

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

PRINTED: 12/13/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315445	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/13/2024
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NAME OF PROVIDER OR SUPPLIER ARBOR AT LAUREL CIRCLE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 MONROE STREET BRIDGEWATER, NJ 08807
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F 000	<p>INITIAL COMMENTS</p> <p>Complaint NJ#s: 169997, 170751</p> <p>Survey Date: 09/13/24</p> <p>Census: 33</p> <p>Sample: 13 + 1 closed record</p> <p>A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.</p>	F 000		
F 584 SS=D	<p>Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)</p> <p>§483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>The facility must provide-</p> <p>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance</p>	F 584		10/7/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 10/07/2024
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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 584	<p>Continued From page 1</p> <p>services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview it was determined that the facility failed to maintain the healthcare dining room in a clean and homelike manner. The deficient practice was evidenced by the following:</p> <p>On 09/10/24 at 11:34 AM, the surveyor observed the meal preparation in the healthcare pantry, located on the 2nd floor, with the U.S. FOIA (b) (6) present. The trays were being assembled for distribution to the residents who eat in their rooms. At that time the surveyor observed an ant crawling up the wall in the kitchen and several small flying insects in the pantry. The US FOIA stated "there was an ant issue" and the facility was notified and the pest people sprayed for ants. At that time, the surveyor observed that there were splatters in several</p>	F 584	<p>How corrective actions will be accomplished for those residents affected by the deficient practice</p> <p>Housekeeping & maintenance services, as well as pest control vendor were called in immediately to ensure the community adequately addressed the dust, debris, ants, insects, worn furniture, and stained/soiled areas.</p> <p>The actions were performed immediately to maintain the healthcare dining room in a clean and homelike manner.</p> <p>Date of Completion: 10/01/24</p> <p>How will the facility identify other residents who have potential to be affected by the same deficient practice</p>		

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F 584	<p>Continued From page 2</p> <p>areas on the wall and crumbs and other debris on the floor behind the equipment and in the corners. The surveyor asked about the pantry cleaning and the [redacted] stated the floors are swept and mopped. The adjacent storage room was observed and contained debris on the floor and in the corners, the walls also had splatters and stains. A soiled dust pan was on the floor next to a small plunger and a broom. There were flying insects observed in the storage room, and boxes of cold cereal and sugar packets were stored on a metal shelf.</p> <p>The surveyor then exited the pantry into the main healthcare dining room and observed the following:</p> <ul style="list-style-type: none"> -Dust and debris on the window sill with several dead insects. -Multiple insects appeared to be stuck to the wall molding. -Chairs and tables had visibly worn table legs and chair legs. -There was a visible crack in the painted ceiling above the resident meal tables which appeared to be approximately one foot long. -Two rugs outside of the door from the pantry to the dining room were visibly soiled with various debris. -There were stains and debris on the floor, including white splatter type stains on the floor and under the resident dining tables. -A black piano in the dining room was visibly 	F 584	<p>All residents have the potential to be affected by this deficient practice. Date of Completion: 10/01/24</p> <p>What measures will be implemented to prevent the recurrence of the deficient practice All Food & Beverage staff to be reeducated by the Staff Development Coordinator or designee on the community's Sanitation Policy. The daily Food & Beverage cleaning and sanitation checklist to be revised and augmented to ensure the community maintains the healthcare dining room in a clean and homelike manner. Housekeeping Services will complete monthly deep cleaning of floors Date of Completion: 10/07/24</p> <p>How will the facility monitor to ensure the deficient practices do not occur The condition of the healthcare dining room will be randomly inspected weekly for the next 3 months by the Director of Food & Beverage and/or designee to ensure the community maintains the healthcare dining room in a clean and homelike manner. Results of the audits will be submitted to the monthly QAPI Committee. The committee will review the findings and make recommendations as appropriate. Date of Completion: 10/07/24</p>		

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F 584	Continued From page 3 dusty. On 09/10/24 at 12:00 PM, the surveyor showed the US FOIA (b)(6) the above concerns and he acknowledged and stated, "give me one hour to have it cleaned".	F 584			
F 657 SS=D	NJAC 8:39- 4.1(a)11 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. (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	F 657		10/11/24	

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F 657	<p>Continued From page 4 assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to revise a resident-centered on-going care plan for a resident who sustained [redacted NJ Exec Order 26.4b1]. This deficient practice was identified for 1 of 13 residents (Resident #34) reviewed for care plans and was evidenced by the following:</p> <p>A review of the facility provided policy, "Care Plans, Comprehensive Person-Centered" revised March 2022, included but was not limited to; Policy Statement: "A comprehensive, person-centered care plan that includes measurable objectives "and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident." "11. Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change.</p> <p>On 09/09/24 at 6:32 PM, the surveyor observed Resident #34 in the [redacted NJ Exec Order 26.4b1] day room visiting with a family member. The family member stated that the resident had [redacted NJ Exec Order 26.4b1].</p> <p>On 09/11/24 at 8:24 AM, the surveyor observed Resident #34 in the [redacted NJ Exec Order 26.4b1] day room eating breakfast while sitting in a wheelchair.</p> <p>On 09/11/24 at 8:31 AM, the Certified Nursing Assistant (CNA) #1 stated Resident #34 needed [redacted NJ Exec Order 26.4b1], could [redacted NJ Exec Order 26.4b1] a few seconds, and has [redacted NJ Exec Order 26.4b1].</p>	F 657	<p>How corrective actions will be accomplished for those residents affected by the deficient practice</p> <p>The resident-centered on-going care plan (focus area of [redacted NJ Exec Order 26.4b1] of Resident #34 was immediately revised to ensure interventions accurately reflected the resident's needs and preferences. Plan of care has been updated to include intervention for [redacted NJ Exec Order 26.4b1] on [redacted NJ Exec Order 26.4b1] as well as the [redacted NJ Exec Order 26.4b1] to utilize the [redacted NJ Exec Order 26.4b1] chair. Date of Completion: 09/13/24</p> <p>How will the facility identify other residents who have potential to be affected by the same deficient practice Residents who have a documented history of falls have the potential to be affected. The resident-centered on-going care plans for residents with a documented history of falls within the past 30 days to be reviewed and revised as needed to ensure interventions accurately reflected the resident's needs and preferences. Date of Completion: 10/04/24</p> <p>What measures will be implemented to prevent the recurrence of the deficient practice All licensed nurses and interdisciplinary team members will be re-educated by the Staff Development Coordinator or designee on the community's</p>		

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F 657	<p>Continued From page 6</p> <p>to include the [redacted] and [redacted] or any interventions put in place. The interventions included but were not limited to; dated [redacted], offer to have (Resident #34) [redacted]; and dated [redacted], "provide [redacted] chair if (Resident #34) prefers to stay in the lounge area.</p> <p>On 09/12/24 at 10:10 AM, the [redacted] was in the conference room with two surveyors and stated Resident #34, "required supervision but it was not always direct, and things happen." The [redacted] further stated that "resident [redacted] should be documented on the care plan. It would include the date of the [redacted] and interventions if appropriate." The [redacted] stated updating the care plan was important but that she would not usually list the dates of the [redacted] just the interventions. When asked about the [redacted] chair listed as an intervention, the [redacted] stated that the resident [redacted] the [redacted] and there was no documentation. The surveyor informed the [redacted] of the concern regarding the missing [redacted] dates and missing updated information.</p> <p>On 09/13/24 at 10:07 AM, the [redacted] again acknowledged that there was no documentation regarding use of the [redacted] and if it was offered to Resident #34 per the documented care plan intervention. There was no further information provided regarding the care plan not being revised or updated with Resident #34's [redacted]</p> <p>NJAC 8:39-11.2 (h)(i)</p>	F 657			
F 679 SS=E	<p>Activities Meet Interest/Needs Each Resident</p> <p>CFR(s): 483.24(c)(1)</p>	F 679		10/11/24	

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F 679	<p>Continued From page 7</p> <p>§483.24(c) Activities.</p> <p>§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to 1) have a system in place to ensure activities were conducted as scheduled, and 2) have a system in place to ensure residents were receiving their identified activity preferences to support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This deficient practice was identified for Resident #34, on 2 of 2 units and was evidenced as follows:</p> <p>A review of the facility provided policy and procedure, "Community Life Services [name redacted] Policies and Procedures" revised 1/2024, included but was not limited to; Monthly Program Calendars. There are 3 neighborhood calendars. Calendars are distributed for each neighborhood.</p> <p>On 09/09/2024 at 6:36 PM, the surveyor toured the NJ Exec Order 26.4b1 and observed that two residents (one unsampled and Resident #34) were in the common area while the other six residents were in their rooms or in bed. One of</p>	F 679	<p>How corrective actions will be accomplished for those residents affected by the deficient practice</p> <p>The resident-centered on-going care plan of Resident #34 was immediately revised to ensure they were receiving their identified activity preferences to support the physical, mental, and psychosocial well-being, encouraging both independence and interaction in the community.</p> <p>A community programming tracking tool was put in place to ensure activities are conducted as scheduled, and to ensure that Resident #34 is receiving their identified activity preferences.</p> <p>Date of Completion: 09/16/24</p> <p>How will the facility identify other residents who have potential to be affected by the same deficient practice</p> <p>All residents have the potential to be affected. Residents' care plans are to be reviewed and revised as needed to ensure they are receiving their identified activity preferences to support the</p>		

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F 679	<p>Continued From page 8</p> <p>the two residents was visiting with family and the other resident was just sitting at a table. There was a Lifestyle Programs Calendar (LPC) on a table that indicated at 6:00 PM there was an "Evening Movie" scheduled but there was no movie playing. The surveyor observed two Certified Nursing Assistants (CNA) working on the unit and no nurse.</p> <p>The surveyor walked over to the [NJ Exec Order 26.4b1] and observed only one resident in the common area. The [US FOIA] indicated that at 6:00 PM there would be "Evening Bingo" scheduled but there was no Bingo activity happening.</p> <p>On 09/09/2024 at 6:39 PM, the [US FOIA (b)(6)] stated that Bingo had happened earlier in the day and there was no evening Bingo.</p> <p>On 09/11/2024 at 9:28 AM, the surveyor was on the [NJ Exec] and observed four residents who had finished breakfast were in the common area. The television was on a music channel, but no residents were watching the television.</p> <p>At that time, the surveyor reviewed the [US FOIA] which noted that at 9:30 AM Morning Meet-Up (SL) [Seasons Lounge], 10:00 AM Morning Exercise Group (SL), and 10:30 AM Daily Chronicle Reading Group (SL).</p> <p>On 09/11/2024 at 9:32 AM, the surveyor observed two CNAs assigned to the [NJ Exec] CNA #1 stated, "the residents usually relax after breakfast and there usually will be activities".</p> <p>On 09/11/2024 at 9:41 AM, Resident #34 [NJ Exec Order 26.4b1] to the surveyor and asked, "where do I go now?"</p>	F 679	<p>physical, mental, and psychosocial well-being, encouraging both independence and interaction in the community. Date of Completion: 10/11/24</p> <p>What measures will be implemented to prevent the recurrence of the deficient practice All programming staff to be educated by the Staff Development Coordinator or designee on proper assessment and documentation from the community's Community Life Services Policies & Procedures Manual. A community programming tracking tool was put in place to ensure activities are conducted as scheduled, and to ensure that Resident #34 is receiving their identified activity preferences. Date of Completion: 10/11/24</p> <p>How will the facility monitor to ensure the deficient practices do not occur 2 randomly selected calendar programs to be audited weekly x 4 weeks, then monthly x 2 months by the Community Life Services Director or designee to ensure activities are conducted as scheduled, and to ensure that residents are receiving their identified activity preferences. Results of the audits will be submitted to the QAPI Committee monthly. The committee will review the findings and make recommendations as appropriate. At the conclusion of three months, a determination will be made of the need for further auditing.</p>		

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F 679	Continued From page 9 A review of Resident #34's Admission Record revealed diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [REDACTED]. A review of most recent Quarterly Minimum Data Set (MDS) an assessment tool used to facilitate resident care dated NJ Exec Order 26.4b1 [REDACTED], included but was not limited to; Section C: Brief Interview for Mental Status (BIMS) of NJ Exec Order 26.4b1 [REDACTED] out of 15 indicating NJ Exec Order 26.4b1 [REDACTED]. A review of the resident-centered on-going care plan included but was not limited to; a focus area of at risk for NJ Exec Order 26.4b1 [REDACTED] and/or NJ Exec Order 26.4b1 [REDACTED] with interventions that included "activities to develop activity plan" dated NJ Exec Order 26.4b1 [REDACTED] upon admission. A focus area NJ Exec Order 26.4b1 [REDACTED], NJ Exec Order 26.4b1 [REDACTED], NJ Exec Order 26.4b1 [REDACTED], and NJ Exec Order 26.4b1 [REDACTED] through out the neighborhood dated NJ Exec Order 26.4b1 [REDACTED], after surveyor inquiry. A focus area for staff to invite the resident to programs of interest. A review of the Life Enrichment Admission Data Collection dated NJ Exec Order 26.4b1 [REDACTED], over NJ Exec Order 26.4b1 [REDACTED] after admission, included but was not limited to; enjoyed NJ Exec Order 26.4b1 [REDACTED] [REDACTED]	F 679	Date of Completion: 10/11/24		

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F 679	Continued From page 10 NJ Exec Order 26.4b1 [REDACTED] Programs Admission Note: "Programming staff will invite and encourage Resident #34 to participate in programs of choice as tolerated." A review of Life Enrichment Quarterly dated NJ Exec Order 26.4b1 , included but was not limited to; [REDACTED] A review of the Life Enrichment Quarterly dated NJ Exec Order 26.4b1 , included but was not limited to; NJ Exec Order 26.4b1 [REDACTED]	F 679			

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F 679	<p>Continued From page 11</p> <p>NJ Exec Order 26.4b1</p> <p>On 09/11/24 at 10:19 AM, CNA #1 reviewed the activities calendar and stated, "I don't know what to do except they don't do anything. I know Resident #34 roams around." The surveyor asked what Resident #34 likes to do and if there was any guideline for staff to follow to see what the residents enjoy. CNA #1 stated, "no."</p> <p>On 09/11/24 at 10:30 AM, the surveyor observed that there was still no activities staff on the NJ Exec O</p> <p>On 09/11/24 at 10:32 AM, during an interview with the surveyors, the US FOIA (b)(6) stated that activities would be scheduled based on resident preferences. The US FOIA (b)(6) stated she was responsible for the NJ Exec and that the activities staff would meet every morning for their assignment and that there were 3 activity staff not including herself. The US FOIA (b)(6) further revealed that she reviewed daily activities and which residents would like to attend those activities and stated, "We invite everyone always. We keep attendance and will write which activity and check off who attended. We have residents who stay in their room, and we ask what independent activities that resident wants. There are designated times for room visits from 1:00 PM to 2:00 PM and it is recommended to spend 20 minutes for each room visit. Where conduct nighttime activities and an activity coordinator will run that." The US FOIA (b)(6) stated that it was important for evening activities as well because, "we want to ensure we are enriching their lives. I noticed after dinner about 6:00 PM, is the most engagement." When asked the process to monitor how many activity hours residents receive, the US FOIA (b)(6) stated</p>	F 679			

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F 679	<p>Continued From page 12</p> <p>they were tracked via attendance. When asked about the system in place to quantify how much time a resident receives in their preferred activities, the [US FOIA (b)(6)] stated through attendance. The [US FOIA (b)(6)] stated that they review the resident care plans also but could not say the process to determine if the goals were met or not.</p> <p>On 09/11/24 at 10:57 AM, the [US FOIA (b)(6)] arrived and stated she works in the assisted living but would help in long term care. The [US FOIA (b)(6)] stated, "Our goal is to have everyone engaged all the time." She further stated that the current system of monitoring was via attendance. The [US FOIA (b)(6)] was unable to provide a process for tracking resident activity attendance and added there was no system to quantify. The [US FOIA (b)(6)] explained that the activities department had conversations daily, but she was not sure if anything was documented or updated in the resident care plans. She stated, "I expect programs to start on time. I make rounds and talk to residents." The [US FOIA (b)(6)] stated she was not aware that the evening bingo on CU and the evening movie on SU had happened. The [US FOIA (b)(6)] stated, "we are leaning on nursing to assist that was the plan. There is no excuse for no program and no help from nursing." When asked about no activities all morning from 9:00 AM through 10:30 AM, she stated she was not aware.</p> <p>On 09/11/24 at 12:42 PM, the [US FOIA (b)(6)] stated in presence of the survey team, that there were no activity records to provide to the surveyors.</p> <p>A review of the facility provided job description, "Community Life Services Manager" revised June 2023, included but was not limited to; " ... responsible for the overall planning and</p>	F 679			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 679	Continued From page 13 implementation of a varied activity program designed to meet the requirements of Lifestyles & Health Services ... "Plans, develops, organizes, implements, evaluates, and directs the activity programs in the health center." Wellness Focus: " ... employees are expected to promote a health community culture for all residents and employees. This is a whole-person approach to health and wellness with includes eight dimension of wellness: emotional, environmental, health services, intellectual, physical, social, spiritual, and vocational. Through these efforts we can ensure and exceed residents' wellness needs relating to their mind, body and soul ..."	F 679			
F 684 SS=G	NJAC 8:39-4.1 (22); 7.1 (a); 7.2; 7.3; 8.1; 8.3; 8.4 (a) Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Complaint # NJ 169997 Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to a.) thoroughly review the hospital discharge summary (After Visit Summary) and communicate the	F 684	How corrective actions will be accomplished for those residents affected by the deficient practice N/A <input type="checkbox"/> Closed record review. Resident #152 no longer under care.	10/15/24	

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F 684	<p>Continued From page 14</p> <p>recommendations for an [redacted] medication to the physician, and b.) follow a physician's order for an [redacted] medication [redacted] ordered to be administered daily at bedtime. This resulted in Resident #152 not receiving the physician ordered [redacted] medication for [redacted] days (from [redacted] through [redacted]) which resulted in Resident #152 experiencing [redacted] which included: [redacted] and [redacted]. This deficient practice was identified for 1 of 7 residents (Resident #152), reviewed for medication administration and was evidenced by the following:</p> <p>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 or 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 well-being, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist."</p> <p>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a</p>	F 684	<p>Date of Completion: 09/13/24</p> <p>How will the facility identify other residents who have potential to be affected by the same deficient practice</p> <p>Newly admitted residents have the potential to be affected. The medical records and MARs for all residents admitted within the last 30 days to be reviewed to ensure physician orders were accurately transcribed & followed. This will ensure they receive treatment and care in accordance with professional standards of practice.</p> <p>Date of Completion: 10/11/24</p> <p>What measures will be implemented to prevent the recurrence of the deficient practice</p> <p>All licensed nurses will be re-educated by the staff educator on the community <input type="checkbox"/>s Reconciliation of Medications on Admission & Medications Administration policies to ensure residents receive treatment and care in accordance with professional standards of practice.</p> <p>The reconciliation of medication orders (hospital discharge summary) for all admissions to the community will be verified by three separate licensed nurses (1) the admitting nurse, (2) the post admitting nurse, and (3) Unit Manager for accuracy.</p> <p>Medications not administered will be</p>	

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F 684	<p>Continued From page 15</p> <p>registered nurse or licensed or otherwise legally authorized physician or dentist."</p> <p>On 09/10/24 at 11:15 AM, a review of the closed medical record for Resident #152 revealed the following:</p> <p>Review of the Admission Face Sheet reflected that Resident #152 was admitted to the facility on [redacted], and discharged [redacted]. The diagnoses included, but was not limited to [redacted].</p> <p>A review of the "After Visit Summary" (hospital discharge instructions), revealed a medication list with an order for [redacted] to be administered by mouth nightly.</p> <p>Review of the [redacted] Order Summary Report revealed a physician's order dated [redacted] for [redacted] for [redacted] give 1 tablet by mouth at bedtime for [redacted]. Further review of the medical record revealed that the order was transcribed on [redacted] as a telephone order.</p> <p>A review of the [redacted] Medication Administration Record (MAR), revealed that the [redacted] was not administered on: [redacted].</p> <p>The [redacted] electronic boxes where the nurses were to sign for the administration of the [redacted] were documented with code 05 and 09. Code 05 indicated to hold the medication and to see Nurses Notes; and Code 09 indicated that the</p>	F 684	<p>monitored through the community's EMR each shift to ensure that there is a clinical note indicating physician notification and appropriate follow up.</p> <p>Medications not administered will then be reviewed daily during stand up meeting by the Director of Nursing of designee. √</p> <p>Date of Completion: 10/15/24</p> <p>How will the facility monitor to ensure the deficient practices do not occur</p> <p>The Director of Nursing or designee will conduct a random audit of the medical records for all new admissions daily for 14 days, followed by 2 randomly selected admissions weekly x 4 weeks, then monthly x 3 months.</p> <p>The Director of Nursing or designee will conduct a random audit of medications not administered for all residents daily for 14 days, then 2 randomly selected residents weekly x 4 weeks, then monthly x 3 months.</p> <p>Results of the audits will be submitted to the QAPI Committee monthly. The committee will review the findings and make recommendations as appropriate. At the conclusion of three months, a determination will be made of the need for further auditing.</p> <p>Date of Completion: 10/11/24 (audits initiated)</p>	

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F 684	<p>Continued From page 16</p> <p>medication is not available. Review of the Nurses Notes indicated medication not available.</p> <p>A review of the progress notes dated [redacted] revealed a treatment plan initiated [redacted] which indicated the following:</p> <p>NJ Exec Order 26.4b1 [redacted]</p> <p>NJ Exec Order 26.4b1 [redacted]</p> <p>NJ Exec Order 26.4b1 [redacted]</p> <p>NJ Exec Order 26.4b1 [redacted]</p> <p>NJ Exec Order 26.4b1 [redacted]</p> <p>Labs reviewed.</p> <p>[redacted] evaluation and treatment.</p> <p>Medications reviewed and reconciled.</p> <p>Transfer Records reviewed.</p> <p>Orders reviewed.</p> <p>Discussed with nursing.</p> <p>A review of the resident's Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that the resident's [redacted] was [redacted]. The assessment further reflected the resident was dependent on staff for [redacted], and needed assistance with [redacted].</p> <p>A review of an individualized care plan initiated in [redacted], included that the resident used NJ Exec Order 26.4b1 related to [redacted]. The goal specified that the resident would be free from [redacted] or [redacted].</p>	F 684		

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F 684	<p>Continued From page 17</p> <p>NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1 through the review date. The care plan interventions included the following:</p> <ul style="list-style-type: none"> - Educate the resident/family/caregivers about risks, benefits, and the side effects and/or toxic symptoms. - Give NJ Exec Order 26.4b1 medications ordered by physician. Monitor/document side effects and effectiveness. <p>A review of the History and Physical Assessment from the hospital record dated NJ Exec Order 26.4b1, reflected that the resident was NJ Exec Order 26.4b1, had a work-up done in the emergency room and was admitted to the facility on NJ Exec Order 26.4b1, with a list of medications to be continued. The NJ Exec Order 26.4b1 medication NJ Exec Order 26.4b1 was changed to NJ Exec Order 26.4b1 to be administered at bedtime. The hospital discharge summary indicated that Resident #152 received NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 at 8:24 PM.</p> <p>A review of the medication reconciliation sheet revealed that the NJ Exec Order 26.4b1 medication NJ Exec Order 26.4b1 was not transcribed as ordered on NJ Exec Order 26.4b1.</p> <p>A review of a Nurse's Notes dated NJ Exec Order 26.4b1 and timed 8:50 PM, reflected that NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 at bedtime for NJ Exec Order 26.4b1 Medication not available".</p> <p>A review of a Nurse's Note dated NJ Exec Order 26.4b1 and timed 8:50 PM, reflected that NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 at bedtime was not administered at bedtime for NJ Exec Order 26.4b1 Medication not available". The nurse's note dated NJ Exec Order 26.4b1, reflected that [Resident #152] was NJ Exec Order 26.4b1 recent change in</p>	F 684		

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F 684	<p>Continued From page 18</p> <p>NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1.</p> <p>A review of a Nurse's Note dated NJ Exec Order 26.4b1 and timed 12:15 PM, suggested to engage Resident #152 in activity to help with their NJ Exec Order 26.4b1.</p> <p>On 12/7/23 at 3:23 PM, the nurse's notes reflected that Resident #152 was NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. The family was notified, the US FOIA (b)(6) was called and gave order to increase NJ Exec Order 26.4b1 an NJ Exec Order 26.4b1 medication to NJ Exec Order 26.4b1 daily. There was no documented evidence that the physician or the US FOIA (b)(6) was made aware that Resident #152 had not been receiving the NJ Exec Order 26.4b1 for their NJ Exec Order 26.4b1 as ordered.</p> <p>A review of a Nurse's Notes dated NJ Exec Order 26.4b1 reflected that Resident #152 has period of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 Resident is being followed by US FOIA (b)(6).</p> <p>A review of the Nurses Progress Notes from NJ Exec Order 26.4b1 did not address that the pharmacy was called and inquired about the NJ Exec Order 26.4b1 not being available and/or notification of the physician in regards to the resident being NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. There was no documented evidence that the family or the physician were notified.</p> <p>A review of the NJ Exec Order 26.4b1 Medication Administration Record (MAR) reflected the corresponding physician's order (PO) dated NJ Exec Order 26.4b1, to administer NJ Exec Order 26.4b1 give NJ Exec Order 26.4b1 at bedtime for NJ Exec Order 26.4b1. The order was plotted for the medication to be administered at 9:00 PM, but there was no evidence that the NJ Exec Order 26.4b1 order was ever faxed to the pharmacy.</p>	F 684			

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F 684	<p>Continued From page 19</p> <p>On 9/10/24 at 10:30 AM, the surveyor requested all investigation reports for Resident #152.</p> <p>On 9/11/24 at 10:00 AM, the US FOIA (b)(6) provided a Medication Error -Other dated NJ Exec Order 26.4b and timed 10:26 AM, that indicated the following:</p> <p>"Nursing Description: NJ Exec Order 26.4b1 po [orally] at hour of sleep was not administered from NJ Exec Order 26.4b1. Pharmacy was called to find out why the medication was not sent and they replied that they needed the order." Resident Description: Resident unable to give description.</p> <p>Immediate action taken: The order was in the chart and had a date faxed NJ Exec Order 26.4b. Both the order and the hard copy of the order was sent to pharmacy and requested NJ Exec Order 26.4b1. Medication arrived.... physician was notified and no new orders at this time. Family to be called today.</p> <p>Statements: No statements found.</p> <p>Notes: No notes found."</p> <p>Further review of the NJ Exec Order 26.4b1 MAR revealed a PO dated NJ Exec Order 26.4b, to administer NJ Exec Order 26.4b1 at 9:00 PM for NJ Exec Order 26.4b1. According to the MAR, the first dose was administered on NJ Exec Order 26.4b at 9:00 PM and was signed as administered.</p> <p>On 09/12/24 at 9:34 AM, the surveyor interviewed the US FOIA (b)(6) in charge of Resident #152 care. The US FOIA (b)(6) stated that she cannot recall that she was notified of the NJ Exec Order 26.4b1 not being administered for NJ Exec Order 26.4b. The US FOIA (b)(6) further stated that Resident #152 had been on the</p>	F 684			

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F 684	<p>Continued From page 20</p> <p>NJ Exec Order 26.4b1 for "a long time." When asked about her expectations, she stated, "My expectation would be that the order will be carried executed, and, if the medication was not available, I would expect to be notified".</p> <p>On 9/12/23 at 10:51 AM, the surveyor interviewed the resident's US FOIA (b)(6). The surveyor asked what the reasons were why the medication was not administered, as ordered by the US FOIA (b)(6). The US FOIA stated that Resident #152 was admitted during the night, the orders were verified and faxed and the 7:00 AM-3:00 PM shift was to review the admission order and follow up. He worked the 11:00 PM- 7:00 AM shift and was not aware that the NJ Exec Order 26.4b1 was not being administered as ordered. The surveyor then inquired regarding the 24 hours chart check scheduled on the 11:00 PM-7:00 AM shift, the nurse did not have any comment. The US FOIA confirmed that the resident did not receive any NJ Exec Order 26.4b1 from NJ Exec Order 26.4b1. He further stated that he did not know if there was documentation in the resident's medical record as to why the NJ Exec Order 26.4b1 was not given or if there was any communication with the US FOIA (b)(6) or the family. The surveyor asked the US FOIA if he was ever asked to write a statement regarding the medication as he was the nurse who admitted the resident, he replied, "No". The surveyor then asked regarding the process for new admission. The US FOIA stated that the nurses were responsible for documenting those issues, the nurses were to call and review all orders with the physician.</p> <p>On 9/12/23 at 11:35 AM, the surveyor interviewed the US FOIA (b)(6) who stated he would need to get back to the surveyor with the information.</p>	F 684			

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F 684	<p>Continued From page 21</p> <p>On 09/12/24 at 12:42 PM, the surveyor interviewed the US FOIA (b)(6) regarding the process for medication verification with the physician. The US FOIA (b)(6) stated that the physician must be called, all orders must be verified with the physician, then faxed and called to the provider pharmacy. The US FOIA (b)(6) stated that some medications could be obtained from the backup [electronic medication dispensing system]. If not available, the nurses must call and notify the physician that the medication was not available. The facility could also call the pharmacy and request a stat delivery and the US FOIA (b)(6) must be informed.</p> <p>On 9/12/24 at 12:50 PM, the US FOIA (b)(6) provided the hospital discharge summary with the order to administer the NJ Exec Order 26.4b1 at bedtime. When inquired regarding the rationale for not calling the pharmacy or the nurses not faxing the order, the US FOIA (b)(6) did not have any comment.</p> <p>On 09/12/24 at 1:30 PM, the surveyor interviewed the US FOIA (b)(6) in the presence of the survey team. The US FOIA (b)(6) stated that she was made aware only "yesterday" (9/11/24). When asked regarding the investigation, she stated, "there was no proper investigation."</p> <p>A review of the Manufacturer's specification indicated that NJ Exec Order 26.4b1 should not be stopped suddenly or without the direct supervision and guidance of a medical professional. Potentially NJ Ex Order 26.4b1 may occur with the sudden cessation of NJ Exec Order 26.4b1</p> <p>On 9/12/24 at 1:45 PM, the US FOIA (b)(6) provided a form titled, " Employee Education</p>	F 684			

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F 684	Continued From page 22 Attendance Record" dated [redacted] Topic of in-service. Adverse Consequences and medication errors which indicated that the staff were in-serviced regarding the medication. Attached to the in-service was the policy titled, "Adverse Consequences and Medication Errors"... the Policy Statement included that "The Interdisciplinary team monitors medication usage in order to prevent and detect medication-related problems such as adverse drugs reactions (ADRs) and side effects"... and "Medication Errors" was defined as the preparation and administration of drugs or biological which is not in accordance with physician's order, manufacturer specifications, or accepted professional standards and principles of the professional (s) providing services.	F 684			
F 689 SS=E	NJAC 8:39-27.1(a) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to ensure [redacted] interventions were consistently implemented, revised after each [redacted] and supervision was provided for residents at risk for [redacted]. This deficient practice was identified for	F 689	How corrective actions will be accomplished for those residents affected by the deficient practice The [redacted] interventions for Residents #9 & #34 were reviewed and updated as indicated.	10/18/24	

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F 689	<p>Continued From page 23</p> <p>2 of 2 residents (Resident #9 and Resident #34) reviewed for [REDACTED] and was evidenced by the following:</p> <p>1.) On 09/09/24 at 7:04 PM, Surveyor #1 observed Resident #9 in bed, the bed was in a [REDACTED], the resident was [REDACTED] and [REDACTED] to the surveyor. Surveyor #1 observed a [REDACTED] on the side of the bed in the resident's room.</p> <p>On 09/10/24 at 8:42 AM, Surveyor #1 observed Resident #9 sitting in a wheelchair at the bedside. Resident #9 was [REDACTED] and [REDACTED] and able to [REDACTED] after the breakfast tray was set-up.</p> <p>On 09/11/24 at 9:32 AM, the surveyor observed Resident #9 in bed. The bed was in a [REDACTED] the surveyor observed a [REDACTED] on the right side of the bed in the resident's room.</p> <p>On 09/11/24 at 12:20 PM, Surveyor #1 observed Resident #9 sitting in the dayroom and there was no staff in attendance, and there was no activity in progress. Most of the residents were observed in the dining room at that time. On that same day at 12:45 PM, the surveyor interviewed the [REDACTED] observed in the hallway. The [REDACTED] stated that the resident was [REDACTED], and should not be left alone in the dayroom. The [REDACTED] further added, "I have been doing this type of work for many years, the residents need to be supervised while in the dayroom."</p> <p>On 09/11/24 at 1:15 PM, the surveyor reviewed the medical record of the resident. The medical record reflected Resident #9 was admitted to the</p>	F 689	<p>Interventions with updated recommendations for safety were communicated to all staff to ensure consistent implementation, revision after any future [REDACTED] and that adequate supervision is provided.</p> <p>Date of Completion: 09/13/24</p> <p>How will the facility identify other residents who have potential to be affected by the same deficient practice Residents who have fallen have the potential to be affected. The fall prevention interventions for residents with a history of falls within the past 30 days will be reviewed and updated as applicable to ensure those interventions were consistently implemented and revised after each fall. Interventions with updated recommendations for safety were communicated to all staff to ensure consistent implementation, revision after any future fall, and that adequate supervision is provided. Active residents who have been identified to be at risk for falls have the potential to be affected. The community has completed a review of residents at risk for falls and ensured a care plan is in place for fall risk and person-centered care plan and interventions.</p> <p>Date of Completion: 10/18/24</p> <p>What measures will be implemented to prevent the recurrence of the deficient practice All nursing staff will be reeducated by the</p>		

