STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315461	A. BUILDING _____ B. WING _____	C 12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN REHABILITATION AND HEALTHCARE CENTER	**100 LONG-A-COMING LANE BERLIN, NJ 08009**

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F 000	INITIAL COMMENTS Complaint #-NJ160250, NJ00163433, NJ00165779, NJ00166442 Survey Date: 12/07/23 Census: 120 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. THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		1/30/24

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

Electronically Signed | 01/12/2024

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to maintain dignity during mealtime for residents during dining observation. This deficient practice of not serving all residents seated at a table at the same time was observed for 2 of 3 meals in 1 of 2 dining rooms. The deficient practice was evidenced by the following: On 11/28/23 at 12:30 PM, in the second floor [redacted] unit dining room, the surveyor observed	F 550	1. Residents cited in the 2567 that were not served meals at the same time with other residents at the table were affected by this deficient practice. The residents who were not served received their meals with the next meal truck. 2. All residents who eat in the dining room have the potential to be affected by this practice. The Food Service Director and DON audited all Dining Room table assignments to assure that table assignment align with meal carts. 3. The DON/ADON re-educated all	

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F 550	Continued From page 2 residents preparing for meal service. Once meal trays arrived, at one table, staff served one resident who began eating and failed to serve the remaining residents at that table. At another table staff served two residents who began eating and failed to serve the remaining residents at that table. At 12:48 PM, the residents who were not served, received their meal trays from a second meal cart as the residents at their tables who were served first were nearly finished with their meals. On 12/05/23 at 11:57 AM, the surveyor observed residents preparing for meal service in the second floor [redacted] unit dining room. When the first meal cart arrived on the unit, at one table staff served one resident who began eating and failed to serve the remaining residents at that table. At another table staff served two residents who began eating and failed to serve the remaining residents at that table. At 12:13 PM, the second meal cart arrived on the unit and the staff began serving the remaining residents who had not been served yet, as the residents at their tables were nearly finished with their meals. On 12/05/23 at 12:11 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #2, who stated that residents are encouraged to come to the dining room. She further stated that they try to have all residents at a table eat at the same time but sometimes it's hard to do. On 12/06/23 at 10:32 AM, the surveyor interviewed the Assistant Director of Nursing, who stated that in the dining rooms, the staff should	F 550	nurses and CNAs must serve all residents seated at the same table at the same time. 4. The DON/designee will audit Dining Room table assignments to assure that table assignment aligns with meal carts weekly x 3 months to review table assignment and coordinating meal cart assignment and will report monthly to QAPI.	

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F 550	Continued From page 3 serve one table at a time and all residents sitting at each table should be served at the same time. Review of the undated facility policy "Assistance with Meals" which was provided by the administrator, did not address this deficient practice. N.J.A.C. 8:39-4.1(a)12	F 550		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's	F 640		1/30/24

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F 640	Continued From page 4 assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to electronically transmit the discharge Minimum Data Set (MDS), an assessment tool used to facilitate the management of care of all residents, for 1 of 25 residents, (Resident #106) reviewed for resident assessments. The deficient practice was evidenced by the following: Review of Resident #106's discharge MDS assessment with initiation date [NJ Exec Order 2] and completion date [NJ Exec Orde], indicated it was not transmitted.	F 640	1. Resident #106 was not affected by this deficient practice. The MDS with ARD of [NJ Exec Order 2] was transmitted on [NJ Exec Order 20] 2. All residents have the potential to be affected by this practice. The Regional Case Manager completed an audit of all MDS. No additional individual MDSs were identified as not transmitted. 3. The Regional Case Manager re-educated MDS staff regarding timely submission. 4. The Regional Case Manager/designee will audit MDS submission weekly x 3 months to ensure all MDS□s are transmitted timely and will	

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F 640	Continued From page 5 On 11/29/23 at 01:02 PM, the surveyor interviewed the MDS Coordinator who stated that the MDS assessment should have been transmitted within 14 days of completion. She further stated that they had remote MDS help at that time, and the transmission was missed. A review of the policy "Electronic Transmission of the MDS" revised on November 2019, indicated that MDS assessments are completed and transmitted to CMS in accordance with current OBRA regulations governing the transmission of MDS data. According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2019) revealed on page 2-17, "Discharge Assessment-return not anticipated must be transmitted no later than MDS Completion Date + 14 calendar days ..."	F 640	report monthly to QAPI.	
F 677 SS=D	NJAC 8:39-11.2 (e) 3 ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: NJ00166442 Based on observations, interviews, review of medical records and other facility documentation, it was determined that the facility failed to ensure that incontinence care was provided to dependent	F 677	1. Resident #173 & #175 no longer reside in the facility. Residents #173, #175 and #104 were interviewed on 12/6/23 and verbalized no concerns related to [NJ Exec Order 26.4b1] care. 2. A [NJ Exec Order 26.4b1] was performed on	1/30/24

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F 677	Continued From page 6 residents in a timely manner. This deficient practice was identified for 3 of 10 residents (Residents #175, # 104, #173) on 1 of 3 units ([redacted] observed for [redacted] care. This deficient practice was evidenced by the following: Refer to F725 and F686 On 12/05/23 at 9:10 AM, the surveyor interviewed Certified Nursing Assistant (CNA #5) who stated that she was assigned to 13 residents. CNA #5 stated that five of the residents on her assignment were dependent on staff for [redacted] care. CNA #5 stated that one of the resident's who she had already [redacted] CNA #5 stated that she still had two additional residents to provide [redacted] care for. On 12/05/23 at 9:23 AM, CNA #5 entered the room of Resident #175 and checked the resident's [redacted] with the resident's permission, in the presence of the surveyor. CNA #5 stated that resident's [redacted] CNA #5 stated that the[redacted] ". Though the [redacted] as described by CNA #5, the frontal portion of the [redacted] Review of Resident #175's Admission Record revealed that the resident was admitted to the facility with diagnosis which included but were not limited to: [redacted]	F 677	resident #104 with [redacted]. All residents that are dependent for incontinence care have the potential to be affected by this practice. DON/desginee completed an audit on all residents that are dependent for incontinence care to ensure incontinence care was rendered. No new issues were identified. 3. The DON/ADON re-educated all nurses and certified nurse assistance on policy Activities of Daily Living , Supporting. 4. The DON/designee will complete weekly audit x 3 months to ensure that incontinence care was provided to dependent residents in a timely manner and will report results of audits monthly to QAPI.	

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NJ Exec Order 26.4b1 [redacted]

Review of Resident #175's Admission Minimum Data Set (MDS), an assessment tool, revealed that it was not yet completed or available for review.

Review of the Resident #175's Care Plan revealed an entry dated NJ Exec Order 26.4b which revealed: "I have NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1". The Goal indicated: "I will not have NJ Exec Order 26.4b1 through the review date." Interventions included: "...Check resident approximately every two hours and provide NJ Exec Order 26.4b1 as needed..." Further review of the Care Plan revealed, "I have NJ Exec Order 26.4b1 r/t (related to) NJ Exec Order 26.4 " Goal: "I will not have NJ Exec Order 26.4b1 through the review date (Target Date: NJ Exec Order 26.4). Interventions included..."Check resident approximately every two hours and provide NJ Exec Order 26.4b1 as needed..."

Review of a Health Status Note dated NJ Exec Order 26.4b at 3:49 PM, indicated that Resident #175 was NJ Exec Order 26.4b1 [redacted] Further review of the Progress Notes (PN) revealed an eMar (electronic Medication Administration Record) Medication Administration Note with an effective date of NJ Exec Order 26.4b at 11:21 AM, which revealed the following: NJ Exec Order 26.4b1 [redacted] Oral Tablet NJ Exec Or

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NJ Exec Order 26.4b1 Give one tablet by mouth one time a day for NJ Exec Order 26.4b1 daughter will bring it from home." "Spoke with patient's daughter, she will bring in med this afternoon...Doctor... made aware."

Review of Resident #175's Medication Administration Record (MAR) revealed that the medication was administered on NJ Exec Order 26.4b and NJ Exec Order 26.4b at 9:00 AM. Further review of the MAR revealed tha NJ Exec Order 26.4b1 give one capsule by mouth in the evening for NJ Exec Order 26.4b1, was administered on NJ Exec Order 26.4b at 6:00 PM.

Review of Resident #175's "Documentation Survey Report" (DSR, documentation of care tasks completed by nursing assistants) revealed that on NJ Exec Order 26.4b the 11 PM to 7 AM CNA assigned to the resident documented that NJ Exec Order 26 was completed at 4:41 AM. Further review of the DSR revealed that on NJ Exec Order 26.4b on the 7 AM to 3 PM shift, there was no documented evidence that the following tasks were documented to indicate completion: NJ Exec Order 26

On 12/05/23 at 9:39 AM, the surveyor interviewed CNA #2 who stated that he was assigned to 14 residents. CNA #2 stated that seven of the residents that he was assigned to required NJ Exec Order 26.4b1

On 12/05/23 at 09:41 AM, CNA #2 entered the

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room of Resident #104 and checked the resident's [redacted] with the resident's permission, in the presence of the surveyor. The surveyor observed that the resident' [redacted] The surveyor asked CNA #2 to turn the resident in order to view the sheet beneath the resident. When the resident was turned to their right side, the surveyor observed [redacted] When interviewed at that time, CNA #2 stated, "The resident was [redacted] during the night per report and was a [redacted] who was on [redacted] or [redacted]" used to treat [redacted] and [redacted])." The surveyor then asked CNA #2 if the resident's [redacted] every two hours in accordance with resident's Care Plan? CNA #2 then stated, '[redacted]."

Review of Resident #104's Admission Record revealed that the resident was admitted to the facility with diagnosis which included but were not limited to: [redacted]

Review of the resident's Admission Minimum Data Set (MDS), an assessment tool, dated [redacted], revealed that the resident had a Brief

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Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that the resident was NJ Exec Order 26.4b1. Further review of Section H of the MDS, Bladder and Bowel, indicated that the resident was [redacted] and was frequently [redacted].

Review of Resident #104's Care Plan revealed an entry dated [redacted], which indicated, [redacted]" Goal: "I will not have [redacted] through the review date (Target Date: [redacted])." Interventions included: ".. [redacted] ... "Provide [redacted] as needed."
Further review of the Care Plan further revealed an entry dated [redacted], "I am on [redacted] r/t (related to) [redacted]" Goal: "I will be free from discomfort or adverse side effects of [redacted] through the review date (Target Date: [redacted])". Interventions included: "...I am on [redacted] and may need to [redacted] frequently and quickly. Routinely check and offer/provide me [redacted]..."

Review of Resident #104's Order Summary Report revealed that on [redacted], the resident was ordered [redacted]. Give one tablet by mouth in the morning for [redacted] at 8:00 AM. Hold fo [redacted]

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Review of the Resident #104's MAR revealed that on NJ Exec Order 26.4b at 8:00 AM, NJ Exec Order 26.4b1 was documented on the MAR with a code of NJ Ex, which indicated " NJ Exec Ord medication. According to the legend that pertained to the entry, the resident's NJ Exec Order 26.4b1 was documented to have been NJ Exec Order 2, the medication was held in accordance with the physician's order to hold the medication for a NJ Exec Order 26.4b1. Further review of the MAR revealed that on NJ Exec Order 26.4b and NJ Exec Order 26.4b at 8:00 AM, the resident's NJ Exec Order 26.4b1 was charted as administered.

Review of Resident #104's, "Documentation Survey Report" revealed that on NJ Exec Order 26.4b, the 11 PM to 7 AM CNA assigned to the resident documented that NJ Exec Order 26.4b1 was completed at 3:36 AM. Further review of the DSR revealed that on NJ Exec Order 26.4b on the 7 AM to 3 PM shift, there was no documented evidence that the following tasks were documented by CNA #2, who was assigned to the resident to indicate task completion: NJ Exec Order 26.4b1

Instead, another employee documented completion of all previously mentioned tasks on NJ Exec Order 26.4b at 2:59 PM.

On NJ Exec Order 26.4b at 9:46 AM, CNA #2 entered the room of Resident #173 and checked the resident's NJ Exec O with the resident's permission, in the presence of the surveyor. CNA #2 viewed the resident's NJ Exec Order 26.4b1

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Review of Resident #173's Admission Record revealed that the resident was admitted to the facility with diagnosis which included but were not limited to: NJ Exec Order 26.4b1 [redacted]

Review of the Resident #173's Admission Minimum Data Set (MDS), an assessment tool, was not yet completed or available for review.

Review of Resident #173's Care Plan revealed an entry dated NJ Exec Order 26.4, which indicated, "I have NJ Exec Order 26.4b1 r/t (related to) NJ Exec Order 26.4b1 [redacted] Goal: "I will not have NJ Exec Order 26.4b1 [redacted] through the review date (Target Date: NJ Exec Order 26.4)" Interventions included: ".. NJ Exec Order 26.4b1 [redacted] "...Provide NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 [redacted] as needed..." Further review of the Care Plan revealed "I have NJ Exec Order 26.4b1 r/t (related to) NJ Exec Order 26.4b1." Goal: "I will not have NJ Exec Order 26.4b1 [redacted] through the review date (Target Date: NJ Exec Order 26.4b1." Interventions included: NJ Exec Order 26.4b1 [redacted] ..." "...Provide NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 as needed."...

Review of Resident #173's, "Documentation Survey Report" revealed that on NJ Exec Order 26.4b, the 11

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PM to 7 AM CNA assigned to the resident documented that NJ Exec Order 26.4b1 care was completed at 4:15 AM. Further review of the DSR revealed that on NJ Exec Order 26.4b on the 7 AM to 3 PM shift, there was no documented evidence that the following tasks were documented by CNA #2, who was assigned to the resident to indicate completion: NJ Exec Order 26.4b1

On 12/06/23 at 10:20 AM, the surveyor accompanied CNA #2 into Resdient #104's room to observe the resident's NJ Exec Or with resident permission. CNA #2 stated that the resident's NJ Exec Order 26.4b1. CNA #2 then assisted the resident to turn to their right side. CNA #2 stated, "NJ Exec Order 26.4b1." The surveyor observed an opened area on the resident's NJ Exec Order 26.4b1 CNA #2 stated, NJ Exec Order 26.4b1."

On 12/06/23 at 10:24 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #6. When asked if the residents on her assignment NJ Exec Order 26.4b1 when she reported to work in the morning LPN #6 stated, "It depends on the day." LPN #6 stated, "A couple of times last week, one of the aides complained that Resident #104 NJ Exec ." LPN #6 stated that there had been an aide who had to leave in the middle of their shift which may have contributed to short staffing." LPN #6 further stated, "Resident #104 was on NJ Exec Or and NJ Exec Order 26.4b1 whether the medication was held or not."

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Review of Resident #104's MAR revealed that on NJ Exec Order 26.4b at 8:00 AM, the resident was medicated with NJ Exec Order 26.4b1 Oral Tablet NJ Exec Order 2

Review of Resident #104's "Documentation Survey Report" revealed that on NJ Exec Order 26.4b, the 11-7 CNA documented that NJ Exec Order 26.4b1 care was documented as completed at at 6:31 AM.

On 12/06/23 at 10:33 AM, the surveyor attempted to interview the Registered Nurse/Unit Manager (RN/UM #1) who was assigned to the medication cart and stated that she would not be available for an interview for another hour or two.

On 12/06/23 at 10:37 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated, " It is my expectation that residents should be found NJ Exec during morning NJ Exec Order 26.4b1 as the night shift should have done rounds before they left and residents should not be NJ Exec Order 26.4b1 " ADON stated, "Residents should have NJ Exec Order 26.4b1 if they received NJ Exec Or prior to AM care." ADON stated, "If the resident was NJ Exec Order 26.4b the aide may have missed them and they should not be that NJ Exec " ADON further stated that nursing was expected to help out if the aides were short-staffed.

On 12/06/23 at 10:48 AM, the surveyor interviewed the Staffing Coordinator (SC) who stated, "On NJ Exec Order 26.4b on the 11-7 shift, she had call outs and a no call no show on the NJ Exec Order 26.4b1 on NJ Exec Order 26.4b into NJ Exec Order 26.4b." SC stated that RN/UM #1 was assigned to the medication cart because there were two nurse call outs today which was unusual.

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On 12/06/23 at 1:10 PM, the surveyor informed the LNHA and the ADON of the concerns that were identified during the NJ Exec Order 26.4b1 that was conducted on NJ Exec Order 26.4b and NJ Exec Order 26.4b

On 12/07/23 at 9:33 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with an "Employee Performance Improvement Notification" (EPIN) forms for both CNA #5 and CNA #2 which indicated that both CNAs failed to complete their POC's (documentation found in Documentation Survey Report) on NJ Exec Order 26.4b Further review of the EPIN revealed that CNA #2 also failed to completed POC documentation on NJ Exec Order 26.4b. The EPIN revealed that CNA #2 "Failed to document in kiosk resident's care. Supervisor asked to do prior to leaving..."

Review of the facility policy, "Urinary Incontinence-Clinical Protocol" (Revised April 2018) revealed the following:
As appropriate, based on assessment of the category and causes of incontinence, the staff will provide scheduled toileting prompted voiding (urination), or other interventions to try to improve the individual's continence status.

Review of the facility policy, "Activities of Daily Living (ADLs), Supporting (Revised March 2018) revealed the following:
Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).

Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming

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F 677	Continued From page 16 and personal and oral hygiene. NJAC 8:39-27.1(a), 27.2 (h)	F 677		
F 686 SS=G	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 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: NJ00166442 Based on interviews, review of closed medical records and other facility documentation, it was determined that the facility failed to consistently implement timely interventions in adherence with the facility [redacted] prevention policy and the resident's care plan to promote [redacted] and prevent the development of [redacted] This deficient practice was identified for 1	F 686	1. The resident #172, cited as being affected by this practice, no longer resides in the facility. 2. All residents have the potential to be affected by this practice. DON/designee completed an audit of resident□s skin integrity care plans to ensure interventions were in place for pressure injury prevention. 3. The DON/ADON re-educated all nurses and unit clerks on pressure injury prevention policy and pressure injury reduction interventions. 4. The DON/designee will audit 5 resident care plans weekly x 3 months to ensure interventions are implemented for	1/30/24

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F 686	Continued From page 17 of 2 residents (Resident #172) reviewed for NJ Exec Order 26.4b1 management. This deficient practice was evidenced by the following: Refer to F 677 Reference: Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP): https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf NPUAP Pressure Injury Stages The updated staging system includes the following definitions: Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate (interaction between skin temperature and moisture at skin surface), nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema (redness), which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon	F 686	pressure injury reduction and will review the results of the audits monthly to QAPI.	

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discoloration; these may indicate deep tissue pressure injury.

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis

Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD, caused by prolonged exposure to moisture), including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

Stage 3 Pressure Injury: Full-thickness skin loss

Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Stage 4 Pressure Injury: Full-thickness skin and tissue loss

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Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole, undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss.

Review of the Admission Record revealed that Resident #172 was admitted to the facility with diagnosis which included but were not limited to: NJ Exec Order 26.4b1 [redacted]

Review of Resident #172's Admission Assessment dated [redacted], indicated the resident's NJ Exec Order 26.4b1 [redacted]. Further review of the assessment indicated to initiate Potential for Skin Breakdown care plan with a focus of, "I have NJ Exec Order 26.4b1 [redacted] and/or potential for NJ Exec Order 26.4b1 [redacted]... Interventions: NJ Exec Order 26.4b1 [redacted], Document NJ Exec Order 26.4b1 [redacted] weekly and PRN (as needed) ..., I need NJ Exec Order 26.4b1 [redacted] as needed ...I need reminding/assistance to turn/reposition at least every two hours, more often as needed or requested, Notify nurse immediately of any NJ Exec Order 26.4b1 [redacted]: NJ Exec Order 26.4 [redacted]

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NJ Exec Order 26.4b1, etc. noted during care. Goal: I will be at reduced risk for NJ Exec O daily through the review date."

Review of Resident #172's Admission Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, indicating the resident was NJ Exec Order 26.4b1 Further review of the MDS revealed that the resident required extensive assistance of one person for NJ Exec Order 26.4b1NJ Exec Order 26.4b, NJ Exec Order 26.4b and NJ Exec Order 26.4b1. Review of Section H of the MDS, for Bladder and Bowel, revealed that the resident was always NJ Exec Order 26.4b1 and frequently NJ Exec Order 26.4b1. Review of Section M of the MDS, for Skin Conditions, indicated the resident was at risk for NJ Exec Order 26.4b1 and had no NJ Exec Order 26.4b1

A review of Resident #172's Comprehensive Care Plan initiated on NJ Exec Order 26.4b, with a focus area for ADL (assistance of daily living) NJ Exec Order 26.4b1 The goal outlined that the resident would be at reduced risk for complications of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 daily through the review date (Target date NJ Exec Order 26.4). Interventions included: NJ Exec Order 26.4b1 daily during care. NJ Exec Order 26.4b1 , etc. (etcetera, used at the end of a list to indicate that further, similar items were included) and report changes to Nurse.

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A review of Care Plan initiated on [redacted], with a focus area for [redacted] related to [redacted]. Goals included: "I will not have [redacted] due to [redacted] through the review date" (Target date [redacted]). Interventions included: Establish [redacted] and [redacted] as needed, [redacted] during care for possible [redacted]. Notify nurse of [redacted], etc.

Review of the Order Summary Report revealed the following Physician's Orders (PO):

- A PO dated [redacted], for [redacted] every shift, [redacted] every shift, and [redacted] for evaluation and treatment as needed.

-A PO dated [redacted], Weekly [redacted] on shower day: Friday on 3-11 shift, every evening shift every Friday. Must complete [redacted]

-A PO dated [redacted] [redacted] otal in 24 hrs (hours): Nursing: [redacted] @ (at) Breakfast [redacted] @Lunch [redacted] @Dinner) every shift. Further review of the PO's revealed that no supplement was ordered.

-A PO dated [redacted], for [redacted]

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conditions including NJ Exec Order 26.4b1

and NJ Exec Order 26.4b1

which includes: NJ Exec Order 26.4b1

one time only for NJ Exec Order 26.4b1

and

"One time only for NJ Exec Order 26.4b1 until ..."

-A PO dated for .

- A PO dated , for NJ Exec Order 26.4b1 in the morning for

- A PO dated , NJ Exec Order 26.4b1 QHS (at bedtime) for .

-A PO dated , NJ Exec Order 26.4b1 on

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-A PO dated NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 Total in 24 hrs (hours): Nursing: NJ Exec Orde [redacted] @ (at) Breakfast, NJ Exec Order [redacted] @Lunch, NJ Exec Order [redacted] @Dinner) every shift. Further review of the PO's revealed that no supplement was ordered.

- A PO dated NJ Exec Order 26.4 [redacted], to NJ Exec Order 26.4b1 [redacted], pat dry, apply NJ Exec Order 26.4b1 and cover with a NJ Exec Order 26.4b1 every day.

- A PO dated NJ Exec Order 26.4 [redacted], to NJ Exec Order 26.4b1 [redacted], pat dry, NJ Exec Order 26.4b1 [redacted]. Leave open to air every day and evening shift.

-A PO dated NJ Exec Order 26.4 [redacted], to NJ Exec Order 26.4b1 [redacted], pat dry, NJ Exec Order 26.4b1 [redacted]. Leave open to air every day and evening shift.

-A PO dated NJ Exec Order 26.4 [redacted], NJ Exec Order 26.4b1 [redacted] One time only for monitoring.

-A PO dated NJ Exec Order 26.4 [redacted], NJ Exec Order 26.4b1 [redacted]

- A PO dated NJ Exec Order 26.4 [redacted], to off load NJ Exec Order 26.4b1 [redacted] while in bed.

-A PO dated NJ Exec Order 26.4 [redacted], Off load NJ Exec Order 26.4b1 [redacted] while in bed. Every

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shift for NJ Exec Order 26.4b1

-A PO dated NJ Exec Order 26.4b, for a NJ Exec Order 26.4b1

-A PO dated NJ Exec Order 26.4b NJ Exec Order 26.4 one time only until NJ Exec Order 26.4b

- A PO dated NJ Exec Order 26.4, for NJ Exec Order 26.4b1 two times a day for NJ Exec Order 26.4b1 by mouth. May provide NJ Exec Order 26.4b1 if unavailable.

-A PO dated NJ Exec Order 26.4, to NJ Exec Order 26.4b1 with NJ Exec Ord, apply NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1

-A PO dated NJ Exec Order 26.4, to NJ Exec Order 26.4b1 every day and every evening shift.

-A PO dated NJ Exec Order 26.4b, for NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 for discharge.

Review of the resident's NJ Exec Order 26.4b1 Treatment Administration Record (TAR) reflected

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the above corresponding physician's orders and the treatments were implemented as ordered.

Review of a NJ Exec Order 26.4b1 Check dated NJ Exec Order 26.4b revealed that the resident had a NJ Exec Order 26.4b noted, NJ Exec Order 26.4b1

Review of a Physiatry Note, titled, Physical Medicine and Rehabilitation Consultation dated NJ Exec Order 26.4b at 11:05 PM, revealed CC (chief complaint): NJ Exec Order 26.4b1 Plan included: ...NJ Exec Order 26.4b1 every morning and NJ Exec Order 26.4b1 every evening. "NJ Exec Order 26.4b1 OVERNIGHT." NJ Exec Order 26.4b1 after removing NJ Exec Order 26.4b1 daily. Please start NJ Exec Order 26.4b1 Including NJ Exec Order 26.4b1 will reduce NJ Exec Order 26.4b1.

Review of a Physical Medicine and Rehabilitation Follow Up note dated NJ Exec Order 26.4b at 4:35 PM, revealed the following:
CC (chief complaint) NJ Exec Order 26.4b1.
..."Continue with daily application of NJ Exec Order 26.4b1 every morning and removal of NJ Exec Order 26.4b1 every evening. NJ Exec Order 26.4b1 OVERNIGHT. Inspect NJ Exec Order 26.4b1 after removing NJ Exec Order 26.4b1 daily. Please start NJ Exec Order 26.4b1. Do NOT start NJ Exec Order 26.4b1. Including NJ Exec Order 26.4b1 will reduce NJ Exec Order 26.4b1. Avoid NJ Exec Orde .."

Review of a Physical Medicine and Rehabilitation Follow Up note dated NJ Exec Order 26.4b at 11:35 AM, revealed the following: NJ Exec Order 26.4b1 . noted to have NJ Exec Order 26.4b1. Also, with NJ Exec Order 26.4b1 ... Plan: ...NJ Exec Order 26.4b1.

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BERLIN REHABILITATION AND HEALTHCARE CENTER	100 LONG-A-COMING LANE BERLIN, NJ 08009

(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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NJ Exec Order 26 care consult.

Review of a Health Status Note (HSN) dated NJ Exec Order 26.4b at 11:20 AM, (19 days after the resident was admitted to the facility), revealed the resident's NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 and noted with "NJ Exec Order 26.4b1" during am care. "A new daily/prn (as needed) Tx (treatment) was put in place to NJ Exec Order 26.4b1, apply NJ Exec Order 26.4b1 with NJ Exec O and NJ Exec Ord. Will encourage frequent NJ Exec Order 26.4b1 while in bed and frequent NJ Exec Order 26.4b1 care.

Review of a Health Status Note dated NJ Exec Order 26.4b at 2:47 PM by the Registered Nurse (RN) revealed the following: "Notified by Physiatry that patient had NJ Exec Order 26.4b1. Upon investigation, Patient with a NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1, and a NJ Exec Order 26.4b1 opening with a NJ Exec Order 26.4b1. Patient wearing NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1. When suggested patient NJ Exec Order 26.4b1, patient became NJ Exec O and stated he/she NJ Exec Order 26.4b1 He/She gets up in the morning and stays up until bed. Patient unsure how he/she NJ Exec Order 26.4b1 Daughter at bedside and stated they were already aware of NJ Exec Order 26.4b MD (Medical Doctor) made aware with order to NJ Exec Order 26.4b1 and for a NJ Exec Order 2 consult. Patient to be seen on NJ Exec Order rounds."

Review of a Nutrition Note dated NJ Exec Order 26.4b at 12:45 PM, revealed, "Per most recent NJ Exec. Order 2 Nurse)

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documentation resident with NJ Exec Order 26.4b1 ....Discussed increased NJ Exec Order 26.4b1 Recommend NJ Exec Order 26.4b1 (twice a day), NJ Exec Order 26.4b1 . Resident reports...discharge NJ Exec Orde. Gave recommendations for home NJ Exec Order 26.4b1

On 11/20/23 at 1:14 PM, the surveyor requested to view all investigations that pertained to Resident #172. The Director of Nursing (DON) provided the surveyor with three (3) Full QA (Quality Assurance) Reports dated NJ Exec Order 26.4, NJ Exec Order 26.4b and NJ Exec Order 26.4b all of which pertained to NJ Exec Order 26.4b1.

Review of the NJ Exec Order 26.4b, incident report revealed an NJ Exec Order 26.4b1 was identified with a root cause analysis of 'NJ Exec

Review of the NJ Exec Order 26.4b, incident report indicated a NJ Exec Order 26.4b1 when transferred from bed to chair.

Review of the NJ Exec Order 26.4b, incident report indicated that a 'NJ Exec Order 26.4b1 s) was identified and was documented as a NJ Exec Order 26.4b1 and a NJ Exec Order 26.4b1

Review of the problem statement portion of the incident revealed that the resident had NJ Exec Order 26.4b1 as patient liked to sit in wheelchair all day. The

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Registered Nurse (RN) documented in the Investigative statement portion of the incident that she was notified by Physiatry (a doctor who specialized in physical medicine and rehabilitation) that patient had NJ Exec Order 26.4b1. Upon investigation, patient with a NJ Exec Order 26.4b1 and a NJ Exec Order 26 Patient wor NJ Exec Order 26.4b1 ...Patient to be seen on NJ Exec Order 26.4b1. There was no documented evidence in the resident's medical record including the Care Plan or Progress Notes the resident's preference to remain in the wheelchair all day as described by the RN.

Further review of the medical record including physician's orders revealed there was no physician's orders for NJ Exec Order 26.4b1 as documented by the RN in the NJ Exec Order 26.4, incident report and Health Status Note dated NJ Exec Order 26.4b at 2:47 PM, that was written by the RN.

Review of the NJ Exec Order 2 Care Consultant documentation dated NJ Exec Order 26.4b, revealed the following:

NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1: unknown. NJ Exec Order 26.4b1, Measurements (not specified) L (length) X W (width) X D (depth): NJ Exec Order 26.4b1, area (sq cm) NJ Exec volume NJ Exec Or), NJ Exec Order 26.4b1, Exudate amount: NJ Exec O Exudate type: NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 : NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Orde. Treatment recommendations: The plan

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for the NJ Exec Order 26.4b1 is to NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 .
NJ Exec Order 26.4b1: 1. NJ Exec Order 26.4b1. This treatment will be done every shift for one week. Today's treatment will be performed by the NJ Exec Order team and other care performed by the staff of the facility.

NJ Exec Order 26.4b1 NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1: unknown.
NJ Exec Order 26.4b1 Measurements: NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, NJ Exec Order 26.4b1.
Exudate amount: NJ Exec. Exudate type: NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 Tissue NJ Exec Order 26.4b1

Treatment Recommendations:
The plan for the NJ Exec Order 26.4b1 is to NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 . This treatment will be done every shift for one week. Today's treatment will be performed by the NJ Exec Order 26.4b1 team and other care performed by the staff of the facility.

Provider Comments: Patient is seen with an NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 both measured in a NJ Exec Order 26.4b1, noted with NJ Exec Order Both treatments are the same with the following instructions: NJ Exec Order 26.4b1 every shift and as needed.
Leave open to air.
...The patient's BMI (body mass index, value derived from the mass and height of a person) is

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greater than NJ Exec Order 26.4b1 Recommend implementing a nutritional care plan per facility policy.

Review of the NJ Exec Order 2 Care Consultant Documentation dated NJ Exec Order 26.4b, revealed the following:

NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 Measurements: NJ Exec Order 26.4b1, Area: NJ , Volume: NJ Exec Ord Tunnels NJ E Exudate amount: NJ Exec . Exudate type: NJ Exec Order , NJ Exec Order 2 Margin: NJ Exec . NJ Exec Order 26.4b1 . NJ Exec Order exposed: NJ Exec Order 26.4b1 .

Treatment Recommendations:
The plan for the NJ Exec Order 26.4b1 is to NJ Exec Order 26.4b1
NJ Exec Order 26.4b1
NJ Exec Order 26.4b1
NJ Exec Order 26.4b1
This treatment will be done every shift for one week. Today's treatment will be performed by the NJ Exec Order 26.4b1 team and other care performed by the staff of the facility.

NJ Exec Order 26.4b1
NJ Exec Order 26.4b1 . NJ Exec Order 2 Type: NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 : NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 Measurements: NJ Exec Order 26.4b1, Area NJ Exec Volume NJ Exec Ord Tunnels: NJ E Exudate amount NJ Exec . Exudate Type: NJ Exec Order 2 . NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1

Treatment recommendations:
The plan for the NJ Exec Order 26.4b1 is to NJ Exec Order 26.4b1

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NJ Exec Order 26.4b1
NJ Exec Order 26.4b1

This treatment will be done every shift for one week. Today's treatment will be performed by the NJ Exec Order 26.4b1 team and other care performed by the staff of the facilty.

Provider Comments: NJ Exec Order 26.4b1, noted NJ Exec Order 26.4b1 Recommend continuing same tx (treatment) and leaving it NJ Exec Order 26.4b1

Review of the NJ Exec Order 2 Care Consultant documentation dated NJ Exec Order 26.4b, revealed the following:

NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, measured NJ Exec Order 26.4b1 (measurements length x width x depth, unit of measurement not specified), NJ Exec Order 26.4b1, NJ Exec Order, NJ Exec Order 26.4b1 (Note: NJ Exec Order 26.4b1 area measured NJ Exec Order 26.4b1).

NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, NJ Exe, NJ Exec Order 26.4b1. (Note: On NJ Exec Order 26.4b1 area measured NJ Exec Order 26.4b1

NJ Exec Order 26.4b1

NJ Exec Order 26.4b1,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NJ Exec Order 26.4b1

NJ Exec Order 26.4b1

) material, NJ Exec Order 26.4b1

Response: The patient NJ Exec Order 26.4b1. NJ Exec Order 26.4b1

On 12/04/23 at 10:46 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) #3 who stated that she worked at the facility for two years. CNA #3 stated that when she was assigned to a resident who had any type NJ Exec Order 26. she would make sure that the resident's NJ Exec Order 26.4b1 if ordered and turn the resident every two hours. CNA #3 stated that if she noted a NJ Exec Order 26.4b1, she would report the finding to the nurse and document it. CNA stated that if NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 were ordered they were removed at bedtime and the CNAs applied the NJ Exec Orde in the am, but nursing was responsible to apply the NJ Exec Order 26.4b1 in the morning as ordered. CNA #3 then proceeded to demonstrate the computer system she utilized to document care rendered.

On 12/04/23 at 11:17 AM, the surveyor

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interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated that she did weekly NJ Exec Order rounds every Tuesday with the Unit Managers, Director of Nursing and Nurse Practitioner from the Wound Consultant group. LPN/UM #1 stated that for a NJ Exec Order 26.4b1 it was automatic that the resident' NJ Exec Order 26.4b1 . LPN/UM #1 explained that an order was required for both NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 LPN/UM #1 further explained that pillows could also be used to NJ Exec Order 26.4b1

On 12/05/23 at 12:53 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that residents received a NJ Exec O upon admission and then weekly NJ Exec Order 26.4b1. She stated that for a resident who had sustained a NJ Exec Order 26.4b1 she would have expected that the resident required frequent turning and NJ Exec Order 26.4b1 which were documented by the CNA's. The ADON stated that NJ Exec Order 26.4b1 were ordered upon admission if the resident was NJ Exec Order 26.4b1. The ADON stated that if a resident liked to stay up in their wheelchair, they were required to have footrests on their wheelchairs and she would have implemented NJ Exec Order 26.4b1 as, "it was better to be safe than sorry."

On 12/05/23 at 2:28 PM, the surveyor interviewed the Registered Nurse, who identified herself as the overnight supervisor via telephone. The surveyor asked if she noted Resident #172 wearing NJ Exec Order 26.4b1 as she had described in both the Incident Report and Progress Notes? The RN responded, "She would have had to have seen the resident wearing NJ Exec Order 26.4b1 if that

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was what she documented." The RN stated that a Physician's Order was required for NJ Exec Orde and they were available in house if ordered. The RN further stated, " We have a doctor's note for anything going on a patient because they are for NJ Exec Order 26.4b1, the doctor may not want them."

On 12/06/23 at 10:58 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with the, "Documentation Survey Report" for NJ Exec Order 26.4b1, that pertained to CNA care provided which included: NJ Exec Order 26.4b1 , and NJ Exec Order 26.4b1 episode. The surveyor observed that there was no documented evidence that the tasks were completed by the assigned staff member who failed to sign that they completed the tasks below on the following dates as indicated:

NJ Exec Order 26.4b1

1. NJ Exec Order 26.4b1

On day shift blanks were noted in the signature column on: NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4, NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b, and NJ Exec Order 26.4b.

On evening shift blanks were noted in the signature column on: NJ Exec Order 26.4b, NJ Exec Order 26.4b, and NJ Exec Order 26.4b.

On night shift blanks were noted in the signature column on: NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b, and NJ Exec Order 26.4b.

2. NJ Exec Order 26.4b1:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 686	Continued From page 35 On day shift blanks were noted in the signature column on: NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b, and NJ Exec Order 26.4b. On evening shift blanks were noted in the signature column on: NJ Exec Order 26.4b, NJ Exec Order 26.4b and NJ Exec Order 26.4b. On night shift blanks were noted in the signature column on: NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b, and NJ Exec Order 26.4b. 3. NJ Exec Order 26.4b1: On day shift blanks were noted in the signature column on: NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b1, NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b and NJ Exec Order 26.4b1. On evening shift blanks were noted in the signature column on: NJ Exec Order 26.4b, NJ Exec Order 26.4b, and NJ Exec Order 26.4b. On night shift blanks were noted in the signature column on: NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b and NJ Exec Order 26.4b. 4. CNA NJ Exec Order 26.4b1: On day shift blanks were noted in the signature column on: NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b and NJ Exec Order 26.4b. On evening shift blanks were noted in the	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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signature column on: [redacted], and [redacted].

On night shift blanks were noted in the signature column on: [redacted], and [redacted].

5. Personal Hygiene including [redacted]

On day shift blanks were noted in the signature column on: [redacted], and [redacted].

On evening shift blanks were noted in the signature column on: [redacted], and [redacted].

On night shift blanks were noted in the signature column on:

[redacted], and [redacted].

6. [redacted] with [redacted] after each [redacted]:

On day shift blanks were noted in the signature column on: [redacted], and [redacted].

On evening shift blanks were noted in the signature column on: [redacted] and [redacted].

On night shift blanks were noted in the signature

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column on:
[redacted], [redacted], [redacted], [redacted] and [redacted].

July 2023:

1. [redacted]:

On day shift blanks were noted in the signature column on:
[redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted] and [redacted]

On evening shift blanks were noted in the signature column on:
[redacted], [redacted], [redacted], [redacted], and [redacted].

On night shift blanks were noted in the signature column on:
[redacted], [redacted], and [redacted]

2. [redacted]:

On day shift blanks were noted in the signature column on:
[redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], and [redacted].

On evening shift blanks were noted in the signature column on:
[redacted], [redacted], [redacted], [redacted] and [redacted].

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F 686	Continued From page 38 On night shift blanks were noted in the signature column on: [redacted], [redacted] and [redacted]. 3.[redacted]: On day shift blanks were noted in the signature column on: [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted] and [redacted]. On evening shift blanks were noted in the signature column on: [redacted], [redacted], [redacted], [redacted] and [redacted] On night shift blanks were noted in the signature column on: [redacted], [redacted], and [redacted]. On night shift blanks were noted in the signature column on: [redacted], [redacted], and [redacted]. 4. CNA [redacted]: On day shift blanks were noted on the signature column on: [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted] and [redacted] On evening shift blanks were noted on the signature column on: [redacted], [redacted], [redacted], [redacted], and	F 686		

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	315461	A. BUILDING ______ B. WING ______	C 12/11/2023

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Continued From page 39
[redacted],

On night shift blanks were noted on the signature column on:
[redacted], [redacted], and [redacted]

5. Personal Hygiene including [redacted]

On day shift blanks were noted on the signature column on:
[redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted] and [redacted].

On evening shift blanks were noted on the signature column on:
[redacted], [redacted], [redacted], [redacted] and [redacted].

On night shift blanks were noted on the signature column on:
[redacted], [redacted], and [redacted].

6. [redacted] with [redacted] after each [redacted]
On day shift blanks were noted on the signature column on:
[redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted] and [redacted].

On evening shift blanks were noted on the signature column on:
[redacted], [redacted], [redacted], [redacted], and

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F 686	Continued From page 40 NJ Exec Order 26.4b .	F 686		

On night shift blanks were noted on the signature column on:
NJ Exec Order 26.4b, NJ Exec Order 26.4b, and NJ Exec Order 26.4b

On 12/06/23 at 1:19 PM, thesurveyor interviewed CNA #3 who stated that blanks on the "Documentation Survey Report" indicated that the tasks were not documented as completed. CNA #3 stated that she always documented the care she provided so that she did not get written up. CNA #3 stated that she has returned to the facility at 8:00 PM in the evening after class to document care provided, because it was her job to do it.

On 12/06/23 at 1:32 PM, the surveyor interviewed Registered Nurse/Unit Manager (RN/UM) #1 who stated that she could not speak to why there were so many blanks on the CNA Documentation Survey Report as it was before she worked here. RN/UM #1 stated that she checked the computer dashboard daily to ensure that documentation was completed. RN/UM #1 explained that if there were blanks on the report she would not know if the care was done if it were not documented. RN/UM #1 stated that if she noted blanks, she would call the staff back to the facility to complete their documentation as required.

On 12/06/23 at 1:47 PM, the surveyor interviewed the ADON who stated that she expected 100% compliance for CNA required documentation. ADON stated that the supervisors were required to check and see what percentage of documentation was completed to see where the staff was with their care. ADON stated that staff should not be permitted to leave the facility before their documentation were completed. ADON

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stated, "If you did not document it, you did not do it." The surveyor showed the ADON Resident #172's Documentation Survey Reports for both [redacted] for review and she stated, "There were a lot of blanks."

On 12/06/23 at 3:05 PM, the surveyor interviewed the Physiatrist (Physical Medicine and Rehabilitation Doctor) via telephone, who stated that she saw Resident #172 for an initial evaluation and she performed the first follow-up examination. The Physiatrist stated that her notes reflected that her recommendations were for the resident to continue with [redacted]. The Physiatrist stated that she saw the resident and noted that the [redacted] and [redacted]. The Physiatrist stated that she only vaguely remembered seeing the resident and the instruction to [redacted] rather than [redacted] may have been for clarification purposes.

On 12/07/23 at 11:00 AM, the surveyor in the presence of the LNHA reviewed the multitude of blanks and lack of CNA signatures to indicate that tasks were completed on Resident #172's Documentation Survey Report for [redacted] care and [redacted] care for a resident who was previously identified to be at risk for [redacted] and had developed facility acquired [redacted].

The surveyor reviewed the facility policy, "Prevention of Pressure Injuries" (Revised April 2020) which revealed the following:
The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific

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risk factors.
Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable.
...Inspect the skin on a daily basis when performing or assisting with personal care or ADLs. Identify any signs of developing pressure injuries (i.e., non-blanchable erythema .... Inspect pressure points (sacrum (a triangular bone in lower back), heels, buttocks, coccyx (tail bone), elbows, ischium (curved bone forming the base of each half of the pelvis), trochanter (upper part of thigh bone), etc.); Moisturize dry skin daily; and Reposition resident as indicated on the care plan.
Prevention:
Skin Care: Keep the skin clean and hydrated, Clean promptly after episodes of incontinence, ...Use barrier product to protect skin from moisture, Use incontinence product with high absorbency.
...Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team. Choose a frequency for repositioning based on the resident's risk factors and current clinical practice guidelines. Teach residents who can change positions independently the importance of repositioning. Provide support devices and assistance as needed. Remind and encourage residents to change positions.
...Monitor regularly for comfort and signs of pressure-related injury. Evaluate, report and document potential changes in the skin. Review the interventions and strategies for effectiveness on an ongoing basis.

Review of the facility policy, "Charting and Documentation" (Revised July 2017) revealed the

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F 686	Continued From page 43 following: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record may be electronic, manual or a combination. NJAC 8:39-27.1(e)	F 686		
F 697 SS=D	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, 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: NJ Complaint # NJ 1560250 Based on interview, record review, and review of pertinent facility documentation it was determined that the facility failed to consistently provide effective NJ Exec Order 26.4b1 allowing the resident to achieve optimal results during NJ Exec Order 26.4b1 [redacted]. This deficient practice was identified in 1 of 1 resident (Resident #222) reviewed for NJ Exec O management and was evidenced by the following: On 12/04/23 at 11:11, AM, the surveyor reviewed the Admission Record for Resident #222 which revealed the resident was admitted to the facility	F 697	1. Resident #222, cited as being affected by this practice, no longer resides in the facility. 2. All residents have the potential to be affected by this practice. DON/designee completed an audit all residents getting physical therapy to ensure they are getting effective pain relief that allows resident to achieve optimal results during physical therapy. Changes were made as needed. 3. The DON/ADON re-educated all nurses to identify pain in residents and develop interventions that are consistent with the resident□s goals and needs that	1/30/24

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F 697	Continued From page 44 following NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. On 12/04/23 at 11:13 AM, the surveyor reviewed the physician orders which showed Resident #222 was prescribed the following medications for NJ Exec Or NJ Exec Order 26.4b1 one tablet every four hours as needed for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 two tablets every six hours as needed for NJ Exec Order 26.4b1. There was an order for the staff to monitor the resident for NJ Exec O every shift and document NJ Exec Order 26.4b1 every shift. On 12/04/23 at 11:19 AM, the surveyor reviewed the care plan which included a focus of NJ Exec O and goals to not have an interruption in normal activities due to NJ Exec O. Another goal was for staff to administer NJ Exec Order 26.4b1 as ordered. On 12/04/23 at 11:32 AM, the surveyor reviewed the five-day Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b. The MDS revealed the resident had a Brief Interview of Mental Status of NJ Exec meaning the resident was NJ Exec Order 26.4b1. Review of section J, titled Health conditions showed the resident was on a NJ Exec Order 26.4b1. The assessment revealed the resident had NJ Exec O which was at a NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1. On 12/04/23 at 11:36 AM, the surveyor reviewed the residents NJ Exec O assessments which showed that the staff were assessing the residents NJ Exec O level every shift with highest NJ Exec Order 26.4b1 being NJ Exec O, meaning NJ Exec Order 26.4b1 and lowest a NJ Exec O meaning NJ Exec Order 26.	F 697	address the underlying cause of pain. 4. The DON/designee will audit 5 residents weekly x 3 months to ensure that resident□s pain is identified and develop interventions that are consistent with the resident□s goals and needs that address the underlying cause of pain. Results of the audits will be reviewed Monthly with QAPI.	

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On 12/04/23 at 01:08 PM, the surveyor reviewed Resident #222 NJ Exec Order 26.4b1 notes which showed that the resident had a NJ Exec evaluation on NJ Exec Order 26.4b. Following the evaluation, the NJ Exec plan was that the resident would receive NJ Exec Order 26.4b five times per week. The next day of NJ Exec Order 26.4b the resident received was on NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b, NJ Exec Order 26.4b, and NJ Exec Order 26.4b. NJ Exec Order 26.4b was discontinued on NJ Exec Order 26.4b as the resident was being transferred to another sub-acute facility.

On 12/04/23 at 01:26 PM, the surveyor reviewed Resident #222 Medication Administration Record (MAR). On NJ Exec Order 26.4b at 01:00 AM the resident received NJ Exec Order 26.4b1 one tablet for NJ Exec Order 26.4b as ordered. At the time the resident received the NJ Exec Order 26.4b1 the resident had NJ Exec O of NJ Exec Order 26.4b on the NJ Exec Order 26.4b1, meaning the resident had NJ Exec Order 26.4b1. Further review of the MAR revealed the resident did not receive any NJ Exec Order 26.4b1 for the rest of the day on NJ Exec Order 26.4b. The surveyor then reviewed the section of the MAR for monitoring of NJ Exec O every shift. On NJ Exec Order 26.4b for evening shift (three to eleven shift), the resident complained of NJ Exec O as a NJ Exec Order 26.4b meaning the resident had NJ Exec Order 26.4b1. The resident did not receive any NJ Exec Order 26.4b1 for the NJ Exec O at that time.

On 12/05/23 at 12:10 PM, the surveyor reviewed the residents NJ Exec Order 26.4b1 notes. Review of the notes showed that on NJ Exec Order 26.4b it was documented that the resident activities during NJ Exec Order 26.4b were NJ Exec Order 26.4b1 Review of the MAR revealed that on NJ Exec Order 26.4b the resident did not receive any NJ Exec Order 26.4b1 until 03:44 PM. Further review of the NJ Exec Order 26.4b1

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F 697	Continued From page 46 notes showed that on NJ Exec Order 26.4b1 it was documented that the residents' activities were NJ Exec Order 26.4b1 On 12/05/23 at 12:43 PM, the surveyor interviewed a facility NJ Exec Order 26.4b1 regarding what actions would be taken if a resident had complaints of NJ Exec O when a therapist was going to pick them up for NJ Exec Order 26 or during NJ Exec Order 26. The therapist told the surveyor, "I would ask the resident if they had any NJ Exec O and if they do, I will ask the nurse if they can be medicated. If a resident needs NJ Exec Order 26.4b1 i will come back half hour later to let the NJ Exec Order 26.4b1 work and then begin NJ Exec Order 26. On 12/06/23 at 01:45 PM the surveyor reviewed the policy titled, "Pain Assessment and Management". The policy had a revision date of 10/2022. The purpose of the policy was to help staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs that address the underlying causes of pain.	F 697		
F 725 SS=D	NJAC 8:39-27.1 (a) 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	F 725		1/30/24

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F 725	Continued From page 47 diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §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: NJ Complaint # NJ00163433 Based on observation, interview, and review of pertinent facility documentation it was determined that the facility failed to a.) provide nursing related services to assure residents maintain the highest practicable physical, mental, and psychosocial wellbeing as determined by resident assessments and individual plans of care in accordance with the facility assessment and b.) 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: Refer to F677 Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance	F 725	1. No specific residents residing in the facility on the day shifts cited were affected by not meeting the State of New Jersey minimum staffing requirements. 2. All residents could have the potential to be affected by not meeting the State of New Jersey minimum staffing requirements on day shift. 3. Recruitment efforts continue to include: a. Daily Staffing meetings / Weekly Labor Meetings b. Mentor program to support and retain staff. c. Culture Committee to promote and improve staff morale. d. Recruitment Bonuses, Sign On Bonuses and Vacant Shift Bonuses offered	

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F 725	Continued From page 48 with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. a.) On 11/27/23 at 12:15 PM, the surveyor reviewed the Payroll Based Journal (PBJ) staffing report submitted by the facility for the third quarter of 2023, April 1st through June 30th, 2023. The report triggered "excessively low weekend staffing" for the third quarter. On 11/28/23 at 10:10 AM, the surveyor interviewed the Unit Manager/Registered Nurse on the Cherry Unit regarding staffing. The UM/RN told the surveyor the unit had 48 residents and five Certified Nursing Assistants, so the ratio was one CNA to nine and 10 residents. On 11/28/23 at 11:00 AM, during the initial tour of	F 725	e. Ongoing job fairs onsite f. Flexible orientation programs g. Prize raffles for staff picking up extra shifts. h. Daily interviews being conducted with any walk ins 4. Scheduling Coordinator will audit schedule weekly to monitor compliance with minimum staffing requirements. Scheduling Coordinator will report results of audits monthly to QAPI to identify trends and identify additional areas of opportunity.	

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the unit the surveyor interviewed an unsampled resident who was in the room in bed. The resident had a NJ Exec Order 26.4b1 and another NJ Exec Order 26.4b1 . The resident told the surveyor that the staff hadn't emptied the NJ Exec Orde since the night shift. The resident told the surveyor, "There isn't enough help".

On 12/04/23 at 10:49 AM, a surveyor interviewed CNA#1 who said she was assigned 11 residents and stated that sometimes it's 13 residents. CNA#1 stated some mornings when she came into the facility (for day shift) the residents were saturated. CNA#1 stated that it could be staffing related.

b.) 1. The facility was deficient in CNA staffing for residents on 13 of 14 day shifts for the two weeks prior to survey:

-11/12/23 had 13 CNAs for 124 residents on the day shift, required at least 15 CNAs.
-11/13/23 had 13 CNAs for 124 residents on the day shift, required at least 15 CNAs.
-11/14/23 had 14 CNAs for 124 residents on the day shift, required at least 15 CNAs.
-11/15/23 had 12 CNAs for 123 residents on the day shift, required at least 15 CNAs.
-11/16/23 had 12 CNAs for 123 residents on the day shift, required at least 15 CNAs.
-11/17/23 had 11 CNAs for 123 residents on the day shift, required at least 15 CNAs.
-11/18/23 had 12 CNAs for 123 residents on the day shift, required at least 15 CNAs.

-11/19/23 had 13 CNAs for 123 residents on the day shift, required at least 15 CNAs.
-11/20/23 had 12 CNAs for 123 residents

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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 725	Continued From page 50	F 725		

on the day shift, required at least 15 CNAs.
-11/21/23 had 13 CNAs for 123 residents on the day shift, required a t least 15 CNAs.
-11/22/23 had 12 CNAs for 123 residents on the day shift, required at least 15 CNAs.
-11/24/23 had 13 CNAs for 120 residents on the day shift, required at least 15 CNAs.
-11/25/23 had 12 CNAs for 119 residents on the day shift, required at least 15 CNAs.

2.For the week of Complaint staffing from11/06/2022 to 11/12/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:

-11/06/22 had 13 CNAs for 124 residents on the day shift, required at least 15 CNAs.
-11/07/22 had 14 CNAs for 123 residents on the day shift, required at least 15 CNAs.
-11/08/22 had 13 CNAs for 123 residents on the day shift, required at least 15 CNAs.
-11/09/22 had 12 CNAs for 123 residents on the day shift, required at least 15 CNAs.
-11/10/22 had 13 CNAs for 123 residents on the day shift, required at least 15 CNAs.
-11/11/22 had 13 CNAs for 123 residents on the day shift, required at least 15 CNAs.
-11/12/22 had 11 CNAs for 123 residents on the day shift, required at least 15 CNAs.

3. For the week of Complaint staffing from 01/08/2023 to 01/14/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:

-01/08/23 had 9 CNAs for 120 residents on the day shift, required at least 15 CNAs.
-01/09/23 had 11 CNAs for 120 residents on the day shift, required at least 15 CNAs.

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F 725	Continued From page 51	F 725		

-01/10/23 had 9 CNAs for 119 residents on the day shift, required at least 15 CNAs.
-01/11/23 had 11 CNAs for 119 residents on the day shift, required at least 15 CNAs.
-01/12/23 had 10 CNAs for 119 residents on the day shift, required at least 15 CNAs.
-01/13/23 had 11 CNAs for 119 residents on the day shift, required at least 15 CNAs.
-01/14/23 had 10 CNAs for 121 residents on the day shift, required at least 15 CNAs.

4. For the week of Complaint staffing from 04/09/2023 to 04/15/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 1 of 14 evening shifts as follows:

-04/09/23 had 10 CNAs for 127 residents on the day shift, required at least 16 CNAs.
-04/10/23 had 12 CNAs for 125 residents on the day shift, required at least 16 CNAs.
-04/11/23 had 11 CNAs for 125 residents on the day shift, required at least 16 CNAs.
-04/12/23 had 12 CNAs for 125 residents on the day shift, required at least 16 CNAs.
-04/13/23 had 12 CNAs for 125 residents on the day shift, required at least 16 CNAs.
-04/14/23 had 11 CNAs for 126 residents on the day shift, required at least 16 CNAs.
-04/15/23 had 8 CNAs for 125 residents on the day shift, required at least 16 CNAs.
-04/15/23 had 11 total staff for 125 residents on the evening shift, required at least 10 total staff.

5. For the 2 weeks of Complaint staffing from 07/02/2023 to 07/15/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:

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-07/02/23 had 9 CNAs for 121 residents on the day shift, required at least 15 CNAs.
-07/03/23 had 9 CNAs for 121 residents on the day shift, required at least 15 CNAs.
-07/04/23 had 10 CNAs for 121 residents on the day shift, required at least 15 CNAs.
-07/05/23 had 12 CNAs for 121 residents on the day shift, required at least 15 CNAs.
-07/06/23 had 12 CNAs for 121 residents on the day shift, required at least 15 CNAs.
-07/07/23 had 13 CNAs for 117 residents on the day shift, required at least 15 CNAs.
-07/08/23 had 14 CNAs for 117 residents on the day shift, required at least 15 CNAs.

-07/09/23 had 9 CNAs for 116 residents on the day shift, required at least 14 CNAs.
-07/10/23 had 11 CNAs for 112 residents on the day shift, required at least 14 CNAs.
-07/11/23 had 10 CNAs for 112 residents on the day shift, required at least 14 CNAs.
-07/12/23 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs.
-07/13/23 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs.
-07/14/23 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs.
-07/15/23 had 8 CNAs for 110 residents on the day shift, required at least 14 CNAs.

On 12/06/23 at 10:48 AM, the surveyor interviewed the Staffing Coordinator (SC). The surveyor asked the SC if she was familiar with the regulations regarding staffing, and she replied, "Every time I ask it changes and is something different." The surveyor asked how scheduling for the Certified Nursing Assistants (CNA) was completed and she said, "Every six weeks".

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F 725	Continued From page 53 The surveyor then asked how you know there are enough CNA on each day, and she responded, "I call at 0:430 AM to see if anyone called out for that day. If staffing is less, I get on the computer and begin calling people. I keep list of people of people available to work for call outs". The surveyor then asked the SC that if she was not aware of the ratios how would you know you have enough staff and she said, "The numbers are on our schedule". She then told the surveyor that June and July of 2023 were "tough". On 12/06/23 at 11:20 AM, the surveyor requested a staffing policy from the Licensed Nursing Home Administrator (LNHA). The LNHA could only provide a policy for Assisted Living Facilities, not Long-Term Care Facilities. On 12/06/23 at 12:50 PM, the surveyor made the LNHA aware of the staffing concerns. No additional information was provided.	F 725		
F 755 SS=D	NJAC 8:39-25.2 (a), (b) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755		1/30/24

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F 755	Continued From page 54 dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and pertinent record review, it was determined that the facility failed to ensure the accountability of the Narcotic Shift Count logs were completed in accordance with facility policy and accurately account for and document the administration of controlled medications. This deficient practice was identified on 1 of 3 medication carts and was evidenced by the following: On 11/29/23 at 12:56 PM, the surveyor, in the presence of the Registered Nurse Supervisor (RNS), reviewed the narcotic logbook for the [redacted] nursing unit's middle hall's medication cart. The logbook contained narcotic shift logs which revealed the following incomplete or blank sections:	F 755	1. No Resident was affected by this deficient practice. The nurse assigned to the middle medication cart on [redacted] was immediately re-educated. 2. All residents have the potential to be affected by this practice. DON/designee completed an audit of all Narcotic Count Logs to identify incomplete or blank sections. 3. The DON/ADON re-educated all nurses on the process for signing out controlled substances in the Narcotic Count Log and the process for shift-to-shift count and documentation to reflect completion, accurate and medication is secure. 4. The DON/designee will complete weekly audits x 3 months to ensure	

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F 755	Continued From page 55 Going off Duty Nurse's Signatures missing for: 7/26/23 3 PM, 7/29 7 AM, 8/2 7AM, 8/14 7 AM, 8/5 7 AM, 8/8 7 AM, 8/12 11:15 AM, 8/13 7 AM, 8/16 7 AM, 8/17 7 AM, 8/18 7 AM, 8/18 11 PM, 8/19 3 PM, 8/22 7 AM, 8/23 7 AM, 8/24 7 AM and 3 PM, 8/25 7 AM, 8/26 7 AM, 8/28 7 AM, 8/29 7 AM and 11 PM, 8/30 7 AM, 8/31 7 AM, 9/1 3 PM, 9/2 7 AM, 9/4 3 PM, 9/5 7 AM, 9//6 7 AM and 11 PM, 9/7 7 AM, 9/8 7 AM, 9/9 7 AM and 3 PM, 9/11 7 AM, 9/12 7 AM, 9/13 7 AM, 9/14 7 AM, 9/15 7 AM, 9/16 7 AM, 9/17 7 AM, 9/18 7 AM and 3 PM, 9/19 7 AM and 3 PM, 9/20 7 AM, 9/22 7 AM, 9/26 7 AM, 9/29 7 AM, 9/30 11 PM, 10/2 7 AM, 10/3 7 AM and 11 PM, 10/4 7 AM, 10/8 7 AM, 10/13 7 AM, 10/14 7 AM, 10/15 7 AM, 10/16 7 AM, 10/17 7 AM, 10/18 7 AM, 10/19 11 PM, 10/20 11 PM, 10/23 7 AM, 10/24 7 AM and 11 PM, 10/25 7 AM, 10/26 7 AM, 10/27 7 AM and 3 PM, 10/29 7 AM, 10/30 7 AM and 3 PM, 10/31 7 AM, 11/1 7 AM, 11/2 7 AM, 11/3 7 AM, 11/5 7 AM and 3 PM, 11/6 7 AM, 11/7 7 AM, 11/8 7 AM, 11/9 7 AM, 11/11 7 AM, 11/12 7 AM and 11 PM, 11/13 7 AM and 3 PM, 11/15 7 AM, 11/16 7 AM, 11/17 7 AM, 11/18 7 AM, 11/19 7 AM 3 and 11 PM, 11/20 7 AM and 11 PM, 11/21 7 AM, 11/22 7 AM, 11/23 7 AM and 11 PM, 11/24 7 AM, 11/25 7 AM and 11 PM, 11/26 7 AM, 11/27 7 AM, 11/28 7 AM and 3 PM. Coming on Duty Nurse's Signature missing for: 8/1 11 PM, 8/2 11 PM, 8/19 7 AM, 8/22 11 PM, 8/23 11 PM, 8/24 7 AM, 8/25 11 PM, 8/26 11 PM, 8/29 3 and 11 PM, 8/31 11 PM, 9/1 11 PM, 9/4 11 PM, 9/5 11 PM, 9/6 3 and 11 PM, 9/7 11 PM, 9/8 11 PM, 9/9 3 and 11 PM, 9/10 11 PM, 9/11 11 PM, 9/12 11 PM, 9/13 11 PM,9/14 11 PM, 9/16 11 PM, 9/17 3 and 11 PM, 9/18 7 AM and 11 PM, 9/19 7 AM, 9/22 7 AM and 11 PM, 9/30 11 PM, 10/2 11 PM, 10/3 3 and 11 PM, 10/4 11 PM, 10/6	F 755	compliance with signing in/out for shift-to-shift count in the Narcotic Count Log. DON/designee will competency 2 nurses per week with licensed nurses related to process for documentation when administering controlled substances and will report monthly to QAPI.	

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11 PM, 10/7 4 PM, 10/12 11 PM, 10/13 11 PM, 10/14 11 PM, 10/16 7 AM, 10/19 11 PM, 10//20 11 PM, 10/22 3 PM, 10/24 3 and 11 PM, 10/25 11 PM, 10/26 11 PM, 10/27 7 AM, 10/28 11 PM, 10/30 7 AM and 11 PM, 10/31 11 PM, 11/1 11 PM, 11/2 11 PM, 11/4 11 PM, 11/5 7 AM and 11 PM, 11/7 11 PM, 11/8 11 PM, 11/9 11 PM, 11/10 11 PM, 11/11 11 PM, 11/12 11 PM, 11/13 7 AM, 11/14 11 PM, 11/15 11 PM, 11/16 11 PM, 11/17 11 PM, 11/18 7 AM and 11 PM, 11/19 7 AM 3 and 11 PM, 11/20 3 and 11 PM, 11/21 11 PM, 11/22 11 PM, 11/23 3 and 11 PM, 11/24 11 PM, 11/25 3 and 11 PM, 11/26 11 PM, 11/28 7 AM.

Time of Day section for: 10/5 and 10/6 7 AM, 3 PM, and 11 PM.

At this time, the surveyor interviewed the RNS, who acknowledged the missing documentation and confirmed that there should be no missing documentation or signatures, and that the incoming and outgoing nurses should be counting the narcotics at shift change and signing the log together to confirm the count.

The surveyor along with the RNS continued review of the logbook and the individual narcotic declining inventory logs. At this time the RNS indicated to the surveyor that she had administered [redacted] NJ Exec. Order 26:4.b.1 [redacted]) to Unsampled Resident #2 at 10:30 AM that day (11/29/23) and failed to sign the narcotic out on the declining inventory sheet. The RNS was able to show that she signed the medication out in the resident's electronic medication administration record (MAR) but did not sign it out in the narcotic log.

On 11/30/23 at 11:53 AM, the surveyor

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interviewed the Director of Nursing (DON) who stated that the shift change narcotic count log should be completed at the change of shift by two nurses and they should both sign for completion and verifying the narcotic count is correct and that there should be no missing signatures. The DON confirmed that if signatures are not documented, the facility cannot confirm if this was completed or not and could result in "inaccuracies" with narcotics. The DON further confirmed that nurses should be completing the declining inventory log for narcotics at the time the medication is dispensed from the pharmacy packaging and "should not wait and complete later on." The DON acknowledged these missing signatures "should not have been missed."

Review of the facility's "Controlled Substances" policy with revision date of 11/2022 included under the section labeled "Dispensing and Reconciling Controlled Substances," included: "1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. 2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: records of personnel access and usage, medication administration records, declining inventory records, and destruction, waste and return to pharmacy records. 3. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory. 4. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services."

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F 755	Continued From page 58 NJAC 8:39-29.7(c)	F 755		
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. §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 facility documentation, it was determined that the facility failed to a.) properly store medications and properly label opened multidose medications. This deficient practice was observed in 1 of 2 medication storage rooms and 3 of 3 medication carts reviewed for	F 761	1. No resident was affected by this deficient practice. Items that were found in the hickory Med Room, open tuberculin purified protein that was not dated, and the plastic bag containing 16 different items, were all discarded. All items from Hickory front medication cart that were	1/30/24

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F 761	Continued From page 59 medication storage and labeling and was evidenced by the following: On 11/29/23 at 10:42 AM, the surveyor, in the presence of the Licensed Practical Nurse Unit Manager #2 (LPN/UM #2) reviewed the [redacted] nursing unit's medication storage room. The surveyor observed an opened tuberculin purified protein (a medication used to test for tuberculosis) multidose vial with no opened date on the vial. The LPN/UM #2 acknowledged the vial and confirmed it should have been dated and initialed once opened. The surveyor further observed a small plastic storage bin with three drawers, a clear plastic bag containing 16 individually packaged, partially used/opened prescription medications which included eye drops, multidose insulin vials, and medicated nasal sprays. These medications were labeled and dated with opened date between 11/2022 and 1/2023. At this point the LPN/UM #2 informed the surveyor that she was not aware that these medications where still stored in the medication storage room, stating "I've been through this med room many times and never seen this bag before," and that these medications were no longer being given to their prescribed residents and should have been returned to the pharmacy once discontinued. On 11/29/23 at 11:10 AM, the surveyor in the presence of Licensed Practical Nurse #3 (LPN #3), observed the "front cart" for the [redacted] nursing unit. The following was observed: One opened and undated foil envelope of ipratropium bromide 0.5 milligrams (mg) and albuterol sulfate 3 mg inhalation solution (a	F 761	opened and not dated and /or labeled & loose pills were discarded. All items from Evergreen medication cart that were opened and not dated and /or labeled were discarded. All items from Cherry middle medication cart that were opened and not dated and/or labeled & loose pills were discarded. 2. All residents have the potential to be affected by this practice. DON/designee completed an audit of all medication rooms and medication carts to assure that all opened medications were labeled and dated and that there were no loose pills. Corrections were made as needed. 3. The DON/ADON re-educated all nurses Medical Storage and Labeling Policy. 4. The DON/designee audit medication rooms and medication carts weekly x 3 months. Results of the audits will be reviewed Monthly with QAPI.	

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medication used to treat respiratory disease) containing four of five single use vials with manufacturer instructions to use within one week of opening.
One opened and undated 414 milliliter (ml) bottle of sucralfate oral suspension 1 gram (g)/10 ml (medication used to treat ulcers).
One opened and undated bottle of fluticasone propionate 50 microgram (mcg) (allergy nasal spray).
Three opened and undated bottles of artificial tears
One opened and undated bottle of ciprofloxacin ophthalmic solution 0.3% (antibiotic eye drops)
One opened and undated bottle of bromide tartrate ophthalmic solution (eye drop medication used to treat glaucoma)
One opened and undated bottle of latanoprost ophthalmic solution (eye drop medication used to treat glaucoma)
One opened and undated bottle of dorzolamide HCL ophthalmic solution (eye drop medication used to treat glaucoma)
One opened and undated bottle of timolol maleate 0.5% (eye drop medication used to treat glaucoma)
One opened and undated bottle of Lumigan ophthalmic solution .01% (eye drop medication used to treat glaucoma)
10 loose pills of varying colors and sizes.

At 11:59 AM, LPN #3 acknowledged there should not be any loose pills in the medication cart drawer, and stated, "I didn't know the bottle should be dated and labeled too, since the box was."

On 11/29/23 at 12:14 PM, the surveyor in the presence of LPN #4, observed the [redacted]

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F 761	Continued From page 61	F 761		

nursing unit's medication cart. The following was observed:
One opened and undated vial of timolol maleate 0.25% eye drops.
One opened and undated bottle of dextromethorphan polistirex extended-release oral suspension (medication used to treat cough).
Two opened and undated Anoro 62.5 mcg / 25 mcg inhalers (medications used to treat lung disease)
One opened and undated fluticasone propionate and salmeterol inhalation powder inhaler (medications used to treat lung disease).
One opened and undated Trelegy 200 mcg / 62.5 / 25 mg inhaler (medications used to treat lung disease).
At this point, LPN #4 informed the surveyor that she had opened these inhalers earlier that morning and "did not get a chance to label them yet."

On 11/29/23 at 12:56 PM, in the presence of the Registered Nurse Supervisor (RNS), the surveyor observed the "middle cart" on the [redacted] nursing unit. The following was observed:
One opened and undated vial of latanoprost ophthalmic solution .005% (medication used to treat glaucoma).
One opened and undated vial of dorzolamide HCL and timolol maleate ophthalmic solution 22.3 mg/6.8 mg per ml
One opened and undated bottle of fluticasone propionate 50 mcg nasal spray
One opened and undated Incurse Ellipta 62.5 mcg inhaler (medication used to treat lung disease).
Eight loose pills of varying colors and sizes.

At this point the RNS acknowledged that these

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F 761	Continued From page 62 multidose medications should have been labeled and dated with the date opened. She further informed the surveyor that the facility "recently had an in-service for med labeling." On 11/30/23 at 11:53 AM, the surveyor interviewed the Director of Nursing (DON), who stated that medications no longer in use should be placed in a return to pharmacy bag and returned to the pharmacy, within a "reasonable" timeframe of 24 hours to be sent back. The DON included the 16 medications observed in the [redacted] unit medication room "should have been returned and not around still." The DON also stated that medications that are opened should be labeled and dated on the actual vial, bottle, or inhaler and not just the box it came in. Review of the facility's "Administering Medications" policy with revised date of 4/2019 included, "the expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container." Review of the facility's "Medication Labeling and Storage" policy with revised date of 2/2023 included, "the nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner." N.J.A.C. 8:39-29.4	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		1/30/24

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F 812	Continued From page 63 §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 other facility documentation, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 11/28/23 from 09:46 AM to 10:29 AM, the surveyor, accompanied by the facility Food Service Director (FSD), observed the following in the kitchen: Upon surveyor entrance into kitchen and during tour, the FSD was not wearing a beard guard. In the walk-in freezer, one box of riblets and one box of chicken tenders were open and the plastic bags inside the boxes were open, leaving the meat products open to air.	F 812	1. No resident was affected by this deficient practice. Chicken tender and items on the shelf with eggs were discarded. Employees #15 was immediately re-educated as it relates to hair nets or caps or beard restraints. Employee #15 donned appropriate equipment. 2. All residents have the potential to be affected by this practice. The Food Service Director and Regional Director of Food Service audited all food to ensure that the kitchen maintained sanitation in a safe and consistent manner. 3. The Food Service Director re-educated all staff regarding Food Receiving and Storage- Labeling and Dating, Sanitization and Employee Hygiene and Sanitary Practices. 4. The Food Service Director/designee	

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F 812	Continued From page 64 On the shelves by the pot sink, a stack of stainless-steel pans (for use in the steam table) were noted with wet nesting. On 12/05/23 at 01:14 PM, the surveyor interviewed the FSD in the presence of the Regional FSD, who stated that all staff should wear hair nets and beard guards while in the kitchen, plastic bags inside boxes in the freezer should be sealed to prevent freezer burn, and pots and pans should be air dried before being stored. A review of the policy "Food Receiving and Storage" revised November 2022, under the section "Refrigerated/Frozen Storage" included: "#8. Frozen foods are maintained at a temperature to keep the frozen food solid. Wrappers of frozen foods must stay intact until thawing." A review of the policy "Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices", revised November 2022, under the section "Hair Nets": "#15. Hair nets or caps and/or beard restraints are worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens." A review of the policy "Sanitation" revised November 2022, "#7. Food preparation equipment and utensils that are manually washed are allowed to air dry whenever practical." N.J.A.C. 8:39-17.2(g)	F 812	will audit daily x5 and weekly x4 and monthly x3 to ensure compliance with food procurement, store/prepare/serve - Sanity and will report monthly to QAPI.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		1/30/24

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F 880	Continued From page 65 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (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		

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F 880	Continued From page 66 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of medical records and other facility documentation, it was determined that the facility failed to maintain proper infection control practices during the a) Medication administration observation and b) Dining observation. This deficient practice was identified on 1 of 3 nursing units ([redacted]) and for 1 of 3 nurses (LPN #5) observed during the medication pass. This deficient practice was evidenced by the	F 880	1. Residents #99 & #1 were affected by this deficient practice. LPN#5 was immediately re-educated, and a Hand Hygiene and Medication Administration competency (including cleaning of equipment) was successfully completed. 2. All residents have the potential to be affected by this practice. ADON completed an audit of all medication and treatment carts. Bleach wipes were present in all other carts.	

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F 880	Continued From page 67 following: 1. On 12/01/23 at 8:16 AM, the surveyor observed Licensed Practical Nurse (LPN #5) as he prepared and administered medications on the [redacted] LPN #5 first obtained a treatment cart from the other end of the hall and placed it beside the medication cart and stated that he intended to use it for additional work space. LPN #5 then opened the locked medication cart with keys, donned (put on) a pair of gloves, and obtained a container of alcohol based disinfectant wipes which he used to clean the top of the treatment cart. LPN #5 then doffed (removed) his gloves and failed to perform hand hygiene with the Alcohol Based Hand Rub (ABHR) that was present on the top of the medication cart before he entered Resident #99's room to assess the resident's [redacted]. LPN #5 then returned to the medication cart and opened the top drawer of the medication cart and obtained a [redacted] and a [redacted] LPN #5 stated that the [redacted] was not dedicated to Resident #99 and was used to obtain [redacted] for multiple residents on the unit. LPN #5 then doffed his gloves and failed to perform hand hygiene after. LPN #5 placed the [redacted] in a plastic cup and carried it into Resident #99's room. LPN #5 then donned gloves, cleaned the resident's [redacted] and the resident's [redacted] and [redacted] onto the [redacted] that was [redacted] in the [redacted].	F 880	3. The DON/ADON re-educated nurses and CNAs about handwashing /Hand Hygiene with medication administration and appropriate times during meal delivery. All nurses were re-educated on cleaning of glucometer. 4. The DON/designee will audit handwashing with medication administration, meal delivery, and glucometer cleaning weekly x 3 months and will report results monthly to QAPI.	

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When finished, he placed the [NJ Exec Order 26.4b1] with the NJ Exec Order 26.4b1 into the plastic cup where he had previously discarded the used [NJ Exec Orde]. LPN #5 then proceed to reach into his pocket and obtained a NJ Exec Order 26.4b1 and placed it on the resident's NJ Exec Order 26.4b1. LPN #5 then proceeded to place a NJ Exec Order 26.4b1 on the resident's [NJ Exec Order 26.4b] and obtained a reading. LPN #5 removed the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 from the resident and documented the results on a piece of paper. LPN #5 then picked up the plastic cup that contained the NJ Exec Order 26.4b1 with [NJ Exec], and [NJ Exec Orde] and returned to the medication cart where he discarded the [NJ Exec Orde] and [NJ Exec Order 26.] into the sharps container that was on the side of the medication cart. LPN #5 then doffed his gloves, and failed to perform hand hygiene, and donned gloves before he obtained the keys to the medication cart and accessed the medication cart to obtain alcohol based disinfectant wipes and proceeded to wipe the NJ Exec Order 26.4b1 with disinfectant wipes and left the items on top of the treatment cart to dry after. LPN #5 stated that the dry time was one minute to ensure that the [NJ Exec Order 26.4b1] was disinfected. LPN #5 then proceeded to doff his gloves and washed his hands for 20 seconds.

At 8:31 AM, LPN #5 returned to the medication cart and began to prepare medications for Resident #99 which included a NJ Exec Order 26.4b1 LPN #5 obtained a black marker to sign and date the time of administration of the NJ Exec Order 26.4b1. He dropped the marker on the floor. LPN #5 then proceeded to donn gloves and picked the marker

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up off of the floor and cleaned it with a disinfectant wipe. LPN #5 then doffed his gloves and failed to perform hand hygiene afterward before he picked up the medication cup filled with NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 one NJ Exec. Order 26:4.b.1 NJ Exec Order 26.4b1 and entered Resident #99's room.

At 8:45 AM, LPN #5 administered oral medications to Resident #99. LPN #5 then proceeded to administer NJ Exec Order 26.4b1, NJ Exec. Order 26 in each of the resident's NJ Exec Order 26.4b1 without first donning gloves. When finished, LPN #5 donned gloves and administered NJ Exec Order 26.4b1 to the resident and instilled NJ Exec Order 26.4b1 as ordered. LPN #5 provided the resident with a tissue to wipe away any NJ Exec Order 26.4b1 . LPN #5 then dated the NJ Exec Order 26.4b1, pulled up the resident's shirt and placed it on the resident's NJ Exec. Order 26 ordered. LPN #5 then placed NJ Exec Order 26.4b1 LPN #5 doffed his gloves after and failed to perform hand hygiene. LPN #5 picked up the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and returned to the medication cart, unlocked the medication cart with keys and returned the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 to the top drawer of the medication cart. LPN #5 then used the computer keyboard and mouse to chart the medications as administered without first performing hand hygiene. LPN #5 then proceeded to return the NJ Exec Order 26.4b1 that had dried to the medication cart.

At 8:56 AM, LPN #5 moved both the medication and treatment carts to the outside of Unsampled

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Resident #1's room. LPN #5 entered the resident's room and assessed the resident's [redacted]. LPN #5 then proceeded to obtain the resident's [redacted] without first performing hand hygiene. When finished, he donned gloves and cleaned the [redacted] and [redacted] with a disinfectant wipe. LPN #5 then doffed his gloves and washed his hands for 21 seconds before he began to prepare the resident's medications. During medication preparation, LPN #5 stated that he needed to phone the doctor to clarify a medication order. He then proceeded to use his cell phone and attempted to both text and call the doctor. LPN #5 then continued to prepare the resident's medications without first performing hand hygiene after using his cell phone. LPN #5 then entered Unsampled Resident #1's room where he administered oral medications and an [redacted] to the resident. LPN #5 returned the [redacted] to the box that it was stored in. LPN #5 then proceeded to move the resident's blanket at the resident's request and placed both gloved hands on the resident's bed. LPN #5 then doffed his gloves and used ABHR afterward before he returned to the medication cart to document the medications as administered.

ON 12/01/23 at 10:53 AM, in a later interview with LPN #5, he stated that he was not required to perform hand hygiene if he only intended to pop medications from their bingo cards (blister packs) into the medication cup. LPN #5 stated that he did not really need to donn gloves when he administered [redacted] as he did not feel their was a risk for spread of infection as there was no contact with the [redacted] or the resident's [redacted]. LPN #5 stated that he was required to wash his

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hands after he doffed his gloves and after cleaning the NJ Exec Order 26.4b1 because he intended to pop someone's medications from the bingo cards for infection control purposes. LPN #5 further stated that hand hygiene should have been done both before he donned gloves and after he doffed gloves. LPN #5 further stated that he should have washed his hands, but thought that he was okay because he washed his hands after he left Resident #99's room.

On 12/01/23 at 11:11 AM, the surveyor interviewed Registered Nurse/Unit Manager (RN/UM #1) who stated that nursing was required to wipe the NJ Exec Order 26.4b1 and allow to dry for one minute between residents to disinfect. RN/UM #1 stated that any time that nursing doffed their gloves hand hygiene should be performed for infection control purposes. RN/UM #1 stated that gloves were required to be worn for NJ Exec Order 26.4b1 administration for infection control. RN/UM #1 stated that nursing should wash their hands after NJ Exec Order 26.4b1 was administered prior to NJ Exec Order 26.4b1 for infection control. RN/UM #1 stated that if LPN #5 failed to wash his hands before he prepared medications he could have potentially contaminated the medications. RN/UM #1 stated that hand hygiene was required to be performed after a NJ Exec Order 26.4b1 was obtained for infection control reasons.

On 12/01/23 at 11:26 AM, the surveyor interviewed the Infection Preventionist/Registered Nurse (IP/RN) who stated that she expected that nursing should wash their hands after they cleaned equipment and before they entered a resident's room because there was always bacteria on the surfaces that could be

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transmitted. IP/RN stated that you could spread germs if hands were not cleaned after gloves were doffed. IP/RN stated that a full minute of contact time was required to kill germs when the NJ Exec Order 26.4b1 were cleaned and two minutes of dry time was required. IP/RN stated that if the proper cleaning time and dry time were not performed we may not kill germs on the surface. IP/RN stated that in order to protect yourself and the patient when NJ Exec Order 26.4b1 was administered gloves should be worn. IP/RN further stated that nursing was required to wash their hands after NJ Exec Order 26.4b1 was administered prior to donning gloves and administering eye drops to prevent the possibility of cross-contamination. IP/RN stated that hand hygiene should be performed after you touched dirty equipment and supplies and gloves were required to be donned prior to resident contact. IP/RN stated that you were required to wash your hands after gloves were doffed when in contact with the resident's covers or bed because there could be bacteria on those items. IP/RN further stated that if hand hygiene were not performed after resident contact prior to documenting medication administration in the computer you could contaminate the computer keyboard and spread things to someone else. The surveyor requested the name of the disinfectant wipes that were required to be used to disinfect the NJ Exec Order 26.4b1

On 12/01/23 at 1:19 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that the disinfectant wipes that were on the middle cart that was observed during the medication pass that was used to clean the NJ Exec. Order 26:4.b.1 was not the correct wipe to disinfect the NJ Exec Order 26.4b1 machine. LNHA stated

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that an in-service was completed previously, with the correct wipes to be used that were identified as appropriate for use in the [NJ Exec Order 26.4b1] procedural manual. LNHA stated that she was not a clinician and was unable to state what possible harm could result if the incorrect wipes were used to clean the [NJ Exec Order 26.4b1] and deferred to nursing for further clarification.

On 12/01/23 at 1:27 PM, in a later interview with the IP/RN, she stated that she identified that bleach wipes were supposed to be used to clean the [NJ Exec Order 26.4b1] in accordance with the [NJ Exec Order 26.4b1] procedural manual. IP/RN stated that if the alcohol based wipes were used to clean the [NJ Exec Order 26.4b1] they may not kill germs effectively.

On 12/01/23 at 1:45 PM, the LNHA provided the surveyor with documentation which indicated that educational in-services were conducted with staff on how to clean the [NJ Exec Order 26.4b1] with bleach wipes on 1/05/23, 1/06/23, 03/25/23, and 05/18/23. Review of the in-service records revealed that LPN #5 attended the aforementioned in-services on [NJ Exec. Order 26.4] , and [NJ Exec. Order 26.4] ,

On 12/05/23 at 1:08 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that staff should wash their hands after gloves were doffed because they were touching things and spreading germs from place to place. ADON stated that gloves should be worn when [NJ Exec Order 26.4b1] was administered. ADON further stated that hands should be washed before gloves were donned and [NJ Exec Order 26.4b1] were administered because you do not know what you have touched. ADON stated that if something were dropped on the floor, clean it, doff your gloves and wash your hands. ADON stated that

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NJ Exec Order 26.4b1 were required to be cleaned with bleach wipes and not alcohol wipes because they would not clean it and germs could be spread. ADON stated that hand hygiene should have been performed after the medication cart was handled and before entering a resident's room to obtain vital signs because the medication cart was not clean.

2. On 11/30/2023 at 12:32 PM during lunch time on the NJ Exec Order 26.4b1, Surveyor #2 observed a Certified Nurse Assistant (CNA #1) delivering food tray to a resident in room NJ Exec Order CNA #1 did not perform hand hygiene upon entering the room. CNA #1 placed the tray on the overbed table, assisted the resident to a sitting position, and exited the room. CNA #1 did not perform hand hygiene upon leaving the room. CNA #1 proceeded to a food truck parked in the hallway, removed another food tray, and delivered it to the resident in room NJ Exec Orde No hand hygiene was observed.

On 11/30/2023 at 12:34 PM, a Certified Nurse Assistant (CNA #2) entered NJ Exec Order 26.4b to deliver a food tray. CNA #2 did not perform hand hygiene upon entering and leaving the room.

On 11/30/2023 at 12:35 PM while still in room 122 B, CNA #1 asked CNA #2 to help him/her NJ Exec Order 26.4b1 resident in NJ Exec Order CNA #2 entered the room, and together with CNA #1 NJ Exec Order 26.4b1 CNA #1 and CNA #2 were observed in contact with resident's bed, bedsheets, and overbed table.

On 11/30/2023 at 12:36 PM, CNA #2 exited room

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NJ Exec Order No hand hygiene was observed at that time. CNA #2 proceeded to push the food truck down the hallway, removed a food tray and delivered it to another room. No hand hygiene was observed upon entering the room.

On 11/30/2023 at 12:37 PM after NJ Exec Order 26.4b1 the resident and assembling food tray in room NJ Exec Order CNA #1 left the room without performing hand hygiene.

On 11/30/2023 at 12:48 PM during an interview with Surveyor #2, CNA #2 stated, "Every time after we go in, or leave the room" when asked about hand hygiene expectations. During the same interview, CNA #2 replied, "Yes" when asked if hand hygiene should be performed during food tray delivery and when assisting residents.

On 11/30/2023 at 12:41 PM during interview with Surveyor #2, a Licensed Practical Nurse (LPN #1) stated, "We wash hands frequently. It depends on what we do. If we provide care like changing patient, we wash our hands with soap and water. If we're just readjusting things, we should use sanitizer" when asked about hand hygiene expectations.

On 12/05/2023 at 12:17 PM during an interview with Surveyor #2, a Registered Nurse/Unit Manager (RN/UM #1) stated, "I wash for 25 seconds during any interaction with patient. I wash before I go to do care, after touching patients or surfaces near patients" when asked about hand hygiene protocol. During the same interview, RN/UM #1 replied, "Yes, before and after" when Surveyor #2 asked if a CNA should perform hand hygiene when delivering food to

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residents' rooms. Furthermore, RN/UM #1 stated, "Infection control. To prevent spread of infections" when asked by the Surveyor #2 about importance of hand hygiene.

On 12/05/2023 at 11:41 AM during an interview with Surveyor #2, Registered Nurse/Infection Preventionist (RN/IP) stated, "Before we go to any patient room, we want to wash hands. Any time you enter patient's room, before and during wound care, peri care, medication administration depending on medication for example liquids. Of course, when they have to give eye drops or when they carry anything soiled. I expect them to wash their hands before leaving the room. I tell them to wash in and wash out" when asked about staff hand hygiene expectations. During the same interview, the RN/IP stated, "Absolutely. They [employees] should wash their hands or use sanitizer when they deliver food trays" when Surveyor #2 asked if hand hygiene should be exercised during meal delivery. Furthermore, the RN/IP replied, "To prevent the spread of infections from resident to resident, and employee to employee" when asked by Surveyor #2 about importance of hand hygiene.

3. On 11/29/23 at 12:13 PM, the surveyor observed a Certified Nursing Assistant #4 (CNA#4) handing out trays on the low side of the [NJ Exec Order 26.4b1]. CNA#4 entered room [NJ Exec Orde], rearranged items on the residents' overbed table, and placed the resident's tray down. CNA#4 then exited the room, went to the enclosed lunch tray cart, and proceeded to get the tray for room [NJ Exec. Orde]. CNA#4 then entered room [NJ Exec Orde], set up the tray for the resident, exited the room, and proceeded to the cart with the lunch trays to get

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the tray for room [NJ Exec Orde]. CNA#4 then set up the lunch tray for the resident in room [NJ Exec Orde] and exited room. CNA#4 then entered room [NJ Exec Order] pulled back the privacy curtain and proceeded to set up the lunch tray for the resident. CNA#4 did not wash hands or use hand sanitizer between the rooms.

On 11/30/23 at 12:06 PM, the surveyor observed lunch being handed out on the [NJ Exec Order 26.4b1]. The surveyor observed CNA#4 place a tray in room [NJ Exec. Order] open utensils, and remove a drink lid. CNA#4 proceeded to go back to cart and get a tray for [NJ Exec Orde] and set up the tray for the resident. CNA#4 then moved the tray cart to the next room, set up room [NJ Exec Orde] and get the tray for [NJ Exec Orde] The surveyor did not observe any handwashing between residents.

On 11/30/23 at 12:24 PM, the surveyor observed CNA#5 passing a lunch tray to room [NJ Exec]. The resident in room [NJ Exec] was on [NJ Exec Order 26.4b1]. CNA#5 applied a gown and gloves prior to entering the room to give the resident the tray. The CNA#5 exited the room, prior to exiting the CNA #5 removed the gown and gloves. The surveyor did not observe any handwashing or use of hand sanitizer. The CNA then walked to room [NJ Exec], which was across the hall. The resident was also on [NJ Exec Order 26.4b1]. CNA #5 applied a gown and gloves prior to entering the room with the tray. CNA#5 set the tray down, offered to put up the resident to get more comfortable to have lunch. She then offered to [NJ Exec Order 26.4b1] and proceeded to touch the residents bed rails, and then the food ticket on the tray. After exiting the room CNA #5 used hand sanitizer and went to another room with a tray.

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A review of the facility provided policy adopted in August 2021 and titled "Handwashing/Hand Hygiene" revealed that "2. All personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infections to other personnel, residents, and visitors." Furthermore, the same policy revealed, "6. Use of an alcohol-based hand rub containing at least 60% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations ... l) after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; m) after removing gloves... o) before and after eating or handling food; p) before and after assisting a resident with meals."

A review of the facility provided policy, "Handwashing/Hand Hygiene" (Revised August 2019) revealed the following:
This facility considers hand hygiene the primary means to prevent the spread of infections.
...Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:
Before and after coming on duty; Before and after direct contact with residents; Before preparing and handling medications;...Before moving from a contaminated body site to a clean body site during resident care; After contact with a resident's intact skin; After contact with blood or bodily fluids;...After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; After removing gloves; Hand hygiene is the final step after removing and disposing of personal protective equipment. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as

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the best practice for preventing healthcare-associated infections. Single-use disposable gloves should be used: before aseptic procedures; when anticipating contact with blood or body fluids;

A review of the facility provided policy, "Administering Medications" (Revised April 2019) revealed the following:
Medications are administered in a safe and timely manner, and as prescribed.
...Staff follows established facility infection control procedures (e.g., handwashing, aseptic technique, gloves,...etc.) for the administration of medications, as applicable.

A review of the facility provided policy, "Blood Glucose Meter Cleaning, Disinfecting, and Storage (Revised October 2019) revealed the following:
Blood Glucose Meters must be appropriately cleaned and disinfected between uses.
...Each medication cart will have a container of appropriate wipes for cleaning and disinfecting. After use, the blood glucose meter must be cleaned and disinfected per manufacturer guidelines. While one blood glucose meter is drying, the other can be in use. Appropriate wipes are indicated in the manufacturer guidelines.

N.J.A.C. 3:39-19.4(n)

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S 000	Initial Comments NJ Complaint #-160250, NJ00163433, NJ00166442 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: Complaint # NJ00163433, NJ00166442 Based on observation, interview, and review of pertinent facility documentation it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey	S 560	5. No residents were affected by not meeting the State of New Jersey minimum staffing requirements. 6. All residents could have the potential to be affected by this area of concern. 7. Recruitment efforts continue to include: a. Daily Staffing meetings / Weekly Labor Management Meetings b. Mentor program to support and retain staff. c. Culture Committee to promote and improve staff morale. d. Recruitment Bonuses, Sign On	1/30/24

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

Electronically Signed | 01/12/24

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S 560	Continued From page 1 Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. The facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -11/12/23 had 13 CNAs for 124 residents on the day shift, required at least 15 CNAs. -11/13/23 had 13 CNAs for 124 residents on the day shift, required at least 15 CNAs. -11/14/23 had 14 CNAs for 124 residents on the day shift, required at least 15 CNAs. -11/15/23 had 12 CNAs for 123 residents on the day shift, required at least 15 CNAs. -11/16/23 had 12 CNAs for 123 residents on the day shift, required at least 15 CNAs. -11/17/23 had 11 CNAs for 123 residents on the day shift, required at least 15 CNAs. -11/18/23 had 12 CNAs for 123 residents on the day shift, required at least 15 CNAs. -11/19/23 had 13 CNAs for 123 residents	S 560	Bonuses and Vacant Shift Bonuses offered e. Ongoing job fairs onsite f. Flexible orientation programs g. Prize raffles for staff picking up extra shifts. h. Daily interviews being conducted with any walk ins 8. Scheduling Coordinator will audit schedule weekly to monitor compliance with minimum staffing requirements. Scheduling Coordinator will report monthly to QAPI to identify trends and identify additional areas of opportunity.	

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S 560	Continued From page 2 on the day shift, required at least 15 CNAs. -11/20/23 had 12 CNAs for 123 residents on the day shift, required at least 15 CNAs. -11/21/23 had 13 CNAs for 123 residents on the day shift, required a t least 15 CNAs. -11/22/23 had 12 CNAs for 123 residents on the day shift, required at least 15 CNAs. -11/24/23 had 13 CNAs for 120 residents on the day shift, required at least 15 CNAs. -11/25/23 had 12 CNAs for 119 residents on the day shift, required at least 15 CNAs. 2.For the week of Complaint staffing from11/06/2022 to 11/12/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -11/06/22 had 13 CNAs for 124 residents on the day shift, required at least 15 CNAs. -11/07/22 had 14 CNAs for 123 residents on the day shift, required at least 15 CNAs. -11/08/22 had 13 CNAs for 123 residents on the day shift, required at least 15 CNAs. -11/09/22 had 12 CNAs for 123 residents on the day shift, required at least 15 CNAs. -11/10/22 had 13 CNAs for 123 residents on the day shift, required at least 15 CNAs. -11/11/22 had 13 CNAs for 123 residents on the day shift, required at least 15 CNAs. -11/12/22 had 11 CNAs for 123 residents on the day shift, required at least 15 CNAs. 3. For the week of Complaint staffing from 01/08/2023 to 01/14/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -01/08/23 had 9 CNAs for 120 residents on the day shift, required at least 15 CNAs.	S 560		

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S 560	Continued From page 3 -01/09/23 had 11 CNAs for 120 residents on the day shift, required at least 15 CNAs. -01/10/23 had 9 CNAs for 119 residents on the day shift, required at least 15 CNAs. -01/11/23 had 11 CNAs for 119 residents on the day shift, required at least 15 CNAs. -01/12/23 had 10 CNAs for 119 residents on the day shift, required at least 15 CNAs. -01/13/23 had 11 CNAs for 119 residents on the day shift, required at least 15 CNAs. -01/14/23 had 10 CNAs for 121 residents on the day shift, required at least 15 CNAs. 4. For the week of Complaint staffing from 04/09/2023 to 04/15/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 1 of 14 evening shifts as follows: -04/09/23 had 10 CNAs for 127 residents on the day shift, required at least 16 CNAs. -04/10/23 had 12 CNAs for 125 residents on the day shift, required at least 16 CNAs. -04/11/23 had 11 CNAs for 125 residents on the day shift, required at least 16 CNAs. -04/12/23 had 12 CNAs for 125 residents on the day shift, required at least 16 CNAs. -04/13/23 had 12 CNAs for 125 residents on the day shift, required at least 16 CNAs. -04/14/23 had 11 CNAs for 126 residents on the day shift, required at least 16 CNAs. -04/15/23 had 8 CNAs for 125 residents on the day shift, required at least 16 CNAs. -04/15/23 had 11 total staff for 125 residents on the evening shift, required at least 10 total staff. 5. For the 2 weeks of Complaint staffing from 07/02/2023 to 07/15/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:	S 560		

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BERLIN REHABILITATION AND HEALTHCARE CENTE	100 LONG-A-COMING LANE BERLIN, NJ 08009

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S 560	Continued From page 4 -07/02/23 had 9 CNAs for 121 residents on the day shift, required at least 15 CNAs. -07/03/23 had 9 CNAs for 121 residents on the day shift, required at least 15 CNAs. -07/04/23 had 10 CNAs for 121 residents on the day shift, required at least 15 CNAs. -07/05/23 had 12 CNAs for 121 residents on the day shift, required at least 15 CNAs. -07/06/23 had 12 CNAs for 121 residents on the day shift, required at least 15 CNAs. -07/07/23 had 13 CNAs for 117 residents on the day shift, required at least 15 CNAs. -07/08/23 had 14 CNAs for 117 residents on the day shift, required at least 15 CNAs. -07/09/23 had 9 CNAs for 116 residents on the day shift, required at least 14 CNAs. -07/10/23 had 11 CNAs for 112 residents on the day shift, required at least 14 CNAs. -07/11/23 had 10 CNAs for 112 residents on the day shift, required at least 14 CNAs. -07/12/23 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -07/13/23 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -07/14/23 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -07/15/23 had 8 CNAs for 110 residents on the day shift, required at least 14 CNAs. On 12/06/23 at 10:48 AM, the surveyor interviewed the Staffing Coordinator (SC). The surveyor asked the SC if she was familiar with the regulations regarding staffing, and she replied, "Every time I ask it changes and is something different." The surveyor asked how scheduling for the Certified Nursing Assistants (CNA) was completed and she said, "Every six weeks".	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	156001	A. BUILDING: _____ B. WING _____	C 12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN REHABILITATION AND HEALTHCARE CENTE	100 LONG-A-COMING LANE BERLIN, NJ 08009

(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
S 560	Continued From page 5 The surveyor then asked how she would know there were enough CNA on each day, and she responded, "I call at 04:30 AM to see if anyone called out for that day. If staffing is less, I get on the computer and begin calling people. I keep list of people of people available to work for call outs". The surveyor then asked the SC that if she was not aware of the ratios how would she know that the facility had enough staff and she said, "The numbers are on our schedule". She then told the surveyor that June and July of 2023 were "tough". On 12/06/23 at 11:20 AM, the surveyor requested a staffing policy from the Licensed Nursing Home Administrator (LNHA). The LNHA could only provide a policy for Assisted Living Facilities, not Long-Term Care Facilities.	S 560		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees.	S1405		1/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	156001	A. BUILDING: _____ B. WING _____	C 12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN REHABILITATION AND HEALTHCARE CENTE	100 LONG-A-COMING LANE BERLIN, NJ 08009

(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
S1405	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and review of newly hired employee files it was determined that the facility failed to ensure that newly hired employees completed a health history or received an examination by a Physician, an Advanced Practice Nurse, or a licensed Physician Assistant within two weeks prior to employment or upon employment. This deficient practice was identified for 7 of 10 newly hired employees reviewed and was evidenced by the following: On 12/04/23 at 09:00 AM the surveyor reviewed 10 employee files of employees hired since the last recertification survey date of 09/03/21. Employee #1, a Licensed Practical Nurse with a date of hire of [NJ Exec Order 26.4b] did not have an employee health examination in the file. Employee #2, a Registered Nurse with a date of hire of [NJ Exec Order 26.4b] did not have an employee health examination in the file. Employee #3, a Certified Nursing Assistant with a date of hire of [NJ Exec Order 26.4] did not have an employee health examination in the file. Employee #4, a Registered Nurse with a date of hire of [NJ Exec Order 26.4b] did not have an employee health examination in the file. Employee #5, a Licensed Practical Nurse with a date of hire of [NJ Exec Order 26.4b] did not have an employee	S1405	1. Employees identified during survey not in compliance with tuberculosis screening received screening. 2. All employees have the potential to be affected by this practice. Infection Preventionist completed an audit of all employees medical files for compliance with tuberculosis screening. 3. The infection preventionist was re-educated on the health record process related to new hires for tuberculosis completion. 4. The infection preventionist/designee will complete audit for all new hires bi-weekly x 3 months for tuberculosis screening to ensure compliance upon hire and will report monthly to QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	156001	A. BUILDING: _____ B. WING _____	C 12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN REHABILITATION AND HEALTHCARE CENTE	100 LONG-A-COMING LANE BERLIN, NJ 08009

(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
S1405	Continued From page 7 health examination in the file. Employee #6, the Assistant Director of Nursing with a date of hire of [NJ Exec Order 26.7] did not have an employee health examination in the file. Employee #7, a Registered Nurse with a date of hire of [NJ Exec Order 26.4b] did not have an employee health examination in the file. On 12/05/23 at 12:51 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) regarding physicals. The LNHA told the surveyor "I'm going to be honest with you, these people were hired in [NJ Exec Orde] and I don't have them". On 12/08/23 at 11:39 AM, the surveyor reviewed the policy titled, "Employee Health Records", an undated policy. The policy statement revealed that health records will be maintained for all employees. Under number one, letter I indicated that a copy of examinations, medical testing and follow up procedures related to employee health will be in the files and employee health records will be maintained for the length of the employee's employment.	S1405		
S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux	S1410		1/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	156001	A. BUILDING: _____ B. WING _____	C 12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN REHABILITATION AND HEALTHCARE CENTE	100 LONG-A-COMING LANE BERLIN, NJ 08009

(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
S1410	Continued From page 8 skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation it was determined that the facility failed to administer two step tuberculin (TB) skin tests (a test to detect past or present tuberculosis infection) on newly hired employees. This deficient practice was identified in 3 of 10 employees reviewed and was evidence by the following: On 12/04/23 at 09:35 AM, the surveyor reviewed ten health files of employees hired since the last recertification survey on 09/03/21. Review of the files identified three employees that did not have TB tests completed. Employee #1 with a date of hire of [redacted], Employee #2 with a date of hire of [redacted] and Employee #3 with a date of hire of [redacted] On 12/05/23 at 12:51 PM, the surveyor met with Licensed Nursing Home Administrator (LNHA)	S1410	1. Employees identified during survey not in compliance with health physicals received their physicals. 2. All employees have the potential to be affected by this practice. Infection Preventionist completed an audit of all employees medical files for compliance with health physical screening. 3. The infection preventionist was re-educated on the health record process related to new hires for health physical screening. 4. The infection preventionist/designee will complete audit for all new hires bi-weekly x 3 months for health physical screening to ensure compliance for all new hires and will report monthly to QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	156001	A. BUILDING: _____ B. WING _____	C 12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN REHABILITATION AND HEALTHCARE CENTE	100 LONG-A-COMING LANE BERLIN, NJ 08009

(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
S1410	Continued From page 9 regarding TB testing. The LNHA told the surveyor "I'm going to be honest with you, these people were hired in [redacted] and I don't have them". On 12/08/23 at 12:19 PM, the surveyor reviewed the policy titled, "Employee Screening for Tuberculosis" an undated policy. The policy statement revealed that all employees are screened for latent tuberculosis and active tuberculosis disease using TB skin test or interferon gamma release assay (blood test) and symptom screening prior to beginning employment.	S1410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315461	A. BUILDING _____ B. WING _____	R-C 02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN REHABILITATION AND HEALTHCARE CENTER	**100 LONG-A-COMING LANE BERLIN, NJ 08009**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS Based on onsite revisit on 2/8/2024, the facilty's POC was verified.	{F 000}		

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

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.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315461		2/8/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN REHABILITATION AND HEALTHCARE CENTER	100 LONG-A-COMING LANE BERLIN, NJ 08009

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 F0677 Reg. # 483.24(a)(2) LSC	Correction Completed 01/30/2024	ID Prefix F0686 Reg. # 483.25(b)(1)(i)(ii) LSC	Correction Completed 01/30/2024	ID Prefix F0697 Reg. # 483.25(k) LSC	Correction Completed 01/30/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
12/11/2023	

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
315461 Y1	A. Building B. Wing Y2	2/8/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN REHABILITATION AND HEALTHCARE CENTER	100 LONG-A-COMING LANE BERLIN, NJ 08009

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0640	Correction	ID Prefix F0677	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.24(a)(2)	Completed
LSC	01/30/2024	LSC	01/30/2024	LSC	01/30/2024
ID Prefix F0686	Correction	ID Prefix F0697	Correction	ID Prefix F0725	Correction
Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.25(k)	Completed	Reg. # 483.35(a)(1)(2)	Completed
LSC	01/30/2024	LSC	01/30/2024	LSC	01/30/2024
ID Prefix F0755	Correction	ID Prefix F0761	Correction	ID Prefix F0812	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	01/30/2024	LSC	01/30/2024	LSC	01/30/2024
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/30/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/11/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
156001 Y1	A. Building B. Wing Y2	2/8/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN REHABILITATION AND HEALTHCARE CENTER	100 LONG-A-COMING LANE BERLIN, NJ 08009

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 01/30/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 12/11/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
156001		2/8/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN REHABILITATION AND HEALTHCARE CENTER	100 LONG-A-COMING LANE BERLIN, NJ 08009

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 01/30/2024	ID Prefix S1405 Reg. # 8:39-19.5(a) LSC	Correction Completed 01/30/2024	ID Prefix S1410 Reg. # 8:39-19.5(b)(1) LSC	Correction Completed 01/30/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 12/11/2023	☐ 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
	315461	A. BUILDING **01** B. WING _____	**12/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN REHABILITATION AND HEALTHCARE CENTER	**100 LONG-A-COMING LANE** **BERLIN, NJ 08009**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 12/11/23. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/11/23 was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Berlin Rehabilitation and Healthcare Center is a two-story building that was built in 1999, It is composed of Type I protected construction. The facility is divided into ten - smoke zones. The generator does approximately 100 % of the building as per the Maintenance Director. The current occupied beds are 118 of 126.	K 000		
K 347 SS=E	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	K 347	1. No residents were cited as being	1/30/24

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

Electronically Signed | 01/12/2024

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
	315461	A. BUILDING **01** B. WING _____	**12/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN REHABILITATION AND HEALTHCARE CENTER	**100 LONG-A-COMING LANE** **BERLIN, NJ 08009**

(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 347	Continued From page 1 failed to ensure smoke detection was installed in rooms open to the corridor in accordance with NFPA 101 Life Safety Code (2012 edition) section 19.3.6.1. This deficient practice had the potential to affect 28 residents who resided at the facility. Findings include: An observation on 12/11/23 at 2:20 PM revealed no smoke detectors were located in the lounge T2039 next to the nurse's station that was open to the corridor. During an interview at the time of the observation, the Maintenance Director confirmed the smoke detectors were not installed in the resident lounge. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 347	directly affected by not having a smoke detector in lounge T2039. 2. All residents on that unit (28) have the potential to be affected by this practice. 3. A smoke detector was placed in the lounge T2039 next to the nurses station that was open to the corridor and was verified as functioning by contracting installation sprinkler company. (PO uploaded as well a photograph of installed sprinkler head) 4. Maintenance Director will submit quarterly monitoring of fire alarm system and will report any changes to smoke detector compliance to QAPI quarterly.	
K 379 SS=F	Smoke Barrier Door Glazing CFR(s): NFPA 101 Smoke Barrier Door Glazing 2012 EXISTING Openings in smoke barrier doors shall be fire-rated glazing or wired glass panels in steel frames. 19.3.7.6, 19.3.7.6.2, 8.5 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure smoke barrier doors were equipped with fire rated glazing or wired glass in accordance with NFPA 101 Life Safety Code (2012 edition) section 19.3.7.6. This deficient practice had the potential to affect all 118 residents who resided on the second floor at the	K 379	1. No residents were affected by this practice. 2. All residents have the potential to be affected by this practice. 3. All smoke barrier doors were audited by testing laboratory and confirmed that all doors met the required door rating of	1/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315461	A. BUILDING **01** B. WING _____	**12/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN REHABILITATION AND HEALTHCARE CENTER	**100 LONG-A-COMING LANE** **BERLIN, NJ 08009**

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K 379	Continued From page 2 facility. Findings include: Observations on 12/11/23 at 12:00 PM to 3:00 PM revealed that four of 18-smoke barrier doors were equipped with regular glass and not fire rated glazing which shall be marked with D-20 or D-W 20 or be equipped with wired glass. During an interview at the time of the observation, the Maintenance Director confirmed the smoke barrier doors were not equipped with fire rated glass or wired glass. NJAC 8:39-31.2(e)	K 379	20 or more. No areas were identified as being non-compliant upon completion of audit. 4. Maintenance Director will audit monthly to ensure smoke barrier doors have rating noted on glass and will report monthly to QAPI for three months.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315461	A. Building 01 - MAIN BUILDING 01 B. Wing	2/9/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN REHABILITATION AND HEALTHCARE CENTER	100 LONG-A-COMING LANE BERLIN, NJ 08009

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 Reg. # NFPA 101 LSC K0347	Correction Completed 01/30/2024	ID Prefix Reg. # NFPA 101 LSC K0379	Correction Completed 01/30/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
12/11/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO