STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint NJ #: NJ 147719, NJ 150149, NJ 150832, NJ 151124, NJ 151993 Survey Date: 5/11/23 Census: 138 Sample: 27+5 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		6/23/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/01/2023

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility documents, it was determined that the facility failed to obtain consent from a resident representative prior to administering a NJ Exec. Order 26:4.b.1 for 1 of 5 residents (Resident #134) reviewed for NJ Exec. Order 26:4.b.1 This deficient practice was evidenced by the following: On 05/01/23 at 9:39 AM, the surveyor observed Resident #134 sitting in the day room during a	F 550	1. Resident #134 was assessed and found to have no ill effects as a result of receiving the NJ Exec. Order 26:4.b.1 Resident #134 had the consent for NJ Exec. Order 26:4.b.1 completed and signed for by two physicians as per facility policy. Date completed 6/9/23. 2. All NJ Exec. Order 26:4.b.1 residents have the potential to be affected	

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F 550	Continued From page 2 music activity. According to the Admission Face Sheet, Resident #134 had diagnoses which included, but were not to, NJ Exec. Order 26:4.b.1 . Further review of the Admission Face Sheet indicated the resident's son as the only next of kin and emergency contact. Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 01/11/23, included the resident had a Brief Interview for Mental Status score of [redacted] which indicated the resident's cognition was NJ Exec. Order 26:4.b.1, and that the resident NJ Exec. Order 26:4.b.1 [redacted] Further review of the MDS included that the resident's NJ Exec. Order 26:4.b.1 was [redacted] Review of the resident's NJ Exec. Order 26:4.b.1 care plan, dated 01/18/23, included, "Assessment of resident's [redacted] indicated by: Staff Assessment [redacted] and, "NJ Exec. Order 26:4.b.1 [redacted] Review of a NJ Exec. Order 26:4.b.1 progress note, dated 01/10/23, included, "ADMISSION NOTE: Social Worker met with Resident ... Upon admission, resident appeared alert, responsive and oriented x1, [he/she] NJ Exec. Order 26:4.b.1 [redacted] known. Resident has NJ Exec. Order 26:4.b.1 [redacted] Review of a NJ Exec. Order 26:4.b.1 progress noted, dated 01/10/23, included, "Barriers Impacting Treatment: NJ Exec. Order 26:4.b.1 and	F 550	Audit to be completed to identify residents with NJ Exec. Order 26:4.b.1 and no representation and who received the NJ Exec. Order 26:4.b.1. Audit Completed 5/29/23. No other residents noted to be NJ Exec. Order 26:4.b.1 with no representation Audit completed by ADON and/or Infection control nurse of all resident charts including those residents deemed to be NJ Exec. Order 26:4.b.1 and unable to sign their own consent for representative's signatures. Completed 5/29/2023 3. NJ Exec. Order 26:4.b.1 [redacted] f Residents policy reviewed by Administrator, DON, Infection control nurse and Medical Director and revised on 5/31/2023 to include any BIMs score between 8-10 will be reviewed by IDC team for ability to consent Education to be provided by the ADON to licensed nurses regarding Resident Rights i.e. appoint a legal representative of his/her choice, self-determination and the right to refuse treatment/medication/care. This Education was Completed on June 16, 2023 Education to be provided by the ADON to all licensed nurses regarding Immunizations i.e. eligibility and obtaining consents. This Education was Completed on June 16, 2023	

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F 550	Continued From page 3 NJ Exec. Order 26:4.b.1 ." Review of a nursing progress note, dated 02/05/23, included, "Resident received in room with roommate NJ Exec. Order 26:4.b.1. Around 5 pm two NJ Exec. Order 26:4.b.1 " Review of the NJ Exec. Order 26:4.b.1 Informed Consent, dated 03/24/23, revealed Resident #134 checked the box that indicated NJ Exec. and signed on the line designated for the resident/legal representative. Review of a nursing progress note, dated 03/30/23, included, "Resident received NJ Exec. Order 26:4.b.1 ." Review of the Quarterly MDS, dated 04/11/23, included the resident's NJ Exec. Order 26:4.b.1 was up to date. During an interview with the surveyor on 05/05/23 at 11:08 AM, Certified Nursing Assistant (CNA) #1 stated Resident #134 was NJ Exec. Order 26:4.b.1. During an interview with the surveyor on 05/05/23 at 11:10 AM, Licensed Practical Nurse (LPN) #8 stated Resident #134 was NJ Exec. Order 26:4.b.1. LPN #8 further stated that he was unsure if the resident could sign a consent because NJ Exec. Order 26:4.b.1 and that he would call the doctor to determine if the resident could	F 550	Education by DON to physicians and NPs of revision to th NJ Exec. Order 26:4.b.1 of Residents policy focusing on for those individuals who are unable to consent and do not have authorized representative, consent will be obtained by two (2) Physicians/ Nurse Practitioner who will be required to sign the consent form. This Education was Completed on June 21, 2023 4. Audit completed by ADON and/or Infection control nurse of all resident charts including those residents deemed to be NJ Exec. Order 26:4.b.1 and unable to sign their own consent for representative's signatures An audit will be completed by ADON or Infection control nurse weekly when new immunizations are administered. The audit will include any residents with BIM score less than NJ Exec Consents for NJ Exec. Order 26 4.b.1 will be obtained by the Infection control nurse/designees as per policy Results will be reported at quarterly QA meeting times 3 meetings.	

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F 550	Continued From page 4	F 550		

sign a consent.

During an interview with the surveyor on 05/09/23 at 10:47 AM, LPN #5 stated that if a resident was NJ Exec. Order 26:4.b.1 for themselves, the nurse should contact the resident's responsible party which was indicated on the Admission Face Sheet. LPN #5 further stated that Resident #134 was NJ Exec. Order 26:4.b.1 .

During an interview with the surveyor on 05/09/23 at 11:02 AM, LPN Unit Manager (UM) #1 stated that prior to administering a NJ Exec. Order 26 4.b.1, the nurse needs to obtain consent from the resident or resident representative. LPN UM #1 further stated that if the resident was unable to sign the consent and did not have a representative, the nurse would not administer the NJ Exec. Order 26:4.b LPN UM #1 then stated that Resident #134 was NJ Exec. Order 26:4.b and, "I think [he/she] could probably NJ Exec. Order 26 4.b.1 ."

On 05/09/23 at 11:12 AM, the surveyor observed the resident sitting with an activity aide. The resident stated he/she was unsure if he/she received any NJ Exec. Order 26 4.b.1 while at the facility, and when asked if the facility offered him/her any NJ Exec. Order 26 4.b.1 the resident stated, "I don't think so."

During an interview with the surveyor on 05/09/23 at 11:36 AM, the Infection Preventionist (IP) stated she oversaw resident NJ Exec. Order 26 4.b.1 and offered the NJ Exec. Order 26:4.b.1 to residents who are 65 years and older or high risk. The IP further stated that if a resident had a low BIMS score of 0 to 7, she would obtain consent from the resident's representative.

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F 550	Continued From page 5	F 550		

During an interview with the surveyor on 05/09/23 at 12:03 PM, Social Worker (SW) #1 stated a resident's BIMS score determines if the resident is "appropriate to weigh in on major decisions." SW #2, who was present in the room, added that residents with a BIMS score of "12" and under could not sign a consent because of impaired cognition. SW #1 further stated that if a resident was unable to sign a consent due to cognition, the facility would reach out the resident's representative which included the resident's next of kin. When asked about Resident #134, SW #1 stated that his/her NJ Exec. Order 26:4.b.1 and that the resident's only family on record NJ Exec. Order 26:4.b.1. SW #1 verified that the resident NJ Exec. Order 26:4.b.1 nd he/she did not have a resident representative.

During an interview with the surveyor on 05/09/23 at 12:39 PM, the Assistant Director of Nursing (ADON) stated that the nurse obtains consent prior to administering a NJ Exec. Order 26 4.b.1 and that the resident's cognition determines whether the resident can sign the consent themselves. The ADON further stated that if the resident was NJ Exec. Order 26:4.b.1, the nurse would reach out to the resident's next of kin.

During a follow up interview with the surveyor on 05/10/23 at 10:01 AM, the IP stated that she spoke with Resident #134 to obtain NJ Exec. Order 26 4.b.1 and not the resident's family. The IP further stated that she asked the nurses which residents can sign their own consents because she doesn't "spend a lot of time with the residents."

During an interview with the surveyor on 05/10/23

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F 550	Continued From page 6 at 12:50 PM, the Director of Nursing (DON) stated consents were obtained from the resident if the resident was alert and oriented. The DON added that if residents could not sign their own consent, the facility would call the resident's representative for consent. The DON further stated that Resident #134's cognitive status NJ Exec. Order 26:4.b.1 the resident NJ Exec. Order 26:4.b.1 representative to sign consents. During an interview with the surveyor on 05/11/23 at 9:43 AM, the Administrator stated Resident #134 NJ Exec. Order 26:4.b.1 to determine NJ Exec. Order 26 4.b.1 Review of the facility's policy titled NJ Exec. Order 26:4.b.1 f Residents," dated 08/01/21, included, "Informed consent requirements include education of risks, benefits, potential side-effects and medical contraindication. All residents and or their authorized representative will be informed by discussion," and, "For those individuals who are unable to consent and do not have authorized representative, consent will be obtained by two (2) Physicians who will be required to sign the consent form. The facility will review residents BIMS score and/or Psychological Evaluation prior to receiving consent."	F 550		
F 609 SS=E	NJAC 8:39 - 4.1(a)(4) Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		6/23/23

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F 609	Continued From page 7 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Complaint # NJ 150832 Based on interview, record review, and review of facility documents, it was determined that the facility failed to report an allegation of [redacted] to the New Jersey Department of Health (NJDOH) for 1 of 2 residents (Resident #193) reviewed for [redacted] This deficient practice was evidenced by the	F 609	1. Resident #193 has not been at the facility since [redacted]. . Nursing management in-serviced by the Administrator on reporting [redacted] to the Administrator or DON immediately on 5/12/2023 2. All residents have the potential to be affected. The DON/designee will audit all incident reports and the 24 hour report and/or progress notes for any documentation that may indicate an	

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F 609	Continued From page 8 following: According to the Admission Face Sheet, Resident #193 had diagnoses which included, but were not limited to, NJ Exec. Order 26:4.b.1 . Review of the resident's Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 12/15/21, included the resident had a Brief Interview for Mental Status score of NJ Exec. Order which indicated the resident's NJ Exec. Order 26:4.b.1 Review of the resident's Progress Note, written by Licensed Practical Nurse (LPN) #3, dated 12/25/21 at 10:42 PM, revealed, "at 9 pm this writer received a call from [Sergeant Name] from [Sheriff's Office] was made aware that [Resident #193's family member] was there with [Resident #193] making claims that [he/she] was being NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 " Upon request, the facility was unable to provide the surveyor with any Facility Reportable Events related to Resident #193. During an interview with the surveyor on 05/09/23 at 2:13 PM, the Assistant Director of Nursing (ADON) stated that if she was made aware of an allegation of NJ Exec. Order 26:4.b.1, the NJ DOH would be notified within one hour. The ADON further stated that the allegation reported by the sheriff's office was not reported to the NJDOH, "because it was an ongoing complaint of the resident's NJ Exec. Order 26:4.b.1 During an interview with the surveyor on 05/10/23	F 609	allegation of NJ Exec. Order 26:4.b.1, for the last 30 days to ensure any reportable that meets the state and federal regulations has been reported. 3. Review of NJ Exec. Order 26:4.b.1 policy and ensure that the policy aligns with state and federal guidelines. Reviewed by the Administrator and Director of Nursing and no revisions were needed Education to be provided to all employees by the ADON on Prevention/Prohibition of abuse, neglect, mistreatment, exploitation, injury of unknown sources and misappropriation of property to report immediately to Administrator and/or DON and to meet the 2-hour reporting regulation. This education was completed on June 16, 2023 4. DON or designee will review incident/accident reports, 24 hour report and/or progress notes for any documentation that may indicate an allegation of NJ Exec. Order 26:4.b.1, daily x 30 days, then 10% weekly for two months. Any discrepancies will be immediately investigated and reported to NJDOH as appropriate and re-education/counseling to specific staff as needed Any notifications of alleged NJ Exec. Order 26:4.b.1 will be reported to the NJDOH as per Federal regulation Result of the audits will reported at quarterly QA meetings x 3 meetings.	

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F 609	Continued From page 9	F 609		

at 12:50 PM, the Director of Nursing (DON) stated that if he was made aware of an allegation of [NJ Exec. Order 26], the NJ DOH would be notified within two to four hours if there was immediate harm, and within 24 hours if there was no immediate harm. When asked about Resident #193, the DON stated he did not work at the facility at that time and could not comment.

During an interview with the surveyor on 05/10/23 at 2:45 PM, the Administrator stated the allegation of [NJ Exec. Order 26] for Resident #193 was not reported to the NJDOH because "there was no allegation of [NJ Exec. Order 26]."

During a follow-up interview with the surveyor on 05/11/23 at 10:42 AM, the ADON verified there were no Facility Reportable Events for Resident #193 and stated, "to me, it was just a difficult family," and, "I didn't have anything specific to report to the NJDOH because there was no event or incident that occurred at the facility."

During a telephone interview with the surveyor on 05/11/23 at 10:55 AM, LPN #3 verified that she received a phone call from the police with an allegation of [NJ Exec. Order 26] for Resident #193 and reported it to the supervisor and ADON that day, 12/25/21. LPN #3 further stated that she believed this was the first [NJ Exec. Order 26] allegation made by the resident's family.

Review of the facility's policy titled, "Prevention/Prohibition of Abuse, Neglect, Mistreatment, Exploitation, Injury of Unknown Sources and Misappropriation of Property," revised 10/24/22, included, "Federal regulation requires the reporting of all alleged violations involving [NJ Exec. Order 26].. are reported to the department

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F 609	Continued From page 10 of health immediately, but not later than 2 hours after the allegation is made, if the events that cause allegation involve [NJ Exec. Order 1]... to the administrator and to other officials."	F 609		
F 610 SS=E	NJAC 8:39-9.4 (f) Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Complaint # NJ 150832 Based on interview, record review, and review of facility documents, it was determined that the facility failed to investigate an allegation of [NJ Exec. Order 1] for 1 of 2 residents (Resident #193) reviewed for	F 610	1. Resident #193 has not been at the facility since [NJ Exec. Order 26:4.b] An investigation was initiated on 5/12/23 and the facility concluded that the alleged [NJ Exec. Order 1] was unsubstantiated 2.	6/23/23

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F 610	Continued From page 11 NJ Exec. Order 26 This deficient practice was evidenced by the following: According to the Admission Face Sheet, Resident #193 had diagnoses which included, but were not limited to, NJ Exec. Order 26:4.b.1 . Review of the resident's Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 12/15/2021, included the resident had a Brief Interview for Mental Status score of NJ Exec. Order which indicated the resident's NJ Exec. Order 26:4.b.1 Review of the resident's Progress Note, written by Licensed Practical Nurse (LPN) #3, dated 12/25/21 at 10:42 PM, revealed, "at 9 pm this writer received a call from [Sergeant Name] from [Sheriff's Office] was made aware that [Resident #193's family member] was there with [Resident #193] NJ Exec. Order 26:4.b.1 Upon request, the facility was unable to provide the surveyor with any incident reports or investigations related to Resident #193. During an interview with the surveyor on 05/09/23 at 10:47 AM, LPN #5 stated that if she was made aware of an allegation of NJ Exec. Order 2, she would notify the supervisor and await further instruction on whether to complete an incident report. During an interview with the surveyor on 05/09/23 at 11:02 AM, LPN Unit Manager (UM) #1 stated	F 610	All residents have the potential to be affected. All incident reports for the last 30 days will be reviewed to ensure any reportable that meets the state and federal regulations has been reported and an investigation initiated. DON or designee will review 24 hour report and/or progress notes for any documentation that may indicate an allegation of NJ Exec. Order 2 and investigation will be initiated 3. Review of NJ Exec. Order policy and ensure that the policy aligns with state and federal guidelines. Reviewed by the Administrator and Director of Nursing and no revisions were needed Education to be provided by the DON to to licensed nurses on initiating an investigation on any allegations of NJ Exec. Order 26:4 This Education was Completed on June 16, 2023 Regional manager will education Administrator and DON on completing a thorough investigations including obtaining witness statements and writing a conclusion. This Education was Completed on June 21, 2023 Systematic change: the process for initiating an incident report and steps to be taken: a. The licensed nurses will initiate the incident report b. The licensed nurses will conduct a nursing assessment of the resident if appropriate to the incident and document findings in the resident□s medical record	

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F 610	Continued From page 12 that if she was made aware of an allegation of [NJ Exec. Order 26] she would notify the supervisor. LPN UM #1 further stated she would start an investigation and collect statements. During an interview with the surveyor on 05/09/23 at 2:13 PM, the Assistant Director of Nursing (ADON) stated that if she was made aware of an allegation of [NJ Exec. Order 26] she would immediately investigate and complete an incident report. The ADON further stated that the investigation would be submitted in a timely manner to the New Jersey Department of Health (NJDOH) upon conclusion. The ADON also stated that an investigation was done for allegations of [NJ Exec. Order 2] to determine whether the allegation is substantiated. During an interview with the surveyor on 05/10/23 at 12:50 PM, the Director of Nursing (DON) stated that if he was made aware of an allegation of [NJ Exec. Order 26] he would start an investigation which included obtaining statements from staff and residents, resident assessment, and implementing interventions based on the allegation. The DON further stated that allegations of [NJ Exec. Order 2] were investigated in order to "take care of the residents, keep them safe, and because of their right to be free from [NJ Exec. Order 26] During an interview with the surveyor on 05/10/23 at 2:45 PM, the Administrator stated the facility was aware of the allegation reported by the sheriff's office, but that an investigation was never completed because "it was an ongoing investigation throughout [his/her] stay." During a follow-up interview with the surveyor on 05/11/23 at 9:14 AM, the ADON verified there were no investigations related to Resident #193	F 610	c. The licensed nurses will notify the Director of Nursing/designee of the incident and initiation of the incident report d. The licensed nurses will notify the primary care provider of the incident and obtain orders for treatment if necessary e. The licensed nurses will notify the resident□s representative f. The licensed nurses will initiate an intervention(s) for prevention if appropriate to the incident g. The licensed nurses will obtain witness statements and resident statement if appropriate h. The licensed nurses will document the incident on the 24-hour report and communicate the information to the oncoming shift i. The licensed nurses will bring the incident report to the next morning meeting for team review j. The IDC Team will review and sign the incident report 4. All incident reports for past 30 days will be audited by DON/ designee for any allegations of abuse, neglect, misappropriation to ensure that a thorough investigation has been completed with witness statements and a conclusion, then 10% every 30 days for 2 months. Audit results will be reported at QAPI times 3 months then quarterly QA times 3. The facility will maintain a record of all incident reports and investigations, ensuring they are completed and reported	

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F 610	Continued From page 13 and stated, "it was an ongoing concern, but not an investigation." During a telephone interview with the surveyor on 05/11/23 at 10:55 AM, LPN #3 verified that she received a phone call from the police with an allegation of [NJ Exec. Order 2] for Resident #193 and reported it to the supervisor and ADON that day, 12/25/21. LPN #3 further stated that she believed this was the first [NJ Exec. Order 2] allegation made by the resident's family. Review of the facility's policy titled, "Prevention/Prohibition of Abuse, Neglect, Mistreatment, Exploitation, Injury of Unknown Sources and Misappropriation of Property," revised 10/24/22, included, "The facility shall conduct a thorough investigation of all alleged violation/sexual abuse involving mistreatment, neglect or abuse, including injuries of an unknown source and prevent further potential abuse while the investigation is in progress," and, "The results of all investigations must be completed and reported to the facility administrator and the NJDOH, if requested, within five (5) working days of the incident." Further review of the policy included, "All information obtained from the investigation must be maintained in the investigative file in the facility." NJAC 8:39-4.1(a)(5)	F 610	within the required timeframe. Any identified deficiencies or areas for improvement will be addressed promptly and corrective action will be taken to include re education of staff and/or counseling	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 658		6/23/23

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F 658	Continued From page 14 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to a.) document medication administered according to standards of practice for 1 of 3 residents (Resident #109), and b.) follow a physician's order as written for 1 of 5 residents (Resident # 69) reviewed for medications. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." On 05/02/23 at 8:19 AM, the surveyor observed LPN #7 as she prepared NJ Exec. Order 26:4.b.1 and administered them to Resident #109. At 8:33 AM, after Resident #109's medications were administered, LPN #7 returned to the medication cart and stated that she was going to prepare medications for the next resident. When the surveyor asked LPN #7 if she needed to document that she administered medications to	F 658	1. Resident #109 and Resident #69 were assessed and found to have no ill effects as a result of this deficiency. Resident #69 order was revised on 5/9/23 with parameters added to the medication administration record.2. 2. All residents who received medications have the potential to be affected All residents who have special indication and parameters for medications were audited to insure correct order entry. 3. The Administering Medication. Treatments policy was reviewed by DON and Medical Director and no revisions were needed Education provided by the ADON to all licensed nurses regarding medication administration according to standards of practice, especially signing medications after administering the medications. This Education was Completed on June 16, 2023 The ADON will educate all licensed nurses on order entry on the EMR specific to orders that have special indication and parameters. This Education was Completed on June 16, 2023 4. All licensed nurses will be observed by	

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F 658	Continued From page 15 Resident #109 she stated, "No, I already did." LPN #7 explained that as she poured each medication into the medication cup, she signed the resident's Electronic Medication Administration Record (eMAR) prior to administration. LPN #7 confirmed she documented Resident 109's NJ Exec. Order 26:4.b.1 as administered before entering the resident's room because she knew that the resident always took his/her medications. When asked what she would do if the resident declined a medication, LPN #7 stated that she would edit the entry and document that the resident refused. According to the Admission Face Sheet, Resident #109 was readmitted to the facility with diagnosis which included but were not limited to: NJ Exec. Order 26:4.b.1 Review of Resident #109's Quarterly Minimum Data Set (MDS), an assessment tool dated 02/26/23, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exe out of 15, which indicated that the resident's NJ Exec. Order 26:4.b.1 During an interview with the surveyor on 05/04/23 at 11:44 AM, LPN/Unit Manager (UM) #2 stated that nursing was required to sign out medications after they were administered in case the resident refused. During an interview with the surveyor on 05/09/23 at 10:25 AM, the Director of Nursing (DON) stated that nursing was supposed to document medication administration after the resident was observed to have taken the medications in the	F 658	June 21, 2023 with a med pass competency by the ADON/designee and then annually thereafter. Any discrepancies will be corrected immediately through reeducation and/or counseling The DON/Designee will audit all new physician orders daily x 30 days to ensure special indications and parameters are entered correctly. Any discrepancies will be corrected immediately through reeducation and/or counseling Results will be reported at quarterly QA x 3 meetings.	

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F 658	Continued From page 16	F 658		

event that the resident refused.

On 05/10/23 at 9:09 AM, the Assistant Director of Nursing (ADON) provided the surveyor with a Medication Pass Audit Tool (MPAT) that was completed for LPN #7 on 02/16/23. Review of the MPAT revealed that section VIII (eight) Charting and Documentation specified the following: Initials Medication Administration Record (MAR) immediately after administration, to which the observer documented that LPN #7 successfully completed at the time of observation.

Review of the facility policy titled, "Administering Medications/Treatment" (Revision Date 08/15/22) revealed the following: The individual administering the medication/treatment must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones.

2. According to the Admission Face Sheet, Resident #69 was admitted to the facility in [redacted] with diagnoses which included but were not limited to; NJ Exec. Order 26:4.b.1 [redacted]

Review of Resident #69's Significant Change MDS assessment, dated 3/9/2023, indicated the resident had active diagnoses that included, but were not limited to NJ Exec. Order 26:4.b.1 [redacted]

Review of the resident's Physician's Order Form

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F 658	Continued From page 17 indicated Resident #69 had a physician order, dated 6/3/22, which read NJ Exec. Order 26:4.b.1 [redacted] Review of the April 2023 and May 2023 Medication Administration Record (MAR) for Resident #69 revealed the NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 for NJ Exec. Order 26:4.b.1 were not located on the MAR. On 5/9/23 at 11:16 AM the surveyor reviewed Resident #69's physicians order and the resident's April and May 2023 MAR with LPN UM #2. LPN UM #2 confirmed the NJ Exec. Order 26:4.b.1 order included NJ Exec and NJ Exec. Order 26:4.b.1, but the parameters were not on the April and May 2023 MAR. LPN UM #2 confirmed the resident's NJ Exec and NJ Exec. Orde were not recorded when NJ Exec. Order 26:4.b.1 was administered. LPN UM #2 stated "it was a glitch" that caused the parameters not to show up on the MAR and she had to clarify the orders with the physician. LPN UM #2 further stated the nurses would not know about the parameters when administering the medication since they could not see them and it could have been that the parameters option was not activated when the order was entered. LPN UM #2 acknowledged that the physician's order should have been transcribed correctly and would call the physician to clarify the NJ Exec. Order 26:4.b.1 order. On 5/10/23 at 2:09 PM, the surveyor informed the Administrator, Director of Nursing, and Assistant Director of Nursing (ADON) about the above concerns.	F 658		

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F 658	Continued From page 18 Review of the undated facility's policy titled, "Medication Orders" revealed under Recording Orders: "1. Medication Orders - When recording orders for medication, specify the type, route, dosage, frequency and strength of the medication ordered." The policy did not address medication physician orders that had special indications, such as, parameters. NJAC 8:39-11.2 (b); 27.1(a)29.2(d)	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure that a resident received NJ Exec. Order 26:4.b.1 as prescribed by the physician for 1 of 1 resident (Resident #13) reviewed for NJ Exec. Order 26:4.b.1 The deficient practice was evidenced by the following: On 04/26/23 at 10:22 AM, the surveyor observed Resident #13 in bed wearing a NJ Exec. Order 26:4.b.1). The surveyor observed that the NJ Exec. Order 26:4.b.1 was	F 695	1. Resident #13 was assessed and found to have no ill effects as a result of the deficiency. The NJ Exec. Order 26:4.b.1 was adjusted to proper setting on 5/1/23 2. All residents requiring NJ Exec. Order 26:4.b.1 were audited to ensure the NJ Exec. Order 26 was set at correct parameters 3. Review policy for NJ Exec. Order 26:4.b.1 ensuring compliances with state and	6/23/23

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F 695	Continued From page 19 connected to an NJ Exec. Order 26:4.b.1 that was set to NJ Exec. Order 26:4.b.1 . On 05/01/23 at 09:57 AM, the surveyor observed Resident #13 lying in bed with their eyes closed. The surveyor observed that the resident was wearing the NJ Exec. Order 26:4.b.1 and that the NJ Exec. Order 26 [redacted] On 05/01/23 at 11:40 AM, the surveyor observed Resident #13 lying in bed with the head of the bed elevated, wearing the NJ Exec. Order 26:4.b.1 and that their NJ Exec. Order 26:4.b.1 . The surveyor observed that the resident was leaning towards her right side and the NJ Exec. Order 26 [redacted] r was located on the floor on the resident's left side. At that time, Resident #13 stated that he/she had been using NJ Exec. Order 26 and that he/she thought the NJ Exec. Order 26:4.b.1 [redacted] The Licensed Practical Nurse (LPN #1) was in the resident's room at the time and confirmed that the NJ Exec. Order 26:4.b.1 was set at NJ Exec. Order 2 . LPN #1 stated that he would check the physician's orders. During an interview with the surveyor on 05/01/23 at 11:46 AM, LPN #1 stated that Resident #13's NJ Exec. Order 26:4.b.1 should have been NJ Exec. Order 26 [redacted] LPN #1 further stated "I don't know why the NJ Exec. Order 26 [redacted] was set at NJ Exec. Order 2 . [Resident #33] is my patient today and I should have known what [Resident #33 NJ Exec. Order 26:4.b.1 should have been set on." According to the Admission Record, Resident #33 was admitted to the facility with diagnoses which included, but were not limited to, NJ Exec. Order 26 4.b.1 [redacted] (a group of diseases that cause	F 695	federal regulations. Reviewed by the Director of Nursing and Medical Director and no revisions were needed Education to be provided by the ADON to all licensed nursing staff regarding NJ Exec. Order 26 [redacted] and correct parameters according to healthcare provider order. This education was completed on June 16, 2023 Nurse manager/designee will round daily to ensure NJ Exec. Order 26 4 is delivered as ordered times 30 days then weekly times 2 months Nurse manager/designee will check provider orders on residents NJ Exec. Order 26 times weekly x 90 days. 4. All residents requiring NJ Exec. Order 26 4.b.1 will be audited by DON/designee for proper settings based on healthcare provider orders weekly x 30 days then monthly for 2 months. Any discrepancies will be corrected immediately by adjusting the NJ Exec. Order 26:4.b.1 , reeducation and/ counseling Results will be reported during quarterly QA x 3	

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F 695	Continued From page 20	F 695		

NJ Exec. Order 26:4.b.1

Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 03/23/23, indicated that Resident #13 had a Brief Interview for Mental Status score of [redacted] out of 15, which indicated that the resident was NJ Exec. Order 26:4.b.1. The MDS also revealed that Resident #13 used NJ Exec. Order 26:4.b.1, that they needed NJ Exec. Order 26:4.b.1 from [redacted] staff members to NJ Exec. Order 26:4.b.1 [redacted]) and did not [redacted] in their room during the assessment window of the MDS.

Review of the Physician's Order Form indicated that Resident #13 had an active physician order for NJ Exec. Order 26:4.b.1 [redacted] dated 03/01/23.

Review of the Pulmonary Care Plan indicated that Resident #13 had an intervention, dated 02/28/23, of 'NJ Exec. Order 26:4.b.1 [redacted] "

Review of the April and May 2023 Treatment Administration Record (TAR) revealed that nurses signed every shift from 04/26/23 to 05/01/23 that Resident #13 received NJ Exec. Order 26:4.b.1 continuously.

During an interview with the surveyor on 05/02/23 at 11:16 AM, LPN #4 stated that when a resident was ordered [redacted] the nurse should check the physicians order and the TAR for the correct [redacted] of [redacted] During the nurse's rounds of the residents, the nurse should check that the [redacted]

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F 695	Continued From page 21 is NJ Exec. Order 26:4.b.1 as ordered. During an interview with the surveyor on 05/04/23 at 11:06 AM, Licensed Practical Nurse Unit Manger (LPN UM) #1 stated that the nurses should check the physician's order for NJ Exec. Order 26 and check that the NJ Exec. Order 26:4.b.1 was set on the NJ Exec. Order 26:4.b.1 when they made their resident's rounds. During an interview with the surveyor on 05/04/23 at 12:106 PM, the Director of Nursing (DON) stated that the nurses should check the physician's order for NJ Exec. Order 26 and make sure that the correct NJ Exec. Order 26:4.b.1 is set on the NJ Exec. Order 26 [redacted] when making their resident's rounds. The DON further stated that the NJ Exec. Order 26 [redacted] should have been set to the physician's ordered NJ Exec. Order The facility policy titled, "NJ Exec. Order 26:4.b.1" with a revised date of 09/17/22, indicated under Preparation to "Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for NJ Exec. Order 26 [redacted]	F 695		
F 698 SS=E	NJAC 8:39-27.1 (a) Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 698		6/23/23

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F 698	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of the medical record and other facility documentation, it was determined that the facility failed to: a.) provide a snack bag to send with the resident on scheduled dialysis (the clinical purification of blood, as a substitute for normal kidney function) days and b.) coordinate medication administration times with scheduled dialysis days. This deficient practice was identified for 1 of 1 resident (Resident #48) reviewed for [redacted] and was evidenced by the following: On 04/28/23 at 12:23 PM, the surveyor observed Resident #48 lying in bed awake. When interviewed, the resident stated that he/she went to [redacted] every Tuesday, Thursday and Saturday at 5:30 AM. The resident explained that since the [redacted] changed from 10:30 AM to 5:30 AM, the facility failed to consistently send a snack such as a peanut butter and jelly sandwich to be eaten at the [redacted] and the resident had to resort to snacks brought in by family members such as goldfish crackers. The resident stated that he/she also had not received any medications prior to going to [redacted] The resident further stated that his/her medications that were scheduled at 9 AM were administered at 12:00 PM when the resident returned from [redacted]. The resident was reportedly unable to recall when the [redacted] time change had occurred. Review of Resident #48's Admission Face Sheet (an admission summary) revealed that the resident was readmitted to the facility in [redacted] diagnosis which included but were not	F 698	1. Resident #48 was assessed and found to have no ill effects as a result of this deficiency. A dietary communication notice was sent to dietary department on 5/4/23 notifying them of Resident #48□s schedule change. Medication administration times were adjusted for Resident #48 on 5/5/2023. 2. All [redacted] residents have the potential to be affected. All [redacted] residents were audited for medication administration times coordinated with [redacted] and if appropriate a lunch and or snack was sent with resident 3. Care of a resident with End Stage Renal Disease Policy and Drug Regimen review were reviewed by DON and Medical Director with no changes needed Education will be provided by the ADON to licensed nurses on ensuring residents going out to [redacted] receive their medications or are coordinated around their [redacted] times. This Education was Completed on June 16, 2023 Education by DON to nursing management staff on the process of the Drug regimen review. 1. Drug regimen reviews are emailed to DON by pharmacy consultant	

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F 698	Continued From page 23 limited to: NJ Exec. Order 26:4.b.1 [redacted] Review of Resident #48's Quarterly Minimum Data Set (MDS), an assessment tool dated 04/04/23, revealed the resident's memory was described as NJ Exec. Order 26:4.b.1 identified. Review of Resident #48's Care Plan Report revealed a NJ Exec. Order 26:4.b.1 dated 04/26/23, which indicated that resident received [redacted] on Tuesday, Thursday and Saturday and had a pickup time of 5:30 AM. Review of Resident #48's Physician's Orders revealed an order dated 04/24/23, which indicated that the resident NJ Exec. Order 26:4.b.1 on Tuesday, Thursday and Saturday at 5:00 AM. Review of Resident #48's Medication Administration Record (MAR) for the month of April 2023 contained within the electronic health record (EHR) revealed that the resident was ordered the following medications on scheduled NJ Exec. Order 26 4.b.1 Tuesday, Thursday, and Saturday: NJ Exec. Order 26:4.b.1 [redacted] he medication was documented as not administered as evidenced by the letter X contained within a circle on the entry on the following dates: 04/01/23, 04/04/23, 04/08/23,	F 698	2. DON will make copies and distribute to nurse managers and/or nurse management 3. Nurse managers/nurse management will notify health providers to obtain verbal orders according to recommendations 4. Completed Drug Regimen will be returned to DON within 7 days for review 5. DON will reconcile any outstanding Drug Regimen reviews for completion This Education was Completed on June 21, 2023 NJ Exec. Order 26:4.b.1 residents snack bags will be brought to the units the evening prior to their scheduled [redacted] day. Dietary to have nursing sign for receipt of snack bags. Nursing will notify dietary of any NJ Exec. Order 26:4.b.1 schedule changes within 24 hours of receiving notification from [redacted] A checklist will be created by DON that includes snack, [redacted] book and required items needed to for the resident to go to [redacted] This checklist will be completed by the licensed nurse before the resident leaves for [redacted] The Checklist was created June 16, 2023 4. [redacted] check sheets will be reviewed daily by the DON/designee for accuracy to include coordination of medication times and lunch/snack if appropriate for 3 months. Any discrepancies will be corrected by reeducation /counseling. Findings will be reported at monthly QAPI times 3 months then quarterly QA times 3.	

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04/13/23, 04/15/23, 04/18/23, 04/22/23, 04/25/23, 04/27/23 and 04/29/23.

NJ Exec. Order 26:4.b.1 at 09:00 AM and 09:00 PM. NJ Exec. Order 26:4.b.1). The medication was documented as not administered as evidenced by the letter X contained within a circle on the entry on the following dates: at 09:00 AM on 04/01/23, 04/04/23, 04/08/23, 04/13/23, 04/15/23, 04/18/23, 04/22/23, 04/25/23, 04/27/23, and 04/29/23.

NJ Exec. Order 26:4.b.1 . The medication was documented as not administered as evidenced by the letter X contained within a circle on the following dates: 04/01/23, 04/04/23, 04/08/23, 04/13/23, 04/15/23, 04/18/23, 04/22/23, 04/25/23, 04/27/23, 04/29/23.

NJ Exec. Order 26:4.b.1 . The medication was documented as not administered as evidenced by the letter X contained within a circle on the following dates: at 09:00 AM on 04/01/23, 04/04/23, 04/08/23, 04/13/23, 04/15/23, 04/18/23, 04/22/23, 04/25/23, 04/27/23, 04/29/23.

NJ Exec. Order 26:4.b.1). The medication was documented as not administered as evidenced by the letter X contained within a circle on the following dates: 04/01/23, 04/04/23, 04/08/23, 04/13/23, 04/15/23, 04/18/23, 04/22/23, 04/25/23, 04/27/23, and 04/29/23.

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NJ Exec. Order 26:4.b.1 at 08:00 AM, 12:00 PM and 5:00 PM (NJ Exec. Order 26:4.b.1) Give with Meals. The medication was documented as not administered as evidenced by the letter X contained within a circle on the following dates: at 08:00 AM on 04/01/23, 04/04/23, 04/06/23, 04/08/23, 04/13/23, 04/15/23, 04/18/23, 04/22/23, 04/25/23, 04/27/23, and 04/29/23.

NJ Exec. Order 26:4.b.1 The medication was documented as not administered as evidenced by the letter X contained within a circle on the following dates: 04/01/23, 04/04/23, 04/08/23, 04/13/23, 04/15/23, 04/18/23, 04/22/23, 04/25/23, 04/27/23 and 04/29/23.

NJ Exec. Order 26:4.b.1

NJ Exec. Order 26:4.b.1

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The medication was documented as not administered as evidenced by the letter X contained within a circle on the following dates: on 04/01/23, 04/04/23, 04/06/23, 04/08/23, 04/11/23, 04/13/23, 04/15/23, 04/18/23, 04/20/23, 04/22/23, 04/25/23, 04/27/23, and 04/29/23.

NJ Exec. Order 26:4.b.1 at 10:00 AM. The NJ Exec. Order 26 4.b.1 was documented as not administered as evidenced by the letter X contained within a circle on the following dates: on 04/01/23, 04/04/23, 04/06/23, 04/08/23, 04/13/23, 04/15/23, 04/18/23, 04/22/23, 04/27/23, and 04/29/23.

On 05/11/23 at 11:30 AM, the Director of Nursing (DON) provided the surveyor with documented evidence (computer screen shots) that Resident #48 did not receive scheduled dosage (s) of NJ Exec. Order 26:4.b.1 on Tuesday, Thursday, and Saturday before NJ Exec. Order 26:4 at 9:00 AM and the rationale that was provided on the electronic (e) MAR/Treatment Administration Record (TAR) was: "Out for NJ Exec. Order 26:4.b" on the following dates: 01/17/23, 02/02/23, 02/11/23, 02/16/23, 03/07/23, 03/28/23, 04/08/23, 04/27/23, 05/02/23, and 05/04/23.

Review of Resident #48's NJ Exec. Order 26:4 Communication Book which contained NJ Exec. Order 26:4 Communication Sheets dated 04/01/23, 04/04/23, 04/06/23, 04/08/23, 04/11/23, 4/15/23, 04/18/23, 04/20/23, 04/25/23, 04/27/23 and 04/29/23 indicated that the resident had not eaten at the facility or received any documented medications prior to scheduled NJ Exec. Order 26:4.b.1.

During an interview with the surveyor on 05/03/28

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at 11:29 AM, the Food Service Director (FSD) stated that the nursing units were responsible to notify the kitchen of any changes in the resident's [redacted]. The FSD stated that the kitchen did not open until 06:00 AM, and if a lunch bag were needed at an earlier time, the kitchen sent a peanut butter and jelly sandwich to the nursing unit the night before. The FSD provided the surveyor with a [redacted] which indicated that Resident #48 attended [redacted] on Tuesday, Thursday and Saturday and had a 10:30 AM pick up time.

During a later interview with the surveyor on 05/03/23 at 1:52 PM, the FSD stated that while he needed to update some of the names of residents on the [redacted], the scheduled times that were provided were accurate. The surveyor questioned why the schedule listed a pickup time of 10:30 AM which did not coincide with Resident #48's reported pickup time of 5:00 AM, to which the FSD did not have an immediate response. At 2:33 PM, the FSD provided the surveyor with an updated list of [redacted] Residents which revealed that the resident's pick-up time was at 4:15 AM. The FSD stated that he previously mistakenly provided the surveyor with an outdated list.

During an interview with the surveyor on 05/04/23 at 10:53 AM, Licensed Practical Nurse (LPN) #9 stated that he was assigned to Resident #48 and confirmed that the resident had left for [redacted] at 5:00 AM. LPN #9 stated that the resident was a [redacted] and the overnight shift sent a lunch bag with the resident to [redacted].
At that time, LPN #9 stated that Resident #48 was scheduled for the following medications at 9:00 AM that he signed out as not given, with the rationale "resident [redacted],

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NJ Exec. Order 26:4.b.1 [redacted]. LPN #9 stated that he was only permitted to administer medications one hour before or one hour after the scheduled medication time of 9:00 AM and indicated that the medications would not be administered during his shift (7:00 AM to 3:00 PM).

During an interview with the surveyor on 05/04/23 at 11:08 AM, Licensed Practical Nurse/Unit Manager (UM) #2 stated that the kitchen provided a snack for Resident #48 in a bag that was labeled with the resident's name and dated and left at the receptionist desk. LPN/UM #2 stated that whoever received notification that the resident's NJ Exec. Order 26:4.b.1 changed was responsible to complete a Dietary Communication Form to alert the kitchen of the change. LPN/UM #2 reviewed the Dietary Communication Book in the presence of the surveyor and the Unit Clerk which failed to contain documented evidence that the kitchen was notified of the change in Resident #48's NJ Exec. Order 26:4.b.1. LPN/UM #2 stated that she had to check and see when the resident's NJ Exec. Order 26:4.b.1 changed to determine why the resident had not received his/snack as required.