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F 689	<p>Continued From page 24</p> <p>facility with medical diagnoses which included NJ Exec Order 26.4b1</p> <p>Review of the NJ Exec Order 26.4b1, Quarterly MDS (Minimum Data Set), an assessment tool used for the management of care, indicated that Resident #9 required NJ Exec Order 26.4b1 assistance of two person for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. The MDS was coded as 01 for activity of daily living which indicated that the resident was dependent on staff for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. Resident #9 had NJ Exec Order 26.4b1 and had a BIMS (Brief Interview for Mental Status score of NJ E and NJ Exec Order 26.4b1</p> <p>Review of the Progress Notes dated NJ Exec Order 26.4b1 revealed that Resident #9 was NJ Exec Order 26.4b1 in their room. Resident #9 was noted with an NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1 measuring NJ E. The NJ Exec Order 26.4b1 event summary dated NJ Exec Order 26.4b1, indicated the resident fell asleep, and NJ Exec Order 26.4b1. The suggested intervention was to place Resident #9 back to bed after lunch.</p> <p>On 8/28/23 at 6:20 PM, Resident #9 was found NJ Exec Order 26.4b1 in the activity room with the NJ Exec Order 26.4b1. The US FOIA assigned to the resident revealed that she was assisting another resident and could not visualize Resident #9 in the activity room. The suggested intervention was that Resident #9 needs to participate in activities but the facility does not know what he/she liked.</p> <p>On 9/27/23 at 8:10 PM, Resident #9 was observed NJ Exec Order 26.4b1 with the wheelchair nearby. No Incident/Accident</p>	F 689	<p>staff educator on the community's policies of Falls & Managing Fall Risk, as well as Safety & Supervision of Residents to ensure fall prevention interventions are consistently implemented and revised after each fall. Date of Completion: 10/18/24</p> <p>How will the facility monitor to ensure the deficient practices do not occur 3 random resident-centered on-going care plans (focus area of fall prevention interventions) to be audited weekly x 4 weeks, then monthly x 2 months by the Director of Nursing or designee to ensure fall prevention interventions are consistently implemented, revised after each fall, and adequate supervision provided. Results of the audits will be submitted to the QAPI Committee monthly. The committee will review the findings and make recommendations as appropriate. At the conclusion of three months, a determination will be made of the need for further auditing. Date of Completion: 10/18/24</p>		

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F 689	<p>Continued From page 25</p> <p>Report was provided for this [redacted] NJ Exec Order [redacted]. The current [redacted] US FOIA (b) [redacted] stated that she could not comment regarding this [redacted] NJ Exec Order [redacted].</p> <p>On 10/05/23 at 3:38 PM, Resident #9 was left in the activity room for supervision. At 1:38 PM, Resident #9 was observed [redacted] NJ Exec Order 26.4b1 [redacted] in front of the wheelchair. The suggested intervention was to pay attention to all residents.</p> <p>On 1/15/24 at 6:45 PM, Resident #9 was [redacted] NJ Exec Order [redacted] in their room. Resident #9 was unable to explain what happened. Suggested interventions, Tell the resident to use the call bell for help.</p> <p>On 5/23/24 at 6:00 PM, Resident #9 was [redacted] NJ Exec Order 26.4b1 [redacted] of the wheelchair. [redacted] NJ Exec Order 26.4b1 [redacted]. Suggested intervention: Put the resident to bed after dinner.</p> <p>On 7/3/24 7:10 PM, Resident #9 was [redacted] NJ Exec Order 26.4b1 [redacted] in the [redacted] NJ Exec Order 26.4b1 [redacted]. Resident noted with [redacted] NJ Exec Order 26.4b1 [redacted] and [redacted] NJ Exec Order 26.4b1 [redacted]. Resident [redacted] NJ Exec Order 26.4b1 [redacted] cause of the incident. Resident was transferred to the Emergency Department for evaluation and treatment. The surveyor requested the New Jersey Universal Transfer Form and it was not provided.</p> <p>On 8/26/24 at 2:10 PM, Resident #9 observed [redacted] NJ Exec Order 26.4b1 [redacted] in the dayroom.</p> <p>Review of the [redacted] NJ Exec Order [redacted] evaluation dated [redacted] NJ Exec Order 26.4b1 [redacted], indicated Resident #9's [redacted] NJ Exec Order 26.4b1 [redacted] indicating [redacted] NJ Exec Order 26.4b1 [redacted] for [redacted] NJ Exec Order [redacted]. Further review of the Interdisciplinary Team (IDT) [redacted] NJ Exec Order 26.4b1 [redacted] revealed current [redacted] NJ Exec Order 26.4b1 [redacted] in place included, [redacted] NJ Exec Order [redacted], call system and personal items within reach,</p>	F 689			

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F 689	<p>Continued From page 26</p> <p>check for activity and toileting. [REDACTED] Keep room well-lit and free from clutter. The facility was not consistently following their interventions. On [REDACTED] at 7:42 PM during the initial tour, Resident #9 was observed in bed and the [REDACTED] to [REDACTED] was not in place.</p> <p>On 09/10/24 at 11:05 AM, Surveyor #1 reviewed the [REDACTED] Order Summary Report which revealed that [REDACTED] measures including [REDACTED], keep personal items and call bell within reach, keep room well lit and clutter free, and the [REDACTED] had been initiated since [REDACTED].</p> <p>On 09/10/24 at 12:15 PM, the [REDACTED] provided a Care Plan Report initiated [REDACTED] which indicated that on [REDACTED], Resident #9 was observed in the [REDACTED] Resident noted with [REDACTED] to [REDACTED] of [REDACTED] and [REDACTED]. Resident #9 was transferred to the hospital for evaluation. The [REDACTED] was [REDACTED]. The facility did not indicate who was responsible to monitor the dayroom when residents were in attendance.</p> <p>The Care Plan Report dated [REDACTED], revealed that Resident #9 was at [REDACTED]. The goal was that the resident will [REDACTED] with [REDACTED]. Supervision was not included in the Care Plan.</p> <p>On 09/12/24 at 1:46 PM, the [REDACTED] provided the surveyor a copy of Incident/Accident (I/A) Report dated [REDACTED]. A review of the I/A Report revealed that Resident #9 was [REDACTED] to the [REDACTED].</p>	F 689		

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F 689	<p>Continued From page 27</p> <p>[REDACTED] The causal factor was not identified.</p> <p>Further review of the [REDACTED], Incident /accident Report report showed that the immediate action taken to prevent further incidents was to put the resident to bed after lunch. There was no documented evidence that the resident was being supervised in the dayroom during the [REDACTED].</p> <p>On 09/12/24 at 12:45 PM, the surveyor and the [REDACTED] went to the activity room and observed Resident #9 sitting alone and unsupervised in the dayroom. The [REDACTED] stated that the resident should not be left unsupervised in the dayroom. During an interview with the [REDACTED] US FOIA (b)(6) that same day at 1:15 PM, the [REDACTED] informed the surveyor that the facility's process was that the team will discuss the resident's [REDACTED], will place an intervention as agreed by the team, put an order and will update the care plan for the intervention. The [REDACTED] confirmed that a staff was to be in the common area when residents were in the dayroom.</p> <p>On 9/12/24 at 1:40 PM, the [REDACTED] provided a copy of the recent Care Plan and Interdisciplinary [REDACTED] notes. The Current Care Plan did not reflect that the care plan was revised after each [REDACTED]. The Incident/Accident Report of [REDACTED] notes revealed that on [REDACTED] was no [REDACTED] NJ Exec Order 26.4b1 that indicated the [REDACTED] was addressed. The [REDACTED] confirmed that the [REDACTED] was not followed as she was unable to identify what interventions were added to further [REDACTED].</p> <p>2.) On 09/09/2024 at 6:32 PM, Surveyor #2 observed Resident #34 in the [REDACTED] NJ Exec Order 26.4b1 day room visiting with a family member. The</p>	F 689			

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F 689	<p>Continued From page 28</p> <p>family member stated that there was usually no staff in the area and Resident #34 [redacted]</p> <p>On 09/11/24 at 8:23 AM, observed one staff member in the day room area on [redacted]. The staff member was identified as a [redacted] who stated that there was just one CNA on the unit who was in a room helping a resident and no nurse on the unit. She stated the nurse works on another unit as well.</p> <p>On 09/11/24 at 8:24 AM, Surveyor #2 observed Resident #24 in the [redacted] day room sitting in a wheelchair eating breakfast. At that time, there was no nurse or CNA present while three residents were eating breakfast.</p> <p>On 09/11/24 at 8:31 AM, CNA #3 stated that Resident #34 required [redacted], [redacted], and has had [redacted].</p> <p>A review of the Admission Record for Resident #34 listed diagnoses which included but were not limited to; [redacted].</p> <p>A review of the quarterly MDS dated [redacted], included but was not limited to; a BIMS of [redacted] out of 15 indicated [redacted]. Resident #34 was noted as having a behavior of [redacted] which occurred [redacted] look back period. Resident #34 was coded as [redacted] or requiring [redacted] from staff for activities of daily living. Resident #34 was noted as having had [redacted] since the previous MDS assessment.</p>	F 689			

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F 689	<p>Continued From page 29</p> <p>A review of the resident-centered ongoing Care)which included but was not limited to; focus area at risk for targeted behaviors of [redacted], NJ Exec Order 26.4b1 with an intervention to monitor targeted behaviors; and a focus area of [redacted] with a goal of not NJ Exec Order 26.4b1 and with interventions including but not limited to; if awake encourage to come in lounge area for NJ Exec Order 26.4b1", after dinner offer transfer to sofa per preferences, and place call system and most frequently used items within resident reach. The care plan documented only NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 having documented updated interventions.</p> <p>A review of the facility provided Incident reports included [redacted] from admission in [redacted]. Of those [redacted] were [redacted] including the following: [redacted] at 6:58 AM, the staff statement "the last time staff saw resident before [redacted] and documented 6:00 AM (almost an hour prior). [redacted] at 8:58 AM, with no staff statement as to when the resident was last NJ Ex Order 26.4(b)(1) by the staff. [redacted] at 9:30 PM, resident was [redacted] dayroom and last supervision by staff was documented at 9:00 PM. The physician ordered Resident #34 to be sent to the Emergency Room for evaluation of their [redacted] at 11:05 PM, with no staff statement as to when the resident was last NJ Ex Order 26.4(b)(1) by the staff. The Incident reports failed to identify causal factors or identify any staff supervision.</p> <p>On 09/12/24 at 10:10 AM, the [redacted] stated, "Resident #34 required NJ Exec Order 26.4b1 [redacted] and things happen." She stated that</p>	F 689			

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F 689	<p>Continued From page 30</p> <p>during the over night shift, the [REDACTED] had only one CNA and the other two shifts there were two CNAs. The [REDACTED] stated that Resident #34,"can't call for assistance and feels like [Resident #34] can [REDACTED] NJ Exec Order 26.4b1</p> <p>On 09/12/24 at 10:35 AM, the [REDACTED] stated it was not appropriate if the staff had not observed a resident within 30 minutes.</p> <p>On 09/12/2024 at 12:45 PM, in the presence of Surveyor #1 and Surveyor #2, the [REDACTED] stated that the facility [REDACTED] NJ Exec Order 26.4b1 was that the team would discuss the resident's [REDACTED] NJ Exec Order 26.4b1, will place an intervention as agreed by the team, put an order and will update the care plan for the intervention. The [REDACTED] confirmed that a staff was to be in the common area when residents were in the dayroom.</p> <p>On 09/12/24 at 1:37 PM, the [REDACTED] confirmed that the facility had no policy or procedure to define what constitutes [REDACTED] NJ Ex Order 26.4(b)(1) and distant supervision or the criteria to determine which resident needs what type of [REDACTED] NJ Ex Order 26.4(b)(1)</p> <p>A review of the facility's Fall Policy last revised 1/2024,indicated the following: "It is the policy of this facility to evaluate all residents for falls. Purpose: A system to prevent and/or minimize accidents and incidents. Procedure: All residents will be assessed for risk for falls upon admission, quarterly and as needed. Based on the completed fall risk assessment, resident medical condition and history, appropriate preventive interventions and referrals to the team (OT,PT,etc) will be initiated, care plans developed and documented in the</p>	F 689			

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F 689	Continued From page 31 resident's chart. Adapt care plan and actions according to the resident's specific disease process.	F 689			
F 695 SS=D	<p>NJAC 8:39-27.1(a) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)</p> <p>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to ensure that [redacted] and [redacted] related treatments were provided in a manner to prevent the [redacted] for 1 of 1 resident (Resident #153) reviewed for [redacted] care. The deficient practice was evidenced by the following:</p> <p>On 9/10/24 at 10:55AM, in the room of Resident #153, the surveyor observed an [redacted] by the chair in a [redacted], unsupported, not in a [redacted]. The [redacted] was wrapped around [redacted] with a label dated [redacted]. The surveyor did not observe an [redacted] in use" sign on the door or over the bed. The surveyor also observed a [redacted] on Resident #153's bedside table, with a mask wrapped in a paper towel. The surveyor did not</p>	F 695	<p>How corrective actions will be accomplished for those residents affected by the deficient practice All [redacted] and [redacted] related treatments for Resident #153 were immediately changed and stored in a manner to prevent [redacted] and [redacted] in Use signs were immediately posted. Date of Completion: 09/13/24</p> <p>How will the facility identify other residents who have potential to be affected by the same deficient practice Residents who utilize oxygen and respiratory equipment have the potential of being affected. The equipment for all residents with orders for oxygen or respiratory related</p>	10/11/24	

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F 695	<p>Continued From page 32</p> <p>observe a label on the NJ Exec Order 26.4b1. Resident #153 stated to the surveyor that their NJ Exec Order 26.4b1 and that they were on NJ Exec Order 26.4b1 when they first came to facility but they had not used it for at NJ Exec Order 26.4b1. Resident #153 also stated that they no longer received NJ Exec Order 26.4b1.</p> <p>On 09/10/24 at 11:03 AM, the surveyor interviewed the US FOIA (b)(6) regarding the NJ Exec Order 26.4b1. The US FOIA stated, "that should be gone, only thing that should be there is the NJ Exec Order 26.4b1. The US FOIA stated that the resident #153's orders are prn (as needed). She also stated that the NJ Exec Order 26.4b1 should be in the bag and the NJ Exec Order 26.4b1 shouldn't be on the floor, it should be in a NJ Exec Order 26.4b1.</p> <p>When asked about the NJ Exec Order 26.4b1, the US, FC stated that the NJ Exec Order 26.4b1 should be in a bag with a label and date.</p> <p>On 09/10/24 at 12:43PM, the surveyor reviewed the medical record which revealed an order dated NJ Exec Order 26.4b1 as needed for NJ Exec Order 26.4b1. The Medication Administration Record for NJ Exec Order 26.4b1 revealed an order for NJ Exec Order 26.4b1 four times a day for NJ Exec Order 26.4b1 for 7 days, start date NJ Exec Order 26.4b1; last dose administered was 11:00 AM on NJ Exec Order 26.4b1. The Treatment Administration Record for NJ Exec Order 26.4b1 revealed an order for NJ Exec Order 26.4b1 at NJ Exec Order 26.4b1 around the clock every shift with a start date of NJ Exec Order 26.4b1 and a discontinued date of NJ Exec Order 26.4b1.</p> <p>According to the medical record, Resident #153 was admitted from the hospital after treatment for</p>	F 695	<p>treatments were inspected to ensure that treatments were provided in a manner to prevent the spread of infection and injury. Date of Completion: 09/13/24</p> <p>What measures will be implemented to prevent the recurrence of the deficient practice All nursing staff to be re-educated on the community's Oxygen Administration policy to ensure that oxygen and respiratory related treatments are provided in a manner to prevent the spread of infection and injury. Date of Completion: 10/11/24</p> <p>How will the facility monitor to ensure the deficient practices do not occur The rooms of two residents with orders for oxygen or respiratory related treatments will be randomly inspected weekly for the next 3 months by the Director of Nursing or designee to ensure that oxygen and respiratory related treatments are provided in a manner to prevent the spread of infection and injury. Results of the audits will be submitted to the monthly QAPI Committee. The committee will review the findings and make recommendations as appropriate. Date of Completion: 10/11/24 (audits initiated)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315445	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/13/2024	
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F 695	<p>Continued From page 33</p> <p>acute NJ Exec Order 26.4b1 due to NJ Exec Order 26.4b1. The Admission Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4b1, indicated a Brief Interview of Mental Status (BIMS) score of NJ Exec which indicated NJ Exec Ord NJ Exec Order 26.4b1</p> <p>On 09/12/24 at 10:41 AM, the surveyor interviewed the US FOIA (b)(6) about the NJ Exec Order 26.4b1 against a chair and she stated, "that an NJ Exec Order 26.4b1 should not be propped up in a corner, because it could NJ Exec O NJ Exec Order 26.4b1. She also stated that NJ Exec Order 26.4b1 and NJ Ex Order 26.4b1 are used and soiled, they should be discarded, and the tanks should be off the floor. She further stated that she was not made aware of the NJ Exec Order 26.4b1 issue.</p> <p>On 09/12/24 at 02:24 PM, the surveyor interviewed the US FOIA (b) about NJ Exec Order 26.4b1 signs, and she stated that the staff usually puts a sign in place when the resident is using NJ Exec Order 26.4b1</p> <p>A review of "Oxygen Administration" policy provided by the U.S. FOIA (b) (6) on 9/11/22 revised on October 2010 included:</p> <p>Steps in Procedure</p> <ol style="list-style-type: none"> Place an "Oxygen in Use" sign on the outside of the room entrance door. Place an "Oxygen in Use" sign in a designated place on or over the resident's bed. <p>Review of "Replacement of Respiratory Disposables" policy provided by the US FOIA (b)(6) NJ Exec Order 26.4b1 on 9/11/24 included:</p> <p>Authority: Night shift nurses or designees are responsible for changing disposables weekly</p>	F 695		

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

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F 695	Continued From page 34 Instruction: Replace all disposable respiratory equipment weekly for infection control Change O2 tubing, nebulizer and humidifier bottles weekly Nasal cannulas and patient bag to be changed weekly Changes should be dated Nasal cannulas and nebulizers are to be kept in the patients' bag at bedside when not in use A policy for proper storage of oxygen tanks was not provided by the facility.	F 695			
F 755 SS=D	NJAC 8:39-27.1 (a) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all	F 755		10/18/24	

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F 755	<p>Continued From page 35</p> <p>aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards by not ensuring a.) proper administration technique for an [redacted] as per manufacturer specifications and b.) vital parameters, [redacted], blood pressure, heart rate), were obtained just prior to administration of medications that had physician's orders which based the results of the parameters on whether to administer the medications for four (4) of seven (7) residents, (Resident #39, #44, #153 and #252), observed for one (1) of two (2) nurses during the medication administration observation.</p> <p>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 well-being,</p>	F 755	<p>How corrective actions will be accomplished for those residents affected by the deficient practice Resident #44 remains in the community and is [redacted]. Resident #44 was assessed and [redacted]. Resident #153, #39, #252 are no longer in the community, and have been discharged. Date of Completion: 09/13/24</p> <p>How will the facility identify other residents who have potential to be affected by the same deficient practice All residents have the potential of being affected by this deficient practice Date of Completion: 09/13/24</p> <p>What measures will be implemented to prevent the recurrence of the deficient practice All licensed nurses will be re-educated on the community's Medication Administration & Insulin Pen</p>		

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F 755	<p>Continued From page 36</p> <p>and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist."</p> <p>The deficient practice was evidenced by the following:</p> <p>1. On 9/11/24 at 8:00 AM, during the medication administration observation, the surveyor observed the Registered Nurse (RN #1) preparing to administer NJ Exec Order 26.4b1 to Resident #44. The surveyor observed the RN #1 refer to a paper on the medication cart that had resident's names on it and stated that the resident's NJ Exec Order 26.4b1 and that according to the physician's order (PO) that she was reading on the electronic medication administration record (EMAR) indicated to administer NJ Exec Order 26.4b1. The RN #1 removed the resident's NJ Exec Order 26.4b1 from the medication cart, added a needle to the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 to read NJ Exec Order 26.4b1.</p> <p>At that time, the RN #1 stated that she had taken the resident's NJ Exec Order 26.4b1 earlier when she came in on her shift at approximately 7:30 AM. The surveyor had not observed the RN #1 obtain a NJ Exec Order 26.4b1 from Resident #44 just prior to NJ Exec Order 26.4b1.</p> <p>On 9/11/24 at 8:10 AM, the surveyor observed the RN #1 NJ Exec Order 26.4b1 using the resident's NJ Exec Order 26.4b1 that had been NJ Exec Order 26.4b1 by NJ Exec Order 26.4b1. The RN then held the NJ Exec Order 26.4b1 for less than four (4) seconds.</p>	F 755	<p>Administration policies to ensure pharmaceutical services are provided in accordance with professional standards. Date of Completion: 10/18/24</p> <p>How will the facility monitor to ensure the deficient practices do not occur One randomly selected resident medication pass to be observed weekly x 4 weeks, then monthly x 2 months by the Director of Nursing or designee to ensure pharmaceutical services are provided in accordance with professional standards. Results of the audits will be submitted to the monthly QAPI Committee. The committee will review the findings and make recommendations as appropriate. Date of Completion: 10/11/24</p>		

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F 755	Continued From page 37 The surveyor had not observed the RN #1 follow manufacturer specifications for priming the NJ Exec Order 26.4b1 before administration of the required dose. The surveyor had not observed the RN #1 follow manufacturer specifications after pushing the dose knob down, hold the NJ Exec O and count slowly to five (5) seconds. On 9/11/24 at 9:26 AM, the surveyor interviewed the RN #1 at the medication cart who stated that "My usual routine is to come in for my shift at 7 AM, get report and then would do rounds on my residents and obtain vitals." The RN #1 added that the approximate time that she was obtaining vitals was usually around 7:30 AM. The RN #1 added that she obtained vital parameters before she started her morning medication pass because it helped with timeliness. The RN #1 also stated that she was unaware of any instructions for using the NJ Exec Order 26.4b1 and thought it was similar to a NJ Exec Order 26.4b1 . The RN #1 then reviewed the labeling of the resident's NJ Exec Order 26.4b1 in the medication cart and stated there was no special instructions that she could see. The RN #1 then described the technique she used for the NJ Exec Order 26.4b1 which included checking to make sure she had the resident's correct medication, NJ Exec Order 26.4b1 correct dose and rotated the NJ Exec Order 26.4b1 . The RN #1 was unable to speak to NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 in the site for a specific time after NJ Exec Order 26.4b1 . The RN #1 added that she was a per diem employee as of NJ Exec Order 26.4b1 but worked two days every week and was usually on a different unit but could float. The RN #1 added that she was unsure if there were any inservices on medication administration or	F 755			

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F 755	<p>Continued From page 38</p> <p>the NJ Exec Order 26.4b1 and that the US FOIA (b)(6) usually did inservices.</p> <p>The surveyor reviewed the electronic medical record for Resident #44.</p> <p>A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated NJ Exec Order 26.4b1, reflected the resident had a brief interview for mental status (BIMS) score of NJ Exec Order 26.4b1 out of 15, indicating that the resident had an NJ Exec Order 26.4b1.</p> <p>A review of the Order Summary Report (OSR) revealed a PO with a start date of NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1, NJ Exec Order 26.4b1; if NJ Exec Order 26.4b1 before meals and at bedtime for NJ Exec Order 26.4b1.</p> <p>A review of the EMAR reflected the above PO.</p> <p>On 9/11/24 at 9:31 AM, the surveyor interviewed the US FOIA (b)(6) who stated that he was the US FOIA (b)(6). The US FOIA (b)(6) also stated there was a specific technique for NJ Exec Order 26.4b1 administration that included priming the NJ Exec Order 26.4b1. The US FOIA (b)(6) added that an inservice on the NJ Exec Order 26.4b1 technique had not been done. The US FOIA (b)(6) stated that he would provide a policy regarding the technique for NJ Exec Order 26.4b1.</p> <p>On 9/11/24 at 9:43 AM, the surveyor interviewed</p>	F 755		

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F 755	<p>Continued From page 39</p> <p>the RN #2 who stated that she has worked at the facility for approximately [redacted] NJ Exec Order 26.4b1 and was familiar with Resident #44. The RN #2 stated that she was unsure if there had been an inservice regarding the [redacted] NJ Exec Order 26.4b1. The RN #2 then explained that the [redacted] NJ Exec Order 26.4b1 with a small amount of [redacted] NJ Exec Order 26.4b1 that you would visualize coming out of the [redacted] NJ Ex Order 26.4b1 prior to dialing the dose that was ordered. The RN #2 added that after [redacted] NJ Exec Order 26.4b1 the [redacted] NJ Exec Order 26.4b1 had to be held in for approximately 10 seconds to make sure all the [redacted] NJ Exec Order 26.4b1 was administered. The RN #2 also added that she tried to obtain a [redacted] NJ Ex Order 26.4b1 as close to before a meal as possible and then administered the [redacted] NJ Exec Order 26.4b1 following taking the [redacted] NJ Exec Order 26.4b1.</p> <p>On 9/11/24 at 12:03 PM, the [redacted] US FOIA (b)(6) provided the surveyor with an undated policy and procedure for Administering [redacted] NJ Exec Order 26.4b1. The [redacted] US FOIA (b)(6) stated that he had a Medication Observation completed by the [redacted] US FOIA (b)(6) for RN #2 but had no Medication Observation completed for the RN #1. The [redacted] US FOIA (b)(6) also stated that usually the [redacted] US FOIA (b)(6) does medication observations but was seeing that there was a gap in time for when nurses were having a completed medication observation after they were first employed.</p> <p>A review of the facility undated policy and procedure for Administering Insulin Pen revealed that the procedure required "Prime pen with two units of insulin while pointing upwards." In addition, "Hold insulin pen in place for 10 seconds."</p> <p>On 9/11/24 at 12:48 PM, the surveyor interviewed the [redacted] US FOIA (b)(6) who stated that</p>	F 755			

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F 755	<p>Continued From page 40</p> <p>she would expect vital parameters such as a [REDACTED] to be obtained right before administering the medication when there was a [REDACTED] NJ Exec Order 26.4b1</p> <p>The surveyor, with the [REDACTED] reviewed the facility policy for Administering Medications which indicated "The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary." The [REDACTED] acknowledged that the policy had not indicated a specific timeframe prior to administering a medication but would expect the [REDACTED] be taken just prior to the administration of the [REDACTED] NJ Exec Order</p> <p>On 9/12/24 at 10:43 AM, the surveyor, in the presence of another surveyor, interviewed the [REDACTED] via the telephone who stated that he was not the [REDACTED] who services the facility but was the [REDACTED] and that the [REDACTED] who services the facility was no longer employed and he could speak to any questions. The [REDACTED] stated that he was unsure if inservices on medication administration and the technique for [REDACTED] NJ Exec Order 26.4b1 was completed but that the [REDACTED] would have the records if there was an inservices. The [REDACTED] explained that [REDACTED] had a specific technique which included [REDACTED] NJ Exec Order 26.4b1 before administering a dose and holding in the [REDACTED] as per manufacturer specifications to ensure proper [REDACTED] NJ Exec Order administration. The [REDACTED] also stated that a [REDACTED] NJ Exe should be taken just prior to administering the [REDACTED] NJ Exec Order 26.4b1 and that results could change if they were taken too early.</p> <p>On 9/12/24 at 11:25 AM, the surveyor interviewed Resident #44 who stated that they had their [REDACTED] taken several times a day and also received [REDACTED] NJ Exec Orde several times a day. The resident was</p>	F 755		

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F 755	<p>Continued From page 41</p> <p>unable to speak to the timing of the NJ Ex in accordance with the NJ Exec Order being administered.</p> <p>On 9/12/24 at 2:19 PM, the survey team met with the US FOIA (b)(6) acknowledged that the nurses should obtain a NJ Ex immediately before administration of NJ Exec Order 26.4b1</p> <p>A review of the current facility policy for Administering Medications with a revision date of April 2019 provided by the US FOIA (b)(6) which reflected "The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary."</p> <p>A review of the manufacturer's specifications for "Instructions for use NJ Ex Order 26.4(b)(1))" reflected that the steps required to properly administer an insulin pen included "Prime before each injection." "Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin." The instructions also revealed "Step 6: To prime your pen, turn the dose knob to select 2 units. Step 7: Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Step 8: Continue holding your pen with the needle pointing up. Push the dose knob in until it stops, and "0" is seen in the dose window. Hold the Dose Knob in and count to 5 slowly, You should see insulin at the tip of the needle. If you do not see insulin, repeat priming steps 6 to 8." In addition, the instructions for giving the injection reflected "Step 11: Insert he needle into your skin.</p>	F 755			

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F 755	<p>Continued From page 42</p> <p>Push the dose knob all the way in. Continue to hold the dose knob in and slowly count to 5 before removing the needle."</p> <p>2. On 9/11/24 at 8:11 AM, during the medication administration observation, the surveyor observed the RN #1 preparing to administer five (5) medications to Resident #44 which included one tablet of NJ Exec Order 26.4b1 [REDACTED]</p> <p>The surveyor observed the RN #1 refer to a paper on the medication cart that had residents names on it and stated that the resident's NJ Exec was NJ Exec and the NJ Exec Order 26.4b1 so she was allowed to administer the NJ Exec Order according to the PO on the EMAR.</p> <p>The surveyor had not observed the RN #1 obtain a NJ Exec or NJ Exec from Resident #44.</p> <p>On 9/11/24 at 9:26 AM, the surveyor interviewed the RN #1 at the medication cart who stated that "My usual routine is to come in for my shift at 7 AM, get report and then would do rounds on my residents and obtain vitals." The RN #1 added that the approximate time that she was obtaining vitals was usually around 7:30 AM. The RN #1 added that she obtained vital parameters before she started her morning medication pass because it helped with timeliness.</p> <p>The surveyor reviewed the electronic medical record for Resident #44.</p> <p>A review of the Order Summary Report (OSR) revealed a PO with a start date of NJ Exec Order for NJ Exec Order 26.4b1 [REDACTED] Give 1 tablet by mouth two times a</p>	F 755			

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NAME OF PROVIDER OR SUPPLIER ARBOR AT LAUREL CIRCLE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 MONROE STREET BRIDGEWATER, NJ 08807		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 755	<p>Continued From page 43</p> <p>day for NJ Exec Order 26.4b1</p> <p>[REDACTED]</p> <p>"</p> <p>A review of the EMAR reflected the above PO.</p> <p>On 9/11/24 at 12:48 PM, the surveyor interviewed the [REDACTED] who stated that she would expect vital signs such as a [REDACTED] and [REDACTED] to be obtained right before administering the medication when there was a PO indicating that a medication be held for specific vital parameters. The surveyor, with the [REDACTED] reviewed the facility policy for Administering Medications which indicated "The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary." The [REDACTED] acknowledged that the policy had not indicated a specific timeframe prior to administering a medication but would expect the vital parameters be taken as close to the administration time of the medication as possible. The [REDACTED] added that she would allow up to 15 minutes prior to the administration of the medication.</p> <p>On 9/12/24 at 10:43 AM, the surveyor, in the presence of another surveyor, interviewed the CP via the telephone who stated that he was not the [REDACTED] who services the facility but was the [REDACTED] and that the [REDACTED] who services the facility was no longer employed and he could speak to any questions. The [REDACTED] stated that he was unsure if inservices on medication administration were completed but that the [REDACTED] would have the records if there was an inservice. The [REDACTED] acknowledged when a PO had hold parameters that vital parameters were to be obtained from a</p>	F 755			

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F 755	<p>Continued From page 44</p> <p>resident. The ^{US FO} stated, "Vital signs were to be obtained just before pouring meds [medication] because vital signs can change." The ^{US FO} added that "Getting vital signs during rounds can be a good marker but when there is a hold order the ^{NJ EX} should be done just prior to the med being administered."</p> <p>On 9/12/24 at 2:19 PM, the survey team met with the ^{US FOIA (b)(6)} acknowledged that the nurses should obtain vital parameters immediately before administration of a medication when there was a PO with hold parameters and would give a grace period of 15 minutes to take the vital signs before administering the medication.</p> <p>3. On 9/11/24 at 8:37 AM, during the medication administration observation, the surveyor observed the RN #1 preparing to administer morning medications to Resident #39. The surveyor observed the RN #1 refer to a paper on the medication cart that had resident's names on it and stated that the resident's ^{NJ EX} was ^{NJ Exec Orde} so she was not going to be administering the ^{NJ Exec Orde} because according to the PO on the EMAR she had to hold both medications because the ^{NJ Exec O} was ^{NJ Exec Order 26.4b1}. The surveyor observed the RN #1 enter electronically a ^{NJ EX} of ^{NJ Exec Order 26.4b1}.</p> <p>The surveyor had not observed the RN #1 obtain a ^{NJ EX} or ^{NJ EX} from Resident #39.</p> <p>On 9/11/24 at 9:26 AM, the surveyor interviewed the RN #1 at the medication cart who stated that "My usual routine is to come in for my shift at 7</p>	F 755			

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F 755	<p>Continued From page 45</p> <p>AM, get report and then would do rounds on my residents and obtain vitals." The RN #1 added that the approximate time that she was obtaining vitals was usually around 7:30 AM. The RN #1 added that she obtained vital parameters before she started her morning medication pass because it helped with timeliness.</p> <p>The surveyor reviewed the electronic medical record for Resident #39.</p> <p>A review of the OSR revealed a PO with a start date of [REDACTED] for NJ Exec Order 26.4b1 [REDACTED] Give 1 tablet by mouth two times a day for [REDACTED] Hold [REDACTED] NJ Exec Order 26.4b1, hold NJ Exec Order 26.4b1 Administer with food/meals."</p> <p>Further review of the OSR revealed a PO with a start date of [REDACTED] for NJ Exec Order 26.4b1 [REDACTED] oral tablet NJ Exec Order 26.4b1 24 hour [REDACTED] Give 1 tablet by mouth in the morning for NJ Exec Order 26.4b1, hold NJ Exec Order 26.4b1."</p> <p>A review of the EMAR reflected the above POs.</p> <p>On 9/11/24 at 12:48 PM, the surveyor interviewed the [REDACTED] who stated that she would expect vital signs such as a [REDACTED] and [REDACTED] to be obtained right before administering the medication when there was a PO indicating that a medication be held for specific vital parameters. The surveyor, with the [REDACTED] reviewed the facility policy for Administering Medications which indicated "The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary." The [REDACTED] acknowledged that the policy had not</p>	F 755			

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F 755	<p>Continued From page 46</p> <p>indicated a specific timeframe prior to administering a medication but would expect the vital parameters be taken as close to the administration time of the medication as possible. The [US FOIA (b)(6)] added that she would allow up to 15 minutes prior to the administration of the medication.</p> <p>On 9/12/24 at 10:43 AM, the surveyor, in the presence of another surveyor, interviewed the [US FOIA (b)(6)] via the telephone who stated that he was not the [US FOIA (b)(6)] who services the facility but was the [US FOIA (b)(6)] and that the [US FOIA (b)(6)] who services the facility was no longer employed and he could speak to any questions. The [US FOIA (b)(6)] stated that he was unsure if inservices on medication administration were completed but that the [US FOIA (b)(6)] would have the records if there was an inservice. The [US FOIA (b)(6)] acknowledged when a PO had hold parameters that vital parameters were to be obtained from a resident. The [US FOIA (b)(6)] stated, "Vital signs were to be obtained just before pouring meds because vital signs can change." The [US FOIA (b)(6)] added that "Getting vital signs during rounds can be a good marker but when there is a hold order the [US FOIA (b)(6)] should be done just prior to the med being administered."</p> <p>On 9/12/24 at 2:19 PM, the survey team met with the [US FOIA (b)(6)] [US FOIA (b)(6)] acknowledged that the nurses should obtain vital parameters immediately before administration of a medication when there was a PO that had hold parameters and would give a grace period of 15 minutes to take the vital signs before administering the medication.</p> <p>4. On 9/11/24 at 8:31 AM, during the medication administration observation, the surveyor</p>	F 755			

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F 755	<p>Continued From page 47</p> <p>observed the RN #1 preparing to administer five (5) medications to Resident #153 which included one tablet of NJ Exec Order 26.4b1 [REDACTED]</p> <p>The surveyor observed the RN #1 refer to a paper on the medication cart that had resident's names on it and stated that the resident's NJ Exe was NJ Exec Order 26.4b1 and the NJ Exe was NJ Exe so she was allowed to administer the NJ Exec Order 26.4b1 according to the PO on the EMAR.</p> <p>The surveyor had not observed the RN #1 obtain a NJ Exe or NJ Exe from Resident #153.</p> <p>On 9/11/24 at 9:26 AM, the surveyor interviewed the RN #1 at the medication cart who stated that "My usual routine is to come in for my shift at 7 AM, get report and then would do rounds on my residents and obtain vitals." The RN #1 added that the approximate time that she was obtaining vitals was usually around 7:30 AM. The RN #1 added that she obtained vital parameters before she started her morning medication pass because it helped with timeliness.</p> <p>The surveyor reviewed the electronic medical record for Resident #153.</p> <p>A review of the OSR revealed a PO with a start date of NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 tablet by mouth every NJ Exec Order 26.4b1 Hold NJ Exec Order 26.4b1, Hold NJ Exec Order 26.4b1 Administer NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 with food."</p> <p>A review of the EMAR reflected the above PO.</p> <p>On 9/11/24 at 12:48 PM, the surveyor interviewed</p>	F 755			

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F 755	<p>Continued From page 48</p> <p>the [US FOIA (b)] who stated that she would expect vital signs such as a [NJ EXM] and [NJ EXM] to be obtained right before administering the medication when there was a PO indicating that a medication be held for specific vital parameters. The surveyor, with the [US FOIA (b)] reviewed the facility policy for Administering Medications which indicated "The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary." The [US FOIA (b)] acknowledged that the policy had not indicated a specific timeframe prior to administering a medication but would expect the vital parameters be taken as close to the administration time of the medication as possible. The [US FOIA (b)] added that she would allow up to 15 minutes prior to the administration of the medication.</p> <p>On 9/12/24 at 10:43 AM, the surveyor, in the presence of another surveyor, interviewed the [US FO] via the telephone who stated that he was not the [US FO] who services the facility but was the [US FOIA (b)] and that the [US FO] who services the facility was no longer employed and he could speak to any questions. The [US FO] stated that he was unsure if inservices on medication administration were completed but that the [US FOIA (b)] would have the records if there was an inservice. The [US FO] acknowledged when a PO had hold parameters that vital parameters were to be obtained from a resident. The [US FO] stated, "Vital signs were to be obtained just before pouring meds because vital signs can change." The [US FO] added that "Getting vital signs during rounds can be a good marker but when there is a hold order the [US FO] should be done just prior to the med being administered."</p> <p>On 9/12/24 at 2:19 PM, the survey team met with</p>	F 755			

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F 755	<p>Continued From page 49</p> <p>the NJ Exec Order 26.4b1 acknowledged that the nurses should obtain vital parameters immediately before administration of a medication when there was a PO that had hold parameters and would give a grace period of 15 minutes to take the vital signs before administering the medication.</p> <p>5. On 9/11/24 at 9:13 AM, during the medication administration observation, the surveyor observed the RN #1 administer five (5) medications to Resident #252 which included one tablet of NJ Exec Order 26.4b1.</p> <p>Upon returning to the medication cart, the surveyor observed the RN #1 refer to a paper on the medication cart that had resident's names on it and electronically entered a NJ Exec Order 26.4b1 and a NJ Exec Order 26.4b1 for the NJ Exec Order 26.4b1 and electronically signed for administration. The RN #1 stated that she had taken the NJ Exe and NJ Exe earlier on her rounds and knew that the NJ Exec Order 26.4b1 was allowed to be administered.</p> <p>The surveyor had not observed the RN #1 obtain a NJ Exe or NJ Exe from Resident #252.</p> <p>On 9/11/24 at 9:26 AM, the surveyor interviewed the RN #1 at the medication cart who stated that "My usual routine is to come in for my shift at 7 AM, get report and then would do rounds on my residents and obtain vitals." The RN #1 added that the approximate time that she was obtaining vitals was usually around 7:30 AM. The RN #1 added that she obtained vital parameters before she started her morning medication pass because it helped with timeliness.</p>	F 755			

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F 755	<p>Continued From page 50</p> <p>The surveyor reviewed the electronic medical record for Resident #252.</p> <p>A review of the OSR revealed a PO with a start date of [REDACTED] for NJ Exec Order 26.4b1. Give 1 tablet by mouth two times a day for [REDACTED] Hold NJ Exec Order 26.4b1, or a NJ Exec Order 26.4b1. To be given with food."</p> <p>A review of the EMAR reflected the above PO.</p> <p>On 9/11/24 at 12:48 PM, the surveyor interviewed the [REDACTED] who stated that she would expect vital signs such as a [REDACTED] and [REDACTED] to be obtained right before administering the medication when there was a PO indicating that a medication be held for specific vital parameters. The surveyor, with the [REDACTED] reviewed the facility policy for Administering Medications which indicated "The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary." The [REDACTED] acknowledged that the policy had not indicated a specific timeframe prior to administering a medication but would expect the vital parameters be taken as close to the administration time of the medication as possible. The [REDACTED] added that she would allow up to 15 minutes prior to the administration of the medication.</p> <p>On 9/12/24 at 10:43 AM, the surveyor, in the presence of another surveyor, interviewed the [REDACTED] via the telephone who stated that he was not the [REDACTED] who services the facility but was the owner and that the [REDACTED] who services the facility was no longer employed and he could speak to any questions. The [REDACTED] stated that he was unsure if inservices on medication administration were</p>	F 755			

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F 755	Continued From page 51 completed but that the [US FOIA (b)(6)] would have the records if there was an inservice. The [US FO] acknowledged when a PO had hold parameters that vital parameters were to be obtained from a resident. The [US FO] stated, "Vital signs were to be obtained just before pouring meds because vital signs can change." The [US FO] added that "Getting vital signs during rounds can be a good marker but when there is a hold order the [NJ Ex] should be done just prior to the med being administered." On 9/12/24 at 2:19 PM, the survey team met with the [NJ Exec Order 26.4b1] acknowledged that the nurses should obtain vital parameters immediately before administration of a medication when there was a PO that had hold parameters and would give a grace period of 15 minutes to take the vital signs before administering the medication.	F 755			
F 758 SS=D	NJAC 8:39-11.2(b), 29.2 (d) Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		10/18/24	

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F 758	Continued From page 52 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and other pertinent facility documents it was determined that the facility failed to document attempted non-drug interventions and the need	F 758	How corrective actions will be accomplished for those residents affected by the deficient practice Resident #25 remains in the community		

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F 758	<p>Continued From page 53</p> <p>for an as needed (PRN) psychoactive medication [redacted] to be administered. The deficient practice was identified for one (1) of five (5) residents reviewed for unnecessary medications, (Resident #25) and was evidenced by the following:</p> <p>On 9/9/24 at 7:15 PM, the surveyor observed the Resident #25 sleeping in the room on an [redacted]</p> <p>On 9/10/24 at 8:58 AM, the surveyor observed the resident in the room sitting on a [redacted]. The resident stated, "I've been here for [redacted]. I'm working with [redacted] a couple of times a week because I try to [redacted]. I would [redacted] that's why I feel [redacted] but I really love it here and working towards that."</p> <p>On 9/10/24 at 1:03 PM, a record review of the electronic health records (EHR) revealed diagnoses which included but not limited to [redacted]</p> <p>A review of the order summary revealed: [redacted]</p> <p>[redacted] ablet by mouth every 6 hours as needed for [redacted] for [redacted]. Administer [redacted] = half tablet of [redacted] end date [redacted]</p> <p>Monitor for behaviors: List targeted behaviors related to [redacted]. Monitor and document every shift. If behavior is observed document the behavior, any contributing factors, interventions, and outcomes in progress notes, every shift if</p>	F 758	<p>and [redacted] NJ Exec Order 26.4b1. Resident #25 was evaluated by [redacted] US FOIA (b)(6) [redacted] medication review conducted, medication has been discontinued. Residents [redacted] NJ Exec Order 26.4b1 [redacted]</p> <p>Date of Completion: 09/13/24</p> <p>How will the facility identify other residents who have potential to be affected by the same deficient practice All residents with prescriptions for an as needed (PRN) psychoactive medication have potential to be affected by the deficient practice. Date of Completion: 09/13/24</p> <p>What measures will be implemented to prevent the recurrence of the deficient practice All licensed nurses will be re-educated on the community's Psychotropic Medication Use policy to ensure residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the medical record. Date of Completion: 10/11/24</p> <p>How will the facility monitor to ensure the deficient practices do not occur One randomly selected medical record of a resident ordered PRN medication to be audited weekly x 4 weeks, then monthly x 2 months by the Director of Nursing or designee to ensure residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is</p>	

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NAME OF PROVIDER OR SUPPLIER ARBOR AT LAUREL CIRCLE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 MONROE STREET BRIDGEWATER, NJ 08807		
(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 758	<p>Continued From page 54</p> <p>behaviors are observed document Yes and document in progress notes. Observe for significant side effects: sedation, drowsiness, agitation, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, weight changes, photosensitivity, dizziness, insomnia, somnolence, nausea, vomiting, confusion, falls, SPECIAL ATTENTION: heart disease, glaucoma, chronic constipation, seizure disorder, edema. every shift for depression document N-No side effects observed, and Y-Yes Side effects observed, enter progress note describing side effects and notify the physician.</p> <p>A review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care with an assessment reference date of [REDACTED], reflected that the resident had a brief interview for mental status (BIMS) score of [REDACTED] out of 15, indicating that the resident had a NJ Exec Order 26.4b1. Furthermore, the resident reflected the health questionnaire-9 (PHQ-9), a mental health screening revealed [REDACTED].</p> <p>A review of the care plans revealed psychotropic medications- [REDACTED] for [REDACTED] for [REDACTED] and [REDACTED] for [REDACTED].</p> <p>On 9/11/24 at 10:53 AM, the surveyor interviewed the Registered Nurse (RN) #1, who has been working in the facility for [REDACTED], the RN stated, "The resident can be [REDACTED] can be [REDACTED] but we re-direct the patient. What eases the patient the most is a call from the [REDACTED]. The patient is on medication for it, and it works. The patient is seen by [REDACTED] US FOIA (b)(6) The patient is on [REDACTED] PRN ordered for [REDACTED] days, usually it's ordered for [REDACTED] days. The [REDACTED] US FOIA (b)(6)</p>	F 758	<p>necessary to treat a diagnosed specific condition that is documented in the medical record.</p> <p>Results of the audits will be submitted to the monthly QAPI Committee. The committee will review the findings and make recommendations as appropriate. Date of Completion: 10/18/24 (audits initiated)</p>		

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F 758	<p>Continued From page 55</p> <p>US FOIA (b)(6) ordered it for NJ ES days. They're usually here every Thursday."</p> <p>On 9/11/24 at 11:09 AM, the surveyor interviewed the US FOIA (b)(6) who has been working in the facility for NJ Exec Order 26.4b, regarding the NJ Exec Order PRN. The NJ Exec stated, "I am aware that the US FOIA (b)(6), ordered it for NJ ES days because the resident has been on this NJ ES, she sees the resident all the time. The US FO knows the PRN (as needed) regulations are ordered for NJ ES days but this resident will probably continue it per US FOIA." </p> <p>On 9/11/24 at 11:15 AM, the surveyor observed the resident in the room sitting on a wheelchair. The resident stated, "I generally don't feel NJ Exec Order 26 or NJ Exec O I am NJ Exec O I love everybody here, they treat me very well."</p> <p>On 9/11/24 at 12:40, PM, a record review of the electronic medication administration record (eMAR) revealed NJ Exec Order ordered as PRN for NJ Exec O were not given for NJ Exec months; on NJ Exec Order 26.4b1 Give NJ Exec tablet by mouth every 6 hours as needed for NJ Exec Order 26.4b1 Administer NJ Exec Order 26.4b1 = half tablet of NJ Exec O 1:00 PM, was administered for one day on NJ Exec Order at 3:46 PM, by RN #2, with no documentation on the nursing progress notes indicating why the medication was given; no documentation of a target behavior; and no documentation of any non-drug interventions done prior to medicating. Furthermore, the RN #2 documented on the eMAR on NJ Exec Order under monitor for behaviors as NJ Exec O behaviors.</p> <p>A review of the physician progress notes on</p>	F 758			

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F 758	<p>Continued From page 56</p> <p>NJ Ex Order 26.4b1 revealed, "Continue NJ Ex Order 26.4b1 for NJ Exec Order 26.4b1. Continue to monitor patient's NJ Exec Order 26.4b1. Continue NJ Exec Order 26.4b1 every 6 hours as needed for NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1 in the morning and NJ Exec Order 26.4b1 at bedtime."</p> <p>A review of the nursing progress notes of RN #3 on NJ Ex Order 26.4b1 at 2:40 PM, revealed, "The US FOIA (b)(6) came to visit the resident and renewed NJ Exec Order 26.4b1 tablet every 6 hours as needed for NJ Exec Order 26.4b1"</p> <p>On 9/11/24 at 3:18 PM, the surveyor interviewed RN #2, who administered the NJ Ex Order 26.4b1 PRN on NJ Ex Order 26.4b1, via telephone call, and she stated, "I've been working at the facility for NJ Ex Order 26.4b1 3-11 PM shift. The resident is fine, sometimes the resident has this NJ Ex Order 26.4b1 you must explain NJ Exec Order 26.4b1. Sometimes the resident has NJ Ex Order 26.4b1 but NJ Exec Order 26.4b1 re-directing works at times. I don't really remember the situation on NJ Ex Order 26.4b1 when I gave the NJ Ex Order 26.4b1 PRN, but I usually will give it if I see NJ Exec Order 26.4b1 and there is NJ Ex Order 26.4b1. If I did everything to re-assure the resident and nothing else worked, that would be the time I would give the PRN NJ Ex Order 26.4b1. The next thing I would do I would be to re-assess the resident to see if it was effective or not and I would ask the resident how they feel and then I will have to document it. I don't remember why I did not document on that day."</p> <p>On 9/12/24 at 9:03 AM, the US FOIA (b)(6) NJ Ex Order 26.4b1, who has been working in the facility for NJ Ex Order 26.4b1, full time, stated, "Sometimes the patient gets NJ Ex Order 26.4b1 because the patient NJ Exec Order 26.4b1 and looking for</p>	F 758			

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F 758	<p>Continued From page 57</p> <p>NJ Exec Order 26.4b1 but then [they] call the family and [they] NJ Exec Order 26.4b1. The patient has no other behaviors I see."</p> <p>On 9/12/24 at 9:10 AM, the US FOIA (b)(6) provided the US FOIA (b)(6) consult dated NJ Exec Order 26.4b1 which revealed the resident, "Reports NJ Exec Order 26.4b1" and consult dated NJ Exec Order 26.4b1 which revealed, "NJ Exec Order 26.4b1 PRN x NJ ES days. May renew as indicated for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1</p> <p>On 9/12/24 at 9:41 AM, in the presence of another surveyor, the surveyor interviewed the US FOIA (b)(6) the US FOIA (b)(6), the US FOIA (b)(6) from the [name redacted] US FOIA (b)(6) group stated, "The collaborating doctor and I have been here for NJ ES." The US FOIA (b)(6) stated regarding the NJ Exec Order 26.4b1 PRN, "The resident has a history of NJ Exec Order 26.4b1 and the order was ordered for NJ ES days with the documented rationale of the resident showing increasing NJ Exec Order 26.4b1. The PRN has an end date of NJ Exec Order 26.4b1. I cannot speak for why there was no nursing documentation on NJ Exec Order 26.4b1." The US FOIA (b)(6) stated, "On the day I ordered it on NJ Exec Order 26.4b1 the nurse should have documented the symptoms on NJ Exec Order 26.4b1." The US FOIA (b)(6) acknowledged that the nurse did not complete a narrative note and stated they should have documented the target behavior/s, what occurred on NJ Exec Order 26.4b1 that required the use of PRN NJ Exec Order 26.4b1 and if any other non-drug interventions were implemented prior to administration of the NJ Exec Order 26.4b1</p> <p>On 9/12/24 at 2:35 PM, the survey team met with the facility US FOIA (b)(6) to discuss the use of NJ Exec Order 26.4b1 PRN. The surveyor informed that on NJ Exec Order 26.4b1 there was no nursing documentation, no documentation</p>	F 758		

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F 758	Continued From page 58 of target behaviors, symptoms, or non-drug interventions prior to medicating Resident #25 with [REDACTED] The [REDACTED] stated, "I totally agree that the nurse should have documented the targeted behavior, symptom/s at that time and what other interventions were taken before medication administration." The surveyor requested for any other additional documentation. On 9/13/24 at 9:55 AM, the facility did not provide any additional documentation. On 9/13/24 at 10:02 AM, a review of the most current facility Policy and Procedure for Psychotropic Medication Use, with a revised date in July 2022 revealed, "Psychotropic medications are not given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record." The most current facility policy and procedure for Administering Medications, revised in April 2019, revealed, "As required or indicated for a medication, the individual administering the medication records in the resident's medical record: any complaints or symptoms for which the drug was administered."	F 758			
F 812 SS=F	NJAC 8:39 11.2(b), 27.1(a), 29.2(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	F 812		10/7/24	

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F 812	<p>Continued From page 59</p> <p>from local producers, subject to applicable State and local laws or regulations.</p> <p>(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.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to ensure the remote healthcare food service pantry area, and adjacent storage room was maintained in a clean and sanitary manner to prevent the potential for food borne illness. The deficient practice was evidenced by the following:</p> <p>On 09/10/24 at 11:34 AM, the surveyor toured the healthcare food service pantry in the presence of the US FOIA (b)(6)</p> <p>-During the meal set up, and placement into the steam table, the surveyor observed an ant crawling up the wall in the kitchen and several small flying insects in the pantry. The US FOIA stated there was an ant issue and the facility was notified and the pest people sprayed for ants. At that time, the surveyor observed that there was splatters in several areas on the wall and crumbs and other debris on the floor behind the equipment and in the corners. The surveyor asked about cleaning and the US FOIA stated the floors are swept and mopped. The surveyor asked if a deep cleaning was performed,</p>	F 812	<p>How corrective actions will be accomplished for those residents affected by the deficient practice</p> <p>Housekeeping & maintenance services, as well as pest control vendor were called in immediately to ensure the community adequately addressed the dust, debris, ants, insects, and stained/soiled carts and areas.</p> <p>The actions were performed immediately to ensure the remote healthcare food service pantry area, and adjacent storage room was maintained in a clean and sanitary manner to prevent the potential for food borne illness.</p> <p>Date of Completion: 10/01/24</p> <p>How will the facility identify other residents who have potential to be affected by the same deficient practice</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>Date of Completion: 09/13/24</p>		

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F 812	<p>Continued From page 60</p> <p>including moving mobile equipment and cleaning the entire pantry. The [REDACTED] stated that has not occurred since he has been in the role.</p> <p>-The steam table used to hold the food items, had an attached cutting board which was grooved, when the [REDACTED] lifted up the cutting board, there was various debris in the crevice along the length of the steam table.</p> <p>-A red bucket was lodged behind a metal table, the wall and blue dish racks. Debris was observed on the lower shelf of the table and there were splatters on the wall.</p> <p>-The adjacent storage room contained debris on the floor and in the corners, the walls had splatters and stains. A soiled dust pan was on the floor next to a small plunger and a broom. There were flying insects in the storage room, and boxes of cold cereal and sugar packets were stored on a metal shelf.</p> <p>-An open cart used to hold resident trays during the meal preparation was cracked on the side of the top shelf and had visible debris on the cart.</p> <p>-Directly outside of the door from the healthcare pantry to the dining room, contained a black insulated food transportation cart which was visibly soiled with debris on the outside of the cart and the handles. A second open cart in the main dining room had visible debris and was soiled.</p> <p>On 09/10/24 at 12:00 PM, the surveyor accompanied the [REDACTED] US FOIA (b)(6) to the storage area and the healthcare pantry to to share the above concerns. The [REDACTED] US FOIA (b)(6) acknowledged the concerns</p>	F 812	<p>What measures will be implemented to prevent the recurrence of the deficient practice</p> <p>All Food & Beverage staff to be reeducated by the Staff Development Coordinator or designee on the community's Sanitation Policy. The daily Food & Beverage cleaning and sanitation checklist to be revised and augmented (including a separate food cart cleaning log) to ensure the remote healthcare food service pantry area, and adjacent storage room was maintained in a clean and sanitary manner to prevent the potential for food borne illness.</p> <p>Date of Completion: 10/07/24</p> <p>How will the facility monitor to ensure the deficient practices do not occur</p> <p>The remote healthcare food service pantry area, and adjacent storage room will be inspected weekly for the next 3 months by the Director of Food & Beverage and/or designee to ensure they are maintained in a clean and sanitary manner to prevent the potential for food borne illness.</p> <p>Results of the audits will be submitted to the monthly QAPI Committee. The committee will review the findings and make recommendations as appropriate.</p> <p>Date of Completion: 10/07/24</p>		

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F 812	Continued From page 61 and stated, "give me one hour to clean it". The surveyor requested 6 months of pest control logs. The Sanitation Policy, undated, revealed "It is the policy of the community to store, prepare, distribute and serve food under sanitary conditions". Procedure: Written effective procedures regarding food procurement, storage, garbage disposal, personal hygiene, pest control, wearing of gloves, handling of ice, food preparation and infection control will be followed by all food service personnel.	F 812			
F 865 SS=E	NJAC 8:39-17.2(g) QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State	F 865		10/15/24	

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F 865	<p>Continued From page 62</p> <p>Survey Agency no later than 1 year after the promulgation of this regulation;</p> <p>§483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and</p> <p>§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.</p> <p>§483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:</p> <p>§483.75(b)(1) Address all systems of care and management practices;</p> <p>§483.75(b)(2) Include clinical care, quality of life, and resident choice;</p> <p>§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.</p> <p>§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.</p> <p>§483.75(f) Governance and leadership.</p>	F 865			

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F 865	<p>Continued From page 63</p> <p>The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:</p> <p>§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.</p> <p>§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;</p> <p>§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;</p> <p>§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.</p> <p>§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and</p> <p>§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.</p> <p>§483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>§483.75(i) Sanctions. Good faith attempts by the committee to identify</p>	F 865			

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F 865	<p>Continued From page 64</p> <p>and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and document review it was determined that the facility failed to have an effective system in place to self- identify concerns and develop and maintain an effective data-driven Quality Assurance Performance Improvement (QAPI) program for: a) reviewing adverse events, including medication errors and falls, b) ensuring an effective pest control program was maintained, c) ensuring kitchen sanitation was maintained, and d) ensuring activity programs occurred as scheduled.</p> <p>The deficient practice was as evidenced by the following:</p> <p>Refer: 679E, 684G, 689E, 812F, 925E</p> <p>On 09/12/24 at 1:44 PM, the US FOIA (b)(6) provided the QAPI minutes for August 2024. The document revealed the following QAPIs: Admin [LHNA]-N/A [not applicable]; Community Life-N/A; EVS [environmental services]- Turnover of rooms after discharge; Nusing-Infection Control, Anti-biotic Stewardship, Falls [# of falls per LNHA], Rehospitalizations; Dietary-Continue to address monthly weights; Food Services-Continue to address labeling of food products, Continue to address equipment wear and tear, Continue to monitor and document dishwasher temperatures, Social Services-N/A, Rehab [rehabilitation]-w/c[wheelchair cushions and appropriateness. At that time the surveyor asked if the identified concerns during survey had been addressed by the QAPI, which included concerns</p>	F 865	<p>How corrective actions will be accomplished for those residents affected by the deficient practice</p> <p>The community QAPI meeting agenda has been revised to include topics including and not limited to adverse events (including med errors, falls, pest control program, kitchen sanitation maintenance, activity programs occurrence as scheduled, facility reportable events) to maintain an effective, comprehensive, data-driven program that focuses on indicators of the outcomes of care and quality of life.</p> <p>Date of Completion: 09/30/24</p> <p>How will the facility identify other residents who have potential to be affected by the same deficient practice</p> <p>What measures will be implemented to prevent the recurrence of the deficient practice</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>Date of Completion: 09/13/24</p> <p>What measures will be implemented to prevent the recurrence of the deficient practice</p> <p>The community QAPI meeting agenda has been revised to include topics including and not limited to adverse events (including med errors, falls, pest control program, kitchen sanitation maintenance, activity programs</p>		

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NAME OF PROVIDER OR SUPPLIER ARBOR AT LAUREL CIRCLE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 MONROE STREET BRIDGEWATER, NJ 08807		
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F 865	<p>Continued From page 65</p> <p>with: hand hygiene, activities, pests, failure to complete thorough investigations, review of significant events and care planning and the [REDACTED] confirmed those concerns were not part of the QAPI.</p> <p>On 09/12/24 at 1:48 PM, the surveyor asked the [REDACTED] to expand on what was reviewed at QAPI regarding falls. The [REDACTED] stated, the number of falls, and nothing else regarding falls. The surveyor asked about significant events and investigations being brought to the QAPI and then asked what should be included in an investigation. The [REDACTED] stated for a fall, a root cause analysis was his expectation to be included as part of an investigation. The surveyor asked the [REDACTED] how the facility determined what should be reviewed at QAPI and the [REDACTED] stated that he would ask the department heads what were the concerns in their respective departments.</p> <p>On 09/13/24 at 8:45 AM, the surveyor interviewed the [REDACTED] regarding how the facility determined what would be reviewed with the QAPI. The [REDACTED] stated he would ask the department heads about the concerns for each area. The surveyor asked what was supposed to be monitored with each QAPI. The [REDACTED] stated, "you are supposed to show progress". The surveyor asked about the the pests and the pest management reports also identifying sanitation concerns with the kitchen as a cause. The [REDACTED] stated "it was not handled in appropriate way. The surveyor asked what should have happened, and the [REDACTED] stated it should have been brought to the QA (Quality Assurance). The [REDACTED] further stated there was a "gap in communication and it [pests] was not brought up." The [REDACTED] also confirmed that the QAPI does not review significant event, including facility</p>	F 865	<p>occurrence as scheduled, facility reportable events) to maintain an effective, comprehensive, data-driven program that focuses on indicators of the outcomes of care and quality of life. Date of Completion: 10/15/24</p> <p>How will the facility monitor to ensure the deficient practices do not occur Data accumulated from results of QAPI audits to be to be collected, reviewed, and analyzed to determine whether the committee is having a positive impact on identified indicators (effectiveness of process). The committee will review the findings and make recommendations as appropriate. Date of Completion: 10/15/2024</p>		

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F 865	Continued From page 66 reportable events. The [REDACTED] also confirmed that activities was not reviewed at the QAPI. The QAPI Improvement Activity Progress Form provided by the [REDACTED] for "Labeling of food items" was reviewed, Activity Start Date: 1/12024. The QAPI did not contain cleanliness of the kitchen. The Quality Assurance Improvement Plan, dated 2019 revealed: III. Guidelines for Governance and Leadership: a. The QA Committee and administration are responsible and accountable for developing, leading, and closely monitoring the QAPI program. IV. Feedback, Data Systems, and Monitoring: b. The following data is monitored through the QAPI Committee: i. Input from staff, residents, families, and others; II. Adverse events ... c. Process for collecting the above information: i. Gather input from caregivers, residents, families, and others (surveys, council meetings...) ii. Adverse events (incident reports, 24 hour reports).	F 865			
F 880 SS=D	NJAC 8:39-33.2(a)(b)(c) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		10/18/24	

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F 880	<p>Continued From page 67</p> <p>and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed</p>	F 880			

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F 880	<p>Continued From page 68 by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow appropriate infection control and hand hygiene practices to prevent the spread of infection. This deficient practice was identified for 6 of 6 resident's observed during the meal delivery. The evidence was as follows:</p> <p>On 9/10/24 at 8:10 AM, the surveyor observed the JS FOIA (b)(6) delivered the breakfast meals to the Unit. The surveyor followed the JS FOIA (b)(6) to the rooms and observed there was no sani-wipe on the tray, The JS FOIA (b)(6) delivered the tray, adjusted the bedside table, set the tray up and left the room. The JS FOIA (b)(6) did not provide the residents with opportunities to cleanse their hands prior to the meals. The JS FOIA (b)(6) left the room and used Alcohol Base Hand Rub (ABHR) to cleanse his hands prior to deliver the next tray.</p> <p>The surveyor followed the JS FOIA (b)(6) to the next room and observed that the resident was not provided with opportunities to cleanse their hands. The</p>	F 880	<p>How corrective actions will be accomplished for those residents affected by the deficient practice The 6 residents identified by the surveyor were offered appropriate hand hygiene options following notification of the deficient practice. They remain at the community and are free from any ill effects. Date of Completion: 09/13/24</p> <p>How will the facility identify other residents who have potential to be affected by the same deficient practice All residents have the potential to be affected by this deficient practice. Date of Completion: 09/13/24</p> <p>What measures will be implemented to prevent the recurrence of the deficient practice All nursing staff to be re-educated on the community's Handwashing policy to</p>		

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F 880	<p>Continued From page 69</p> <p>surveyor followed another [REDACTED] in the next hallway and observed that none of the residents served were provided with opportunity to cleanse their hands.</p> <p>On 9/11/24 at 12:15 PM, the surveyor observed the lunch meals being delivered to the residents at the table. The residents were not provided with opportunity to cleanse their hands.</p> <p>On 9/12/24 at 12:35 PM, the surveyor observed the [REDACTED] delivered the lunch tray to the residents in their rooms. The residents were not provided with opportunity to wash their hands.</p> <p>On 9/12/24 at 12:45 PM, an interview with a random resident who was awake and alert confirmed there was no sani-wipe delivered with the tray and no hand sanitizer was being offered also prior to the meals.</p> <p>On 9/12/24 at 1:30 PM, the surveyor interviewed the [REDACTED]. The surveyor asked the [REDACTED] about hand hygiene for the residents prior to consume their meals. The [REDACTED] stated, "If the resident requested hand sanitizer we will provide but we do not offer regularly."</p> <p>The surveyor then asked the [REDACTED] where the sani-wipes were located. The [REDACTED] accompanied the surveyor to the storage room and showed the wipe used when the residents requested. The surveyor reviewed the instructions on the bag with the [REDACTED] and informed the [REDACTED] that these wipe were indicated to clean the perineal area, not the hands prior to meals. The [REDACTED] was not aware.</p> <p>On 09/12/24 at 1:42 PM, the surveyor reviewed the facility's policy and procedures. A Review of the facility's Handwashing Policy and Procedure dated 2001, included that this facility considers</p>	F 880	<p>ensure they follow appropriate infection control and hand hygiene practices which help to prevent the spread of infection. Sani hand wipes are available to all staff to use with residents in the dining room. Sani wipes are also available in all hallways for staff and residents to use. Date of Completion: 10/18/24</p> <p>How will the facility monitor to ensure the deficient practices do not occur Random meal pass to be audited weekly x 4 weeks, then monthly x 2 months by the Director of Nursing or designee to ensure the community follows appropriate infection control and hand hygiene practices to help to prevent the spread of infection. Results of the audits will be submitted to the QAPI Committee monthly. The committee will review the findings and make recommendations as appropriate. At the conclusion of three months, a determination will be made of the need for further auditing Date of Completion: 10/11/24 (audits initiated)</p>		

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F 880	Continued From page 70 hand hygiene the primary means to prevent the spread of healthcare -associated infections. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare associated infections. Residents, family members and/or visitors are encouraged to practice hand hygiene. On 9/12/24 at 2:00 PM, the surveyor interviewed the U.S. FOIA (b) (6) . The U.S. FOIA stated that the residents should be provided with hand sanitizer. She stated the facility used to provide sani-wipes on the tray but the facility stopped the process after COVID.	F 880			
F 925 SS=E	NJAC 8:39-19.4(a) Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review it was determined that the facility failed to maintain an effective pest control program for the healthcare dining room, attached meal service pantry and food storage area. The deficient practice was evidenced by the following: On 09/10/24 at 11:34 AM, the surveyor observed the meal preparation in the healthcare pantry, located on the 2nd floor, with the US FOIA (b)(6) present. The trays were being assembled for distribution to the resident and for dining room service. The surveyor observed an	F 925	How corrective actions will be accomplished for those residents affected by the deficient practice Housekeeping & maintenance services, as well as pest control vendor were called in immediately to ensure the community adequately addressed the dust, debris, ants, insects, drains, stained/soiled areas, leaky hoses from soda machines, and any standing water. These actions were performed immediately to help maintain an effective pest control program for the healthcare	10/7/24	

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F 925	<p>Continued From page 71</p> <p>ant crawling up the wall in the kitchen and several small flying insects in the pantry. The [REDACTED] stated there was an ant issue and the facility was notified and the pest people sprayed for ants. At that time, the surveyor observed that there was splatters in several areas on the wall and crumbs and other debris on the floor behind the equipment and in the corners. The surveyor asked about cleaning and the [REDACTED] stated the floors are swept and mopped. The adjacent storage room contained debris on the floor and in the corners, the walls had splatters and stains. A soiled dust pan was on the floor next to a small plunger and a broom. There were flying insects observed in the storage room, and boxes of cold cereal and sugar packets were stored on a metal shelf.</p> <p>During the observation, the surveyor exited the pantry into the main healthcare dining room and observed. dead insects on the window sill and multiple insects on the wall molding.</p> <p>On 09/10/24 at 12:00 PM, the surveyor showed th [REDACTED] US FOIA (b)(6) the insects and condition of the healthcare pantry, attached storage area and adjacent dining room. The surveyor requested 6 months of pest control documentation.</p> <p>On 09/10/24 at 2:09 PM, the surveyor reviewed the "Pest Sighting/ Evidence Log" which revealed: Date/Time; Pest/Issue; Exact Location/Description; Person Reporting; Date/Time [Vendor] Called; Name/Date/Action Taken. On 08/21/24, ants "inspected and treated [3 room numbers listed]"; 08/15/24 "inspected/treated for ants weekly kitchen". The surveyor requested the reports associated with</p>	F 925	<p>dining room, attached meal service pantry, and food storage areas. Date of Completion: 09//27/24</p> <p>How will the facility identify other residents who have potential to be affected by the same deficient practice All residents have the potential to be affected by this deficient practice. Date of Completion: 09/13/24</p> <p>What measures will be implemented to prevent the recurrence of the deficient practice All Food & Beverage staff to be reeducated by the Staff Development Coordinator or designee on the community's Sanitation Policy. The daily Food & Beverage cleaning and sanitation checklist to be revised and augmented (including a drain cleaning log) to help maintain an effective pest control program for the healthcare dining room, attached meal service pantry, and food storage areas. Date of Completion: 10/07/24</p> <p>How will the facility monitor to ensure the deficient practices do not occur The condition of the healthcare dining room attached meal service pantry, and food storage areas will be inspected weekly for the next 3 months by the Director of Food & Beverage and/or designee to help maintain an effective pest control program for the healthcare dining room, attached meal service pantry, and food storage areas. Results of the audits will be submitted to</p>		

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F 925	<p>Continued From page 72</p> <p>the pest control treatments which were provided by the [REDACTED] The reports revealed:</p> <p>-06/18/24 Pest Company Report: Service Related Comment: I inspected 10 drains in 2nd floor kitchen and bar for small fly activity. Pest Activity Found, Location, Kitchen Area-Interior, Finding: Small flies noted during service, I treated small flies by drains in kitchen, Action Needed/Taken: This area was inspected and serviced.</p> <p>-8/15/24 Pest Company Report: Service Related Comment: "I inspected the kitchen and office space and treated for ants in mds (Material Data Set) office on 2nd floor and main kitchen and secondary kitchen on first and 2nd floor".</p> <p>Structural Concerns: Receiving-introduction Point, Finding: -Exit door doesn't close/seal properly, Action Needed/Taken: Install/replace door sweep. Install weather stripping. Exclusion measures here will reduce the number of pests entering the area.</p> <p>Sanitation Issues: Kitchen, Area- interior, Finding: Floor drains need cleaning, Action Needed/Taken: Please clean in and around drains frequently to help prevent pest breeding sites; Kitchen, Area-interior, Finding: excess water noted. Found standing water in containers under juice and coffee maker, wet rag and leaking hoses under soda machine leaks and drippings on the floor, small fly active areas where they reproduce in these wet areas and drips, Action Needed/Taken: Keep area dry; Kitchen, Area-Interior, Finding: Main kitchen 2nd floor great job on keeping the cook lines and floors clean your sanitation efforts speak volumes, Action Needed/Taken: Please address</p>	F 925	<p>the monthly QAPI Committee. The committee will review the findings and make recommendations as appropriate. Date of Completion: 10/07/24 (audits initiated)</p>		

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F 925	<p>Continued From page 73 sanitation issue.</p> <p>On 09/12/24 at 2:58 PM, the surveyor, in the presence of the survey team, reviewed with the [REDACTED] the observations of pests and sanitation concerns that have been observed during the survey, and about the reports of sanitation concerns regarding the kitchen areas related to pests that was documented by the Pest Company. The surveyor asked the [REDACTED] if he was aware of the concerns and if he made rounds of the different areas. The [REDACTED] stated, "I'm not going to say anything".</p> <p>On 09/13/24 at 9:33 AM, during the Exit conference conducted with the facility, there was no additional information provided regarding the pests observed during survey.</p> <p>NJAC 8.39-31.5(a)</p>	F 925			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315445	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 11/12/2024	Y3
NAME OF FACILITY ARBOR AT LAUREL CIRCLE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 MONROE STREET BRIDGEWATER, NJ 08807		

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 F0684	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 483.25	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	10/15/2024	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	_____	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	_____	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	_____	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	_____	LSC _____	_____	LSC _____	_____

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 9/13/2024

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315445	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 11/12/2024	Y3
NAME OF FACILITY ARBOR AT LAUREL CIRCLE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 MONROE STREET BRIDGEWATER, NJ 08807		

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 F0584	Correction	ID Prefix F0657	Correction	ID Prefix F0679	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.24(c)(1)	Completed
LSC	10/07/2024	LSC	10/11/2024	LSC	10/11/2024
ID Prefix F0684	Correction	ID Prefix F0689	Correction	ID Prefix F0695	Correction
Reg. # 483.25	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(i)	Completed
LSC	10/15/2024	LSC	10/18/2024	LSC	10/11/2024
ID Prefix F0755	Correction	ID Prefix F0758	Correction	ID Prefix F0812	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(c)(3)(e)(1)-(5)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	10/18/2024	LSC	10/18/2024	LSC	10/07/2024
ID Prefix F0865	Correction	ID Prefix F0880	Correction	ID Prefix F0925	Correction
Reg. # 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(i)(4)	Completed
LSC	10/15/2024	LSC	10/18/2024	LSC	10/07/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/13/2024		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

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

PRINTED: 12/13/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315445	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER ARBOR AT LAUREL CIRCLE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 MONROE STREET BRIDGEWATER, NJ 08807	
(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	E 000		
K 000	INITIAL COMMENTS	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING	K 222		10/11/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/07/2024

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

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K 222	<p>Continued From page 1</p> <p>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.</p> <p>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS</p> <p>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.</p> <p>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS</p> <p>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS</p> <p>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be</p>	K 222			

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K 222	<p>Continued From page 2</p> <p>permitted. 18.2.2.2.4, 19.2.2.2.4</p> <p>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS</p> <p>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and interview on 09/12/2024 in the presence of US FOIA (b)(6) [REDACTED] it was determined that the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with NFPA 101:2012 Edition, Section 19.2.2.5.1, 19.2.2.5.2 and 19.2.2.2.6. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>An observation at 12:15 PM in the presence of the US FOIA (b)(6), revealed one set of glass sliding doors located at the main entrance of the facility had a lockset that engaged a hook-type deadbolt. The device on the door could restrict emergency use of the exit. The US FOIA (b)(6) tested the doors by locking and pushed to open, but he could not open the door.</p> <p>In an interview at the time, the US FOIA (b)(6) confirmed the observation.</p> <p>The facility's US FOIA (b)(6) was notified of the</p>	K 222	<p>How corrective actions will be accomplished for those residents affected by the deficient practice</p> <p>The lockset that engaged a hook-type deadbolt was immediately removed from the set of glass sliding doors located at the main entrance of the community.</p> <p>This ensures the community provides exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with NFPA 101:2012</p> <p>How will the facility identify other residents who have potential to be affected by the same deficient practice</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>Date of Completion: 09/13/24</p> <p>What measures will be implemented to</p>		

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K 222	Continued From page 3 deficient practice at Life Safety Code survey exit conference at 4:15 PM. N.J.A.C. 8:39-31.2(e).	K 222	prevent the recurrence of the deficient practice All Maintenance staff to be educated by the Staff Development Coordinator or designee on the contents of NFPA 101:2012 Edition <input type="checkbox"/> Section 19.2.2.2.5.1, 19.2.2.2.5.2, and 19.2.2.2.6 to ensure the community provides exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies Date of Completion: 10/11/24 How will the facility monitor to ensure the deficient practices do not occur All community means of egress will be inspected monthly for the next 3 months by the Plant Director or designee to ensure the community provides exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with NFPA 101:2012 Edition <input type="checkbox"/> Section 19.2.2.2.5.1, 19.2.2.2.5.2, and 19.2.2.2.6 Results of the audits will be submitted to the monthly QAPI Committee. The committee will review the findings and make recommendations as appropriate. Date of Completion (inspections initiated): 10/11/24		

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K 225 K 225 SS=F	Continued From page 4 Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2.18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 09/12/2024 in the presence of the Facility's US FOIA (b)(6) , it was determined that the facility failed to ensure that exit stair landings and exit stair handrails were marked in accordance with NFPA 101:2012 Edition, Sections 19.2.2.3, 7.2.2.5.5.2, and 7.2.2.5.5.3. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations during the tour between 9:00 AM and 3:45 PM in the presence of the US FOIA (b)(6) , revealed exit stairways H1, H2 and H3 had no marking stripes on the steps and the upper surface of the handrails were not marked as required by the Code. In an interview at that time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code survey exit on at approximately 4:15 PM.	K 225 K 225	How corrective actions will be accomplished for those residents affected by the deficient practice Marking stripes were painted on landings and exit handrails of stairways H1, H2, and H3 in accordance with NFPA 101:2012 Edition, Sections 19.2.2.3, 7.2.2.5.5.2, and 7.2.2.5.5.3 Date of Completion: 09/13/24 How will the facility identify other residents who have potential to be affected by the same deficient practice All residents have the potential to be affected by this deficient practice. Date of Completion: 09/13/24 What measures will be implemented to prevent the recurrence of the deficient practice All Maintenance staff to be educated by	10/11/24

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K 225	Continued From page 5 NJAC 8:39 31.2 (e)	K 225	<p>the Staff Development Coordinator or designee on the contents of NFPA 101:2012 Edition, Sections 19.2.2.3, 7.2.2.5.5.2, and 7.2.2.5.5.3 to ensure the community exit stair landings and exit stair handrails remain marked as required by the Code.</p> <p>Date of Completion: 10/11/24</p> <p>How will the facility monitor to ensure the deficient practices do not occur</p> <p>Stairways H1, H2, and H3 will be inspected monthly for the next 3 months by the Plant Director or designee to ensure the community exit stair landings and exit stair handrails remain marked in accordance with NFPA 101:2012 Edition, Sections 19.2.2.3, 7.2.2.5.5.2, and 7.2.2.5.5.3</p> <p>Results of the audits will be submitted to the monthly QAPI Committee. The committee will review the findings and make recommendations as appropriate.</p> <p>Date of Completion (inspections initiated): 10/11/24</p>		
K 324 SS=F	<p>Cooking Facilities CFR(s): NFPA 101</p> <p>Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:</p>	K 324		10/11/24	

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K 324	<p>Continued From page 6</p> <p>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2</p> <p>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or</p> <p>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.</p> <p>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.</p> <p>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interview on 09/12/2024 in the presence of US FOIA (b)(6) [REDACTED], it was determined that the facility failed to ensure that 6 of 8 kitchen cooking equipment's Wet Chemical fire suppression systems nozzles were in the proper position to protect against fire in accordance with NFPA 101:2012 edition, Section 19.3.2.5.3*(10) and NFPA 96. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>An observation at approximately 10:38 AM, revealed in the facility kitchen that the wet chemical fire suppression system (over the</p>	K 324	<p>How corrective actions will be accomplished for those residents affected by the deficient practice The community's kitchen cooking equipment's Wet Chemical fire suppression systems nozzles were immediately realigned in the proper position to protect against fire in accordance with NFPA 101:2012 Edition, Section 19.3.2.5.3*(10) and NFPA 96.</p> <p>Date of Completion: 09/13/24</p> <p>How will the facility identify other residents who have potential to be affected by the same deficient practice</p>		

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K 324	<p>Continued From page 7</p> <p>cooking equipment) had six (6) suppression spray nozzles aimed backward and not positioned to protect the cooking equipment.</p> <p>The US FOIA (b)(6) confirmed the finding at the time of observation.</p> <p>The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code survey exit on at approximately 4:15 PM.</p> <p>NJAC 8:39-31.2(e) NFPA 96</p>	K 324	<p>All residents have the potential to be affected by this deficient practice. ¿¿</p> <p>Date of Completion: 10/11/24</p> <p>What measures will be implemented to prevent the recurrence of the deficient practice</p> <p>All Maintenance staff to be educated by the Staff Development Coordinator or designee on the contents of NFPA 101:2012 Edition, Section 19.3.2.5.3*(10) and NFPA 96 to ensure the community's kitchen cooking equipment's wet chemical fire suppression systems nozzles remain in the proper position to protect against fire.</p> <p>Date of Completion: 10/11/24</p> <p>How will the facility monitor to ensure the deficient practices do not occur</p> <p>The community's kitchen cooking equipment's wet chemical system will be inspected monthly for the next 3 months by the Plant Director or designee to ensure the nozzles remain in the proper position to protect against fire in accordance with NFPA 101:2012 Edition, Section 19.3.2.5.3*(10) and NFPA 96.</p> <p>Results of the audits will be submitted to the monthly QAPI Committee. The committee will review the findings and make recommendations as appropriate.</p>		

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K 324	Continued From page 8	K 324			
K 351 SS=E	<p>Sprinkler System - Installation CFR(s): NFPA 101</p> <p>Sprinkler System - Installation 2012 EXISTING</p> <p>Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.</p> <p>In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.</p> <p>19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interview on 09/12/2024 in the presence of US FOIA (b)(6) [REDACTED] it was determined the facility failed to provide automatic fire sprinkler protection to all areas of the facility in accordance with NFPA 13 and NFPA 101: 2012, Sections 9.7 and 19.3.5.1. This deficient practice had the potential to affect all residents and was evidenced by the following:</p>	K 351	<p>Date of Completion (inspections initiated): 10/11/24</p> <p>How corrective actions will be accomplished for those residents affected by the deficient practice</p> <p>NJ Ex Order 26.4(b)(1) (vendor) was immediately contacted to schedule the installation of fire sprinkler for first accessible landing of stairwell H1 in accordance with NFPA 13 and NFPA 101:2012, Sections 9.7 and 19.2.5.1.</p>	10/31/24	

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K 351	<p>Continued From page 9</p> <p>Observations between 9:00 AM and 3:45 PM at exit stairwell H1, revealed there was no fire sprinkler coverage under the first accessible landing.</p> <p>In an interview at the time, the US FOIA (b)(6) confirmed the observation.</p> <p>The facility's US FOIA (b)(6) was notified of the findings at the Life Safety Code survey exit at 4:15 PM.</p> <p>NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25</p>	K 351	<p>Date of Completion: 09/13/24 (work to be completed on or before 10/31/24)</p> <p>How will the facility identify other residents who have potential to be affected by the same deficient practice</p> <p>All residents have the potential to be affected by this deficient practice. 22</p> <p>Date of Completion: 09/13/24</p> <p>What measures will be implemented to prevent the recurrence of the deficient practice</p> <p>All Maintenance staff to be educated by the Staff Development Coordinator or designee on the contents of NFPA 13 and NFPA 101:2012, Sections 9.7 and 19.2.5.1.</p> <p>to ensure the community provides automatic fire sprinkler protection to all necessary stairwell areas.</p> <p>Date of Completion: 10/11/24</p> <p>How will the facility monitor to ensure the deficient practices do not occur</p> <p>All stairway areas will be inspected monthly for the next 3 months by the Plant Director or designee to ensure the community provides automatic fire sprinkler protection to all necessary stairwell areas in accordance with NFPA 13 and NFPA 101:2012, Sections 9.7 and 19.2.5.1.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315445	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER ARBOR AT LAUREL CIRCLE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 MONROE STREET BRIDGEWATER, NJ 08807		
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K 351	Continued From page 10	K 351	Results of the audits will be submitted to the monthly QAPI Committee. The committee will review the findings and make recommendations as appropriate. Date of Completion (inspections initiated): 10/11/24		
K 353 SS=F	<p>Sprinkler System - Maintenance and Testing CFR(s): NFPA 101</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 09/12/2024 in the presence of Regional Plant US FOIA (b)(6) it was determined that the facility failed to A.) maintain all parts of the automatic fire sprinkler heads free from corrosion and loading in</p>	K 353	<p>How corrective actions will be accomplished for those residents affected by the deficient practice</p> <p>A sprinkler head escutcheon plate was immediately installed to the identified</p>	10/31/24	

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K 353	<p>Continued From page 11</p> <p>accordance with NFPA 25: 2011 Edition, Section 5.2.1.1.1 and B.) to maintain the sprinkler system by ensuring that the ceiling was smoke resistant and fire rated in accordance with NFPA 101: 2012 Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13: 2010 Edition, Section 6.2.7.1 and NFPA 25: 2011 Edition, Section 5.1, 5.2.2.1. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>Observations in the presence of the US FOIA (b)(6), revealed the following:</p> <ol style="list-style-type: none"> At 9:25 AM in the kitchen pass-through area, 1 of 1 sprinkler head escutcheon plates were not in place. At 10:26 AM in the first floor closet next to elevator room, 1 of 1 sprinkler head was covered with Styrofoam cup. At 10:00 AM in the second-floor housekeeping closet, there was a hole in the ceiling. At 10:34 AM in the kitchen, 4 of 15 sprinkler heads were green with a coating of oxidation. At 10:45 AM in the sprinkler room, 2 of 2 sprinkler spare head boxes had no wrench for emergency replacement of sprinkler heads. <p>In an interview at that time, the US FOIA (b)(6) confirmed the findings.</p> <p>The facility's US FOIA (b)(6) was notified of the deficient practice at the Life Safety Code exit conference at 4:15 PM.</p> <p>NJAC 8:39 - 31.1(c), 31.2(e)</p>	K 353	<p>sprinkler in kitchen pass-through area.</p> <p>The Styrofoam cup was immediately removed from the sprinkler head in the first floor closet next to the elevator room.</p> <p>The hole in the ceiling of the second-floor housekeeping closet was immediately fixed/corrected.</p> <p>NJ Ex Order 26.4(b)(1) (vendor) was immediately contacted and scheduled to repair/replace the 4 of 15 kitchen sprinkler heads found with green coating of oxidation.</p> <p>Wrenches were immediately placed for the 2 of 2 sprinkler spare head boxes in the identified sprinkler room for emergency replacement of sprinkler heads.</p> <p>Date of Completion: 09/13/24 (work to be completed on or before 10/31/24)</p> <p>How will the facility identify other residents who have potential to be affected by the same deficient practice</p> <p>All residents have the potential to be affected by this deficient practice. 22</p> <p>Date of Completion: 09/13/24</p> <p>What measures will be implemented to prevent the recurrence of the deficient practice</p> <p>All Maintenance staff to be educated by</p>	

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K 353	Continued From page 12 NFPA 13, 25	K 353	<p>the Staff Development Coordinator or designee on the contents of NFPA 101: 2012 Edition, Sections 5.2.1.1, 19.3.5.5.1, 4.6.12, 9.7 and NFPA 13: 2010 Edition, Section 6.2.7.1 and NFPA 25: 2011 Edition, Section 5.1, 5.2.2.1 to ensure the community (A) maintains all parts of the automatic fire sprinkler heads free from corrosion, and (B) maintains the sprinkler system by ensuring that the ceilings are smoke resistant and fire rated.</p> <p>Date of Completion: 10/11/24</p> <p>ow will the facility monitor to ensure the deficient practices do not occur</p> <p>All parts of the community automatic sprinkler heads, as well as ceilings will be inspected monthly for the next 3 months by the Plant Director or designee to ensure there are no further occurrences of corrosion, and that ceilings remain smoke resistant and fire rated in accordance with NFPA 101: 2012 Edition, Sections 5.2.1.1, 19.3.5.5.1, 4.6.12, 9.7 and NFPA 13: 2010 Edition, Section 6.2.7.1 and NFPA 25: 2011 Edition, Section 5.1, 5.2.2.1</p> <p>Results of the audits will be submitted to the monthly QAPI Committee. The committee will review the findings and make recommendations as appropriate.</p> <p>Date of Completion (inspections initiated): 10/11/24</p>		
K 355 SS=F	Portable Fire Extinguishers	K 355		10/11/24	

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K 355	<p>Continued From page 13 CFR(s): NFPA 101</p> <p>Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 09/12/2024 in the presence of US FOIA (b)(6) [REDACTED], it was determined that the facility failed to 1) ensure that 1 of 15 Fire extinguishers observed, pressure gauge reading, or indicator were in the operable range or position and 2) perform and document on the tag attached to the fire extinguisher, a monthly visual examination for 2 of 15 fire extinguishers in accordance with NFPA 101:2012 Edition, Section 19.3.5.12, 9.7.4.1 and NFPA 10:2010 Edition, Sections 7.2.2(3) and 7.2.3. These deficient practices had the potential to affect all residents and were evidenced by the following:</p> <p>An observation during the tour between 9:00 AM and 3:45 PM in the presence of US FOIA (b)(6), revealed the following:</p> <p>1) The fire extinguisher by room #664 pressure gauge reading was in the overcharge position posing a risk of rupture.</p> <p>2) The fire extinguisher in elevator room had no monthly inspection recorded on the tag. The tag year on it was from 2022.</p> <p>Additionally, the fire extinguisher in the laundry</p>	K 355	<p>How corrective actions will be accomplished for those residents affected by the deficient practice</p> <p>The fire extinguishers by room #664 and in the elevator room were immediately removed from service and replaced with properly charged and inspected extinguishers in accordance with NFPA 101: 2012 Edition, Section 19.3.5.12, 9.7.4.1, and NFPA 10: 2010 Edition, Sections 7.2.2(3) and 7.2.3. Laundry room extinguisher was inspected, recharged and signed appropriately.</p> <p>Date of Completion: 09/13/24</p> <p>How will the facility identify other residents who have potential to be affected by the same deficient practice</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>Date of Completion: 09/13/24</p> <p>What measures will be implemented to prevent the recurrence of the deficient</p>		

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

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K 355	Continued From page 14 room was last inspected and signed on 4/2024. In an interview at that time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) was informed of the deficient practices during the Life Safety Code exit conference at 4:15 PM. N.J.A.C 8:39-31.1(c), 31.2(e) NFPA 10	K 355	practice All Maintenance staff to be educated by the Staff Development Coordinator or designee on the contents of NFPA 101: 2012 Edition, Section 19.3.5.12, 9.7.4.1, and NFPA 10: 2010 Edition, Sections 7.2.2(3) and 7.2.3. to ensure (1) all fire extinguishers <input type="checkbox"/> pressure gauge readings / indicators are in the operable range and (2) that the community performs and documents monthly visual inspections Date of Completion: 10/11/24 How will the facility monitor to ensure the deficient practices do not occur Visual inspections of all 15 fire extinguishers including extinguishers housed in the laundry room will be conducted monthly for the next 3 months by the Plant Director or designee to ensure (1) all fire extinguishers <input type="checkbox"/> pressure gauge readings / indicators are in the operable range and (2) that the community performs and documents monthly visual inspections in accordance with NFPA 101: 2012 Edition, Section 19.3.5.12, 9.7.4.1, and NFPA 10: 2010 Edition, Sections 7.2.2(3) and 7.2.3. Results of the audits will be submitted to the monthly QAPI Committee. The committee will review the findings and make recommendations as appropriate. Date of Completion (inspections initiated): 10/11/24		

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K 362 SS=F	<p>Corridors - Construction of Walls CFR(s): NFPA 101</p> <p>Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code.</p> <p>Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames.</p> <p>If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area.</p> <p>19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 09/12/2024 in the presence of US FOIA (b)(6) [REDACTED], it was determined the facility failed to ensure that corridor walls were constructed to resist the passage of smoke in accordance with NFPA 101: 2012 Edition, Section 19.3.6.2 and 19.3.2.7. This deficient practice had the potential to affect residents and was evidenced by the following:</p> <p>An observation at 2:29 PM with the US FOIA (b)(6) [REDACTED], revealed a hole in the wall above the north hallway corridor door in the ceiling.</p>	K 362	<p>How corrective actions will be accomplished for those residents affected by the deficient practice</p> <p>The hole in the ceiling above the north hallway corridor door was immediately filled with fire rated sealant (fire block) to ensure all community corridor walls remain resistant to the passage of smoke.</p> <p>Date of Completion: 09/13/24</p> <p>How will the facility identify other residents who have potential to be affected by the</p>	10/11/24	

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K 362	Continued From page 16 In an interview at the time, the US FOIA (b)(6) confirmed the observation. The facility's U.S. FOIA (b)(6) was informed of the deficient practice during the Life Safety Code exit conference at 4:15 PM. N.J.A.C. 8:39-31.2(e)	K 362	same deficient practice All residents have the potential to be affected by this deficient practice. ¿¿ Date of Completion: 09/13/24 What measures will be implemented to prevent the recurrence of the deficient practice All Maintenance staff to be educated by the Staff Development Coordinator or designee on the contents of NFPA 101: 2012 Edition, Section 19.3.6.2 and 19.3.6.2.7 to ensure that corridor walls and ceilings remain resistant to the passage of smoke. Date of Completion: 10/11/24 How will the facility monitor to ensure the deficient practices do not occur Visual inspections of all corridor walls and ceilings will be conducted monthly for the next 3 months by the Plant Director or designee to ensure the community corridor walls remain resistant to the passage of smoke in accordance with NFPA 101: 2012 Edition, Section 19.3.6.2 and 19.3.6.2.7. Results of the audits will be submitted to the monthly QAPI Committee. The committee will review the findings and make recommendations as appropriate. Date of Completion (inspections initiated):		

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K 362	Continued From page 17	K 362			
K 511 SS=F	<p>Utilities - Gas and Electric CFR(s): NFPA 101</p> <p>Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interview on 09/12/2024 in the presence of US FOIA (b)(6) [REDACTED], it was determined that the facility failed to ensure that 2 of 2 gas boilers were equipped with a remote manual stop station in accordance with NFPA 101:2012 Edition, Section 9.5, 19.5.1. NFPA 54 National Fuel and Gas Code. NFPA 70 National Electric Code. This deficient practice has the potential to affect all residents and was evidenced by the following:</p> <p>An observation at 12:50 PM in the boiler room, revealed that 2 of 2 boilers were not equipped with a Remote Manual Emergency Stop Switch remote from the unit. There was an emergency stop located on the boiler that was not remote from the units to shut down in a catastrophic failure.</p>	K 511	<p>10/11/24</p> <p>How corrective actions will be accomplished for those residents affected by the deficient practice</p> <p>NJ Ex Order 26.4(b)(1) (vendor) was immediately contacted to schedule the installation of remote manual stop stations for 2 of 2 identified gas boilers in accordance with NFPA 101:2012 Edition, Section 9.5, 19.5.1 and NFPA 54 National Fuel and Gas Code and NFPA 70 National Electric Code.</p> <p>Date of Completion: 09/13/24 (work to be completed on or before 10/31/24)</p> <p>How will the facility identify other residents who have potential to be affected by the same deficient practice</p>	10/31/24	

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K 511	<p>Continued From page 18</p> <p>In an interview at the time of observation, the US FOIA (b)(6) confirmed the boilers were not equipped with a manual stop station that was remote from the units.</p> <p>The facility's US FOIA (b)(6) was informed of the deficient practice during the Life Safety Code exit conference at 4:15 PM.</p> <p>N.J.A.C 8:39-31.2(e) NFPA 54,70</p>	K 511	<p>All residents have the potential to be affected by this deficient practice. ¿¿</p> <p>Date of Completion: 09/13/24</p> <p>What measures will be implemented to prevent the recurrence of the deficient practice</p> <p>All Maintenance staff to be educated by the Staff Development Coordinator or designee on the contents of NFPA 101:2012 Edition, Section 9.5, 19.5.1 and NFPA 54 National Fuel and Gas Code and NFPA 70 National Electric Code to ensure that all equipment using gas or related gas piping or work to such equipment continues to comply with code.</p> <p>Date of Completion: 10/11/24</p> <p>How will the facility monitor to ensure the deficient practices do not occur</p> <p>Visual inspections of the gas boilers will be conducted monthly for the next 3 months by the Plant Director or designee to ensure that all equipment using gas or related gas piping or work to such equipment continues to comply with NFPA 101:2012 Edition, Section 9.5, 19.5.1 and NFPA 54 National Fuel and Gas Code and NFPA 70 National Electric Code.</p> <p>Results of the audits will be submitted to the monthly QAPI Committee. The committee will review the findings and make recommendations as appropriate.</p>		

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K 511	Continued From page 19	K 511	Date of Completion (inspections initiated): 10/11/24	
K 521 SS=F	<p>HVAC CFR(s): NFPA 101</p> <p>HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interview on 09/12/2024 in the presence of US FOIA (b)(6) [REDACTED] it was determined that the facility failed to ensure resident bathroom ventilation systems were adequately maintained and operating condition in accordance with the National Fire Protection Association (NFPA) 90 A. This deficient practice was identified for all residents in East and South wing room bathrooms observed and was evidenced by the following:</p> <p>Observations in the presence of the US FOIA (b)(6) [REDACTED] revealed that the ventilation in East and South wings for resident's bathroom was not functioning.</p> <p>The surveyor requested that the US FOIA (b)(6) [REDACTED] confirm if the units were functioning. When tested by placing a piece of single-ply toilet tissue paper</p>	K 521	<p>How corrective actions will be accomplished for those residents affected by the deficient practice</p> <p>All ventilation systems for resident rooms on the East and South wings were immediately inspected to determine the source of malfunction. Rooftop fans were found to be not functioning correctly, and replacement parts have been ordered to ensure bathroom ventilation is adequately maintained and operating properly in accordance with NFPA 90 A.</p> <p>Date of Completion: 10/11/24</p> <p>How will the facility identify other residents who have potential to be affected by the same deficient practice</p> <p>Residents of the East and South wings</p>	10/23/24

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K 521	Continued From page 20 across the ceiling grills, the tissue was not held in place by any suction. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. In an interview at the time, the US FOIA (b)(6) confirmed that the exhaust vents in the East and South resident room bathrooms were not functioning when tested. The facility's US FOIA (b)(6) was notified of the deficient practice at Life Safety Code survey exit conference at 4:15 PM. NJAC 8:39-31.2(e). NFPA 90 A.	K 521	have the potential to be affected by this deficient practice. <i>i.i</i> Date of Completion: 09/13/24 What measures will be implemented to prevent the recurrence of the deficient practice All Maintenance staff to be educated by the Staff Development Coordinator or designee on the contents of NFPA 90 A to ensure resident bathroom ventilation systems remain adequately maintained and operating properly. Date of Completion: 10/23/24 How will the facility monitor to ensure the deficient practices do not occur The bathroom ventilation systems on the East and South wings will be randomly tested monthly for the next 3 months by the Plant Director or designee to ensure the system functions properly in accordance with NFPA 90 A. Results of the audits will be submitted to the monthly QAPI Committee. The committee will review the findings and make recommendations as appropriate. Date of Completion (inspections initiated): 10/23/24		
K 531 SS=E	Elevators CFR(s): NFPA 101	K 531		10/11/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315445	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER ARBOR AT LAUREL CIRCLE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 MONROE STREET BRIDGEWATER, NJ 08807		
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K 531	Continued From page 21 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 09/12/2024 in the presence of US FOIA (b)(6) [REDACTED] it was determined that the facility failed to maintain elevator emergency communication telephones for 1 of 3 elevator telephones tested in accordance with ASME/ANSI A17.3. This deficient practice had the potential to affect all residents and was evidenced by the following: At 10:21 AM, the US FOIA (b)(6) [REDACTED] conducted a test of the emergency communication telephone system for elevator #8. The emergency telephone did not function when the button was activated.	K 531	How corrective actions will be accomplished for those residents affected by the deficient practice The elevator emergency communication telephone of the 1 of 3 identified areas was immediately corrected to function properly in accordance with ASME/ANSI A17.3 Date of Completion: 09/13/24 How will the facility identify other residents who have potential to be affected by the same deficient practice		

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K 531	Continued From page 22 In an interview at that time, the US FOIA (b)(6) confirmed the emergency communication telephone in elevator #8 did not function when tested. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code survey exit on at approximately 4:15 PM. NJAC 8:39-31.2(e) ASME/ANSI A17.3	K 531	All residents have the potential to be affected by this deficient practice. Date of Completion: 09/13/24 What measures will be implemented to prevent the recurrence of the deficient practice All Maintenance staff to be educated by the Staff Development Coordinator or designee on the contents of ASME/ANSI A17.3 to ensure the community maintains elevator emergency communication telephones and the system function properly. Date of Completion: 10/11/24 How will the facility monitor to ensure the deficient practices do not occur The elevator emergency communication telephones will be randomly tested monthly for the next 3 months by the Plant Director or designee to ensure the system functions properly in accordance with ASME/ANSI A17.3 Results of the audits will be submitted to the monthly QAPI Committee. The committee will review the findings and make recommendations as appropriate. ate of Completion (inspections initiated): 10/11/24		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		10/11/24	

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

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315445	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER ARBOR AT LAUREL CIRCLE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 MONROE STREET BRIDGEWATER, NJ 08807		
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K 918	Continued From page 23 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 9/11/2024 in the presence of the US FOIA (b)(6) s	K 918	How corrective actions will be accomplished for those residents affected		

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K 918	<p>Continued From page 24</p> <p>NJ Exec Order 26.4b1 [REDACTED], it was determined that the facility failed to ensure that the emergency and standby power generator diesel fuel quality was tested and maintained in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 8.3.8. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>A review of the facility's generator annual service report year 2024, provided by the [REDACTED] revealed no record on diesel fuel sample analysis test had been conducted. No further documentation was provided regarding diesel fuel sample analysis test had been conducted.</p> <p>In an interview at 11:20 AM, the [REDACTED] confirmed the findings.</p> <p>The facility's [REDACTED] was informed of the deficient practice at the Life Safety Code survey exit on 9/12/2024 at approximately 4:15 PM.</p> <p>NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110</p>	K 918	<p>by the deficient practice</p> <p>NJ Ex Order 26.4(b)(1) (generator vendor) was immediately contacted to schedule and conduct a diesel fuel quality test in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition), Section 8.3.8.</p> <p>Date of Completion: 09/13/24 (work to be completed on or before 10/07/24)</p> <p>How will the facility identify other residents who have potential to be affected by the same deficient practice</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>Date of Completion: 09/13/24</p> <p>What measures will be implemented to prevent the recurrence of the deficient practice</p> <p>All Maintenance staff to be educated by the Staff Development Coordinator or designee on the contents of</p> <p>NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition), Section 8.3.8 to ensure that emergency and standby power generator diesel fuel quality continues to be tested and maintained properly.</p> <p>In addition, the community has added diesel fuel quality inspections (annually) to its existing maintenance agreement with</p>		

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K 918	Continued From page 25	K 918	<p>Genserve Inc.</p> <p>Date of Completion: 10/11/24</p> <p>How will the facility monitor to ensure the deficient practices do not occur</p> <p>The emergency generator maintenance logs will be randomly audited monthly for the next 6 months by the Plant Director or designee to ensure that emergency and standby power generator diesel fuel quality continues to be tested and maintained properly in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition), Section 8.3.8.</p> <p>Results of the audits will be submitted to the monthly QAPI Committee. The committee will review the findings and make recommendations as appropriate.</p> <p>Date of Completion (inspections initiated): 10/11/24</p>		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315445	Y1	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	DATE OF REVISIT 11/19/2024	Y3
NAME OF FACILITY ARBOR AT LAUREL CIRCLE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 MONROE STREET BRIDGEWATER, NJ 08807		

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	10/11/2024	LSC K0225	10/11/2024	LSC K0324	10/11/2024
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	10/31/2024	LSC K0353	10/31/2024	LSC K0355	10/11/2024
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0362	10/11/2024	LSC K0511	10/31/2024	LSC K0521	10/23/2024
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # _____	Completed
LSC K0531	10/11/2024	LSC K0918	10/11/2024	LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/13/2024		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO 		