STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315337	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McAuley Hall Health Care Cente	1633 Highway 22 Watchung, NJ 07069

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Potential for minimal harm Residents Affected - Many	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 38327 Based on the interview and record review, it was determined that the facility failed to issue the required Medicare Beneficiary Protection Notification. This deficient practice was identified for two (2) out of three (3) residents reviewed, Resident #10 and #170. The deficient practice was evidenced by the following: According to the Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS (Centers for Medicare & Medicaid Services)-10123, When to Deliver the NOMNC, A Medicare provider or health plan (Medicare Advantage plans and cost plans, collectively referred to as plans) must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services. The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. On 3/11/24 at 11:25 AM, the surveyor reviewed the facility provided list of residents who were discharged from Medicare (Med) covered Part A in the last six months. These residents should have received Beneficiary Notices. The surveyor reviewed three residents selected from the list. Residents #10 and #170 remained at the facility and Resident #171 was discharged from the facility. According to the SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review form, Resident #170's Med Part A skilled services episode start date was on 9/13/23 and the last covered day of Part A service was on 10/11/23. The NOMNC that included the effective date coverage of specialized wound care will end on 10/11/23 and the resident's representative was contacted on 10/11/23 at 3:45 PM to notify of the last covered day and when the member's liability begins date on 10/12/23. The required Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) form was also presented to the resident's representative on 10/11/23 at 3:45 PM. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Potential for minimal harm Residents Affected - Many	Further review of the facility provided SNF Beneficiary Protection Notification form showed that Resident #10's Med Part A skilled services episode start date was on 3/01/24 and the last covered day of Part A service was on 3/06/24. The NOMNC that included the effective date coverage of physical therapy, occupational therapy, and skilled nursing will end on 3/06/24 and the resident's representative was contacted on 3/06/24 at 9:15 AM to notify of the last covered day and when the member's liability begins date on 3/07/24. The required SNFABN form was also presented to the resident's representative on 3/06/24 at 9:15 AM. On 3/11/24 at 01:02 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The surveyor notified the facility management of the above concerns regarding NOMNC. The LNHA stated that the facility had no policy regarding SNF Beneficiary Notification and the facility just followed the regulation. NJAC 8:39-4.1(a)(8), 5.1

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 45449 Based on interview and review of pertinent documentation provided by the facility, it was determined that the facility failed to implement the facility's abuse policy to ensure a) licensed staff credentials were verified upon hire (Staff #1 and #4) This deficient practice was identified for two (2) of four (4) newly hired staff reviewed, and was evidenced by the following: The surveyors randomly selected five new employee files for license verification which revealed the following: Staff #1, a Licensed Practical Nurse (LPN), with a date of hire of 4/27/22, had a New Jersey Division Consumer Affairs (NJCA) license verification printout for license verification (used to verify the license status of a nurse) which was dated 3/07/24, Staff #4, a Registered Nurse (RN), with a date of hire of 12/08/22, had a NJCA verification print out for license verification which was dated 03/07/24. On 3/11/24 at 01:04 PM, during a meeting with the surveyors, the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA), the surveyor discussed the concern regarding the two newly hired staff that did not have evidence of verification prior to the date of hire. At that time, the DON stated that the Human Resources staff was expected to verify the applicant's license, along with the criminal background check and reference checks. At that time, the DON could not explain why the license check for Staff #1 and #4, reflected a date after the date of hire. A review of the facility policy provided, Abuse, Neglect and Exploitation of Resident's Property under Procedure included: [Facility Name redacted] will investigate the background or perspective new hires by checking with applicable certification, boards, and local authorities to verify that licenses, certifications, and criminal backgrounds are appropriate for employment in Long-term care facility. N.J.A.C. 8:39- 9.3(b), 43.15(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 45449 Complaint# NJ169416 Based on interviews, review of medical records and other facility documentation, it was determined that the facility failed to report an allegation of Abuse/Neglect to the New Jersey Department of Health (NJDOH) in the required timeframe for one (1) of three (3) residents, reviewed for incident/event (Residents #57). This deficient practice was evidenced by the following: On 3/07/24 at 10:16 AM, Resident #57 was not in the room, the room was observed to be clean, the bed was positioned against the wall with the floor mat on the right-hand side of the bed. At 10:16 AM, the surveyor observed the resident in the main dining room where at that time activities were being conducted. The resident was observed sitting at a round table with three (3) other residents. At 01:15 PM, the resident was observed in the main dining room having lunch with two (2) other residents. The surveyor reviewed the hybrid (combination of both paper and electronic) medical record for Resident #57. The Admission Record (an admission summary) reflected that the resident had been admitted with diagnoses which included dementia (loss of cognitive functioning), restlessness, agitation, and mood affective disorder. A review of Resident #57's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated 02/09/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 4 out of 15, which indicated the resident had a severely impaired cognition. Additionally, the MDS revealed that the resident was not delusional and had no behavior relating to care. A review of the resident's Care Plan included a focus under activities that the resident had memory problems and was poor at decision making started on 8/22/23. Additionally, the interventions included I want you to provide me with choices in regard to my daily care initiated on 8/22/23. If I become agitated during care, I would [prefer] you to stop what you were doing and return at a later time, when I am calm. Just make sure that I remain safe, initiated on 8/17/22. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the reportable event record report (FRE; Facility Reported Incident/Event) revealed the FRE was called in on 11/28/23 at 7:56 AM, and the event date was on 11/25/23 at 01:30 PM. The FRE was reported as a significant event of an alleged staff to resident abuse. The event was described as follows: The event occurred in the nursing home, on the west wing of the second floor. According to the housekeeping staff, as she was coming off the elevator, she saw the CNA forcing the resident to go and attend activities despite the resident's verbal refusal, physically holding on to rails and planted feet on the floor. Housekeeping staff also stated that the CNA kneed the back of the wheelchair causing the resident to thrust forward. A review of the facility investigation revealed that on 11/27/23 at 8:00 AM, the Director of Nursing (DON) was called by the Human Resource Office. The Human Resource (HR) Department was informed by housekeeping staff that he/she had witnessed the Certified Nursing Assistant (CNA) force a resident to attend activities despite the resident's refusal. The HR staff also witnessed the CNA say No, you are going. The HR was called in provided a signed witness statement regarding the narrative of what she witnessed on 11/25/23 at 01:30 PM -02:00 PM. On 11/27/23 at 02:25 PM. The report further reflected that on 11/27/23 at around 02:35 PM, the CNA was asked about her recollection of the events. The CNA informed the DON and HR that she provided 1 on 1 care to the resident at 02:00 PM, and at that time, the resident refused to attend activities, fought with the CNA about not wanting to go and stated the resident was confused. The record also reflected that the CNA explained that there were times that the resident would often refuse a lot of things but eventually was okay to do to do the task anyway. The HR, CNA statements were attached to the investigation and included the staff assignments for the second floor. At the conclusion of the investigation, the CNA was terminated for violating the Resident's rights to self determination and dignity. The facility staff was in-serviced on Resident Rights from 11/29/23, through 12/18/23. On 3/11/23 at 11:51 AM, during an interview with the surveyors, and the Licensed Nursing Home Administrator (LNHA), the DON stated that an incident/event of abuse should be reported within 24 to 48 hours. At that time, the surveyor asked the DON if that was the same time frame in the facility's policy. The LNHA replied we will get back to you. On 3/11/23 at 01:04 PM, during a meeting with the surveyors and the DON, the LNHA stated that the staff was educated on the process for reporting an incident of abuse as part of their compliance plan. A review of the provided facility policy; Abuse Neglect and Exploitation of Residents Property updated on 3/08/24, under Abuse Investigation included: All allegation involving abuse or result in serious bodily injury will be reported to the Administrator, Director of Nursing, Department of Health and Senior Services, the Ombudsman Office immediately but no later than two hours after the allegation is made . NJAC 8:39-4.1(a)(5),9.4(f)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 39885 Based on interview, record review and review of other pertinent facility documents, it was determined that the facility failed to provide the resident and the resident's representation written notification of the reason for transfer to the hospital and also send a copy to a representative of the Office of the State Long-Term Care Ombudsman (LTCO) for two (2) of two (2) resident's (Resident #10 and #16) reviewed for hospitalization . This deficient practice was evidenced by the following: 1. A review of Resident #10's electronic medical record included the following: Resident #10's discharge return anticipated Minimum Data Set's (DRAMDS), an assessment tool used to facilitate the management of care, for the two DRAMDS, reflected that the resident was transferred to the hospital. A review of the medical record did not include a written notification of the reason for transfer to the resident or resident representative and a copy to the LTCO for each transfer to the hospital. 2. A review of Resident #16's closed medical record included the following: Resident #16's two DRAMDS's reflected that the resident was transferred to the hospital. A review of the medical record did not include a written notification of the reason for transfer to the resident or resident representative and a copy to the LTCO for each transfer to the hospital. On 3/11/24 at 11:24 AM, during surveyor interview, the Licensed Nursing Home Administrator (LNHA) stated that she believed the Director of Social Services (DoSS) did the notifications. On 3/11/24 at 11:25 AM, during surveyor interview, the DoSS stated that she did not send out the notifications. She added that the nurses would call the family when a resident was transferred. On 3/11/24 at 11:31 AM, the LNHA stated that the ombudsman was not being notified when a resident was transferred to the hospital. She stated that the family was notified by a phone call or sometimes by email. On 3/11/24 at 01:34 PM, in the presence of the survey team, the surveyor notified the LNHA and Director of Nursing (DON) the concern that there was no written notification to the resident or resident representative and a copy to the ombudsman for Resident #10 and Resident #16. On 3/12/24 at 10:43 AM, in the presence of the survey team and the DON, the LNHA stated that the DoSS was working on a policy for emergency transfer notification to the family and ombudsman. The facility did not provide any additional information. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	N.J.A.C. 8:39-4.1(a)31,32

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 39885 Based on interview, review of the medical record, and review of other pertinent facility documentation, it was determined that the facility failed to provide the resident or resident representative written notification of the facility's bed hold policy prior to transfer to the hospital for two (2) of two (2) resident's (Resident #10 and #16) reviewed for hospitalization s. This deficient practice is evidenced by the following: 1. A review of Resident #10's electronic medical record included the following: Resident #10's discharge return anticipated Minimum Data Set's (DRAMDS), an assessment tool used to facilitate the management of care, for two DRAMDS, reflected that the resident was transferred to the hospital. A review of the medical record did not include a written notification of the facility's bed hold policy to the resident or resident representative prior to each transfer to the hospital. 2. A review of Resident #16's closed medical record included the following: Resident #16's two DRAMDS's reflected that the resident was transferred to the hospital. A review of the medical record did not include a written notification of the facility's bed hold policy to the resident or resident representative prior to each transfer to the hospital. On 3/11/24 at 11:24 AM, during surveyor interview, the Licensed Nursing Home Administrator (LNHA) stated that she believed the Director of Social Services (DoSS) did the notifications. On 3/11/24 at 11:25 AM, during surveyor interview, the DoSS stated that she did not send out the notifications. She added that the bed hold was usually done by admissions. On 3/11/24 at 11:27 AM, during surveyor interview, the Admissions Coordinator stated that when the resident or representative signed the contract/admission agreement that there was a clause for bedholds. She added that she did not send a notification each time a resident was transferred. On 3/11/24 at 11:31 AM, during surveyor interview, the LNHA stated that for a resident on Medicaid there was no bed hold and for a resident on Medicare the facility would take them back but they were not charged for the bedhold. She added that a resident that was private pay would be notified when they are transferred that if they wanted a bedhold then they would be responsible for the daily rate. On 3/11/24 at 01:34 PM, in the presence of the survey team, the surveyor notified the LNHA and Director of Nursing (DON) the concern that there was no written notification to the resident or resident representative of the bed hold policy for Resident #10 and Resident #16. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	On 3/12/24 at 10:43 AM, in the presence of the survey team and the DON, the LNHA stated that there was a section in the admission agreement on bedholds but that they did not have a policy. She added that the only one they notified was a private pay resident. She then stated that the facility took the resident back. The facility did not provide any additional information. A review of the facility provided undated Admission Agreement included the following: 17. In the event it becomes necessary to transport the Resident, the Resident and/or Representative agree to pay all ambulance charges. The Resident and/or Representative also agree to pay, unless otherwise covered by insurance or a third-party payer, an agreed upon rate for holding the bed vacant for a Resident until [facility name redacted] is notified to release the bed or the Resident returns to [facility name redacted]. N.J.A.C. 8:39-5.1 (a); 5.2 (a)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure each resident receives an accurate assessment. 38327 Based on the interviews, record review, and review of pertinent facility documentation it was determined that the facility failed to accurately code the Minimum Data Set (MDS) for one (1) of the 19 residents reviewed, Resident #19. This deficient practice was evidenced by the following: On 3/06/24 at 10:36 AM, the surveyor observed the Registered Nurse (RN) administer medications to Resident #19 inside the resident's room while the resident was seated in a recliner chair. The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #19 as follows: According to the Admission Record (admission summary), Resident #19 was admitted to the facility with a diagnosis that included but was not limited to essential hypertension (abnormally high blood pressure that's not the result of a medical condition), encephalopathy (a broad term for any brain disease that alters brain function or structure), major depressive disorder, unspecified dementia (group of thinking and social symptoms that interferes with daily functioning) without behavioral disturbance, unspecified psychosis (symptoms that happen when a person is disconnected from reality) not due to a substance or known physiological condition, and post-traumatic stress disorder (PTSD, a mental health condition triggered by a terrifying event, causing flashbacks, nightmares and severe anxiety) chronic. A review of the resident's quarterly MDS (qMDS) with an assessment reference date (ARD) of 01/23/24 revealed in Section C Cognitive Status Brief Interview for Mental Status (BIMS) score of 14 out of 15 which reflected that the resident's cognition was intact. Section P Physical Restraints for bedrail was coded as 2 (two) which reflected that the bedrail was used daily as a restraint. A review of the personalized care plan with a focus on the use of 1/4 side rail up while the resident is in bed and use it to help the resident with positioning and mobility. Further review of the personalized care plan showed that the resident had no care plan for bed rails (or side rails) as a restraint. On 3/08/24 at 11:50 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The surveyor notified the facility management of the above findings and concerns. On 3/11/24 at 9:13 AM, the surveyor interviewed the Registered Nurse/MDS Coordinator (RN/MDSC). The RN/MDSC informed the surveyor that she was responsible for MDS sections B, GG, H, I, J, L, M, N, O, and P. The RN/MDSC stated that the facility has a policy with regard to MDS and also follows the RAI (Resident Assessment Instrument) Manual when doing resident's MDS. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Many	On that same date and time, the RN/MDSC informed the surveyor that responses to MDS Section P were auto-populated from the electronic medical records in the assessment area. The RN/MDSC stated that it was the nurse in the unit who did the assessment. At this time, the surveyor notified the RN/MDSC of the above findings and concerns. The MDSC/RN stated that Resident #19's qMDS on 01/23/24 was inaccurately coded for restraint in Section P because the resident uses the bedrail for positioning and not as a restraint. She further stated that she did not check the autopopulated assessment in Section P, and I did not catch it and it was unfortunate. She added, Unfortunately sometimes things fall through the cracks, and it was not intentional. Furthermore, the RN/MDSC stated that it was important that the MDS was accurate because it reflects the current condition of the resident, and the plan of care should follow. The RN/MDSC acknowledged that she should have checked the assessment. On 3/11/24 at 01:02 PM, the survey team met with the LNHA and DON, and the surveyor notified the facility management of the above findings and concerns. The DON stated that she spoke to RN/MDSC about the MDS and according to them, the resident's bedrails were not a restraint and should not be coded as a restraint. The DON further stated that they were aware of the inaccurate MDS after the surveyor's inquiry. A review of the facility's undated MDS & Care Assessment (CAA) Protocol Policy that was provided by the LNHA included the purpose: to ensure facility compliance with regulations pertaining to resident assessment and to encourage resident and or representative's input in the assessment process. To provide interdisciplinary observation and assessment to ensure the most accurate assessment of the resident's functional capacity. Procedure: .9. MDS is prepared and kept electronically on the computer. Information is to be entered directly into electronic MDS by each discipline, by population from other modules, by the MDS Coordinator. Sections are reviewed, signed, and dated by responsible parties. RN Coordinator signs for completion . On 3/12/24 at 10:41 AM, the survey team met with the LNHA, and the DON, and there was no additional information provided by the facility management. NJAC 8:39-33.2(d)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 38327 Based on interviews, record review, and review of pertinent facility documentation it was determined that the facility failed to accurately complete and update a Preadmission Screening and Resident Review (PASaRR) to include all psychiatric diagnoses to ensure the resident was referred to the appropriate state-designated authority for level II PASARR evaluation and determination. This deficient practice was identified for one (1) of one (1) resident (Resident #19) reviewed for level II PASARR and was evidenced by the following: On 3/06/24 at 10:36 AM, the surveyor observed the Registered Nurse (RN) administer medications to Resident #19 inside the resident's room while the resident was seated in a recliner chair. The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #19 as follows: According to the Admission Record (AR, admission summary), Resident #19 was admitted to the facility with a diagnosis that included but was not limited to essential hypertension (abnormally high blood pressure that's not the result of a medical condition), encephalopathy (a broad term for any brain disease that alters brain function or structure), major depressive disorder, unspecified dementia (group of thinking and social symptoms that interferes with daily functioning) without behavioral disturbance, unspecified psychosis (symptoms that happen when a person is disconnected from reality) not due to a substance or known physiological condition, and post-traumatic stress disorder (PTSD, a mental health condition triggered by a terrifying event, causing flashbacks, nightmares and severe anxiety) chronic. Further review of the AR revealed that the diagnosis of major depressive disorder and unspecified psychosis onset was 5/12/21 during the stay of the resident at the facility. The PTSD diagnosis onset was on 9/20/22 during the stay as well of the resident at the facility. A review of the resident's quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 01/23/24 revealed in Section C Cognitive Status the Brief Interview for Mental Status (BIMS) score of 14 out of 15 which reflected that the resident's cognition was intact. The qMDS in Section I Active Diagnosis included depression, psychotic disorder, and PTSD. The PASaRR Level I Screen dated 12/11/18 showed that the resident had no diagnosis or evidence of a major mental illness and the screen was negative. Further review of hybrid medical records revealed that there was no further documentation of PASaRR to reflect the new diagnosis for depression, psychotic disorder, and PTSD. (continued on next page)

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	315337	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McAuley Hall Health Care Cente	1633 Highway 22 Watchung, NJ 07069

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/07/24 at 01:52 PM, the surveyor interviewed the Director of Social Services (DoSS) regarding the facility's process and policy regarding PASaRR. The DoSS informed the surveyor that PASaRR was initiated from the hospital, and if there was no PASaRR provided upon admission, the DSS would initiate PASaRR. She further stated that since the DoSS started working in the facility back in October 2020, there have been no changes from residents PASaRR. The surveyor then notified the DoSS of the above findings and concerns. At that same time, the DoSS stated that Resident #19 was receiving services for PTSD for Psychotherapy sessions. On 3/08/24 at 11:50 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and the surveyor notified the facility management of the above concerns and findings. A review of the undated facility's PASaRR Policy that was provided by the LNHA included that it is the policy of the facility that PASaRR be completed for each resident prior to admission and again at points of significant change in status. If a current resident exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a diagnosis of mental illness as defined under 42 CFR 483.100 (where dementia is not the primary diagnosis), a new PASaRR will be completed .Social Worker will keep copies of PASaRR Level I Screen and PASaRR Level II Evaluation and Determination (if applicable) in the resident's active medical record . On 3/12/24 at 10:41 AM, the survey team met with the LNHA, and the DON, and there was no additional information provided by the facility management. NJAC 8:39-11.2(i), 27.1(a)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 38327 Based on observations, interviews, record review, and review of other pertinent facility provided documentation, the facility failed to: a) obtain a physician's order for droplet precaution and b) ensure that the required posted sign was followed according to the facility's practice and policy, and standard of clinical practice, for one (1) of five (5) residents reviewed for infection control (Resident #10). This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. On 3/06/24 at 9:46 AM, during the Entrance Conference of Surveyor #1 (S#1) and S#2 with the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA), the DON stated that there was a resident with a diagnosis of RSV (respiratory syncytial virus, causes infections of the lungs and respiratory tract) who was on droplet precaution (used to prevent the spread of pathogens that are passed through respiratory secretions and do not survive for long in transit) on the 1st floor. The DON further stated that it was an expectation for visitors and staff to use full PPE (personal protective equipment) gown, gloves, mask and eye protection when entering the resident's room. On 3/06/24 at 10:38 AM, S#1 observed Resident # 10's room with a posted sign outside the door on how to use (put on or donn) PPE that included instructions for gown, gloves, mask, and eye protection. The posted sign also included how to remove (doff) the PPE. There was a non-smoking sign for oxygen in use on the doorknob of the resident. In addition, there was a PPE bin outside the room, on top of the PPE bin was a container of disinfecting wipes, and inside the box were gowns, eye protection, BP (blood pressure) apparatus, and gloves. Inside, upon entering the room was a black covered bin. There was no posted sign for what kind of infection control precaution to observe. On that same date and time, S#1 asked the Registered Nurse (RN) regarding the resident. The RN was just across the resident's room with the medication cart. The RN stated, while looking at the resident's room, that Resident #10 was on contact and droplet precaution for RSV. Both the surveyor and the RN did not observe a posted sign for contact and droplet precautions outside the resident's room. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/07/24 at 10:10 AM, S#3 observed the resident's room with a PPE bin and sign on how to don and doff the PPE. There were no posted signs for contact and droplet precautions outside the door of the resident. On 3/07/24 at 10:13 AM, S#3 interviewed the Licensed Practical Nurse (LPN). The LPN informed the surveyor that Resident #10 was still in isolation. The LPN confirmed that there should be a stop sign to check with the nurse first and posted a sign for contact and droplet precautions. The LPN further stated that the sign may have fallen off. The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #10 as follows: According to the Admission Record (admission summary), Resident #10 was admitted to the facility with a diagnosis that included but was not limited to essential hypertension (abnormally high blood pressure that's not the result of a medical condition), cardiomegaly (an enlarged heart, which is usually a sign of another condition), hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone), vascular dementia (a common type of dementia caused by reduced blood flow to the brain), unspecified atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and chronic diastolic (congestive) heart failure. The resident's comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 3/04/24 revealed in Section C Cognitive Status Brief Interview for Mental Status (BIMS) score of 6 out of 15 which reflected that the resident's cognition was severely impaired. The personalized care plan showed a focus on RSV with interventions that included but were not limited to I want staff to comply with droplet and contact precaution when caring for me. The intervention was initiated on 3/05/24. A review of the March 2024 Order Summary Report (OSR) revealed an active order dated 3/01/24 for contact precaution for RSV infection every shift for preventive measures. Further review of the March 2024 OSR showed that there was no order for droplet precaution. On 3/08/24 at 8:56 AM, S#1 interviewed the Infection Preventionist Nurse (IPN) regarding the facility's process and standard of practice regarding RSV. The IPN stated that the facility nurse would notify the IPN of the resident with a diagnosis of RSV as well as the DON. The IPN further stated that, as an Infection Preventionist of the facility, she will make sure that the resident will be placed in both droplet and contact precautions. The IPN also stated that the resident should be in a single room, and all required PPE and posted signs for precaution will be in place as well. The IPN acknowledged that there should be a physician order for both droplet and contact precautions and care plan. At that same time, S#1 notified the IPN of the above findings regarding Resident #10. The IPN stated It's my mistake there should be a sign for droplet and contact precautions and there should be an order for droplet precaution. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/08/24 at 11:50 AM, the survey team met with the LNHA and the DON, and S#1 notified the facility management of the above findings. A review of the facility's Transmission Based Precaution Policy that was provided by the LNHA with an updated date of 01/26/23 included that the transmission-based precautions (TBP) are the second tier of basic infection control and are to be used in addition to standard precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. Contact Precaution Precaution: use contact precaution for patients with known or suspected infections that represent an increased for contact transmission. Droplet Precaution for residents known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a resident who is coughing, sneezing, or talking. On 3/11/24 at 01:02 PM, the survey team met with the LNHA and DON. The DON stated that there should be an order for droplet precaution and posted a sign outside the resident's door for contact and droplet precautions. NJAC 8:39-11.2(b)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39885 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to: a.) maintain infection control practices to reduce the risk of infection during a pressure ulcer (PU) treatment; b.) follow a physicians order during a PU treatment; c.) follow the recommendations of the wound care center physician; and d.) assess and document the measurements of the PU one (1) of two (2) residents reviewed for PU (Resident #39). This deficient practice was evidenced by the following: On 3/06/24 at 11:13 AM, the surveyor observed that Resident #39's door had a stop sign that indicated the resident was on enhanced barrier precautions. After donning the appropriate personal protective equipment required, the surveyor entered Resident #39's room and interviewed the resident. Resident #39 stated that he/she was transferred to the facility approximately four years ago with COVID-19 and developed a PU. Resident #39 stated that he/she had PU treatment two times a day and that the PU was almost healed. Resident #39 stated that the PU had healed and that after he/she started getting up into a wheelchair the PU reopened. On that same date and time, Resident #39 stated that he/she went to a wound care center every 2 or 3 weeks. The surveyor asked Resident #39 if he/she was able to turn on his/her side without help. Resident #39 stated that he/she turned on his/her own. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/07/24 at 10:34 AM, the surveyor observed Resident #39's PU treatment performed by the Registered Nurse/Unit Manager (RN/UM) of the first floor. After the RN/UM checked the physician's order in the computer, she performed hand hygiene (HH) with an alcohol based handrub (ABHR) and then obtained the supplies for the treatment from inside the treatment cart and placed them on top of the cart. The RN/UM and the surveyor donned a gown and gloves before entrance into the resident's room. The RN/UM wiped the bedside table with a disinfectant wipe. The RN/UM brought the supplies for the treatment into the room and placed them on the bedside which included the tubes and bottles of the medications and ointments/creams. The RN/UN performed handwashing (HW) for 20 seconds. The RN/UM dried her hands with a paper towel that she pulled from the dispenser. The dispenser did not automatically feed another section of paper towel and the RN/UM used the same paper towel that she dried her hands with to turn off the faucet. The RN/UM donned a pair of gloves and prepared some of the supplies on the bedside table by opening the packages of the dressings and silver alginate and placed them on a towel that was placed on the bedside table. The RN/UM turned the resident so the sacral area was exposed and then doffed (took off) her gloves. The RN/UM performed HW for less than 20 seconds. She then took a paper towel from the dispenser and the dispenser did not automatically feed another section of paper towel that she could grasp and the RN/UM used the paper towel that she dried her hands with to move the dial on the side of the dispenser to feed a section of the paper towel. She then took another paper towel to turn off the faucet. The RN/UM donned a new pair of gloves and removed the dressing that was on Resident #39's sacral area. The RN/UM used a wipe to remove fecal matter that was on Resident #39's perianal area. The surveyor observed that Resident #39's right and left buttocks were reddened and that there was an opening on the sacrum that was pinkish color that was less than quarter size and a smaller area above the opening that was blackish color that was less than dime size. The RN/UM measured the opening with a paper ruler and stated that it measured 1.5 cm x 1 cm. The RN/UM removed her gloves performed HW for 20 seconds and was able to retrieve a second clean paper towel to turn off the faucet. The RN/UM donned a new pair of gloves and sprayed a cleansing spray on both buttocks and wiped both buttocks with a 4 x 4 dressing. The RN/UM then cleaned the opening on the sacrum with a 4 X 4 that she placed [NAME] solution on. The RN/UM did not change her gloves. The RN/UM grasped the tube of bacitracin ointment in her gloved hand and squeezed some of the ointment onto a cotton tipped applicator and applied it to the opening on the sacrum. The RN/UM then grasped the tube of A & D (preventative medication) ointment and squeezed some onto a clean 4 x 4 dressing and then grasped the tube of Triad cream and squeezed some onto the same 4 x 4 dressing. She then took a cotton tipped applicator and mixed the two together on the 4 x 4 dressing. The RN/UM then applied the mixture with the cotton tipped applicator to each buttock. The RN/UM then spread the mixture across each buttock with her gloved hand. The RN/UM did not use an applicator to spread the mixture. The RN/UM removed her gloves and performed HW. The RN/UM donned a new pair of gloves. She placed the square piece of silver alginate over the opening on the sacrum and then placed a 4 x 4 dressing over the silver alginate. She stated that she did not need to use the adaptic since the resident did not have any small tears on the surrounding skin. The RN/UM then placed the ABD (abdominal) pad on the sacrum and placed a mepilex dressing over it. The RN/UM did not write the date on the dressing prior to the dressing being placed on the resident. The RN/UM started to clean off the bedside table, placed some of the items in a plastic bag. The RN/UM then reached her gloved hand into her pocket and took out a red marker. She used the red marker to date the dressing that was on Resident #39. The RN/UM then placed the red marker back in her pocket. The RN/UM removed her gloves and performed HW for 20 seconds. The RN/UM dried her hands with a paper towel. She then used her bare hand to move the dial on the side of the dispenser to get another paper towel. The RN/UM donned a new pair of gloves. The RN/UM took the tubes and bottles of medications and ointments/creams off the bedside table and placed them on the treatment cart. The RN/UM did not wipe the bedside table with a disinfectant wipe after the treatment and placed Resident #39's belongings back on the bedside table. The RN/UM doffed her gown and gloves and performed HH with ABHR. The RN/UM wiped the tubes and bottles with a disinfectant wipe and then placed them in the treatment cart. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/07/24 at 11:30 AM, the surveyor interviewed the RN/UM regarding the PU treatment observations. The RN/UM stated that she would usually get a new towel to turn off the faucet but that she tried to grab a new paper and that the paper towel dispenser was not working correctly. The surveyor asked the RN/UM if she should have changed her gloves after cleansing the areas. The RN/UM stated that she should have changed her gloves. The surveyor asked the RN/UM about dating the dressing. The RN/UM stated that she usually dated it before she placed the dressing but that if she forgot to write it before that she would write the date while it was on the resident. At that same time, the RN/UM confirmed that she took the red marker from her pocket and returned it to her pocket. She stated that she would usually use a clean marker. The surveyor asked the RN/Um if she should have wiped the bedside table after the completion of the PU treatment. The RN/UM stated that she completely forgot to wipe the bedside table but that she usually did. A review of Resident #39's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to spinal stenosis (the spaces inside the bones of the spine get too small which can put pressure on the spinal cord and the nerves that travel through the spine), left foot drop (difficulty lifting the front part of the foot) and hypertension (high blood pressure). A review of Resident #39's modified quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 01/18/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that Resident #39 was cognitively intact. A review of Resident #39's March 2024 Medication Administration Record/Treatment Administration Record (MAR/TAR) included the following order: Treatment to sacral ulcer and periwound (the area around the wound): Cleanse actual ulcer with [NAME] (wound solution intended for mechanically cleansing, irrigating, moistening, debriding, and removing foreign material, including microorganisms, from a wide variety of wounds and non-intact skin), pack ulcer with silver alginate (a highly absorbent, antimicrobial pad that is placed on wounds). Cleanse open areas to right and left buttocks with [NAME] and apply Bacitracin (an antibiotic that can prevent infection of minor cuts, burns, and scrapes when applied topically) and cover with Adaptic (primary dressing made of knitted cellulose acetate fabric and impregnated with a specially formulated petrolatum emulsion and designed to help protect the wound while preventing the dressing from adhering to the wound). Apply mixed Triad paste (Zinc-oxide based hydrophilic paste for light-to- moderate levels of wound exudates that helps maintain an optimal wound healing environment to facilitate natural autolytic debridement and an ideal alternative for difficult-to-dress areas and varying wound etiologies) and A&D (used as a moisturizer to treat or prevent dry, rough, scaly, itchy skin and minor skin irritations) to surrounding pink areas, cover with ABD pad (cut ABD pad to fit only over sacral ulcer and open areas to buttocks), then apply bolster gauze and cover with Mepilex dressing (soft, conformable silicone foam dressing that absorbs exudate and maintains a moist wound environment) every day and evening shift related to PRESSURE ULCER OF SACRAL REGION, STAGE 4 with a start date of 12/15/23. The RN/UM did not follow the physician's order for the PU treatment. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #39's weekly Skin Assessment in the electronic medical record included the following: Skin assessment dated [DATE]-stage 4 sacral wound, measurement: 1.5 cm X 1 cm. Skin assessment dated [DATE]- stage 4 sacral wound. There was no measurement of the wound. Skin assessment dated [DATE]- stage 4 sacral wound. There was no measurement of the wound. Skin assessment dated [DATE]- stage 4 sacral wound. There was no measurement of the wound. A review of Resident #39's Progress Notes from 02/11/24 to 3/06/24 did not include a weekly note containing the measurements of the sacral wound. The facility was not monitoring the measurements of the sacral wound. A review of Resident #39's Report of Consultation record for the wound care center physician included the following under Recommendations: 1) Continue Silver Alginate Dressing 2) Minimize Pressure 3) Nystatin Cream BID (two times a day) of rash of surrounding skin prn (as needed) 4) Return 2 weeks A review of Resident #39's February 2024 MAR/TAR did not include a prn order for Nystatin Cream as recommended by the wound care center physician. A review of the After Visit Summary (wound care center) dated 02/23/24 included the following wound care order: Associated Wounds: Wound 01/08/21 .#1 Pressure injury Sacrum. Wound Cleansing: Normal Saline; Pack wound with: ag alginate (Alginate Dressing with Antibacterial Silver), bolster gauze; Cover and secure with: mepilex border; Change dressing every: 2 x a day. A review of Resident #39's February and March 2024 MAR/TAR included a PU treatment that was different from the recommended wound care order provided by the wound care center physician. On 3/11/24 at 10:05 AM, the surveyor interviewed the Assistant Director of Nursing/Infection Preventionist (ADON/IP) regarding Resident #39's PU treatment that was observed by the surveyor. The ADON/IP stated that the nurse should get a new paper towel to close the faucet. She added that the handle/dial on the paper towel dispenser was dirty. The ADON/IP stated that the nurse should not use the same paper towel that she dried her hands with to turn the faucet off. She added that if she did then she should have washed her hands again or performed HH with an ABHR. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On that same date and time, the ADON/IP stated that the nurse should have placed all the medications, creams, pastes in a medicine cup and that if they were in a cup and used an applicator would not need to change gloves. She added that if the nurse was grasping the tubes or bottles that they were not considered clean and would need to change gloves. The ADON/IP stated that she taught the nurses to place them in medicine cups and not bring the tubes into the room. The ADON/IP stated that the nurse should have used a tongue depressor to spread the ointment/cream across the buttock and not a gloved hand. Furthermore, the ADON/IP stated that the date should be written on the dressing prior to it being placed on the resident. The ADON/IP stated that the nurse should not have taken the marker from her pocket and should not have placed it back in her pocket. The ADON/IP stated that the nurse should have wiped the table at the end of the treatment. On 3/11/24 at 01:40 PM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) the concerns regarding Resident #39's PU treatment observation, the physician's order was not followed and that the wound care center recommendations were not followed. On 3/12/24 at 10:50 AM, in the presence of the survey team and the LNHA, the DON stated that the RN/UM updated Resident #39's PU treatment order and that the RN/UM was inserviced on PU treatments. On 3/12/24 at 11:03 AM, surveyor interviewed the DON regarding skin assessments. The DON stated that the weekly skin assessment did not contain a measurement of the PU. She added that if the resident was seen by the wound care nurse that a measurement would be in the progress note. On 3/12/24 at 11:14 AM, the surveyor interviewed the ADON/IP regarding Resident #39's weekly skin assessments. The ADON/IP stated that a weekly measurement was not done for Resident #39. She added that the measurement was on the wound care center consult sheet. The surveyor asked the ADON/IP if Resident #39 was going to the wound care center weekly. The ADON/IP stated that Resident #39 in the past went weekly but that now the resident was not going weekly. She added that Resident #39's PU was stable. On 03/12/24 at 11:40 AM, the surveyor interviewed the DON regarding Resident #39's skin assessments. The DON stated that the skin assessments should have the PU measurement recorded weekly to monitor the effectiveness of the treatment and monitor for any changes in the PU status. In the presence of the survey team, the surveyor notified the LNHA and DON the concern that Resident #39's skin assessments did not contain measurements of the PU. The facility did not provide any additional information. A review of the facility provided policy titled, Skin Breakdown Prevention and Treatment with an updated date of 02/13/24, included the following: Policy It is the policy of [name redacted] that all residents will be assessed for risk of skin breakdown and appropriate strategies developed to prevent and treat pressure ulcers/skin abnormalities. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procedure Skin Management Program: 1. All residents will be considered at risk for skin breakdown on admission. An interim care plan will be implemented to include but not limited to daily skin check, weekly skin assessment, and pressure relieving mattress . 4. Resident's skin will be observed daily by CNAs performing personal hygiene. Any skin abnormality or change in skin condition will immediately be reported to the nurse. 5. Head to toe skin assessment by the nurse will take place at least once a week as per the resident's shower schedule . 10. At the time of identification of a change in a resident's skin integrity and weekly thereafter until healed, a full description will be documented in the resident's medical record. 11. Wound care consultant is available for any significant wound 12. Treatment recommendations of consultant services will be made available by the unit nurse to the resident's physician and consultation reports added to the medical record. 13. An interdisciplinary team will discuss and evaluate wound progress at least weekly. Any recommendations to improve the outcome of the wound will be added to the resident's care plan . A review of the facility provided policy titled, Hand Hygiene with an updated date of 11/29/22, included the following: How to Perform Handwashing: . Dry your hands using a clean paper towel and discard in the proper receptacle or air dry them. Use another clean paper towel to close the faucet and dispose it properly N.J.A.C. 8:39-27.1

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 38327 Based on observation, interview, and review of facility documentation, it was determined that the facility failed to ensure: a) that appropriate care was provided for the hemodialysis (the filtration of waste when the kidneys are no longer able to do so) access site and b) care plan was developed with regard to the care of the hemodialysis access site. This deficient practice was identified for one (1) of one (1) resident (Resident #20) reviewed for hemodialysis and was evidenced by the following: On 3/06/24 at 10:41 AM, the surveyor observed Resident #20 was seated in a wheelchair wearing dark eyeglasses, with a call bell within reach, and with a left lower leg prosthetic in use. The resident stated that the dialysis was every Tuesday, Thursday, and Saturday at around 01:30 PM pick up. The resident showed their right upper chest dialysis access site covered with a clean dressing. The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #20 as follows: According to the Admission Record (admission summary), Resident #20 was admitted to the facility with a diagnosis that included but was not limited to essential hypertension (abnormally high blood pressure that's not the result of a medical condition), peripheral vascular disease unspecified (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), end-stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), dependence on renal dialysis (or hemodialysis), type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) with other specified complications, legal blindness, and acquired absence of left leg below knee. The resident's annual Minimum Data Set (aMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 01/18/24 revealed in Section C Cognitive Status, Brief Interview for Mental Status (BIMS) score of 15 out of 15 which reflected that the resident's cognition was intact. The aMDS in Section O Special Treatments, Procedures, and Programs included that the resident was on dialysis. The March 2024 Order Summary Report (OSR) revealed that there was no order to monitor and care for the right upper chest dialysis access site. A review of the personalized care plan showed that there was no mention of the care and monitoring of the right upper chest dialysis access site. Further review of the hybrid medical records revealed that there was no routine documentation that the facility was monitoring and caring for the resident's right upper chest dialysis access site. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/07/24 at 12:10 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) regarding the resident's dialysis status. The surveyor asked what was the facility's process, policy, and procedure regarding checking of resident's dialysis access site. The RN/UM stated that they monitor the access site for dialysis and document it in the Hemodialysis Communication Record (HCR). Then, the RN/UM showed the binder of the resident's dialysis HCR where she pointed out the first part To be completed by nurse prior to dialysis treatment as follows: Access site: swelling___ Drainage____ Pain_____ AV shunt (arteriovenous shunt (AVS) is the most commonly used vascular access in patients receiving regular hemodialysis) Only (indicate + or -) Bruit_____ Thrill____ The above information about the access site was also listed in the same paper but in the bottom part of the HCR To be completed by licensed nurse post-dialysis treatment. On that same date and time, RN/UM informed the surveyor that the first and the bottom part of the HCR should be filled out by the facility nurses and the middle part of the HCR by the dialysis center. At this time, the surveyor then asked the RN/UM what about the days that the resident was not in dialysis, and how the facility monitored the access site. The RN/UM stated Let me look first, then she went to the electronic medical record, and checked the electronic Treatment Administration Record (eTAR). The RN/UM stated that it was the responsibility of the in-charge nurse (the RN/UM) to make sure that there was an order from the physician on routine monitoring of the hemodialysis access site and to be reflected in the eTAR for the nurses to sign. The RN/UM further stated that there was no order for monitoring the dialysis access site. The RN/UM also stated that it should be in the eTAR to make sure that the resident is being monitored for the dialysis access site to promote safety and prevent infection because the resident can bleed on the access site. The RN/UM further stated that she did not know why it was missed. Furthermore, the surveyor asked the RN/UM if the care for the dialysis access site should be in the care plan of the resident and the RN/UM stated yes. The RN/UM had no answer as to why there was no care plan for care of dialysis access site. On 3/08/24 at 11:50 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and the surveyor notified the facility management of the above findings and concerns. The DON stated that the RN/UM called the Nurse Practitioner (NP) yesterday for an order. The DON further stated that the order for care of the dialysis access site and care plan were done after the surveyor's inquiry. According to the LNHA, there was no general policy for hemodialysis. NJAC 8:39-27.1(a)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 45449 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that the posted Resident Care Staffing Report (24-hour staffing report) was up to date and provided accurate information. This deficient practice was evidenced by the following: On 3/06/24 at 8:55 AM, the surveyors entered the facility and observed the posted 24-hour staffing report which was dated 3/06/24. The resident census was not included. The staffing report did not indicate if a Registered Nurse, was on duty. The posting indicated the number of licensed nursing staff and certified nursing staff on a shift. The shift did not specify the total number and actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care. At 9:15 AM, the Licensed Nursing Home Administrator (LNHA) informed the surveyors that the census was 68 without bed hold. At 9:20 AM, during an interview with the surveyor, the receptionist informed the surveyor that she posted the 24-hour staffing report located at the front door vestibule. The receptionist stated that the Director of Nursing (DON) and the LNHA instructed her on which information was required to be posted. She also stated that she was not instructed to include the census. At 12:51 PM, in the presence of three surveyors, the LNHA stated that she was not the LNHA from the last survey and that she did not know the census had to be added to the 24-hour staffing report At that time, in the presence of two surveyors, and the LNHA, the surveyor discussed the concern regarding the inaccuracy of the posted 24-hour staffing report. At that time, The LNHA stated she would review the regulation. On 3/07/24 at 8:51 AM, the surveyors observed the posted 24-hour staffing report dated 3/07/24, and the census was included. However, the 24-hour staffing report did not indicate if a Registered Nurse, was on duty. The posting indicated the number of licensed nursing staff and certified nursing staff on a shift. The shift did not specify the total number and actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care. At 10:03 AM, during a meeting with the surveyors, the LNHA stated that she and the DON gave the receptionist the information to post for the 24-hour staffing report. The LNHA stated she had not checked the regulation to ensure compliance. On 3/08/24 at 11:51 AM, during a follow-up meeting with the surveyors the LNHA stated the 24-hour staffing report posting had been resolved and the accurate information was posted. At 01:04 PM, during a meeting with the surveyors, the DON stated that they have educated the staffing coordinator and the weekend receptionist regarding information required to be on the 24-hour staffing report. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/24 at 9:52 AM, the LNHA confirmed the facility had no policy on staffing. N.J.A.C. 8:39-41.2 (a)(b)(c)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 39885 Based on observation, interview, record review, and review of other facility provided documents, it was determined that the facility failed to: a.) maintain a system of record keeping of DEA (Drug Enforcement Administration) Form-222 (a federal narcotic requisition form used for ordering controlled substances), that ensured drug records were in order, and controlled dangerous substance (narcotics medications), with high potential for abuse were tracked with detail to enable prompt identification of loss or potential diversion of controlled substance; and b.) develop a policy and procedure for narcotic medications which included record keeping of DEA Form-222. This deficient practice was evidenced by the following: On 3/11/24 at 8:45 AM, in the presence of the Director of Nursing (DON), the surveyor reviewed the facility provided binder that contained the DEA 222 forms. A review of the binder included the following non-executed (blank forms that were not used yet to order controlled substances) DEA 222 forms: Order Form Number:202074228 Order Form Number:202074229 Order Form Number:202074230 Order Form Number:202074231 Order Form Number:202074232 Order Form Number:202074234 Order Form Number:202074235 Order Form Number:202074236 There was no DEA 22 form with Order Form Number:202074233. There was not a copy of an executed (form filled out with an order for controlled substances) DEA 222 form with the Order Form Number:202074233. There was no log of the numbers of the DEA 222 forms to account for what numbers were received and what numbers had been used to order medications through the pharmacy. At 8:51 AM, the surveyor interviewed the DON regarding the process of the DEA 222 forms. The DON stated that she would fill out the DEA 222 form and send it to the pharmacy. She added that she did not make a copy of the form and keep it. The surveyor asked the DON how she knew what was ordered and if what medication received was what was ordered. The DON stated that when the medication was received it would come with a different paper from the pharmacy listing the medication and the amount. The DON then stated that she was contacting the pharmacy to get a copy of the executed DEA 222 form. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/11/24 at 10:50 AM, the surveyor asked the DON for a policy related to controlled substances and DEA 222 form. The DON stated that she did not think the facility had a policy. On 3/11/24 at 11:48 AM, the DON stated that the pharmacy faxed over a copy of the missing DEA 222 form. The surveyor reviewed the form and asked what the importance was for keeping track of the DEA 222 forms. The DON stated that it was important to keep track of what was ordered and what was received to prevent diversion and make sure the right amount was received. She added that it was important to know the form numbers to make sure no one else was using them. On 3/11/24 at 01:36 PM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and DON the concern that there was no accountability/log for the DEA 222 forms. The surveyor requested a policy on narcotics. The DON stated that the facility did not have a policy on narcotics. On 3/12/24 at 10:46 AM, in the presence of the survey team and LNHA, the DON stated that the facility did not have a policy regarding the ordering procedure for narcotics and that she created a process on 3/11/24. She added that she created a tracking log for the DEA 222 forms that will be in the binder moving forward. The facility did not provide any additional information. A review of the backside of the DEA Form-222 included the following: Instructions for DEA Form 222 (see Title 21 CFR Part 1035 for details) . Part 1. Purchaser Information . 6. The order form must be signed and dated by the purchaser on the day it is submitted for filling. Purchaser must make a copy of the order form for its records before mailing the original to the supplier . Part 5. Controlled Substance Receipt 1. The purchaser fills out this section on its copy of the original order form. 2. Enter the number of packages received and date received for each line item. 3. Purchaser must keep its copy of each executed order form and all copies of unaccepted or defective forms and any attached statements or other related documents available for inspection for a period of two years. N.J.A.C. 8:39-29.1(e);29.4(k);29.7(c)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 39885 Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to maintain complete and readily accessible medical records. This deficient practice was identified for one (1) of seventeen (17) residents reviewed (Resident #16). This deficient practice was evidenced by the following: On 3/11/24 at 10:41 AM, the surveyor reviewed Resident #16's closed electronic medical record. Resident #16's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to asthma (a condition in which a person's airways become inflamed, narrow and swell, and produce extra mucus, which makes it difficult to breathe), hypertension (elevated blood pressure), and heart failure. Review of the electronic medical record information on some of the sections only went to January 2024 which was a readmission to facility after a hospitalization . The surveyor could not review any information in the electronic medical record prior to the readmitted in January 2024. On 3/11/24 at 10:57 AM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) that the complete medical record was not accessible in the computer system. On 3/12/24 at 9:27 AM, the Minimum Data Set (MDS) Coordinator informed the surveyor that the electronic medical record was fixed. The surveyor reviewed the electronic medical record and the complete medical record was not accessible prior to the readmitted in January 2024. On 3/12/24 at 10:10 AM, in the presence of the survey team, the surveyor notified the LNHA and Director of Nursing (DON) the concern that the facility did not maintain complete and readily accessible medical records for Resident #16. On 3/12/24 at 10:52 AM in the presence of the survey team and DON, the LNHA stated that she notified the computer system again about the issue and was waiting for a response. The facility did not provide any additional information. N.J.A.C. 8:39-35.2

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45449 Based on observation, interview, review of the medical record and other facility documentation, it was determined that the facility failed to ensure the consistent coordination/communication was provided between facility staff and hospice staff to meet the resident's needs (Resident #26). This deficient practice was identified for one (1) of two (2) residents reviewed for hospice and end of life care. This deficient practice was evidenced by the following: On 3/06/24 at 10:12 AM, during the initial tour, the surveyor observed Resident #26 sleeping on a low positioned bed with knees bent. The surveyor reviewed the hybrid (combination of both paper and electronic) medical record for Resident #26. According to the Admission Record (an admission summary), the resident was admitted to the facility with diagnoses that included cerebral aneurysm unruptured (ballooning of a blood vessel in the brain), unspecified dementia (loss of cognitive functioning), psychosis (loss of contact with reality) and seizures. The quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated 12/13/23, reflected a Brief Interview for Mental Status (BIMS) was not conducted since the resident was rarely/never understood. A review of the active Order Summary Report (OSR) revealed a physician order (PO) for Hospice Care with a start date of 6/20/23. The Care Plan (CP) included a focus that the resident was under Hospice Care related to dementia/Alzheimer's, initiated on 6/13/23. The hybrid medical record for the resident revealed a hospice recommendation by the Hospice Nurse (HN) in the paper medical record, dated 6/10/23, and an electronic documentation by a facility nurse in the electronic Medical Record (eMR), 01/10/24, that the resident was seen by hospice who at that time had no recommendation. A review of a nursing Progress Note (PN) dated 02/04/24, revealed the resident was found lying on the floor mat next to his/her bed. The bed was in a low position and the resident denied hitting their head. The resident was assessed for range of motion, bruising, had no open areas seen on the skin, neuro checks were initiated, no signs of distress, blood pressure was 136/76, respiratory rate was 18 (normal range 12 to 16 breaths per minute), temperature was 98.1 (normal range 97.6 to 99 degrees Fahrenheit), Oxygen Saturation was 99 % room air (normal range 95% to 100 %). There was no documentation that reflected hospice was informed of the fall. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/07/24 at 10:58 AM, during an interview with the surveyor, the Registered Nurse (RN) stated that the hospice aids (HA) visited with the assigned resident in the morning and before visiting with the hospice resident the HA would check in with the assigned nurse on the floor. At the end, of the HA visit the aid would show the nurse on duty at the facility what tasks they have completed and the nurse on the floor would sign off on the completed tasks. At that time, the RN explained that the HN visited in the evening and the recommendations/communication record would be placed in the chart, flagged for the nurses to review, and communicated with the nurse on duty verbally. At that time, the RN stated they only had one hospice provider. On 03/07/24 at 12:05 PM, the surveyor and the RN/Unit Manager (UM) reviewed the hybrid medical record for the resident. At that time, the RN/UM stated the HN visited every 14 days but was unsure. The resident was admitted to [name redacted] hospice on 6/10/23 and the HN visit did not occur during her shift. At that time the RN/UM confirmed that hybrid medical record contained only two communication records which were the paper documentation on 6/10/23, and an eMR documentation made by the facility nurse on 1/10/24. At that time, the RN/UM confirmed the communication record from hospice could not be located. The RN/UM acknowledged it should have been, and stated she would call hospice to retrieve the communication records. The RN/UM could not recall when she last checked the resident's record to ensure collaboration and communication between hospice and the facility occurred. At that time, the RN/UM confirmed the resident fell on [DATE], and that they had no written documentation that the incident was communicated to hospice and confirmed it should have been. At that time, the RN/UM stated that the communication record was important to collaborate and communicate changes in the resident's condition. In this case after a fall, the communication would have initiated the HN to also assess the resident. A review of the faxed document from hospice dated 3/11/24, reflected the following dated visits by hospice: 1. June 10, 2023, communication record from hospice on file. Facility PN reflected that Hospice was in the facility, saw the resident, and made recommendations. 2. June 12, 2023, no communication record on file. 3. June 28, 2023, no communication record on file. 4. July 18, 2023, no communication record on file. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. July 28, 2023, no communication record on file. 6. August 4, 2023, no communication record on file. 7. August 15, 2023, no communication record on file. 8. September 5, 2023, no communication record on file. 9. September 13, 2023, no communication record on file. 10. September 20, 2023, no communication record on file. 11. October 4, 2023, no communication record on file. 12. October 20, 2023, no communication record on file. 13. November 3, 2023, no communication record on file. 14. November 9, 2023, no communication record on file. 15. November 17, 2023, no communication record on file. 16. November 24, 2023, no communication record on file. 17. December 1, 2023, no communication record on file. 18. December 6, 2023, no communication record on file. 19. December 12, 2023, no communication record on file. 20. December 22, 2023, no communication record on file. 21. January 10, 2024, no communication record on file. Facility PN reflected that Hospice was in the facility, saw the resident, and had no recommendation. 22. January 17, 2024, no communication record on file. 23. January 24, 2024, no communication record on file. 24. January 29, 2024, no communication record on file. 25. February 6, 2024, no communication record on file. 26. February 14, 2024, no communication record on file. 27. February 20, 2024, no communication record on file. 28. March 1, 2024, no communication record on file. (continued on next page)

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	315337	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McAuley Hall Health Care Cente	1633 Highway 22 Watchung, NJ 07069

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The communication reflected that in nine months, 26 out of 28 visits had no documented collaboration/communication between hospice and the facility regarding Resident #26. Further review of the hospice fax was a written note from [name redacted] hospice that reflected no paper recommendations in our record, policy is they [HN] are supposed to write recommendation a recommendation order page, leave at facility and bring back a copy to hospice office. On 3/08/24 at 11:51 AM, during a meeting with the surveyors, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the surveyor discussed the concern regarding the lack of coordination and communication between hospice and the facility. On 3/11/24 at 01:04 PM, during a meeting with the surveyors, and the LNHA, the DON stated she had reached out to the liaison of [name redacted] hospice. Moving forward a tracking of the HN visit and communication record was changed and the DON communicated the expectation with [name redacted] hospice. At that time, the DON stated that she was assured in writing by the hospice liaison that the new protocol initiated by the DON will be followed and the current HN was educated on the process to write the recommendation for each patient on every visit. A review of the undated facility provided policy; Hospice Program indicated under section 11. The unit manager on the unit is designated to coordinate care provided to the resident by our facility staff and the Hospice staff she is responsible for the following: b. Communicating with Hospice care representatives and other health care providers participating in the provision of care for terminal illness, related conditions, and other conditions to ensure quality of care for the resident and family. A review of the facility provided Hospice Inpatient, Respite and Home Care Services Agreement dated May 3, 2023, under section B. Initiation and Coordination of Impatient and Respite Services subsection 4. The Hospice nurse shall coordinate the services provided to each patient with facility staff by reviewing the Hospice plan of care . NJAC 8:39-27.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 45208 Based on the interview and record review, it was determined that the facility failed to ensure that the Infection Preventionist (IP), Director of Nursing (DON), Medical Director (MD), or designee attended the quarterly Quality Assurance (QA) meetings. This was identified for three (3) of the three (3) quarterly QA meetings reviewed. This failure had the potential to affect all 68 residents who currently live in the facility. The deficient practice was evidenced by the following: The surveyor reviewed the QA meeting sign-in sheets for the last three (3) quarters dated June 30,2023, September 30, 2023, and January 12, 2024. The sign-in sheets for those three (3) quarters revealed no DON signatures to show that the DON was in attendance for June 30, 2023, and January 12, 2024, QA meetings. There were no IP signatures to show that the IP was in attendance for June 30, 2023, QA meeting, and there were no MD signatures to show that the MD or a designee attended the QA meeting on September 30, 2023. On 3/11/24 at 10:15 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who confirmed the abovementioned concerns. The LNHA stated that she knows the regulations require those individuals to attend. No further information was provided. On 3/11/24 at 10:30 AM, the surveyor interviewed the DON, who stated that she was not sure why she did not sign. She did not recall attending the meeting. The QAPI (Quality Assurance Performance Improvement) plan provided to the survey team revealed that the MD, DON, and IP should be an active member of the organization's quality committee, and the Department Directors (DON, Rehab, Dietary, etc.) should participate in the QAPI activities. As evidence by the following: Guiding Principles section which revealed #3. In QAPI includes all employees, all departments, and all services provided. It further revealed, Guidelines for Governance and Leadership Responsibility and Accountability section, the administrator has the responsibility and is accountable to the board of trustees for ensuring that QAPI is implemented throughout our organization. QAPI activities and discussion will be a standing item on our board of trustees meeting agenda. The administrator will attend all board of director meetings, report on and solicit input on all QAPI activities on a regular basis. The administrator is responsible for assuring that all QAPI activities and required documentation is provided to our corporation. N.J.A.C. 8:39-33.1 (b)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327 Complaint# NJ154270 Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to maintain: a) the residents' patio in a safe and homelike condition for one (1) of two (2) patios, b) the laundry area in a safe and sanitary condition, and c) a safe and sanitary environment in one (1) of three (3) kitchenettes in accordance with the facility procedures and federal regulations, and were identified during the environment tour of the facility. This deficient practice was evidenced by the following: 1. A review of the [DATE] at 9:37 AM phone interview of another surveyor with the anonymous resident's Responsible Party (RP) revealed that according to the RP (also known as the caller), the following was the physical environment outside of the facility's building: -ripped screens in a common area, porch area where the residents hang out. -one screen was ripped by the front door. -The paint was coming off the lower panels in the front of the building On [DATE] at 9:14 AM, during the first day of the survey, the surveyor observed one ripped screen window by the left side front entry of the facility with a chair in that area. There were also multiple lower panels in the front of the building where the paint was coming off. On [DATE] at 11:03 AM, the surveyor toured the laundry area in the presence of the Housekeeping Director (HD), who had been working in the facility as an outside contractor for five years. Upon entry to the laundry area, the surveyor observed grayish substances on the ceiling vent and surrounding two tiles with brownish discoloration. The HD informed the surveyor that a week ago there was a plumbing issue that was resolved, which was why there was a brownish discoloration on two ceiling tiles. The HD stated that the grayish substances on the ceiling vent were an accumulation of dust. The HD stated that there was no accountability log for cleaning the ceiling vent. On that same date and time, both the surveyor and the HD observed a puddle of water on the floor and the surrounding floor area was stained with brownish discoloration. The HD stated that there should be no water on the floor for safety and that the floor should have been cleaned. There was no accountability log for cleaning the floor. On [DATE] at 11:27 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team regarding the ripped screen by the front door. The LNHA stated that it was scheduled for replacement because it was a customized size, and required ordering, this coming spring and part of the preventative maintenance schedule. The surveyor asked for the document regarding the ripped screen and she said she will get back to the surveyor. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 01:10 PM, the Director of Maintenance (DM) provided a copy of the facility's Maintenance Department Preventative Maintenance Spring List schedule as follows: 1. Replacing all broken screen window 2. Replacing all a/c (airconditioned) filters 3. Cleaning the roof and drainage 4. Cleaning the a/c condenser unit Further review of the above preventative maintenance spring list revealed that there was no mention of the front of the building's lower panels paint. On [DATE] at 10:46 AM, the surveyor interviewed the DM about the above findings and concerns. The DM informed the surveyor that he was unable to remember when this year he recommended to the LNHA about repainting the front building panel to make it a little better. The surveyor then asked the DM why he recommended to repaint the front building panel. The DM stated, to improve the structure of the building, for the cleanliness and homelike environment of the residents who live here. He further stated that it was also his responsibility as a DM to make that recommendation to the LNHA because it was the LNHA who would decide. The DM also stated that as per LNHA there was no budget for now. He further stated that the recommendations were all verbal and not documented. On [DATE] at 11:50 AM, the surveyor and the DM went outside the building and observed the ripped screen in the common area entrance of the building where a chair was located. The DM stated that during summer and when the weather was nice, residents come out and sit in the chair to hang out. At that same time, both the surveyor and the DM observed the lower panels in the front area of the building with paint coming off. The DM stated that he was aware of the paint coming off which was why he previously recommended that to the LNHA, and the answer was there was no budget, and that he could only recommend. Furthermore, both the surveyor and the DM observed three plastic screen panels coming out from three airconditioned systems in residents' rooms, facing the front of the facility's main entrance on the right side of the building. The DM stated that it only happened probably the last storm and yes, it should have been fixed. On that same date and time, the surveyor also notified the DM of the concern regarding the laundry area. The surveyor and the DM also went inside the laundry area and the two tiles were replaced and the air vent was still with grayish substances which the HD stated yesterday as dust. The DM stated that it was not due to plumbing issues that the two tiles had brownish discoloration, it was because of the condensation from the washers and dryers in the laundry. He further stated that the maintenance staff did work on it and now fixed after surveyor's inquiry. On [DATE] at 11:50 AM, the survey team met with the LNHA and the Director of Nursing (DON), and the surveyor notified the facility management of the above findings and concerns. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 01:02 PM, the survey team met with the LNHA and DON. The LNHA stated that the facility had no policy with regard to the environment. 45208 2. On [DATE] at 11:14 AM, the surveyor toured the 2nd floor kitchenette. Observations were made of the following: ~Ice machine bottom outside vent had brown colored sediment in the vent grid. ~Full size refrigerator: the door gasket around door was dirty with particles in the grooves of the rubber and parts of the rubber gasket were torn. The surveyor also observed was the right lower drawer was cracked on front panel and brown debris and hair were noted under the cracked drawer. The outside of the refrigerator bottom vent was splattered with brown sticky debris at the base of the refrigerator. ~coffee pot glass carafe had white flake sediment crusted on internal bottom. ~trash can: no lid or containment top noted lined with a trash bag. ~wall above trash can: observed sediment, stains, and brown sticky substance on the wall ~shelving units under countertop housed a jar of fish spread that was opened, unlabeled and undated, On [DATE] at 11:26 AM, the surveyor interviewed floor staff licensed practical nurse (LPN) who stated, the nursing staff was to notify the kitchen if items are expired, need restock or things are soiled, and they will take care of it. They come every morning to stock the kitchen and check refrigerator temperature. On [DATE] at 11:31 AM, the surveyor interviewed the food service director (FSD) who stated, the kitchen staff was responsible for stocking the refrigerator and keeping the temperature log up to date daily. Housekeeping was responsible for the cleaning. She further elaborated that juice, health shakes crackers and graham were stocked by the dietary department. But I expect my staff to report to me if there are any cleaning or maintenance issues. Then I will report it to the proper department either housekeeping or maintenance depending on the problem. On [DATE] at 11:49 AM, the surveyor interviewed the DON. The DON stated that it was her expectation to have clean kitchenette and the door be closed. She further stated that she expected staff to notify her and housekeeping if there was something soil, and/or maintenance if there was something broke. Housekeeping was a verbal notification and maintenance was a log notification. The DON also stated that it was every departments responsibility to maintain a clean and sanitary environment. On [DATE] at 01:05 PM, the survey team met with the LNHA and DON, and the surveyor notified the facility management of the above findings. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 01:35 PM, the surveyor interviewed the HD who stated, we make sure the counters, sink, refrigerator, and floors were clean, strip and wax the floors as well, kitchenettes were on a daily schedule. The HD added that anyone can notify the department with an issue. The HD further stated that it was verbal notification and there was no accountability log. The HD stated that it was his expectation that the kitchenette was cleaned, disinfected and suitable for residents or staff to use. A review of the facility's housekeeping and laundry service agreement with an outside source, which was provided by the LNHA, revealed; 1.) Scope of work: commencing on [DATE], the company will provide such housekeeping and laundry management, supervision, labor, and materials as company determines necessary, in its discretion, to provide the services identified in exhibit A. a further review of exhibit A includes but is not limited to: Full-service housekeeping and laundry service shall be provided. On [DATE] at 12:16 PM, the survey team met for an Exit Conference with the LNHA and DON. The facility management had no additional information provided. NJAC 8:,d+[DATE].4(a)(b)(f)

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 45449 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure the facility staff had mandatory training that outlined and informed staff of the elements and goals of the facility's Quality Assurance and Performance Improvement (QAPI) program for five (5) of five (5) Certified Nurse Assistants (CNAs) reviewed for mandatory education. The deficient practice was evidenced by the following: The surveyor requested five (5) random CNA education files for the year 2023. A review of the facility form, Employee Official Inservice Transcript for [facility name redacted] for the 2022 to 2023 revealed the log did not include the mandated QAPI education training. On 3/11/24 at 11:51 AM, during a meeting with the surveyors, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the surveyor discussed the concern regarding the missing in-services for the CNAs. At 01:04 PM, during a meeting with the surveyors, the DON stated they had no policy and/or procedure for the CNA mandatory education. At that time, the LNHA confirmed that they did not do annual in-service for the QAPI program. On 3/12/24 at 10:41 AM, during a follow-up meeting with the surveyors, and the DON, the LNHA stated the in-services for QAPI should have been done and moving forward it has been added to the list of yearly mandatory training for the CNAs. No additional information was provided. N.J.A.C. 8:39-9.3(2),33.1

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 45449 Based on interview and review of other facility documentation, it was determined that the facility failed to ensure the facility staff had the mandatory behavioral health training for five (5) of the five (5) Certified Nursing Assistants (CNAs) reviewed for mandatory education. The deficient practice was evidenced by the following: The surveyor requested five (5) random CNA education files for the year 2023. A review of the facility form, Employee Official Inservice Transcript for [facility name redacted] for 2022 to 2023 revealed the log did not include the mandated behavioral health education training. On 3/11/24 at 11:51 AM, during a meeting with the surveyors, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the surveyor discussed the concern regarding the missing in-services for the CNAs. At 01:04 PM, during a meeting with the surveyors, the DON stated they had no policy and/or procedure for the CNA mandatory education. At that time, the LNHA confirmed that they did not do annual in-service for the behavioral health training. On 3/12/24 at 10:41 AM, during a follow-up meeting with the surveyors, and the DON, the LNHA stated the in-services for behavioral health training should have been done and moving forward it has been added to the list of yearly mandatory training for the CNAs. No additional information was provided. NJAC 8:39-9.3(2), Appendix B XI-5