At that time, LPN/UM #2 stated that Resident #48's medications should have already been plotted to be administered later when the resident returned from NJ Exec. Order 26:4 according to the resident's NJ Exec. Order 26:4.b.1. The surveyor asked LPN/UM #2 to view the MAR within in the electronic health record (EHR) in the presence of the surveyor. LPN/UM #2 reviewed the MAR and stated that the following 9:00 AM medications should have been ordered to have been administered at another time when Resident #48 was available:

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NJ Exec. Order 26:4.b.1

LPN/UM #2 stated that the resident's NJ Exec. Order 26:4 hanged more than one month ago. LPN/UM #2 stated that she received the Consultant Pharmacist Recommendations via e-mail monthly to change the resident's medications according to the resident's NJ Exec. Order 26: but the recommendation was not clear.

During an interview with the surveyor on 05/04/23 at 1:36 PM, the FSD stated that he was notified of NJ Exec. Order 26:4.b.1 changes via "pink slips" or Dietary Communication Forms. At 1:51 PM, the FSD provided the surveyor with a Dietary Communication Form for Resident #48 dated 05/04/23 that was signed by LPN/UM #2 and specified: Provide snack bag NJ Exec. Order 26:4.b pick-up time is 5 AM. The FSD stated that he was not notified that Resident #48's schedule changed from 10:30 AM to 5:00 AM until today (5/4/23).

During an interview with the surveyor on 05/05/23 at 10:27 AM, the Consultant Pharmacist (CP) stated that in December 2022, February, March and April of 2023 she made recommendations for the facility to hold Resident #48's medications during NJ Exec. Order 26:4 and administer them upon return to the facility. The CP stated that the medications times needed to be adjusted.

During an interview with the surveyor on 05/05/23 at 11:11 AM, LPN #2 stated that she began working at the facility on 12/19/22, and Resident #48 had been on the 4:15 AM pick-up time since she was hired. LPN #2 stated that she signed the resident's medications out as not given, with the rationale of resident NJ Exec. Order 26:4.b.1. LPN #2 stated

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that she administered the resident's [NJ Exec. Order 26:4.b.1] medications at noon when the resident returned to the facility. LPN #2 further stated that the medication schedule was changed to reflect the resident's current [NJ Exec. Order 26:4.b.1] when she arrived at work today.

During an interview with the surveyor on 05/09/23 at 10:12 AM, the Director of Nursing (DON) stated he was not aware that the CP made the recommendation to adjust the resident's medications to accommodate the [NJ Exec. Order 26:4] in December of 2022, February, March and April of 2023. The DON stated, "all medications should be adjusted around [NJ Exec. Order 26:4.b.1] in order to maintain therapeutic levels and ensure that the medications were not [NJ Exec. Order 26:4.b.1])."

At that time, the surveyor asked the DON what the process was for Resident #48 to receive a snack bag once his/her [NJ Exec. Order 26:4.b.1] changed? The DON stated that a dietary slip should have been sent to the kitchen by the nurse or UM. The DON stated that if the snacks were not provided the resident was not getting the nutrients that he/she needed to [NJ Exec. Order 26:4.b.1]

On 05/10/23 at 9:34 AM, the DON provided the surveyor with a sticky note which indicated that Resident #48's [NJ Exec. Order 26:4.b.1] changed to 5 AM on 12/12/22.

During an interview with the surveyor on 05/10/23 at 9:34 AM, LPN #10 stated that she worked at the facility since 11/22. LPN #10 stated that she never saw the facility send a snack bag to the unit for the Resident #48 since she began working

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F 698	Continued From page 31 there until 05/09/23. LPN #10 further stated that the kitchen sent a snack bag up to the unit on 05/09/23, and she forgot to give it to the resident. Review of the facility policy titled, "Care of a Resident with End-Stage Renal Disease" (Revision Date 09/05/2018) revealed the following: ...Staff caring for residents with ESRD (end-stage renal disease), including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. Education and training of staff includes, specifically: The nature and clinical management of ESRD (including infection prevention and nutritional needs) ...Timing and administration of medications, particularly those before and after dialysis ... Review of the facility policy titled, "Drug Regimen Review" (Reviewed 06/17/22) revealed the following: Drug regimen reviews that require physician intervention will be responded to by the physician/designee in a timely manner but no later than the next 30/60 day physician visit.	F 698		
F 711 SS=D	NJAC 8:39-27.1(a)(b) Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this	F 711		6/23/23

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F 711	Continued From page 32 section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 151993 Based on interviews and review of the closed medical record, it was determined that the facility physician failed to have a face to face visit for a resident who was [redacted] to the [redacted] on [redacted] and did not return. This deficient practice was identified for 1 of 4 residents (Resident #192) reviewed for [redacted]. This deficient practiced was evidenced by the following: Review of Resident #192's Face Sheet revealed that the resident was admitted to the facility in [redacted] with diagnosis which included but were not limited to: [redacted] Review Resident #192's Admission Minimum Data Set (MDS), an assessment tool dated 01/14/21, revealed that the resident's memory was described [redacted] and the resident had [redacted] Further review of the MDS revealed that the resident was [redacted] and required [redacted] and [redacted].	F 711	1. Resident #192 is no longer in the facility as of [redacted] 2. All residents have the potential to be affected. The DON will review all resident charts in the facility for the last 60 days to ensure there was a face to face visit by the physician for an admitting history and physical, progress notes and signed physician orders. This Audit was completed on June 9, 2023 3. The policy on physician services was reviewed by Director of Nursing and Medical Director and no revisions were needed Education to be done by DON to the physicians on Physician Services to ensure a face to face visit is completed after admission/readmission, progress notes are present and the physician orders have been signed, according toe NJDOH and federal regulations. This	

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F 711	Continued From page 33 Review of Resident #192's Clinical Notes dated 01/07/21 at 6:30 PM, revealed that the resident was transferred to the facility from an [redacted] at 6:30 PM via [redacted] with diagnosis which included NJ Exec. Order 26:4.b.1 [redacted]. The resident was described as being NJ Exec. Order 26:4.b.1 [redacted] The writer documented that the resident's physician was notified and all orders were verified and approved. The surveyor reviewed the Resident #192's closed record which failed to contain a history and physical or physician progress notes to validate that the resident had received a face to face assessment with the attending physician or medical doctor. Further review of Resident #192's closed record revealed a fax cover sheet dated 01/13/21, that was sent to the attending physician by LPN/UM #3, with the following message notated: [redacted] Review of Resident #192's 2021 Physician's Orders for the both January and February 2021 were not signed by the physician in the space provided. Further review of the Physician's Orders revealed that the attending physician provided telephone orders to the nursing staff on 01/14/21, 01/30/21, 02/05/21 and 02/08/21. Additional review of the Physician's Orders revealed a telephone order dated 02/08/21 that was not timed, written by LPN #11, to send the	F 711	Education was Completed on June 21, 2023 DON to educate nursing managers on how to audit physician visits on medical record and to notify DON when a physician visit has not been completed. This Education was Completed on June 21, 2023. DON will notify Medical Director as needed 4. DON/ designee will audit all new admissions to ensure H&P is completed within 48 hours x 30 days then 10% x 20 months. Any discrepancies will be corrected immediately by notification to physician for face to face visit DON/Designee will audit for physician progress notes and signed orders monthly x 3 months. Any discrepancies will be corrected immediately by notification to physician for face to face visit Audit results to be reported at quarterly QA x 3 meetings	

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resident to the NJ Exec. Order 26:4.b.1 [redacted]

Review of Resident #192's Clinical Notes revealed an entry that was written by LPN #11 on 02/08/21 at 3:00 PM, which revealed that Resident #192 was noted to be NJ Exec. Order 26:4.b.1 [redacted] and requested to go to NJ Exec. Order 26:4.b.1. The physician was made aware. At 9:00 PM, the resident was transported by NJ Exec. Order 26 4.b.1 to the NJ Exec. RN #1 documented that the resident's physician was notified of the resident transfer.

During a telephone interview with the surveyor on 05/05/21 at 11:50 AM, the physician whose name appeared in Resident #192's closed record as the attending physician, stated that he did not remember the resident and would have to review his records.

On 05/05/23 at 2:16 PM, the attending physician phoned the surveyor and left a voice message which revealed that he reviewed the facility's records and confirmed that he was not assigned to Resident #192 and did not complete a history and physical for the resident. He stated that the current Medical Director was assigned to the resident and he suggested that the surveyor contact him to obtain the resident's history and physical.

During a telephone interview with the surveyor in the presence of the survey team on 05/09/23 at 11:19 AM, the Medical Director (MD) stated he was not assigned to Resident #192 and confirmed that it was the attending physician whose name appeared within the resident's closed record. The MD stated that when he

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reviewed a chart, he saw that the attending physician was not seeing his residents on a monthly basis. The MD stated that he informed both the physician and the administrator. The MD confirmed that the attending physician was required to come into the facility to see the resident within 48 hours of admission and then on a monthly basis there after. The MD stated that the attending physician claimed that he documented notes in his own records, but not in the onsite documentation as required. The MD stated that the resident's History and Physical should have been completed by the assigned attending physician timely.

During an interview with the surveyor on 05/09/23 at 2:09 PM, the Administrator stated that he began working at the facility in August of 2021. The Administrator stated that Resident #192's History and Physical should have been completed within 48 hours of admission. The Administrator further stated that a physician visit was warranted to assess the resident's condition. The Administrator stated that sometimes there was a delay with the physician coming into the facility as required.

Review of an undated facility policy titled, "Physician Services" (Revised April 2013) revealed the following:
The resident's attending physician participates in the resident's assessment and care planning, monitoring changes in resident's medical status, providing consultation or treatment when called by the facility, and overseeing a relevant plan of care for the resident.
...The physician will perform pertinent, timely medical assessments; prescribe an appropriate medical regimen; provide adequate, timely

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F 711	Continued From page 36 information about the resident's condition and medical needs; visit the resdient at appropriate intervals; and ensure adequate alternative coverage. NJAC 8:39-27.1	F 711		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility documents, it was determined that facility failed to provide NJ Exec. Order 26:4.b.1 for a resident with NJ Exec. Order 26:4.b.1 . This deficient practice was identified for 1 of 5 vulnerable residents (Resident #134) reviewed and was evidenced by the following: On 05/01/23 at 9:39 AM, the surveyor observed Resident #134 sitting in the day room during a music activity. According to the Admission Face Sheet, Resident #134 had diagnoses which included, but were not to, NJ Exec. Order 26:4.b.1 . Further review of the Admission Face Sheet indicated the resident's son as the only next of kin (NOK) and emergency contact. Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 04/11/23, included	F 745	1. On May 31, 2023 the Social Worker contacted the Long Term Care Ombudsman for guidance on resident # 134 2. Social Service will conduct an audit for all residents who are NJ Exec. Order 26:4.b.1 and have no representative or legal guardian. There were no other residents noted from the audit completed on 5/31/2023 3. Appointing a Resident Representative policy, Ethics Committee policy and Social Service Worker□s job description were reviewed by the Administrator and no changed were needed Administrator will education Social Services and the need to begin	6/23/23

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F 745	Continued From page 37 the resident had a Brief Interview for Mental Status score of [redacted] which indicated the resident's NJ Exec. Order 26:4.b.1. Further review of the MDS included the resident [redacted] Review of the resident's NJ Exec. Order 26:4.b.1 care plan, dated 01/18/23, included, "Assessment of resident's [redacted] indicated by: Staff Assessment [redacted]," and, NJ Exec. Order 26:4.b.1 [redacted] Review of a NJ Exec. Order 26:4.b.1 progress note, dated [redacted], included, "ADMISSION NOTE [redacted] met with Resident ... Upon admission, resident appeared alert, responsive and oriented x1, [he/she] pleasant [sic] [redacted] but able to male [sic] NJ Exec. Order 26:4.b.1. Resident has NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 [redacted] Review of a NJ Exec. Order 26:4.b.1 progress note, dated 01/12/23, included, "[NJ Exec. Order 26:4.b.1] made an attempt to contact resident's NOK (next of Kin) (son) to be able to complete psychosocial assessment/intake, but SW was unable to reach NOK and voice message was left." Review of a NJ Exec. Order 26:4.b.1 progress note, dated 01/16/23, included, "SW met with resident to complete psychosocial assessment but due to resident's NJ Exec. Order 26:4.b.1 [redacted] Therefore, SW contacted NOK (son) to complete psychosocial assessment but this writer was not able to reach son and a voice message was left." Review of a NJ Exec. Order 26:4.b.1 progress note, dated	F 745	interventions for any NJ Exec. Order 26:4.b.1 residents that do not have a representative and/or legal guardian Social Services will be responsible for contacting the Long Term Care Ombudsman for guidance for any residents that do not have a representative and/or legal guardian Social services will be responsible for monitoring of residents whose only representative does not wish to continue as the resident□s representative, or the representative expires and will notify Administrator and Long Term Care Ombudsman for guidance 4. Social Worker /designee will audit all NJ Exec. Order 26:4.b.1 residents to ensure there is a representative and/or legal guardian noted as the contact at the resident□s quarterly IDC team care plan meeting. Social Worker will report results of audit at monthly QAPI meeting times 3 months then at quarterly QA times 3.	

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01/18/23, included, "SW met with resident to complete psychosocial assessment, but due to resident's NJ Exec. Order 26:4.b.1 SW was [redacted] SW will follow up with family."

Review of a NJ Exec. Order 26:4.b.1 progress note, dated 02/01/23, included, "In the effort to complete psychosocial assessment, SW made several attempts in reaching out to resident's NOK, (son) but unable to reach him and a voice message was left. Staff made aware."

Review of a nursing progress note, dated 02/05/23, included, "Resident received in room with roommate NJ Exec. Order 26:4.b.1. Around 5 pm two [police officers] accompanied by supervisor showed up to patient's room with a message about NJ Exec. Order 26:4.b.1."

Review of the resident's progress notes, dated 02/05/23 through 05/09/23, did not include any further NJ Exec. Order 26:4.b.1 progress notes.

During an interview with the surveyor on 05/05/23 at 11:08 AM, Certified Nursing Assistant (CNA) #1 stated Resident #134 was [redacted]

During an interview with the surveyor on 05/05/23 at 11:10 AM, Licensed Practical Nurse (LPN) #8 stated Resident #134 was [redacted] and would look at the resident's Admission Face Sheet if he needed to contact the resident's representative.

During an interview with the surveyor on 05/09/23 at 10:47 AM, LPN #5 stated Resident #134 was [redacted]. LPN #5 further stated that if a [redacted] resident did not have a representative, she would ask the social worker to find out who to contact.

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F 745	Continued From page 39 During an interview with the surveyor on 05/09/23 at 11:02 AM, LPN Unit Manager (UM) #1 stated that if a NJ Exec. Order 26:4.b. resident did not have a representative, she would refer to the SW who handles resident guardians. On 05/09/23 at 11:12 AM, the surveyor observed the resident sitting with an activity aide. The resident stated NJ Exec. Order 26:4.b.1 and that he/she didn't have any other family that the facility could contact. During an interview with the surveyor on 05/09/23 at 12:03 PM, SW #1 stated a resident's BIMS score determines if the resident was "appropriate to weigh in on major decisions," and that contact information for a resident's representative was listed on the Admission Face Sheet. SW #1 further stated that if a NJ Exec. Order 26:4.b.1 resident did not have a representative, he would see about a guardianship and the Administrator would get involved. When asked about Resident #134, SW #1 stated that NJ Exec. Order 26:4.b.1 nd that the resident's only family on record NJ Exec. Order 26:4.b.1. SW #1 then stated he did not notify the Administrator that Resident #134 did not have a representative and would typically wait until "an issue arose." SW #1 verified that he did not initiate anything in terms of a guardian or representative for Resident #134. During an interview with the surveyor on 05/09/23 at 12:54 PM, the Administrator stated that upon admission, information is obtained to determine who is allowed to make decisions for a resident. The Administrator further explained that if a resident no longer had a representative, the facility would rely on the admission agreement	F 745		

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packet signed upon admission to the facility. When asked how the facility obtains a representative for [NJ Exec. Order 26 4.b.1] resident, the Administrator stated the Long-Term Care Ombudsman would be contacted for guidance.

During an interview with the surveyor on 05/10/23 at 12:38 PM, the Admissions Director stated Resident #134's admission agreement packet was mailed to the resident's son to fill out, however, [NJ Exec. Order 26:4.b.1] before the packet could be completed.

During an interview with the surveyor on 05/10/23 at 12:50 PM, the Director of Nursing (DON) stated that Resident #134's [NJ Exec. Order 26:4.b.1] and was unsure if the resident had a representative. The DON further stated that if the resident did need a representative, he would refer to the Interdisciplinary Care (IDC) Team.

During a follow-up interview with the surveyor on 05/11/23 at 9:28 AM, the Administrator stated the facility had an Ethics Committee that handled resident situations on an individual basis, however, the Ethics Committee was not involved with Resident #134. The Administrator further stated the SW should have made referrals if necessary and notified the IDC Team. At 9:43 AM, the Administrator stated Resident #134 has [NJ Exec. Order 26:4.b.1] and that the SW was responsible for initiating that process.

Review of the facility's policy titled, "Appointing a Resident Representative," dated 08/01/21, included, "The term 'Resident Representative' is defined as: An individual chosen by the resident ... Legal representative ... or The court-appointed

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F 745	Continued From page 41 guardian or conservator of a resident." Review of the facility's policy titled, "Ethics Committee," dated 08/01/21, included, "The facility maintains an Ethics Committee which will provide a forum in which to confidentially review and discuss ethical issues surrounding patient care, end of life decisions, resident preference and culture/social concerns." Further review of the policy included, "The Ethics Committee members include representation from medicine, nursing, administration and social work," and, "Ethics Committee meetings may be requested be [sic] staff, patients, family members, and practitioners at any time. Requests will be directed to the Social Work Department to convene an Ethics Committee Meeting." Review of the facility's Social Worker's job description, undated, included, "Refer resident/family member to appropriate social service agencies when facility does not provide services or needs of resident."	F 745		
F 804 SS=D	NJAC 8:39 - 39.4 (i) Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.	F 804		6/23/23

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F 804	Continued From page 42 This REQUIREMENT is not met as evidenced by: Complaint #NJ 150149 Based on observation, interview and review of pertinent facility documentation it was determined that the facility failed to ensure meals were served at safe and appetizing temperatures. This deficient practice was on one (1) of three (3) nursing units (the third floor), during the lunch meal service on 5/3/23 and was evidenced by the following: On 5/3/23 at 10:30 AM, the surveyor conducted a Resident Council Meeting with five (5) alert and oriented residents in which 5 of 5 residents (Resident #29, #40, #89, #90, and #91) at the meeting stated that the food was cold. They stated that the food was "cold and old", and they "never have received a hot piece of pizza or a burger." The residents further stated that the trays were on open food carts. On 5/3/23 at 11:44 AM, the surveyor arrived in the kitchen, in the presence of the Food Service Director (FSD) to observe the serving of the lunch meal for the day including food temperatures. The FSD calibrated the food thermometer to 32 degrees Fahrenheit (F) in the presence of the surveyor using the ice bath method. The surveyor observed the FSD take the following temperatures for the regular texture lunch meal: eggplant -190 F; sloppy joe -150 F; and	F 804	1. Residents # 29, # 40, #89, #90 and #91 were interviewed by the dietician regarding food temperatures. None of these residents have had any [redacted] The FSD reheated the sloppy joe to the required temperature of 165 F or above. 2. All residents have the potential to be affected by food temperatures. Food temperature audits were done on random meals on 5/10, 5/11 and 5/12 and there were temperature issues. 3. Food Preparation and Service policy was reviewed by the Administrator and Food Service Director and no changes were needed FSD/designee will be responsible for monitoring and ensuring compliance with proper food temperature practices. Daily audits and inspections by the Food Service Director/designee to assess adherence to temperature requirements Education for dietary staff by FDS or Dietician to reinforce proper food handling techniques, including temperature monitoring and maintenance When tray carts leave the kitchen for all	

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F 804	Continued From page 43 vegetable (carrots and peas)- 190 F The FSD instructed dietary staff to reheat the sloppy joe. The surveyor asked the FSD why he was reheating the sloppy joe. The FSD stated it should be at 165 F or above. The dietary staff placed the sloppy joe on the stovetop to be reheated. The FSD intermittently checked on the temperature. On 5/3/23 at 12:12 PM, the cook checked the temperature of the sloppy joe, which was 166 F. On 5/3/23 at 12:22 PM, the cook began serving the lunch meal. The cook served the hot foods on a plate and the dietary aide placed the plate in plastic insulated bases and covered with domes, which were then placed on the resident meal trays on the truck. The first truck was completed and went to the first-floor dining room. The second truck was going to the third-floor unit, "high-side". The surveyor requested from the FSD a regular texture test tray for the third-floor unit truck. On 5/3/23 at 12:40 PM, the dietary aide left the kitchen with the meal truck to be delivered to the third-floor unit. The surveyor and the FSD with calibrated thermometer accompanied the dietary aide. On 5/3/23 at 12:42 PM, the dietary aide arrived on the 3rd floor unit with the meal truck and informed the nursing staff that the truck had arrived. On 5/3/23 at 12:52 PM, the last resident meal tray on the truck was served by the nursing staff. The surveyor observed the FSD take the following	F 804	meals and announcement will be made to alert the units for timely tray pass to residents Licensed nursing staff will be educated by the DON on the importance of timely tray pass A resident food committee will be formed and held monthly with the Food Service Director and Activities Director. 4. Food temperature checks to be completed daily times 2 weeks then three times per week Food Service Director will report his findings from his audits and inspections at monthly QAPI times 3 months then quarterly times 3 months The DON/designee will audit the tray pass times, from the arrival of meal trays to the last tray passed to the resident to ensure meal trays are passed to the residents timely. One meal per day weekly (alternating to cover all three meals) for two weeks then three meals a week (one breakfast, one lunch and one dinner) times 4 weeks The Administrator will review the minutes of monthly resident council meeting for any food concerns mentioned by resident.	

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temperatures for the regular texture lunch meal:

coffee- 140 F;

sloppy joe-120 F;

orange juice- 38 F;

pudding- 38 F;

milk- 38 F; and

green peas and carrots-100 F

At that time, the surveyor asked the FSD what would be the expected temperature range for the hot foods and cold foods served. The FSD replied that it should be above 135 degrees F for hot foods, and lower than 40 degrees F for cold food items. The surveyor asked about the temperature of the green peas and carrots at 100 degrees F and the temperature of sloppy joe was at 120 degrees F. The FSD stated they check the food temperatures routinely and have not had issues with the food temperatures. The FSD stated it could depend on the specific food items. The surveyor asked what was used to help maintain food temperatures for food served. The FSD stated they used insulated domes and bases, and pre-heated plates to help maintain temperature. The surveyor asked the FSD, if it was expected for the food temperatures of the sloppy joe and green peas and carrots to have been above 135 degrees, as indicated for hot foods. The FSD replied, "...Yes, it should be".

On 5/10/23 at 2:09 PM, the surveyor informed the Administrator, the Director of Nursing, and the Assistant Director of Nursing of concerns

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F 804	Continued From page 45 regarding food temperatures. No verbal response was provided at that time. Review of the facility's policy titled, "Food Preparation and Service", dated 8/1/2021, revealed under Cooking and Handling temperatures and times: ...Food service employees shall prepare and serve food in a manner that complies with safe food handling practices...The "danger zone" for food temperatures is between 41 [degree] and 135 [degree] Fahrenheit. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness...". The policies provided did not further address food temperatures and maintaining hot foods. NJAC 8:39-17.4(a)2	F 804		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Complaint #NJ 147719, Complaint #NJ 150149 Based on observation, interview, record review, and review of other facility documents, it was determined that the facility failed to ensure a	F 806	1. Dietician reviewed preferences with Resident #85 and they had NJ Exec. Order 26 4.b.1 such as NJ Exec. Order 26 4.b.1 as a result of this deficiency	6/30/23

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F 806	Continued From page 46 resident's dietary preferences were honored for 1 of 4 residents reviewed for food concerns (Resident #85) This deficient practice was evidenced by the following: On 05/03/23 at 1:31 PM, during lunch mealtime, the surveyor observed Resident #85 sitting at the bedside. Resident #85 was NJ Exec. Order 26:4.b.1 [redacted]. A lunch tray was on the resident's bedside table. Resident #85 stated they could not eat what was on the lunch tray. Resident #85 removed the insulated dome and the plate contained sloppy joe which had sauce and peas and carrots. Resident #85 stated they had preferences listed on the meal ticket and always received something they shouldn't. The meal ticket observed on the tray for the resident, listed no gravy/sauce and resident was to have peanut butter and jelly sandwich with the meal. There was no peanut butter and jelly sandwich observed. Resident #85 stated they had already discussed this concern with the Registered Dietitian (RD), Food Service Director (FSD), and the Administrator. Resident #85 further stated the current Administrator had been trying to address their concerns, but they still received items they could not eat. The resident stated the alternative food included food that they could not eat and that staff response was "they don't have anything else". The surveyor reviewed the hybrid (paper and electronic) medical record of Resident #85 which revealed the following: Review of the Annual Minimum Data Set (MDS), an assessment tool used to facilitate the	F 806	2. Resident council meeting to be held to discuss food preferences with the Food Service Director being invited. 3. Food Preferences policy was reviewed by the Administrator and Food Service Director and no changes were needed Education of dietary staff by FDS on importance of respecting and honoring individual resident preferences and special requests 4. Food Service Director / designee to audit every meal for food preferences times 1 week then 10% times 2 months. Findings will be reported at monthly QAPI times 3 months Administrator to review Resident Council minutes times 3 months for resident preferences and likes or dislikes	

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F 806	Continued From page 47	F 806		

management of care, dated 04/17/23, indicated that the facility assessed the resident's NJ Exec. Order 26:4.b [redacted] using a Brief Interview for Mental Status (BIMS). The resident scored a [redacted] out of 15 which indicated that the resident's NJ Exec. Order 26:4.b.1 Diagnoses included, but were not limited to, Gastro-esophageal reflux disease without NJ Exec. Order 26:4.b.1 [redacted]

Review of Resident #85's physician orders, revealed the resident had a physician's order, dated 03/28/2022, for a NJ Exec. Order 26:4.b.1 [redacted], and an NJ Exec. Order 26:4.b.1 products.

Review of a Dietary Progress Note, dated 04/26/2023, written by the Registered Dietician (RD), revealed that the resident's food preferences were in place, and the resident had a [redacted].

Review of Resident #85's care plans, included a NJ Exec. Order 26:4.b.1 plan with interventions that read NJ Exec. Order 26:4.b.1 " and [redacted] The care plan did not address the resident's food preferences.

During an interview with the surveyor on 05/09/23 at 11:16 AM, LPN UM #2 stated there were a lot of residents who were particular with their food, and they tried to accommodate their preferences. The LPN UM #2 stated there were alternative options available and staff on the unit would call down to the kitchen for the residents.

During an interview with the surveyor on 05/10/23

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F 806	Continued From page 48	F 806		

at 9:27 AM, the RD stated that food preferences were discussed with residents upon admission, quarterly, and as requested to speak with the RD. She further stated food preferences were emailed to the Food Service Director (FSD) and entered in the meal tracker for their meal tickets.

The RD stated Resident #85 had NJ Exec. Order 26:4.b.1 and the meal ticket listed the resident's preferences, such as NJ Exec. Order 26:4.b.1. She had went over alternative options with Resident #85 and informed the kitchen of Resident #85's alternative options. The RD stated she was not sure why the resident was still getting food items that Resident #85 shouldn't, as the meal ticket listed the resident's food preferences and alternatives to provide. The RD provided a meal ticket from the meal tracker which showed Resident #85's food preferences and alternative options were listed on the ticket.

On 05/10/23 at 2:09 PM, the surveyor informed the Administrator, Director of Nursing, Assistant Director of Nursing about concerns with Resident #85's food preferences not being honored.

During and interview with the surveyor on 05/11/23 at 8:30 AM, the FSD stated that food preferences were indicated on the meal tickets and were usually highlighted in a different color. The FSD stated they usually tried to accommodate a resident's food preferences and if there was an issue, it would be immediately caught as meal tickets for resident meals were reviewed during tray line for accuracy by the dietary aide. The FSD stated "I do admit that dietary aide might miss it."

Review of the facility's policy titled, "Resident

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F 806	Continued From page 49 Food Preferences", which revealed under Policy Interpretation and Implementation: " ...The resident's clinical record (orders, care plan, or other appropriate locations) will document the resident's likes and dislikes and special dietary instructions or limitation such as altered food consistency and caloric restrictions ...The Food Services Department will offer a limited number of food substitutes for individuals who do not want to eat the primary meal ..." The provided facility policies did not further address honoring a resident's food preferences. NJAC 8:39-17.4 (c), (e)	F 806		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		6/23/23

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F 812	Continued From page 50 Based on observation, interview, and policy review it was determined that the facility failed to a.) store and label potentially hazardous foods in a manner to prevent food borne illness, b.) failed to sanitize and air-dry cookware in a manner to prevent microbial growth, and c.) maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 04/26/23 at 10:00 AM, the surveyor, in the presence of the Food Service Director (FSD), observed the following during the kitchen tour: 1. Dietary Aide #1 was observed with hair hanging outside of her hair net by each ear. The surveyor asked the FSD about the observation and the expectation of hair restraint use. The FSD acknowledged hair should be restrained and stated "it happens, sometimes hair will come out of the hairnet" and that Dietary Aide #1 would usually fix her hairnet. The surveyor interviewed Dietary Aide #1, about the expectation of hair restraint use. Dietary Aide #1 acknowledged all hair should be covered by the hairnet and stated she would fix her hairnet. 2. On a shelving storage unit, the surveyor observed, three six-inch pans stacked on each other, facing down. The FSD lifted the top pan from the middle pan. The surveyor observed pans with water in-between them. The FSD acknowledged the pans were wet-nested (stacking of dishes before completely air-drying that could create conditions for microorganism growth) and stated he would put them to wash again. The FSD lifted the middle pan from the	F 812	1. Dietary Aide #1 was in-serviced on proper use of hair net or other hair covering by the FDS Pans were all re- cleaned thoroughly and dried Baked chicken pieces were discarded Two 32 ounce containers of yogurt were discarded The paper bag with peanut butter and jelly sandwich were discarded The three unlabeled and undated pies were discarded The 3 boxes of baking soda in the dry storage were discarded The undated/unlabeled fish was discarded 2. All residents have the potential to be affected by improper food handling, storage, labeling and sanitation procedures. 3. The FDS audited the remainder of the kitchen and no issues were noted A dietary checklist has been initiated listing inspection of all refrigerators, freezers, storage areas and general food preparation area for proper labeling, dating, food discarded after expiration date and infection control Sanitization policy, Food Preparation and Service Policy, Food Receiving and Storage policy and Policy & Procedure: Dating of Food were reviewed by the Administrator and Food Service Director	

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F 812	Continued From page 51 bottom pan. The surveyor observed on the inside of the pan, a clear to white in color, solid substance dried on the bottom of the pan. The FSD acknowledged the pan was soiled and stated he would put the pan to wash again. 3. On a shelf in the walk-in refrigerator, the surveyor observed a full-size pan covered with foil. The foil had a written date of 4/20 in marker. The FSD stated the date was the date the item was prepared and that it was leftovers. The surveyor asked how long leftovers were good for. The FSD stated that leftovers were good for three days. The FSD opened the foil cover that revealed baked chicken pieces. The FSD stated it should have been thrown out as it had been more than 3 days. 4. On a top shelf in the walk-in refrigerator, the surveyor observed two 32 ounce containers of vanilla fat free yogurt, with a written date in marker of 2/9. The FSD stated the written date was the date the items were received. The two yogurt containers had a manufacturers expiration date of 03/03/23 and were unopened. The FSD acknowledged the yogurts were expired and would be discarded. 5. On a shelf in the walk-in refrigerator, the surveyor observed a brown sandwich bag with a name and no written date. The FSD stated that it was a resident's snack for dialysis and believed it was for today. The FSD stated the snack was stored in the refrigerator and would be brought to the unit when it was requested. The FSD opened the bag which revealed a peanut butter and jelly sandwich covered in plastic wrap with a labeled written date of 4/19, a plastic cup of jello and container of orange juice. The FSD stated that	F 812	and no changes were needed FDS will education all dietary personal on: 1. Proper use of hair and beard nets 2. Proper cleaning and drying of pots and pans. No nesting or stacking to dry 3. Proper dating of food and discarding food after expiration date 4. The Food Service Director/designee, using the Dietary checklist as an audit tool, will audit the kitchen daily times 30 days then 3 times per week times 2 months. Any discrepancies will be immediately corrected and reeducation of staff and/or counseling. Findings will be reported at monthly QAPI times 3	

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F 812	Continued From page 52	F 812		

the snack must have been from several days ago and discarded the snack.

6. On a shelf in the walk-in freezer, the surveyor observed three pies covered in plastic wrap that were undated and unlabeled. The FSD stated they were made last Sunday and were good for two weeks.

7. On a shelf in the walk-in freezer, the surveyor observed a sheet pan with a seasoned fish that was unlabeled and undated. The FSD stated that it was just prepared.

8. In the dry food storage area, the surveyor observed three boxes of pure baking soda with a received written date of 01/23/20 and a best use manufacturers date of 11/2021. The FSD acknowledged items were expired and should be discarded.

On 05/03/23 at 10:00 AM, the surveyor asked the FSD who was responsible for inventory and checking the expiration of food items. The FSD stated there was an assigned utility person who was responsible for deep clean weekly. The FSD stated that every day when the staff went to retrieve items, items should be checked for expiration. The FSD acknowledged he was also responsible for ensuring appropriate storage and labeling of items.

On 05/10/23 at 2:09 PM, the surveyor informed the Administrator, the Director of Nursing, and the Assistant Director of Nursing, about the above concerns.

A review of the facility's policy titled, "Sanitization" with an issue date of 08/01/21, indicated: " ...The

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F 812	Continued From page 53	F 812		

food service area shall be maintained in a clean and sanitary manner ...3. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions ...10. Food preparation equipment and utensils that are manually washed will be allowed to air dry whenever practical." The policy did not further address the drying of items after washing.

A review of the facility's policy titled, "Food Preparation and Service", with an issue date of 08/01/21, revealed under Policy Interpretation and Implementation: ...Food preparation staff will adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness ...Dietary staff shall wear hair restraints so that hair does not contact food...

A review of the facility's policy titled, "Food Receiving and Storage", with a revision date of 12/01/22, revealed under Policy Interpretation and Implementation: " ...Foods shall be received and stored in a manner that complies with safe food handling practices ...7. All foods stored in the refrigerator or freezer will be covered, labeled and dated ..."

A review of the undated facility's policy titled, "Policy & Procedure: Proper Dating of Food" indicated to follow manufacturer's expiration date on all un-opened product. If there was no printed manufacturer's date on the product, the dating protocol listed on the policy were to be followed. The policy's dating protocol revealed leftovers were good for 3 days.

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F 812	Continued From page 54 NJAC 8:39-17.2 (g)	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		6/23/23

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F 880	Continued From page 55 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of medical records and other facility documentation, it was determined that the facility failed to maintain proper infection control practices identified during a.) laboratory specimen collection (blood drawn for the purpose of laboratory testing), b.) medication administration	F 880	1. Resident #111: 5/3/23 dining room table and immediate area was thoroughly disinfected. Contracted laboratory was notified and informed of the NJ Exec. Order 26 4.b.1 actions and this NJ Exec. Order 26 4.b.1 will not be allowed to return to the facility.	

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F 880	Continued From page 56 observation identified on 1 of 3 Nursing Units (Second Floor) and for 1 of 2 nurses (Licensed Practical Nurse #1) observed during the medications pass, c.) storage of linens and supplies for 1 of 2 storage areas observed ("the nursery"), and d.) 2 of 2 kitchen staff observed during kitchen tours. This deficient practice was evidenced by the following: 1.) On 05/03/23 at 12:38 PM, the surveyor observed a NJ Exec. Order 26:4.b.1 om Resident #111 who was seated in a NJ Exec. Order 26 4.b.1 in the second-floor day room. The resident's NJ Exec. Order 26:4.b.1 on the table and had a NJ Exec. Order 26:4.b.1 as the NJ Exec. Order 26 4.b.1 attempted to NJ Exec. Order 26 4.b.1 from the resident's NJ Exec. Order 26:4.b.1. There was also a NJ Exec. Order 2 on the table. The surveyor called the Second Floor Licensed Practical Nurse Unit Manager (LPN/UM) #2 into the day room. LPN/UM #2 stated that the NJ Exec. Order 26:4.b.1 was not permitted to NJ Exec. Order 26 4.b.1 on the table where the residents would soon eat lunch as it was both a privacy and NJ Exec. Order 26:4.b.1 issue. LPN/UM #2 stated that the NJ Exec. Order 26:4.b.1 needed education. The NJ Exec. Order 26:4.b.1 then placed a NJ Exec. Order 26:4.b.1 and the NJ Exec. Order 26:4.b.1 that was used during the NJ Exec. Order 26:4.b.1 on the table after the NJ Exec. Orde was collected. LPN/UM #2 then stated that the table needed to be disinfected. At that time, the surveyor interviewed the NJ Exec. Order 26 4.b.1 t and asked what possible negative consequences could result from NJ Exec. Order 26:4 and NJ Exec. Order 26:4.b.1 in a dining area. The NJ Exec. Order 26 4.b.1 t stated that it was her first day at the	F 880	LPN #1 was educated by the ADON on NJ Exec. Order 26:4.b.1 between use of residents and hand hygiene/ hand hygiene competency on 5/11/23. On 5/6/23 all boxes were placed on a raised platform so that they would not be on the floor in the nursery. Infection Control nurse educated Dietary Aide #2 and FSD in handwashing and completed competencies on for both on 5/10/23. 2. All residents have the potential to be affected by improper infection control practices 3. Administering Medication/Treatments, Handwashing/Hand Hygiene, Infection Prevention and Control Program, Receipt & Storage of Supplies and Equipment, Storage Areas and Linen Handling and Storage Policy were reviewed by Administrator, DON, Infection Control Nurse and Environmental Service Director and no revisions were needed Laboratory vendor notified of responsibility to provide infection control education to their staff prior to sending to facility. Education received for NJ Exec. Order 26:4.b.1 that routinely come to facility. Infection control nurse will be responsible to ensure that the NJ Exec. Order 26:4.b.1 has received infection control education prior to coming to the facility.	

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	315454	A. BUILDING _____ B. WING _____	C 05/11/2023

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F 880	Continued From page 57 facility and her second day working for her employer and she was not aware that people ate in that area. The [NJ Exec. Order 26 4.b.1] further stated that the nurse sent her in there. The surveyor pointed out the adjacent vending machines which contained food items. The [NJ Exec. Order 26:4.b.1] stated, "I have no clue what they do in here." During an interview with the surveyor on 05/03/23 at 12:46 PM, LPN #6 stated that she informed the [NJ Exec. Order 26:4.b.1] that she was not permitted to [NJ Exec. Orc] in the hallway and did not tell her to do it in the day room. During an interview with the surveyor on 05/03/23 at 1:28 PM, Resident #111 stated that the [NJ Exec. Order 26 4.b.1] offered to do his/her [NJ Exec. Orc] in the hall, day room, or in the resident's room. The resident stated that it was his/her choice to do it in the day room. Review of Resident #111's Admission Face Sheet revealed that the resident was admitted to the facility with diagnosis which included but were not limited to: [NJ Exec. Order 26:4.b.1] Review of Resident#111's Quarterly Minimum Data Set (MDS), an assessment tool dated 03/16/23, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of [NJ Exe] out of 15, which indicated that the resident was [NJ Exec. Order 26:4.b.1]. During an interview with the surveyor on 05/04/23 at 12:38 PM, the surveyor interviewed the	F 880	Education by Infection control nurse to all staff on Infection Prevention and Control Program Education by Infection control nurse to all staff Handwashing/Hand Hygiene Education by Administrator to department managers on Receipt & Storage of Supplies & Equipment and Linen Handling and Storage Infection control nurse/designee will audit [NJ Exec. Order 26 4.b.1] for cleaning of equipment and [NJ Exec. Order 26:4.b.1] in correct area weekly License nursing staff to be educated by Infection control nurse on disinfecting multi resident use equipment before and after use and proper hand hygiene during medication pass. 4. All licensed nurses will be observed with a med pass competency by the ADON/designee. Any discrepancies will be corrected immediately through reeducation and/or counseling by June 23, 2023 Infection control nurse will audit any phlebotomist entering the facility have proper infection control education monthly Infection Control nurse /designee will perform hand hygiene competencies for 10 employees per week times 4 weeks (encompassing all shifts) and then 5 employees per week times 2 months and	

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F 880	Continued From page 58 Assistant Director of Nursing (ADON) who stated that the facility could not ensure that the NJ Exec. Order 26:4.b.1 who were sent to the facility by an outside company were educated prior to coming into the building. The ADON stated that there was a potential for the residents to become "very ill" if they ate at a table NJ Exec. Order 26:4.b.1 During an interview with the surveyor on 05/05/23 at 9:23 AM, the Administrator stated that he was aware that the NJ Exec. Order 26:4.b.1 in the day room and that was both a dignity and NJ Exec. Order 26:4.b.1 issue as there was a chance of NJ Exec. Order 26:4.b.1 During an interview with the surveyor on 05/09/23 at 10:30 AM, the Director of Nursing (DON) stated that the NJ Exec. Order 26:4.b.1 should have adhered to NJ Exec. Order 26:4.b.1 guidelines and NJ Exec. Orde the resident's NJ Exec. Orde in their room, not in a common area. The DON further stated that it was an NJ Exec. Order 26:4.b.1 issue if there were any NJ Exec. Orde present on the table where the NJ Exec. Order 26:4.b.1. During an interview with the surveyor on 05/09/23 at 1:10 PM, the Infection Preventionist (IP) stated that the NJ Exec. Order 26 4.b.1 was required to follow the facility's NJ Exec. Order 26:4.b.1 policies and that NJ Exec. Orde should have been NJ Exec. Order 26 in the resident's room for privacy. The IP further stated that a NJ Exec. Order 26 4.b.1 t should never NJ Exec. Order 26 4.b.1 in a dining area, and everyone should know that as it could have placed the whole facility in danger as it may not have been evident that there was NJ Exec. Orde on the table. The IP added that NJ Exec. Order 26:4.b.1 was a concern. 2.) On 05/02/23 at 8:42 AM, during the medication administration observation the	F 880	report results at monthly QAPI times 3. Audit results of NJ Exec. Order 26 4.b.1 for cleaning of equipment and NJ Exec. Order 26:4.b.1 in correct area will be reported by Infection control nurse at monthly QAPI times 3 then quarterly times 3. Administrator/designee will audit the nursery weekly times 2 months to ensure all items are raised on a platform and are not resting on the floor. Any discrepancies will be immediately corrected and reeducation/counseling of staff and report findings at monthly QAPI	

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surveyor observed LPN #1 use an automated NJ Exec. Order 26:4.b.1 to obtain Resident #60's NJ Exec. Order 26:4.b.1 and a NJ Exec. Order 26:4.b.1 NJ Exec. Order 26:4.b.1 was placed on the resident's NJ Exec. Order 26 4.b.1 to obtain a reading. LPN #1 questioned the accuracy of the NJ Exec. Order 26:4.b.1 reading and obtained a NJ Exec. Order 26:4.b.1 NJ Exec. O and NJ Exec. Order 26 4.b.1 instead. LPN #1 cleaned the NJ Exec. Order 26:4.b.1) of the NJ Exec. Order 26 4.b.1 with an NJ Exec. Order 26 4.b.1 prior to use but did not clean the NJ Exec. Order 26:4.b.1 or NJ Exec. Orde prior to or after use. LPN #1 then placed the NJ Exec. Order 26:4.b.1 on the resident's NJ Exec. Order 26:4.b.1 and then placed the NJ Exec. Order 26:4.b.1 of the s NJ Exec. Order 26 4.b.1 beneath the NJ Exec. Orde as he obtained a reading. When finished, LPN #1 cleaned the NJ Exec. Order 26:4.b.1 of the NJ Exec. Order 26 4.b.1 with an NJ Exec. Order 26:4.b.1 and did not clean the NJ Exec. Order 26:4.b.1.

At 9:39 AM, LPN #1 used a NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 as he obtained Resident #29's NJ Exec. Orde and NJ Exec. Order 26:4.b.1 readings. When finished, he placed both the NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26 4.b.1 on top of the medication cart and did not sanitize either the NJ Exec. Order 26:4.b.1 or the NJ Exec. Order 26:4.b.1 after use.

At 9:46 AM, LPN #1 donned (put on) gloves and applied a NJ Exec. Order 26:4.b.1 (used for NJ Exec. O to Resident #29's NJ Exec. Order 26 4.b.1 region. LPN #1 then doffed (removed) his gloves and proceeded to document the medication administration into the electronic health record without first performing hand hygiene. LPN #1 then proceeded to access the medication cart, and obtained a medication cup, and two bingo

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cards (medication storage unit) as he began to prepare medications for an unsampled resident without first performing hand hygiene.

When interviewed at that time. LPN #1 stated that he should have cleaned the NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 in between residents, as failure to do so could have resulted in cross-contamination. LPN #1 stated that when he failed to wash his hands after he doffed his gloves and before he accessed the medication cart, it could have resulted in cross-contamination of both the medication cart and the items that he had handled.

During an interview with the surveyor on 05/04/23 at 11:44 AM, LPN/UM #2 stated that both the NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 should have been cleaned with bleach wipes in between each resident to prevent the spread of infection.

During an interview with the surveyor on 05/09/23 at 10:25 AM, the Director of Nursing (DON) stated that for infection control purposes the NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 should have been disinfected in between residents according to the manufacturer's recommendations.

During an interview with the surveyor on 05/09/23 at 1:16 PM, the Infection Preventionist (IP) stated that reusable equipment such as NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 should have been wiped down in between each resident as there was a chance of cross-contamination. The IP stated that nurses were required to wash their hands after they doffed their gloves, as a failure to do so may have resulted in contamination of

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the medication cart.

During an interview with the surveyor on 05/10/23 at 3:15 PM, the Assistant Director of Nursing (ADON) stated that LPN #1 had not had a medication observation performed by the consultant pharmacist or the facility as he was previously employed by an outside agency who was contracted with the facility before he was permanently employed by the facility.

Review of the facility policy titled, "Administering Medications/Treatments," revised 08/15/22, revealed the following: Staff will follow established facility infection control procedures (e.g., handwashing ..., gloves ..., etc.) when these apply to the administration of medications.

Review of the facility policy titled, "Handwashing/Hand Hygiene," revised 07/01/22, revealed the following: The facility considers hand hygiene the primary means to prevent the spread of infections ...Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ...before and after direct contact with residents, ...before preparing or handling medications, ...after contact with a resident's intact skin, ...after removing gloves ...The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.

3.) On 05/05/23 at 8:20 AM, the surveyor accompanied the Environmental Service Director (ESD) to a storage area the facility referred to as

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"the nursery" where additional linens were stored. The Administrator joined and entered the storage area with the surveyor and the ESD. At that time, the surveyor observed six cardboard boxes directly on the floor. One box contained sealed paper towels, two boxes contained resident clothing, and three sealed boxes contained linen. The ESD Services stated the boxes should be off the floor and on pallets so they could clean the area underneath.

During an interview with the surveyor on 05/05/23 at 11:29 AM, the IP stated storage of the boxes should not be directly on the floor in case the boxes get wet or dirty.

Review of an undated policy titled, "Receipt and Storage of Supplies and Equipment," included but was not limited to;" It shall be the Purchasing Agent's responsibility to assure that proper storage procedures are maintained."

Review of an undated policy titled,"Storage Areas," Environmental Services included but was not limited to; "Housekeeping and laundry department storage areas shall be maintained in a clean and safe manner."

Review of an undated policy titled, "Linen Handling and Storage Policy," included but was not limited to; "clean linen is not stored on the floor ..."

4.) On 04/26/23 at 10:00 AM, the surveyor arrived to tour the kitchen with the Food Service Director (FSD) who stated he would wash his

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hands. The surveyor observed the FSD wash his hands at a designated sink. The FSD wet his hands with water, lathered his hands with soap for 7 seconds, then placed his hands under the running water, continuing to rub his hands together for the remainder of the time. The FSD took a paper towel to dry his hands and then turned off the faucet with the same paper towel. The surveyor asked the FSD how long he had washed his hands for and the FSD replied 20 seconds. He further stated the facility policy was to wash hands for 20-30 seconds. The surveyor informed FSD of the observation of washing his hands for 7 seconds and asked the FSD about the handwashing procedure. The FSD stated he had been washing his hands constantly as he has been in and out getting deliveries. The FSD provided no verbal response about the hand washing procedure.

5.) On 05/03/23 at 11:34 AM, the surveyor observed Dietary Aide #2 wash her hands at a sink in the kitchen. Dietary Aide #2 applied soap to her hands, lathered the soap, then immediately put her hands under the running water, and continued to scrub her hands for 40 seconds under the water. Dietary Aide #2 dried her hands with a paper towel and turned off the faucet with a paper towel. The surveyor interviewed Dietary Aide #2 about her handwashing and about the handwashing procedure. Dietary Aide #2 stated that she always washed her hands that way. The surveyor asked Dietary Aide #2 what the expected amount of time was to perform handwashing and Dietary Aide #2 stated 10 seconds, but then added she was not sure. The surveyor informed the FSD of the observations and he stated Dietary Aide #2 would be re-educated on handwashing.

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F 880	Continued From page 64 On 5/5/23 at 11:20 AM, the surveyor interviewed the IP about hand hygiene education to kitchen staff. The IP stated she provided education on hand hygiene and the staff had an online training on hand hygiene. The surveyor informed IP of the handwashing observations for the FSD and Dietary Aide #2. The IP acknowledged hands should be rubbed with soap for at least 20 seconds prior to rinsing hands with water during handwashing. The IP stated she would re-educate the staff members. On 5/10/23 at 2:09 PM, the surveyor informed the Administrator, DON, and ADON of the handwashing observations for the FSD and Dietary Aide #2. Review of the facility's policy titled, "Food Preparation and Service," with an issue date of 08/01/21, revealed under Policy Interpretation and Implementation: "...Food preparation staff will adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness..." A review of CDC guidance of hand hygiene in healthcare settings indicated the CDC Guideline for Hand Hygiene in Healthcare Settings recommended: " ...When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use towel to turn off the faucet ..."	F 880		

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F 880	Continued From page 65 NJAC 8:39-19.4 (a)	F 880		

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 21 of 28 day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	1. There were no care issues reported on the twenty one shifts that were identified 2. All residents have the potential to be affected by this practice. The Director of Nursing/designee reviewed the last 30 days of the C.N.A. staffing report. The interdisciplinary team reviewed the grievance logs and care conference meetings and no care issues were identified. 3. Administrator in – serviced the staffing coordinator regarding the requirement for	6/23/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/01/23

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SHORE GARDENS REHABILITATION AND NURSING C	231 WARNER STREET TOMS RIVER, NJ 08755

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S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The survey team requested staffing for the weeks of 01/02/22 to 01/15/22 and 04/09/2023 to 04/22/23. Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on 21 of 28 day shifts as follows: 1. For the 2 weeks of staffing (01/02/2022 to 01/15/2022), the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -01/02/22 had 11 CNAs for 139 residents on the day shift, required 17 CNAs. -01/03/22 had 11 CNAs for 139 residents on the day shift, required 17 CNAs. -01/04/22 had 16 CNAs for 139 residents on the day shift, required 17 CNAs.	S 560	S560 to ensure C.N.A. staffing needs are reviewed daily and addressed as needed to meet the staffing requirement. Recruitment efforts are in place to assist the facility in recruiting, C.N.A. receive sign on bonuses, referral bonuses, reimbursement for C.N.A. tuition, and transportation service from certain locations, Facility also has contracts with agencies to recruit C.N.As. The Director of Nursing/designee also reviews staff attendance records to ensure that excessive absences are addressed accordingly. 4. The Administrator/designee will have weekly meetings with the staffing coordinator to review staffing schedules, needs, and the efficacy of the systems in place to fill needs. The findings of the audits will be presented at the Quarterly QAPI meetings x 3 meetings or until a timeframe determined by the QAPI members	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	656002	A. BUILDING: _____ B. WING _____	C 05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING C	231 WARNER STREET TOMS RIVER, NJ 08755

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S 560	Continued From page 2 -01/05/22 had 11 CNAs for 139 residents on the day shift, required 17 CNAs. -01/06/22 had 17 CNAs for 143 residents on the day shift, required 18 CNAs. -01/07/22 had 15 CNAs for 143 residents on the day shift, required 18 CNAs. -01/08/22 had 15 CNAs for 143 residents on the day shift, required 18 CNAs. -01/09/22 had 11 CNAs for 144 residents on the day shift, required 18 CNAs. -01/10/22 had 11 CNAs for 144 residents on the day shift, required 18 CNAs. -01/11/22 had 16 CNAs for 144 residents on the day shift, required 18 CNAs. -01/12/22 had 11 CNAs for 144 residents on the day shift, required 18 CNAs. -01/14/22 had 15 CNAs for 140 residents on the day shift, required 17 CNAs. -01/15/22 had 15 CNAs for 140 residents on the day shift, required 17 CNAs. 2.For the 2 weeks of staffing (04/09/2023 to 04/22/2023), the facility was deficient in CNA staffing on 8 of 14 day shifts as follows: -04/09/23 had 14 CNAs for 142 residents on the day shift, required 18 CNAs. -04/10/23 had 14 CNAs for 141 residents on the day shift, required 18 CNAs. -04/11/23 had 14 CNAs for 141 residents on the day shift, required 18 CNAs. -04/13/23 had 16 CNAs for 135 residents on the day shift, required 17 CNAs. -04/15/23 had 11 CNAs for 135 residents on the day shift, required 17 CNAs. -04/16/23 had 15 CNAs for 134 residents on the day shift, required 17 CNAs. -04/21/23 had 15 CNAs for 133 residents on the day shift, required 17 CNAs. -04/22/23 had 15 CNAs for 136 residents on the	S 560		

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S 560	Continued From page 3 day shift, required 17 CNAs. During an interview with the surveyor on 05/04/23 at 12:01PM, the Director of Nursing and the Staff Development Coordinator were aware of the staffing ratios for each shift as day shift 1:8, evening shift 1:10 and night shift 1:14.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315454 Y1	A. Building B. Wing Y2	7/7/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

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	F0609	Correction	ID Prefix	F0610	Correction	ID Prefix	F0711	Correction
Reg. #	483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. #	483.12(c)(2)-(4)	Completed	Reg. #	483.30(b)(1)-(3)	Completed
LSC		06/23/2023	LSC		06/23/2023	LSC		06/23/2023
ID Prefix	F0804	Correction	ID Prefix	F0806	Correction	ID Prefix		Correction
Reg. #	483.60(d)(1)(2)	Completed	Reg. #	483.60(d)(4)(5)	Completed	Reg. #		Completed
LSC		06/23/2023	LSC		06/30/2023	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
5/11/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
656002 Y1	A. Building B. Wing Y2	7/7/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 06/23/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 5/11/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING **01** B. WING _____	**05/11/2023**

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SHORE GARDENS REHABILITATION AND NURSING CENTER	**231 WARNER STREET** **TOMS RIVER, NJ 08755**

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K 000	INITIAL COMMENTS The nursing home building construction was stated to be 90's with no current major renovations or noted additions. It is a three-story building Type II (222) construction and is fully sprinklered. The facility is divided into 12-smoke zones, the Kohler 150 KW diesel generator does approximately 40% to 50 % of the building as per the Maintenance Director. The 3-story facility utilizes 3-elevators (2-passenger and 1-service device) The building is attached to a (Closed Daycare) 1-story structure now used for storage. The attached structure cannot be entered from the nursing home and was not observed. The facility utilizes an electric fire pump to support the fire sprinkler system. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 149 certified beds. At the time of	K 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/31/2023

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 the survey the census was 138. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/01/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to provide a battery back-up emergency light above the electric fire pump transfer switch, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 19.2.9.1.- 7.9.1 (general). This deficient practice was identified for 1 of 1 transfer switches and was evidenced by the following: On 3/29/23 at 11:31 AM, the surveyor in the presence of the Maintenance Director, observed one fire pump transfer switch, inside the fire pump electrical room. The general area was not provided with any emergency lighting. The Maintenance Director confirmed the finding at the time of the observation. The Administrator was informed of the findings at the Life Safety Code exit on 5/01/23.	K 291	Step 1 Emergency lighting independent of Facility Generator and Facility Electricity will be installed in the pump room to illuminate the transfer switch within. Step 2 All residents are at risk for not having emergency lighting in the pump room. Step 3 Inspection of emergency lighting in pump room will be added to monthly tasks on Facility building maintenance and compliance software. Step 4 Maintenance director will report on the status of monthly emergency lighting inspections to the Administrator at Quarterly QA Meeting for the next three quarters. Completion date May 31, 2023	5/31/23

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K 291	Continued From page 2 NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/01/23, in the presence of the Maintenance Director	K 321	1 Enclosure of hazardous area will be	6/15/23

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K 321	Continued From page 3 (MD), it was determined that the facility failed to provide a fire barrier with two hour fire resistance rating in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1 and 8.7.1. The deficient practice was ideintifie for 2 of 9 hazardous areas observed and was evidenced by the following: At 09:24 AM, the surveyor and Maintenance Director observed in the floor-2 mechanical room identified as C3-11F that 2 new boilers were installed. The protected metal decking was cut into to provide white flue pipe approximately 6"each, that were installed through the metal ceiling decking in both areas of the (2) new boilers. The flue pipe was then surrounded with non-fire rated press board plywood. The plywood was exposed at the ceiling approximately 2' at both pipe penetrations from the removed protected metal decking. The (2) two exposed areas were not fully encased in fire rated material. The findings were verified by the Maintenance Director at the time of the observations. The Administrator was informed of the findings at the Life Safety Code exit conference on 5/01/23. NJAC 8:39-31.2(e)	K 321	repaired with a two hour fire barrier between the boiler room and the roof. 2 All residents are at risk for not having an appropriately rated fire barrier in hazardous areas. 3 Maintenance Director will follow behind any outside contractors that may penetrate a fire barrier to ensure that repairs are done correctly. 4 The Maintenance Director will report to the Administrator at Quarterly QA meeting the results of any inspections and repairs.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design,	K 353		6/7/23

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K 353	Continued From page 4 maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on interview and record review on 4/28/23 and 5/01/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to a.) annually inspect 3 of 3 private property fire hydrants as per NFPA 25 and b.) ensure that their automatic sprinkler system fire pump was in optimal condition in accordance with the National Fire Protection Association (NFPA) 20 & 25 and c.) ensure that the electric fire pump was tested monthly and documented as per NFPA 25. This deficient practice was evidenced by the following: a.) On 4/28/23 at approximately 11:30 AM, the surveyor reviewed all related documentation from the fire sprinkler vendor. The reports did not indicate any annual inspection of the three (3) private fire hydrants on the facility's property as required by NFPA 25. The Maintenace Director indicated that the annual fire hydrant inspection requirement was	K 353	1 The 3 Fire hydrant has been scheduled for inspection on June 6. Fire pump repair is scheduled for June 6. The Monthly Fire Pump inspection log has been updated to now include: visually inspecting gauges for proper water pressures, any leaks and to ensure pump switches are in automatic position. 2 All residents are at risk for the Facility not in compliance with sprinkler inspection requirements. 3 Annual Fire Hydrant inspection has been added to the Facility Maintenance & Compliance building software. Monthly Fire Pump testing to covering all regulatory aspects of NFPA 25 has been added to the Building Facility Maintenance & Regulatory Compliance Software The Administrator will audit the monthly logs in the Facility Maintenance & Regulatory Compliance Software to	

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K 353	Continued From page 5 not performed, and no further documentation was provided. b.) At 11:33 AM, the surveyor and Maintenace Director observed in the fire pump electrical room, that the red fire pump was observed to be leaking, along with rust on the bottom of the pump motor that was attached to the concrete pad. The Maintenance Director confirmed the finding during the observation. c.) During document review, the surveyor observed that the electric fire pump monthly test reports were not provided. The Maintenance Director confirmed that he could not provide any documentation for the testing of the electric fire pump. He indicated the fire pump was tested weekly, but could not provide any documentation testing logs indicating so. The Administrator was notified of the findings at the Life Safety Code exit conference on 5/01/23. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 20: Standard for the Installation of Stationary Pumps for Fire Proctetion NFPA 25: Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems	K 353	ensure monthly tests of Fire Pump & inspections including visual inspections of gauges, leaks & switches are in compliance for the next three months. 4 The Maintenance Director will report the status of all items on the monthly fire pump inspection log at Quarterly QA meeting for the next three quarters.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 363		6/14/23

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K 363	Continued From page 6 hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/01/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to	K 363	1 Hardware was replaced with appropriate hardware utilizing existing holes in doors.	

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SHORE GARDENS REHABILITATION AND NURSING CENTER	**231 WARNER STREET** **TOMS RIVER, NJ 08755**

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K 363	Continued From page 7 ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring room doors closed completely to properly confine fire and smoke products and to properly defend occupants in place was identified in 31 of 50 resident room (RR) doors observed and was evidenced by the following: During the building tour on 5/01/23 from 9:15 AM, to 01:45 PM, the surveyor in the presence of the Maintenance Director toured the facility and observed the following compromised RR doors: RR 316 loose hardware RR 318 approximately 1/4 hole in door, above the hardware RR 321 approximately 1/4 hole in door, above the hardware RR 326 loose hardware RR 331 loose hardware RR 332 will not latch into frame RR 334 loose hardware RR 202 loose hardware RR 203 loose hardware RR 205 will not latch into frame RR 206 approximately 1/4 hole in door, above the hardware RR 207 loose hardware RR 211 loose hardware RR 214 loose hardware RR 215 loose hardware and door sticks into frame RR 218 loose hardware RR 221 loose hardware RR 224 approximately 1/4 hole in door, above the	K 363	Any holes listed on the report are now covered by the existing metal door closure hardware. Doors repaired so that they no longer rub. 2 All residents are at risk for failure to have doors that properly resist the passage of smoke or fire. 3 All doors will be inspected by the Director of Maintenance on a monthly basis for the next three months and Quarterly thereafter. The inspection will include ensuring the latching hardware is in proper condition, door latches properly and that the door closes freely and does not rub onto the frame. 4 The Maintenance Director will report the status of all items on the room door inspection checklist at Quarterly QA meeting for the next three quarters.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING **01** B. WING _____	**05/11/2023**

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SHORE GARDENS REHABILITATION AND NURSING CENTER	**231 WARNER STREET** **TOMS RIVER, NJ 08755**

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K 363	Continued From page 8 hardware RR 226 approximately 1/4 hole in door, above the hardware RR 229 loose hardware RR 230 loose hardware (latch NG) RR 231 loose hardware (latch NG) RR 233 door rubs into frame and approximately 1/4 hole above hardware RR 234 approximately 1/4 hole in door, above the hardware RR 101 door rubs into top of the frame RR 104 door rubs into top of the frame RR 107 door will not latch RR 109 door rubs into frame RR 111 door will not latch RR 113 loose hardware RR 115 door rubs into top of frame At the time of observations, the surveyor interviewed the MD who confirmed the above findings. The Administrator was informed of the findings at the Life Safety Code exit conference on 5/01/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 741 SS=F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such	K 741		6/16/23

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K 741	Continued From page 9 area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/01/23, in the presence of the Maintenance Director (MD) and Administrator (Admin), observed that the facility failed to maintain smoking areas in accordance with the requirement of NFPA 101, 2012 Edition, Section 19.7.4. This deficient practice was identified for 1 of 1 smoking areas observed and was evidenced by the following: At approximately 01:00 PM, the Surveyor, Maintenance Director and Administrator observed the first floor exterior smoking area. The outer perimeter of the smoking area was dried grass and dirt. The surveyor observed 100-plus ciggerate butts in that area, along with ciggerate	K 741	1 Proper ashtrays were provided in the smoking area. The cigarette butts in the outer perimeter of the smoke patio were removed. 2 All residents who use the patio for either smoking or leisure can be at risk for failure to maintain a proper smoke area. 3 Ashtrays will be cleaned out on a weekly basis and placed on weekly Maintenance rounds in Facility building Maintenance software. Residents were educated to use ashtrays and will be reminded weekly by Facility staff.	

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K 741	Continued From page 10 butts on the occupied concrete pad. The occupied resident smoking area was provided with 6-oasis type ashtrays, but a metal container with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted was not observed at the time of the observation. The Maintenance Director and Administrator confirmed the finding's during the observations. The Administrator was informed of the finding's at the Life Safety Code exit conference on 5/01/23. NJAC 8:39-31.2(e)	K 741	4 The Maintenance Director will report on the status of the smoking area at Quarterly QA meeting for the next three quarters.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or	K 914		6/16/23

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K 914	Continued From page 11 area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, interview and documentation review on 5/01/23, in the presence of the facility's Maintenance Director (MD), it was determined that the facility failed to functionally test electrical receptacles in residents' rooms annually for grounding, polarity, and blade tension in accordance with NFPA 99. This deficient practice was evidenced for 50 of 50 resident rooms observed by the following: From approximately 9:30 AM to 1:30 PM, the surveyor and MD, observed that resident rooms were provided with electrical receptacles that were less than hospital grade and required an annual electrical inspection. The annual electrical inspection from the facility vendor dated: 11/22/22 did not indicate any testing of resident room outlets and did not indicated the identification of the outlets as hospital or non-hospital grade. The MD confirmed that the resident rooms had non-hospital grade outlets installed during the resident room observations and could not provided any further testing documentation. The Administrator was informed of the findings at the Life Safety Code exit conference on 5/01/23. NJAC 8:39-31.2(e) NFPA 99	K 914	1 The Facility will test all room electrical receptacles for grounding, polarity and blade tension. 2 All residents are at risk for failing to test all room electrical receptacles for grounding, polarity and blade tension. 3 Annual Electrical testing of all room electrical receptacles for grounding, polarity and blade tension to be performed by the Director of Maintenance has been added to the Facility tasks software for annual testing. 4 The Maintenance Director will report to the Administrator on the status of annual electrical receptacle testing at Quarterly QA Meeting.	
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101	K 921		6/2/23

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K 921	Continued From page 12 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 5/01/23, it was determined that the facility failed to ensure electrical equipment wiring was safe and in accordance with NFPA 70 and 99. This deficient practice was evidenced for 3 of 9 bug lights observed and installed in exit/egress	K 921	1 bug lights with modified spliced plugs were removed from service and discarded. Maintenance staff were in-serviced on maintenance and inspection of electrical equipment. 2	

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K 921	Continued From page 13 corridors. 1.) At 09:59 AM, the surveyor and Maintenace Director observed in the exit/egress corridor on floor #2 by resident room 213, that a wall mounted bug light was plugged into a duplex wall outlet. The bug light fixture wire had a modified spliced plug attached (not the orginal) to the fixture. 2.) At 10:02 AM, the surveyor and Maintenace Director observed in the exit/egress corridor on floor #2 by resident room 224, that a wall mounted bug light was plugged into a duplex wall outlet. The bug light fixture wire had a modified spliced plug attached (not the orginal) to the fixture. 3.) At 10: AM, the surveyor and Maintenace Director observed in the exit/egress corridor on floor #2 by resident room 233, that a wall mounted bug light was plugged into a duplex wall outlet. The bug light fixture wire had a modified spliced black cord spliced into the orginal cord. During an interview, at the time of observation, the Maintenance Director confirmed that the replacement cords and plugs were not permitted and should not be like that in the facility. The Administrator was informed of the finding's at the Life Safety Code exit conference on 5/01/23. NJAC 8:39-31.2(e) NFPA 70 (National Electrical Code) NFPA 99 (Health Care Facilities Code)	K 921	All residents can be at risk for failure to maintain electrical equipment. 3 All bug lights and other electrical equipment plugged into outlets in exit/ egress corridors were inspected and any electrical item found with a modified spliced plug was removed from service and discarded. An inspection of all electrical equipment plugged into outlets in exit/ egress corridors will be placed on the Maintenance Director□s monthly tasks list. 4 The Maintenance Director will report the results of these monthly inspection to the Administrator at quarterly QA meeting for the next three quarters.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101	K 923		6/16/23

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K 923	Continued From page 14 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 923		

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K 923	Continued From page 15 Based on observations and interview on 5/01/23, in the presence of the Maintenance Director, it was determined that the facility failed to prohibit combustible storage within 5-feet of quantities of oxygen exceeding 300 cubic feet in accordance with NFPA 99. This deficient practice was identified for 41 of 41 portable oxygen cylinders and was evidenced by the following: At 10:18 AM, the surveyor, Maintenance Director observed in the floor #2 main oxygen storage closet, that 41-portable oxygen cylinders were observed to be stored within 3' of combustible cardboard boxes. An interview was conducted with the Maintenance Director who stated that the cylinders must be separated by five-feet (5') from combustibles when an automatic fire sprinkler system is provided. The building has a fully functional sprinkler system. The Administrator was informed of the finding at the Life Safety Code exit conference on 5/01/23. NJAC 8:39-31.2(e) NFPA 99	K 923	1 Combustible items were removed from within 5 feet of stored oxygen in the storage area. The area was marked off to alert staff not to store combustibles and central supply & Maintenance staff were in-serviced accordingly. 2 All residents can be at risk for failure to store oxygen in a safe manner. 3 The Central Supply clerk has been in-serviced on oxygen storage requirements. Weekly inspection of the oxygen storage area to be done by Director of Maintenance or designee has been added to weekly tasks on the Facility Maintenance software. 4 The Maintenance Director will report on the status of weekly oxygen storage area compliance at Quarterly QA meeting for the next three quarters.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315454 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	7/7/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

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 K0291	05/31/2023	LSC K0321	06/15/2023	LSC K0353	06/07/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	06/14/2023	LSC K0741	06/16/2023	LSC K0914	06/16/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0921	06/02/2023	LSC K0923	06/16/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
5/11/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO