action for the residents affected by the deficient practice will be accomplished as follows: All Sampled residents showed no negative outcome from the deficient process. Resident 15 was immediately referred to the EX Order 26.4B1 department per doctors order to address use of NJ Exec. Order 26:4 and was picked up for ongoing skilled therapy on 9/6/23. The NJ Exec. Order 26:4.b.1 was discontinued per doctor's order pending outcome rehabilitation evaluation. 3.The facility failed to follow acceptable standards of clinical practice with regards to accurately documenting the EX Order 26.4B1 output for residents with EX Order 26.4B1 EX Order 26.4B1 Resident numbers 39 and 78. The corrective action for the residents affected by the deficient practice will be accomplished as follows: All sampled residents showed no negative outcome from the deficient process.	

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F 658	Continued From page 13 Assessment every shift document pain using one of the codes below 0 = no pain, 1-3 = mild pain, 4-6 = moderate pain, 7-10 = severe pain." Review of the EX Order 26.4B1, and EX Order 26.4B1 electronic Medication Administration Record (eMAR) revealed that Resident #15 received several doses of EX Order 26.4B1 s (650 mg) for documented scale rates between On 9/12/23 at 12:30 PM, the surveyor interviewed Resident #15, who stated that the EX Order 26.4B1 that was ordered by the Physician was not too effective at times. On 9/12/23 at 12:56 PM, the surveyor interviewed the Licensed Practical Nurse #1 (LPN #1) who provided care for Resident #15. The LPN #1 stated that before administering the EX Order 26.4B1 of the resident. LPN #1 added that she considered EX Order 26.4B1 to be rated from and if the resident's EX Order 26.4B1 was above the LPN #1 explained that she would call the physician. On 9/13/23 at 1:15 PM, the surveyor presented this concern to the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA). No further information was provided. 2. On 9/5/23 at 11:14 AM, Resident #15 was observed in the day room seated in a reclining -chair watching TV. The surveyor also observed that Resident #15's EX Order 26.4B1 were EX Order 26.4B1 . The surveyor reviewed Resident #15's hybrid	F 658	All residents have the potential to be affected. Nurse Educator will in-service all licensed nurses on medication administration protocol and correctly following medication parameters (scale). Any level outside of parameter requires notification to doctor for additional orders by 10/15/23. Nurse Educator will in-service all licensed nurses, Registered Nurses and Licensed Practical Nurses on treatment administration protocol □ application of per order and immediately signing for once is applied by 10/8/23. Nurse Educator will do competency with all nursing staff on measurement and recording of output. Competency evaluations will be completed by 10/15/23 and will be continued on hire, annually and as needed. 2.All Residents have the potential to be affected. Nurse Educator will in-service all Registered Nurses and Licensed Practical nurses on treatment administration protocols- application of per physician□s order and immediately signing for once is applied by 10/8/23.	

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F 658	Continued From page 14 medical record. Review of the facility Face sheet revealed that Resident #15 was admitted to the facility with diagnoses that included but not limited t [redacted] A review of the Annual MDS, dated [redacted] reflected that the resident had a BIMS of [redacted] out of [redacted] indicating that the resident had [redacted]. A review of the [redacted] OSR revealed a PO to [redacted] and [redacted] schedule: [redacted]" A review of the [redacted] electronic Treatment Administration Record (eTAR) revealed that from [redacted] through [redacted] the assigned nurses to Resident #15 signed for the PO in the electronic medication administration record (eMAR) indicating that the [redacted] were provided to the resident. On 9/5/23 at 11:21 AM, the surveyor interviewed LPN #1 who stated that the Registered Nurse/Unit Manager (RN/UM) applies the [redacted] on the resident in the morning. The surveyor interviewed the RN/UM who stated that she was the person responsible to place the devices on the resident's hands in the morning. The RN/UM in the presence of the surveyor tried to place the [redacted] on Resident #15's [redacted] The resident refused and stated to the surveyor that they never [redacted]	F 658	3..All residents have the potential to be affected. Nurse Educator will do competencies with all nursing staff on measurement and recording of [redacted] r output. Competency evaluations will be completed by 10/15/23 and will be continued on hire, annually and as needed. Unit Managers will audit residents on as needed [redacted] medication to verify compliance with parameters. Audits will be conducted on 5 residents per month for 3 months and then 2 residents per month for 3 months. A medication error report will be completed for any non-compliance with mediation [redacted] parameters. Assistant Director of Nursing will do 5 medication administration competencies per month and review with Director of Nursing. Competencies will continue for all licensed nurses on hire, annually and as needed. Unit Managers will audit 3 residents on [redacted] per week for 3 months to verify [redacted] are being applied per the physician□s orders and then 3 residents per month for 3 months. Assistant Director of nursing or Rehabilitation Director will conduct competencies on all nurses upon hire,	

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F 658	Continued From page 15 every day. The surveyor interviewed the LPN #1 who cared for Resident #15, acknowledged that she signed the PO documenting that the devices were applied to Resident #15, when the devices were not applied. On 9/13/23 at 1:15 PM, the surveyor presented this concern to the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA). No further information was provided. 3. On 9/5/23 at 10:52 AM, during the initial tour, the surveyor observed Resident #39 inside their room, seated on a wheelchair, watching TV. The surveyor also observed that there was a [redacted] hanging on the left side of the wheelchair covered in a EX Order 26.4B1. The surveyor reviewed Resident #39's hybrid medical record. Review of Resident #39's Face sheet revealed that they were admitted to the facility with diagnoses that included but were not limited to [redacted] A review of the Quarterly MDS, dated [redacted] reflected that the resident had a BIMS of [redacted] out of [redacted] indicating that the resident was [redacted] Review of section [redacted] of the MDS, dated [redacted] which revealed that Resident #39 had an [redacted]	F 658	annually and as needed on [redacted] application and removal. Unit Managers will audit 3 residents on catheters per week for 3 months to verify [redacted] output is being appropriately recorded and then 3 residents per month for 3 months. 2.Unit Managers will audit 3 residents on [redacted] per week for 3 months to verify [redacted] are being applied per the physician□s orders and then 3 residents per month for 3 months. Assistant Director of Nursing or Director of Rehabilitation will conduct competencies on all nurse upon hire, annually and as needed on splint application and removal. 3.Unit Managers will audit three residents on [redacted] per week for three months to verify [redacted] output is being appropriately recorded and then three residents per month for three months. Unit Managers will review audits biweekly with the Director of Nursing to review findings and ensure education and or corrective action is taken or being given as needed. Audits will be reviewed quarterly with the Quality Assurance Committee for next 3 quarters.	

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F 658	Continued From page 16 A review the resident's EX Order 26.4B1 OSR revealed a PO for 'EX Order 26.4B1 EX Order 26.4B1 output every shift" that was ordered on EX Order 26.4B1 A review of the eTAR revealed the following: for the month of EX Order 26.4B1, the nurse's failed to document the EX Order 26.4B1 for 14 of 93 shifts. For the month of EX Order 26.4B1, the nurse's failed to document the EX Order 26.4B1 for 8 of 93 shifts. For the month of EX Order 26.4B1 the nurse's failed to document the EX Order 26.4B1 for 1 of 39 shifts. On 9/12/23 at 1:04 PM, The surveyor interviewed LPN #1 who was assigned to care for Resident #39 and stated that the blank portions found in the eTAR indicated that the output was not documented at the end of the shift as indicated by the PO. A review of the facility's policy titled, "Suprapubic Catheter Care" under Procedure "#12. Maintain an accurate record of the resident's daily output, if indicated." On 9/13/23 at 1:15 PM, the surveyor presented this concern to the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA). No further information was provided. 4. On 9/5/23 at 11:01 AM, Resident #108 was observed lying in bed, NJ Exec. Order 26:4.b.1 to communicate their needs. The resident informed the surveyor that they had episodes of NJ Exec. Order 26:4.b.1 and received NJ Exec. Order 26:4.b.1.	F 658	2.Unit Managers will review audits biweekly with the Director of Nursing to review findings and ensure education and/or corrective action is taken or being given as needed. Audits and competencies will be reviewed quarterly with the Quality Assurance Committee for the next three quarters. 3.Unit Managers will review audits biweekly with Director of Nursing to review findings and ensure education and/or corrective action is taken or being given as needed. Audits and competencies will be reviewed quarterly with the Quality Assurance Committee for the next three quarters.	

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F 658	Continued From page 17 The surveyor reviewed the electronic health record (EHR) of Resident #108 which revealed the following: According to the facility Face sheet, Resident #108 was admitted with diagnoses that included but were not limited to EX Order 26.4B1 [redacted] The resident's 7/31/23 Annual MDS, revealed that the facility performed a BIMS which indicated that Resident #108 had a score of [redacted] out of [redacted] The resident was assessed to be EX Order 26.4B1 [redacted] A physician's order dated EX Order 26.4B1 read EX Order 26.4B1 [redacted] A physician's order dated EX Order 26.4B1 read EX Order 26.4B1 [redacted] A review of the EX Order 26.4B1 [redacted] (PRN) EX Order 26.4B1 was administered 9 of 16 times outside of the order's EX Order 26.4B1 [redacted] Review of the EX Order 26.4B1 eMAR revealed PRN EX Order 26.4B1 [redacted] of the order's parameters, with a documented EX Order 26.4B1 [redacted].	F 658		

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F 658	Continued From page 18 A review of the September 2023 eMAR revealed [redacted] was administered 5 of 10 times outside of the order's parameters, with documented [redacted] levels of [redacted] Review of the September 2023 eMAR revealed [redacted] was administered 1 of 2 times outside of the order's parameters, with a documented [redacted] On 9/13/23 at 11:23 AM, the surveyor interviewed LPN #2 about pain assessment and administering prn [as needed] pain medication. LPN #2 stated if the resident was alert, he would ask the resident to rate their pain using a numeric pain scale [1-10]. LPN #2 stated a PRN pain medication order in the EHR would specify the numeric pain level a medication should be given. LPN #2 further stated if a resident had a pain level outside the medication order parameters, the physician would be notified to obtain instruction or new pain orders. On 9/13/23 at 11:26 AM, the surveyor interviewed RN #2 who stated she would assess the resident's numeric pain level, review pain medication orders and call the physician if the pain level was outside of the medications' parameters. On 9/13/23 at 11:51 AM, the surveyor interviewed 2nd floor Registered Nurse/Unit Manager #2 (RN/UM #2) in reference to administering PRN pain medication and pain assessment. RN/UM #2 stated that nurses should follow the physician's medication order parameters specific for the ordered pain level. The RN/UM #2 added	F 658		

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F 658	Continued From page 19 that nurses should call the physician if resident's pain levels are outside the parameters ordered in the PO for instruction. The surveyor reviewed the September 2023 eMAR with the RN/UM #2 for Resident #108. The RN/UM #2 acknowledged that nurses were documenting [NJ Exec. Order 26:4.b.1] outside the PO medication's parameters with the administration of the [NJ Exec. Order 26:4.b.1] and [NJ Exec. Order 26:4.b.1] mg. On 9/13/23 at 1:15 pm, the surveyor informed the LNHA and DON in reference to the above concerns involving the medication administration for [NJ Exec. Order 26:4.b.1] and [NJ Exec. Order 26:4.b.1] mg medication with documented [NJ Exec. Ord] levels outside of the PO [NJ Exec. Ord] level parameters. On 9/14/23 at 1:36 PM, the surveyor met with the LNHA, DON, and regional nurse. The DON stated that the resident's [NJ Exec. Ord] management was effective for the resident. No further information was provided. Review of the facility's policy titled, "Pain Assessment and Management", with a reviewed date of January 2023, under Procedure: " ...7. The physician must be notified of new onset of pain, need to re-evaluation or medical intervention (e.g. pain medication ineffective)". Review of the facility's policy titled, "Medication Administration Policy, with a reviewed date of September 2022, under Procedure read: " ...3. Medications must be administered in accordance with the orders, including any required time frame ..."	F 658		

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F 658	Continued From page 20 N.J.A.C. 8:39-11.2 (b); 27.1(a); 29.2 (d)	F 658		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as	F 690		10/4/23

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F 690	Continued From page 21 possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to maintain a EX Order 26.4B1 and provide services in a manner consistent with standards of practice for 2 of 3 residents reviewed for EX Order 26.4B1 care (Resident #108, and #78). This deficient practice was evidenced by the following: 1. On 9/5/23 at 11:01 AM, Resident #108 was observed lying in bed, NJ Exec. Order 26:4.b.1 to communicate their needs. The resident was observed with a EX Order 26.4B1 attached to a EX Order 26.4B1 hanging at their bedside. The surveyor smelled a EX Order 26.4B1 at the resident's bedside. The resident verbalized no concerns. The surveyor reviewed the electronic health record (EHR) of Resident #108 which revealed the following: According to the Admission Record, Resident #108 was admitted with diagnoses that included but were not limited to EX Order 26.4B1 [redacted] Review of the EX Order 26.4B1 Annual Minimum Data Set (MDS), an assessment tool, revealed that the facility performed a Brief Interview for Mental Status (BIMS) which indicated that the resident	F 690	The facility failed to maintain EX Order 26.4B1 EX Order 26.4B1 and provide services in a manner consistent with standards of practice for 2 of 3 residents reviewed. Residents 108 and 78. The corrective action for the residents affected by deficient practice will be accomplished as follows: Resident 78 and 108 showed no negative outcome from the deficient process. Resident 108 was offered to have EX Order 26.4B1 changed by Nurse Practitioner on EX Order 26.4B1 and refused. Resident 108 also refused going to EX Order 26.4B1 for EX Order 26.4B1 change stating they would prefer to wait for scheduled EX Order 26.4B1 appointment on EX Order 26.4B1 EX Order 26.4B1 clinic will notify facility if they have an earlier cancellation. The Primary Care Physician was made aware and was agreeable with plan. Resident 78 had EX Order 26.4B1 appointment with EX Order 26.4B1 on EX Order 26.4B1 All residents with NJ Exec. Order 26:4.b.1 have potential to be affected. Nurse Educator will in-service all licensed nurses on NJ Exec. Order 26:4.b.1 care, changing NJ Exec. Order 26:4.b.1, documenting NJ Exec. Order 26:4 output and how to manage residents with	

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F 690	Continued From page 22 had a score of [redacted] out of [redacted]. The resident was assessed to be EX Order 26.4B1. A physician's order dated [redacted] read, "Change EX Order 26.4B1 balloon when clogged or dislodged using sterile technique. Change [redacted] as well. as needed." The resident had a EX Order 26.4B1 EX Order 26.4B1 . Another physician's order dated [redacted] read, EX Order 26.4B1. Check EX Order 26.4B1. Good for 24 hours only. Must be signed and dated when opened. Use sterile syringe daily as needed." A review of the [redacted] and EX Order 26.4B1 electronic Treatment Administration Record (eTAR) revealed there were no entries documented that the resident's EX Order 26.4B1 had been changed. On 9/13/23 at 11:51 AM, the surveyor interviewed 2nd floor Registered Nurse/Unit Manager #2 (RN/UM #2) in reference to Resident #108's [redacted] status. RN/UM #2 explained that she followed up with the physician who recommended to follow up with [redacted] and called the [redacted] office. She explained that it should be documented in the progress notes as she could not recall when it was. RN/UM #2 revealed that the resident had a urologist appointment previously, but there were transportation issues and the appt had to be	F 690	[redacted] malfunction by 10/12/23. Assistant Director of Nursing will do 5 [redacted] care competencies with licensed nurses (RN□s and LPNs) per month for 3 months and then 2 per month for 3 months Unit managers will submit weekly audit of all residents on their units with [redacted] addressing [redacted] function, last date changed, last [redacted] consult to Director of Nursing for 3months and then submit monthly reports for 3 months. Unit Managers will review audits biweekly with DON to review findings and ensure education and or corrective action is taken or being given as needed Audits and competencies will be reviewed quarterly with Quality Assurance Committee for next 3 quarters	

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rescheduled. She could not recall the approximate date and stated it should be in the progress notes. No further information was provided nor could be located in the progress notes.

The RN/UM #2 identified that Resident #108's catheter had not been functioning properly or EX Order 26.4B1 since EX Order 26.4B1. The RN/UM #2 that the physician recommended to maintain the EX Order 26.4B1 and follow up with the EX Order 26.4B1

The RN/UM #2 added that the resident had refused to go to the hospital to change the EX Order 26.4B1 documented in the progress notes on 7/28/22 in the progress notes provided.

The RN/UM #2 further stated that the EX Order 26.4B1 was changed as needed, per the physician's order and would have to look up for when the last time it was changed. The RN/UM #2 identified that the resident had no EX Order 26.4B1, no discomfort, and there was no EX Order 26.4B1 recorded as the resident was voiding in their EX Order 26.4B1

On 9/13/23 at 1:15 PM, the surveyor informed the Licensed Nursing Home Administration (LNHA) and Director of Nursing (DON) regarding the above concerns for the EX Order 26.4B1 of Resident #108 not EX Order 26.4B1.

On 9/14/23 at 1:36 PM, the surveyor met with the DON, LNHA and a Regional Nurse. The DON stated Resident #108 was admitted with the EX Order 26.4B1 and the resident had a follow up appointment for the next month on EX Order 26.4B1

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which was cancelled as the resident was scheduled to be discharged the day of appointment to another facility. The resident remained in the facility and a EX Order 26.4B1 appointment was scheduled for EX Order 26.4B1. There was an issue with the resident's transport on EX Order 26.4B1 and the resident did not go to the appointment. No further information was provided to explain what the issue with transportation involved.

The DON continued to explain that Resident #108's EX Order 26.4B1 worked for two days after admission. She presented that on EX Order 26.4B1 the EX Order 26.4B1 was not EX Order 26.4B1 and was changed at that time. The DON revealed that after the EX Order 26.4B1 was changed it was not functioning correctly and the resident was EX Order 26.4B1 voiding into an EX Order 26.4B1.

The surveyor discussed the concern for Resident #108 potentially being a higher risk of infection as the resident had an extended period of time with a EX Order 26.4B1 that was not functioning. The DON explained that it was generally recommended not to frequently change a EX Order 26.4B1 and it had been discussed with primary physician team and Infection Disease team. No further documentation was provided.

At that time the DON provided a timeline of the resident's EX Order 26.4B1 status and progress notes regarding the resident's EX Order 26.4B1. The DON stated the documentation included any progress notes about follow-ups with EX Order 26.4B1 and if the EX Order 26.4B1 was changed.

A review of the timeline and progress notes

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F 690	Continued From page 25 revealed the following: A progress note, dated EX Order 26.4B1, documented the resident's EX Order 26.4B1 was not draining EX Order 26.4 the EX Order 26.4B1 was changed, and drained little to no EX Order 26.4 The progress note documented that the nurse practitioner was instructed to monitor for EX Order 26.4B1 in an EX Order 26.4B1 and if voiding of EX Order 26 was not evident, the resident would be sent to the hospital. The documentation included that the resident refused to go to hospital despite education. A progress note dated EX Order 26.4B1 documented that the resident was scheduled for a EX Order 26.4B1 appointment on EX Order 26.4B1 The resident at this time was voiding EX Order 26 in their EX Order 26.4B1. The EX Order 26.4B1 was not draining EX Order 26.4 A progress note dated EX Order 26.4B1, documented the resident was to be EX Order 26.4B1 to another facility on EX Order 26.4B1 and the facility Social Worker was made aware on EX Order 26.4B1 that the resident was not EX Order 26.4B1. From EX Order 26.4B1 there was no documented follow up with the EX Order 26.4B1. A progress note, dated EX Order 26.4B1, documented the resident had a EX Order 26.4B1 appointment that day and the appointment had to be rescheduled due to transportation issues (not disclosed). There was no documentation that indicated a follow up with EX Order 26.4B1 or documentation of EX Order 26.4B1 functioning EX Order 26.4B1 from EX Order 26.4B1 EX Order 26.4B1.	F 690		

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There was no other documentation provided to show that the resident's [redacted] was changed after [redacted].

A review of the facility's policy titled, "Suprapubic Catheter Care", with a reviewed date of January 2023, under Procedure read: "Maintain an accurate record of the resident's daily output, if indicated ...Document assessment data in the resident's clinical record". The policy did not address the process of maintain a catheter in the event the resident's catheter was not functioning.

On 9/18/23 at 10:40 AM, the survey team met with the DON and LNHA. The DON provided the policy for [redacted]. No further information was provided.

2. On 9/5/23 at 11:50 AM, Resident #78 was observed lying in bed, [redacted] Resident #78 had a [redacted].

The surveyor reviewed the electronic health record (EHR) of Resident #78 which revealed the following:

According to the Admission Record, Resident #78 was admitted with diagnoses that included but were not limited to [redacted]

The 8/8/23 Annual MDS, revealed that the facility performed a BIMS which indicated that the resident had a score of [redacted] out of 15. The resident was assessed to be [redacted].

A physician's order dated [redacted] read, "Measure

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EX Order 26.4B1 . every Shift".

A progress note, dated 9/4/23, indicated the resident's EX Order 26.4B1 was EX Order 26.4B1 and the resident's EX Order 26.4B1.

On 9/8/23 at 12:41 PM, the surveyor interviewed the Registered Nurse (RN #1) about EX Order 26.4B1 and EX Order 26.4B1 care. RN #1 explained that her responsibilities included reviewing and following the physician orders, EX Order 26.4B1 EX Order 26.4B1 and any signs and symptoms of EX Order 26.4B1. She continued to explain that at the end of the shift the resident's EX Order 26 EX Order 26.4B1 should be documented into the electronic Treatment Administration Record (eTAR). RN #1 stated that if the EX Order 26.4B1 was not working or draining, the physician should be called to be made aware and for instruction.

A review of the August 2023 eTAR for the EX Order 26 EX Order 26.4B1 output pertaining to Resident #78 revealed that "0" was coded as the output for 22 of 93 entries for the month. There were also 13 of 93 entries that were blank and had no documented EX Order 26.4 output for the month.

Review of the September 2023 eTAR for the EX Order 26 EX Order 26.4B1 output pertaining to Resident #78 revealed that "0" was coded as the output for 30 of 40 entries for the month. There were also 3 of 40 entries that were blank and had no documented EX Order 2EX Order 26.4B1 for the month.

On 9/11/23 at 12:36 PM, the surveyor spoke with the 6th floor RN/UM (RN/UM #3)who stated at this time Resident #78's EX Order 26.4B1 was not working well, EX Order 26.4B1, and the resident

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had EX Order 26.4B1 episodes, voiding large amounts of EX Order 26.4 in their NJ Exec. Order 26:4.b.1 brief. RN/UM #3 explained that Resident #78 had gone for a EX Order 26.4B1 consult last month, but the EX Order 26.4B1 was not able to see Resident #78, which was documented in the progress notes. The appt was rescheduled for November 2023.

On 9/11/23 at 12:56 PM, the surveyor visited with Resident #78 to inquire about their EX Order 26.4B1 EX Order 26.4B1. Resident #78 stated that their EX Order 26.4B1 EX Order 26.4B1 was not working right, not EX Order 26.4B1 and was not sure about what would be done about the EX Order 26.4B1.

On 9/13/23 at 1:15 PM, the surveyor reviewed their findings with the Licensed Nursing Home Administration (LNHA) and Director of Nursing (DON) regarding the above concerns for the EX Order 26.4B1 not functioning for Resident #78 and EX Order 26 output documented as "0". The DON stated they would review and provide further information.

On 9/14/23 at 1:36 PM, the surveyor met with the DON, LNHA and a regional nurse. The DON revealed that for the August 2023 entry dates where the eTAR for EX Order 26.4 output were documented as "0", the resident's EX Order 26.4B1 had periods of not EX Order 26.4B1 and Resident #78's EX Order 26.4B1 was changed on EX Order 26.4B1. The DON confirmed the resident had a appointment on EX Order 26.4B1 and was not able to be seen by the EX Order 26.4B1.

The DON provided a timeline of the resident's EX Order 26.4B1, which included progress notes from EX Order 26.4B1. There was no further verbal

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F 690	Continued From page 29 response provided by the facility. A review of the timeline and progress notes provided included the following: A EX Order 26.4B1 consult note, dated EX Order 26.4B1 was provided and documentation from EX Order 26.4B1 of the resident's EX Order 26.4B1 insertion procedure. There were no further EX Order 26.4B1 consultation notes. A progress note dated EX Order 26.4B1 documented that the resident's EX Order 26.4B1, and EX Order 26.4B1 was noted in the EX Order 26.4B1. The progress notes further indicated the primary physician, and the EX Order 26.4B1 were notified. A progress note dated EX Order 26.4B1, documented that the resident returned from EX Order 26.4B1 appointment without being seen by the EX Order 26.4B1 A review of the facility's policy titled, "Suprapubic Catheter Care", with a reviewed date of January 2023, under Procedure read: "Maintain an accurate record of the resident's daily output, if indicated ...Document assessment data in the resident's clinical record". The policy did not further address the documentation of the resident's urinary output by the nurses. The policy did not address the process in the event of a resident's catheter is not functioning. No further information was provided by the facility. NJAC-8:39-27.1 (a); 33.2 (c) 5	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		9/27/23

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F 692	Continued From page 30 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy, it was determined that the facility failed to 1. enter weekly weights in the electronic medical record (EMR) for 3 of 4 residents, Resident #133, #16, and #85, 2. Address the cause(s) between current medical condition and significant (sig) EX Order 26.4B1 for 4 of 4 residents, Resident #133, #16, #31 and #85 and 3. address identified actual or possible reasons of significant EX Order 26.4B1 in the resident's care plan for 4 of 4 residents, Resident #133, #16, #31 and # 85, all reviewed for EX Order 26.4B1 EX Order 2 per facility policy.	F 692	The Facility failed to enter weekly weights in the electronic medical record, address the causes between current medical condition and significant NJ Exec. Order 26 and address identified actual or possible reasons of significant of NJ Exec. Order 26 in the resident□s care plan. The corrective action for the residents affected by deficient practice will be accomplished as follows: Sample residents #133, #16, #31, & #85 showed no negative from the deficient	

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F 692	Continued From page 31 This deficient practice was evidenced by the following: 1. On 9/5/2023 at 10:35 AM, the surveyor observed Resident #133 in bed with a EX Order 26 EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1 running EX Order 26.4B1 er per hour (ml/hr.) delivering NJ Exec. Order 26:4.b.1 to the resident. On 9/7/2023 at 9:25 AM, the surveyor reviewed the resident's EMR and found the following information: Resident #133 was admitted to the facility on EX Order 26.4B1 with diagnoses which included but were not limited to: EX Order 26.4B1 A review of Resident #133 Significant Change Minimum Data Set (MDS) which is a standardized, comprehensive assessment of an adult's EX Order 26.4B1 EX Order 26.4B1) showed an MDS dated for EX Order 26.4B1, under EX Order 26.4B1 " that the resident had a EX Order 26.4B1 EX Order 26.4B1 more in last 6 months" and that the resident is "not on a prescribed EX Order 26.4B1." Continued review of the EX Order 26.4B1 Cognitive Patterns Brief Interview for Mental Status (BIMS), (BIMS stands for Brief Interview for Mental Status. The BIMS test is used to get a	F 692	practice. The facility Registered Dietician was in-serviced by the Regional Registered Dietician on both the facility weight policy and the facility weight assessment and intervention policy on 9/8/23. Audit done by the regional Registered Dietician on all units and nutrition notes/care plans of all residents with significant NJ Exec. Order 26:4.b.1 were reviewed and updated to better reflect the facility weight policy and the facility weight assessment and intervention policy on 9/8/23. All residents have the potential to be affected. Regional Registered Dietitian, Director of Nursing, Administrator, & Unit Managers reviewed both the facility weight policy and the facility weight assessment and intervention policy on 9/8/23. Monthly weight meetings will be held with a focus on identifying root causes of NJ Exec. Order 26:4.b.1. Weekly weights will be reviewed by Registered Dietitian with Director of Nursing and unit managers on a weekly basis with a focus on identifying root cause of NJ Exec. Order 26:4.b.1 and entering into the electronic medical record by the Dietitian.	

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F 692	Continued From page 32 quick snapshot of how well you are functioning cognitively at the moment.) EX Order 26.4B1. Should Brief Interview for Mental Status be Conducted? Resident #131 could not have a BIMS conducted due to NJ Exec. Order 26:4.b.1 [redacted]. The surveyor reviewed the weight record in the EMR. Weights were documented as the following: EX Order 26.4B1 [redacted] The documented weights reflect a significant NJ Exec. Order 26:4.b.1 on EX Order 26.4B1. which supports a [redacted] over 90 days. A review of the Registered Dietitian (RD) documented nutrition progress note dated EX Order 26.4B1 [redacted]	F 692	Regional Registered Dietitian will maintain a monthly audit of all RD documentation regarding significant NJ Exec. Order 26:4.b.1 [redacted]. Regional Registered Dietician will maintain a monthly audit of all RD care plans regarding significant NJ Exec. Order 26:4.b.1. Regional Registered Dietician will maintain a weekly audit of weekly weights to ensure entry into the electronic medical record. Audits will be reviewed quarterly with the Quality Assurance committee for the next three quarters.	

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Review of the RD's [EX Order 26.4B1] progress note, there was no documentation of the relationship between the resident's current medical condition which includes but was not limited to acute [EX Order 26.4B1] The RD does not explain why a resident on a [NJ Exec.] who is receiving a predetermined measure of calories, protein and fluids would have a significant [NJ Exec. Order 26:4.b.1].

A review of Resident #133's individualized care plan for [NJ Exec. Order 26:4.b.] with an onset date of [EX Order 26.4B1] and completed on [EX Order 26.4B1] failed to address any identified causes of [EX Order 26.4B1], as the facility [EX Order 26.4B1] policy dictates.

On 9/7/2023 the Regional Registered Dietitian (RRD) provided the surveyor with a paper copy of weekly weights for all residents who resided on the 5th floor of the facility from February through August 2023. The RRD informed the surveyor that the weekly weight sheet is kept by the RD in a notebook in her office. The information submitted was not stored in the paper medical chart and unavailable to the facility staff for review.
The surveyor observed weekly weights for Resident #133 starting on 5/29/2023 and ending on 8/28/2023. Weights were documented as follows:
[EX Order 26.4B1]

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EX Order 26.4B1

None of the weekly weights were documented into the EMR as per facility policy.

The Surveyor observed a Physician Order (PO) for weekly weights in the electronic medication administration record (eMAR), "one time a day every Mon for weight monitoring obtain weight and document on weight form at nurses' station", starting on EX Order 26.4B1 and discontinued on EX Order 26.4B1. No weekly weights were reflected in the eMAR from EX Order 26.4B1

2. On 9/5/2023 at 10:46 AM, the surveyor observed Resident #16 in bed with a EX Order 26.4B1 at their bedside, not currently running. Resident #16 was also observed with a EX Order 26.4B1 EX Order 26.4B1 in place.

On 9/7/2023 at 10:13 AM, the surveyor reviewed the resident's EMR. The resident was admitted on EX Order 26.4B1 with diagnosis which included but were not limited to: EX Order 26.4B1

A review of Resident #16's Significant Change MDS dated EX Order 26.4B1, Under EX Order 26.4B1 EX Order 26.4B1 Status that the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315352	A. BUILDING _____ B. WING _____	C 09/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT ST MARY'S	**135 SOUTH CENTER STREET ORANGE, NJ 07050**

(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 692		F 692		

Continued From page 35

had a NJ Exec. Order 26:4.b.1 and that the resident in "not on a prescribed NJ Exec. Order 26:4.b.1 regiment." Resident #16 was noted under EX Order 26.4B1 could not have a BIMS conducted due to not being understood.

The surveyor reviewed the weight record in the EMR. Weights were documented as follows:

EX Order 26.4B1

The weights documented reflect significant NJ Exec. Order 26:4.b.1 on 3/7/2023 of NJ Exec. Order 26:4.b. supporting an NJ Exec. Order 26 over 30 days, NJ Exec. Order 26:4.b.1 on 4/20/2023 of NJ Exec. Order 26. which reflects a NJ Exec. Order 26 over 30 days and an additional NJ Exec. Order 26:4.b.1 on 5/8/2023 of NJ Exec. Ord lbs. which reflects a NJ Exec. Orde over 90 days.

A review of the RD documented NJ Exec. Order 26:4.b. progress note dated EX Order 26.4B1

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	315352	A. BUILDING _____ B. WING _____	C 09/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT ST MARY'S	135 SOUTH CENTER STREET ORANGE, NJ 07050

(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 692	Continued From page 36 needs. Monitor, intervene as needed." Review of an additional RD documented NJ Exec. Order 26:4.b weight review note dated EX Order 26.4B1 [redacted] needs, as assessed. Monitor, intervene as needed." An additional RD documented NJ Exec. Order 26:4.b weight review note dated EX Order 26.4B1 [redacted] Monitor, intervene as needed." Review of the RD's progress notes dated EX Order 26.4B1 [redacted], there was no documentation of the relationship between the resident's current medical condition which includes but not limited to EX Order 26.4B1 [redacted] The RD added no	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315352	A. BUILDING _____ B. WING _____	C 09/18/2023

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ALARIS HEALTH AT ST MARY'S	135 SOUTH CENTER STREET ORANGE, NJ 07050

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F 692	Continued From page 37	F 692		

documentation in the progress notes to explain why a resident on a [NJ Exec] who is receiving a predetermined measures of calories, protein and fluids would have a significant [NJ Exec. Order 26:4.b.1]

A review of Resident #16's individualized care plan for [NJ Exec. Order 26:4.b.] with an onset date of [EX Order 26.4B1] and completed on [EX Order 26.4B1], failed to address any identified causes of [NJ Exec. Order 26:4.b.1], as the facility [NJ Exec. Order 26:4.b.1] policy dictates.

On 9/7/2023 the RRD provided the surveyor with a paper copy of weekly weights for all residents who resided on the 5th floor of the facility from EX Order 26.4B1 The RRD informed the surveyor that the weekly weight sheet is kept by the RD in a notebook in her office. The surveyor reviewed the documented weekly weights for Resident #16 starting on [EX Order 26.4B1] and ending on [EX Order 26.4B1] Weights were documented as follows:
EX Order 26.4B1
.
None of the weekly weights were entered into the EMR.

The surveyor observed a Physician Order (PO) for weekly weights, EX Order 26.4B1 , with a start date of [EX Order 26.4B1] and a discontinuation date of [EX Order 26.4B1] The eMAR had no weekly weights documented for facility staff to access.

3. On 9/5/23 at 10:28 AM, the surveyor observed Resident #31 in bed asleep with [EX Order 26.4B1] [EX Order 26] connected.

On 9/7/23 at 11:23 AM, the surveyor reviewed

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	315352	A. BUILDING _____ B. WING _____	C 09/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT ST MARY'S	135 SOUTH CENTER STREET ORANGE, NJ 07050

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F 692	Continued From page 38	F 692		

the resident's EMR. The resident was admitted on [EX Order 26.4B1] with diagnoses which included but not limited to: [EX Order 26.4B1]

A review of Resident #31's Quarterly MDS dated [EX Order 26.4B1] noted under [EX Order 26.4B1] and [EX Order 26.4B1] Status that the resident had a [NJ Exec. Orde] of [NJ Exec. O] or more in the last month or [NJ Exec. Orde] of [NJ Exec. Orde] or more in last 6 months" and that the resident in "not on a prescribed [NJ Exec. Order 26:4.b.1] regiment."

Review of the Resident's noted documentation under [EX Order 26.4B1] Should Brief Interview for Mental Status be Conducted, Resident #13 could not have a [EX Order 26:4] conducted to due [NJ Exec. Order 26:4.b.1]

The surveyor reviewed the weight record in the EMR. Weights were documented as follows:
[EX Order 26.4B1]

These weights reflect a significant [NJ Exec. Order 26:4.b.1] on 6/5/2023 of [EX Order 26.4B1]. which supports a [ ] over 90 days.

A review of the RD [NJ Exec. Order 26:4.b.] weight review note dated 6/12/2023, "June Weight., 6/12/2023 [NJ Exec. Order] lbs., Prior Weights., 1 month 5/10/2023 [NJ Exec. Order] lbs., down [NJ Exec. Order 26:4.b.1] % Sig Loss. 3 month 3/4/2023 [NJ Exec. Order 26:4.b.1]., down [NJ Exec. Order 26:4.b.1] % Sig

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ALARIS HEALTH AT ST MARY'S	135 SOUTH CENTER STREET ORANGE, NJ 07050

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Loss. EX Order 26.4B1 [redacted] intervene as needed."

In the RD's progress notes dated EX Order 26.4B1 there was no documentation of the relationship between current medical condition which included EX Order 26.4B1 [redacted]

A review of the EX Order 26.4B1 resident's individualized care plan for NJ Exec. Order 26:4 n, failed to address any identified causes of EX Order 26.4B1 as the facility EX Order 26.4B1 policy dictates.

4. On 9/5/23 at 10:30 AM, the surveyor observed Resident #85 in bed, NJ Exec. Order 26:4.b.1 questions. Resident goes to EX Order 26.4B1 [redacted] Resident made surveyor aware that he/she does not get an early breakfast, but sometimes gets a bagged lunch to bring, but that this is very inconsistent.

On 9/8/2023 at 9:00 AM, the surveyor reviewed the resident's EMR. The resident was admitted on EX Order 26.4B1 with diagnoses which included but were not limited to: EX Order 26.4B1 [redacted]

A review of Resident #85 Quarterly MDS dated

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F 692	Continued From page 40 6/12/2023 noted under EX Order 26.4B1 and EX Order 26.4B1 that the resident had not any EX Order 26.4B1 Review of the Resident's MDS documentation noted under EX Order 26.4B1 BIMS could not be conducted to due EX Order 26.4B1. The surveyor reviewed the weight record in the EMR. Weights were documented as follows: EX Order 26.4B1 These weights reflect significant NJ Exec. Order 26:4.b.1 on EX Order 26.4B1 A review of the RD nutrition weight review note dated EX Order 26.4B1 Follow new	F 692		

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ALARIS HEALTH AT ST MARY'S	**135 SOUTH CENTER STREET ORANGE, NJ 07050**

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F 692	Continued From page 41 Labs, Weight trends, Monitor, intervene as needed." An additional RD [NJ Exec. Order 26.4.b] weight review note dated 8/16/2023 documented [EX Order 26.4B1] [redacted]. Monitor, intervene as needed." On 9/7/2023 the RRD provided this surveyor with a paper copy of weekly weights for all residents who resided on the 5th floor of the facility from [EX Order 26.4B1]. The RRD informed the surveyor that the weekly weight sheet is kept by the RD in a notebook in her office. The Surveyor observed weekly weights for Resident #85 starting on [EX Order 26.4B1] and ending on [EX Order 26.4B1]. Weights were documented as follows: [EX Order 26.4B1] [redacted]	F 692		

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F 692	Continued From page 42 EX Order 26.4B1 None of the weekly weights were entered into the EMR, as the facility policy dictates should be done. The Surveyor observed a PO, "weekly weights-obtain from NJ Exec. Order 26:4.b.1 communication sheet one time a day for weight monitoring", with start date of EX Order 26.4B1 and a discontinue EX Order 26.4B1 A review of the EX Order 26.4B1 , revealed that weights were not taken consistently. A review of Resident #85's individualized NJ Exec. Order 26:4.b care plan with an onset date of 3/12/2023 and completed on 7/6/2023, failed to address any identified causes of the resident's NJ Exec. Order 26:4.b.1 . On 9/7/23 the RRD provided the surveyor with a copy of the facility policy titled, Weight Assessment and Intervention. Under the Policy Interpretation and Implementation section of the policy, subsection weight assessment it states, "3. Verified weights will be recorded in each residents Electronic Medical Record." Under the subsection analysis it states, "1. Assessment information shall be analyzed, and conclusions shall be made regarding the: c. The relationship between current medical condition or clinical situation and recent fluctuations in weight." Under subsection Care Planning it states, "2 Individualized care plans shall address to the extent possible: a. The identified causes of weight loss." On 9/11/23 at 10:50 AM, the surveyor interviewed the RD and RRD. Both the RD and RRD stated	F 692		

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F 692	Continued From page 43	F 692		

they are familiar with the facility weight policy. The RRD informed the surveyor that weekly weights are not put into the EMR but kept in a notebook in the RD's office. Neither the RRD nor RD could state why the weekly weights were not entered into the EMR per the facility policy. The surveyor reviewed the policy with the RD and RRD in reference to whether the RD's progress or weight notes should include weight change, whether it is desirable or undesirable and what medical conditions could be the cause of the weight change. The RRD responded, "That is at the discretion of the RD." Surveyor asked, in the resident's care plan should address and identify the cause of the weight loss? The surveyor asked if in the resident's care plan what is entered regarding weight changes? The RRD responded, "We state what interventions are in place." The RRD agreed that weekly weights should be entered in the EMR. The RD and RRD provided no further information regarding the analysis and care plan sections of the policy.

On 9/14/2023 at 01:34 PM, the surveyors met with the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA) and Regional DON. The Regional DON stated they would provide the surveyor with a timeline for the residents who were observed with significant weight loss but could not provide any other additional information.

On 9/16/2023 at 10:38 AM, the Regional DON provided the surveyor with a timeline sheet for Residents #133, #16, #31 and #85 [redacted], which included the resident's name, weights, RD note/additional interventions, Nursing Notes/additional team interventions and RD care

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ALARIS HEALTH AT ST MARY'S	135 SOUTH CENTER STREET ORANGE, NJ 07050

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F 692	Continued From page 44 plans. No further information was provided to explain NJ Exec. Order 26:4.b.1 or why the facility failed to follow their policy and procedure. NJAC 8:39-11.2(e), 17.1(c), 27.1(a)	F 692		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility polices it was determined that the facility failed to maintain proper kitchen sanitation practices. This deficient practice was evidenced by the following:	F 812	On 9/05/2023 Observed, interview and review the facility policies that the facility failed to maintain proper kitchen sanitation practices. The temperature for the low-temperature dishwasher did not reach the minimum 120 Fahrenheit degrees upon observation. The dishwasher was inspected on	9/25/23

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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F 812	Continued From page 45 On 9/5/23 from 9:35 AM through 10:20 AM, the surveyor completed the initial kitchen tour with the Food Service Director (FSD) and Regional Registered Dietitian (RRD). Upon entering the dish room, the surveyor observed a dietary aide (DA) using the dish washing machine, that was filled with soiled breakfast dishes. The surveyor observed the wash and rinse cycle reaching 114 degrees Fahrenheit (F). The FSD stated, "the dish machine is a low temperature machine. The wash and rinse cycles should be 120 F." The FSD ran the dish machine two more times, with the wash and rinse cycle temperature maintaining 114 F. The RRD provided the temperature log showing the dish machine temperature readings of 120 F from 9/1-9/5/23. The FSD informed the surveyor that the temperature of the dishwashing machine is checked with the initial use of the machine. Neither the DA, FSD, or RRD could explain the sudden change in temperature. Observation of the identification tag of the low temperature dish washing machine revealed, "Wash temperature 120 degrees F minimum. Rinse temperature 120 degrees F minimum." Temperature settings for the low-temperature dishwasher are designed to reach a minimum temperature of 120 °F, to avoid the following risks: inadequate sanitization of dishes, glasses, and utensils, which may lead to the spread of harmful bacteria and viruses. It is important to ensure that dishwashers meet the required temperature standards to maintain proper hygiene and prevent potential health hazards.	F 812	9/5/2023 to meet the minimum standard. All residents have the potential to be affected. The Director of Dietary or Designee will conduct a daily audit on dish machine temperature to ensure the minimum 120 Fahrenheit degree standard is accomplished. Inservice with dietary department staff regarding required temperature prior to washing dishes was done on 9/6/23 Director of Dietary or designee will present daily findings at the quarterly Safety Committee Meeting for one year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 46 On 9/18/23 at 11:47 AM, the RRD provided a copy of the facility policy titled, Dishwashing Machine Use. Under the section, Low Temperature Machine Chemical Sanitizer Temperatures and Concentrations, the policy states, "4. Wash Temp/Rinse Temp 120/120". NJAC 8:39-17.2(g)	F 812		

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
315352 Y1	A. Building B. Wing Y2	10/23/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT ST MARY'S	135 SOUTH CENTER STREET ORANGE, NJ 07050

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0578	Correction	ID Prefix F0641	Correction	ID Prefix F0657	Correction
Reg. # 483.10(c)(6)(8)(g)(12)(i)-(v)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed
LSC	09/20/2023	LSC	09/20/2023	LSC	09/21/2023
ID Prefix F0658	Correction	ID Prefix F0690	Correction	ID Prefix F0692	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.25(g)(1)-(3)	Completed
LSC	10/02/2023	LSC	10/04/2023	LSC	09/27/2023
ID Prefix F0812	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/25/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/18/2023	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315352	A. BUILDING **01** B. WING _____	**09/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 09/07/2023. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/07/23 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Alaris Health at St Mary's is a six-story building with a basement that was built in 1988. It is composed of Type II protected construction. The facility is divided into 14 - smoke zones. The generator does approximately 97 % of the building as per the Maintenance Director. The current occupied beds are 149 of 188. .	K 000		
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation	K 311		10/23/23

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

Electronically Signed | 10/07/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315352	A. BUILDING **01** B. WING _____	**09/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT ST MARY'S	**135 SOUTH CENTER STREET** **ORANGE, NJ 07050**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 311	Continued From page 1 shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure fire rated door assemblies for 14-stairway exit doors were equipped with approved fire exit hardware in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.7.2. This deficient practice had the potential to affect 149 residents. Findings include: Observations on 09/07/23 at 12:00 PM to 2:30 PM revealed the stairway exit doors were equipped with panic hardware and not fire exit hardware which violated the listing of the rated fire door assemblies. At the time of observation, the Maintenance Director confirmed the stairway doors were equipped with panic hardware. NJAC 8:39-31.2(3) NFPA 80 .	K 311	On 9/07/2023 Observed stairwell exit doors were equipped with panic hardware and not fire exit hardware which violated the listing of the rated fire door assemblies. All stairwell exit doors panic door assemblies will be replaced in accordance with NFPA 80 standards for Fire Doors. All residents have the potential to be affected. The Maintenance Director or Designee will conduct an daily audit on all egress stairwell doors to ensure there is fire rated exit door assemblies. Maintenance director or designee will present daily findings at the quarterly Safety Committee Meeting for one year.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		10/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315352	A. BUILDING **01** B. WING _____	**09/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT ST MARY'S	**135 SOUTH CENTER STREET** **ORANGE, NJ 07050**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 2 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: . Based on document review and interview, the facility failed to ensure the fire doors were properly inspected annually in accordance with NFPA 101 Life Safety Code (2012 edition) 7.2.1.15. This deficient practice had the potential to affect all 149 residents. Findings include: A document review of the facility's binder, dated 2022 and 2023 provided by the Maintenance Director, revealed the fire doors were not properly documented and not reported as failing the inspections. During an interview on 09/07/23 at 12:30 PM, the Maintenance Director confirmed the reports did not fail the fire doors with panic hardware. NJAC 8:39-31.2(e)	K 761	On 9/07/2023 the facility failed to ensure the fire doors were properly inspected annually in accordance with NFPA 101 life safety code (2012 Edition). The fire doors were not properly documented and not reported as failing inspections. All stairwells exit doors panic door assemblies will be replaced in accordance with NFPA 80 standards for Fire Doors. The facility will properly inspect and document in accordance with NFPA 101 life safety code. All residents have the potential to be affected. The facility acquired fire door- panic door assemblies in accordance with NFPA 80 standards for fire doors.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315352	A. BUILDING **01** B. WING _____	**09/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT ST MARY'S	**135 SOUTH CENTER STREET** **ORANGE, NJ 07050**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 3 NFPA 80 .	K 761	The door assemblies for all stairwell doors will be replaced by 10/17/23. The Maintenance staff will conduct an daily audit on all egress stairwell doors to ensure there are fire rated exit door assemblies. The Maintenance Director will audit all stairwell doors once per week for three months. Then once every other week for three months. The Maintenance Director will review weekly audit for three months then bi-weekly audit for three months with the administrator. The Maintenance Director will present daily findings and audit at the quarterly Safety Committee Meeting for the next two quarters.	

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
315352 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/23/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT ST MARY'S	135 SOUTH CENTER STREET ORANGE, NJ 07050

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0311	10/23/2023	LSC K0761	10/17/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/18/2023	☐ YES ☐ NO