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F 000	INITIAL COMMENTS Complaint #: NJ#167713, #167973, #171148, #171923, #174669, #175244, #175260, and #176352 Survey Date: 9/20/24 Census: 124 Sample: 25 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580		10/4/24

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

Electronically Signed | 10/10/2024

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

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F 580	Continued From page 1 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Complaint NJ#175244 Based on interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to notify the resident's representative and physician of a [redacted] in a timely manner for one (1) of three (3) residents, (Resident #209), reviewed for [redacted]	F 580	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #209 no longer in the facility [redacted] involved was educated on the policy titled, “Accidents and Incidents-Investigating and Reporting,” which included notification of resident’s	

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F 580	Continued From page 2 This deficient practice was evidenced by the following: A review of the closed medical record for Resident #209 revealed the resident was admitted to the facility in [redacted] and discharged from the facility in [redacted] A review of the Admission Record (an admission summary) revealed that Resident #209 was admitted to the facility with diagnoses which included but were not limited to: [redacted], [redacted], and [redacted]). A review of the resident's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected the resident had a Brief Interview for Mental Status (BIMS) of [redacted] out of 15, which indicated the resident had [redacted] A review of the individualized Care Plan (CP) created [redacted], reflected a focus area: resident had [redacted] and the interventions included but not limited to: Communicate with the resident/family/caregivers regarding resident's capabilities and needs. A review of the nursing Progress Note (PN) reflected the following: "[redacted] at 23:48 [11:48 PM], at around 11 PM, pt (patient; also known as resident) came to nurses' station stating, "[redacted], remember I told you earlier [redacted] pt did not tell writer that the resident had [redacted], nor	F 580	physician and family with date/time by Director of Nursing. How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents who fall in the facility may be affected by this practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The Director of Nursing and Assistant Director of Nursing created a fall checklist for nurse and Nurse Supervisor to ensure notification to physician and resident representative on day of fall. Assistant Director of Nursing and Unit Managers provided education to all nurses on the policy and procedure of "Accidents and Incidents-Investigating and Reporting," along with the new falls checklist. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change? The Director of Nursing and Assistant Director of Nursing created a fall checklist for nurse and Nurse Supervisor to ensure notification to physician and resident representative on day of fall.	

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F 580	Continued From page 3 are there any reports of NJ Ex O Pt had NJ Ex Order at times, ... Writer asked pt where specifically NJ Ex Order 26 and pt pointed to NJ Ex Order 26.4(b)(1) no noted NJ Ex Order 26.4(b and medicated as ordered for NJ Ex Ord Further review of the PN dated NJ Ex Order 26.4 revealed that the resident's representative (RR) and the physician were not notified of the incident immediately after the incident. NJ Ex Order 26.4(b at 16:20 [4:20 PM], Pt noted NJ Ex Order 26.4(, when asked what happened, patient stated NJ Ex Order 26.4(b)(1) and now their NJ Ex Order 26.4(, MD [physician] notified, new orders received for NJ Ex Order 26.4(b)(1) ordered NJ Exec Ord NJ Exec Order 26.4b1 waiting for results, RR called, no answer, left msg. (message) endorsed to oncoming shift to follow up. A review of the NJ Ex Order 26.4(b)(1) Grievance log that was provided by U.S. FOIA (b) (6) did not have a Grievance for Resident #209. During an interview with the surveyor on 9/19/24 at 12:54 PM, in the presence of the survey team, the U.S. FOIA (b) (6)) stated she did not remember if she had notified the RR of resident's NJ Ex on NJ Ex Order 26.4 during her shift and had to read her notes to verify if the RR was notified or not. The U.S. FOIA further stated, "I would typically document when I notify the family of any incidents in PN or in incident report." On 9/19/24 at 01:27 PM, the survey team met with U.S. FOIA (b) (6)), U.S. FOIA (b) (U.S. FOIA (b) (6) and Regional Nurse Consultant Nurse #1 (RNC #1). The surveyor notified the	F 580	Assistant Director of Nursing and Unit Managers provided education to all nurses on the policy and procedure of "Accidents and Incidents-Investigating and Reporting," along with the new falls checklist. When will corrective action be accomplished? 10/04/2024	

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F 580	Continued From page 4 facility management of the above findings and concerns. The [U.S. FOIA] and [U.S. FOIA (b)] acknowledged that the RR and the physician would be notified immediately of incidents or [NJ Ex Order 26.4(b)(] once the residents were assessed. They further stated, "Usually that's our process." A review of the facility's "Accidents and Incidents-Investigating and Reporting" policy dated 4/2024 revealed: Policy Interpretation and Implementation section: 2g.) The time the injured person's attending physician was notified, as well as the time the physician responded and his or her instructions; h.) The date/time the injured person's family was notified and by whom. On 9/20/24 at 01:15 PM, the survey team met with [U.S. FOIA (b)] [U.S. FOIA (b) (6)] RNC#1, RNC#2, [U.S. FOIA (b) (6)] for an exit conference. There was no additional information was provided. NJAC 8:39-13.1(c)	F 580		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Complaint #NJ175244 Refer to F883 Based on interview and record review it was	F 641	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #148 section N and section O; modification applied to MDS dated	10/10/24

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F 641	Continued From page 5 determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for three (3) of 28 residents, (Residents #62, #148, and #209), reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: According to the CMS (Centers for Medicare & Medicaid Services) MDS 3.0 RAI (Resident Assessment Instrument) Manual of October 2023, for definitions of the types of therapies listed in this section, please refer to the Glossary in Appendix A. O-23 Coding Instructions: Coding Instructions for Respiratory, Psychological, and Recreational Therapies. o Total Minutes-Enter the actual number of minutes (mins) therapy services were provided in the last 7 (seven) days. Enter 0 if none were provided. o Days-Enter the number of days therapy services were provided in the last 7 days. A day of therapy is defined as treatment (tx) for 15 min or more in the day. Enter 0 if therapy was provided but for less than 15 mins every day for the last 7 days. If the total number of mins during the last 7 days is 0, skip this item and leave blank. 1. On 9/16/24 at 10:27 AM, the surveyor observed Resident #148 seated on the bed with breakfast in front of the resident, the [NJ Ex Order 26.4(b)] was hung on the [NJ Ex Order 26.4(b)(1)] attached to the wall.	F 641	8/29/2024. Resident # 62 section [NJ] and [NJ Ex] modification applied to MDS dated [NJ Ex Order 26.4(b)]. Resident # 209 (discharged) section [NJ] modification applied to MDS dated [NJ Ex Order 26.4(b)(1)]. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. ALl residents have the potential to be affected by this deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The MDS coordinators have been in-serviced on the accuracy of MDS coding by the administrator and MDS consultant. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The MDS consultant will conduct audits of MDS coding for 10 assessments weekly for 4 weeks, then monthly for 1 quarter to ensure accuracy. The results of the audits will be reviewed during the monthly Quality Assurance Performance Improvement Committee meeting. The Quality Assurance Performance Improvement committee will make recommendations based upon the results	

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F 641	Continued From page 6 The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #148 and revealed: The Admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to [redacted], and [redacted]). A review of the [redacted] Order Summary Report (OSR) revealed an order for: -[redacted]) give 1 capsule by mouth one time a day for [redacted]) for [redacted] Administrations-Start Date [redacted]. - Incentive [redacted] Assist resident (as needed) to place the [redacted] in the [redacted]. [redacted] and [redacted] as possible. Try to [redacted] toward the top of th [redacted] sets. [redacted]. three times a day for 14 days- Start Date [redacted] The above order for [redacted] was transcribed to the [redacted] electronic Medication Administration Record (eMAR) and signed by nurses as administered. The above order for [redacted]	F 641	of the audits. The Quality Assurance Performance Improvement Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. Include dates when corrective action will be completed. 10/10/24	

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NJ Ex Order 26.4(b)(1)) was transcribed to the NJ Ex Order 26.4(b)(1) eMAR and signed by nurses from NJ Ex Order 26.4(b)(1) through NJ Ex Order 26.4(b)(1) for a total of seven days and 155 mins as follows:

Date		Minutes
NJ Ex Order 26.4(b)(1)	AM	none
	Noon	5
	Evening	15
NJ Ex Order 26.4(b)(1)	AM	none
	Noon	5
	Evening	15
NJ Ex Order 26.4(b)(1)	AM	15
	Noon	15
	Evening	15
NJ Ex Order 26.4(b)(1)	AM	none
	Noon	15
	Evening	15
NJ Ex Order 26.4(b)(1)	AM	5
	Noon	5
	Evening	15
NJ Ex Order 26.4(b)(1)	AM	none
	Noon	5
	Evening	5
NJ Ex Order 26.4(b)(1)	AM	none
	Noon	5
	Evening	blank
Total minutes:		155 mins
Total days: 7 days		

The most recent admission MDS with an assessment reference date (ARD) of NJ Ex Order 26.4(b)(1), under Section NJ Ex Order 26.4(b)(1), reflected a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26.4(b)(1) out of 15 which reflected that the resident was NJ Ex Order 26.4(b)(1). Section NJ Ex Order 26.4(b)(1) showed that the resident was not coded for NJ Ex Order 26.4(b)(1). Section NJ Ex Order 26.4(b)(1) reflected that the

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resident received NJ Ex Order 26.4(b)(1) for 165 mins and six days during the lookback period (the time period over which the resident's condition or status is captured by the MDS assessment).

On 9/18/24 at 10:32 AM, the surveyor interviewed Registered Nurse/MDS Coordinator #1 (RN/MDSC#1). The RN/MDSC informed the surveyor that the facility followed the RAI Manual for MDS. She further stated that she gathered the information that was put in the MDS or to answer the MDS from the resident's chart, orders, nurses, and other IDT (interdisciplinary team) notes including doctors and consultants, eMAR, eTAR (electronic Treatment Administration Record), and resident's interview.

At that same date and time, the surveyor notified the RN/MDSC of the above findings and concerns that the MDS on NJ Ex Order 26.4 did not show that the resident received NJ Ex Ord even though the nurses signed the eMAR from NJ Ex Order 26.4(through NJ Ex Order 26.4 for NJ Ex Order 26.4(b)(1) The surveyor also notified the RN/MDSC of the concern regarding Section NJ Ex Order 26.4(b)(1). The surveyor asked why the NJ Ex Order 26.4 MDS was not coded for NJ Ex Orde what happened why there was a discrepancy between what was coded in Section NJ E of the MDS, and the RN/MDSC stated that she would get back to the surveyor.

On 9/18/24 at 11:39 AM, the survey team met with the U.S. FOIA (b) (6) , U.S. FOIA (b) (6)) U.S. FOIA (b) (6) and Regional Nurse Consultant #1 (RNC#1). The surveyor notified the facility management of the above concerns with the accuracy of MDS for ARD NJ Ex Order 26.4.

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2. On 9/16/24 at 9:06 AM, the surveyor observed Resident #62 in their room, lying in bed with the head of the bed elevated. The resident NJ Ex Or alert, NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) . Resident #62 verbalized no concerns with their care.

The surveyor reviewed the hybrid medical record of Resident #62.

The AR documented that the resident had diagnoses that included but were not limited to, NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1).

A Significant Change in Status Assessment (SCSA) MDS assessment, dated NJ Ex Order 26.4, indicated the facility assessed the resident's cognition using a BIMS test. Resident #36 scored a NJ E out of 15, which indicated the resident had NJ Ex Order 26.4(b)(1) .

A review of a social services' note dated NJ Ex Order 26.4 read "Annual review- U.S. FOIA (b) (6)] and IDT met with [resident representative] earlier last week NJ Exec Order 26.4b1 noted NJ Ex Order 26.4(b)(1) . [Resident #62] appears to be NJ Ex Order 26.4(b)(1) to facility and routine with NJ Ex Order 26.4(b)(1) ...."

There was no additional documentation found that the IDT reviewed and determined there was a significant change with the resident. Additionally, a review of the resident's care plan (CP) revealed there was no documentation to indicate a NJ Exec Order 26.4b1 in the resident's status.

On 9/18/24 at 10:42 AM, the surveyor interviewed

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RN/MDSC#1, about the SCSA completed for Resident #62. The RN/MDSC stated she was not MDS coordinator at the time and would have to review why the SCSA was completed for the resident.

On 9/19/24 at 9:10 AM, RN/MDSC#1 met with the surveyor and stated the SCSA was completed as the resident was on [NJ Exec Order 26] and believed the IDT at the time assessed the resident who showed a [NJ Exec Order 26.4b1] for a [NJ Exec Order 26.4b1]. The surveyor stated the notes from [NJ Ex Order 26.4(b)(1)] do not reflect a [NJ Exec Order 26.4b1] in resident and requested additional supportive documentation for the SCSA of Resident #62.

On 9/19/24 at 02:15 PM, the survey team met with the [U.S. FOIA (b) (6)], and RNC#1. The surveyor informed the facility of the concern for the SCSA. The documentation did not reflect reason for SCSA was completed and the RN/MDSC did not provide any additional information. The [U.S. FOIA (b)] stated they would follow up to provide additional information.

Additional review of the SCSA dated [NJ Ex Order 2] revealed:

Under Section [NJ Ex Order 26.4(b)(1)] it was coded "3. N/A (not applicable) because no prior MDS assessment". A review of the resident's MDS assessments revealed there were previous MDS assessments.

Under Section [NJ Ex Order 26.4(b)(1)] it was coded the resident had not received [NJ Ex O] because it was offered and declined.

There was no documentation in the medical

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record found to indicate the resident was offered and declined a NJ Ex Order 26.4(b)(1).

On 9/20/24 at 9:54 AM, the surveyor interviewed RN/MDSC#1 about Section NJ Ex Order 26.4(b)(1 coding of the SCSA. The surveyor reviewed the entry with the RN/MDSC. She stated she believed the "N/A" coding would not be appropriate if the resident had a previous MDS. She further stated she would like to review Resident #62's medical record to verify if NJ Ex Order 2 was coded inaccurately.

On 9/20/24 at 11:21 AM, the survey team met with the U.S. FOIA (b) (the U.S. FOIA (b the RNC#1, and the U.S. FOIA (b) (6) who were made aware of concern with coding of NJ Ex Order 2 and NJ Ex Order 26.4 There was no additional information provided by facility.

A review of the latest version of the CMS - RAI 3.0 Manual (updated October 2023), Chapter 2-page 2-24, under SCSA (A0310A = 04)" it read, "The SCSA is a comprehensive assessment for a resident that must be completed when the IDT has determined that a resident meets the significant change guidelines for either major improvement or decline ... 'significant change' is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered 'selflimiting'; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the CP."

A review of the latest version of the CMS - RAI 3.0 Manual (updated October 2023), Chapter 3-page E-22, under E1100 Steps for Assessment read: "1. Review responses provided to items

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E0100-E1000 on the current MDS assessment. 2. Compare with responses provided on prior MDS assessment. 3. Taking all of these MDS items into consideration, make a global assessment of the change in behavior from the most recent to the current MDS. 4. Rate the overall behavior as same, improved, or worse." Under Coding Instructions, it read: " ...Code 0, same: if overall behavior is the same (unchanged) ...Code 1, improved: if overall behavior is improved ...Code 2, worse: if overall behavior is worse ...Code 3, N/A: if there was no prior MDS assessment of this resident ..."

A review of the latest version of the CMS - RAI 3.0 Manual (updated October 2023), Chapter 3-page O-17, under O0300B Coding Instructions it read: "Code 2, Offered and declined: resident or responsible party/legal guardian has been informed of what is being offered and chooses not to accept the pneumococcal vaccine ..."

3. A review of the closed medical record for Resident #209 revealed:
The AR showed that Resident #209 was admitted to the facility with diagnoses which included but were not limited to: NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) [redacted], and NJ Ex Order 26.4(b)(3) [redacted].

A review of the resident's Quarterly MDS (QMDS) dated NJ Exec Order 26 [redacted], reflected the resident had a BIMS of [redacted] out of 15, which indicated the resident had NJ Ex Order 26.4(b)(1) [redacted].

The QMDS with an ARD (is the last day of that period of time that the MDS assessment coves for that particular assessment for that particular

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resident) of [NJ Exec Order 2] Section NJ Ex Order 26.4(b)(1) [redacted] signed by RN/MDSC#2 on [NJ Ex Order 26.4] [redacted], revealed the assessment was done eight (8) days after the ARD of [NJ Ex Order 26.4(b)] [redacted] "This interview is conducted during the look-back period of the ARD."

On 9/19/24 at 10:30 AM, in the presence of second surveyor, the surveyor interviewed RN/MDSC#1 about the process for completing section NJ Ex Order 26.4(b)(1). RN/ MDSC#1 stated that she would check eMARs/eTARs, interview the residents and the staff. She further explained the interview should be conducted during five (5) day look back period.

The surveyor asked RN/MDSC #1 if the Section J- NJ Exec Order 26.4b1 interview should be conducted prior to or after the ARD date. The RN/MDSC did not provide verbal response to the question.

On 9/19/24 at 01:27 PM, the survey team met with [U.S. FOIA (b) (6)] and RNC#1. The surveyor notified the facility management of the above findings and concerns.

On 9/20/24 at 11:21 AM, the survey team met with [U.S. FOIA (b) (6)] RNC #1, U.S. FOIA (b) (6) for responses. No responses were provided.

On 9/20/24 at 01:15 PM, the survey team met with [U.S. FOIA (b) (6)] RNC #1, RNC #2, [U.S. FOIA (b) (6)] [redacted] for an exit conference. No additional information was provided by the facility.

A review of the latest version of CMS- RAI 3.0 Manual (updated October 2023), Chapter 3, page J-5, Under tips and Special Populations, it read,

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F 641	Continued From page 14 "Attempt to conduct the interview with all residents. This interview is conducted during the look-back period of the ARD and is not contingent upon item B0700, Makes self-Understood." NJAC 8:39-11.1; 11.2(e)(1); 33.2 (d)	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) ensure that staff monitor and document resident's condition status NJ Ex Order 26.4(b)(1) and clarify the NJ Ex Order 26.4(b)(1) documentation according to standards of clinical practice for one (1) of three (3) residents, Resident #148, reviewed for NJ Ex Order 26.4b1 b.) follow the physician's written order and appropriately document NJ Ex Order 26.4(b)(1) for one (1) of two (2) residents, Resident #358, reviewed for NJ Ex Order 26.4(b)(1). c.) ensure staff follow the physician's order for one (1) of three (3) nurses, (Registered Nurse), observed during medication administration according to the facility's policies and standards of clinical practice. This deficient practice was evidenced by the following:	F 658	How will any corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident #148 had NJ Ex Order 26.4(b)(1) related to this practice. Resident was seen by Nurse practitioner NJ Ex Order 26.4(b) Resident #78 physician notified of NJ Ex Or [redacted] on NJ Ex Order 26.4(. NJ Ex Orde [redacted] order updated to include NJ Ex Order [redacted] parameters for physician notification. Nurses found to be deficient in practice with completing Treatment record for NJ Ex Order 26.4(b)(1) as well as notification to physician of NJ Ex Order 26.4(b)(1) Resident # 260 is no longer at the facility but NJ Ex Order 26.4(b)(1) order was changed to NJ Ex Order 26.4(b)(1) [redacted] tablet on NJ Ex Order 26.4 when deficient	10/4/24

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F 658	Continued From page 15 Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 9/16/24 at 10:27 AM, the surveyor observed Resident #148 seated on the bed with breakfast in front of the resident. The resident informed the surveyor that they had a NJ Ex Order 26.4(b) at the facility because the resident forgot to lock the wheelchair (w/c) when they transferred themselves from w/c to bed. The resident further stated that it was the NJ Ex Order 26.4(b)(1), and the resident was NJ Ex Order 26 if they NJ Ex Order 26.4(b)(1) when the resident NJ Ex O	F 658	practice was noted. U.S. FO was educated on the policy titled, “Administering Medications” regarding ensuring medications are administered as prescribed, including form. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents that sustain a fall in the facility can potentially be affected by this deficient practice. All residents that have an indwelling catheter can be potentially affected by the deficient practice. All residents that have medications administered in the facility can be potentially affected by the deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Post Fall Monitoring order set was created by Director of Nursing to monitor and document status post fall x 3 days. Current Fall Investigation checklist was updated to include the post fall monitoring order set and documentation. Assistant Directors of Nursing provided in-service education to all nurses on properly documenting on a resident status post fall x 3 days and making sure post fall monitoring order is ordered immediately after fall. Director of Nursing updated the order set for Indwelling catheter urine output order	

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F 658	Continued From page 16 The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #148 and revealed: The Admission Record (AR, an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to [redacted], and [redacted]. The most recent Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of [redacted] under Section [redacted], reflected a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which reflected that resident was [redacted]. Section [redacted] revealed that the resident had [redacted] with a [redacted]. A review of the provided [redacted] reports showed the following: -#[redacted] at around 3:22 PM, the resident [redacted], and was sent out to ER (emergency room) for [redacted] of [redacted] and evaluation. -#[redacted] incident, the resident [redacted] and [redacted]. The resident sustained [redacted] on the [redacted]	F 658	with instructions on when to notify physician of low urine output as well as updated the policy titled “Management of the Patient with Indwelling Catheter” to include documentation of urine output and procedure when low urine output present. Assistant Directors of Nursing and Nursing Supervisors provided in-service education to all nurses on policy titled, “Management of the Patient with an Indwelling Catheter” Assistant Directors of Nursing provided in-service education on policy titled “Administering Medications”, including but not limited to administering medications as prescribed, including form of medication. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change? Director of Nursing or Assistant Director of Nursing will audit all falls for proper three-day follow-up monitoring weekly x 4 weeks, then randomly choose 2 falls bi-monthly x 2 months. All findings will be presented to the monthly Quality Assurance Performance Improvement Committee for review and further follow-up. The Director of Nursing and Assistant Directors of Nursing will audit all residents with foley catheters TAR weekly x 4 weeks and then monthly x 3 months to ensure proper documentation and also to	

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F 658	Continued From page 17 A review of the Progress Notes (PN) of the [redacted]) with an effective date of [redacted] at 12:26 PM included "Seen and examined in room, [redacted]. Pt (patient) is [redacted]. denies any [redacted], denies any [redacted]. Remains on [redacted] Further review of the PN revealed that there was no documented evidence from the nurses that the resident was [redacted] from [redacted] and [redacted] except for the date of [redacted] A review of the above [redacted] and hybrid medical records showed that there was no documented evidence that [redacted]) was done according to the notes of the NP. On 9/18/24 at 11:39 AM, the survey team met with the [redacted], and Regional Nurse Consultant #1 (RNC#1). The surveyor notified the facility management of the concerns regarding the [redacted] On that same date and time, the surveyor asked the facility management what the expectations for the nurses about any [redacted] with regard to documentation and monitoring [redacted] were. The [redacted] stated that it was an expectation to monitor and document in the PN every shift for three days. The surveyor then notified the facility management of the concerns that for Resident #148 [redacted] that there was no documentation from nurses routinely every shift	F 658	ensure parameters are being met. Findings will be presented at Quality Assurance Performance Improvement meetings to determine if further follow-up is needed. The Pharmacy Consultant will conduct medication observations for 1 nurse per month on an ongoing basis to include proper administration of medications. Findings will be presented at the monthly Quality Assurance Performance Improvement meeting. The Assistant Director of Nursing- Educator will conduct regular medication observations for 2 nurses per month on an ongoing basis to include proper administration of medications. Findings will be presented at the Quality Assurance Performance Improvement meeting. When will corrective action be accomplished? 10/04/2024	

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for three days.

On 9/19/24 at 01:26 PM, the survey team met with the [redacted], [redacted], [redacted] and RNC#1. The LNHA stated that when the resident went to the hospital and came back, the doctor did not order the [redacted] The surveyor then asked the facility management, if the physician did not order [redacted] and why it was documented in the NP's PN that the resident remained on [redacted] RNC#1 stated that it should have been clarified.

At that same time, the [redacted] stated that we needed to re-educate the nurses with regard to documentation protocol every shift for three days when the resident had an incident or accident. The [redacted] further stated that this concern will also be added to their QAPI (quality assurance performance improvement).

A review of the facility's Falls-Clinical Protocol with an updated date of 4/2024 that was provided by the [redacted] showed:
Monitoring and Follow-up:
1. The staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications..
a. Delayed complications such as late fractures and major bruising may occur hours or days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall.
2. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling.
a. Frail elderly individuals are often at greater risk for serious adverse consequences of falls.

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b. Risks of serious adverse consequences can sometimes be minimized even if falls cannot be prevented ...

On 9/20/24 at 01:14 PM, the survey team met with the U.S. FOIA (b) (6), RNC#1, and RNC#2 for an exit conference. There was no additional information provided by the facility management.

2. On 9/16/24 at 11:50 AM, Resident #78 was observed lying in bed, NJ Ex Order 26.4(b) and NJ Ex Order 26.4 [redacted]. The resident had an NJ Ex Order 26.4(b)(1) [redacted]. The resident verbalized no concerns with their care.

The surveyor reviewed the medical record of Resident #358 which revealed the following: The AR documented that the resident had diagnoses that included but were not limited to, NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) [redacted]).

A CMDS with an ARD of NJ Ex Order 26.4(b) [redacted] indicated the facility assessed the resident's cognition using a BIMS test. Resident #358 scored a NJ Ex [redacted] out of 15, which indicated the resident was NJ Ex Order 26.4(b)(1) [redacted].

A physician's order (PO) dated NJ Ex Order 26.4 [redacted] read, NJ Ex Order 26.4(b)(1) every shift.

A PO dated NJ Ex Order 26.4 [redacted] read, NJ Ex Order 26.4(b)(1) every shift.

A review of the NJ Ex Order 26.4(b)(1) electronic

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Treatment Administration Record (eTAR) revealed no recorded [redacted] and [redacted] as follows:

[redacted] on 3-11 shift, the [redacted] recorded was [redacted]).
[redacted] on 3-11 shift, there was [redacted] recorded and the entry was left blank.
[redacted] on 11-7 shift, the [redacted] recorded was [redacted]
[redacted] on 3-11 shift, there was [redacted] recorded and the entry was left blank.
[redacted] on 7-3 shift, the [redacted] recorded was [redacted]
[redacted] on 3-11 shift, there was [redacted] recorded and the entry was left blank.
[redacted] on 7-3 shift, the [redacted] recorded was [redacted]
[redacted] on 3-11 shift, the [redacted] recorded was [redacted]
[redacted] on 3-11 shift, there was [redacted] recorded and the entry was left blank.
[redacted] on 3-11 shift, the [redacted] recorded was [redacted]
[redacted] on 3-11 shift, the [redacted] recorded was [redacted]

A review of [redacted] PN revealed there was no documentation of the physician or NP being notified of the resident's episodes of [redacted] Additionally, there was no documentation of what actions were taken for when the resident had [redacted].

A care plan (CP) with a focus that read, [Resident #358] has [redacted] for [redacted] status [redacted] The CP had an initiation date of [redacted] Interventions of the CP included: to monitor and

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F 658	Continued From page 21 document NJ Ex Order 26.4b1 as per facility policy; Monitor/record/report to MD for s/sx[signs/symptoms] NJ Ex Order 26.4(b)(1) [redacted] On 9/19/24 at 9:45 AM, the surveyor interviewed the U.S. FOIA (b) (6) about facility protocol for monitoring and documenting NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) (6) stated NJ Ex Order 26.4(b)(1) was recorded by the nurses every shift and if NJ Ex Order 26.4(b)(1) less than NJ Ex Order 26.4(b)([redacted] it was considered a NJ Ex Or [redacted]. The U.S. FOIA (b) (6) further explained if the NJ Ex Order 26.4(b)(1) was NJ Ex O the nurse should assess the resident for NJ Ex Order 26.4(b)(1), NJ Ex Or and NJ Ex Order 26.4(b)(1) [redacted]; the nurses were to notify the physician; and possibly do a NJ Ex Order 26.4(b)(1) if ordered by the physician. The surveyor reviewed with the U.S. FOIA (b) (6) the concerns found on the NJ Ex Order 26.4(b)(1) eTAR. The U.S. FOIA (b) (6) stated it was expected for nurses to document on the eTAR and not leave entries blank. The U.S. FOIA (b) (6) stated it would be expected to notify the physician o NJ Ex Order 26.4(b)(1) and for it to be documented in a note. The U.S. FOIA (b) (6) could not speak to why there was no nurses PN found by the surveyor. On 9/19/24 at 02:15 PM, the survey team met with the U.S. FOIA (b) U.S. FOIA (b) (6), U.S. FOIA (6 and RNC#1. The surveyor notified the facility management of the above concerns. The surveyor asked if it would be expected for the nurses to complete their documentation on the eTAR on their scheduled shift and for there to be a nurse PN to indicate	F 658		

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actions taken for a resident with NJ Ex Order 26.4(b)(1), including notifying the physician. The U.S. FOIA and U.S. FOIA (b) (6) acknowledged it was expected for nurses to complete their documentation on their shift and a nurses' note to be documented for the resident's NJ Ex Order 26.4(b)(1) including physician notification.

On 9/20/24 at 11:21 AM, the survey team met with the U.S. FOIA (b) (6), the U.S. FOIA (b) RNC#1, and the U.S. FOIA (b) (6). There was no additional information provided by the facility.

The surveyor reviewed the undated facility policy titled, "Management of the Patient with an Indwelling Catheter". Under Purpose it read: "To prevent complications associated with indwelling catheterization". Under Procedure it read, " ...5. Monitor patient and catheter every 8 hours or more frequently for drainage, grit, color, odor and pain ..." The policy did not further address the documentation of the resident's urinary output by the nurses or protocol for residents with low urine output.

3. On 9/17/24 at 9:54 AM, the surveyor observed medication (med) administration for Resident #260. The surveyor observed the resident's electronic Medication Administration Record (eMAR) which contained a list of medications (meds) ordered by the resident's attending physician for administration at that time. The eMAR reflected an order for NJ Ex Order 26.4(b)(1) , a med used to NJ Ex Order 26.4(b)(1), give 1 capsule by mouth two times a day for NJ Ex Order 26.4(b)(1)

The surveyor observed the U.S. FOIA (b) (6) prepare seven (7) of the resident's meds

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that were scheduled for administration. The surveyor observed the [U.S. FO] prepare and crush a med obtained from a bottle labeled "[NJ Ex Order 26.4(b)(1)] [redacted] Tablets". The surveyor questioned the [U.S. FO] if that med was the correct med and what the physician ordered. The surveyor asked the [U.S. FO] to compare the order on the eMAR to the bottle where the med was obtained. The [U.S. FO] agreed that the order was for capsules and the med she obtained was a tablet. The [U.S. FO] stated that the resident gets their meds NJ Ex Order 26.4(b)(1). The surveyor asked the [U.S. FO] what the procedure is if an order on the eMAR was for a med that cannot be given appropriately to a resident such as not to be crushed. The [U.S. FO] stated that she would call the physician to get the order changed.

The surveyor inspected the med cart and observed a bottle that was labeled "[NJ Ex Order 26.4(b)(1)] [redacted] Capusles."

The surveyor interviewed the [NJ Ex] floor [U.S. FOIA] [redacted]) who was present during the observation. The surveyor asked the [U.S. FO] if it was appropriate to give a different dosage form of a med than what was listed on the order. The [U.S. FO] stated no, it should be what was ordered, or the order should be changed.

The surveyor reviewed the hybrid medical record for Resident #260 which revealed a PO for NJ Ex Order 26.4(b)(1) [redacted]) give 1 capsule by mouth two times a day for [NJ Ex Order 26.4(b)(1)]

On 9/18/24 at 10:15 AM, the surveyor interviewed the U.S. FOIA (b) (6) [redacted]). The surveyor asked the [U.S. FO] if they do med pass observations.

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The [U.S. FO] stated "yes," they do regular med pass observations. The surveyor asked the [U.S. FO] if it is appropriate for a nurse to administer a tablet form of a drug if the capsule form is ordered. The [U.S. FO] stated no, the correct dose form should be given, or the order should be changed.

On 9/18/24 at 11:38 AM, the surveyor received a policy from the facility [U.S. FOIA (b)] dated 4/2024 titled "Administering Medications". The surveyor reviewed the policy. The policy reflected under "Policy heading," "Meds are administered in a safe and timely manner, and as prescribed." Under Line 4, "Meds are administered in accordance with prescriber orders, including any required time frame."

On 9/18/24 at 11:39 AM, the surveyor, in the presence of the survey team, met with the facility administrative team which included the [U.S. FOIA (b)] [U.S. FOIA (b)] RNC#1, and [U.S. FOIA (b) (6)]. The surveyor notified the facility management of the med pass results and the concern with the med error. The surveyor requested a recent invoice or packing list for the facility specifically for [NJ Ex Order 26.4(b)(1)] [redacted]

On 9/19/24 at 9:54 AM, the [U.S. FOIA] provided Shipment Pack Lists for the facility with a ship date of 9/09/24. The lists reflected two (2) lines that show [NJ Ex Order 26.4(b)(1)] or the generic equivalent (NJ Ex Order 26.4(b)(1)) were shipped to the facility.

No further pertinent information was provided by the facility.

NJAC 8:39-11.2(a)(b); 19.4(a); 27.1(a)

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F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.	F 660		10/4/24

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F 660	Continued From page 26 (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Complaint #NJ 174669	F 660	How will any corrective action be	

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F 660	Continued From page 27 Based on interview, record review and review of other documents provided by the facility, it was determined that the facility failed to obtain a physician's order for discharge and document the response of an approval or acceptance for the referral of NJ Ex Order 26.4b1 services post discharge to ensure a safe discharge for one (1) of two (2) residents reviewed for discharge (Resident #308). The deficient practice was evidenced by the following: On 9/17/24 at 12:55 PM, the surveyor reviewed the closed hybrid (paper and electronic) medical record for Resident #308 which revealed the following: Resident #308's Admission Record (or face sheet; admission summary) indicated that the resident was admitted to the facility with medical diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1) [redacted] , [redacted] an [redacted] A review of Resident #308's individualized care plan included a focus area that was related to discharge (d/c) planning and included but were not limited to the following interventions: Make arrangements with required community resources to support independence post-d/c (specify: [redacted], NJ Ex Order 26.4(b)(1)), [redacted]	F 660	accomplished for those residents found to have been affected by the deficient practice? Resident #308 was disharged from the facility. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by this deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The U.S. FOIA (b) (6) was educated by the Administrator on documenting acceptance of home care service agencies. Social Services documenting referral and acceptance of Home Care Service Agency has been implemented. Nurses were reeducated by Director of Nursing to obtain a physician's order for discharge. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change? The Administrator or Director of Nursing will conduct audits of 5 discharged residents weekly for 3 weeks, then 5	

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F 660	Continued From page 28 NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1)) [NJ Ex Order 26.4(b)(1)] will be arranged prior to d/c RX (Prescription) will be obtained from MD NJ Ex Order 26 will order recommended equipment A review of Resident #308's Discharge assessment-return not anticipated Minimum Data Set (DRNAMDS), an assessment tool used to facilitate the management of care, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, which indicated that Resident #308 NJ Exec Order 26.4(was NJ Ex Order 26.4(b)(1). Further review reflected that Resident #308 had a planned d/c to NJ Ex Order 26.4b1 and that a referral was not made to the Local Contact Agency and the reason was the referral was not wanted. A review of Resident #308's Progress Note (PN) included the following note written by U.S. FOIA (b)) on NJ Ex Order 26.4(b)(1): Resident #308 was dc yesterday per [resident's representative or RR] request. U.S. FOIA (b) (6) visited [resident] routinely to monitor adjustment. Resident #308 appeared NJ Ex Order 26.4(b)(1) and participated in care and services. RR updated on Resident #308's wellbeing throughout stay. RR was aware of need for NJ Ex Order 26.4b1. Community resources/options reiterated and info was provided on pvt (private) help, LTC (long term care), respite stay, Medicaid. RR plans on hiring pvt help to NJ Ex Order 26.4(b)(1). NJ Ex Order 26 was ordered via [name redacted] and referral was made to [name redacted of HCSA #1] for continuum of care. Transportation arranged per request. There was no documentation that HCSA #1 (Home Care Service Agency #1) approved or	F 660	discharged residents monthly for 2 months. The results of the audits will be reviewed during the monthly Quality Assurance Performance Improvement Committee meeting. The Quality Assurance Performance Improvement committee will make recommendations based upon the results of the audits. The Quality Assurance Performance Improvement Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. When will corrective action be accomplished? 10/04/2024	

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accepted the referral.

A review of Resident #308's Physician's Order (PO) Recap Report did not include a PO for d/c.

There was no documentation in Resident #308's of an acceptance or approval from the NJ Ex Order 26.4b1 service agency or a PO for d/c.

On 9/17/24 at 01:23 PM, in the presence of a U.S. FOIA (b) (6), the surveyor interviewed the U.S. FOIA (regarding the process for d/c and d/c planning. The U.S. FOIA (stated that the process started at admission with the resident and their family and then the facility had a weekly internal meeting and the family was updated. The U.S. FOIA (stated that the insurance company would notify the facility of the d/c date. She added dependent on the type of the insurance, the notification could be three days to twenty four hours before the date. The U.S. FOIA (stated that when the d/c date was known, the facility would call the physician, NJ Ex Order would order equipment and she would set up the NJ Ex Order 26.4(b)(1) . She added that she would send a referral to the NJ Ex Order 26.4(b)(1) and they would "say yes we can take it." The U.S. FOIA (stated that sometimes the NJ Ex Order 2 may have staffing issues and then the NJ Ex Order 2 would communicate to me that they could not take the referral and then she would "refer to a different agency." The U.S. FOIA (stated that the NJ Ex Order 2 would text her and that she would document the referral in the medical record.

On that same date and time, the surveyor asked the U.S. FOIA (about Resident #308's d/c planning. The U.S. FOIA (stated that if she remembered that she sent the referral to HCSA#1 and that they accepted the referral. She stated that after the

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resident went home, HCSA #1 called her a few days later and told her the agency could not take the resident and that HCSA #1 referred the resident to HCSA #2. The [redacted] stated that they would have kept Resident #308 at the facility longer or referred the resident to a different HCSA if she had known. The [redacted] stated that she called RR when she found out and that the RR told her that when HCSA #2 had reached out to RR to set up the [redacted] that RR had already taken Resident #308 to the hospital. The surveyor asked the [redacted] if she received an email from the HCSA or documented the acceptance or approval from the HCSA. The [redacted] stated that she only received an email if the HCSA refused the referral. The surveyor asked the [redacted] to provide any documented evidence that the HCSA accepted or approved the referral.

On 9/17/24 at 02:15 PM, the [redacted] provided the surveyor a screen shot of test message conversation between her and HCSA #1 which revealed the following:

[redacted]-Resident #308 dc [redacted] Has [redacted] from [company name redacted] 4:18 PM

[redacted]

HCSA #1-we need order for ...Resident #308 ...asked our nurses to try for a verbal. Are you able to get an order for either? 5:26 PM

[redacted]-On Sunday as I'm home now. 5:53 PM

[redacted]-Resident has [redacted] 5:53 PM

[redacted]-Mon wed Friday 5:54 PM

[redacted]

[redacted]-a picture of a physician's RX which included the following: [name of homecare agency] U.S. FOIA (b) (6) [redacted]

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There was no documented evidence that HCSA#1 accepted or approved the referral.

On 9/18/24 at 10:55 AM, the U.S. FOIA (stated that HCSA#1 had confirmed and needed a RX. The U.S. FOIA (stated that Resident #308 had commercial insurance and they gave a d/c date for the next day which she thought they found out on NJ Ex Order 26.4. She added that the RR wanted the resident to stay out the facility for NJ Ex Order 26.4b1 (planned or emergency temporary care that is not paid for by the insurance company). The U.S. FOIA (stated that she sent the referral to HCSA#1 on NJ Ex Order 26.4 and the resident was d/c on NJ Ex Order 26.4(b).

On 9/18/24 at 12:02 PM, in the presence of the survey team, the surveyor notified the U.S. FOIA (b) (6) U.S. FOIA (b) (6), Regional Nurse Consultant #1 (RNC #1) and U.S. FOIA (b) (6) the concerns that Resident #308 did not have any documentation that the referral for NJ Ex Order 26.4b1 services was accepted or approved by the agency prior to the resident's d/c to home and that there was no PO for d/c.

On 9/20/24 at 10:14 AM, the surveyor interviewed, via telephone, the U.S. FOIA (b) (6) for HCSA #1 regarding the process for referrals. The U.S. FOIA stated that he would call and talk to U.S. FOIA (to get an update of the residents that were being d/c and that he would follow up with the branch of the HCSA#1 to see if there was availability. The surveyor asked the U.S. FOIA if he sent any documentation that the resident's referral was

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accepted. The [U.S. FOIA] stated "not really." The surveyor asked the [U.S. FOIA] if he had any documentation regarding Resident #308's referral. The [U.S. FOIA] stated that he would check if he had any emails. He added that the communication was mostly verbal and by phone. The [U.S. FOIA] stated that he submitted everything for the resident on a Thursday and that over the weekend he was notified that the branch of HCSA#1 could not take the resident. He added that he was not sure if the reason was a nurse callout or not. The [U.S. FOIA] stated that he then contacted HCSA#2 to take the resident but that in the meantime the resident went to the hospital. The [U.S. FOIA] added that moving forward he may do a specific email regarding the referral.

On 9/20/24 at 11:26 AM, in the presence of the survey team, [U.S. FOIA (b)] RNC #1, [U.S. FOIA (b) (6)], the [U.S. FOIA (b)] stated that the facility documented that a [NJ Ex Order 26.4b1] referral was made. She added that unless otherwise noted the staff only write a note if the referral was not accepted. The [U.S. FOIA (b)] stated that the resident referral was accepted. She added that it was always an approval unless there was specific documentation of not being approved.

The facility did not provide any additional information.

A review of the undated facility provided policy titled, "Discharge Summary and Plan" included the following:
Policy Statement
When a resident's d/c is anticipated, a d/c summary and post-d/c plan will be developed to assist the resident to adjust to their new living environment.

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Policy Interpretation and Implementation
1. When the facility anticipates a resident's d/c to a private residence, another nursing care facility ..., a d/c summary and a post-d/c plan will be developed which will assist the resident to adjust to their new living environment.
4. The resident will be evaluated for their d/c needs and will have an individualized post-d/c plan.
5. The post-d/c plan will be developed by the care planning/interdisciplinary team (IDT) with the assistance of the resident and their family and will include: ...
b. arrangements that have been made for follow-up care and services; ...
8. Residents will be asked about their interest in returning to the community. If the resident indicates an interest in returning to the community, they will be referred to local agencies and support services that can assist in accommodating the resident's post-d/c preferences.

A review of the facility provided policy titled, "Discharge Procedures" with an adopted date of February 2023, included the following:
Purpose
To ensure that each patient d/c proceeds in an orderly fashion and that appropriate preparation and/or referral to community resources has been accomplished ...
Procedure
2. When the Interdisciplinary patient care team determines that the patient has reached their maximum potential appropriate for an inpatient stay, a projected d/c date will be established.
3. The Social Worker will discuss the patient's d/c date with the patient/family including community resource involvement ....

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 34 6. The IDT will maintain communication with the patient and family relative to the d/c planning ... 8. Prior to d/c the nurse will check that the physician has written the d/c order and has completed the RX, if any. N.J.A.C. 39.4 (f)(h)	F 660		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.	F 661		10/4/24

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F 661	Continued From page 35 This REQUIREMENT is not met as evidenced by: Complaint # NJ174669 Based on the interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to document a discharge summary which included a recapitulation of the resident's stay and a final summary of the resident's status for one (1) of two (2) residents reviewed for discharge (Resident #308). This deficient practice was evidenced by the following: On 9/17/24 at 12:55 PM, the surveyor reviewed the closed hybrid (paper and electronic) medical record for Resident #308 which revealed the following: Resident #308's Admission Record (or face sheet; admission summary) indicated that the resident was admitted to the facility with medical diagnoses that included but were not limited to [redacted] A review of Resident #308's Discharge assessment-return not anticipated Minimum Data Set (DRNAMDS), an assessment tool used to facilitate the management of care, reflected that the resident had a Brief Interview for Mental	F 661	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident # 308 (Discharged from facility) How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents who are scheduled to discharge home have the potential to be affected What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The nurses and the [redacted] have been in-serviced on the requirements for a discharge summary including the recapitulation of the resident's stay but not limited to diagnosis, course of illness/treatment or therapy, and pertinent lab, radiology and consultation reports. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change? The administrator and /or DON will audit 5 discharging resident's charts a week for four weeks, then 5 charts a month for 1	

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F 661	Continued From page 36 Status (BIMS) score of [NJ Ex] out of 15, which indicated that Resident #308 [NJ Exec Order 26.4] was [NJ Ex Order 26.4(b)(1)] Further review reflected that Resident #308 had a planned discharge (d/c) to home/community. A review of Resident #308's Progress Notes reflected that the resident was d/c [NJ Ex Order 2] A review of Resident #308's hybrid medical record did not include a d/c summary. On 9/20/24 at 11:33 AM, in the presence of the survey team, the surveyor notified the [U.S. FOIA (b) (6)] [U.S. FOIA (b) (6)], Regional Nurse Consultant (RNC#1) and [U.S. FOIA (b) (6)] the concern that Resident #308 did not have a d/c summary in their hybrid medical record. The [U.S. FOIA (b)] confirmed that the paper medical record did not contain a d/c summary. The [U.S. FOIA] stated that she was looking in the electronic medical record and that she observed a d/c instructions and d/c planning review. The surveyor asked if the facility could confirm that there was no d/c summary in the electronic medical record. The facility administration did not respond. The facility did not provide any additional information. A review of the undated facility provided policy titled, "Discharge Summary and Plan" included the following: Policy Statement When a resident's d/c is anticipated, a d/c summary and post-d/c plan will be developed to assist the resident to adjust to their new living environment.	F 661	quarter to ensure completion. The results of the audits will be reviewed during the monthly Quality Assurance Performance Improvement Committee meeting. The Quality Assurance Performance Improvement committee will make recommendations based upon the results of the audits. The Quality Assurance Performance Improvement Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. When will corrective action be accomplished? 10/4/24	

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F 661	Continued From page 37 Policy Interpretation and Implementation 1. When the facility anticipates a resident's d/c to a private residence, another nursing care facility ..., a d/c summary and a post-d/c plan will be developed which will assist the resident to adjust to their new living environment. 2. The d/c summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the d/c in accordance with established regulations governing release of resident information and as permitted by the resident. The d/c summary shall include a description of the resident's: a. current diagnosis; b. medical history ... c. course of illness, treatment and/or therapy since entering the facility ... o. cognitive status and p. medication therapy ... 13. A copy of the following will be provided to the resident ...and a copy will be filed in the resident's medical records: ... c. The d/c summary. N.J.A.C. 8:39-35.2(d)(16)	F 661		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		10/4/24

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F 686	Continued From page 38 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to provide care and services consistent with professional standards of practice for a resident with NJ Ex Order 26.4(b)(1). This deficient practice was identified in one (1) of two (2) residents (Resident #36), reviewed for NJ Ex Order 26.4(b)(1) care and prevention. The deficient practice was evidenced by the following: On 9/16/24 at 9:36 AM, the surveyor observed Resident #36 lying in their bed with the head of the bed elevated. The resident was NJ Ex Or and NJ Ex Order 26.4(b)(1). Resident #36 stated they had a NJ Ex Order 26.4(b)(1) which they were receiving treatment (tx) for. The resident added the NJ Ex Order 26 was NJ Ex Ord and they did not have it prior to being admitted to the facility. On 9/18/24 at 11:17 AM, the surveyor requested from the U.S. FOIA (b) (6)) any NJ Exec Order 26.4b1 for Resident #36. On 9/19/24 at 9:00 AM, the surveyor asked the U.S. FOIA (b) and U.S. FOIA (b) (6)) if there were any skin investigations for Resident #36. The U.S. FOIA (stated the U.S. FOIA (b) (6) had the investigation and it would be provided to the surveyor. The provided NJ Ex Order 26.4(b)(1) dated NJ Ex Order 26.4	F 686	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #36 was seen by NJ Ex Order 26 on NJ Ex Order 26.4(and treatment rendered by physician with new orders Resident #36 is no longer in the facility as of NJ Exec Order 2 Nurse involved in ordering the wound consult order on NJ Ex Order 26 was educated by U.S. FOIA (b) (6) on importance of documenting new skin injury , notifying physician and obtaining treatment order. How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents with new skin injury can be potentially affected by the deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Assistant Directors of Nursing and Unit Managers provided in-service education for all nurses on proper bi-weekly skin evaluation and documentation in	

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F 686	Continued From page 39 revealed that the resident was found with an NJ Ex Order 26.4(b)(1). The NJ Ex Order 26.4(b)(was NJ Ex Order 26.4(b)(with NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) applied and NJ Ex Order 26.4(b)(1). A NJ Ex Order 26 was also recommended. The investigation indicated the physician was made aware and an order for NJ Ex Order 26.4(b)(1) tx was to begin. The resident's representative was also made aware. The surveyor reviewed the hybrid (paper and electronic) medical records of Resident #36. The Admission Record (a summary of important information about the resident) documented that the resident had diagnoses that included but were not limited to, NJ Ex Order 26.4(b)(1), NJ Ex Orde , NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) A comprehensive Minimum Data Set (MDS) assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #36 scored a NJ Ex out of 15, which indicated the resident was NJ Ex Order 26.4(b)(1). Under Section NJ Ex Order 26.4(b)(1) of the MDS assessment, it was documented that the resident was at risk for NJ Ex Order 26.4(b)(1) and it was determined by clinical assessment. A review of physician's orders (PO) included the following: A PO dated NJ Ex Order 26.4 with a start date of NJ Ex Order 26.4(read, 'NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1)	F 686	Treatment Administration Record. Education was also provided regarding the policy titled, “Wound Care” which includes but not limited to documentation of “any change in the resident’s condition”. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change? Assistant Directors of Nursing will audit the bi-weekly Skin evaluation order for 5 random residents on each unit weekly x 4 weeks, then monthly x 2 months for accuracy of assessment and notification to physician with treatment orders for any new skin injury. All findings will be presented at monthly Quality Assurance Performance Improvement Committee for review and to ensure compliance and further follow-up as needed. When will corrective action be accomplished? 10/04/2024	

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F 686	Continued From page 40	F 686		

solution] and [redacted]. Apply [redacted] and cover with [redacted] every day shift for [redacted]."

A PO dated [redacted] read [redacted] as needed."

A review of the [redacted] electronic Treatment Administration Record (eTAR) revealed:
An entry dated [redacted] that read "[redacted] with [redacted] schedule every day shift every Tues (Tuesday), Fri (Friday) for [redacted]" Additionally, it read, "Document using the following [redacted] .. [redacted] .. [redacted] ...If you respond with "[redacted] further documentation in progress note (PN) and physician notification and [redacted] ...".

For the following dates of the [redacted] the nurse documented the following. On [redacted] the nurse documented "[redacted] On [redacted] the nurse documented "[redacted] and on [redacted] the nurse document "[redacted]

The eTAR included the entry for the [redacted] [redacted] tx to the [redacted] that started on [redacted] There were no other [redacted] tx entries for the [redacted] documented in the [redacted] eTAR.

The resident had a care plan (CP) with a focus that read, "[Resident #36] has potential/actual [redacted] r/t [related to] [redacted] The CP was initiated on [redacted] and last revised on [redacted]. Interventions listed were: "Administer meds (medications)/vitamins as ordered" and "Avoid [redacted] and keep hands and body parts from [redacted] Keep [redacted]."

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F 686	Continued From page 41	F 686		

The resident had a CP with a focus that read, " [Resident #36] has a NJ Ex Order 26.4(b)(1) ". The CP was initiated on NJ Ex Order 26.4 and last revised on NJ Ex Order 26.4. The interventions indicated the resident was NJ Ex Order assist with NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1).

The resident had a CP with a focus that read, "[Resident #36] has NJ Ex Order 26.4(b)(1)". The CP was initiated on NJ Ex Order 26.4 and last revised on NJ Ex Order 26.4. The interventions indicated the resident was a NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(

A review of nurse PN in NJ Ex Order 26.4(b)(1) revealed there was no documentation about the resident being found with a NJ Ex Order 26.4(b)(1) to the NJ Ex Order 26.4(b)(1).

A review of the NJ Ex Order 26.4(b)(1) note dated NJ Ex Order 26.4 revealed the resident was seen for a NJ Ex Or to the NJ Ex Order 26.4(b)(1) that was diagnosed as a NJ Ex Order 26.4(b)(1) and included the NJ Ex Order 26.4(assessment. The NJ Ex Order 26.4(b)(1) physician recommended NJ Ex Order 26.4(b)(1) tx to the NJ Ex Order 26.4(b)(1) once daily. Additionally, the NJ Ex Order 26.4(b)(1) recommended to NJ Ex Order 26 the NJ Ex Order 26. reposition per facility policy, and a NJ Ex Order 26.4(b)(1).

On 9/19/24 at 10:03 AM, the surveyor interviewed the U.S. FOIA (b The surveyor reviewed the NJ Ex Order 26.4(b)(1) eTAR's NJ Exec Order 26.4b1 assessment entry. The surveyor asked what the documented "n" meant which was electronically signed by the nurse. The U.S. FOIA stated she was not sure why the nurse documented "n" since the entry indicated NJ E

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F 686	Continued From page 42	F 686		

NJ or NJ should be used when completing the entry. The U.S. FOIA stated she would follow up with the nurse for the meaning of the "n" documented.

On 9/19/24 at 11: 54 AM, the U.S. FOIA stated it was clarified with the nurse that the "n" indicated there was NJ Ex Order 26.4b1.

On 9/19/24 at 02:00 PM, the policy titled "Wound Care" was provided to the survey team.

On 9/19/24 at 02:15 PM, the survey team met with the U.S. FOIA (b) (6), and U.S. FOIA (b) (6). The surveyor informed the facility about the concerns for Resident #36's NJ Ex Order 26.4(b)(1) including: there was no NJ Ex Order 26 tx order found between NJ Ex Order 26.4(and NJ Ex Order 26.4, there was no documentation of the resident's NJ Ex Order 26 in the nurse PN, and the coding of the bi-weekly NJ Ex Or in the eTAR were not accurate. There was no verbal response by the facility at this time.

On 9/20/24 at 8:50 AM, the surveyor requested from the U.S. FOIA (b) any additional policies related to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) besides the "Wound Care" policy provided.

On 9/20/24 at 11:21 AM, the survey team met with U.S. FOIA (b) U.S. FOIA (b) U.S. FOIA and U.S. FOIA (b) (6). There was no additional information and no additional policies provided by the facility.

The surveyor reviewed the provided undated facility's policy titled, "Wound Care," under documentation, it read: "The following information should be recorded in the resident's medical record ...4. Any change in the resident's condition

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F 686	Continued From page 43 ..." Further review of the above "Wound Care" Policy revealed that the policy did not further address wound assessments and its documentation.	F 686		
F 688 SS=D	NJAC 8:39-27.1 (a)(e) Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record, and other facility documentation, it was determined that the facility failed to ensure that residents admitted with c[NJ Ex Order 26.4(b)(1)] [redacted] and [NJ Ex Order 26.4] received appropriate treatment, [NJ Ex Order 26] appropriate services, and assistance to maintain and prevent [NJ Ex Order 2] [redacted]. This deficient practice was identified for	F 688	How will any corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident #67 did not have a care plan to address [NJ Ex Order 26.4(b)(1)] on [NJ Ex Order 26.4(b)(1)] [redacted]. Care plan was added on	10/8/24

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F 688	Continued From page 44 one (1) of two (2) residents, Resident #67, reviewed for a NJ Ex Order 26.4(b)(1)). This deficient practice was evidenced by the following: On 9/16/24 at 10:25 AM, the surveyor observed Resident #67's room closed. Licensed Practical Nurse #1 (LPN#1) came out from the resident's room and informed the surveyor that the surveyor had to come back later. The LPN further stated that there were two aides providing care. The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #67 and revealed: The Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) The most recent quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of NJ Ex Order 26.4, under Section NJ Ex Order 26.4(b)(1), reflected NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) made regarding tasks of daily life score of NJ Ex out of 15 which indicated that the resident's NJ Ex Order 26.4(b)	F 688	9/18/2024. Resident #67 MDS with an ARD date of NJ Ex Order 26.4 indicated NJ Ex Order 26.4(b)(1). MDS was modified on 10/12/23 to reflect NJ Ex Order 26.4(b)(1) after a return from the hospital. No documentation that NJ Ex Order 26.4(b)(1) was completed for resident #67. Therapy quarterly screening forms were not signed by therapists. All screens completed now are assigned to the therapist on their schedule prior to the ARD Date for completion. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents with decreased range of motion and mobility have the potential to be affected by the deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? U.S. FOIA (b) (6) completed “Rehab to nursing Communication” education on 10/8/2024 regarding range of motion compliance. Assistant Director of Nursing and/or facility nurse educator completed education with the unit managers and nurses on care planning for physical impairments on 10/8/2024. How will the facility monitor its corrective	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 45 was NJ Ex Order 26.4(b)(1). Section NJ Ex Order 26.4(b)(1) showed that Resident #67 had NJ Ex Order 26.4(b)(1) Further review of the MDS revealed that on admission MDS ARD NJ Ex Order 26.4, modified on NJ Ex Order 26.4(b), reflected that Section NJ Ex O was coded for NJ Ex Order 26.4(b)(1). A review of the personalized care plan (CP) showed that the NJ Ex Order 26.4(b)(1) were not addressed. There was no documented evidence that services were provided or attempted to include interventions, care, and equipment to address the NJ Ex Order 26.4(b)(1) A review of the Progress Notes (PN) dated NJ Ex Order 26.4(b) by the U.S. FOIA (b) (6) included that the resident was seen for follow-up and resident had no NJ Ex Order 26.4(b)(1). The U.S. FO further documented that the resident was on NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) fairly. A review of the provided NJ Ex Order 26.4(b)(1) Encounter Note(s) dated NJ Ex Order 26.4(b) revealed in the Summary of Daily Skilled Services that was electronically signed by NJ Ex O NJ Ex Order 26.4(b)(1) no NJ Ex Order 26.4(b)(1) present. NJ Ex Order 26.4(b)(1); as tolerated for NJ Ex Ord ; at NJ Ex Order 26.4(as tolerated; to improve NJ Ex O and prevent further NJ Ex Order 26.4(b)(1) ... Patient's (Resident) family was updated that the patient is not candidate for NJ Ex Order 26.4(b)(1 services at this time; to be dc (discontinued) from NJ Ex Order at present; will be re evaluated if any significant change in NJ Ex Order 26.4(b)(1) noted.	F 688	actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change? Director of Rehab will randomly audit 5 rehab quarterly screens 1x a month x 3 months and then present to the Quality Assurance Performance Improvement committee to determine compliance with facility policy and need for further auditing. Unit Managers to audit care plans to ensure impairments and range of motion are reflected 1x a week for 4 weeks and then monthly x 2 months. Results will be presented at Quality Assurance Performance Improvement meeting to determine need for further auditing. When will corrective action be accomplished? 10/08/2024	

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	315526	A. BUILDING _____ B. WING _____	C 09/20/2024

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F 688	Continued From page 46 Response to Tx (treatment): response to session interventions: actively participates with skilled interventions. Complexities: Barriers impacting treatment?=[redacted] There was no documented evidence in hybrid medical records that the NJ Ex Order 26.4(b)(1) was followed through, documented in CP, and addressed to tasks. A review of the Task List Report of the Certified Nursing Aide did not include tasks that the aide performed from NJ Ex Order 26.4(b) to the current date that address the NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) [redacted] On 9/18/24 at 9:49 AM, the surveyor and LPN#2 went to the resident's room and observed the resident on the bed at approximately 45 degrees sitting position with NJ Ex Order 26.4(b)(1) being NJ Ex Order 26.4(b)(1). Afterward, LPN#2 asked the U.S. FOIA (b) (6) [redacted]) to help her reposition the resident. Both the LPN and U.S. FOIA (b) (6) confirmed that the resident had NJ Ex Order 26.4(b)(1) [redacted] The U.S. FOIA (b) (6) stated that the contractures of the resident were not something new. The U.S. FOIA (b) (6) further stated that the resident was NJ Ex Order 26.4(b)(1), and the resident did not have an NJ Ex Order 26.4(b)(1) or NJ Ex Order 2 since she started (U.S. FOIA (b) (6) claimed she had been working in the facility for a NJ Exec O and NJ Exec Order 26.4b1) at the facility. The U.S. FOIA (b) (6) also stated that "come to think of it the resident should at least have a NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1) [redacted]	F 688		

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NJ Ex Order 26.4(b)(1)

On 9/18/24 at 10:05 AM, the surveyor interviewed the U.S. FOIA (b) (6)). The U.S. FOIA (b) (6) informed the surveyor that she had been working in the facility since NJ Ex Order 26.4(b)(1). The surveyor asked what the facility's process was, with regard to LTC (Long Term Care) residents about residents' maintenance and rehabilitation (rehab) for their NJ Ex Order 26.4(b)(1), specifically residents who came in with NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) (6) stated that LTC residents were being seen by Therapists under NJ Ex Order 26.4(b)(1) we screened them quarterly and the screen was placed in a binder "in my office." She further stated that when residents have NJ Ex Order 26.4b1, we do NJ Ex Orde and NJ Ex Orde as appropriate during NJ Ex Order 26.4 and then transition them to NJ Ex Order 26.4

On that same date and time, the U.S. FOIA (b) (6) informed the surveyor that at times nursing will refer residents to NJ Ex Order 2 if needed, and if the resident was NJ Ex Order 26.4(b)(1) would provide NJ Ex Orde as appropriate. The surveyor asked the U.S. FOIA (b) (6) to show the surveyor the binder where compilations of NJ Ex Order 26.4(b)(1) was, and the U.S. FOIA (b) (6) stated she would get back to the surveyor to bring the binder.

On 9/18/24 at 10:23 AM, the surveyor notified the U.S. FOIA (b) (6)) regarding the NJ Ex Order 26.4(b)(1) binder that the surveyor asked the U.S. FOIA (b) (6) to show to the surveyor. The U.S. FOIA (b) (6)) stated that she would get the U.S. FOIA (b) (6) and the binder.

Afterward, the U.S. FOIA (b) (6) came and informed the surveyor in the presence of the survey team that

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she was unable to find the NJ Ex Order 26.4(b)(1) binder because the one who had the binder resigned in NJ Ex Order 26.4(b)(. The U.S. FOIA (b) (6) further stated that she was unable to find "right now" the NJ Ex Order 26.4(b)(1) as well. The surveyor then asked the U.S. FOIA (b) (6) how she knew that the NJ Ex Order 26.4b1 were all done and who needed the NJ Ex Order screens. The U.S. FOIA (b) (6) stated that she knew it was done and would get back again to the surveyor.

On 9/18/24 at 11:33 AM, the U.S. FOIA (b) (6) provided a copy of the NJ Ex Order 26.4(b)(1) Screen Forms. The surveyor notified the U.S. FOIA (b) (6) about the above concerns and findings that Resident #67 with NJ Ex Order 26.4b1 had no CP to address the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) and had no care and services attempted to address the NJ Ex Order 26.4(b)(1) The surveyor also notified the U.S. FOIA (b) (6) that there was no documented evidence that the resident had a NJ Ex Order screen quarterly and addressed the NJ Ex Order 26.4(b)(1) The U.S. FOIA (b) (6) stated that she would get back to the surveyor.

A review of the NJ Ex Order 26 and NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(Screen Form that was provided by the U.S. FOIA (b) (6) revealed: NJ Ex Order 26.4(b)(1):
-14 out of 17 residents that were screened did not include the name(s) of the NJ Ex (Staff that performed the NJ Ex Order 26.4 screen.
-3 out of 17 residents had no name(s) and title(s) of NJ Ex Order 26 staff who screened the residents.
-8 out of 17 residents did not specify if the evaluation was recommended or not (yes or no was not encircled).
September 2024:
-5 out of 5 residents that were screened did not include the name(s) of the NJ Ex (Staff that

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performed the NJ Ex Order 26.4 screen.
-3 out of 5 residents did not specify if the evaluation was recommended or not.

Further review of the above NJ Ex Order 26. and NJ Ex Order 26.4(b)(1) Screen Form revealed that Resident #67 was not included on the list. The facility management was unable to provide documented evidence that the resident was screened quarterly by NJ Ex Order 2 according to the previous statement of the U.S. FOIA (b) (6) as part of the facility's process and practice.

On 9/18/24 at 11:39 AM, the survey team met with the U.S. FOIA (b) (6) and Regional Nurse Consultant #1 (RNC#1). The surveyor notified the facility management of the above concerns with Resident#67.

On 9/18/24 at 01:51 PM, the surveyor in the presence of the survey team informed RNC#1 about the concern that Resident #67's tasks and CP did not address the resident's NJ Ex Order 26.4(b)(1) The surveyor asked RNC#1 why there was no CP for the resident's NJ Ex Order 26.4(b)(1) , and RNC#1 had no response.

On 9/19/24 at 01:26 PM, the survey team met with the U.S. FOIA (b) (6), U.S. FOIA (b) (6), U.S. FOIA (b) and RNC#1. The U.S. FOIA (b) stated for Resident #67, "I did the digging," the resident was contracted prior to admission and was NJ Ex Order 26.4b1, the resident was on NJ Ex Order 26.4(b)(1) two different times, and dc NJ Ex Order 26.4 . The U.S. FOIA (b) acknowledged that the U.S. FOIA (b) (6) documented in the PN that the resident will not benefit from NJ Ex Orde and NJ Ex Order 2 due to NJ Ex Order 26.4 after the surveyor's inquiry.

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On 9/20/24 at 9:20 AM, the surveyor asked the U.S. FOIA (b) (6) in the presence of the U.S. FOIA about the U.S. FO who did the notes of the resident during NJ Ex txs. The U.S. FOIA (b) (6) stated that the U.S. FO was out of the country and the surveyor would not be able to interview the U.S. FO The surveyor then asked U.S. FOIA (b) (6) why the provided copies for NJ Ex Order 26.4(and U.S. FO had no physician signatures. The U.S. FOIA (b) (6) stated that for NJ Ex Order tx notes from NJ Ex Order 26.4(b)(through NJ Ex Order 26.4(b, the physician should have signed them off. The facility management did not respond to why the physician did not sign the documents.

On 9/20/24 at 10:33 AM, the surveyor in the presence of the survey team interviewed the U.S. FOIA (b) (6) via a phone interview. The U.S. FOIA (b) (6) informed the surveyor that she had been working in the facility for a year now but was unable to state the exact date. The U.S. FOIA (b) (6) also confirmed that it was yesterday only that she was able to see and evaluate Resident #67. The U.S. FOIA (b) (6) informed the surveyor that as a standard of practice, she and her team when assessing or evaluating the residents with high risk or presented with NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) it will be expected to initiate and attempt to treat residents with NJ Ex Orde and NJ Ex Order 26.4(b)(1) or other NJ Ex Order 26.4(b)(1) to prevent or further NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) and document.

On that same date and time, the surveyor notified the U.S. FOIA (b) (6) of the above findings and concerns. The surveyor asked the U.S. FOIA (b) (6) would a NJ Ex Order 26.4(b)(or NJ Ex Order 26.4(b)(1) would be beneficial for residents with NJ Ex Order 26.4(b)(1) to their NJ Ex Order 26 or will it harm the resident. The U.S. FOIA (b) (6) stated that "we do that for prevention." She

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F 688	Continued From page 51 further stated that "we" can use a [NJ Ex Order 26.4b1] [redacted], very easy to clean and will not hurt the resident. The surveyor then asked the [US FOIA (b)(6)] after seeing the resident yesterday if the [NJ Ex Order 26.4(b)(1)] or [NJ Ex Order 26.4(b)(1)] would be appropriate or will it harm the resident. The [U.S. FOIA (b) (6)] responded that the [NJ Ex Order 26.4(b)(1)] or [NJ Ex Order 26.4(b)(1)] would not hurt the resident and would "probably" be appropriate to the resident. A review of the facility's Range of Motion Devices with an updated date of 4/2024 that was provided by the [U.S. FOIA] showed: Policy: Residents with limited ROM may be candidates for the use of orthotic devices such as splints and braces. When used, these devices will be maintained to increase and/or prevent a further decrease in ROM and to reduce the risk of complications. Procedure: 1. Physical and occupational therapists may make recommendations for the use of ROM devices within their scope of practice ... 5. The licensed nurse will document in the medical record the completion of monitoring for potential complications as ordered by the physician. a. In the event that a complication or potential complications is observed, the nurse will document details of the observation in the medical record ... 6. The resident's CP will include measurable goals and objectives as well as resident-specific interventions for the use of ROM devices. The above policy did not contain any information about [NJ Ex Order 26.] The facility did not provide any policy with regard to [NJ Ex Order 26.]	F 688		

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F 688	Continued From page 52 On 9/20/24 at 01:14 PM, the survey team met with the U.S. FOIA (b) (6), U.S. FOIA (b) (6), U.S. FOIA (b) (6), U.S. FOIA (b) (6), RNC#1, and RNC#2 for an exit conference. There was no additional information provided by the facility management. The facility management was unable to show resident's quarterly NJ Ex Order screens for Resident #67. N.J.A.C. 8:39-27.1(a), 27.2(m)	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY	F 692	How will any corrective action be accomplished for those residents found to	10/4/24

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F 692	Continued From page 53 Based on observation, interview, and record review, it was determined that the facility failed to ensure that a.) the monthly NJ Ex Order 2 and NJ Ex Order 26.4(b)(1 were done, documented, and monitored for two (2) of two (2) residents, Residents #2 and #67, b.) the physician was notified the NJ Ex Order 26.4(b)(1) for one (1) of two (2) residents, Resident #2, reviewed for NJ Ex Order 26.4(b and c.) the duplicate physician orders for NJ Ex Order 26.4(b)(1) were clarified for one (1) of one (1) resident, Resident #67, reviewed for NJ Ex Order 26.4(b)(1 This deficient practice was evidenced by the following: 1. On 9/16/24 at 10:40 AM, the surveyor observed Resident #2 seated on the bed with a breakfast tray in front of the resident with the U.S. FOIA (b) (6)) at the bedside. The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #2 and revealed: The Admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) , NJ Ex Ord , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) .	F 692	have been affected by the deficient practice? Resident #2 physician notified of NJ Ex Order 26.4(b Resident #67 duplicate order for NJ Ex Ord was discontinued, physician notified of NJ Ex Order 26.4(b)(1) How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by this deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? CNA staff was reeducated by DON/ADON/UM on process of obtaining weights. UM's were reeducated by DON/ADON on process of entering weights into EMAR and notifying physicians of any significant weight change. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change? The DON/ADON will conduct an audit of weights weekly for 3 weeks then monthly for 2 months. A monthly weight meeting will be conducted with the interdisciplinar	

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F 692	Continued From page 54 The most recent admission (modified) Minimum Data Set (MDS) with an assessment reference date (ARD) of [redacted] under Section [redacted], showed a brief interview for mental status (BIMS) score of [redacted] out of 15 which reflected that the resident's [redacted] status was [redacted]. A review of the personalized care plan (CP) showed a focus CP that the resident had a [redacted] problem or [redacted] problem r/t (related to) [redacted], and that was initiated on [redacted]. The CP goal included but was not limited to the resident will maintain [redacted] as evidenced by [redacted] that was initiated on [redacted]. According to the [redacted] Order Summary Report (OSR), there was an active physician's order (PO) with an order date of [redacted] to obtain [redacted] time a day starting on the 1st and ending on the 7th every month for [redacted] in MAR (Medication Administration Record) and [redacted])/vitals. A review of the [redacted] Summary revealed the following: Date Value Warnings [redacted] [comparison [redacted], [redacted], [redacted], [redacted] MDS: [redacted] over 30 day(s)	F 692	team. The DON or UM will conduct an audit to review for duplicate orders of 5 charts weekly for 3 weeks, then 5 charts monthly for 2 months. The results of the audits will be reviewed during the monthly Quality Assurance Performance Improvement Committee meeting. The Quality Assurance Performance Improvement committee will make recommendations based upon the results of the audits. The Quality Assurance Performance Improvement Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. When will corrective action be accomplished? 10/04/2024	

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NJ Ex Order 26.4 NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)(1)
[comparison NJ Ex Order 26.4(b)(1),
NJ Ex Order 26.4(b)(1)
NJ Ex Order 26.4 , NJ Ex Order 26.4(b)]
NJ Ex Order 26.4(b)(1) from last wt
[comparison
NJ Ex Order 26.4(b)(1),
NJ Ex Order 26.4 , NJ Ex Order 26.4
NJ Ex Order 26.4 NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)(1)
[comparison NJ Ex Order 26.4(b)(1)
NJ Ex Order 26.4(b) , NJ Ex Order 26.4(b) ,
NJ Ex Order 26.4(b)]
NJ Ex Order 26.4(b)(1) from last wt
[comparison
NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)
NJ Ex Order 26.4 , NJ Ex Order 26.4(b)(1)
NJ Ex Order 26.4 NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)(1)
[comparison NJ Ex Order 26.4(b)(1)
NJ Ex Order 26.4(b) , NJ Ex Order 26. , NJ Ex Orde
[redacted]
MDS: NJ Ex Order 26.4(b)(1) over
30 day(s)
[comparison NJ Ex Order 26.4(b)(1)
NJ Ex Order 26. , NJ Ex Order 26. , NJ Ex Order 26

A review of the Progress Notes (PN) dated NJ Ex Order 26.4 at 8:52 AM by the U.S. FOIA (b) (6) revealed that Resident #2 was triggered for NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1). The PN showed that NJ Ex Order 26 was possible prior to admission due to NJ Ex Order 26.4(b)(1)), which was NJ Ex Order 26.4(b)(1) . The plan was to monitor NJ Ex Ord , NJ Ex Or and NJ Ex Order 26.4(b)(1) , and intervene as appropriate.

Further review of the hybrid medical records showed that there was no documented evidence that the physician was notified of the NJ Ex Order 26.4(b)(1)
[redacted]

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	315526	A. BUILDING _____ B. WING _____	C 09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVINGSTON POST ACUTE CARE	348 E CEDAR STREET LIVINGSTON, NJ 07039

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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On 9/17/24 at 10:56 AM, the surveyor interviewed Licensed Practical Nurse #1 (LPN#1) in the nursing station on the 3rd floor. The LPN informed the surveyor that Resident #2 was NJ Ex Order 26.4(b)(1). The LPN stated that she was unsure if the resident had NJ Ex Order 26 because it was the aide who was responsible for obtaining NJ Ex O of the resident, and it was the U.S. FOIA (b) (6)) who entered the NJ Ex O in the resident's electronic medical records (EMR).

On 9/17/24 at 11:22 AM, the surveyor interviewed the U.S. FOIA (b) (6) The U.S. FOIA (b) (6) stated that in the facility's process about wts, the staff takes residents' NJ Ex O the first seven days of the month, if there will NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4 must be done on or before the 1 of the month. She further stated that she documents every month, every after NJ Ex O were done, and as needed for NJ Ex Order 26.4(b)(1

On that same date and time, the U.S. FOIA (b) (6) informed the surveyor that the nursing department was responsible for obtaining the residents' NJ Ex O and the staff documented it in a NJ E book. The U.S. FOIA (b) (6) stated that it was the U.S. FOIA responsibility to enter the NJ E in the EMR. She further stated that there was no other documentation of NJ Ex O except for those two areas, the NJ E binder and the EMR.

At that same time, the surveyor asked the U.S. FOIA (b) (6) if she notified the doctor about the significant NJ E loss or NJ E changes, and if she documented the communication between the U.S. FOIA (b) (6) and physicians about NJ E changes. The U.S. FOIA (b) (6) stated that she did not call a doctor, she

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documented her assessment and notes in EMR. She further stated that when she started at the facility on [redacted] there was no [redacted] meeting, and this would be the plan to have [redacted] meetings.

Afterward, the surveyor asked the [redacted] why there were no [redacted] in NJ Ex Order 26.4(b)(1) and [redacted] when the NJ Ex Order 26.4(b)(1) Summary indicated a [redacted] of [redacted] or more. The [redacted] stated, "I can't answer that question." The [redacted] stated that the [redacted] was aware that the resident should have a [redacted] for NJ Ex Order 26.4(b)(1) because she verbally notified the [redacted] about it.

Furthermore, the surveyor asked the [redacted] should there be a note that the physician was notified of the NJ Ex Order 26.4(b)(1) identified on [redacted] PN of the [redacted] The [redacted] stated "Yes." The surveyor notified the [redacted] of the above concern.

On 9/17/24 at 11:45 AM, the surveyor interviewed the [redacted]. The [redacted] informed the surveyor that [redacted] should be done within the 1st seven days of the month and [redacted] done on or before the 1 of the month. The [redacted] stated that it was the aide's responsibility to take the residents' [redacted] and log it in the binder, and it was her responsibility as [redacted] to enter the [redacted] in the EMR.

On that same date and time, the surveyor notified the [redacted] of the above findings and concerns. The [redacted] stated that the [redacted] of Resident#2 was obtained and she forgot to enter them into the EMR. The [redacted] further stated that the physician should be notified of [redacted] and documented in the EMR. The

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surveyor asked the U.S. FOIA (b) (6) why there was no documented evidence that the physician was notified of the NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(PN), and the U.S. FOIA (b) (6) did not respond.

On 9/18/24 at 11:39 AM, the survey team met with the U.S. FOIA (b) (6)), U.S. FOIA (b) (6)), U.S. FOIA (b) (6) , and Regional Nurse Consultant #1 (RNC#1). The surveyor notified the facility management of the above concerns and findings with Resident#2. The surveyor also notified the facility management that Nurse Practitioner #1 (NP#1) did not call back when the surveyor called the NP today at 8:37 AM.

On 9/18/24 at 02:00 PM, the surveyor interviewed NP#2 in the presence of the survey team via phone conference. NP#2 informed the surveyor that she called back on behalf of NP#1 and the U.S. FOIA (b) (6)). The surveyor notified NP#2 of the above findings and concerns regarding NJ Ex Order 26.4(b)(1) documented by the U.S. FOIA (b) (6) on NJ Ex Order 26.4 . The surveyor asked NP#1 if she or the U.S. FOIA and the other US FO were made aware by the facility about the NJ Ex Order 26.4(b)(1). NP#2 stated that they were not made aware of the NJ Ex Order 26.4(b)(1). She further stated that they were made aware today of the NJ Ex Order 26.4(b)(1) monthly NJ Ex Order 26.4(b)(1)

On that same date and time, NP#2 stated that the NJ Ex Order 26.4(b)(1) was "possibly" a problem with the NJ Ex Order 2 She further stated that according to the facility, the NJ Ex Order 26.4 was done yesterday and it was NJ Ex Order 26. . NP#2 also stated that it was "probably" not a true NJ Ex Order 26 and that she would make sure to follow up on it.

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2. On 9/16/24 at 10:25 AM, the surveyor observed Resident # 67's room closed. LPN#2 came out from the resident's room and informed the surveyor that the surveyor had to come back later. The LPN further stated that there were two aides providing care. The LPN also stated that the resident was NJ Ex Order 26.4(b)(1)), with NJ Ex Order 26.4(b)(1)).

The surveyor reviewed the hybrid medical records of Resident #67 and revealed:
The AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) .

The most recent quarterly MDS with an ARD of NJ Ex Order 26.4, under Section NJ E reflected NJ Ex Order 26.4(b) for NJ Ex Order 26.4(b)(1) made regarding NJ Ex Order 26.4(b)(1) score of NJ out of 15 which indicated that the resident's NJ Ex Order 26.4(b) was NJ Ex Order 26.4(b)(1). Section NJ E Status showed that the resident had NJ Ex O

A review of the personalized CP showed a focus that the resident had a NJ Ex Order 26.4(b)(1) problem or

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NJ Ex Order 26.4(b)(1) problem NJ Ex Orde status, dependent on NJ Ex as the primary source of NJ Ex Order 26.4(b)(1), altered NJ Ex Order 26.4(b)(1) [redacted]), and NJ Ex Order 26.4(b)(1), date initiated NJ Ex Order 26.4(. The goal was to NJ Ex Order 26.4(b)(1) within NJ Ex Order 26.4(b)(1)) or have NJ Ex Order 26.4(b)(1) to a NJ Ex Or of more than NJ Ex Orde Interventions included but were not limited to record [redacted] (per facility protocol or MD (Medical Doctor) order that was initiated on NJ Ex Order 26.4 .

A review of the NJ Ex Order 26.4(b)(1) OSR revealed:
-an active PO with an order date of NJ Ex Order 26.4(b)(to obtain NJ E everyday shift starting on the NJ Ex [redacted] and ending on the NJ Ex [redacted] of every month for monthly NJ E enter NJ E in MAR and NJ Ex Order 26.4(b)(1) .
-NJ Ex Order 26.4(b)(1)) with NJ Ex Order [redacted] before and after medication (med) pass. every shift for NJ Ex Order 26.4(b)(1) -Start Date NJ Ex Order 26.4(b)(1)
- NJ Ex Order 26.4(b)(with NJ Ex Order 26.4(b)(1) before and after med pass, NJ Ex Order 26.4(b)(1 with NJ Ex Or between each med every shift for Monitoring-Start Date NJ Ex Order 26.4(b)(1) .

The above duplicate orders for NJ Ex Order 26.4(b)(1) were transcribed to the NJ Ex Ord NJ Ex Order 26.4 and NJ Ex Order 26.4(b)(1) electronic Medication Administration Record (eMAR) and signed by nurses as administered.

The above order for monthly NJ E was transcribed to the NJ Ex Order 26 NJ Ex Orde and NJ Ex Order 26.4(b)(1) electronic Treatment Administration Record (eTAR) and revealed:
NJ Ex Order 26.4(b)(1) = NJ Ex Order 26.4 , NJ E coded as NA (not applicable), by LPN#1
NJ Ex Order 26.4(b)(= NJ Ex Order 26.4 , NJ E coded as NA, by LPN#1

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NJ Ex Order 26.4(b)(1) = NJ Ex Order 26.4, NJ E was blank

A review of the NJ Ex Order 26.4(b)(1) Summary showed the following:

NJ Ex Order 26 Summary:

NJ Ex Order 26.4 = NJ Ex Order 26.4(b)
NJ Ex Order 26.4 = NJ Ex Order 26.4
NJ Ex Order 26.4 = NJ Ex Order 26.4
NJ Ex Order 26.4 = NJ Ex Order 26.4
NJ Ex Order 26.4 = NJ Ex Order 26.4
NJ Ex Order 26.4(b) = NJ Ex Order 26.4(b)
NJ Ex Order 26.4(b) = NJ Ex Order 26.4(b)
NJ Ex Order 26.4(b) = NJ Ex Order 26.4(b)

Further review of the above wt summary revealed that there were no NJ Ex O obtained in NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). In addition, the PO for monthly wts to be done on NJ Ex O of the month was not followed.

A review of the PN by the U.S. FOIA (b) (6) dated NJ Ex Order 26.4 revealed the following:
-Resident #67 remained dependent on NJ Ex as the primary source of NJ Ex Order 26.4 and NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1)
- NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)(1) pending; NJ Ex Order 26.4(b)(1), NJ Ex Or missing, NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4 reviewed NJ Ex Order 26.4(b)(1) pending- unable to assess for any NJ Exec Order 26.4b1. Otherwise, NJ Ex O appear NJ Ex Order 26
-PLAN:
Continue NJ Ex Regimen as ordered.
Continue NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1)
Continue monthly NJ Ex Or and monitor NJ Ex Order 26.4(b)(1), labs, NJ Ex Or and NJ Ex Order 26.4(b)(1) F/u (follow up) monthly.

On 9/17/24 at 11:13 AM, the surveyor interviewed LPN#1. The LPN acknowledged that she worked on NJ Ex Order 26.4 and NJ Ex Order 26.4 whose initial appeared in

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the eTAR. The LPN stated that the code NA meant not applicable and the reason she documented NA on [NJ Ex Order 26.4] and [NJ Ex Order 26.4] was that the aides did not enter the [NJ Ex] in the binder. She further stated that it was the [U.S. FOIA] responsibility to enter the [NJ Ex] in the EMR.

At that same time, the surveyor notified LPN#1 of the above findings and concerns regarding the duplicate order for [NJ Ex Order 26.4(b)(1)]. The LPN stated that the order on [NJ Ex Order 26.4] for NJ Ex Order 26.4(b)(1) [redacted] before and after meds should have been discontinued (d/c) and acknowledged that it was a duplicate order for [NJ Ex Order 26.4(b)]

On 9/17/24 at 11:35 AM, the surveyor asked the [U.S. FOIA (b) (6)] why she documented that the [NJ Exec] wt was missing and if she followed up on the missing [NJ E]. The [U.S. FOIA (b) (6)] stated, "I can't answer that question."

On 9/17/24 at 11:38 AM, the surveyor interviewed the [U.S. FOIA (b) (6)]. The [U.S. FOIA (b) (6)] stated that the nurses in the unit only enter [NJ E] upon admission and readmission which was why the nurses documented NAs in the eTAR for [NJ Ex Or] The surveyor notified the [U.S. FOIA (b) (6)] of the above findings and concerns and asked the [U.S. FOIA (b) (6)] why there was no [NJ E] for [NJ Ex Or] and [NJ Ex Order 26.4(b)(1)] for the resident. The [U.S. FOIA (b) (6)] stated that the aide did not get the [NJ Ex] and it should have been taken even though it was late and documented in the EMR.

Furthermore, the [NJ Ex Order 26.4(b)] further stated that the order for NJ Ex Order 26.4(b)(1) on [NJ Ex Order 26.4(b)] should have been d/c when the new order on [NJ Ex Order 26.4] was entered.

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F 692	Continued From page 63 On 9/18/24 at 11:39 AM, the survey team met with the U.S. FOIA (b) (6), and RNC#1. The surveyor notified the facility management of the above concerns and findings with Resident#67. A review of the facility's Weight Assessment and Intervention Policy with an updated date of 4/2024 that was provided by the U.S. FOIA (b) (6) showed: Policy Statement: Resident wts are monitored for undesirable or unintended wt loss or gain. Weight Assessment: 1. Residents are weighed upon admission and at intervals established by the interdisciplinary team. 2. Wts are recorded in each unit's wt record chart and in the individual's medical record. 3. Any wt change of 5% or more since the last wt assessment is retaken the next day for confirmation. 1. If the wt is verified, nursing will immediately notify the dietitian in writing.... 5. The threshold for significant unplanned and undesired wt loss will be based on the following criteria: a. 1 month-5% wt loss is significant; greater than 5% is severe. b. 3 months-7.5% wt loss is significant; greater than 7.5% is severe. c. 6 months-10% wt loss is significant; greater than 10% is severe... Evaluation:.. 2. The physician and the multidisciplinary team identify conditions and meds that may be causing anorexia, wt loss or increasing the risk of wt loss. For example: a. cognitive or functional decline;... On 9/20/24 at 01:14 PM, the survey team met with the U.S. FOIA (b) (6), U.S. FOIA (b) (6), RNC#1, and RNC#2 for an exit conference.	F 692		

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F 692	Continued From page 64 There was no additional information provided by the facility management. NJAC 8:39-27.2(a)	F 692		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to: a.) administer [NJ Ex Order 26.4(b)(1)] according to the physician's order for one (1) of five (5) residents, Resident #67, b.) followed and clarified the plan for [NJ Ex Order 26.4(b)(1)] of one (1) of five (5) residents, Resident #148), c.) ensure [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 26.4(b)] and [NJ Ex Order 2] were stored in accordance with infection control measures for four (4) of five (5) residents, Residents #11, #103, #124, and #148, and d.) obtain a physician order for [NJ Ex Order 26.4(b)(1)] for one (1) of five (5) residents, Resident #124, reviewed for [NJ Ex Order 26.4(b)(1)] care according to the standard of clinical practice, and the facility's policy and procedure. This deficient practice was evidenced by the following:	F 695	How will any corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident #67 [NJ Ex Order 26.4(b)(1)] was corrected to [NJ Ex Order] on [NJ Ex Order 26.4(b)] per physician order. Resident #148 [NJ Ex Order 26.4(b)(1)] report from [NJ Ex Order 26.4] was reported to resident's Nurse Practitioner(NP) on [NJ Exec Order 2] who declined recommendation as resident did not require [NJ Ex Order 26.4] medication. NP reported to Director of Nursing that her progress note indicating "[NJ Ex Order 26.4(b)(1)] [redacted]" was a typo and should have been "[NJ Ex Order 26.4(b)(1)] [redacted]". NP wrote a progress note to reflect this error. [NJ Ex Order 26.4(b)(1)] was also notified and gave Unit Manager verbal order to disregard recommendation	10/1/24

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F 695	Continued From page 65 Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 9/16/24 at 10:25 AM, the surveyor observed Resident #67's room closed with an NJ Ex Order 26.4(b)(1)) sign outside the door. Licensed Practical Nurse #1 (LPN#1) came out from the resident's room and informed the surveyor that the surveyor had to return later. The LPN further stated that there were two aides providing care. The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #67 and revealed: The Admission Record (AR; an admission	F 695	since resident already on as needed NJ Ex Order 26.4(b)(1). Also, NJ Ex Order 26.4(b)(1) and NJ Ex Order 2 was removed from room and replaced with a NJ Ex Order 26.4(b)(1) which was dated and bagged. Resident# 11 NJ Ex Order 26.4(b)(1) on back of wheelchair was removed on NJ Ex Order 26.4 Resident #103 NJ Ex Order 26.4(b)(1) from back of wheelchair was removed as resident no longer NJ Ex Order 26.4(b)(1). NJ Ex Order 26.4(b)(1) and NJ Ex Order 2 were discarded and replaced with NJ Ex Order 26.4(b)(1), dated and placed in a bag on NJ Ex Order 26.4(Resident #124 NJ Ex Order 26.4 as needed orders were added along with weekly change of NJ Ex Order 2 and care plan updated with NJ Ex Order 26.4 use on NJ Ex Order 26.4. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents on nebulizer and oxygen therapy have the potential to be affected by deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Assistant Directors of Nursing and Unit Managers provided education to all nurses on the policy and procedure titled, “Oxygen Administration”, which includes but is not limited to, the procedure regarding dating tubing and mask and storage of respiratory equipment when not in use and ensuring there is physician	

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summary) reflected that the resident was admitted to the facility with diagnoses (Dx) that included but were not limited to [redacted].

The most recent quarterly Minimum Data Set (qMDS) with an assessment reference date (ARD) of [redacted], an assessment tool used to facilitate the management of care, under Section [redacted], reflected [redacted] for [redacted] made regarding [redacted] score of [redacted] out of 15 which indicated that the resident's [redacted] was [redacted]. Section [redacted] reflected that the resident received [redacted] during the last 14 days.

A review of the personalized care plan (CP) with the focus that the resident had [redacted] with an intervention that included [redacted] at [redacted]) that was initiated on [redacted].

A review of the [redacted] Order Summary Report (OSR) revealed an active physician order (PO) with an order date of [redacted] for [redacted] at

order for oxygen therapy and respiratory equipment care.
Director of Nursing provided education to [redacted] and Unit Managers regarding ensuring all pulmonology consult recommendations are addressed with Attending Physician or Nurse Practitioner in a timely manner.

How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change?

Unit Managers will conduct audits on all residents on oxygen and nebulizer therapy to ensure that all tubing and masks are dated, bagged when not in use and physician order noted in electronic health record weekly x 4 weeks then random audits of 5 residents from each unit monthly x 3 months then quarterly x 2 quarters. Audits to be presented at monthly Quality Assurance and Performance Improvement committee meetings for review and further follow-up.

Director of Nursing will audit all pulmonary consult recommendations to ensure notification to Attending Physicians or Nurse Practitioners weekly x 4 weeks then random audits of 4 residents seen by Pulmonologist monthly x 2 months then quarterly x 1 quarter.

Audits to be presented at monthly Quality Assurance and Performance

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F 695	Continued From page 67 NJ Ex Order 26.4(b)(1)) per NJ Ex for NJ Ex Order 26.4(b)(1)) every shift. The above order for NJ Ex was transcribed to the NJ Ex Order 26.4(b)(1) electronic Treatment Administration Record (eTAR) and signed every shift by nurses as administered. On 9/18/24 at 9:49 AM, the surveyor and LPN#2 went to the resident's room, and both observed the resident on the bed at approximately 45 degrees sitting position with NJ Ex Order 26.4(b)(1)) running via NJ Ex Order 26.4(b)(1). The resident was on NJ Ex Order 26.4(b)(1). LPN#2 confirmed it was at NJ Ex Order and the date in the NJ Ex Order 2 wrapped around tape was NJ Ex Order 26.4 which she claimed was the date the NJ Ex Order 2 was changed. On that same date and time, LPN#2 asked the U.S. FOIA (b) (6)) to help her reposition the resident. Both LPN#2 and U.S. FOIA (b) (6) confirmed the resident was on NJ Ex Order 26.4(b)(1). On 9/18/24 at 9:53 AM, the U.S. FOIA (b) (6) checked the electronic medical record (EMR) for the resident's order for NJ Ex O The U.S. FOIA (b) (6) stated that the resident's PO was NJ Ex Order , not NJ Ex Order 2 and she did not know who changed the NJ Ex to NJ Ex Order 2 She further stated that she would assess the resident, and she immediately went to the resident's room. On 9/19/24 at 01:26 PM, the survey team met with the U.S. FOIA (b) (6) , U.S. FOIA (b) (6) IP), U.S. FOIA (b) (6)), and Regional Nurse Consultant #1 (RNC#1). The U.S. FOIA stated that the nurses should follow the PO for NJ Ex Order and it was a human error	F 695	Improvement committee meetings for review and further follow-up. When will corrective action be accomplished? 10/01/2024	

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when the [NJ Ex] was observed at [NJ Ex Order 2]

2. On 9/16/24 at 10:27 AM, the surveyor observed Resident #148 seated on the bed with breakfast in front of the resident. The [NJ Ex Order 26.4(b)] was hung on the [NJ Ex Order 26.4(b)(1)] attached to the wall, undated, and not properly stored (exposed to environment).

The surveyor reviewed the hybrid medical records of Resident #148 and revealed:
The AR reflected that the resident was admitted to the facility with Dx that included but were not limited to NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1)).

The most recent comprehensive MDS (cMDS) with an ARD of [NJ Ex Order 26.4], under Section [NJ], a Brief Interview for Mental Status (BIMS) score of [NJ Ex] out of 15 which reflected that resident was [NJ Ex Order 26.4(b)(1)].

A review of the [NJ Ex Order 26.4(b)(1)] OSR revealed an active PO with an order date of [NJ Ex Order 26.4] of NJ Ex Order 26.4(b)(1) every 6 hours (hrs) as needed (PRN) for [NJ Ex Ord] or [NJ Ex Order 26.4(b)(1)] NJ Ex Order 26.4(b)(1) total. Not to exceed [NJ Ex Order 26.4(b)(1)]

The personalized CP with focus was that the resident had a [NJ Ex Order 2] r/t (related to) [NJ Ex Order 26.4(b)] with an intervention that included to give [NJ Ex Order 26.4] or [NJ Ex Order 26.4(b)(1)] as ordered that was initiated on

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NJ Ex Order 26.4(

Further review of the CP revealed that there was no documented evidence for care of NJ Ex Order 26.4(b)(1) equipment and supplies r/t on how to store NJ Ex Or when not in use or the proper storage.

A review of the NJ Ex Order 26.4(b)(1) notes dated NJ Ex Order 26.4(showed that the resident was referred to due to a Dx of NJ Ex Order 2 with Impression/Plan: Dx NJ Ex Order 26. NJ Ex Order 26.4(b)(1)) every 6 hrs, supplement NJ Ex Order 26.4(, and monitor NJ Ex Orde

A review of the Progress Notes (PN) revealed that the Physician who did the NJ Ex Order 2 consult on NJ Ex Order 26.4 documented in the PN that the resident was seen and examined, and to see documents for NJ Ex Order 2 consultation.

A review of the NJ Exec Order 2 and NJ Exec Order 2 PN of the U.S. FOIA (b) (6)) showed that the U.S. FO documented on both PNs ' NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b NJ Ex Order 26.4(b)(1) , Now NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4 or NJ Ex Order 26.4(b)(1

Further review of the PN showed that the plan for the resident that was documented on NJ Ex Order 26.4(by the NJ Ex Order 2 doctor was not followed. There was no documented evidence that the U.S. FOIA (b) (6)) nor the U.S. FO caring for the resident was notified of the plan.

On 9/18/24 at 9:27 AM, the surveyor interviewed the U.S. FOIA (b) (6) . The surveyor notified the U.S. FOIA (b) (6) of the above findings and concerns regarding the NJ Ex Order 26.4(b)(1) consult. The U.S. FOIA (b) (6) stated that

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there should be documentation that the NJ Ex Order 2 consult was relayed to the U.S. FOIA and if the U.S. FOIA agreed or disagreed with the recommendations it should be in the PN.

On that same date and time, the U.S. FOIA (b) (6) stated that the NJ Ex Order 26.4(b)(1 should have been stored in a bag when not in use and dated. She further stated that the reason for proper storage was for infection control and to protect from NJ Ex Order 26.4(b

On 9/18/24 at 9:40 AM, the surveyor and the U.S. FOIA (b) (6) went inside the resident's room, and both observed the NJ Ex Order 26.4(b)(1 was hung on the NJ Ex O attached to the wall, not stored in a bag, and no date in NJ Ex Order 26.4b1.

On 9/18/24 at 11:39 AM, the survey team met with the U.S. FOIA (b) U.S. FOIA (b U.S. FOIA (b) (6), and RNC#1. The surveyor notified the facility management of the above concerns and findings.

On 9/18/24 at 01:56 PM, the U.S. FOIA informed the surveyor in the presence of the survey team that according to the U.S. FOIA (b) (6), during their (NJ Ex Order 2 doctor and the U.S. FOIA (b) (6) rounds on NJ Ex Order 26.4(the NJ Ex Order 2 doctor was made aware that the resident had an order for NJ Ex Order 26.4(b)(1), and the doctor verbally stated to the U.S. FOIA (b) (6) not to proceed with the plan of NJ Ex Order 26.4 and the monitoring of NJ Ex . The U.S. FOIA further stated that according to the U.S. FOIA (b) (6) she was unaware that the NJ Ex Order 2 consult paper was handed to someone (unsure who was the person) and it was uploaded to the EMR. The U.S. FOIA also stated that per U.S. FOIA (b) (6), if she knew it was uploaded, she should have questioned the recommendations.

At that same time, the surveyor asked the U.S. FOIA

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who was responsible for reviewing the PN of the [redacted] and should the notes had been clarified prior to the surveyor's inquiry. The [redacted] acknowledged that the [redacted] had written a note regarding the round with the [redacted] doctor after the surveyor's inquiry. The [redacted] further stated that the NP's PN should have been clarified as well.

On 9/20/24 at 11:19 AM, the survey team met with the [redacted] and [redacted], RNC#1, and [redacted]. The [redacted] stated "I think we provided everything," and nothing to add.

A review of the facility's Care Plans, Comprehensive Person-Centered Policy with last updated date of 4/2024 that was provided by the [redacted] showed:
Policy Statement: a comprehensive, person-centered CP that included measurable objectives, and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.
Policy Interpretation and Implementation:
3. The CP interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment ....
7. The comprehensive, person-centered CP:
e. reflects currently recognized standards of practice for problem areas and conditions ...

A review of the facility's Physician Orders Policy with an updated date of 4/2024 that was provided by the [redacted] revealed:
Policy: Medication (med) and treatment (tx) orders will be accepted only from authorized, credentialed physicians or from other authorized, credentialed practitioners in accordance with state regulations regarding prescriptive privileges.
Process: Type of Order:

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2. Must be recorded in the EMR ...
Consultant Recommendations/Orders:
1. Consultants may make recommendations for any med or tx, as necessary as long as in all cases, the attending physician must be notified of the order and approved per state regulations.
4. Findings and recommendations will be documented on the Consultation Form by the consultant;
5. The nurse will notify the attending physician of findings and recommendations.
6. The attending physician, if in agreement, will order the specific tx as outlined by the consultant.

On 9/20/24 at 01:14 PM, the survey team met with the U.S. FOIA (b) (6), U.S. FOIA (b) (6), U.S. FOIA (b) (6), U.S. FOIA (b) (6), RNC#1, and RNC#2 for an exit conference. There was no additional information provided by the facility management.

3. On 9/16/24 at 10:16 AM, the surveyor observed Resident #11 lying in a low to the floor bed with NJ Ex being delivered via NJ Ex Order 26.4(b)(1) from the NJ Ex Order 26.4(b)(1) connected to the wall. The surveyor observed that there was an additional NJ Ex Order 26.4(b)(1) that was not dated that was attached to a NJ Ex Order 26.4(b)(1) that was on the back of Resident #11's wheelchair (w/c). The NJ Ex Order 26.4(b)(1) was hung over the NJ Ex Order 26.4(b)(1) and it was not contained in a bag.

On 9/17/24 at 9:44 AM, the surveyor observed that Resident #11's additional NJ Ex Order 26.4(b)(1) that was not dated that was attached to a NJ Ex Order 26.4(b)(1) on the back of the w/c. The NJ Ex Order 26.4(b)(1) was hung over the NJ Ex Order 26.4(b)(1) and it was not contained in a bag.

A review of Resident #11's AR indicated that the

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resident was admitted to the facility with medical Dx that included but were not limited to [redacted] , [redacted] and NJ Ex Order 26.4(b)(1)

A review of Resident #11's most recent [redacted] in status MDS, reflected that the resident had a BIMS score of [redacted] out of 15, which indicated that Resident #11's [redacted] was [redacted]. Further review reflected that the resident received [redacted].

On 9/17/24 at 10:19 AM, the surveyor interviewed LPN#1 regarding the process for [redacted] LPN#1 stated that [redacted] was changed weekly and dated using tape. She added that when it was not in use that it should be placed in a bag. The surveyor asked LPN#1 to observe Resident #11's [redacted] on the w/c. The LPN confirmed the [redacted] was not dated and not in bag and that it should have been.

On 9/17/24 at 12:31 PM, the surveyor interviewed the third [redacted] regarding [redacted]. The [redacted] stated that [redacted] was changed weekly on Sunday and dated. She added that if it was not in use that it should be placed in a bag.

4. On 9/16/24 at 9:55 AM, the surveyor observed Resident #103 seated in a w/c. The surveyor observed that on the back of the w/c was a NJ Ex Order 26.4(b)(1) that had a [redacted] that was not dated and was hung over [redacted]. The [redacted] was not placed in a bag when not in use. The surveyor also observed a [redacted] and [redacted] dated [redacted], that was partially wrapped in a paper towel. The [redacted] was not contained in

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a bag. Resident # 103 stated that they did not need [redacted] anymore and only received [redacted].

A review of Resident #103's AR indicated that the resident was admitted to the facility with medical Dx that included but were not limited to [redacted] NJ Ex Order 26.4(b)(1) [redacted]) and [redacted].

A review of Resident #103's most recent qMDS reflected that the resident had a BIMS score of [redacted] out of 15, which indicated that Resident #11's [redacted] was [redacted]. Further review reflected that the resident received [redacted]

On 9/17/24 at 10:25 AM, the surveyor interviewed LPN#1 regarding the process for [redacted] and [redacted] tx. The LPN stated that [redacted] was changed weekly and dated using tape. The LPN further stated that the [redacted] should be washed and dried and placed in a bag when not in use. She added that when the [redacted] was not in use that it should be placed in a bag. The surveyor asked the LPN to observe Resident #103's [redacted] on the w/c. LPN#1 confirmed the [redacted] was not dated and not in bag and that it should have been.

On 9/17/24 12:37 PM, the surveyor interviewed the [redacted] regarding [redacted]. The third floor [redacted] stated that [redacted] should be in a bag when not in use.

On 9/18/24 at 12:00 PM, in the presence of the survey team, the surveyor notified the [redacted] RNC#1 and [redacted] the concerns that Resident #11 and #103 had [redacted] not dated and not contained in a bag when not in use and

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Resident #103 had the [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 2] partially wrapped in paper towel and not contained in a bag when not in use.

The facility did not provide any additional information.

A review of the undated facility provided policy titled, "Oxygen Administration" included the following:
Purpose
The purpose of this procedure is to provide guidelines for safe oxygen administration.
The policy did not contain information regarding dating the tubing or storage of respiratory equipment when not in use.

5. On 9/16/24 at 10:33 AM, during the initial tour the surveyor observed Resident #124 eating breakfast in their chair. The surveyor observed undated [NJ Ex Order 26.4(b)(1)] connected to the wall [NJ Ex] [redacted]. The [NJ Ex Order 2] was open and placed on top of the nightstand. There was a signage posted outside the resident's room which indicated "[NJ Ex Order 26.4(b)(1)]."

On 9/17/24 at 12:20 PM, the surveyor observed the resident in their bed, watching television. The surveyor did not observe [NJ Ex Order 26.4(b)(1)] in the room. [NJ Ex Order 26.4(b)(2)] signage was observed at the door before entering in the room.

The surveyor reviewed the medical record for Resident #124.
The AR revealed that Resident #124 was admitted to the facility with Dx which included but were not limited to: NJ Ex Order 26.4(b)(1) [redacted]

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NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1)

A review of the cMDS dated NJ Ex Order 26.4 reflected a BIMS score of NJ E out of 15, which indicated that the resident had a NJ Ex Order 26.4(b)(1). Section NJ E of the MDS, indicating NJ Ex Order 26.4 received by Resident #124 in the last 14 days documented, NJ Ex Order 26.4(b)(1).

A review of Resident #124's PN which reflected that Resident #124 was on NJ Ex Order 26.4(b)(1) are as follow:
A PN dated NJ Ex Order 26.4 at 7:56 AM - Patient received in bed .... NJ Ex Order 26.4(b)(1) in place.
A Skilled Evaluation NJ Ex O note dated NJ Ex Order 26.4 at 13:22 (01:22 PM) stated NJ Ex Order 26.4(b)(1) Method: NJ Ex Order 26.4(b)(1).
A NJ Ex Order 26.4b1) PN dated NJ Ex Order 26.4 at 16:57 (4:57 PM) mentioned NJ Ex O.

A review of Resident #124's OSR did not reflect PO for NJ Ex Order 26.4(b)(1).

A review of Resident #124's electronic Medication Administration Record (eMAR) did not reflect an order to administer NJ Ex Order 26.4(b)(1).

A review of Resident #124's eTAR did not reflect an order to change Equipment (NJ Ex Order 26.4(b)(1)) as per PO or per facility policy/protocol.

A review of Resident #124's CP did not reflect a CP for NJ Ex Order 26.4(b)(1).

On 9/19/24 at 01:27 PM, the survey team met

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F 695	Continued From page 77 with the [redacted] and RNC#1. The surveyor notified the facility management of the above findings and concerns. The [redacted] acknowledged that it was not an acceptable practice to place a resident on [redacted] without a PO. On 9/20/24 at 9:28 AM, the [redacted] explained that [redacted] would be dated once it was removed out of the packing. It would be stored in a small plastic bag when the equipment [redacted] was not in use. [redacted] further stated that [redacted] would be changed every 7 days. The nurses would document that in eTAR. A review of the facility's policy "Oxygen Administration" with a last updated date of 4/2024, revealed: Purpose of this procedure is to provide guidelines for safe O2 administration. Under Preparation: 1.) Verify that there is a PO for this procedure. Review the PO or facility protocol for O2 administration. 2.) Review the resident's CP to assess for any special needs of the resident. On 9/20/24 at 01:15 PM, the survey team met with [redacted] RNC #1, RNC #2, [redacted] for an exit conference. No additional information was provided.	F 695		
F 697 SS=D	N.J.A.C. 8:39-11.2 (a)(b)(e); 19.4(a); 27.1(a) Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	F 697		10/4/24

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	315526	A. BUILDING _____ B. WING _____	C 09/20/2024

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F 697	Continued From page 78 consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Complaint NJ#175244 Based on interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure a NJ Ex Order 26.4(b)(1) [redacted] resident received care and services with regard to NJ Ex Order 26.4(b)(1) for one (1) of one (1) resident, Resident #209, reviewed for NJ Ex Ord according to standards of clinical practice and facility's policy. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case	F 697	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 209 is no longer in facility Director of Nursing reviewed the NJ Ex Or assessment order set and reinstated it for all current residents as well as for all incoming new admissions. How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents could potentially be affected by deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Assistant Director of Nursing/Nurse Supervisors provided in-service education for all nurses regarding the policy titled “Pain Assessment and Management”, reviewed the new pain assessment order set in the electronic health record and how to correctly document pain scale as well as Pain scale for those with cognitive impairment. How the facility will monitor its corrective actions to ensure that the deficient	

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F 697	Continued From page 79 finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." A review of the closed medical record for Resident #209 revealed: The Admission Record (an admission summary) showed that Resident #209 was admitted to the facility with diagnoses which included but were not limited to: NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) [redacted], and NJ Ex Order 26.4(b)(1) [redacted] According to the resident's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4 [redacted], reflected the resident had a Brief Interview for Mental Status (BIMS) of NJ Ex [redacted] out of 15, which indicated the resident had NJ Ex Order 26.4(b)(1) [redacted] A review of the Physician Order (PO) Recap Report dated NJ Ex Order 26.4 [redacted] - NJ Ex Order 26.4 [redacted] indicated that Resident #209 had the following orders: -A PO with a start date of NJ Ex Order 26.4(b [redacted] - NJ Ex Order 26.4(b)(1) Tablet (tab(s) NJ Ex Order 26.4(b)(1)), give 2 tabs by mouth every 6 hours (hrs) as needed (PRN) for NJ Ex Order [redacted] greater than NJ Ex O [redacted] ... and give 2 tabs by mouth every 6 hrs PRN for NJ Ex Orde [redacted] -A PO with a start date of NJ Ex Order 26.4 [redacted] - NJ Ex Order 26.4(b)(1) [redacted] - give NJ Ex Order 26.4 [redacted] by mouth every 6 hrs as PRN for NJ Ex Or [redacted] on	F 697	practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change? Unit Managers on each unit will randomly audit 10 residents on each of their units for completion of pain assessment weekly x4 weeks, monthly x 2 months, then quarterly x 2 quarters. Results of the audits will be presented at the monthly Quality Assurance Performance Improvement committee meeting for review and follow-up as needed. When will corrective action be accomplished? 10/04/2024	

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NJ Ex Order 26.4(b

-A PO with a start date of NJ Ex Order 26.4(- NJ Ex Order 26.4(b)(1) - give 1 tab by mouth three times a day for NJ Ex Orde

A review of the electronic Medication Administration Record (eMAR) revealed that NJ Ex Or was done every shift not until NJ Ex Orde when NJ Ex Order 26.4(b)(1) was stopped.

Further review of the above PO revealed that there was no documented evidence that routine NJ Ex Order 26.4(b)(1) was done from NJ Ex Orde through NJ Ex Order 26.4(b)(1. In addition, there was no documented evidence as to why the every shift NJ Ex Or was discontinued.

A review of the individualized Care Plan (CP) did not reflect a CP for NJ Ex Orde

During an interview with the surveyor on 9/19/24 at 9:54 AM, in the presence of the survey team, the U.S. FOIA (b) (6)) stated that NJ Exec D was assessed upon admission, every shift by the nurse. The U.S. FOIA also stated that the nurses would assess for NJ Ex Or as part of their vital signs (are group of the four to six most crucial medical signs that indicate the status of the body's functions) and minimum quarterly or PRN. She further stated that if the resident was NJ Ex Order 2 , then they (nurse) would administer NJ Ex Or medication (med(s) and an hour later they would re-assess for effectiveness. If the NJ Ex Or med was effective, then they (nurse) would document and if the NJ Ex Or med was not effective then they would notify the doctor. The U.S. FOIA further stated that the U.S. FOI did the quarterly assessment in Electronic Medical Record (EMR). The U.S. FOIA

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stated that the nurses verbally ask the residents about [redacted] and did not have to document. The [redacted] also stated that for resident with [redacted], the nurses would use [redacted]

On 9/19/24 at 10:49 AM, in the presence of second surveyor, the U.S. FOIA (b) (6) [redacted] stated as standards of practice, the [redacted] assessment should be done and documented in the EMR every shift. The [redacted] further stated that "we verbally ask them." The [redacted] acknowledged that [redacted] should be included in the CP.

On 9/19/24 at 10:56 AM, in the presence of second surveyor and Licensed Practical Nurse #1 (LPN#1), the LPN#2 stated she would assess her residents for [redacted] during daily rounds. LPN#2 showed the surveyors a [redacted] assessment for an unsampled resident in the eMAR, completed for every shift. The eMAR reflected [redacted] and [redacted] (7 AM-3 PM), [redacted] and [redacted] (3 PM-11 PM) and [redacted] and [redacted] (11 PM-7 AM) and the nurses entered the [redacted] in numbers and signed off with their initials in the blank boxes for their shift. LPN#2 further stated if the residents were not able to [redacted], then she would see the resident's NJ Ex Order 26.4(b)(1) for [redacted] assessment. LPN#1 agreed with LPN#2's statements and stated she assessed the [redacted] for her residents as described by LPN#2.

On 9/19/24 at 01:27 PM, the survey team met with the [redacted] U.S. FOIA (b) (6) [redacted] U.S. FOIA (b) (6) [redacted] and Regional Nurse Consultant Nurse #1 (RNC#1). The surveyor notified the facility management of

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the above findings and concerns. The [redacted] confirmed that the [redacted] assessment fell off from their orders and it would be reinstated.

A review of the facility's "Pain Assessment and Management" policy dated 4/2024 revealed:
The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain.
Under General Guidelines:
1.) The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive CP, and the resident's choices related to pain management. ..
5.) Acute pain (or significant worsening of chronic pain) should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained.
6.) For stable chronic pain the resident's pain and consequences of pain are assessed at least weekly.
In section under Assessing Pain:
2.) Assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level.
In section under Defining Goals and Appropriate Interventions:
4.) For those situations where the cause of the resident's pain has not been or cannot be determined, follow current standards of practice for managing pain to help determine appropriate options.
In section under Monitoring and Modifying Approaches:
1.) Re-assess the resident's pain and

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F 697	Continued From page 83 consequences of pain at least each shift for acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain. A review of the facility's policy "Care Plans, Comprehensive Person-Centered" with a last updated date of 4/2024, revealed: Policy statement: A comprehensive, person-centered CP that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: 1.) The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered CP for each resident. 2.) The comprehensive, person-centered CP is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 3.) The CP interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. On 9/20/24 at 01:15 PM, the survey team met with U.S. FOIA (b) (6) RNC#1, RNC#2, U.S. FOIA (b) (6) for an exit conference. There was no additional information was provided. NJAC 8:39-11.2(b); 27.1(a)	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis.	F 698		10/4/24

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F 698	Continued From page 84 The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Complaint #NJ167713 Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to: a) maintain the [NJ Ex Order 26.4] communication record between the facility and the [NJ Ex Order 26.4] center for one (1) of two (2) residents (Resident #458) and b.) provide care and services in accordance with professional standards clinical practice and facility policy for two (2) of two (2) residents (Resident #98, 458), reviewed for [NJ Ex Order 26.4] services. 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." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse	F 698	How will any corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident #98 – nurses involved in the [NJ Ex Order 26.4] communication records that were missing information were educated on the importance of accurate completion, including but not limited to the evaluation of [NJ Ex Order 26.4(b)(1)] for [NJ Ex Order 26.4(b)(1)] Resident #458 is no longer in the facility. [NJ Ex Order 26.4] communication records were not located for this resident. How will the facility identify other residents having the potential to be affected by the same deficient practice? All hemodialysis residents have the potential to be affected by this practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Director of Nursing and Assistant Director of Nursing updated Dialysis Communication Policy to include protocol for completion of Dialysis Communication Record. Assistant Director of Nursing in-serviced	

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F 698	Continued From page 85 Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 9/16/24 at 8:48 AM, the surveyor observed Resident #98 in their room sitting in bed, watching television. The resident had NJ Ex Order 26.4(b)(1) with care. The surveyor reviewed the electronic medical record (EMR) for Resident #98. A review of the Admission Record (AR; or face sheet; admission summary) reflected that Resident #98 was admitted to the facility with diagnoses that included but not limited to NJ Ex Order 26. [redacted]), and NJ Ex Order 26.4(b)(1) . A review of the comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care dated NJ Ex Order 26.4 showed that the resident's Brief Interview for Mental Status (BIMS) score was NJ Ex [redacted] out of 15, which indicated that Resident #98's NJ Ex Order 26.4(b)(1) was NJ Ex Order 2 [redacted] Section NJ Ex Order 26.4(b)(1) reflected that the resident received NJ Ex Order 26.4 [redacted] services NJ Ex Order 26.4(b)(1)	F 698	all nurses and nurse supervisors on the updated policy for "Dialysis Communication" including process for accurate completion of dialysis communication record. Director of Nursing in-serviced all Unit Clerks to upload all Dialysis communication records into electronic health record at least weekly to prevent loss of records. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change? The Assistant Director of Nursing or Unit Managers will audit all dialysis communication records for completion and uploading into electronic health record x 4 weeks, then monthly x 2 months, then quarterly x 2 quarters. Results of the audit will be presented to the monthly Quality Assurance Performance Improvement committee meeting for review and follow-up as needed. When will corrective action be accomplished? 10/04/2024	

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NJ Ex Order 26.4(b)(1)).

A review of the resident's individualized Care Plan (CP) revised [NJ Ex Order 26.4], reflected that Resident #98 needed [NJ Ex Order 26.4(b)(1)] r/t [related to] [NJ Ex Orde] The CP interventions included: to assess [NJ Ex Order 26.4(b)(1)] each shift for [NJ Ex Order 26.4(b)]

The [NJ Ex Order 26.4(b)(1)] Order Summary Report (OSR) revealed an active physician orders (PO) for the following:
-Start date [NJ Ex Order 26.4(b)(1)] Assess [NJ Ex Order 26.4(b)(1)] for signs and symptoms of [NJ Ex Order 26.4(b)] every shift for monitoring access [NJ Ex Order 26.4(b)(1)] and indicate yes/no, if yes please indicate in progress notes (PN).
-Start date [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)]: Located [NJ Ex Order 26.4(b)] [NJ Ex Order 26.4(b)(1)] present? (Y/N) every shift for [NJ Ex Order 26.4(b)(1)] evaluation [NJ Ex Order 26.4(b)(1)] every shift for [NJ Ex Order 26.4(b)(1)] if not present notify US FOIA (b)(6) immediately.
-Start date [NJ Ex Order 26.4(b)]: [NJ Ex Order 26.4] Treatment Center: [name redacted] every: M-W-F (Monday-Wednesday-Friday) pick up time: [NJ Ex Ord] AM Chair time [NJ Ex Order 26.4(b)(2] Transportation: [name of transportation company].

On 9/18/24 at 01:45 PM, the surveyor reviewed the [NJ Ex Order 26.4] Center Communication Record ([NJ Ex Order 2], also referred as CR) (a binder on the unit which contains a resident's status on [NJ Ex Order 26.4(b)(1)] treatment days between the facility and the [NJ Ex Order 26.] center) contained three separate areas to be filled out; the top section was to be completed by the facility nurse prior to the resident leaving the facility for the [NJ Ex Order 26.] treatment (tx), the middle section was to be completed by the [NJ Ex Order 26.4] center staff after tx and

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in the bottom section, was NJ Ex Order 26.4(b)(1) vitals and NJ Ex Order 26.4(b)(1) to be completed by the facility nurse immediately upon the resident's return to the facility.

A review of the NJ Ex Order 2 from NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) revealed that CR were not consistently filled out for the following dates: NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b). The surveyor observed the NJ Ex Order 26's top and bottom sections were completely blank on NJ Ex Order 26.4(b

A review of the PN from NJ Ex Order 26.4(b)(1) did not reflect assessment of the NJ Ex Order 26.4(b)(1) post NJ Ex Order 26.4(b)(1) tx for the following dates: NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(

Further review of the PN for NJ Ex Order 26.4(b)(1) did not reflect if the NJ Ex Order 26.4(b)(1) were evaluated for NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) for the above mentioned dates.

During an interview with the surveyor on 9/18/24 at 01:51 PM, Licensed Practical Nurse #1 (LPN#1) stated that the nurses were responsible for filling out the pre-tx and post-tx vital signs on the NJ Ex Order 26. She further stated that nurses were responsible for checking and documenting NJ Exec Order 26.4b1 for any signs of NJ Ex Order 26.4(b) or NJ Ex Order 26.4(b) at the NJ Ex Order 26.4(b)(1)). LPN #1 confirmed that the expectation was that the communication record would be completely filled out once resident returned from their NJ Ex Order 26.4(b)(1) session.

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F 698	Continued From page 88 On 9/19/24 at 01:27 PM, the survey team met with U.S. FOIA (b) (6)), U.S. FOIA (b) (6)), U.S. FOIA (b) (6)) and Regional Nurse Consultant #1 (RNC#1). The surveyor notified the facility management of the above findings and concerns regarding the Resident #98's NJ Ex Order 26. The U.S. FOIA (b) (6) confirmed that the communication form should be completed upon the residents return to the facility. A review of the facility's policy, "Dialysis Communication," updated 4/2024 did not address the protocol for the nurses to complete Communication form for the residents who receive hemodialysis services. On 9/20/24 at 01:15 PM, the survey team met with U.S. FOIA (b) U.S. FOIA (b) RNC#1, RNC#2, U.S. FOIA (b) (6) for an exit conference. The facility management did not provide additional information and did not refute findings. 2. The surveyor reviewed the EMR of Resident #458 and revealed: The AR documented that the resident had diagnoses that included but were not limited to, NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) , NJ Ex Order 2 NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). The cMDS dated NJ Ex Order 26.4 indicated the facility assessed the resident's NJ Exec Order 26.4(using a BIMS test. Resident #458 scored a NJ Ex out of 15, which indicated the resident had NJ Ex Order 26.4(b)(1)	F 698		

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NJ Ex Order 26.4(b)(1)

A PO dated NJ Ex Order 26.4 read, NJ Ex Order 26.4 on Tuesday, Thursday, and Saturday with a chair time at NJ Ex Order AM and a pickup time of NJ Ex Order AM.

A review of PN from NJ Ex Order 26.4(b)(1) revealed there were no PN for when the resident was to be sent for NJ Ex Order 26.4 on the following days: NJ Ex Order 26.4, NJ Ex Order 26.4 and NJ Ex Order 26.4.

Further review of the PN from NJ Ex Order 26.4(b)(1) revealed there were no PN for when the resident returned from NJ Ex Order 26.4 on the following days: NJ Ex Order 26.4, NJ Ex Order 26.4, NJ Ex Order 26.4, NJ Ex Order 26.4, NJ Ex Order 26.4, NJ Ex Order 26.4, NJ Ex Order 26.4, and NJ Ex Order 26.4.

A review of a CP with a focus that read "[Resident #458] has a NJ Ex Order 26.4(b)(1) problem or NJ Ex Order 26.4(b)(1), meets criteria for NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) interactions. PMH [primary medical history] includes NJ Ex Order NJ Ex Order NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1)] ..." The CP had an initiation date of NJ Ex Order 26.4 and a last revised date of NJ Ex Order 26.4. An intervention of the CP read, "Provide, NJ Ex Order 26.4(b)(1) as ordered. Monitor NJ Ex Order 26.4 and record q [every] NJ Ex Order 26.4.

On 9/18/24 at 12:56 PM, the surveyor interviewed LPN#1 who had cared for the resident. LPN#1 had recalled Resident #458 was NJ Ex Order 26.4, with NJ Ex Order 26.4(b)(1) frequently refused care, and had NJ Ex Order 26.4(b)(1). LPN#1 further recalled that the resident needed to NJ Ex Order 26.4, staff would attempt to NJ Ex Order resident and would make the resident's family aware when the resident refused.

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On 9/18/24 at 01:51 PM, the surveyor interviewed LPN#2 about nursing responsibilities for NJ Ex Order 26.4 residents. LPN#2 stated when sending a resident to NJ Ex Order 26.4 the nurse would assess the NJ Ex Order 26.4 , check vital signs (blood pressure, pulse, temperature, respiratory rate, oxygen saturation), and complete the pre-tx section of the NJ Ex Order 26.4 including any changes with the resident.

LPN#2 further explained upon a resident's return to the facility from NJ Ex Order 26.4(the NJ Ex Order 26.4 would be reviewed for documentation by NJ Ex Order 26.4 nurse regarding the status of the resident and the post-tx assessment section would be completed by the nurse on the form. The surveyor asked LPN #2 about any NJ Ex Order 26.4(b)(1) provided for NJ Ex Order 26.4 residents. LPN#2 replied that a resident would receive a NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4 if the resident was unable to NJ Ex Order 26.4(b) prior to their pick up for NJ Ex Order 26.4(

On 9/19/24 at 9:00 AM, the surveyor requested from the U.S. FOIA (b) and U.S. FOIA (the paper medical records for Resident #458.

On 9/19/24 at 9:30 AM, the US FOIA (b)(6 provided the paper medical record for Resident #458. A review of the provided medical record revealed there were no NJ Ex Order 26.4(6 or NJ Ex Order 26.4 communication forms for the resident.

On 9/19/24 at 9:31 AM, the surveyor informed the U.S. FOIA (b) and the U.S. FOIA (that there were no NJ Exec Order 26 communication forms found in the resident's closed medical records. The U.S. FOIA (b) stated they would have medical records recheck the files for them.

On 9/19/24 at 02:15 PM, the survey team met

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with the U.S. FOIA (b) (6), U.S. FOIA (b) (6), U.S. FOIA (b) (6), and RNC#1. The surveyor notified the facility management of the concern that there were no NJ Ex Order 26.4 communication forms found for the resident. The U.S. FOIA (b) (6) stated they have not found and would continue to look for to provide to the surveyor. The surveyor requested the printout of the Certified Nurse Aide (CNA) tasks documentation for Resident #458 in NJ Ex Order 26.4(b)(1).

On 9/19/24 at 3:00 PM, the U.S. FOIA (b) (6) provided the CNA tasks documentation titled "Documentation Survey Report" for NJ Ex Order 26.4(b)(1).

On 9/20/24 at 10:00 AM, the surveyor reviewed the provided NJ Ex Order 26.4(b)(1) Documentation Survey report for Resident #458. An entry of the form read "ADL- NJ Ex Order 2 and percentage NJ Ex Order 26.4(b)(1) with scheduled entry times of 9 AM, 1 PM, and 6 PM. There were 84 of 90 entries that were not signed and left blank. The unsigned entries did not indicate how the resident NJ Ex Order 26.4(b) (independent, limited assistance, extensive assistance or total dependence) and the percentage of NJ Ex Order 26.4(b)(1).

On 9/20/24 at 8:29 AM, the surveyor interviewed a US FOIA (b) (6) about CNA task documentation. The US FOIA (b) (6) stated US FOIA (b) (6) documentation was completed in the EMR and completed what applied to the specific resident. The surveyor asked the US FOIA (b) (6) how often the NJ Ex Order 2 and percentage NJ Ex Order 26.4(b)(1) entry was completed for the residents. The US FOIA (b) (6) replied that for each resident it should be completed every shift. The US FOIA (b) (6) confirmed entries should not be left blank.

On 9/20/24 at 8:38 AM, the surveyor interviewed the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6)

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U.S. FOIA (b) (6)) about CNA documentation. The U.S. FOIA (b) (6) stated CNA tasks were triggered upon resident's admission based on the nurse's evaluation in the EMR. The surveyor asked about the NJ Ex Order 2 and percentage NJ Ex Order 26.4(b)(1) entry for residents. The U.S. FOIA (b) (6) stated it was expected to be completed by the CNAs every shift for the residents and entries should not be left blank.

On 9/20/24 at 8:50 AM, The surveyor requested from the U.S. FOIA (b) any additional policies for NJ Ex Order 26.4 other than the NJ Ex Order 26.4 communication policy already provided to the survey team by the facility.

On 9/20/24 at 10:30 AM, the surveyor interviewed the U.S. FOIA about Resident #458 and CNA task documentation. The U.S. FOIA did not recall the resident. The surveyor discussed the concern for Resident #458 that there was no documentation of percentage NJ Ex Order 26.4(b)(1). The U.S. FOIA stated NJ Ex Order 2 and percentage NJ Ex Order 26.4(b)(1) by the resident should be documented by the CNA every shift.

The surveyor asked about NJ Ex Order 2 and NJ Ex Order 26 for NJ Ex Order 26.4 residents. The U.S. FOIA stated the residents depending on their pick-up time would receive their scheduled meals prior to leaving the facility. If the NJ Ex Order 26.4 pick-up time was at an off hour or between NJ Ex Order 26.4(b)(1) the resident would be provided a NJ Ex Order 2 If the resident did not want to NJ Ex Order 26.4(b)(1) before going to NJ Ex Order 26.4 it would be held until they returned from NJ Ex Order 26.4 At time if resident refuses NJ Ex Ord will be held for resident until they return from NJ Ex Order 26.4(b)

On 9/20/24 at 10:36 AM, the surveyor interviewed the U.S. FOIA (b) (6) about Resident #458. The U.S. FOIA (b)

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that she did recall Resident #458, who had [redacted], [redacted] to care, and at times [redacted]. The [redacted] added that she recalled the resident's family had to be called as the resident would [redacted] care or [redacted] to go to [redacted]

On 9/20/24 at 11:21 AM, the survey team met with the [redacted] the [redacted] RNC#1, and the [redacted]. The surveyor informed the facility about the concerns that no [redacted] communication forms were provided for the resident and 6 of the 90 [redacted] entries were completed on the "Documentation Survey Report." There was no additional information provided by the facility.

The surveyor reviewed the facility's policy titled "Dialysis Communication" with a last updated date of 4/2024. Under Policy Interpretation and Implementation, it read, " ...3. The facility and dialysis center will determine a method to exchange written information between the centers on dialysis days. Examples of communication methods may include but are not limited to: forms, binders, books and copies of medical records ...4. Examples of information that may be communicated between the facilities include ...b. Hemodialysis Communication Form (or equivalent) ...j. dietary needs ..." The policy did not address record keeping of the dialysis communication form and it did not address meals/snacks for residents going to dialysis.

The surveyor reviewed the facility policy titled, "Activities of Daily Living (ADLs), Supporting" with an updated date of 4/2024. Under Policy Interpretation and Implementation, it read, " ...3. The resident's ability to participate in ADLs and

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F 698	Continued From page 94 the support provided during ADL care and resident-specific tasks will be documented each shift by CNAs in the medical record ..." NJAC 8:39 - 27.1(a); 2.9	F 698		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Complaint#: NJ175260 and NJ176352	F 725	How will any corrective action be	10/10/24

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F 725	Continued From page 95 Based on observation, interview, record review, and review of pertinent facility documentation, it was determined the facility failed to ensure sufficient nursing staff and ensure call bells were answered timely without waiting a long period of time for seven (7) of 28 residents (Residents # 36, 60, 83, 84, 100, 102, and 153). This deficient practice was evidenced by the following: 1. On 9/16/24 at 7:45 AM, the surveyor observed the posted Nursing Home Resident Care Staffing Report (NHRCSR) dated 9/15/24 -Day shift 7:00 AM- 3:00 PM, which displayed Current Resident Census: 120 and the CNA (Certified Nursing Aide) to Resident ratio of 1:8.6. On 9/17/24 at 8:45 AM, the surveyor observed the posted NHRCSR dated 9/16/24 - Day shift 7:00 AM-3:00 PM, Current Resident Census: 126 and the CNA to Resident ratio of 1:9. On 9/20/24 at 9:45 AM, the surveyor interviewed the U.S. FOIA (b) (6)). The U.S. FO informed the surveyor that she was aware of the mandated New Jersey staffing law. The U.S. FO stated that on 7 AM to 3 PM, day shift, the CNA to Resident ratio should be 1:8. 2. On 9/16/24 at 10:18 AM, during the initial tour the surveyor observed Resident #83 resting in their bed. The resident stated that the night staff takes longer to answer the call light and was worried to NJ Ex Order 26.4(b)(1) when the resident was NJ Ex Order 26.4(b)(1). On 9/17/24 at 11:11 AM, the surveyor observed	F 725	accomplished for those residents found to have been affected by the deficient practice? Resident # 36 (discharged) Resident # 60 Concern was relayed into a grievance Resident # 83 (discharged) Resident # 84 Concern was relayed into a grievance Resident # 100 Concern was relayed into a grievance Resident # 102 Concern was relayed into a grievance Resident # 153 (discharged) How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by this practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? All department heads and nursing staff have been in-serviced on call bell response. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change? Administrator or Department head will perform Call bell response audits. These	

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F 725	Continued From page 96 the resident watching television in the bed and the resident stated that last night they had [redacted] and used the call bell to get some help, and no one answered the call bell. The resident further stated that they had to call their family member and then the staff came to assist the resident after the family member called the facility and asked them to help the resident. At 11:50 AM, Resident #83's representative (RR) called the surveyor into the room. The RR confirmed that the resident had called the family member overnight to get some help after waiting for someone to answer the call bell. The staff came to assist the resident after the family member's phone call to the facility. The family member stated when they called the facility, they were told that the staff was on break. The surveyor reviewed the medical records of Resident #83 and revealed: A review of the Admission Record (AR; admission summary) revealed that Resident #83 was admitted to the facility with diagnoses which included but were not limited to: [redacted], and [redacted] A review of the resident's comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected the resident had a Brief Interview for Mental Status (BIMS) of [redacted] out of 15, which indicated the resident had [redacted]. Further review of MDS Section [redacted]-	F 725	audits will be completed daily for 30 days on alternating shifts, then weekly for four weeks X 1 month, and randomly throughout shifts for one quarter. The results of the audits will be reviewed during the monthly Quality Assurance Performance Improvement Committee meeting. The Quality Assurance Performance Improvement committee will make recommendations based upon the results of the audits. The Quality Assurance Performance Improvement Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. When will corrective action be accomplished? 10/10/2024	

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NJ Ex Order 26.4(b)(1) reflected that Resident was NJ Ex Order 26.4(b)(1) "where the NJ Ex Order 26.4(b)(1) , resident did NJ Ex Order 26.4(b)(1) ," for NJ Ex Order 26.4(b)(1)

The resident had a care plan (CP) with a focus that read, "[Resident #83] has a NJ Ex Order 26.4(b) ." The CP was initiated on NJ Ex Order 26.4 and last revised on NJ Ex Order 26. The interventions indicated the resident was a NJ Ex O with NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(

The resident had a CP with a focus that read, "[Resident #83] has NJ Ex Order 26.4(b)(1) ." The CP was initiated on NJ Ex Order 26. and last revised on NJ Ex Order 26.4(b) The interventions indicated the resident was a NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(

3. On 9/16/24 at 9:26 AM, the surveyor observed Resident #100 lying in their bed, NJ Ex Orc and NJ Ex Order 26.4 . The resident stated there were long wait times when using the call bell for assistance and it could happen on any shift.

The surveyor reviewed Resident #100's medical records which revealed the following:
The AR documented that the resident had diagnoses that included but were not limited to, NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) .

A cMDS assessment dated NJ Ex Order 26.4 , indicated the facility assessed the resident's NJ Exec Order 26.4(using a BIMS test. Resident #100 scored a NJ Ex out of 15,

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which indicated the resident was NJ Ex Order 26.4(b)(1) [redacted]

On 9/16/24 at 9:36 AM, the surveyor observed Resident #36 lying in their bed with the head of the bed elevated. Resident #36 was NJ Ex Ord [redacted] and NJ Ex Order 26.4(b)(1). The resident reported a concern with long wait time for call bell response on a couple of night shifts. Resident #36 stated it most recently occurred the week prior and wait times were longer than twenty minutes (mins).

4. The surveyor reviewed Resident #36's medical records which revealed the following:
The AR documented that the resident had diagnoses that included but were not limited to, NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1) [redacted]).

A cMDS assessment dated NJ Ex Order 26.4 [redacted], indicated the facility assessed the resident's NJ Exec Order 26.4 [redacted] using a BIMS test. Resident #100 scored a NJ Ex [redacted] out of 15, which indicated the resident was NJ Ex Order 26.4(b)(1) [redacted]

On 9/18/24 at 11:17 AM, the surveyor interviewed the U.S. FOIA (b) (6) [redacted] regarding the facility's call bell system. The U.S. FOIA (b) [redacted] stated the call bell system does not have an automated report or keep record of call bell light response. The U.S. FOIA (b) [redacted] stated that call bell audits were conducted to assess the call bell response by staff and would provide call bell audits completed to the surveyor.

On 9/19/24 at 9:00 AM, the surveyor requested the call bell audits that were to be provided by the

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U.S. FOIA (b) (6)

On 9/19/24 at 9:40 AM, the U.S. FOIA (b) provided the call bell audits that were conducted.

The surveyor reviewed the provided documents titled "CALL BELL AUDIT FORMS." The call bell audits were completed on 02/12/24, 02/21/24, 5/29/24, 6/03/24, 7/05/24, and 8/28/24. The call bell audits each included from two to four rooms call bell response times and 01 of the 06 call bell audits were conducted during the 11-7 shift between 6-7 AM. The call bell audits revealed wait times ranged from 04 to 25 mins. Additionally, it was documented that the staff members were "in-service" or re-educated when longer wait times occurred. This occurred for wait times of 16 mins, 25 mins, 18 mins, 24 mins and 15 mins.

On 9/19/24 at 10:00 AM, a review of call bell audits provided by U.S. FOIA (b) revealed call bell audits completed in February, May, June, July, and August 2024 with wait times ranging from 04-25 mins. Additionally documented were "in-service" for the CNA when longer wait times found, 16 mins on 02/12/24, 25 mins on 6/03/24, 18 mins on 6/03/24, 24 mins PM 8/28/24, and 15 mins on 8/28/24.

On 9/19/24 at 02:04 PM, the survey team met with the U.S. FOIA (b) (6)), U.S. FOIA (b) (6)
U.S. FOIA (b) (6)
, and Regional Nurse Consultant #1 (RNC#1). The surveyors informed the facility regarding the concerns with call bell response. The surveyor asked the U.S. FOIA (b) what the expected call bell response time by staff was. The U.S. FOIA (b) stated will ask family and residents their

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expectation and it was a difficult number to quantify. The [U.S. FOIA (b)] stated the goal was 15 mins. The [U.S. FOIA (b)] acknowledged that in the case of something emergent or a resident needing immediate assistance it was important for staff to answer call bells as promptly as possible.

The surveyor reviewed the provided facility policy titled, "Call System, Resident" with an updated date of 4/2024. Under Policy Interpretation and Implementation, it read: " ...6. Calls for assistance are answered as soon as possible ..."

5. On 9/18/24 at 11:03 AM, during the resident Council meeting, four (4) of four (4) residents (Resident #84, #153, #60, and #102) stated that the average call bell response time was at least 20 mins.

A review of Resident #60's most recent MDS, dated [NJ Ex Order 26.4(b)] reflected the resident scored a [NJ Ex] out of 15 on the BIMS which indicated the resident's NJ Ex Order 26.4(b)(1).

A review of Resident #84's most recent MDS, dated [NJ Ex Order 26.4], reflected the resident scored a [NJ Ex] out of 15 on the BIMS which indicated the resident had NJ Ex Order 26.4(b)(1).

A review of Resident # 102's most recent MDS, dated [NJ Ex Order 26.4], reflected the resident scored a [NJ Ex] out of 15 on the BIMS which indicated the resident's NJ Ex Order 26.4(b)(1).

A review of Resident #153's most recent MDS, dated [NJ Exec Order 26.4] reflected the resident scored a [NJ Ex] out of 15 on the BIMS which indicated the resident's NJ Ex Order 26.4(b)(1).

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F 725	Continued From page 101 On 9/19/24 at 9:44 AM, the surveyor observed the Registered Nurse entered room NJ Ex O and responded to the call bell after 14 minutes. A review of the provided facility policy titled, "Call System, Resident" with an updated date of 4/2024. Under Policy Interpretation and Implementation, it read: " ...6. Calls for assistance are answered as soon as possible ..." On 9/20/24 at 01:14 PM, the survey team met with the U.S. FOIA (b) (6) U.S. FOIA (b) (6) U.S. FOIA (b) (6), RNC#1, and RNC#2 for an exit conference. There was no additional information provided by the facility management. NJAC 8:39-25.2(a,b)	F 725		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements.	F 732		10/10/24

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F 732	Continued From page 102 (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to ensure the daily posting of licensed nurses, certified nursing aide staffing, and the resident census on two (2) of five (5) days during the survey. This deficient practice was evidenced by the following: On Monday, 9/16/24 at 7:45 AM, upon entry into the facility, the surveyor observed a Nursing Home Resident Care Staffing Report (NHRCSR) which was posted in the reception area of the lobby. The NHRCSR posted for day shift was dated 9/15/24. There was no NHRSCR posted for 9/16/24 day shift.	F 732	How will any corrective action be accomplished for those residents found to have been affected by the deficient practice? It was determined that the facility failed to ensure the daily posting of licensed nurses, certified nursing aide staffing, and the resident census on 2 of the 5 days during state survey. Corrected staffing has been posted daily since, adjusted as need be. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be	

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F 732	Continued From page 103 On Tuesday, 9/17/24 at 8:45 AM, the surveyor observed the NHRCSR posted in the lobby. The NHRCSR posted for day shift was dated 9/16/24. There was no NHRSCR posted for the 9/17/24 day shift. On 9/18/24 at 11:39 AM, in the presence of the survey team, the surveyor notified the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6), U.S. FOIA (b) (6)), and Regional Nurse Consultant #1(RNC#1) about the concern that the NHRSCR was not posted daily for two out of the five days during the survey. The U.S. FOIA stated that the U.S. FOIA (b) (6)) was responsible for posting the NHRSCR and acknowledged that staffing should be posted prior to beginning of each shift. During an interview with the surveyor, on 9/20/24 at 9:45 AM, U.S. FO confirmed that she was responsible to post the NHRCSR at the front desk. The U.S. FO further explained that it was important to post NHRSCR everyday to let the residents and their families know that "we" had right number of staff to care for their loved ones. The U.S. FO acknowledged that it was not acceptable that the staffing was not posted for each shift as the shift changed. A review of a facility's Staffing, Sufficient and Competent Nursing Policy with an updated date of 4/2024, revealed: 6.) Direct care daily staffing numbers (the number of nursing personnel responsible for providing direct care to residents) are posted in the facility for every shift. On 9/20/24 at 01:15 PM, the survey team met for	F 732	affected by this practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The staffing sheet was updated to include all three shifts of the day on one sheet along with accurate census at the beginning of the shift which will be posted daily before the beginning of each shift. Any corrections to staffing numbers will be made by the staffing coordinator and continue to be posted in the front desk receptionist area for all residents and guests to view. The Staffing Coordinator educated the Shift Nurse Supervisors on the Posted Nurse Staffing Requirements and how they are responsible for updating the daily staffing sheet to include accuracy of staffing numbers and census at the beginning of each shift. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change? The Administrator will check daily staffing postings x 2 weeks Monday through Friday, and the Administrators on Duty will check on their corresponding weekends. After the first 2 weeks of daily checks, then the posting will be monitored weekly x 4 weeks and report findings during the	

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F 732	Continued From page 104 Exit conference with U.S. FOIA (b) (6), RNC#1, RNC#2 and the U.S. FOIA (b) (6). The facility management did not provide an additional information and did not refute the findings. NJAC 8:39-41.2	F 732	monthly Quality Assurance Performance Improvement meeting to determine how long it will need to be reported for. When will corrective action be accomplished? 10/10/2024	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		9/23/24

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F 756	Continued From page 105 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to address the recommendations made by the U.S. FOIA (b) (6) [redacted] in a timely manner. This deficient practice was identified for one (1) of five (5) residents (Resident #62) reviewed for unnecessary medications. This deficient practice was evidenced by the following: On 9/16/24 at 9:06 AM, the surveyor observed Resident #62 in their room, lying in bed with the head of the bed elevated. The resident was NJ Ex Orde NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) [redacted]. Resident #62 verbalized NJ Ex Order 26.4(b)(1) with their care. The surveyor reviewed the hybrid (paper and electronic) medical record of Resident #62. The Admission Record (a summary of important information about the resident) documented that the resident had diagnoses that included but were not limited to, NJ Ex Order 26.4(b)(1) [redacted] and NJ Ex Order 26.4(b)(1)	F 756	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice? For Resident #62, it was determined that the facility failed to address the recommendations made by the pharmacy consultant in a timely manner. For Resident #62, on 09/19/24, the Nurse Practitioner and NJ Ex Order 26.4(Nurse were contacted by unit manager regarding the non-use of as needed NJ Ex Order 26.4(b)(1) Medication was discontinued off the resident's medication regimen. How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents with as needed psychoactive medication on medication regimen have the potential to be affected by this deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	

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F 756	Continued From page 106 A comprehensive Minimum Data Set (MDS) assessment, dated [redacted], indicated the facility assessed the resident's [redacted] using a Brief Interview Mental Status (BIMS) test. Resident #36 scored a [redacted] out of 15, which indicated the resident had NJ Ex Order 26.4(b)(1) . A physician's order dated [redacted] read, "NJ Ex Order 26.4(b)(1) [redacted] give [redacted] by mouth every 4 hours as needed (PRN) for [redacted] and [redacted] A care plan with a focus that read, "[Resident #62] uses [redacted] medication (med) ([redacted] r/t [related to] [redacted] not resolved by use." The care plan was dated [redacted] and last revised on [redacted]. An intervention for the care plan read [redacted] as directed by physician" with an initiation date of [redacted]. A review of the [redacted] consultant notes revealed there were no notes found after [redacted]. On 9/18/24 at 02:00 PM, the surveyor requested the CP recommendations from the last three months and [redacted] consultant notes. On 9/19/24 at 9:00 AM, the U.S. FOIA (b) (6) [redacted]) and U.S. FOIA (b) (6) [redacted]) provided documentation that indicated the resident representative wanted the primary physician to be responsible for the resident's med regimen and not the [redacted] consultant after [redacted]. The [redacted] stated they would provide the CP recommendations to the surveyor.	F 756	Director of Nursing educated Assistant Director of Nursing on the policies titled, "Medication Regimen Reviews" and "Psychotropic Medication Use" to ensure all recommendations are addressed with physician. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change? Director of Nursing or Administrator will audit the Medication Regimen reports monthly x 3 months All audits will be presented at the monthly Quality Assurance Performance Improvement committee for review and further follow-up as needed. When will corrective action be accomplished? 09/23/2024	

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On 9/19/24 at 9:30 AM, the U.S. FOIA (b) provided the CP recommendations for Resident #62.

A review of the CP reports for NJ Ex Order 26.4(b)(1) NJ Ex O and NJ Ex Order 26.4(b)(1) revealed there were recommendations to specify a duration for the PRN NJ Ex Order 26.4(b)(1) medications (meds) (NJ Ex Order 26.4(b)(1) unless clinical rationale documented by physician.

The NJ Ex Order 26.4(b)(1) report, dated NJ Ex Order 26.4, handwritten by the entry indicated the physician was informed and NJ Ex Order 26.4 to communicate.

The NJ Ex Order 26.4(b)(1) report dated NJ Ex Order 26.4, handwritten by the entry read "awaiting NJ Ex Order 26.4 recommendation."

The NJ Ex Order 26.4(b)(1) report dated NJ Ex Order 26.4, handwritten by the entry indicated the resident had not taken the med since ordered.

Additional review of progress notes revealed there was no documentation of follow up with physicians or hospice regarding CP recommendations. There was also no documentation by the primary physician and U.S. FOIA (b) (6)) about review of the resident's psychotropic med regimen.

On 9/19/24 at 10:12 AM, the surveyor interviewed and reviewed the CP recommendation reports with the U.S. FOIA (b) The U.S. FOIA stated she had reviewed the NJ Ex Order 26.4(b)(1) CP report on NJ Ex Order 26.4 and reviewed the Medication Administration Record (MAR) for Resident #62. The U.S. FOIA further explained that the resident had not received any PRN NJ Ex Order 26.4(b)(1) and she was going to follow up with the physician and NJ Ex Order 26.4(b) The U.S. FOIA

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acknowledged that she had not followed up with the physician or [NJ Exec Order 26] yet.

On 9/19/24 at 02:15 PM, the survey team met with the [U.S. FOIA (b) (6)], and the [U.S. FOIA (b) (6)]). The surveyor informed the facility of the concern that the CP recommendations were not followed up and there was no documentation by the primary physician that indicated follow up about the resident's [NJ Ex Order 26.4(b)(1)] med regimen. The surveyor asked who was responsible for reviewing the CP recommendation reports. The [U.S. FOIA] replied that the [U.S. FOIA (b) (6)] were responsible and that she assisted with them when needed. The surveyor asked when it was expected for the CP recommendations to be followed up. The [U.S. FOIA] responded within two weeks after the report was received.

On 9/20/24 at 11:21 AM, the survey team met with the [U.S. FOIA (b) (6)] the [U.S. FOIA (b)] the [U.S. FOIA (b)] and the [U.S. FOIA (b) (6)]. There was no additional information provided by the facility.

The surveyor reviewed the provided facility policy titled "Psychotropic Medication Use" with a last updated date of 4/2024. Under Policy Interpretation and Implementation it read, " ...12. Psychotropic meds are not prescribed or given on a PRN basis unless that med is necessary to treat a diagnoses specific condition that is documented in the clinical record ...PRN orders for psychotropic meds are limited to 14 days ...For psychotropic meds that are not antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will

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F 756	Continued From page 109 document the rationale for extending the use and include the duration for the PRN order ..." Under Resident Evaluation of the policy, it read, " ...3. When determining whether to initiate, modify, or discontinue med therapy, the IDT [Interdisciplinary Team] conducts an evaluation of the resident ..." The surveyor reviewed the provided facility policy titled "Medication Regimen Reviews" with a last updated date of 4/2024. Under Policy Interpretation and Implementation it read, " ...11. If the physician does not provide a timely or adequate response, or the consultant pharmacist identifies that no action has been taken, he/she contacts the medical director or (if the medical director is the physician of record) the administrator ...12. Documentation will be placed in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it ...14. The CP provides the director of nursing services and medical director with a written, signed and dated copy of all med regimen reports. Follow up will be completed within 30 days ..." NJAC 8:39-27.1 (a); 29.3	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		10/8/24

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F 761	Continued From page 110 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to ensure that medications were stored securely and appropriately. This deficient practice was identified in one (1) of two (2) medication carts observed on the third floor during the surveyor's initial tour of the facility. This deficient practice was evidenced by the following: On 9/16/24 at 11:49 AM, the surveyor observed the medication (med) cart located on the 3rd floor, side three. The surveyor observed two vials of med located on the top of the med cart. The vials were observed to be opened for use and had a manufacturer label that reflected they contained the drug Acetylcysteine (a med used to decrease mucous in some lung conditions). The surveyor did not observe a nurse or other authorized person at the med cart.	F 761	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents identified to be affected. Nurse assigned to med side 3 floor 3 was immediately in serviced on leaving medications unattended. How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents would have the potential to be affected by this deficiet practice. What measures will be put into place or systemic changes made to ensure that	

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F 761	Continued From page 111 As the surveyor was attempting to locate the nurse assigned to the med cart, a nurse approached the cart and placed the vials in her pocket. The surveyor asked the nurse if she was the nurse assigned and she stated that she was. The surveyor asked the nurse if any medications (meds) should be left on top of the cart unattended. The nurse stated "no, but I went to check on a resident and was going to put them back in the refrigerator." On 9/18/24 at 10:15 AM, the surveyor interviewed the U.S. FOIA (b) (6) The surveyor asked the U.S. FOIA if any meds should be left unattended and unsecured on top of a med cart. The U.S. FOIA stated, no, there should never be any meds left unattended or unsecured. The surveyor requested a policy for Med Storage from the U.S. FOIA (b) (6) On 9/18/24 at 11:39 AM, the surveyor, in the presence of the survey team, met with the U.S. FOIA (b) (6)), the U.S. FOIA (b) (6) the U.S. FOIA (b) (6)), and the U.S. FOIA (b) (6)). The U.S. FOIA (b) (6) provided the surveyor with a policy titled "Storage of Meds" with a date last updated of 4/2024. The surveyor discussed the concern with meds being left unattended and unsecured on top of a med cart. The surveyor asked the U.S. FOIA if meds should be left on top of the med cart unattended. The U.S. FOIA stated no they should not be. The surveyor reviewed the policy "Storage of Medications." The policy reflected under item 1. "Drugs and biologicals used in the facility are	F 761	the deficient practice will not recur? DON/ADON reeducated nurses on medications being stored securely and appropriately. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change? DON/ADON will audit 2 medications carts weekly x 3 weeks then 2 medication carts monthly x 2 months to ensure medications are being stored securely and appropriately. Consultant pharmacist will come monthly to check medication carts for compliance. The results of the audits will be reviewed during the monthly Quality Assurance Performance Improvement Committee meeting. The Quality Assurance Performance Improvement committee will make recommendations based upon the results of the audits. The Quality Assurance Performance Improvement Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. When will corrective action be accomplished? 10/08/2024	

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F 761	Continued From page 112 stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer meds have access to locked meds.". The policy heading also reflected "The facility stores all drugs and biologicals in a safe, secure, and orderly manner." The facility did not provide any further pertinent information. NJAC 8:39-29.4(h)	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, it was determined that the	F 812	How any corrective action will be accomplished for those residents found to	10/8/24

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F 812	Continued From page 113 facility failed to handle potentially hazardous foods and maintain kitchen sanitation in a manner intended to prevent the spread of food borne illness and in accordance with professional standards for food service safety. The deficient practice was evidenced by the following: On 9/16/24 at 7:55 AM, the surveyor toured the facility kitchen with Dietary Aid (DA#1). DA#1 stated that the U.S. FOIA (b) (6)) was not at the facility. The surveyor observed the following concerns: 1. The surveyor observed a refrigerator next to the stove. The contents in the refrigerator included but were not limited to two (2) packages of waffles, one (1) bowl of substance that looked like a chicken salad or tuna salad covered with aluminum foil and one (1) silver pan with pasta and red sauce covered with aluminum foil. The items were not labeled or dated. There was debris on the bottom of the refrigerator. 2. The surveyor observed 2 wheeled carts positioned together with the following food items on the cart's three shelves: a box of bacon with 9/09/24 written on it; three (3) trays of chicken; two (2) metal containers with a pureed substance; one (1) container of macaroni; one (1) container of red sauce; one (1) container of mashed potatoes; one (1) container of rice; one (1) container of a whitish liquid; four (4) containers of sauces; a red lidded container with substance inside; a box of bacon with 9/09/24 written on it and a small square pan with chicken covered with aluminum foil with 9/17/24 written on it. The surveyor observed that only two of the items were	F 812	have been affected by the deficient practice? All items in the refrigerator that are opened/cooked are labeled with a “use by” date. All items received that have not been opened are labeled with a “received” date. Any items that were not labeled on the day of survey were discarded. All prepared/cooked food in the kitchen is be labeled and dated and left in appropriate temperature and monitored. Any items tht were not labeled and datedb were discarded. New Sanitizer strips were obtained and are accurately testing the sanitizer used for the 3 compartment sink. Logs are being maintained daily to reflect sanitizer usage. Personal fan was removed from the kitchen 9.16.24. Ceiling tiles and utensil racks were cleaned 9.16.24. All refrigerators are monitored for accurate temperatures 2 times daily and logs are kept to reflect temperatures. New thermometers placed. How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by this deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	

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F 812	Continued From page 114 labeled and dated. The surveyor asked DA#1 what the items on the cart were for and who had put them there. DA#1 stated that the U.S. FOIA (b) (6) had been here and had taken out the food and that the U.S. F was on a break. 3. The surveyor observed DA#2 washing pans in the 3-compartment sink (a manual sink used in commercial kitchens to wash, rinse, and sanitize dishes). The surveyor asked DA#2 to test the solution that should have contained sanitizing solution that was in the third compartment. DA#2 took a test strip from a bottle that did not contain an expiration date. The test strip result was colored blue which indicated a measurement of 0 as compared to the color legend on the bottle. The surveyor observed the bottle of test strips which included the following: Match the center of the test strip pad to the color chart to determine antimicrobial fruit and vegetable treatment concentration. The surveyor asked DA#2 if he was trained to use the 3- compartment sink and what was the solution in each compartment. DA#2 stated that he was trained and that the first compartment had soap in the water, the second compartment had water and the third compartment had "just water." The surveyor then asked DA #1 the process of the 3-compartment sink. DA #1 stated that the first compartment had soap and water to wash, the second compartment had clean water to rinse and the third compartment had sanitizing solution. The surveyor observed that there was sanitizing solution available and DA#1 showed the surveyor that the solution flowed through the tubing into the third compartment. The surveyor also observed that the facility dishwasher was working. 4. The surveyor observed a box fan on the	F 812	New and experienced (over NJ Ex years) Food Service Director began working NJ Ex Order 26.4(b)(1). Education was provided to dietary team on 9.16.24 and again on 10.8.24 on the following areas: Labeling and dating Food temperatures and storage 3 compartment sink and sanitation Kitchen cleanliness No personal fans in the kitchen Cleaning schedule including ceiling tiles and utensil rack Maintaining Refrigerator temperature logs How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change? Food Service Director and/or Administrator to audit compliance 1x a week for 4 weeks and then weekly x 2 months for compliance. Audits will be presented to the Quality Assurance team to determine if compliance has been met after 2 months	

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F 812	Continued From page 115 container that was running and blowing air on a container of utensils. The box fan had an accumulation of dust on both sides of the fan. 5. The surveyor observed four air circulation vents in the ceiling that had brownish discoloration on them. 6. The surveyor observed eight ceiling tiles that had black debris or brownish black splattered stains. 7. The surveyor observed an accumulation of dust on the silver serving utensil rack. On 9/16/24 at 8:28 AM, in the presence of two other surveyors, the surveyor showed the U.S. FOIA (b) (6)) the concerns that were observed in the kitchen during the initial tour with DA#1. At 8:29 AM, the surveyor asked DA#2 to test the solution in the third compartment of the 3-compartment sink. DA#2 tested the solution with a test strip and the result was a blue color. The surveyor asked the U.S. FOIA (b) to confirm the result with the color legend on the bottle. The U.S. FOIA (b) confirmed that the result indicated zero. The surveyor asked the U.S. FOIA (b) what zero meant. The U.S. FOIA (b) stated that zero meant that there were no chemicals in the solution and that there should be. The surveyor asked the U.S. FOIA (b) to view the test strip bottle for an expiration date. The U.S. FOIA (b) stated that she did not observe an expiration date on the bottle. The U.S. FOIA (b) then stated that the U.S. FOIA usually tested the 3-compartment sink and that there was a new U.S. FOIA that was starting soon. She added that the facility just had a local kitchen inspection and that it was satisfactory.	F 812	or if the audit needs to be continued with new interventions. When will corrective action be accomplished? 10/08/2024	

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At 8:34 AM, the surveyor showed the U.S. FOIA (b) the two carts of food that were not labeled or dated. The surveyor asked DA#2 if he knew when the food on the carts were placed there. DA#2 stated that when he came in at 6 AM the carts with the food were already out. The surveyor asked if the food that was out should be labeled or dated. The U.S. FOIA (b) stated that the food should not be left out like that. She added that it should have been labeled and that if the food was for garbage that it should have been thrown out. The U.S. FOIA (b) attempted to contact the U.S. F that was at the facility earlier but was unable to reach the U.S. FO The kitchen staff discarded the food on the carts.

At 8:38 AM, the surveyor showed the U.S. FOIA (b) the refrigerator and asked if the food should be labeled and dated. The U.S. FOIA (b) stated that the refrigerator was not for resident food and that it should not be like it was. The dietary staff discarded the unlabeled and undated food.

At 8:39 AM, the surveyor showed the U.S. FOIA (b) the box fan. The U.S. FOIA (b) stated that the box fan should not be there. The dietary staff removed the fan.

At 8:40 AM, the surveyor showed the U.S. FOIA (b) the air circulation vents, the ceiling tiles and the silver serving utensil rack. The U.S. FOIA (b) did not say anything.

At 8:47 AM, the surveyor asked the U.S. FOIA (b) to view the log book for the three compartment sink that DA#1 stated earlier that was locked in the office. The U.S. FOIA (b) looked for the log book in the office but was unable to find it in the office. The U.S. FOIA (b) stated that the log book was normally out for staff but that the U.S. FOIA was leaving the facility and that

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currently was out on an emergency. She added that she went over all the log books with the [U.S. FOIA] on Friday before she left and everything was up to date.

At 8:53 AM, the [U.S. FOIA (b)] found the log book on a shelf in the kitchen. The surveyor viewed the log book which included the following:
Three Compartment Sink Sanitation Test Procedure
Sept. 2024
Date 2 through 15 indicated that QT-10 Quaternary Test Strip was at 200 PPM and initialed by DA#2.
The surveyor asked DA#2 if he had worked on 9/14/24 and 9/15/24. DA#2 stated that he did not work on those two days and that he did not know who signed the log book with his initials.

On 9/16/24 at 11:50 AM, in the presence of the survey team, the [U.S. FOIA (b)] stated that in [NJ Exec Order 2] the [U.S. FOIA] was placed on a PIP (performance improvement plan) with expectations and goals. The [U.S. FOIA (b)] stated that the [U.S. FOIA] refused to sign the PIP and that she resigned. The [U.S. FOIA (b)] stated that they inserviced the [U.S. FOIA] and wanted to correct the issue. The [U.S. FOIA (b)] gave the surveyor a copy of the plan.

A review of the PIP that the [U.S. FOIA] refused to sign included the following areas of concern:
Running out of food items, patients getting trays that are missing items and or not what they order.
Consistent call outs, lack of staffing, lack of ability to recruit or retain appropriate staff.
Lack of communication to [U.S. FOIA (b)] and regional staff regarding issues in the building.
Not holding staff accountable for their performance, insubordination, behavior. Not

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holding staff accountable to dress code. Labeling and dating all items. Log books all complete. Not coming to department meetings. Lack of consistent follow up with resident complaints and grievances.
The U.S. FOIA was not present during the survey.

On 9/18/24 at 11:15 AM, the surveyor requested the training for DA#2. The U.S. FOIA (b) stated that there were not competencies done for each individual task. The surveyor requested the time card for DA#2. The U.S. FOIA (b) stated that DA#2 had told the surveyor that he was not working on the weekend and that the staff had told her that they were just copying the initials on the log book. The U.S. FOIA (b) confirmed that no other dietary staff had the same initials as DA#2.

On 9/18/24 at 11:57 AM, in the presence of the survey team, the surveyor notified the U.S. FOIA (b) (6)), Regional Nurse Consultant#1 (RNC#1) and U.S. FOIA (b) (6) the concerns observed in the kitchen: three compartment sink testing showed no sanitizing solution; sanitizer log book signed by staff not working; food left out unlabeled and undated; refrigerator had food unlabeled and undated; accumulation of dust on box fan and serving utensil rack; and discolored vents and ceiling tiles.

On 9/20/24 at 11:29 AM, in the presence of the survey team, U.S. FOIA (b) RNC#1, U.S. FOIA (b) (6)), the U.S. FOIA (b) stated that education was done with dietary staff. The U.S. FOIA (b) (6) stated that the U.S. FOIA (b) had identified an issue with the U.S. FOIA and followed the steps of identifying an issue, creating a PIP and doing followup on the PIP.

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The facility did not provide any additional information.

A review of the facility provided policy titled, "Food Receiving and Storage" with a revised date of October 2017, included the following:
Policy Statement
Foods shall be received and stored in a manner that complies with safe food handling practices.
Policy Interpretation and Implementation
1. Food services, or other designated staff, will maintain clean food storage areas at all times ...
8. All foods stored in the refrigerator or freezer will be covered, labeled and dated ("use by" date).

A review of the facility provided policy titled, "Sanitization" with a revised date of October 2008, included the following:
Policy Statement
The food service area shall be maintained in a clean and sanitary manner.
Policy Interpretation and Implementation
1. All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects.
2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning...
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.
4. Sanitizing of environmental surfaces must be

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performed with one of the following solutions:
a. 50-100 ppm chlorine solution;
b. 150-200 ppm quaternary ammonium compound (QAC); or
c. 12.5 ppm iodine solution.
5. Sanitizing of utensils and removable parts of equipment should be accomplished in one of the following ways:
a. Contact for at least 30 seconds with an iodine solution (at approved concentration);
b. Contact with QAC (at approved concentration) per manufacturer's instructions;
c. Contact for at least 10 seconds with a chlorine (at approved concentration); or
d. Immersion for thirty (30) seconds in hot (at least 171 degrees F) water ...
9. Manual washing and sanitizing will employ a three-step process for washing, rinsing and sanitizing:
a. Scrape food particles and wash using hot water and detergent;
b. Rinse with hot water to remove soap residue; and
c. Sanitize with hot water or chemical sanitizing solution. Chemical sanitizing solutions may consist of:
(1) chlorine 50 ppm for 10 seconds;
(2) iodine 12.5 ppm for 30 seconds; or
(3) quaternary ammonium compound 150-200 ppm for time designated by the manufacturer ...
14. Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime.
15. The food services manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas. Food service staff will be trained to maintain cleanliness throughout their work areas during all

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F 812	Continued From page 121 tasks, and to clean after each task before proceeding to the next assignment. N.J.A.C. 8:39-17.2(g)	F 812		
F 838 SS=F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care	F 838		10/11/24

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needed for the resident population;
(iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.71(a)(2) The facility's resources, including but not limited to the following:
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies;
(iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1).

§ 483.71(b) In conducting the facility assessment,

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the facility must ensure:
§ 483.71(b)(1) Active involvement of the following participants in the process:
(i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and
(ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable.
(iii) The facility must also solicit and consider input received from residents, resident representatives, and family members.

§483.71(c) The facility must use this facility assessment to:
§483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3).

§483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population.

§483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population.

§483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff.

§483.71(c)(5) Inform contingency planning for

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F 838	Continued From page 124 events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by: Based on the interview and review of facility documentation, it was determined that the facility failed to a.) ensure that facility wide assessment included the resources required to establish policies and procedures for the management of staffing contingency plan to meet the requirements and needs of all residents in the facility and b.) meet the staffing plan as reflected in the Facility Assessment. These failures had the potential to affect all 126 residents who currently live in the facility. This deficient practice was evidenced by the following: During the entrance conference on 9/16/24 at 7:54 AM, the surveyor requested from the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)) a copy of the Facility Assessment (FA). Both the U.S. FOIA (b) and U.S. FOIA (b) stated that the facility's census (the number of residents currently under the care of a specific facility) was 126. 1. A review of the facility's "Facility Assessment" with a date of July 23, 2024. The FA submitted by the U.S. FOIA (b) on 9/17/24 at 9:00 AM did not reflect, under Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies, Section 3.2 Staffing Plan, Section	F 838	How the facility will identify other residents having the potential to be affected by the same deficient practice? The resident assessment must indicate a contingency plan for staffing and provision of care for all residents. The assessment provided to the surveyor was missing a section due to printing, when the assessment was reprinted it had all sections including contingent staffing based on an average number of residents for a census maximum of 124. The contingency plan indicates how many staff are needed on any given day/shift and reflect so in the staffing reports as appropriate based on average census and needs of the building. On Week 1 the staffing indicated less than 16 aides on 4 occasions and for week 2 there were 2 occasions under 16 hours. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The resident assessment must indicate a contingency plan for staffing and provision	

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F 838	Continued From page 125 3.5 Policies and Procedures for provision of care, any contingency plan for staffing. The FA provided by the [U.S. FOIA (b)] included a document titled "Attachment 1." Attachment 1 reflected an excerpt from the Federal Register Volume 81, dated 10/4/16 titled Facility Assessment. On 9/19/24 at 12:53 PM, the surveyor interviewed the [U.S. FOIA (b)] regarding the FA and showed the [U.S. FOIA (b)] "Attachment 1." The [U.S. FOIA (b)] informed the surveyor that she was aware of the updates and new memo from CMS (Centers for Medicare and Medicaid Services) about the FA with an effective date of 8/08/24. The [U.S. FOIA (b)] stated that "Attachment 1" was just an attachment, and that the regulation was being followed. The [U.S. FOIA (b)] stated that the FA was reviewed with the QAPI (Quality Assurance Performance Improvement) Committee on 8/08/24 as indicated on the FA. 2. A review of the facility's "Facility Assessment" with a date of July 23, 2024. The FA submitted by the [U.S. FOIA (b)] on 9/17/24 at 9:00 AM reflected, under Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies, Section 3.2 Staffing Plan, "Based on your resident population and their needs for care and support, describe your general approach to staffing to ensure that you have sufficient staff to meet the needs of the resident at any given time." Under the section "Nurse aides," the Total Number Needed or Average or Range was reflected as "16-18." A review of the facility's nurse staffing reports, provided by and signed by the [U.S. FOIA (b)] dated	F 838	of care for all residents. The assessment provided to the surveyor was missing a section due to printing, when the assessment was reprinted it had all sections including contingent staffing based on an average number of residents. The contingency plan indicates how many staff are needed on any given day/shift and reflect so in the staffing reports as appropriate based on average census and needs of the building. On Week 1 the staffing indicated less than 16 aides on 4 occasions and for week 2 there were 2 occasions under 16 hours. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change? Performance Improvement Meeting quarterly to ensure the staffing contingency plan continues to meet the needs of the facility. If the Quality Assurance committee deems that the needs need to be changed then changes will be implemented and monitored monthly x 3 months to ensure appropriateness. When will corrective action be accomplished? 10/11/24	

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9/16/24, for the weeks of 9/01/24-9/07/24 (week 1) and 9/08/24-9/14/24 (week 2) revealed the following:

For week 1, Nurse Aide staffing on the day shift was less than 16 four (4) time, on the evening shift seven (7) times, on the night shift seven (7) times.
For week 2, Nurse Aide staffing on the day shift was less than 16 two (2) times, on the evening shift seven (7) times, on the night shift seven (7) times.

Further review of the facility provided Staffing Plan in the FA reflected the statement "...sufficient staff to meet the needs of the residents at any given time," and a number range of 16-18 which was not met.

On 9/19/24 at 02:04 PM, the surveyor in the presence of the survey team met with the U.S. FOIA (b) (6)), and U.S. FOIA (b) (6)). The surveyor notified the U.S. FOIA (b) of the concern with the FA not containing a staffing contingency plan as per the CMS update published 5/10/24, effective 8/08/24 and the Quality Safety Oversight (QSO) memo dated 6/18/24.

On 9/20/24 at 12:16 PM, the surveyor met with the U.S. FOIA (b) and asked if there was any further information or documentation the facility wished to provide.

The Facility did not provide any further pertinent information.

NJAC 8:39-5.1(a)

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F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		10/10/24

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F 842	Continued From page 128 by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other pertinent documents, it was determined that the facility failed to maintain a complete, available, accurate, and readily accessible medical records. This deficient practice was identified for two (2) of the 28 residents reviewed (Residents #62 and #148). This deficient practice was evidenced by the following:	F 842	How will any corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident # 62 The order was clarified with the NP Resident # 148 The recommendations from the NJ Ex Order 26.4(b)(1) were declined from the primary care physician and documented in the medical record.	

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F 842	Continued From page 129 1. On 9/16/24 at 9:06 AM, the surveyor observed Resident #62 in their room, lying in bed with the head of the bed elevated. The resident was NJ Ex Orde NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) . Resident #62 verbalized NJ Ex Order 26.4(b)(1) with their care. The surveyor reviewed the hybrid (paper and electronic) medical record of Resident #62. The Admission Record (AR; a summary of important information about the resident) documented that the resident had diagnoses (Dx) that included but were not limited to, NJ Ex Order 26.4(b)(1 and NJ Ex Order 26.4(b)(1) A comprehensive Minimum Data Set (MDS) assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of NJ Ex Order 26.4 , indicated the facility assessed the resident's NJ Exec Order 26.4(using a Brief Interview Mental Status (BIMS) test. Resident #36 scored a NJ E out of 15, which indicated the resident had NJ Ex Order 26.4(b)(1) A physician's order (PO) dated NJ Ex Order 26.4(b read, "NJ Ex Order 26.4(b)(1)]." A PO dated NJ Ex Order 26.4(b read, "[agency name] NJ Ex Order 26.4(b)(A care plan (CP) with a focus that read, "[Resident #62] has advance directives/wishes in place. Copy requested, NJ Ex Order 26.4(b)(1)] on file." The intervention read "NJ Ex Order 26.4(b)(1)" which was dated NJ Ex Order 26.4 . The care plan was last revised NJ Ex Order 26.4(b)(	F 842	Confirmed with NP that "NJ Ex Order 26.4(b)(1)" was in fact a typo and should have been "NJ Ex Order 26.4(b)(1)". How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by this practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Administrator in-serviced the U.S. FC on verification of orders and not utilizing the copy and paste function when documenting in the medical record. The U.S. FC was reminded to re-read documentation to ensure accuracy before saving progress notes. The unit managers and nurses were in-serviced on documenting after consultant recommendations are approved or declined regardless of the outcome status. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change? The DON or nursing management will audit 5 resident charts a month after consultation appointments to ensure documentation of approval or denial of	

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F 842	Continued From page 130 A completed [NJ Ex Order 26.4] dated [NJ Ex Order 26.4] documented the resident wished to have a [NJ Ex Order] status. A [U.S. FOIA (b) (6)]) progress note (PN) dated [NJ Ex Order 26.4] documented that the [U.S. FOIA] and interdisciplinary team [IDT] met with resident's representative previous week to discuss the resident's status and CP. The note indicated advance directives were reviewed and the resident had a [NJ Ex Order] status. A review of physician PN revealed the primary [U.S. FOIA (b) (6)] and the [US FOIA (b)(6)] documented that the resident was a [NJ Ex Order 26.4(b)(1)] status. There was no additional documentation found in the hybrid medical records that detailed the resident having a [NJ Ex Order 26.4(b)(1)] status. On 9/18/24 at 12:08 PM, the survey team met with the [U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)] and Regional Nurse Consultant #1 (RNC#1). The surveyor notified the facility management of the concern that the [US FOIA (b)(6)] PN by the primary [U.S. FOIA] and [US FOIA (b)(6)] did not accurately reflect the resident's [NJ Ex Order 26.4(b)(1)] of [NJ Ex Order] The physician PN conflicted with all order medical record documentation. The facility stated they would review and provide further information. On 9/19/24 at 01:29 PM, the [U.S. FOIA (b) (6)] and [U.S. FOIA] met with the survey team. The [U.S. FOIA (b)] stated the [NJ Ex Order] status of Resident #62 was the accurate and most up to date advance	F 842	recommendations. This audit will continue monthly for 1 quarter. The results of the audits will be reviewed during the monthly Quality Assurance Performance Improvement Committee meeting. The Quality Assurance Performance Improvement committee will make recommendations based upon the results of the audits. The Quality Assurance Performance Improvement Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. When will corrective action be accomplished? 10/10/2024	

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directive for the resident. The U.S. FOIA (b) acknowledged the US FOIA (b)(6) PN were not accurately documenting the resident's advance directives. There was no additional information provided by the facility.

The surveyor reviewed the facility provided, undated policy titled "Electronic Medical Records". The policy did not address medical record accuracy or documentation.

On 9/20/24 at 8:50 AM, the surveyor requested from the U.S. FOIA (b) any additional policies related to medical records, record keeping and US FOIA (b)(6) documentation.

On 9/20/24 at 11:21 AM, the survey team met with the U.S. FOIA (b) (6) the U.S. FOIA (b) the U.S. FOIA (b) and the U.S. FOIA (b) (6) There was no additional information provided by the facility.

2. On 9/16/24 at 10:27 AM, the surveyor observed Resident #148 seated on the bed with breakfast in front of the resident. The NJ Ex Order 26.4(b) was hung on the NJ Ex Order 26.4(b)(1) attached to the wall.

The surveyor reviewed the hybrid medical records of Resident #148 and revealed:
The AR reflected that the resident was admitted to the facility with Dx that included but were not limited to NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1)).

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The most recent admission MDS with an ARD of [redacted], under Section [redacted] had a BIMS score of [redacted] out of 15 which reflected that resident was [redacted].

A review of the [redacted] Order Summary Report (OSR) revealed an active PO with an order date of [redacted] of [redacted] orally every 6 hours (hrs) as needed (PRN) for [redacted]) or [redacted] total. Not to exceed 6 doses/24 hrs.

The personalized CP with focus was that the resident had a [redacted] r/t (related to) [redacted] with an intervention that included to give [redacted] or [redacted] as ordered that was initiated on [redacted]

A review of the [redacted]) Consult notes dated [redacted] showed that the resident was referred to due to a Dx of [redacted] with Impression/Plan: Dx [redacted] every 6 hrs, [redacted] PRN, and monitor [redacted]

A review of the PN revealed that the [redacted] who did the [redacted] consult on [redacted] documented in the PN that the resident was seen and examined, and to see documents for [redacted] consultation.

A review of the [redacted] and [redacted] PN of the [redacted] showed that the [redacted] documented on both PNs [redacted], [redacted] Now

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F 842	Continued From page 133 NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4 or NJ Ex Order 26.4(b)(1) Further review of the PN showed that the plan for the resident that was documented on NJ Ex Order 26.4 by the NJ Ex Order 26 doctor was not followed. There was no documented evidence that the U.S. FOIA (b) (6)) nor the U.S. FOIA caring for the resident was notified of the plan. On 9/18/24 at 9:27 AM, the surveyor interviewed the U.S. FOIA (b) (6). The surveyor notified the U.S. FOIA (b) (6) of the above findings and concerns regarding the NJ Ex Order 26.4(b)(1) consult. The U.S. FOIA (b) (6) stated that there should be documentation that the NJ Exec Order consult was relayed to the U.S. FOIA and if the U.S. FOIA agreed or disagreed with the recommendations it should be in the PN. On 9/18/24 at 11:39 AM, the survey team met with the U.S. FOIA (b) U.S. FOIA (b) U.S. FOIA (b) (6), and RNC#1. The surveyor notified the facility management of the above concerns and findings. On 9/18/24 at 01:56 PM, the U.S. FOIA informed the surveyor in the presence of the survey team that according to the U.S. FOIA (b) (6) during their (NJ Ex Order 26 doctor and the U.S. FOIA (b) (6)) rounds on NJ Ex Order 26.4, the NJ Ex Order 26 doctor was made aware that the resident had an order for PRN NJ Ex Order 26.4(b)(1) and the doctor verbally stated to the U.S. FOIA (b) (6) not to proceed with the plan of NJ Ex Order 26.4 and the monitoring of NJ Ex . The U.S. FOIA further stated that according to the U.S. FOIA (b) (6), she was unaware that the NJ Ex Order 26 consult paper was handed to someone (unsure who was the person) and it was uploaded to the electronic medical record. The U.S. FOIA also stated that per U.S. FOIA (b) (6), if she knew it was uploaded, she should have questioned the	F 842		

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F 842	Continued From page 134 recommendations. At that same time, the surveyor asked the [U.S. FOIA] who was responsible for reviewing the PN of the [U.S. FOIA] and should the notes had been clarified prior to the surveyor's inquiry. The [U.S. FOIA] acknowledged that the [U.S. FOIA] had written a note regarding the round with the [NJ Exec Order] doctor after the surveyor's inquiry. The [U.S. FOIA] further stated that the NP's PN should have been clarified as well. Furthermore, the [U.S. FOIA] stated that the NP notes should not copy and paste notes. She further stated that the [NJ Ex Order 26.4] and [NJ Ex Order 26.4b] PN of the NP about "[NJ Exec Order 26.4b1]" should have been [NJ Exec] [redacted]" On 9/20/24 at 11:19 AM, the survey team met with the [U.S. FOIA (b)] and [U.S. FOIA (b)] RNC#1, and [U.S. FOIA (b) (6)] [redacted]. The [U.S. FOIA (b)] stated "I think we provided everything," and nothing to add. A review of the facility's Electronic Medical Records Policy with an updated date of 4/2024 that was provided by the [U.S. FOIA] revealed: Policy Statement: Electronic medical records may be used in lieu of paper records when approved by the administrator. Policy Interpretation and Implementation: 1. Electronic records are an acceptable form of medical record management ... On 9/20/24 at 01:14 PM, the survey team met with the [U.S. FOIA (b)] [U.S. FOIA (b)] [U.S. FOIA (b) (6)], [U.S. FOIA (b) (6)], RNC#1, and RNC#2 for an exit conference. There was no additional information provided by the facility management. NJAC 8:39-23.2 (a)(b); 35.2 (d)(6)	F 842		

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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 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		10/4/24

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F 880	Continued From page 136 (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 observation, interview, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to a.) follow appropriate hand hygiene and use of personal protective equipment (PPE) practices for four (4) of nine (9) staff (two Recreation Staff, one Certified Nursing Aide, and one NJ Exec Order 26 Aide), b.) follow appropriate infection control practice during the medication pass observation when administering NJ Ex Order 26.4(b)(1) for one (1) of three (3) nurses, c.) maintain infection	F 880	How will any corrective action be accomplished for those residents found to have been affected by the deficient practice? On 9/16/24, CNA#1 was educated on proper hand hygiene immediately after glove use. On 9/16/24, CNA#2 and CNA#3 were educated on policy titled, “Enhanced Barrier Precautions” and use of proper	

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F 880	Continued From page 137 control standards and procedures during [NJ Ex Order 26] care treatment for one (1) of one (1) nurse observed for [NJ Ex Order 26] treatment, and d.) follow appropriate infection control practices prevent the potential spread of infection for one (1) of two (2) linen carts observed during environmental tour in accordance with the Center for Disease Control and Prevention (CDC) guidelines and facility's policy. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 02/27/24 revealed: Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient ... Before moving from work on a soiled body site to a clean body site on the same patient ... After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal. According to the CDC guidelines dated 4/02/24, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) included information for EBP (enhanced barrier precautions) when to use PPE (personal protective equipment) during high contact resident care activities. Examples of high-contact resident care activities requiring gown and glove use for EBP include:	F 880	PPE during high-contact care activities with residents on these precautions. On 9/16/24, the styrofoam cup with food and utensils was removed from inside of the linen cart. CNA involved was educated on policy titled, “Laundry and Linen Policy” and importance of clean linen being kept hygienically clean and free from environmental contamination. On 9/16/24, CNA#2 and LPN who were noted not wearing surgical mask appropriately over both nose and mouth were educated on proper mask wearing. On 9/18/24, RN#1 was educated on proper medication administration of [NJ Ex O] and providing a separate tissue for [NJ Ex Order 26.4b1] to prevent possible infection control issue. On 9/19/24, RN#2 was educated on policy titled, “Wound Care” which includes but not limited to, procedure to disinfect reusable supplies before returning to treatment cart and to bring only necessary supplies into resident’s room. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by poor infection control practices. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Assistant Director of Nursing and Infection Preventionist provided in-service	

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F 880	Continued From page 138 Dressing ... Providing hygiene Changing linens ... Device care or use: central line, urinary catheter, ... Implementation When implementing Contact Precautions or EBP, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies. To accomplish this: Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g., gown and gloves) For EBP, signage should also clearly indicate the high-contact resident care activities that require the use of a gown and gloves. Make PPE, including gowns and gloves, available immediately outside of the resident room ... Incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education Provide education to residents and visitors ... 1. On 9/16/24 at 9:26 AM, during the Entrance Conference meeting with two surveyors with the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)), the U.S. FOIA informed the surveyors that the facility was on a NJ Ex Order 26.4(b)(1). The U.S. FOIA further stated that the NJ Ex Order 26.4(b) started on NJ Ex Order 26.4 with one resident. She also stated that the resident was discontinued (d/c) on NJ Ex Order 26.4(and there were no other residents in the facility that were on precaution except for residents on NJ Ex Order 26.4(b)(1) .	F 880	education on the policy and procedure of Enhanced Barrier Precautions, Linen cart maintenance, Proper Hand Hygiene and Mask wearing to all nursing assistants and nurses. Infection Preventionist provided RN#1 and RN#2 with education on policy and procedure for medication administration of eye drops and wound treatments as it pertains to infection prevention. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change? Infection Preventionist or Assistant Director of Nursing will conduct random observation of 6 nursing staff on rotating shifts and units to ensure proper hand hygiene after glove use, proper wearing of masks and proper use of Enhanced Barrier Precautions. Audits will be conducted weekly x 4 weeks, monthly x3 months then quarterly x 2 quarters. Audits will be presented at the monthly Quality Assurance Performance Improvement committee meeting for review. Pharmacy Consultant will conduct medication observation for one nurse per month on an on-going basis including proper eye drop administration. Findings will be presented at the monthly Quality Assurance Performance Improvement committee meeting for review or follow-up as needed.	

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F 880	Continued From page 139 On 9/16/24 at 10:40 AM, during the initial tour of the 3rd-floor unit, the surveyor observed Certified Nursing Aide #1 (CNA#1) and assisted Resident #2 in their room for breakfast. CNA#1 had a pair of gloves in use during the meal setup. Afterward, the surveyor observed CNA#1 remove her used gloves, discard them into the garbage receptacle that was inside the resident's room, and immediately leave the resident's room without performing hand hygiene. Outside the resident's room, the surveyor interviewed the CNA. CNA#1 informed the surveyor that she wore gloves inside the resident's room because she assisted the resident repositioned on the bed and set up the resident's breakfast tray. The CNA stated that she should have performed hand hygiene inside the resident's room but was unable to because there was no ABHR inside the resident's room. She further stated that she could perform hand hygiene either inside or outside the resident's room because the resident was not on precaution. On that same date and time, the CNA informed the surveyor that she had previously received in-service and education about hand hygiene and PPE use but was unable to remember who the person was provided the education. The CNA acknowledged that she should have performed hand hygiene immediately after the removal of gloves. Afterward, the surveyor observed the CNA performed hand hygiene with ABHR outside room	F 880	Infection Preventionist will conduct monthly treatment administration observations for two nurses per month x 12 months then one nurse per month ongoing. Findings will be presented at the monthly Quality Assurance Performance Improvement committee meeting When will corrective action be accomplished? 10/04/2024	

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2. On 9/16/24 at 10:40 AM, the surveyor observed CNA#2 inside room [NJ Ex O] with bilateral gloves and surgical mask in use while setting up the breakfast tray of Resident # 8. There was a posted sign outside the resident's door for [NJ Ex Orde] The CNA surgical mask was in her [NJ Exec Order 26] her nose and mouth were not covered, and it was below the chin.

On 9/16/24 at 10:52 AM, the surveyor interviewed the CNA#2. The CNA acknowledged that her mask was not properly used when she was in Resident #8's room. The CNA stated that at times the surgical mask fell which was why it was below her nose. She further stated that the mask should be able to cover her nose and properly be worn.

3. On 9/16/24 at 10:50 AM, the surveyor observed a linen cart parked between rooms [NJ Ex O] and [NJ Ex Ord] Inside the linen cart were folded linens, towels, and gowns. In between the folded linen supplies was a styrofoam (styro) cup with cover, and there was a spoon and fork.

At that time, the [U.S. FOIA (b) (6)]) was in the hallway, and the surveyor interviewed the [U.S. FO] regarding the linen cart. The [U.S. FO] informed the surveyor that the linen cart was considered clean. The [U.S. FO] then took the covered styro cup and removed the lid. The [U.S. FO] confirmed that there was cornbread inside the styro cup. The [U.S. FO] further stated that she did not know who put the cornbread inside the clean linen cart. The [U.S. FO] acknowledged that there should be no food inside the clean linen cart.

A review of the Departmental (Environmental Services)-Laundry and Linen Policy with an

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F 880	Continued From page 141 updated date of 4/2024 that was provided by the U.S. FOIA (b) showed: Purpose: The purpose of this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen. General Guidelines: 11. Keep soiled and clean line, and their respective hampers and laundry carts, separate at all times. 12. Clean linen will remain hygienically clean (free from pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination, such as covering clean linen carts... 4. On 9/16/24 at 10:54 AM, the surveyor observed the U.S. FOIA (b) (6)) in the hallway near the nursing station with a surgical mask that was below her nose and mouth. The surveyor asked the U.S. FOIA about the mask and the U.S. FOIA stated that the mask in the facility was optional. The surveyor asked the U.S. FOIA should the mask be worn below the nose and mouth and the U.S. FOIA stated "No." On 9/18/24 at 9:27 AM, the surveyor interviewed the U.S. FOIA (b) (6) . The surveyor also notified the U.S. FOIA (b) (6) of the concern regarding the observations of CNA#1's use of gloves and did not perform hand hygiene after gloves removal, CNA#2 and the LPN's improper use of mask, and the clean linen cart with food and utensils. On 9/18/24 at 9:40 AM, both the surveyor and the U.S. FOIA (b) (6) observed the U.S. FOIA in the 3rd-floor nursing station with a surgical mask in use that was below her nose and mouth. The surveyor asked the U.S. FOIA (b) (6) if that was appropriate how	F 880		

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F 880		F 880		

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the U.S. FOIA wore her mask. The U.S. FOIA (b) (6) stated that it was inappropriate, the mask should cover her nose and mouth.

On 9/18/24 at 11:39 AM, the survey team met with the U.S. FOIA (b) (6), and Regional Nurse Consultant #1 (RNC#1). The surveyor notified the facility management of the above findings and concerns.

On 9/19/24 at 01:26 PM, the survey team met with the U.S. FOIA (b) (6), and RNC#1. The U.S. FOIA (b) stated that with regard to infection control, the staff were previously educated about PPE and hand hygiene. The U.S. FOIA (b) further stated that currently, the facility had no mask requirement, and masks were optional.

On 9/20/24 at 01:14 PM, the survey team met with the U.S. FOIA (b) (6), U.S. FOIA (b) (6), RNC#1, and RNC#2 for an exit conference. There was no additional information provided by the facility management.

5. On 9/16/24 at 10:22 AM, during a tour on a unit, the surveyor observed CNA#3 in Resident #33's room, talking with the resident who was seated in their wheelchair at the bedside. Resident #33's door had an NJ Ex Ord sign posted and a PPE supply bin at the door.

The NJ Ex Ord signage indicated that PPE such as gloves and NJ Ex Order should be worn while providing high-contact care activities with a resident to reduce the spread of NJ Ex Order 26.4(b) NJ Exec Order 26.4b1 care activities included but were not limited to, NJ Ex Order 26.4(b)(1) .

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F 880	Continued From page 143 On 9/16/24 at 10:26 AM, while passing Resident #33's room, the surveyor observed from the doorway of the room, the resident was no longer at the bedside in their wheelchair. The resident's bathroom door was open and it was not visible from the hallway. The surveyor heard Resident #33 and CNA#3 talking in the resident's bathroom. On 9/16/24 at 10:27 AM, the surveyor from the hallway, observed CNA#3 come out of the resident's bathroom wearing gloves and CNA#3 closed Resident #33's room door. CNA #3 was not wearing a PPE [NJ Ex Order 2] On 9/16/24 at 10:36 AM, the surveyor observed CNA#3 came out of Resident #33's room, no longer wearing gloves, went to a cart and retrieved supplies which included an [NJ Ex Order 26.4(b)(1)] [redacted]. CNA#3 returned directly to the resident's room and did not retrieve any PPE supplies from the bin at the resident's door. On 9/16/24 at 10:50 AM, the surveyor interviewed CNA#3. CNA#3 stated she had assisted Resident #33 with [NJ Ex Order 26.4] and [NJ Ex Order 26.4(b)(1)]. The CNA confirmed she was only wearing gloves in the room and did not wear a PPE [NJ Ex Order] when assisting the resident. The surveyor reviewed [NJ Ex Order 26.4b1] posted at the resident's door. CNA#3 acknowledged signage posted, explained that she missed it and should have worn a [NJ Ex Order] when providing care to the resident. On 9/16/24 at 10:56 AM, the surveyor interviewed the U.S. FOIA (b) (6) [redacted]) about [NJ Ex Order] protocol. The [U.S. FOIA (b) (6)] stated for residents who were on [NJ Ex Order] staff assisting with activities such as, NJ Ex Order 26.4(b)(1)	F 880		

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would be expected to wear PPE [NJ Ex Order] and gloves. The surveyor informed the [U.S. FOIA (b) (6)] regarding observation of CNA#3. [U.S. FOIA (b) (6)] stated she would follow up with CNA#3.

On 9/18/24 at 12:08 PM, the survey team met with the [U.S. FOIA (b)] [U.S. FOIA (b)] [U.S. FOIA (b) (6)], and RNC#1. The surveyor informed the facility of the above concerns. The [U.S. FOIA] acknowledged it would be expected for CNA#3 to wear [NJ Ex Order] and gloves when assisting a resident on [NJ Ex Ord] during NJ Ex Order 26.4(b)(1).

On 9/19/24 at 01:29 PM, the [U.S. FOIA (b)] [U.S. FOIA (b) (6)], [U.S. FOIA] and RNC#1 met with the survey team. The [U.S. FOIA (b)] stated the CNAs were re-educated about infection control and [NJ Ex Ord] protocol to prevent re-occurrence.

A review of the facility's policy titled "Enhanced Barrier Precautions" with an edited date of 4/10/2024, under Policy Interpretation and Implementation, number 2 read: " ...a. Gloves and gowns are applied prior to performing the high contact resident care activity ..."

Under number 3 it read, " ...Examples of high-contact resident care activities in which gown and gloves are used as part of EBPs include: d. dressing; e. bathing/showering; f. transferring; g. providing hygiene; h. changing linens; i. changing briefs or assisting with toileting ..."

6. On 9/17/24 at 9:54 AM, the surveyor observed medication (med) administration for Resident #260. The surveyor observed the resident's Electronic Medication Administration Record

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(eMAR) which contained a list of medications (meds) ordered by the resident's attending physician for administration at that time. The eMAR reflected an order for NJ Ex Order 26.4(b)(1) [redacted] a med used to treat NJ Ex Order 26.4(b)(1) due to NJ Ex Order 26. [redacted] two times a day for NJ Ex Order 26.4(b)(1).

The surveyor observed Registered Nurse #1 (RN#1) prepare seven (7) of the resident's meds that were scheduled for administration. The surveyor observed the RN select the NJ Ex Order 26.4(b [redacted] along with NJ Ex Order 26.4 and administer NJ Ex Order 26.4(b)(to the resident. The surveyor observed the RN use the NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) after NJ Ex Order 26.4(b)(1) was administered. The surveyor asked the RN if the NJ Ex Order 26.4(b)(1) should be used for NJ Ex Order 26.4(b)(1). The RN agreed that she should have used NJ Ex Order 26.4(b)(1), one for NJ Ex Order 26.4(b)(1)

The surveyor interviewed the 3rd floor U.S. FO who was present during the observation. The surveyor asked the U.S. FO if it was an acceptable practice to use the NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1). The U.S. FO stated no, it was an infection risk.

On 9/18/24 at 10:15 AM, the surveyor interviewed the U.S. FOIA (b) (6)). The surveyor asked the U.S. FO if they do med pass observations. The U.S. FO stated yes, they do regular med pass observations. The surveyor asked the U.S. FO if it is appropriate for a nurse to use the NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) when administering NJ Ex Order 26.4(b)(1). The U.S. FO stated no, it could be an infection control issue.

The surveyor reviewed the hybrid medical record for Resident #260 which revealed a physician's

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order for NJ Ex Order 26.4(b)(1) in NJ Ex Ord two times a day for NJ Ex Order 26.4(b)(1)

On 9/18/24 at 11:38 AM, the surveyor received a policy from the U.S. FOIA (b) dated 4/2024 titled "Administering Medications". The surveyor reviewed the policy. The policy reflected under "Policy heading", "Meds are administered in a safe and timely manner, and as prescribed.". Under Line 25, "Staff follows established facility infection control procedures ...for the administration of meds, as applicable.".

On 9/18/24 at 11:39 AM, the surveyor, in the presence of the survey team, met with the facility administrative team which included the U.S. FOIA (b) U.S. FOIA (b) RNC#1, and U.S. FOIA (b) (6). The surveyor notified the facility management of the med pass results and the concern with infection control.

No further pertinent information was provided by the facility.

7. On 9/16/24 at 9:26 AM, the surveyor observed Resident #100 in bed with a NJ Ex Order 26.4(b)(1) in place. Resident #100 stated they had a NJ Ex Order 26. at the NJ Ex Order 26.4(b)(1). The Resident further stated that they had NJ Ex Order 26.4(b)(1) prior to their admission to the facility.

The surveyor reviewed the medical record for Resident #100 and revealed:
The Resident's Admission Record or face sheet (an admission summary) showed that Resident #100 was admitted to the facility with diagnoses that included NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1)

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A review of the Admission Minimum Data Set (MDS), an assessment tool dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated the resident was [redacted]. Section [redacted] indicated the resident had [redacted]

A review of the resident's [redacted] Order Summary Report reflected a physician's order (PO) dated [redacted], to [redacted] the [redacted]), [redacted]; apply [redacted] and [redacted] with [redacted] daily.

A review of Resident #100's Care Plan (CP) reflected a focus area that the resident had a [redacted] to the [redacted] dated [redacted]. The goal of the resident's CP was the resident's [redacted] would remain free from complications r/t [redacted]. The interventions in the resident's CP included but was not limited to administer meds/vitamins as ordered, [redacted] and keep [redacted] and [redacted] from [redacted]. Keep [redacted]. Apply [redacted] to [redacted] with each episode of [redacted] care.

The surveyor observed outside of Resident #100's room a sign that indicated the resident was on [redacted] which instructed before entering and exiting the room, everyone must perform hand hygiene; [redacted] for [redacted] resident care activities which included.. [redacted]

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NJ Ex Order 26.4(b)(1)

On 9/19/24 at 11:00 AM, the surveyor observed RN#2 perform a NJ Ex Order 26.4(b)(1) care treatment to Resident #100's NJ Ex Order 26.4(b)(1) and observed the following: RN#2 reviewed the PO with the surveyor, donned appropriate PPE, cleansed her hands, disinfected the over bed table (OBT), gathered supplies and brought the supplies into Resident #100's room which included: an open package of NJ Ex Order 26.4(b)(1) a tube of NJ Ex Order 26.4(b)(1), 4 NJ Ex Order 26.4(b)(1), 2 NJ Ex Order 26.4(b)(1) and 2 plastic med cups.

RN#2 performed the wound treatment according to the PO. The RN discarded the used supplies in the trash, and then brought the tube of NJ Ex Order 26.4(b)(1) and package of NJ Ex Order 26.4(b)(1) into the bathroom and set them on the wet, unclean bathroom sink vanity. The RN washed her hands, then picked up the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) and placed the NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) and package of NJ Ex Order 26.4(b)(1) back into the treatment cart without disinfecting the NJ Ex Order 26.4(b)(1)

At this same time, the surveyor interviewed RN#2. RN#2 acknowledged that only supplies needed for the NJ Ex Order 26.4(b)(1) treatment were to be brought into the resident's room and any extra supplies should have been left in the cart. The RN further stated that once supplies were brought into the room, the supplies should not be brought back and placed into the cart as it would

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F 880	Continued From page 149 contaminate the cart, which is used for multiple resident's treatment and that the remaining NJ Ex O [redacted] should have been discarded. On 9/19/24 at 11:51 AM, the surveyor interviewed the U.S. FOIA (b) (6) who confirmed that RN#2 should only bring in the amount of NJ Ex Order 2 needed for the NJ Ex Order 26.4 The NJ Exec O of NJ Ex Order 2 should not have been brought into the room and further stated that putting the tube of NJ Ex Order 2 and open package of NJ Ex Order 26.4(b)(1) back into the treatment cart was unacceptable as it was an infection control concern. On 9/19/24 at 01:29 PM, the surveyor discussed the above observations and concerns with the facility administration. A review of the facility's "Wound Care" policy undated, included the purpose of this procedure is to provide guidelines for the care of wounds to promote healing .... disinfect reusable supplies as indicated i.e., outsides of containers ...	F 880		
F 883 SS=D	NJAC 8:39-19.4(a)(1,2),(m,n) Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 883		10/2/24

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immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal

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F 883	Continued From page 151 immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and review of other pertinent facility documents, it was determined that the facility failed to offer residents a NJ Ex Order 26.4(b)(1) or document the reason for ineligibility for the NJ Ex Order 26.4(b)(1) for three (3) of five (5) residents reviewed for NJ Ex Order 26.4(b)(1) (Resident #43, #62 and #148). The deficient practice was evidenced by the following: Reference: Centers for Disease Control (CDC) recommends pneumococcal vaccination (PCV) for many adults based on age, having certain risk conditions, and pneumococcal vaccines already received ... CDC recommends PCV15, PCV20, or PCV21 for adults who never received a PCV and are Ages 65 years or older Ages 19 through 64 years with certain risk conditions. Chronic conditions and other factors that increase someone's risk for pneumococcal disease include: Chronic heart, kidney, liver, or lung disease (Chronic lung disease includes chronic obstructive pulmonary disorder (COPD), emphysema, and asthma); Diabetes; Immunocompromising condition (having a weakened immune system). 1. On 9/18/24 at 12:39 PM, the surveyor reviewed Resident #43's hybrid (combination of paper and	F 883	How will any corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident #62 NJ Ex Order 26.4(b)(1) offered and documented Resident #43 NJ Ex Order 26.4(b)(1) offered and documented Resident # 148 NJ Ex Order 26.4(b)(1) offered and documented How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by this practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? An audit was completed to identify all residents in the facility who have not received the pneumococcal vaccine and who are medically eligible. Residents/Responsible parties have been contacted by the Assistant Director of Nursing/Infection Preventionist/Unit Managers to provide education and obtain consent or declination. Upon	

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F 883	Continued From page 152 electronic) medical record and revealed: Resident #43's Admission Record (AR; or face sheet; admission summary) indicated that the resident was admitted to the facility with medical diagnoses (Dx) that included but were not limited to NJ Ex Order 26.4(b)(1) [redacted] Further review of the above AR showed that the resident had NJ Ex Order 26.4b1 [redacted] A review of Resident #43's Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that Resident #43 was NJ Ex Order 26.4(b)(1). Further review of the MDS indicated that the resident's NJ Ex Order 26.4(b)(1) was not up	F 883	administration of the pneumococcal vaccine documentation will be updated into electronic medical record system. Declination will also be documented into the electronic medical record EMAR system and consent forms will be placed into hard charts. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change? Upon completion of the facility wide audit the IP will then perform audits on 5 resident's charts weekly for 4 weeks, then 5 charts monthly for 2 months. New admissions will be offered the pneumococcal vaccination. The results of the audits will be reviewed during the monthly Quality Assurance Performance Improvement Committee meeting. The Quality Assurance Performance Improvement committee will make recommendations based upon the results of the audits. The Quality Assurance Performance Improvement Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. When will corrective action be accomplished? 10/01/2024	

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to date and that the reason was the resident was not eligible.

A review of the immunizations tab in the electronic medical record (EMR) revealed there was no documentation to indicate administration, declination or not eligible status of the NJ Ex Order 26.4(b)(1). Additional review of Resident #43's hybrid medical record revealed no documentation of the resident's NJ Ex Order 26.4(b)(1) status being assessed or NJ Ex Order 26.4(b)(1) being offered.

On 9/18/24 at 12:58 PM, in the presence of another surveyor, the surveyor notified the U.S. FOIA (b) (6)) the concern that there was no documentation of the reason why Resident #43 was ineligible for the NJ Ex Order 26.4(b)(1).

On 9/20/24 at 11:21 AM, in the presence of the survey team, U.S. FOIA (b) (6)), Regional Nurse Consultant #1 (RNC#1), and U.S. FOIA (b) (6) , the U.S. FOIA (b) stated that residents were offered the NJ Ex Order 26.4(b)(1) The U.S. FOIA (b) stated that Resident #43's NJ Ex O would typically be the reason why NJ Ex O was not eligible. The facility did not provide any documentation of the reason why Resident #43 was not offered or was ineligible for the NJ Ex Order 26.4(b)(1).

The facility did not provide any additional information.
2. The surveyor reviewed the hybrid medical record of Resident #62 and revealed:

The AR documented that the resident had Dx that included but were not limited to, NJ Ex Order 26.4(b)(1 and NJ Ex Order 26.4(b)(1)

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F 883	Continued From page 154 A comprehensive MDS assessment, dated [redacted], indicated the facility assessed the resident's [redacted] using a BIMS test. Resident #36 scored a [redacted] out of 15, which indicated the resident had NJ Ex Order 26.4(b)(1). Section [redacted] of the MDS indicated the NJ Ex Order 26.4(b)(1) was offered and decline. A review of immunizations listed in the EMR revealed there was no documentation to indicate administration or declination of the NJ Ex Order 26.4(b)(1) [redacted]. Additional review of the EMR revealed no documentation of the resident's NJ Ex Order 26.4(b)(1) status being assessed or NJ Ex Order 26.4(b)(1) being offered. A review of the paper chart revealed there was no documentation indicate administration or declination of the NJ Ex Order 26.4(b)(1). A review of physician orders revealed there was no physician orders for NJ Ex Order 26.4(b)(1) administration. On 9/19/24 at 9:45 AM, the surveyor interviewed the U.S. FOIA (b) (6) [redacted] about resident immunization. The U.S. FOIA (b) (6) stated all residents were offered NJ Ex Order 26.4(b)(1) unless contraindicated and the resident's NJ Ex Order 26.4(b)(1) was assessed upon admission by the nurses. The U.S. FOIA (b) (6) further explained if a NJ Ex Order 26.4(b)(1) was declined it should be documented in the EMR. The surveyor discussed with the U.S. FOIA (b) (6) that there was no documentation found in Resident #62's EMR regarding NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) (6) stated she would follow up to provide further information.	F 883		

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On 9/19/24 at 12:05 PM, the [U.S. FOIA (b) (6)] stated she could not find documentation to indicate Resident #62 was a assessed or offered a [NJ Ex Order 26.4(b)(1)] [redacted]. The [U.S. FOIA (b) (6)] stated there was no declination forms that the facility used and that it would be documented in the [NJ Ex Order 26.4(b)(1)] tab and progress note in the EMR. The surveyor asked who was responsible for resident's [NJ Ex Order 26.4(b)(1)] The [U.S. FOIA (b) (6)] stated that she currently was and that previously it was former [U.S. FOIA (b) (6)] The surveyor asked how often a resident's [NJ Ex Order 26.4(b)(1)] would be reviewed to ensure their [NJ Ex Order 26.4(b)(1)] were up to date. The [U.S. FOIA (b) (6)] replied she would specifically for long term residents review every six months and that she could not speak to what happened with Resident #62's NJ Ex Order 26.4(b)(1) record.

On 9/19/24 at 02:15 PM, the survey team met with the (b) (9) [U.S. FOIA (b) (6)], and RNC#1. The survey notified the facility management about the concern that there was no documentation of Resident #62 being assessed and offered the NJ Ex Order 26.4(b)(1). There was no verbal response by the facility at this time.

On 9/20/24 at 11:21 AM, the survey team met with the [U.S. FOIA (b) (6)] the [U.S. FOIA (b) (6)] RNC#1, and the U.S. FOIA (b) (6). The regional [U.S. FOIA (b) (6)] stated that a resident/resident representative would be educated regarding NJ Ex Order 26.4(b)(1) upon admission and that it was included in the admission packet, which was signed by the resident/resident representative.

The surveyor reviewed the facility provided admission packet for Resident #62. The document included an overall outline which

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LIVINGSTON POST ACUTE CARE	348 E CEDAR STREET LIVINGSTON, NJ 07039

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included a page for NJ Ex Order 26.4(b)(1). There was no documentation in the provided admission packet which indicated the NJ Ex Order 26.4(b)(1) was offered or declined. There was no additional information provided.

3. On 9/16/24 at 10:27 AM, the surveyor observed Resident #148 seated on the bed with breakfast in front of the resident. The NJ Ex Order 26.4(b)(1) was hung on the NJ Ex Order 26.4(b)(1) attached to the wall.

The surveyor reviewed the hybrid medical records of Resident #148 and revealed:
The AR reflected that the resident was admitted to the facility with Dx that included but were not limited to NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1)).

The most recent admission MDS assessment dated NJ Ex Order 26.4(b)(1), under Section NJ Ex Order 26.4(b)(1) had a BIMS score of NJ Ex Order 26.4(b)(1) out of 15 which reflected that resident was NJ Ex Order 26.4(b)(1). Section NJ Ex Order 26.4(b)(1) showed that the NJ Ex Order 26.4(b)(1) was not offered.

Further review of the hybrid medical records revealed that there was no documented evidence that the NJ Ex Order 26.4(b)(1) was offered and declined by the resident. There was no documented evidence that the resident received an education about the risks and benefits of the NJ Ex Order 26.4(b)(1)

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On 9/18/24 at 9:27 AM, the surveyor interviewed the U.S. FOIA (b) (6). The U.S. FOIA (b) (6) stated that NJ Ex Order 26.4(b)(1) records should be found in the resident's medical records and everything should be entered either in the NJ Ex Order 26.4(b)(1) tab or miscellaneous of the EMR. She further stated that it was usually done by the Admitting Nurse, once the resident was admitted to the facility the nurse would check the hospital or other facility records provided upon admission. She also stated that if the resident did not have records, all NJ Ex Order 26.4(b)(1) that included NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) would be offered, and education provided to the resident.

On that same date and time, the surveyor notified the U.S. FOIA (b) (6) of the above findings and concerns. The U.S. FOIA (b) (6) checked the EMR and stated that she did not find any immunization records on the computer. The U.S. FOIA (b) (6) also checked the paper chart of the resident and stated that she did not find any records for NJ Ex Order 26.4(b)(1) that the NJ Ex Order 26.4(b)(1) was offered, declined and education was provided. She stated she did not know what happened and why there was no documentation that the NJ Ex Order 26.4 was offered. She also stated that there was no education and no consent found. She further stated that it should have been offered.

On 9/18/24 at 10:32 AM, the surveyor interviewed the U.S. FOIA (b) (6)). The U.S. FOIA (b) (6) informed the surveyor that she thinks the facility had a policy for MDS and they also follow the RAI (Resident Assessment Instrument) Manual for doing MDS. She further stated that she gathered the information that was put in the MDS or to answer the MDS in the resident's chart, orders, nurses,

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and other IDT (interdisciplinary team) notes including doctors and consultants, eMAR (electronic Medication Administration Record), eTAR (electronic Treatment Administration Record), resident/representative's interviews.

At that same time, the surveyor asked the NJ Ex Order 26.4(b)(1) about Section NJ E was coded NJ Ex Order 26.4(b)(1) was not offered. The NJ Ex Order 26.4(b)(1) stated that during the lookback, there was no documentation that the NJ Ex Order 26.4 was offered, and that was why it was coded as not offered.

On 9/18/24 at 11:39 AM, the survey team met with the U.S. FOIA (b) (6) and RNC#1. The surveyor notified the facility management of the above concerns.

On 9/19/24 at 01:26 PM, the survey team met with the U.S. FOIA (b) (6), U.S. FOIA (b) (6), and RNC#1. The U.S. FOIA (b) stated that as per concern with the NJ Ex Order 26.4(b)(1), the facility utilized an outside company for doing their MDS, unlike now, the facility had an in-house MDS staff.

A review of the facility's Pneumococcal Vaccine Policy with an updated date of 02/2024 revealed:
Policy Statement: All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections.
Policy Interpretation and Implementation:
1. Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series unless medically contraindicated or the resident has already been vaccinated.
2. ...Provision of such education shall be documented in the resident's medical record.

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F 883	Continued From page 159 3. Pneumococcal vaccines will be administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician approved pneumococcal vaccination protocol. 4. Residents/representatives have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the pneumococcal vaccination. .. 6. Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current CDC and Advisory Committee on Immunization Practices recommendations at the time of the vaccination. On 9/20/24 at 01:14 PM, the survey team met with the U.S. FOIA (b) (6), U.S. FOIA (b) (6), U.S. FOIA (b) (6), U.S. FOIA (b) (6), RNC#1, and RNC#2 for an exit conference. There was no additional information provided by the facility management.	F 883		
F 920 SS=F	NJAC 8:39-19.4 (a,4)(d)(h)(i) Requirements for Dining and Activity Rooms CFR(s): 483.90(h)(1)-(4) §483.90(h) Dining and Resident Activities The facility must provide one or more rooms designated for resident dining and activities. These rooms must-- §483.90(h)(1) Be well lighted; §483.90(h)(2) Be well ventilated; §483.90(h)(3) Be adequately furnished; and §483.90(h)(4) Have sufficient space to	F 920		10/15/24

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F 920	Continued From page 160 accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and review of other pertinent provided facility documents, it was determined that the facility failed to ensure that residents provided one or more rooms designated for residents dining and dining activities according to the federal regulation, approved floor plan, and facility policy. This failure had the potential to affect all 126 residents who currently live in the facility. This deficient practice was evidenced by the following: On 9/16/24 at 9:26 AM, Surveyor #1 (S#1) and Surveyor #2 (S#2) met with the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) for an Entrance Conference. The U.S. FOIA (b) informed the surveyors that the facility census (the current total number of residents in the facility) was 126. On that same date and time, the U.S. FOIA (b) stated that since she started at the facility, there was no physical dining area which was why there were no dining services offered to the residents. The U.S. FOIA (b) further stated that "we have room tray services." Both the U.S. FOIA (b) and U.S. FOIA (stated that they were present during the last recertification survey (8/15/23). On 9/18/24 at 11:39 AM, the survey team met with the U.S. FOIA (b) (U.S. FOIA (b) U.S. FOIA (b) (6)), and Regional Nurse Consultant #1 (RNC#1). S#1 notified the facility management of the concerns with the facility not having dining services even	F 920	How will any corrective action be accomplished for those residents found to have been affected by the deficient practice? No residents were listed as affected. Residents were made aware that communal dining services on the first floor will be available on 10/15/2024. Residents were encouraged to engage in communal dining in the lounge area on their floors already being utilized by other residents at this time. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the ability to be affected by this practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Administrator procured a new Dietary Director and tasked with opening the communal dining area on the first floor by 10/15/2024. Residents were all made aware of upcoming accommodations. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued	

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F 920	Continued From page 161 though the facility was approved for communal dining on the 1st floor according to the floor plan submitted by the facility. The surveyor asked for the facility's policy regarding dining services. On 9/19/24 at 01:26 PM, the survey team met with the U.S. FOIA (b) (6), U.S. FOIA (b) (6), U.S. FOIA (b) and RNC#1. Surveyor #3 (S#3) notified the facility management of the resident council meeting concerns that four (4) of four (4) residents wanted to have dining activity and that they were not offered communal dining. The four residents claimed that would be nice to have communal dining. At that same time, the U.S. FOIA (b) stated that will be corrected and "we" will offer communal dining on 10/15/24 because the new U.S. FOIA (b) (6) will start on NJ Ex Order 26 who will be responsible for dining activities and services. A review of the facility's Accommodation of Needs Policy with an updated date of 4/2024 that was provided by the U.S. FOIA (b) revealed: Policy Interpretation and Implementation: 1. The resident's individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered... 4. In order to accommodate individual needs and preferences, staff attitudes and behaviors are directed towards assisting the residents in maintaining independence, dignity and well-being to the extent possible and in accordance with the resident's wishes. For example: d. Making accommodations for the resident to be able to consume meals in their preferred environment. For example: If the resident wishes	F 920	effectiveness of the systemic change? Administrator or Life Enrichment Director will ensure residents including all new admissions are aware of communal dining offered on the first floor of the facility. When will corrective action be accomplished? 10/15/2024	

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F 920	Continued From page 162 to dine in their rooms, the food is brought to the and set up, feeding assistance is provided as needed. If the resident chooses to attend communal dining, their food is delivered in the communal dining area, resident is assisted to the dining area and assisted with set-up feeding as needed. On 9/20/24 at 01:14 PM, the survey team met with the U.S. FOIA (b) (6) U.S. FOIA (b) (6) U.S. FOIA (b) (6), RNC#1, and RNC#2 for an exit conference. There was no additional information provided by the facility management. NJAC 8:39-18.4(c); 27.3(a)	F 920		

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This deficient practice was evidenced by the following. Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General	S 560	How will any corrective action be accomplished for those residents found to have been affected by the deficient practice? No residents were identifies as affected. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents hvae the potential to be affected. What measures will be put into place or systemic changes made to ensure that the	9/23/24

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

Electronically Signed | 10/10/24

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S 560	Continued From page 1 Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.	S 560	deficient practice will not recur? Director of Nursing or Assistant Director of Nursing and Staffing Coordinator will meet in person daily Monday through Friday to review recruitment efforts, staffing for next day, and staffing for upcoming week. They will meet Fridays to review the upcoming weekend staffing.If staffing coordinator is out, Director of Nursing or Assistant director of nursing will cover all staffing responsabilities. The facility has implemented a multifaceted approach for recruitment and retention of employees, which includes Job fairs, Flexible scheduling, Increased utilization of PRN/Per diem staff, Implementation of advanced staffing management software system, Multimedia advertisements, Partnership with schools, Sign on bonuses, Referral bonuses, Pick-up shift bonuses, Boomerang campaign to rehire staff that have resigned, Rate adjustments, Benefit adjustments, Text message campaigns. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change? Administrator or Nursing management will review the minutes from monthly resident council meetings for 3 months to determine whether there are any concerns regarding care and services.	

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S 560	Continued From page 2 (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 2 weeks of staffing prior to survey from 09/01/2024 to 09/14/2024, the facility was not in compliance with the State of New Jersey minimum staffing requirements in CNA staffing for residents on 1 of 14 day shifts as follows: -09/01/24 had 15 CNAs for 126 residents on the day shift, required at least 16 CNAs. During an interview with the surveyor on 9/20/24 at 9:45 AM, the Staffing Coordinator (SC) stated that the New Jersey minimum requirements for staffing were one CNA for eight residents on the 7:00 AM - 3:00 PM shift, one CNA for 10 residents on the 3:00 PM - 11:00 PM shift, and one CNA for 14 residents on the 11:00 PM - 7:00 AM shift. On 9/20/24 at 01:15 PM, the survey team met with Director of Nursing, Licensed Nursing Home Administrator, Assistant Director of Nursing /Infection Preventionist, Regional Nurse Consultant #1 (RNC#1), RNC#2, and Regional LNHA during an exit conference. The team coordinator notified the facility management of	S 560	Administrator or Nursing management will review the minutes from the daily staffing meeting to determine whether all efforts are resulting in staffing levels meeting the requirements. Administrator or Ambassador will interview five residents weekly for 4 weeks and then monthly for an additional 2 months to determine if needs are being met. When will corrective action be accomplished? 09/23/2024	

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S 560	Continued From page 3 the above findings and concerns.	S 560		
S 720	8:39-7.3(d) Mandatory Resident Activities (d) Resident activities shall be scheduled for seven days each week, and during at least two evenings per week. Religious services shall be considered resident activities for purposes of complying with this requirement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to provide residents two evening activity programs per week. This deficient practice was identified for three (3) of four (4) months reviewed, July 2024, August 2024 and September 2024 as evidenced by the following: On 9/17/24 at 10:41 AM, the surveyor reviewed the facility's September 2024 activity calendar that was at receptionist desk. The surveyor observed that the second evening activity each week was "Men's Club." On 9/17/24 at 01:04 PM, the surveyor interviewed the Director of Activities (DoA) regarding the facility's activities program. The DoA stated that she had just started at the facility NJ Ex Order 26.4b1. She stated that the facility had two (2) evening programs a week which were on Monday and Wednesday that started at 6 and ended at about 8. The surveyor asked the DoA to provide the facility's July and August calendars. On 9/17/24 at 01:35 PM, the DoA provided the	S 720	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice? Men's Club announcement stated all are welcome to attend, Activity name was changed to a more inclusive title. The activity calendar was updated to reflect at least two evening activities per week How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The administrator in-serviced the Director of Life Enrichment on proper and all-inclusive titles posted on activity	9/23/24

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S 720	Continued From page 4 surveyor the facility's June, July, August and September 2024 calendars. A review of the calendars included the following information: June 2024 had 2 evening activities each week. July 2024 had 1 evening activity each week. August 2024 had 1 evening activity each week. September 2024 had 2 evening activities each week; one of the two activities listed was "Men's Club." On 9/17/24 at 01:56 PM, the surveyor interviewed the DoA regarding the evening activities on the calendars provided. The DoA stated that she believed that someone stayed and did an evening activity even though it was not on the calendar. The surveyor asked the DoA what "Men's Club" was. The DoA stated that it was typically a movie and a male resident specifically ran the club. She added that the movie was a "western" and the majority of residents did not like "westerns," so the men's club take that opportunity to watch "westerns." The DoA stated that it was open to all residents but that they just call it Men's club. The surveyor asked the DoA how female residents would know that they could attend "Men's Club." The DoA stated that they announce that it was open to everyone but that it was a "men's film that's played." On 9/18/24 at 11:59 AM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Nurse Consultant #1 (RNC#1) and Assistant DON/Infection Preventionist (ADON/IP) the concern that the facility did not have two evening activities on two (2) of four (4) months and that one (1) of the four (4) months had Men's Club as one of the evening activities.	S 720	calendars and providing at least two evening activities a week. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change? The administrator will review the monthly activity calendar prior to posting to ensure activity titles are all inclusive and at least two evenings per week. The results will be reviewed during the monthly Quality Assurance Performance Improvement Committee meeting. The Quality Assurance Performance Improvement committee will make recommendations based upon the results of the audits. The Quality Assurance Performance Improvement Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. When will corrective action be accomplished? 9/23/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH07001	A. BUILDING: _____ B. WING _____	C 09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVINGSTON POST ACUTE CARE	348 E CEDAR STREET LIVINGSTON, NJ 07039

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S 720	Continued From page 5 On 9/20/24 at 11:24 AM, in the presence of the survey team, DON, RNC #1, Regional LNHA, the LNHA stated that women attended the men's club but that they would change the name. She added that the staff did room visits on multiple nights even when it was not scheduled. The LNHA stated that with the new DoA the second evening activity was added to the calendar but that a second evening activity was being done. The facility did not provide any additional information. A review of the undated facility policy titled "Group Programs and Activities Calendar" included the following: ...Policy Statement Activity programs designated to meet each resident's needs are available daily. 2. Our activity programs are designated to encourage maximum individual participation and are geared to individual resident needs .... 4. Their activity programs consist of individual and small and large group activities that are designed to meet the needs of interest of each resident and include as a minimum ... d. At least 2 evening activities is offered per week depending on population needs .... 6. Individuals and group activities are provided that: ... b. are offered at hours convenient to the residents including evening holidays and weekends; ... d. Appeal to men and women as well as those of various age groups residing in the facility.	S 720		
S2345	8:39-31.6(o) Mandatory Physical Environment (o) The facility shall conduct at least one evacuation drill each year, either simulated or	S2345		9/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH07001	A. BUILDING: _____ B. WING _____	C 09/20/2024

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LIVINGSTON POST ACUTE CARE	348 E CEDAR STREET LIVINGSTON, NJ 07039

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S2345	Continued From page 6 using selected residents. State, county, and municipal emergency management officials shall be invited to attend the drill at least 10 working days in advance. This REQUIREMENT is not met as evidenced by: Based on interviews and review of documentation on 9/17/2024 and 9/18/2024 in the presence of the Administrator, it was determined that the facility failed to invite state, county, and municipal emergency management officials to at least one evacuation drill at least 10 working days in advance. This deficient practice had the potential to affect all residents and was evidenced by the following: In an interview on 9/17/2024 at 10:00 AM, the surveyor requested documentation regarding collaboration with emergency management officials. The Administrator provided documentation of drills conducted on 11/07/2023 and 12/01/2023 but was unable to provide documentation regarding the invitation or attendance of emergency management officials. The facility's Administrator was notified of the deficient practice at the Life Safety Code exit conference on 9/18/2024 at 02:00 PM.	S2345	How will any corrective action be accomplished for those residents found to have been affected by the deficient practice? Administrator provided documentation of drills conducted on 11/07/2023 and 12/01/2023 but was unable to provide documentation regarding the invitation or attendance of emergency management officials. For 2024, administrator was able to provide documented proof that representative from the Office of Emergency Management for Essex County was invited to the planned table top disaster drill on September 25, 2024. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by this practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Administrator and/or maintenance director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH07001	A. BUILDING: _____ B. WING _____	C 09/20/2024

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S2345	Continued From page 7	S2345	(who was hired and started in September 2024) have documented all conversations/emails with representative from the Office of Emergency Management to ensure that there is documented evidence to ensure facility is in compliance with regulation. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change? Administrator and/or Maintenance Director will email proof of communication and record/save all correspondence for reference. Correspondence will be placed in the Emergency Preparedness Binder and reviewed at the next quarterly Quality Assurance/Performance Improvement Meeting. When will corrective action be accomplished? 9/25/2024	

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
315526 Y1	A. Building B. Wing Y2	11/19/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVINGSTON POST ACUTE CARE	348 E CEDAR STREET LIVINGSTON, NJ 07039

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 F0580	Correction	ID Prefix F0641	Correction	ID Prefix F0658	Correction
Reg. # 483.10(g)(14)(i)-(iv)(15)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	10/04/2024	LSC	10/10/2024	LSC	10/04/2024
ID Prefix F0660	Correction	ID Prefix F0661	Correction	ID Prefix F0686	Correction
Reg. # 483.21(c)(1)(i)-(ix)	Completed	Reg. # 483.21(c)(2)(i)-(iv)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed
LSC	10/04/2024	LSC	10/04/2024	LSC	10/04/2024
ID Prefix F0688	Correction	ID Prefix F0692	Correction	ID Prefix F0695	Correction
Reg. # 483.25(c)(1)-(3)	Completed	Reg. # 483.25(g)(1)-(3)	Completed	Reg. # 483.25(i)	Completed
LSC	10/08/2024	LSC	10/04/2024	LSC	10/01/2024
ID Prefix F0697	Correction	ID Prefix F0698	Correction	ID Prefix F0725	Correction
Reg. # 483.25(k)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.35(a)(1)(2)	Completed
LSC	10/04/2024	LSC	10/04/2024	LSC	10/10/2024
ID Prefix F0732	Correction	ID Prefix F0756	Correction	ID Prefix F0761	Correction
Reg. # 483.35(g)(1)-(4)	Completed	Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	10/10/2024	LSC	09/23/2024	LSC	10/08/2024

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

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
315526 Y1	A. Building B. Wing Y2	11/19/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVINGSTON POST ACUTE CARE	348 E CEDAR STREET LIVINGSTON, NJ 07039

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 F0812	Correction	ID Prefix F0838	Correction	ID Prefix F0842	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.71(a)(1)(3)(b)(1)(c)(1)-(5)	Completed	Reg. # 483.20(f)(5), 483.70(h)(1)-(5)	Completed
LSC	10/08/2024	LSC	10/11/2024	LSC	10/10/2024
ID Prefix F0880	Correction	ID Prefix F0883	Correction	ID Prefix F0920	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80(d)(1)(2)	Completed	Reg. # 483.90(h)(1)-(4)	Completed
LSC	10/04/2024	LSC	10/02/2024	LSC	10/15/2024

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/20/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
NH07001 Y1	A. Building B. Wing Y2	11/19/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVINGSTON POST ACUTE CARE	348 E CEDAR STREET LIVINGSTON, NJ 07039

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	Correction	ID Prefix S0720	Correction	ID Prefix S2345	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-7.3(d)	Completed	Reg. # 8:39-31.6(o)	Completed
LSC	09/23/2024	LSC	09/23/2024	LSC	09/25/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
9/20/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315526	A. BUILDING **01** B. WING _____	**09/20/2024**

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by the New Jersey Department of Health on 09/17/2024 and 09/18/2024. Livingston Post Acute Care was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/17/2024 and 09/18/2024 and Livingston Post Acute Care was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancy. Spring Hills Post Acute Livingston is a three-story building with a two-level parking garage below grade that was built in 2018. Five stories total. It is composed of Type II protected construction. The facility is divided into 14 - smoke zones. The generator does approximately 100 % of the building as per the Maintenance Director.	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1	K 211		10/9/24

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

Electronically Signed | 10/10/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 211	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 09/17/2024 in the presence of the U.S. FOIA (b) (6) [redacted] and the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that the means of egress was continuously maintained free of all obstructions to full use in case of an emergency in accordance with NFPA 101:2012 Edition Sections 18.2.1 - 18.2.11 and Chapter 7. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:18 PM, revealed that a resident room mattress was propped up next to the stairs in the exit 4 stairway enclosure on the third floor. An observation at 1:43 PM, revealed that a chair was placed behind stair 4 exit door near the gym which restricted the door from opening any more than 24-inches. In interviews at the time, the U.S. FOIA [redacted] confirmed the observations. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 09/18/24 at 2:00 PM. N.J.A.C 8:39-31.2(e)	K 211	How will any corrective action be accomplished for those residents found to have been affected by the deficient practice? All items that were blocking or in the way of a fire door or emergency exit were removed. How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents have the ability to be affected by this deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Education was provided to staff regarding fire doors, means of egress, and not blocking or obstructing them. Auditing will be completed on all egress doors by Director of Maintenance or Director of Housekeeping once a week for one month and then monthly times two months. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, what program will be put into place to monitor the continued effectiveness of the systemic change? Director of Maintenance or Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315526	A. BUILDING **01** B. WING _____	**09/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 211	Continued From page 2	K 211	Housekeeping will audit egress doors weekly for one month and then monthly for two additional months. The results and compliance of the audits will be reviewed at Quality Assurance Meeting monthly and quarterly and reviewed for further need to audit. When will corrective action be accomplished? 10/09/2004	
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is	K 222		10/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315526	A. BUILDING **01** B. WING _____	**09/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 222	Continued From page 3 protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 09/17/2024 in the presence of the U.S. FOIA (b) (6) [redacted] and the U.S. FOIA (b) (6) [redacted], it was determined that	K 222	How will any corrective action be accomplished for those residents found to have been affected by the deficient practice?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315526	A. BUILDING **01** B. WING _____	**09/20/2024**

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K 222	Continued From page 4 the facility failed to ensure doors that were provided with delayed-egress systems were properly functioning in accordance with NFPA 101:2012 Edition, Sections 19.2.2.2.4, 19.2.2.5 and 7.2.1.6. This deficient practice was observed for 1 of 8 tested doors, had the potential to affect all residents and was evidenced by the following: An observation on 09/17/2024 at 1:13 PM, revealed that exit stair 2 on the second floor was provided with delayed egress but did not release after 15 seconds when tested by the U.S. FOIA (b) The door did release with the access code. In an interview at the time, the U.S. FOIA (confirmed the observations. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 09/18/24 and 2:00 PM. N.J.A.C 8:39-31.2(e)	K 222	One of eights tested doors did not have a delayed opening after fifteen seconds of holding, and only opened with the code was entered. The door magnets were too tight and required loosening which was completed and the door then opened after holding it down for 15 seconds without a code needed, in compliance. How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents have the ability to be affected by this deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The door was fixed on October 4, 2024 by internal maintenence staff and all doors were tested by maintenence staff. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, what program will be put into place to monitor the continued effectiveness of the systemic change? Director of Maintenance or Director of Housekeeping will audit all egress doors weekly for one month and then monthly for two additional months. The results and compliance of the audits will be reviewed at Quality Assurance Meeting monthly and	

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K 222	Continued From page 5	K 222	then quarterly and reviewed for further need to audit. When will corrective action be accomplished? October 4, 2024.	
K 225 SS=F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 09/17/2024 in the presence of the U.S. FOIA (b) (6) [redacted]) and the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that stairways serving 3 or more stories were provided with stairway identification in accordance with NFPA 101:2012 Edition Sections 17.2.2.5.4 and 17.2.2.5.4.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:18 PM, revealed that exit stair 4 on the third floor did not contain stairway identification. An observation at 12:50 PM, revealed that exit stair 1 on the second floor did not contain stairway identification. An observation at 1:13 PM, revealed that exit stair	K 225	How will any corrective action be accomplished for those residents found to have been affected by the deficient practice? No floor identification was present or posted in the stairwell identifying which floor is which in accordance with NFPA regulations. Floor level signs were added to each floor in the stairwells. How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents have the ability to be affected by this deficient practice. What measures will be put into place or systemic changes made to ensure that	10/8/24

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K 225	Continued From page 6 4 on the first floor did not contain stairway identification. In interviews at the time, the U.S. FOIA (confirmed the observations. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 09/18/24 at 2:00 PM. N.J.A.C 8:39-31.2(e)	K 225	the deficient practice will not recur? Eduation provided to maintenence staff. Floor signs were permanently affixed to the floors on all levels in each stairwell on October 8, 2024 to meet compliance standards. See pictures attached. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, what program will be put into place to monitor the continued effectiveness of the systemic change? Director of Maintenance or Director of Housekeeping will audit all floor egress doors weekly for one month and then monthly for two months and the results and compliance of the audits will be reviewed at Quality Assurance Meeting and reviewed for further need to audit. When will corrective action be accomplished? October 8, 2024	
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 NEW Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 09/17/2024 in the presence of the U.S. FOIA (b) (6)	K 293	How will any corrective action be accomplished for those residents found to	11/15/24

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K 293	Continued From page 7 U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6) , it was determined that the facility failed to ensure that a sign with directional indicator showing the direction of travel was provided in every location where the direction of travel to reach the nearest exit was not apparent in accordance with NFPA 101:2012 Edition, Sections 19.2.10.1 and 7.10. This deficient practice had the potential to affect all residents and was evidenced by the following: Observation between 12:18 PM and 12:50 PM, revealed that when exiting the smoke barrier near room 216 and 316 on the east side of the building, there was no directional indicator showing the direction of travel to the nearest exit. In an interview at the time, the U.S. FOIA (confirmed the observations. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 09/18/24 at 2:00 PM. N.J.A.C 8:39-31.2(e)	K 293	have been affected by the deficient practice? Directional exit door indicators to be placed in hallways on either side of smoke doors by maintenence director to indicate which way exit doors are placed in the event of an emergency. Education provided to maintenence staff. How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents have the ability to be affected by this deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Education was provided to maintenance team. Directional signs indicating which way the fire exits are will be placed on the floors by maintenance director and staff. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, what program will be put into place to monitor the continued effectiveness of the systemic change? Director of Maintenance or Director of Housekeeping will audit sign placement weekly for one month and then monthly for two months and the results and compliance of the audits reviewed at Quality Assurance Meeting monthly and	

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K 293	Continued From page 8	K 293	then quarterly and reviewed for further need to audit. When will corrective action be accomplished? November 15, 2024	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: *residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. *cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or *cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on record review on 09/17/2024 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that the kitchen suppression system was inspected semi-annually and the exhaust hood was cleaned semi-annually in accordance with	K 324	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice? Kitchen suppression system was not	9/25/24

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K 324	Continued From page 9 NFPA 96, Standard for the Ventilation Control and Fire Protection of Commercial Cooking Operations. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review revealed that the kitchen suppression system was inspected on 05/09/2023. The following inspection was conducted on 3/20/2024 more than 9 months later. A record review revealed that the kitchen hood was cleaned on 05/08/2023. The following cleaning was conducted on 03/27/2024 more than 9 months later. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 09/18/24 at 2:00 PM. N.J.A.C 8:39-31.2(e) NFPA 96	K 324	cleaned semi annually, it was completed on 5/9/23 then not until 3/20/24, and then 9/18/24. The kitchen exhaust hood was cleaned on on 3/26/24 and then on 9/25/24. How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents have the ability to be affected by this deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Staff educated on regulation for how often systems need to have maintenence. All kitchen suppression and hood cleaning are scheduled two times a year in order to be in compliance with the regulation. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change? The administrator and/or Director of Maintenance monitor the biannual inspections and ensure that inspections are completed as per regulation monthly in Quality Assurance meeting and review in end of year Qaulity Assurance meeting to ensure all annual inspections have been completed.	

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K 324	Continued From page 10	K 324	When will corrective action be accomplished? September 25, 2024.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and interviews on 09/17/2024 and 09/18/2024 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that semi-annual fire alarm system inspections, testing and maintenance (ITM) were conducted in accordance with NFPA 101:2012 Edition, Sections 9.6.1.3, 9.6.1.5, NFPA 70, and NFPA 72. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review revealed that fire alarm inspections were conducted on 8/14/2023 and 8/28/2024. Semi-annual inspections were not provided. In an interview at 2:00 PM on 9/18/2024 with the U.S. FOIA (b) the surveyor asked how often the fire alarm gets inspected. The U.S. FOIA (stated, "I spoke with the fire alarm company, and was informed that it was only conducted annually".	K 345	How will any corrective action be accomplished for those residents found to have been affected by the deficient practice? Bi-annual fire alarm inspection was not completed for the past year, only one inspection was completed in August 2024. For compliance of twice a year inspection, a second inspection was scheduled with NJ Ex Order 26.4(b)(1) for February of 2025. Education provided to maintenence team on how often inspection needs to be completed. See evidence attached. How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents have the ability to be affected by this deficient practice.	10/10/24

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K 345	Continued From page 11 The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 09/18/24 at 2:00 PM. N.J.A.C 8:39-31.2(e) NFPA 70,72	K 345	What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Bi-annual fire alarm inspections will be completed moving forward during February and August of each year in order to maintain compliance. Education provided to maintenence team. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, what program will be put into place to monitor the continued effectiveness of the systemic change? Administrator, and/or Director of Maintenance/Director of Housekeeping will audit annual inspections monthly and quarterly for Quality Assurance Meeting to ensure all inspections are completed timely. When will corrective action be accomplished? October 10, 2024	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 NEW Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, Safety Code for	K 531		11/6/24

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K 531	Continued From page 12 Elevators and Escalators, including Firefighter's Service Requirements. (Includes firefighter's Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 18.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on record review and interviews on 09/18/2024 in the presence of the U.S. FOIA (b) (6) [redacted]) and the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that elevators were inspected and tested in accordance with NFPA 101:2012 Edition, Section 18.5.3, 9.4.2, 9.4.3, 9.4.6.1, 9.4.6.2, 9.4.6.3. and ASME A 17.1/CSA B44. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review revealed that fire fighters' emergency operations were not conducted for the months of February, March, June, or July of 2024 on elevators 1 and 2. An observation at 10:00 AM, revealed that the emergency communication system in elevator 2 was not functioning. In an interview at the time, the U.S. FOIA ([redacted] confirmed the observation and stated that the elevator company was at the facility that morning and they were informed that there was a problem with the telephone line. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 09/18/24 at 2:00 PM.	K 531	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility failed to ensure that elevators were inspected and tested monthly. Fire fighters emergency operations were not conducted for February, March, June, or July 2024. Telephone Line is not functioning inside the elevator. Inspections were completed monthly and fire phases were completed and appropriate documentation was added to the binder. Phase 1 and Phase 2 were found and replaced in the binder, the paper compliance was completed by 09/25/24 and the elevator phone was fixed and functioning on 11/06/24. Administrator trained maintenence staff on elevator regulations. How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by this deficient practice. What measures will be put into place or	

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K 531	Continued From page 13 N.J.A.C 8:39-31.2(e) ASME A 17.1/ CSA B44	K 531	systemic changes made to ensure that the deficient practice will not recur? Elevator company was informed that their technician wasn't completed or leaving inspection reports and all of the inspection reports were immediately provided and placed in the elevator room. Phase one and phase two were completed and filed. Fire Fighter operations were all completed. New phone line was installed on November 6, 2024. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change? Director of Maintenance or Housekeeping will audit elevator compliance and working telephone 1x a month x 3 months and report audit findings to the Quality Assurance team monthly and quarterly. After three months, the Quality Assurance Team will determine need to continue audit or if compliance has been achieved. When will corrective action be accomplished? 11/06/24	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.	K 761		9/30/24

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K 761	Continued From page 14 Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 18.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (NFPA 80) This REQUIREMENT is not met as evidenced by: Based on record review and interviews on 09/17/2024 and 09/18/2024 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that each fire door assembly was inspected and tested annually in accordance with NFPA 80: 2010 Edition, Section 5.2.4. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 9/17/2024, revealed that a monthly fire door inspection was conducted at the facility for floors 1, 2, and 3. The inspection consisted of verifying that the fire doors were unobstructed and that all fire door hardware was intact. The inspection sheet that was provided did not indicate which fire door assembly was inspected. In an interview with the U.S. FOIA(at 2:00 PM on 9/17/2024, a requested was made by the surveyor for the annual inspection of fire door assemblies for review the following morning. No further documentation was provided regarding	K 761	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice? No annual inspection was completed during the survey window for the fire rated doors in the facility. The corrective action is to have every fire rated door inspected. This was completed on September 30, 2024. Maintenence staff were educated by Administrator on compliance with yearly inspections for doors. How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents have the ability to be affected by this deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Fire doors will be inspected annually every	

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K 761	Continued From page 15 annual fire door assembly inspections. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 09/18/24 at 2:00 PM. N.J.A.C 8:39-31.2(e) NFPA 80	K 761	September going forward. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into place to monitor the continued effectiveness of the systemic change? The Administrator and or Director of Maintenance will monitor for completion going forward to ensure compliance. Audits for annual inspections for the fire doors are reviewed in Quality Assurance meeting quarterly and reviewed for compliance. When will corrective action be accomplished? September 30, 2024.	
K 907 SS=F	Gas and Vacuum Piped Systems - Maintenance Pr CFR(s): NFPA 101 Gas and Vacuum Piped Systems - Maintenance Program Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the	K 907		9/30/24

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	315526	A. BUILDING **01** B. WING _____	**09/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVINGSTON POST ACUTE CARE	**348 E CEDAR STREET** **LIVINGSTON, NJ 07039**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 907	Continued From page 16 requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interviews on 09/17/2024 and 09/18/2024 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6) it was determined that the facility failed to ensure that medical gas system had a documented maintenance program which included an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets in accordance with NFPA 99: 2012, Sections 5.1.14.2.1, 5.1.14.2.2, 5.1.14.2.3, 5.1.15, 5.2.13, 5.3.13, 5.2.14 and 5.3.13.4.2 . This deficient practice had the potential to affect all residents and was evidenced by the following: In an interview at 9:00 AM on 09/17/2024 during the Life Safety Code entrance conference, a request was made to the U.S. FOIA (b) (6) for all gas piped systems inspections testing and maintenance (ITM). In an interview at 3:00 PM, a request was made to the U.S. FOIA (for all gas piped systems ITM for review the following morning. Documentation review on 09/18/2024, revealed that the only documentation provided by the facility was a proposal for repair of the right-side solenoid valve and pressure test of the medical gas manifold to NFPA 99 codes from their medical gas provider. No further documentation regarding gas piped systems ITM was provided by the facility.	K 907	How any corrective action will be accomplished for those residents found to have been affected by the deficient practice? Annual inspection for medical gas system had a documented maintenance program completed on September 30, 2024. Administrator educated maintenence staff on compiance with annual inspection. How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents on oxygen have the potential to be affected by this deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Administrator educated maintenence staff on inspection compliance. Contract was completed to initiate documented medical gas annual inspectio via our oxygen provider. Annual inspection was completed on September 30, 2024. See attached for evidence. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur ie., what program will be put into	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315526	A. BUILDING **01** B. WING _____	**09/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVINGSTON POST ACUTE CARE	**348 E CEDAR STREET** **LIVINGSTON, NJ 07039**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 907	Continued From page 17 The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 09/18/2024 at 2:00 PM. N.J.A.C 8:39-31.2(e) NFPA 99	K 907	place to monitor the continued effectiveness of the systemic change? Administrator and/or Director of Maintenance will monitor completion for all inspections monthly and report to Quality Assurance meeting on annual compliance at quarterly meeting. When will corrective action be accomplished? September 30, 2024.	

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
315526 Y1	A. Building 01 - ATRIUM POST ACUTE CARE LIVINGSTON B. Wing Y2	11/19/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVINGSTON POST ACUTE CARE	348 E CEDAR STREET LIVINGSTON, NJ 07039

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 K0211	10/09/2024	LSC K0222	10/04/2024	LSC K0225	10/08/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0293	11/15/2024	LSC K0324	09/25/2024	LSC K0345	10/10/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0531	11/06/2024	LSC K0761	09/30/2024	LSC K0907	09/30/2024
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	
9/20/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO