STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. Building B. Wing	11/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Healthcare Center	1417 Brace Road Cherry Hill, NJ 08034

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33106 Complaint# NJ149075, NJ149176 Based on observation, interview, and review of other facility documentation it was determined that the facility failed to a.) maintain the resident's environment, equipment and living areas in a safe, sanitary, and homelike manner. This was cited at an E level. This deficient practice was cited at a lower level at the last annual survey of 3/12/21. A plan of correction submitted by the facility at the time failed to maintain cleanliness in the facility. This deficient practice was identified for 3 of 5 units (Court 1, Court 2 and Pavilion Units) and was evidenced by the following: Surveyor #1 conducted a tour of the Court 2 Unit on 10/8/21 at 9:15 AM. Surveyor #1 interviewed a staff member who was sitting at the nursing station who identified herself as the LPN/UM. The LPN/UM stated that the Court 2 Unit was comprised of all Dementia (cognitively impaired) residents and some residents that had behavioral disturbances related to dementia. She stated that the census was 58 residents and that 33 of the residents ambulated independently. The LPN/UM identified the two hallways as A hallway and B hallway During the tour Surveyor #1 identified the following: 1.) Hallway floors in front of the nurse's station on the A and B hallways were sticky, dirty with brown dried substance that the staff (Housekeeping and Certified Nursing Assistant) identified as feces. It appears that someone walked in the feces and tracked it through the unit. There were pieces of trash, orange needle covers, tissues and cups on the floors throughout the halls. 2.) The resident bathroom that was located on the B hallway had dried feces on the toilet and cups and trash were on the floor. 3.) room [ROOM NUMBER]'s floor was wet with black substance and debris and tissues were on the floor. The resident was confused and laying in bed and was not able to be interviewed. (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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The B hallway housekeeper confirmed that the hallway floors were dirty with food, debris, and dried areas of feces. She also accompanied Surveyor #1 to the resident's bathroom on the B hallways and confirmed that the toilet had dried feces all over the seat and trash on the floor. She explained that she came in late and did not have a chance to clean the unit. She added that she used a string mop to clean the floors but that it was the floor technician's responsibility to deep clean the floor with an electric floor scrubber, but they did not have a floor scrubber at this time. She also added that any staff member could have wiped up the dried feces that was located throughout the halls. (during the interview, Surveyor #1 observed multiple staff members walking throughout the halls and past the dried feces that was located on the hallway floors). The housekeeper did not have an explanation about the cleanliness of the unit. On 10/8/21 at 10:15 AM, Surveyor #1 conducted a tour of the A and B hallways of the Court Unit with the housekeeper from the B hallway and the Housekeeping Director (HD). At the time of tour, the HD could not locate the housekeeper from the B hallway. During the tour, the HD confirmed that the hallways and the resident room floors were very, very dirty and unsanitary. He stated that he relayed his concerns to corporate office that he needed the proper supplies and assistance to sanitize and scrub the floors in the halls and the resident's rooms. He stated that he only had string mops instead of microfiber mops. He said that the microfiber mops were effective at preventing cross contamination. He also added that resident rooms were supposed to be carbolized (deep cleaned), but that it has not been done for months. He said that when a resident's room was carbolized that all the furniture from the resident's room was removed, bedside curtains were cleaned and that floors were stripped and rewaxed. He revealed that this had not been done in months because he didn't have the staff to do the job and he didn't have a floor scrubber to be able to clean the floor properly. He added that the floor scrubber broke a few months ago and that he has been asking the cooperate office for a new one but has not received yet. On 10/8/21 at 10:25 AM, the Director of Nursing (DON), the Infection Preventionist (IP), the LPN/UM and the Maintenance Director (MD) accompanied Surveyor #1 to tour Court 2-unit, A and B hallways. All disciplines agreed that that they were very concerned about the cleanliness of the hallway's floors and floors in the resident's rooms. All disciplines also agreed and confirmed that the cleanliness of the floors and walls in the hallways and in resident rooms were unacceptable. The MD confirmed that the facility has not had a floor scrubber, but that it was ordered. The IP stated that it was an infection control issue because of the excessive amount of fecal matter present and urine on the floor within the resident's environment posed an infection control issue. On 10/8/21 at 11:30 AM, Surveyor #1 interviewed CNA who stated that maintenance issues were reported through a computer system and the maintenance department were supposed to check the system and fix the concerns. She stated that she was unsure on how to enter the concerns in the computer system, but that she would report it to the nurse so the nurse could notify maintenance. She added that the environmental conditions on the Court 2 were horrible and that even when issues were reported nobody does anything about it. On 10/8/21 at 11:35 AM, Surveyor #1 interviewed the Licensed Practical Nurse (LPN) who had been employed in the facility for 7 years and who worked on the Court 2 Unit. The LPN stated that she reported concerns to the maintenance staff directly about the broken handrails however they don' fix them. The LPN also revealed that the resident rooms have not been carbolized for months. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/8/21 at 2:30 PM, Surveyor #1 interviewed the Licensed Nursing Home Administrator (LNHA). The LNHA stated that he and the Regional Directors of Operations conducted an environmental round together on 10/4/21. The LNHA stated that a few dirty rooms were identified but admitted that they did not go into all the resident rooms. The LNHA provided Surveyor #1 with an email dated 10/5/21 at 11:13 AM from the Regional Director of Operations (RDO) and titled, Housekeeping Rounds. The email contained the following information: 1.) room [ROOM NUMBER] needs better floor cleaning. 2.) room [ROOM NUMBER] needs cleaning. 3.) room [ROOM NUMBER] needs to be carbolized ASAP (as soon as possible) 4.) room [ROOM NUMBER] needs to be carbolized ASAP 5.) room [ROOM NUMBER] total carb needs to be done ASAP 6.) Vent hallway needs to be stripped. 7.) room [ROOM NUMBER] total carb needed ASAP. 8.) room [ROOM NUMBER] total carb needed ASAP. 9.) room [ROOM NUMBER] total carb needed ASAP. The email indicated that the work needed to be done by the end of the week, however this was not done and this was confirmed by the LNHA. The LNHA admitted that the environmental and housekeeping concerns identified by himself and the RDO were not rectified because the facility did not have the proper floor scrubber. The LNHA then provided Surveyor #1 with a receipt dated 10/6/21 for a floor scrubber. The LNHA could not provide Surveyor #1 with any documentation as to when the residents rooms on the Court 2 Unit were last carbolized. On 10/12/21 at 9:30 AM, Surveyor #1 interviewed the LNHA who stated that he did not have the staffing to carbolize resident rooms and stated that he was not a, Slum Lord. He then stated that it would be important to assure that resident rooms were carbolized and deep cleaned to prevent the spread of germs and admitted that the rooms were dirty but did not give a detailed explanation as to why. He did indicate that he felt that someone was doing it on purpose because he did make sure that things were fixed and cleaned but had no evidence to this claim. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor #1 interviewed the RDO on 10/12/21 at 9:42 AM who stated that when environmental rounds were conducted on 10/4/21 he provided the LNHA with a list of concerns. He could not answer as to why the environmental concerns were not fixed but felt that it was sabotage or vandalism but had no evidence to this statement. He then stated that the rooms should have been carbolized and cleaned as per the carbonization schedule and that a lack of staff was a huge factor as to why the environment was not clean or sanitary. He then added that it was not an excuse and that a lot of work needed to be completed in the facility. Surveyor #1 conducted a tour of Court 1 Unit on 10/18/21 at 12:31 and observed the following: 1.) The staffing office hallway had broken handrail. The surveyor touched the handrail, and a piece of the handrail broke off. 2.) The surveyor observed that there were multiple loose handrails in the staffing hallway. 3.) On Court 1 the surveyor observed a loose handrail near the nurse's station near the double fire doors. 4.) Both air conditioning units were broken in the small sitting room in front of the nurse's station. 5.) The push bar on fire doors had pieces missing which exposed sharp edges on both doors. 6.) The wallpaper in the dining room was peeling off the walls, cobwebs were observed in the corners of walls and water stains were observed on the ceiling tiles. 7.) The air conditioning unit in the TV room was broken on the wall. 8.) Broken handrail with sharp edges located between the janitor's closet and soiled utility room. 9.) The call bell system was not functioning in resident rooms and bathrooms in rooms 105, 106, 107, 108, 112, and 116 B. 10.) The toilet in room [ROOM NUMBER] was not flushing correctly. The resident in that room stated that he/she was manually pouring water down the toilet so that it would flush. 11.) The fish tank in the staffing hallway was without a proper filtration system. The water was stagnant and dirty with algae. There was a live fish in the tank. On 10/18/21 at 01:57 PM, Surveyor #1 interviewed the MD in the presence of the life safety surveyor who stated that the call bell system on Court 1 unit has been broken for a month due to faulty wiring in the walls. He stated that administration knew that the call light system was not working, and that the unit was not ready for residents to live there. He also stated that the Administrator was supposed to provide the residents with tap bells but does not know why he didn't provide them to the residents. On 10/08/2021 at 10:30 AM, Surveyor #3 conducted the tour after the breakfast meals and observed the following: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.) Hall A on the Court Unit (Dementia Unit) the double door leading to the resident rooms, the Aluminum cover was missing exposing a jagged sharp edges creating a potential for injury. 2.) Observation on 10/08/2021 at 10:45 AM, Hall A revealed flooring with brownish stains, stained wallpaper, and furniture in disrepair. 3.) Observations on 10/08/2021 at 11: 00 AM, revealed missing blinds in room [ROOM NUMBER]. 4.) Observations on 10/08/2021 at 11:15 AM, revealed hands rails not mounting properly on the wall. 15 of the 25 handrails on Hall A were not properly mounted to the wall. 12 of the 25 handrails were broken exposing jagged edges. 5.) Observations on 10/08/2021 at 11:30 AM, of room [ROOM NUMBER] and # 223 revealed 2 broken air conditioning. The air conditioning covers were missing, large amount of dust and debris were noted inside the air conditioning units. 6.) Observations on 10/08/2021 at 11:35 AM, of Resident rooms # 215 and # 218 revealed 2 uncovered electrical outlets. 7.) Observations on 10/08/2021 at 11:40 AM, of Resident room # 210 revealed a clogged toilet covered with feces. The toilet was observed in the same condition on 10/12/2021 at 08:30 AM. 8.) Observation on 10/08/2021 at 11:45 AM, revealed a discolored, torn mattress in room # 207. 9.) Observation on 10/08/2021 at 11:50 AM, of Resident room [ROOM NUMBER] revealed a brown substance splattered on the wall and brown substance on the floor. 10.) Observations on 10/08/2021 at 11:55 AM, of Resident room # 219 a black substance on the floor. Surveyor #3 conducted an interview with a CNA assigned to the Court 2 unit on 10/08/2021 at 12:05 PM who stated, Life is nasty here. Since I start working here, no trash bag to place the dirty linen. You cannot get clean linen every day. We do not have gown or wash cloth. We had feces on the floor since Monday. We had asked housekeeping to clean the floor, we were told , I am not assigned to this hall. We are working short of staff every day. Surveyor #3 conducted an interview with the LPN/UM assigned to the Court 2 Dementia Unit on 10/08/2021 at 12:15 PM. The LPN/UM stated that the feces had been on the floor on Court 2 Unit since Monday. The LPN/UM stated that the housekeeping staff were informed but she did not reach out to the Housekeeping Director (HD) for follow up. On 10/08/2021 at 12:30 PM, Surveyor #3 observed a housekeeping staff in the soiled utility room. An interview with the staff revealed that housekeeping staff were scheduled to work the day shift only. There was no staff assigned on the 3:00 PM-11:00 PM shift. The housekeeping staff went on to state that the facility did not have the staff to perform the required cleaning. We do not have the supplies. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor #3 interviewed the HD on 10/08/2021 at 1:15 PM. The HD stated that he scheduled eight staff for work that day, but only 4 staff reported to work. The HD further stated that housekeeping staff were expected to clean resident rooms and common areas daily and follow a cleaning schedule. However, he indicated that staff failed to report to work almost every day. He acknowledged that the floor had not been scrubbed because the facility did not have the equipment needed to clean the floor. Upon further inquiry, the HD revealed that he did not have the staff to complete the work. During a follow up interview on 10/08/2021 at 2:30 PM, the HD stated that he was aware of the condition of the Court 2 Unit and he kept requesting supplies from the Administrator and was left empty handed. He went on to say, It is a travesty, imagine having a family member living in that condition. Behaviors or not the condition of the room, fully all operational things, the simple decor, cracking walls, over all the customer service. The facility needed to be staffed better. These are nursing issues, cannot speak for them. Additionally the HD stated, I do not have the equipment needed, such as an auto scrubber. I had asked the corporate administrator and the Administrator for an auto scrubber it falls on deaf ears. I have been told numerous times, 'We are working on it.' It had been seven weeks. Surveyor #9 made the following observations in room [ROOM NUMBER] on Court 1: On 10/21/21 at 8:50 AM, Surveyor #9 observed Resident #99 sitting up in his/her wheelchair eating breakfast. The resident complained that the toilet in the room was clogged. At that time, the surveyor observed the toilet in the resident's room was clogged with a bowel movement and there were multiple flies flying around the toilet. Resident #99 further stated that every time the toilet is fixed, it breaks again. The resident also stated the toilet has been currently broken for the last one to two days and that the resident will just use the toilet even if it is clogged with bowel movements. The surveyor further observed there were multiple flies flying around the resident while he/she was eating breakfast and a fly landed on his/her Styrofoam water cup. The resident stated that the flies have been in the room for about a month and that it is worse when the toilet is broken. The resident further stated that sometimes the flies land on his food. On 10/21/21 at 8:55 AM, Surveyor #9 observed Resident #21 sitting up in bed. The resident stated every time the toilet is fixed, it works for a day or two before clogging again. The resident further stated the odor in the bathroom is terrible. The surveyor then observed a fly land on the resident's forehead and the resident stated the flies have been bad all summer. On 10/21/21 at 9:00 AM, Surveyor #9 observed Resident #12 sitting on the side of bed. The resident stated he/she can't use the toilet in the room because it is broken and that he/she has to use the bathroom across the hall which is very inconvenient. The resident further stated the flies are a pain. On 10/21/21 at 11:11 AM, Surveyor #9 observed Resident #99 lying in bed and a fly landed on the resident's arm. On 10/22/21 at 9:08 AM, Surveyor #9 observed Resident #21 sitting up in his/her wheelchair next to the bed which had two flies on the pillows and one fly on the privacy curtain. (continued on next page)

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Assist the Maintenance Director in developing and implementing waste disposal policy and procedures. -Assure that the facility is maintained in a clean and safe manner for resident comfort and convenience. -Assure that all residents receive care in a manner and in an environment that maintains or enhances their quality of life without abridging the safety and right of other residents. The job description titled, Maintenance Director and dated May 2020 indicated that the primary purpose of this position is to maintain the orderly functioning of all equipment in the facility including the kitchen, laundry, heating, air conditioning and elevators as well as purchasing the necessary supplies for repair, maintenance, and emergencies within the budgetary guidelines. The main duties include the following: -Assure the proper maintenance and running of all electricity and plumbing in the entire building. -Assure the proper maintenance and running condition of all equipment in the building. -Perform all repairs that do not fall under the purview of housekeeping. -Supervise repairs and routine maintenance of the building and all departmental equipment. The undated Maintenance and Repair policy provided to Surveyor #1 on 10/12/21 at 3:46 PM indicated the following: -existing structures should be replaced or repaired as needed. The job description titled, Director of Housekeeping with a of May 2020 indicated that the Director of Housekeeping was responsible for planning, organizing, staffing, directing, coordinating, reporting, budgeting and physical management of the housekeeping departments employees and equipment in a way that maximum cleanliness and order throughout the building and laundry services for both resident clothing and facility linen are maintained. The HD must - Be physically and mentally capable of performing job duties. -Must have compassion, tolerance and understanding for the elderly. -Update and correct personnel policies pertaining to the housekeeping and laundry staffs and submit to the Administrator for approval. To staff and residents (at a ratio of 3:1). -Supervise the laundry staff to ensure proper handling of isolation linen and clothing, laundering, and drying all delivered linen and clothing, proper distribution of clean clothing to residents, and proper distribution of bed linen and towels on all wings to ensure continuous service to residents. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Implement any plan of corrections as required by state and federal surveys in the housekeeping department. -Provide monthly, quarterly, and annual reports including recommendations for changes in center practice for the Quality Assurance and Performance Improvement Committee. The facility policy titled, Cleaning Methods-Housekeeping, updated on 05/17/21 indicated that the facility will develop a cleaning schedule utilizing the same procedure for rooms on isolation precautions. Clean the room thoroughly once the resident had been discharged . Terminal cleaning of the walls, blinds, curtains are not recommended unless they are visibly soiled. High touch cleaning surfaces will be cleaned and disinfected on a more frequent schedule compared to minimal touch housekeeping surfaces. High touch surfaces include, but are not limited to: -bed rails -call bells -doorknobs -faucet handles -light switches -surfaces in and around toilets in resident rooms Cleaning of resident rooms will be performed daily to include: -high dusting -spot-cleaning the walls -windows -doors -light fixtures -ledges -tables -chairs -beds -call bells -floors (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-vacuuming carpets The policy also indicated that curtains were to be cleaned on a routine basis and when visible soiled, bathrooms daily and that equipment was to be maintained in good repair. The facility undated and unsigned Admission Agreement indicated that the facility would provide the resident with services in accordance with State and Federal regulations. Such services included: room and board, general nursing care and nursing treatments such as administration of medication, preventative skin care, assistance with bathing toileting, feeding, dressing, mobility, housekeeping services, recreational activities and social programs and certain personal care services and as may be required for health, safety, and well-being of the resident among other services. The facility undated form titled, Housekeeping Carbed Room Schedule indicated that terminal cleaning of room would be done on a revolving schedule and the following cleaning would take place: -Remove waste -High dust -Clean and disinfect all flat surfaces -dust mop -Disinfect the bathroom -Stock supplies -Wet mop the floor The facility policy dated March 2016 and titled, Bathroom Cleaning indicated that housekeeping was to be provided with a complete outline of the equipment and supplies necessary to perform daily routine cleaning of the bathrooms. The policy specified that daily cleaning would be done to ensure optimum levels of cleanliness and sanitation, prohibit the spread of infection and bacteria and maintain the outward appearance of the facility. NJAC 8:39-4.1 (a), 11, 12, 21.3 (a) (b), 27.2 (j), 31.2 (a-e), 31.3, 31.4 (a-f), 27193 41260

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 27193 Based on observation, interview, and record review, it was determined that the facility failed to implement Care Plan interventions to address residents with known maladaptive behaviors such as spitting and urinating on the floor in their bathroom and common areas of the facility. This deficient practice was identified for 2 of 38 residents reviewed for care planning (Residents #95, and #96), and was evidenced by the following: During the tour of the Pavilion Unit on 10/18/2021, Surveyor #3 observed that the dayroom had stained flooring, urine on the floor in the sunroom, feces in dayroom, and feces on the furniture. The above concerns were addressed with the nursing staff which revealed that both residents, Resident #95 and #96 shared a room and had behaviors of spitting and urinating on the floor. 1. According to the Admission Face Sheet, Resident #95 was admitted to the facility with diagnoses which included vascular dementia with behavioral disturbances, Alzheimer's disease, unspecified abnormality of gait, agitation and diabetes mellitus. The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 08/21/2021 revealed that Resident #95 scored 02 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident had severely impaired cognition. A further review of the MDS revealed Resident #95 was rarely or never understood, and could responds adequately to simple direct communication only. Further review of the clinical record revealed that Resident #95 was totally dependent on staff for care. On 10/26/2021 at 10:11 AM, two surveyors observed Resident #95 urinating on the floor at the entrance of the nursing station. Housekeeping was called to mop the floor, Resident #95 was escorted to the room for care after the episode. An interview with the nurse confirmed that Resident #95 had a behavior of spitting and urinating on the floor. Resident #95's Comprehensive Care Plan initiated on 05/16/2021 was reviewed. There was no identified focus/ goals or interventions related to the maladaptive behavior of urinating and spitting on the floor in the room and common areas of the facility. The behavior was not addressed in the care plan. There was no directive in place for the staff to manage the behavior. 2. Resident #96 shared the room with Resident #95. Resident #96 displayed behaviors of urinating and spitting on the floor. Resident #96 had a care plan that addressed the behavior as follows: Care Plan focus area noted the following: Resident #96 had a behavior problem of urinating & spitting on the floor; yelling/cursing disrupting others related to schizoaffective disorder, dementia & decreased vision. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The goal was: Resident #96 will have fewer episodes of Specify: urinating on the floor initiated since 2019. Interventions for the resident's Care Plan included: - Resident #96 will have fewer episodes of Specify: urinating on the floor. - Anticipate and meet needs. - Document behaviors, and resident response to interventions. - Housekeeping to clean bathroom twice a day. - If reasonable, discuss behavior. Explain/reinforce why behavior inappropriate and/or unacceptable. -Praise any indication of progress/improvement in behavior. The Care Plan was not revised to implement specific intervention on how the behavior would be addressed. Surveyor #3 observed Resident #96 spitting on the floor during meals, staff confirmed the behavior. According the Infection Preventionist the nursing staff were to initiate cleaning and call housekeeping for disinfecting the area. The care plan did not include how Resident #96 would be educated or redirected to curtail the behavior. There were no meaningful interventions in place for the staff to manage the behavior. The facility policy dated 01/05 and titled, Care Plans-Comprehensive reflected that the policy of this facility is to develop a individual and comprehensive care plan for each resident which includes measurable objectives and timetables to meet the resident's medical, nursing and psychological needs. The policy specifically indicated that in the Pavilion Unit that the team would meet and review the resident's plan of care on admission and weekly and that Care Plans were also reviewed and updated as changes in the resident's condition dictates The undated and unsigned facility Admission Agreement (AA) indicated that the facility would provide the resident with services in accordance with State and Federal regulations. Such services included: room and board, general nursing care and nursing treatments such as administration of medication, preventative skin care, assistance with bathing toileting, feeding, dressing, mobility, housekeeping services, recreational activities and social programs and certain personal care services and as may be required for health, safety, and well-being of the resident among other services. The AA also indicated that the resident and the resident designees are encouraged to participate in the development of the resident's Care Plan. The Resident's care plan was to be developed upon admission and updated throughout the resident's stay based on the resident's medical condition and personal needs and lays out specific care and assistance to be provided to the resident by the facility's staff members. The AA specified that as the resident's wishes or needs change, the resident's care plan would be updated. NJAC 8:39-11.2e2.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39770 Based on observation, interview, and record review, it was determined the nursing staff failed to a.) document the administration of medications on the Medication Administration Record (MAR), and b.) ensure the reconciliation, accountability, and notification of the physician for the use of a floor mat. This deficient practice was identified for 3 of 5 residents, (Resident #8, #117, and #31) reviewed for documentation and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case 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. According to the Resident Face Sheet, Resident #117 was admitted to the facility with medical diagnoses that included, dementia with behavioral disturbance, anxiety disorder, major depressive disorder, psychosis, bradycardia, and muscle wasting/atrophy. Review of the resident's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 8/19/2021 revealed that Resident #117 was identified with severe cognitive impairment, mild depression, bipolar disorder with behaviors that occurred daily, needed limited assistance from staff for Activities of Daily Living (ADLs) and identified with no impairment of upper or lower extremities. On 10/21/2021 at 10:41 AM, the Surveyor #8 reviewed Resident #117's MAR for the month of October 2021. During the review of the MAR, Surveyor #8 observed 15 signature areas on the MAR that were not completed by the Registered Nurses (RN) and Licensed Practical Nurses (LPNs) across all shifts. Resident #117's medications included: Vistaril 50 milligrams (mg) 1 tablet by mouth every 6 hours for anxiety to be given at 12AM, 6AM, 12PM and 6PM. The dates and times of missing signatures were as follows: 12AM on 10/18/21; 6AM 10/18/21; 12PM on 10/6/21, 10/7/21, 10/8/21, 10/12/21, 10/13/21, 10/18/21, 10/19/21, 10/20/21; 6PM 10/1/21, 10/2/21, 10/16/21, 10/17/21, 10/20/21. Seroquel 100mg 1 tab by mouth at bedtime for bipolar disorder to be given at 9PM. The dates of missing signatures on those dates were 10/7/21 and 10/16/21. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Donepezil tablet 5mg 1 tab by mouth at bedtime (9PM). The dates for the missing signatures were 10/1/21, 10/4/21, 10/7/21, 10/19/21. Venlafaxine tab 75 mg 1 tablet by mouth once daily (9AM) - missing signature date 10/3/21. Risperidone 0.5mg tablet 1 tablet by mouth every morning and bedtime (9AM & 9PM) - missing signatures 9PM 10/1/21, 10/2/21, 10/7/21. No other documentation was observed noting why the medications were not given or signed by the nursing staff. On 10/21/2021 at 10:58 AM, the surveyor interviewed the LPN on Court 2 who worked the day shift. The MAR was not signed for eight days of the October MAR during the day shift. The LPN stated signing the MAR indicated that a medication was given. The LPN also stated, My job is to give the medications and sign for it. There is no reason the MAR didn't get signed, but I know I gave it to him every day. I just forgot to sign the MAR. On 10/25/21 at 11:03 AM, the surveyor interviewed the Infection Preventionist (IP) regarding medication administration. The IP stated that she expected documentation on the MARs immediately after the resident was administered the medications. The IP stated, If the MAR is not signed, it means you didn't give the medications. If not signed for multiple times, there needs to be a one-on-one meeting with the staff member, because it meant it was probably a routine occurrence. The surveyor informed the IP, the LPN informed Surveyor #8 she was too busy to sign the MAR after giving the medications. The IP stated, How are you too busy to sign the MAR? It's a part of your job. The IP further stated, Yes, she was supposed to sign the MAR. Everyone should sign the MAR immediately after giving medication, on all shifts. On 10/26/21 at 11:17 AM, the surveyor interviewed the Interim Director of Nursing (DON) regarding medication administration. The DON stated she would expect the LPN to read the order, identify the resident, right dose, right route, then stand next to resident to make sure they take the meds and were not choking. The DON further stated if there were pain medications given, the LPN must check to make sure the pain medication was effective. After the medications were given, the LPN should sign for the medications after administration. The DON stated If there are missing signatures, I would assume that the med [medication] wasn't given. If it isn't signed, it isn't done. If a medication error occurred, the staff would have to call the physician to let him know. The DON stated her expectation was the LPN would give the medication to the resident and sign the MAR immediately after administering the medications to the resident. On 10/27/21 at 1:30 PM, the surveyor conducted a follow up interview with the IP regarding the LPN on the night shift who didn't sign the October 2021 MAR for Resident #117. The IP stated she would be getting a statement from the LPN about why the MAR wasn't signed. The IP did not provide the surveyor with any statements from the staff regarding failure to sign the MAR. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Medication Administration - Policy and General Guidelines, dated 5/02. Under the heading Documentation: Charting the Administration of a Medication - a. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of the medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications. Charting of medication administration shall be kept current and shall be completed immediately following the administration of the drug; and d. The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration. Initials on each MAR are verified with a full signature in the space provided. On 10/18/21 at 10:04 AM, during the initial tour, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) on the Pavilion unit who stated she had started on 8/17/21. The UM/LPN stated Resident #31 had a fall recently with no major injuries. The surveyor reviewed the medical record for Resident #31. A review of the Admission Record face sheet revealed the resident was admitted with diagnoses which included: history of falls, presence of artificial hip joint and other abnormalities of gait (walking) and mobility. A review of the annual MDS, dated [DATE], reflected that the resident had a Brief Interview of Mental Status (BIMS) score of 3 out of 15 which indicated the resident had severely impaired cognition. It further reflected that the resident required extensive assistance with most activities of daily living, including transferring, dressing and toileting. In addition, in section J: Health conditions that the resident had two (2) or more falls since admission. A review of the resident's individualized care plan revised 9/20/2021, included that the resident had falls on 5/5/21, 5/20/21, 8/23/21, 9/15/21, 9/22/21 and 9/30/21 with an intervention which included the use of floor mats to bedside initiated on 5/20/21. A review of the current physician's Order Summary Report (OSR) dated October 2021, reflected there was not a physician's order (PO) for the floor mats. On 10/18/2021 at 10:29 AM, the surveyor observed Resident #31 lying in bed resting. The left side of the resident's bed was against the wall with the half side rail up on the right side. There were no floor mats (made from high-impact foam to help prevent injury from potential falls) observed in the resident's room while Resident #31 was lying in bed. On 10/22/2021 at 10:58 AM, the surveyor observed Resident #31 in bed and no fall mats on the side of the bed. At approximately 11:00 AM, the surveyor interviewed the UM/LPN who stated Resident #31 had fall mats in the room. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At approximately 11:05 AM, the surveyor interviewed the LPN, who stated Resident #31 never had fall mats and had not fallen recently. At approximately 11:10 AM, the surveyor interviewed the CNA, who stated Resident #31 never needed fall mats. On 10/26/21 at 12:35 PM, the surveyor observed Resident #31's bed against the wall and no floor mats in the room. Resident #31 was observed seated in the dayroom [ROOM NUMBER] in a high back wheelchair. At that time, surveyor #14 interviewed a second CNA #2. The CNA #2 stated that she got the resident up out the bed that morning and did not see any floor mats in the resident's room. On 10/27/21 at 10:58 AM, the surveyor interviewed the UM/LPN. The UM/LPN acknowledged if there was a floor mat intervention on the care plan then the resident should have the floor mats. He stated Resident #31 was a high fall risk so he/she should have the floor mats while in bed. He further stated he was not familiar with any interventions put in place prior to him starting at the facility but knows since he started, Resident #31's falls have been from the wheelchair and not out of the bed. The UM/LPN stated he was not sure if there was an order for the floor mats but if so, it would be on the Treatment Administration Record (TAR). The UM/LPN and surveyor #4 reviewed the TAR and the UM/LPN acknowledged there was no evidence for the reconciliation, accountability, or notification to the physician for the floor mats. On 10.27.21 at 9:53 AM, the Survey Team Coordinator (TC) requested the facility policy for the policy for Charting and Documentation policy. The facility did not provide the policy. NJAC 8:39-11.2(b), 29.2(d) 43308

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33106 Complaint # NJ 149075 Part A. Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to provide a safe physical environment to prevent the likelihood of serious injury, harm or death, by failing to a.) ensure all hallway handrails (used by residents as mobility enablers and assist with ambulation or standing) were securely mounted to the walls for 15 of 25 handrails on the Court #2 Dementia Unit, and ensure hallway handrails were in good repair and free from sharp, jagged edges with exposed nails and missing pieces for 26 of 50 handrails on the Court #2 Dementia Unit, exposed nails on a piece of wood located within a handrail located on the Court #1 Unit, and improperly secured and loose handrails identified on 3 of 5 resident units (Court #1 Unit, #2 Unit and Pavilion), b.) ensure that electrical outlets were covered with outlet covers in 6 of 6 resident rooms (rooms 215, 218, 230, 231, 238, and 240), and an appropriate cover protected a bathroom light fixture to prevent exposed live wires (identified in 1 of 36 resident rooms, room # 229, on, 1 of 5 units (Court #2 Dementia Unit). The facility's failure to provide securely mounted handrails in good repair, free of jagged edges, missing pieces, and free of exposed nails on wood located inside a handrail, posed a serious and immediate threat to the safety and wellbeing of all residents who resided in the facility. A serious adverse outcome was likely to occur/occurred as the identified non-compliance resulted in an Immediate Jeopardy (IJ) situation that was identified on 10/08/21 at 5:00 PM. It was also identified that the IJ situation began on 07/18/21, when a resident sustained a fall due to a broken handrail on the Pavilion unit, which remained in disrepair. The facility submitted an acceptable removal plan via electronic mail (e-mail) on 10/22/21 at 5:38 PM. The removal plan was verified by the survey team during a removal plan revisit on 11/1/2021. See Example 1. Part B Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to provide a safe physical environment to prevent the likelihood of serious injury, harm or death, by failing to c.) ensure that 2 supply closets containing hazardous materials were securely locked and free from the likelihood of resident access. The two supply closets were observed to be in unsafe, unsanitary conditions and contained items that would be detrimental to the health and safety of the residents for 2 of 25 residents (Resident #49 and 109), who were cognitively impaired and ambulated independently on the Court 1 unit, and d.) consistently implement fall interventions per a resident's care plan, complete an incident report and documentation per facility policy for a resident with a history of falls and who sustained a fall (Resident #141). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility administrator was made aware of the immediate jeopardy (IJ) related to the unsecured supply closets on 10/19/2021, a removal plan was submitted on 10/20/2021 and verified by the surveyors on 10/20/2021. See Example 1. Part C Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to provide a safe physical environment to prevent the likelihood of serious injury, harm or death, by failing to e.) ensure a safe environment for residents throughout the facility when an active gas leak was identified in the facility laundry room. The faulty ill-maintained conditions of the dryers in combination with the active gas leak posed a serious and immediate threat to all residents who resided in the facility. This resulted in an Immediate Jeopardy (IJ) situation that began on 10/19/21 at 9:10 AM and continued until 10/19/21 at 10:15 AM, when the gas company responded and subsequently issued a violation. See Example 1. PART D Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to provide a safe physical environment to prevent the likelihood of serious injury, harm or death, by failing to f.) securely safeguard hazardous materials, chef knives, over-the-counter medications, and potentially dangerous equipment (self-closing door device) and devices (belts) from vulnerable and ambulatory residents by ensuring a functional locking mechanism was installed, maintained, or utilized on the respective doors to keep residents safe and free of serious injury, harm, impairment, or death, on 3 of 5 units (Court 1, Atrium, and Pavilion Unit). The facility's failure to identify the environmental hazards posed a serious and immediate threat to the safety and wellbeing of all residents residing on the identified units. A serious adverse outcome was likely to occur as the identified non-compliance was occurring on a unit identified as having residents diagnosed with dementia or psychiatric diagnoses, who were also able to ambulate independently around the unit. This resulted in an IJ situation that began on 10/24/21 when the Two (2) knives were observed in the unsecured drawer in the unlocked Medication Room. The IJ continued facility alleged complete implementation of the elements of their removal plan accepted on 10/29/21 and verified by the survey team. The facility administration was notified of the Immediate Jeopardy situation on 10/24/21 at 4:00 PM. The facility failed to securely safeguard hazardous chemicals, chef knives, over-the-counter medications, and potentially dangerous equipment (self-closing door device) and devices (belts) from vulnerable and ambulatory residents by ensuring a functional locking mechanism was installed, maintained, (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Healthcare Center	1417 Brace Road Cherry Hill, NJ 08034

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After consultation with the office, it was determined that an Immediate Jeopardy (IJ) situation was identified on 10/24/2021 at 4:00 PM. An acceptable removal plan was received on 10/27/21 (for hazardous knives) and the removal plan was verified onsite on 10/29 /21.

See Example 1.

The evidence is as follows:

Part A

1. On 10/08/21 at 9:15 AM, Surveyor #1 conducted a tour of the Court 2 Unit. Surveyor #1 interviewed a staff member who was sitting at the nursing station who identified herself as the Licensed Practical Nurse Unit Manager (LPN/UM). The LPN/UM stated that the Court 2 Unit was comprised of residents who had Dementia (a cognitive impairment) and some of the residents had behavioral disturbances that were related to the Dementia. The LPN/UM stated that the current resident census was 58, and 33 of the 58 residents ambulated independently on the unit.

Surveyor #1 observed the following:

a. Resident room: #215, #218, #230, #231, #238, and #240 had uncovered exposed electrical outlets that were accessible to residents.

b. Resident room [ROOM NUMBER] had an uncovered bathroom electrical light fixture with exposed electrical wires which were at the ground level and accessible to vulnerable residents.

c. The hallway A and hallway B on the Court 2 unit had 15 of 25 handrails that were observed as being loose and were not securely mounted to the walls and some of the handrails were observed as hanging off of the wall; and 26 out of 50 hallway handrails were broken with sharp, jagged edges, and missing pieces with exposed nails.

At that time, the surveyors observed multiple residents ambulating through the halls and using the handrails as enablers for ambulation.

On 10/08/21 at 9:30 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that she was assigned to provide care to the residents in rooms 221 through 231. She stated that if she noticed any maintenance issues that she would report concerns to the nurse so that the nurse could notify the maintenance staff. She added that she was unaware that electrical outlets in rooms [ROOM NUMBERS] needed to be covered and stated that she did not report it because she was not aware. She stated that the uncovered light fixture in room [ROOM NUMBER] had been that way (did not specify length of time) and that she did not report it because she did not know that it should have been covered.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/08/21 at 10:25 AM, Surveyor #1 interviewed that Maintenance Director (MD) who stated that he was unaware that there were uncovered electrical outlets in rooms #215, #218, #230, #231, #238, and #240. He further stated that he was unaware that there was an uncovered light fixture with exposed electrical wires in room [ROOM NUMBER]. He stated that those concerns would be a hazard because of the confused residents that resided on the Court #2 Unit. At that time, the MD, Director of Nursing (DON), Infection Preventionist (IP) and LPN/UM accompanied the surveyor on a tour of the Court 2 Unit and confirmed the surveyors observations regarding the handrails on the A and B hallways that were not securely mounted to the walls, were loose and broken. The MD stated to Surveyor #1, at that time, that he was not aware that so many handrails in the halls were broken and had jagged, sharp edges. He admitted that the handrails were in disrepair and that they needed to be addressed right away to prevent someone from getting injured. He also revealed that the building was in bad shape when the new owner took over, but that was no excuse. The DON, IP and LPN/UM were all in agreement that the aforementioned areas of concern were a hazard to the residents safety on the Court 2 unit. On 10/08/21 at 11:30 AM, the Surveyor #1 interviewed a CNA who stated that maintenance issues were reported through a computer system and the maintenance department was supposed to check the system and fix the concerns. She stated that she was unsure on how to enter the concerns in the computer system, but that she would report it to the nurse so the nurse could notify the maintenance department. She stated that the environmental conditions on Court #2 were horrible and that even when issues were reported nobody did anything about it. The CNA did not elaborate about what the horrible conditions were and at that time, made a hand gesture and pointed around the unit to the handrails that were in disrepair. On 10/08/21 at 11:35 AM, Surveyor #1 interviewed the Licensed Practical Nurse (LPN) who had been employed in the facility for 7 years and who worked on the Court 2 Unit. The LPN stated that she reported concerns to the maintenance staff directly about the broken handrails and they don't fix them. On 10/08/21 at 11:40 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) who had been employed at the facility for one week. She stated that she was not educated on how to enter maintenance concerns into the computer but that she would verbally tell the maintenance staff about the issues concerning the broken, loose handrails in the hallways on the Court #2 unit. She added that nothing happens. On 10/08/21 Surveyor #3 reviewed three randomly selected facility investigations for resident accidents. Surveyor #3 reviewed an investigative report (IR) dated 07/18/21. The IR report reflected under Nursing Description the following documentation was noted: Resident [referring to Resident #1] stood up out of wheelchair and attempted to hold onto rail outside of his/her room to close his/her door, when the rail fell causing him/her to lose balance and fall on his/her buttocks to the floor. The IR indicated that the nursing supervisor was notified. The IR also indicated that the resident had no injury apparent and that the Resident did not hit his/her head. A statement obtained from Resident #1 on 07/18/21, the day of the fall indicated the following: I was trying to close my room door and grabbed hold of the rail to support me and it fell , causing me to fall. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/12/21 at 12:45 PM, Surveyor #3 conducted a tour of the Pavilion Unit where Resident #1 resided. Surveyor #3 conducted an interview with Resident #1 at that time, while Resident #1 was seated in the hallway across from Resident room [ROOM NUMBER]. Resident #1 stated to the surveyor that he/she recalled the incident when he/she fell , and proceeded to point to the handrail where the incident occurred. At that time, Surveyor #3 touched the handrail identified by Resident #1, and the handrail fell from the wall to the floor. Resident #1 further stated the nurse can tell you all about the incident. On 10/12/21 at 1:15 PM, Surveyor #3 interviewed the Licensed Practical Nurse (LPN) who revealed that maintenance staff attempted to re-attach the handrail on the morning of 10/12/21. Upon further inquiry the LPN indicated that the handrail was never repaired after Resident #1 fell . The LPN could not elaborate on whether or not a work order was generated for the repair of the handrail after it fell from the wall on 07/18/21. On 10/12/21 at 2:10 PM, Surveyor #3 interviewed the MD who indicated that he was not aware that a broken handrail on the Pavilion Unit needed to be repaired. He further stated that he was not aware that Resident #1 had sustained a fall on 07/18/21, due to a faulty handrail. The surveyor inquired about the process for repair and escorted the MD to the Pavilion Unit where both observed the handrail on the floor. The MD stated to the surveyor that he did not have a work order for the handrail and he stated that he toured the Pavilion Unit twice weekly. The MD stated there was no maintenance book as the facility implemented an electronic reporting system and he would review the electronic report, look at the timeframe and request the materials needed to complete the work. He further added, If you can get the material, the work would be completed. The MD stated he was clearly not aware of the broken handrail. The hand rail identified as the causal factor for the fall of 07/18/21, was not repaired until 10/12/21 at 3:00 PM. The facility's failure to identify the environmental hazards posed a serious and immediate threat to the safety and wellbeing of all residents on all the units and resulted in an immediate jeopardy situation that began on 7/18/21, when Resident #1 on the Pavilion Unit had a fall caused by a broken handrail which was not corrected by the facility and the facility handrails continued to be in disrepair until 10/26/21, during the standard survey. On 10/18/21 to 10/19/21, Surveyor #14 observed the following: 1. On 10/18/21 At 09:41 AM, the surveyor observed a 1-foot linear section of handrail located by the Medical Supply room and Resident room [ROOM NUMBER], that was loose and not anchored securely to the wall when tested . The edge of the handrail was missing its protective cover and produced a sharp edge. 2. On 10/19/21 at 01:52 PM, the surveyor observed a loose corner handrail by Resident rooms #252 and #253. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	3. On 10/19/21 at 03:28 PM, the surveyor observed the closed section of unoccupied resident rooms # 335, 336, 337, 338, 339, 340, 341, 342, 343, and 344, the corridor was still maintained as an active exit in the event of an emergency. The entire top protective cap to the handrails was missing approximately 50' on each side. The missing protective cap now produced sharp edges and would hinder residents that used that exit in the event of an evacuation. These findings were acknowledged and confirmed by the Maintenance Director in an interview during the observation. He stated that the section of handrail cap was missing as the protective caps were being used in other areas of the facility. On 10/18/21 at 11:00 AM, Surveyor #5 observed the handrail by room [ROOM NUMBER], on the Court #1 Unit. The handrail had a piece of broken molding-type wood that had exposed nails located inside of the resident handrail, and the handrail outside of the residents room was broken and was not securely fastened to the wall. At that time, the facility IP was on the unit and Surveyor #5 interviewed the IP about the broken handrail and wood with exposed nails in the handrail. The IP stated she was unaware of the broken hand rail, looked at the piece of wood with the nails and removed it and stated yes it is confirming the handrail was broken and confirmed there was ambulatory residents on the unit and stated Resident #19 and #37 were ambulatory. On 10/18/21 at 12:31 PM through 12:55 PM, Surveyor #1 and #5 observed the following on the Court #1 Unit: 1. The handrail near the staffing office near the dining room, lifted off of the wall when the surveyor touched it. 2. There was an unstable, loose handrail near the fire door by the nurses station. 3. The push panic bar on both fire doors had pieces missing and there was sharp edges on both doors. 4. There was a broken handrail with sharp edges located in between the janitors closet and the soiled utility room. The facility's failure to ensure that electrical outlets in 6 of 6 resident rooms (#215, #218, #230, #231, #238 and #240) and exposed live wiring in 1 resident room (#229) posed a serious and immediate threat to vulnerable residents and resulted in an immediate jeopardy situation was identified on 10/08/2021 at 5:14 PM. The facility provided an acceptable IJ Removal Plan on 10/12/2021 at 4:00 PM. The IJ removal plan was verified on-site on 10/12/2021. Part B 1. On 10/19/2021 at 9:45 AM, Surveyor #15 and Surveyor #16 observed an unlocked room labeled supply closet during a tour of the Court #1 unit. The surveyors observed a lock was present and attached to the door, in a locked position, but was not in a fixed position to lock and secure the door. The supply closet was found to be unsafe, and with unsanitary conditions. The supply closet was in disarray. The following was observed upon entry: a. A used housekeeping cart with wet mop bucket. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/24/21 at 12:26 PM, the two surveyors observed on the Pavilion unit a door easily accessible to residents in the resident area adjacent to the nurses station. The door was labeled as a Restroom and was marked for male or female use. The door was unlocked and there was a small hole in the door. There was also a tongue blade sitting in the wedge of the molding next to the door. The surveyors easily entered the bathroom and observed that there was no emergency pull cord installed in the bathroom. It was not labeled as a staff bathroom either. At that time, the DON came around the corner and the surveyors pointed it out to her. The DON acknowledged that it was not labeled as a staff bathroom, but she believed it was intended for staff. She confirmed that if it was not locked and had no functioning lock residents would be able to easily access it. She could not speak to why there was a tongue blade on the wall next to the door, except that maybe it was just because staff are lazy and left it there. She then removed the blade. She stated that they would have to get a new lock for that bathroom, so it would not be accessible to residents especially since it did not have an emergency pull cord installed. She stated that they would relabel the door to indicate it was for staff use only because there was no emergency call bell system installed. The DON was unsure if any residents had entered or used the bathroom in the past, adding that she had only been working here for a few weeks. 27193 Part C 1. On 10/19/21 at 9:10 AM, Surveyor #14 conducted a tour of the facility laundry room with the Maintenance Director (MD). The large laundry room contained four commercial clothes dryers. There was a small enclosed room in the back of the four dryers that was vented with outside air. The surveyor identified an odor of what seemed like natural gas. The surveyor in the presence of the MD, who had been employed by the facility for 6 months, initially stated he did not smell the odor of natural gas, but then confirmed he did smell something, but

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 39460 Based on observation, interview, and record review it was determined the facility failed to: a.) accurately document the administration of controlled medications, b.) ensure Narcotic Shift Count logs were completed for accuracy and accountability, and c.) maintain a system of record keeping that ensures an accurate inventory of controlled medications. This deficient practice was identified for 1 of 2 medication carts reviewed on 1 of 4 units. The evidenced was as follows: On 01/06/22 at 8:56 AM, the surveyor in the presence of the Licensed Practical Nurse (LPN) inspected the Court 1 cart A which revealed: 1. A reconciliation review of the narcotics located in the secured and locked narcotic box revealed, for one unsampled resident, that the number of tablets remaining on the declining inventory sheet did not match the number of tablets remaining inside the packaging. The declining inventory sheet indicated there should be 23 tablets of clonazepam 0.5 milligram (mg) (medication used for anxiety) remaining. A review of the corresponding actual medication revealed there were 22 tablets remaining. 2. A review of the facility narcotic shift to shift count/sign in sheet for January 2022 date 1/6/22 under the heading In 7A-3P and under the columns INITIALS, CARDS #, # Bottles, Patches # revealed the sections were not endorsed by nursing and were left blank. 3. In the locked and secured narcotic lockbox which was located under the resident specific controlled substance blister packages of medication were #50 completed and signed resident specific controlled substance prescriptions. The prescriptions were rolled and bound in a rubber band. At that time the LPN stated that she had administered one tablet of clonazepam to the unsampled resident that morning, and had forgotten to sign it out. She further stated that she had been distracted by another resident who required her attention as she walked out of the unsampled resident's room and forgot to sign the declining inventory sheet. When interviewed regarding the narcotic shift to shift count/sign in sheet the LPN stated there was a whole lot of confusion when she came in that morning. She further stated that it was her first time working at that facility and that the off-going shift nurse mentioned something about a narcotic sheet and signing it, but that she hadn't seen the page to sign. The LPN stated she had no idea why there were completed prescription blanks being stored in the narcotic lock box. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 9:20 AM, the surveyor interviewed the Court 1 Register Nurse Unit Manager (RNUM) who stated she had been working as the Unit Manager for two months. The RNUM stated the narcotic shift to shift sheet should have been signed by both the incoming and outgoing nurses and she, herself, had witnessed the nurses counting the cards earlier that day. The RNUM stated it was important that the nurses count the items in the lock box to acknowledge the counts are correct at change of shift. The RNUM and the surveyor then reviewed the declining inventory sheet and the unit dose blister pack for the unsampled resident's clonazepam. The RNUM acknowledged the discrepancy and stated the LPN should have signed the declining inventory sheet as soon as she poured the medication. When asked about the rolled up completed prescription blanks, the RNUM stated that before the new ownership took over the nurses would keep the prescriptions there to keep them secure. The RNUM stated the prescriptions should be sent to the pharmacy or placed in the resident's medical recort. At 10:49 AM, the surveyor interviewed the Director of Nursing (DON) who stated she had been the DON at the facility for 6 weeks. The Don stated the declining inventory sheets must be signed when the nurse pulls/poured the narcotic, because even if the resident refused the controlled mediation it must be accounted for. The DON acknowledged the narcotic shift to shift count sheet should have been completed and initialed by the in-coming nurse. The DON further stated there should not be any resident prescription blanks located in the narcotic lock box and that after talking to the RNUM there was no procedure in place to deal with the prescription blanks. At 12:51 PM, the surveyor interviewed the facility provider pharmacy pharmacist who stated the procedure for filling a controlled substance prescription was that the facility would fax the prescription to the pharmacy, the prescription would then be filled and upon delivery to the facility, the facility would place the original prescription in a red envelope for the driver to deliver back to the provider pharmacy. The script would then be reconciled at the provider pharmacy which would retain the record. At 1:00 PM, the surveyor reviewed the facility provided consultant pharmacist report dated 01/04/22 which revealed the pharmacist had completed an inspection of Unit Court 1. The pharmacist indicated on the report No discrepancies were found in spot check count, 2 cards that were off count by 1; nurse was notified and corrected. At 1:08 PM, the surveyor interviewed the consultant pharmacy (CP) representative, who was not the consultant pharmacist who completed the floor inspection for Court 1 on 01/04/22. The CP stated they had just started their contract with the facility and part of the responsibilities of the CP was to ensure the narcotic counts were correct by doing spot checks, educating the nurses, and completing medication pass observation. The CP further stated that a CP had done an inspection on 1/4/22 and that they did find irregularities, but they had not found any completed and rubber banded prescription blanks anywhere in either cart A or cart B. If the CP had found the prescriptions that would be something that would have been brought to the attention of the DON. A review of the undated Silver Healthcare Center Policy/Procedure Medication Administration did not reveal facility procedure for narcotic medication administration. Also, the facility failed to provide a copy of the facility's medication storage policy for review. N.J.A.C. 8:39-29.7

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Reference F689, F700, F760, F880, F908. Based on observations, interviews, review of medical records and review of facility documents, it was determined that the facility Licensed Nursing Home Administrator (LNHA) failed to ensure: a.) the residents environment was safe and free from accidents/hazards by ensuring all handrails were properly secured throughout the facility after the LNHA was made aware that improperly secured handrails caused a fall on 7/18/2021, and during survey on 10/08/2021, surveyors observed the handrail that caused the fall on 7/18/2021, remained improperly secured. A total of 15 of 25 handrails were observed as not secured to the walls, and 26 of 50 handrails had jagged edges; b.) exposed outlets and electrical wires were covered to prevent serious injury; c.) provide effective environmental, housekeeping, pest control measures to limit the spread of infections; d.) ensure staff follow a system to inform the Dialysis Center of contagious infection diseases upon resident transfer; e.) staff adhered to the appropriate transmission based precautions during resident care and environmental cleaning for the Ventilator Unit; f.) ensure a system to install and maintain bed rails in a safe and secure manner was followed; g.) a system for identifying an active gas leak was in place in the facility laundry room; and, h.) the facility clothes dryers were maintained in a safe operating manner. The failure of the LNHA to ensure the facility operated in manner that ensured residents were cared for in a manner and in an environment that enabled residents to maintain or attain their highest practicable physical, mental, and psychosocial well-being posed a serious and immediate threat to the health, safety and welfare of all residents who resided in the facility, as well as ensure the staff followed Policy & Procedures for the above, as outlined in the Facility Administrator Job Description, resulted in an initial immediate jeopardy (IJ) that was identified on 10/08/21 at 5:00 PM. Additional deficient practices that rose to the IJ level were identified during the on-site visit on 10/12/2021, and the facility was notified on 10/14/21 at 1:30 PM. The facility submitted a removal plan by e-mail on 10/14/2021 however, the LNHA administrator of record resigned on 10/19/2021 and a new administrator of record was in place on 10/22/2021. The survey team conducted a removal plan revisit on 11/1/2021 and verified the removal plan. Part A Refer to F689J, F880L, F700J, 760J. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/12/2021, The LNHA further failed to ensure that effective housekeeping and environmental services were provided in the facility to prevent the transmission and spread of infectious disease on 1 of 5 units reviewed (Court 2, Dementia unit where 58 residents resided and 33 were ambulatory) by ensuring: hallway floors, walls, resident rooms (210, 216, 218, 221, 234) and bathrooms on Court 2 were free from dried feces on surfaces throughout the unit, loose trash was removed and discarded, individual resident HVAC (Heating, Ventilation & Air Conditioning) units (room [ROOM NUMBER] and 223) had covers to prevent the excessive buildup of dust and debris within their filters, privacy curtains were free from stains and dirt, and resident rooms were on a carbolization (deep cleaning) schedule (this was not occurring for months per staff interviews due to a lack of functioning cleaning equipment). This immediate jeopardy was identified on 10/08/2021 and the facility was notified of the IJ on 10/14/2021. The LNHA resigned on 10/19/2021. Findings included: 1. The facility administrator failed to protect residents from accidents hazards. The facility Administrator failed to ensure that the environment was safe and free of accidents hazards. During the tour on 10/08/2021, the surveyors observed that handrails used by residents on the Dementia Unit were broken; that 25 of the 50 handrails on Court 2 (Hall A, Hall B) were not properly mounted to the wall; and that 12 of the hand rails were observed with jagged sharp edges creating a potential for injury. 31654 Surveyor #1 conducted a tour of the Court 2 Unit on 10/8/21 at 9:15 AM. The surveyor interviewed a staff member who was sitting at the nursing station who identified herself as the Licensed Practical Nurse Unit Manager (LPN/UM). The LPN/UM stated that the Court 2 Unit was comprised of all Dementia (cognitively impaired) residents and some residents that had behavioral disturbances related to dementia. She stated that the census was 58 residents and that 33 of the residents ambulated independently. During the tour the Surveyors #1 and #3 identified the following: The surveyor observed residents' rooms: #215, #218, #230, #231, #238, and #240 had uncovered exposed electrical outlets accessible to residents. The surveyor also observed that in resident room [ROOM NUMBER] there was an uncovered bathroom electrical light fixture with exposed live electrical wires which was at ground level and accessible to residents. The surveyor observed that on hallway A and hallway B of the Court 2 unit there were 15 of 25 hallway handrails that were loose and not securely mounted to the walls. Some handrails were loose while others were hanging off the wall. There were also 26 out of 50 hallway handrails that were broken with sharp and jagged edges exposed. The surveyors also observed multiple residents ambulating through the halls and using the handrails as enablers for ambulation. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/8/21 at 9:30 AM, Surveyor #1 interviewed the Certified Nursing Assistant (CNA) who stated that she was assigned to provide care to the residents in rooms 221 to 231. She stated that if she noticed any maintenance issues that she would report concerns to the nurse so that the nurse could notify the maintenance staff. She added that she was unaware that electrical outlets in rooms [ROOM NUMBERS] needed to be covered. She also stated that she did not report it because she did not know about it. She revealed that the uncovered light fixture in room [ROOM NUMBER] had been that way and that she did not report it because she did not know that it needed to be covered. On 10/8/21 at 10:25 AM, Surveyor #1 interviewed that Maintenance Director (MD) who stated that he was unaware that there were uncovered electrical outlets in rooms #215, #218, #230, #231, #238, and #240. He also stated that he was unaware that there was an uncovered light fixture with exposed electrical wires in room [ROOM NUMBER]. He revealed that these issues would be a hazard because of the confused residents that resided on the Court 2 Unit. At this time, the MD, Director of Nursing (DON), Infection Preventionist (IP) and LPN/UM accompanied Surveyor #1 on a tour of the Court 2 Unit and acknowledged that a lot of the handrails on the A and B hallways were not securely mounted to the walls, were loose and broken. The MD stated to the surveyor at this time, that he was not aware that so many handrails in the halls were broken with jagged, sharp edges. He admitted that the handrails were in disrepair and needed to be addressed right away to prevent someone from getting injured. He also revealed that the building was in bad shape when the new owner took over, but that was no excuse. The DON, IP and LPN/UM were all in agreement that the aforementioned areas of concern were a hazard to the residents safety on the Court 2 unit. On 10/8/21 at 11:30 AM, Surveyor #1 interviewed the CNA who stated that maintenance issues were reported through a computer system and the maintenance department was supposed to check the system and fix the concerns. She stated that she was unsure on how to enter the concerns in the computer system, but that she would report it to the nurse so the nurse could notify the maintenance department. She added that the environmental conditions on the Court 2 were horrible and that even when issues were reported nobody does anything about it. The CNA did not elaborate about the horrible conditions but made hand gestures and pointed around the unit to the handrails that were in disrepair. On 10/8/21 at 11:35 AM, Surveyor #1 interviewed the Licensed Practical Nurse (LPN) who had been employed in the facility for 7 years and who worked on the Court 2 Unit. The LPN stated that she reported concerns to the maintenance staff directly about the broken handrails, however they don't fix them. On 10/8/21 at 11:40 AM, Surveyor #1 interviewed the LPN/UM who had only been employed in the facility for one week stated that she was not educated on how to put maintenance concerns in the computer but that she would verbally tell the maintenance staff about the issues concerning the broken, loose handrails in the hallways on the Court two unit. She added that nothing happens. She also denied knowing about the uncovered electrical outlets and uncovered light fixture with exposed live wires. On 10/8/21 at 2:30 PM, Surveyor #1 interviewed the Licensed Nursing Home Administrator (LNHA) who stated that he was unaware of the exposed electrical outlets in rooms #215, #218, #230, #231, #238, and #240 or about the bathroom light uncovered in room [ROOM NUMBER] with exposed live wires. He also denied having any knowledge that some of the hallway handrails were loosely mounted to the walls and that a lot of the handrails were broke with sharp jagged edges. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The LNHA stated that he made environmental rounds on 10/4/21, with the facilities Regional Director of Operations (RDO) and Regional DON. He revealed that the MD was not included in the environmental rounds. He then added that they found a few dirty rooms but admitted that he did not go into every room. At this time the LNHA viewed pictures that the surveyor had taken of the environmental hazardous on Court 2 Unit. The LNHA admitted that the aforementioned areas of concern were a hazard to the resident's safety on the Court 2 Unit and that a resident could get hurt. When the surveyor asked the LNHA why they could get hurt on the Court 2, he verified that the residents on that unit had decreased cognition. During the complaint survey conducted on 10/12/2021, the surveyor reviewed three random investigations for accidents and hazards, for Resident #1 who was admitted to the facility with diagnoses which included vascular dementia with behavioral disturbances, Hypertension, Dysphasia following other cerebrovascular disease. The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 07/06/2021, revealed that Resident #1 was awake, alert, and able to make his/her needs known. Resident #1 scored 14 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated intact cognition. On 10/08/2021 at 2:30 PM, Surveyor #1 reviewed a random investigative report dated 07/18/2021. Under Nursing Description the following was noted: Resident [referring to Resident #1] stood up out of wheelchair and attempted to hold onto rail outside of his/her room to close his/her door, when the rail fell causing him/her to lose balance and fall on his/her buttocks to the floor. Supervisor notified. No injury apparent. Resident did not hit his/her head. A statement obtained from the resident on 07/18/2021, the day of the fall indicated the following: I was trying to close my room door and grabbed hold of the rail to support me and it fell , causing me to fall. The causal factor identified by the facility was a faulty handrail and the intervention was to notify maintenance to fix the handrail. On 10/12/2021 at 12:45 PM, Surveyor #1 toured the Unit to ensure the handrail was fixed and interview the resident. The surveyor observed Resident #1 sitting in the hallway across from room [ROOM NUMBER]. The resident told the surveyor that he/she recalled the incident and pointed to the handrail where the incident occurred. The surveyor went and touched the handrail, and the handrail fell on the floor. The resident further stated that the nurse can tell you all about the incident. During an interview on 10/12/2021 at 1:15 PM, the LPN assigned to the unit revealed that staff attempted to re-attach the handrail this morning. Upon further inquiry the LPN indicated that the handrail was never repaired after the fall. The LPN could not elaborate on whether or not a work order was generated for repair. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/12/2021 at 2:10 PM, Surveyor #1 interviewed the Maintenance Director (MD) who indicated that he was not aware that a broken handrail on the Pavilion Unit needed to be repaired. He was not aware that a resident sustained a fall on 07/18/2021, due to a faulty handrail. The surveyor inquired about the process for repair. The surveyor escorted the MD to the Pavilion Unit where both observed the handrail on the floor. The MD told the surveyor that he did not have a work order for the handrail. He went on to say that he toured the Pavilion Unit twice weekly. There was no maintenance book as the facility implemented an electronic report system. He will review the electronic report, look at the timeframe and requested the materials needed to complete the work. He further added, If you can get the material the work would be completed. For the broken handrail he stated clearly he was not aware of it. Resident #1 had a care plan for fall initiated on 07/20/2021. The goal was for Resident #1 to resume usual activities without further incident. The interventions were: 1. Continue the interventions on the at-risk plan. 2. Educate Resident #1 to call for assistance when attempting to close doors. 3. For no apparent acute injury, determine and address causative factors of the falls. (The hand rail identified as the causal factor for the fall of 07/18/2021, was not repaired until 10/12/2021 at 3:00 PM.) On 10/12/21 at 9:42 AM, the surveyor interviewed the RDO who provided the surveyor with an email that he gave the LNHA concerning the environmental rounds that the RDO and LNHA conducted on 10/04/21. The email was titled, Housekeeping Rounds and was dated 10/5/2021 at 11:13 AM. There were no maintenance issues documented on the email. When the surveyor asked the RDO about the maintenance issues, he stated that they did not see any broken, loose, or jagged sharp handrails nor did they see any uncovered electrical outlets or light fixtures. He then stated that he believed, someone was sabotaging us and breaking the equipment on purpose. He then admitted that they had to do a better job and that lack of staff was a huge part as to why things were not getting done. We are trying to hire more staff and a higher rate. He then stated that this was no excuse and that these aforementioned concerns should have been identified and fixed. 2. During the tour Surveyor #1 identified the following: 1.) Hallway floors in front of the nurse's station on the A and B hallways were sticky, dirty with brown dried substance that the staff identified as feces. It appears that someone walked in the feces and tracked it through the unit. There were pieces of trash, needle covers, tissues and cups on the floors throughout the halls. 2.) The resident bathroom that was located on the B hallway had dried feces on the toilet and cups and trash were on the floor. 3.) room [ROOM NUMBER]'s floor was wet with black substance and debris and tissues were on the floor. The resident was confused and laying in bed and was not able to be interviewed. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The B hallway housekeeper confirmed that the hallway floors were dirty with food, debris, and dried areas of feces. She also accompanied Surveyor #1 to the resident's bathroom on the B hallways and confirmed that the toilet had dried feces all over the seat and trash on the floor. She explained that she came in late and did not have a chance to clean the unit. She added that she used a string mop to clean the floors but that it was the floor technician's responsibility to deep clean the floor with an electric floor scrubber, but they did not have a floor scrubber at this time. She also added that any staff member could have wiped up the dried feces that was located throughout the halls. (during the interview, Surveyor #1 observed multiple staff members walking throughout the halls and past the dried feces that was located on the hallway floors). The housekeeper did not have an explanation about the cleanliness of the unit. On 10/8/21 at 10:15 AM, Surveyor #1 conducted a tour of the A and B hallways of the Court Unit with the housekeeper from the B hallway and the Housekeeping Director (HD.) At the time of tour, the Housekeeping Director could not locate the housekeeper from the A hallway. During the tour, the HD confirmed that the hallways and the resident room floors were very, very dirty and unsanitary. He stated that he relayed his concerns to corporate office that he needed the proper supplies and assistance to sanitize and scrub the floors in the halls and the resident's rooms. He stated that he only had string mops instead of microfiber mobs. He said that the microfiber mobs were effective at preventing cross contamination. He also added that resident rooms were supposed to be carbolized (deep cleaned), but that it has not been done for months. He said that when a resident's room was carbolized that all the furniture from the resident's room was removed, bedside curtains were cleaned and that floors were stripped and rewaxed. He revealed that this had not been done in months because he did not have the staff to do the job and he did not have a floor scrubber to be able to clean the floor properly. He added that the floor scrubber broke a few months ago and that he has been asking the cooperate office for a new one but has not received yet. On 10/8/21 at 10:25 AM, the Director of Nursing (DON), the Infection Preventionist (IP), the LPN/UM and the MD accompanied Surveyor #1 to tour Court 2-unit, A and B hallways. All staff members voiced that they were very concerned about the cleanliness of the hallway's floors and floor in the resident's rooms. All disciplines agreed and confirmed that the cleanliness of the floors and walls in the hallways and in resident rooms were unacceptable. The MD confirmed that the facility has not had a floor scrubber, but that it was ordered. The IP stated that it was an infection control issue because of the excessive amount of fecal matter present and urine on the floor within the resident's environment posed an infection control issue. On 10/8/21 at 11:30 AM, Surveyor #1 interviewed CNA#3 who stated that maintenance issues were reported through a computer system and the maintenance department were supposed to check the system and fix the concerns. She stated that she was unsure on how to enter the concerns in the computer system, but that she would report it to the nurse so the nurse could notify maintenance. She added that the environmental conditions on the Court 2 were horrible and that even when issues were reported nobody does anything about it. On 10/8/21 at 11:35 AM, Surveyor #1 interviewed the Licensed Practical Nurse (LPN) who had been employed in the facility for 7 years and who worked on the Court 2 Unit. The LPN stated that she reported concerns to the maintenance staff directly about the broken handrails, however, they do not fix them. The LPN also revealed that the resident rooms have not been carbolized for months. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/8/21 at 2:30 PM, Surveyor #1 interviewed the Licensed Nursing Home Administrator (LNHA). The LNHA stated that he and the Regional Directors of Operations conducted an environmental round together on 10/4/21. The LNHA stated that a few dirty rooms were identified but admitted that they did not go into all the resident rooms. The LNHA provided Surveyor #1 with an email dated 10/5/21 at 11:13 AM from the Regional Director of Operations (RDO) and titled, Housekeeping Rounds. The email contained the following information: 1.) room [ROOM NUMBER] needs better floor cleaning. 2.) room [ROOM NUMBER] needs cleaning. 3.) room [ROOM NUMBER] needs to be carbolized (carb) ASAP (as soon as possible) 4.) room [ROOM NUMBER] needs to be carbolized ASAP 5.) room [ROOM NUMBER] total carb needs to be done ASAP 6.) Vent hallway needs to be stripped. 7.) room [ROOM NUMBER] total carb needed ASAP. 8.) room [ROOM NUMBER] total carb needed ASAP. 9.) room [ROOM NUMBER] total carb needed ASAP. The email indicated that the work needed to be done by the end of the week, however, this was not done and this was confirmed by the LNHA. The LNHA admitted that the environmental and housekeeping concerns identified by himself and the RDO were not rectified because the facility did not have the proper floor scrubber. The LNHA then provided Surveyor #1 with a receipt dated 10/6/21 for a floor scrubber. The LNHA could not provide Surveyor #1 with any documentation as to when the residents rooms on the Court 2 Unit were last carbolized. On 10/12/21 at 9:30 AM, Surveyor #1 interviewed the LNHA who stated that he did not have the staffing to carbolize resident rooms and stated that he was not a, Slum Lord. He then stated that it would be important to assure that resident rooms were carbolized and deep cleaned to prevent the spread of germs and admitted that the rooms were dirty, but did not give a detailed explanation as to why. He did indicate that he felt that someone was doing it on purpose because he did make sure that things were fixed and cleaned but had no evidence to this claim. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Surveyor #1 interviewed the RDO on 10/12/21 at 9:42 AM, who stated that when environmental rounds were conducted on 10/4/21, he provided the LNHA with a list of concerns. He could not answer as to why the environmental concerns were not fixed but felt that it was sabotage or vandalism, but had no evidence to this statement. He then stated that the rooms should have been carbolized and cleaned as per the carbolization schedule and that a lack of staff was a huge factor as to why the environment was not clean or sanitary. He then added that it was not an excuse and that a lot of work needed to be completed in the facility. On 10/18/21 at 12:31 PM, Surveyor #1 observed the following on the Court 1 Unit: 1.) The handrail near the staffing office broke off from the wall when the surveyor touched it. 2.) There was an unstable, loose handrail near the fire door by the nurses station. 3.) The push bar on the fire doors had pieces missing and there was sharp edges on both doors. 4.) There was a broken handrail with sharp edges located in between the janitors closet and the soiled utility room. On 10/08/2021 at 10:30 AM, Surveyor #3 conducted the tour after the breakfast meal and observed the following: Hall A on the Court Unit (Dementia Unit) the double door leading to the resident rooms, the Aluminum cover was missing exposing jagged sharp edges creating a potential for injury. Observation on 10/08/2021 at 10:45 AM, Hall A revealed flooring with brownish stains, stained wallpaper, and furniture in disrepair. Observations on 10/08/2021 at 11: 00 AM, revealed missing blinds in room [ROOM NUMBER]. Observations on 10/08/2021 at 11:15 AM, revealed hands rails not mounted properly to the wall. 15 of the 25 handrails on Hall A were not properly mounted to the wall. 12 of the 25 handrails were broken exposing jagged edges. Observations on 10/08/2021 at 11:30 AM, of room [ROOM NUMBER] and # 223 revealed 2 broken air conditioning units. The air conditioning covers were missing, large amounts of dust and debris were noted inside the air conditioning units. Observations on 10/08/2021 at 11:35 AM, of Resident rooms # 215 and # 218, revealed 2 uncovered electrical outlets. Observations on 10/08/2021 at 11:40 AM, of Resident room # 210, revealed a clogged toilet covered with feces. The toilet was observed in the same condition on 10/12/2021 at 08:30 AM. Observation on 10/08/2021 at 11:45 AM, revealed a discolored, torn mattress in room # 207. Observation on 10/08/2021 at 11:50 AM, of Resident room [ROOM NUMBER], revealed a brown substance splattered on the wall and brown substance on the floor. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observations on 10/08/2021 at 11:55 AM, of Resident room # 219, a black substance on the floor. On 10/18/21 at 12:42 PM, Surveyor #5 observed that the panic door bar on the Court 1 Unit had sharp, jagged areas. Surveyor #1 conducted a tour of Court 1 Unit on 10/18/21 at 12:31 PM, and observed the following: 1.) The staffing office hallway had a broken handrail. The surveyor touched the handrail, and a piece of the handrail broke off. 2.) The surveyor observed that there were multiple loose handrails in the staffing hallway. 3.) On Court 1 the surveyor observed a loose handrail near the nurse's station near the double fire doors. 4.) Both air conditioning units were broken in the small sitting room in front of the nurse's station. 5.) The push bar on fire doors had pieces missing which exposed sharp edges on both doors. 6.) The wallpaper in the dining room was peeling off the walls, cobwebs were observed in the corners of walls and water stains were observed on the ceiling tiles. 7.) The air conditioning unit in the TV room was broken on the wall. 8.) Broken handrail with sharp edges located between the janitor's closet and soiled utility room. 9.) The call bell system was not functioning in resident rooms and bathrooms in rooms 105, 106, 107, 108, 112, and 116 B. 10.) The toilet in room [ROOM NUMBER] was not flushing correctly. The resident in that room stated that he/she was manually pouring water down the toilet so that it would flush. 11.) The fish tank in the staffing hallway was without a proper filtration system. The water was stagnant and dirty with algae. There was a live fish in the tank. 10/18/21 at 1:00 PM Surveyor #5 interviewed the Registered Nurse (RN) on Court 1. She stated she was the only nurse on the unit, responsible for 25 residents. She stated she knew the call bells did not work and the unit was shut down during covid, and then opened back up 1-2 months ago and the call bells were not functioning. She stated she has addressed this a couple of times and stated the LNHA's last day was on Friday. She stated that the maintenance told her they were getting a new system. She further stated that she tried to do rounds and it gets a bit difficult. She stated other units have tap bells and I have not seen any down on this unit. The RN further stated, it was a problem and repeated it was a problem. The surveyor interviewed a Certified Nurse Aide who stated staff complains of paper towels not being available in the staff bathroom, the residents do not have soap, linens and we do who shifts without towels. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/18/21 at 3:47 PM Surveyor #5 interviewed the LNHA and the Operation Manager for the management company (OM) . The Surveyor discussed the concerns with the OM and LNHA. The OM stated all of the issues you have seen, are issues, I totally agree and they need to be taken care of. On 10/19/21 at 8:23 AM, Surveyor #5 entered the building and observed that the OM was at the LNHA's office an approached the surveyor. The OM stated he was gone and referred to the LNHA. The OM stated that the LNHA had given his notice a few weeks ago and he was not going to deal with the survey. The OM stated the LNHA sent an email last night to the State LNHA board and he pulled his LNHA license from the facility. The OM stated the LNHA has not reached out and that the OM was not listed as the current LNHA of the facility. 33106 On 10/08/2021 at 12:05 PM, Surveyor #3 conducted an interview with a CNA assigned to the unit who stated, Life is nasty here. Since I start working here, no trash bag to place the dirty linen. You cannot get clean linen every day. We do not have gown or wash cloth. We had feces on the floor since Monday. We had asked housekeeping to clean the floor, we were told , 'I am not assigned to this hall.' We are working short of staff every day. On 10/08/2021 at 12:15 PM, Surveyor #3 conducted an interview with the LPN/UM assigned to the Court 2 Dementia Unit. The LPN/UM stated that the feces had been on the floor on Court 2 Unit since Monday. The LPN/UM stated that the housekeeping staff were informed but she did not reach out to the Housekeeping Director (HD) for follow-up. On 10/08/2021 at 12:30 PM, Surveyor #3 observed a housekeeping staff in the soiled utility room. An interview with the staff revealed that housekeeping staff were scheduled to work the day shift only. There was no staff assigned on the 3:00-11:00 PM shift. The housekeeping staff went on to state that the facility did not have the staff to perform the required cleaning, We do not have the supplies. On 10/08/2021 at 1:15 PM, Surveyor #3 interviewed the Housekeeping Director (HD). The HD stated that he scheduled eight staff for work that day, but only 4 staff reported to work. The HD further stated that housekeeping staff were expected to clean resident rooms and common areas daily and follow a cleaning schedule. However, he indicated that staff failed to report to work almost every day. He acknowledged that the floor had not been scrubbed because the facility did not have the equipment needed to clean the floor. Upon further inquiry, the HD revealed that he did not have the staff to complete the work. During a follow-up interview on 10/08/2021 at 2:30 PM, the HD stated that he was aware of the condition of the unit and he kept requesting supplies from the Administrator and was left empty handed. He went on to say, It is a travesty, imagine having a family member that lived in that condition. Behavior or not, the condition of the room, fully operational things, the simple decor, cracking walls, and over all the customer s

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 37218 Complaint # NJ149176 Based on observation, interview, and review of pertinent facility documentation it was determined that the facility failed to provide nursing and related services to assure the residents safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident, as determined by resident assessments and individual plans of care in accordance with the facility assessment. This deficient practice was observed on 4 of 4 nursing units for care related to staffing. On 10/18/2021 at 10:20 AM, Surveyor #1 observed an unsampled resident in the 300 hallway who required help with grooming. The resident stated that because the facility was short staffed he/she did not get help when needed. The resident stated to the surveyor that the, place should be shut down. On 10/18/2021 at 10:23 AM, Surveyor #1 interviewed an unsampled resident on the 300 hallway who stated that they had been residing at the facility for over a month and no one had offered him/her a bath. On 10/19/2021 at 10:25 AM, Surveyor #5 observed Resident #18's room in the presence of the resident's Primary Care Physician (PCP) who stated that the cleanliness of the facility was lacking, and all a person had to do was look at the floors to notice. The PCP further stated that the nurses who worked at the facility had too many residents to take care of which was evidenced by dressings not getting changed and the resident's left soiled in their own urine. During the tour of the Ventilator Unit on 10/21/2021 at 9:49 AM, Surveyor #2 observed Resident #110 lying in bed asleep. Surveyor #2 observed that the resident's hands were clenched bilaterally (on both sides). Surveyor #2 did not observe hand splints or hand rolls in the resident's room. Surveyor #2 interviewed the Registered Nurse (RN) who was present outside of the resident's room at that time. She stated that the resident was in a chronic vegetative state, wore hand splints bilaterally for a couple of hours per day and required Hoyer Lift (mechanical lift) assistance to transfer out of the bed. On 10/22/2021 at 9:48 AM, Surveyor #2 observed Resident #110 lying in bed asleep. Surveyor #2 observed that the resident did not have a Palm Guard on the left hand or a Hand Roll on the right hand. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 9:52 AM, Surveyor #2 interviewed the Certified Nursing Assistant (CNA) who stated that Resident #110's care entailed mouth care, full body wash, lotion, and a clean gown. She stated that the resident was required to wear palm guards around the clock, and they were only removed during care. She stated that the resident had not had them on since Wednesday 10/20/2021 when they were sent to the laundry to be washed. She further stated that the resident had a new palm guard in the drawer and she did not put it on the resident because the resident was supposed to have two of them on, not one as the resident should have worn them bilaterally. She stated that the purpose of the Palm Guard was to prevent contractures and to prevent the resident's finger nails from cutting into his/her palms. She further stated that she was not required to document Palm Guard use, it was just part of the resident's daily ritual. On 10/25/2021 at 8:52 AM, Surveyor #4 observed inside the room of Resident #31 his/her bedside commode (portable toilet) had feces stains inside of it with flies in the room and on the bedside commode. On 10/25/2021 at 9:13 AM, Surveyor #5 interviewed a resident representative who stated that he/she would visit their family member who resided in the facility every other day, but now went to the facility two times a week due to visitation related to the Pandemic. The resident representative stated that he/she didn't like the facility because it was dirty and understaffed and he/she was in the process of moving his/her family member, out of there. The resident representative further stated that the facility was dirty, things were hanging out of walls, the bathroom had clothes laying on the floor, and he/she did not receive updates of their family members condition from the nursing staff. On 10/25/2021 at 9:44 AM, Surveyor #4 interviewed the CNA. He stated the aides were responsible for cleaning the commode and then housekeeping will also come in to clean it. He further stated he did not get to Resident #31's room yet because he had to stop and assist with breakfast. He concluded, it's just not enough staff. Review of New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report for the weeks of 9/12/2021 and 9/19/2021, revealed the facility was deficient in CNA staffing for 14 of 14-day shifts, deficient for total staff to residents on 1 of 14 evening shifts, and deficient in total staff to residents for 1 of 14 overnight shifts as follows: 09/12/2021 had 11 CNAs for 152 residents on the day shift, required 19 CNAs. 09/13/2021 had 11 CNAs for 152 residents on the day shift, required 19 CNAs. 09/14/2021 had 12 CNAs for 152 residents on the day shift, required 19 CNAs. 09/15/2021 had 15 CNAs for 151 residents on the day shift, required 19 CNAs. 09/16/2021 had 15 CNAs for 151 residents on the day shift, required 19 CNAs. 09/17/2021 had 16 CNAs for 151 residents on the day shift, required 19 CNAs. 09/18/2021 had 13 CNAs for 151 residents on the day shift, required 19 CNAs. 09/18/2021 had 8 CNAs to 17 total staff on the evening shift, required 9 CNAs. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/19/2021 had 11 CNAs for 155 residents on the day shift, required 20 CNAs. 09/19/2021 had 11 total staff for 155 residents on the overnight shift, required 12 total staff. 09/20/2021 had 8 CNAs for 153 residents on the day shift, required 20 CNAs. 09/21/2021 had 13 CNAs for 153 residents on the day shift, required 20 CNAs. 09/22/2021 had 14 CNAs for 153 residents on the day shift, required 20 CNAs. 09/23/2021 had 17 CNAs for 153 residents on the day shift, required 20 CNAs. 09/24/2021 had 16 CNAs for 153 residents on the day shift, required 20 CNAs. 09/25/2021 had 15 CNAs for 153 residents on the day shift, required 20 CNAs. 09/25/2021 had 14 total staff for 153 residents on the evening shift, required 16 total staff. Review of New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report for the weeks of 9/26/2021, 10/03/2021, and 10/10/2021, revealed the facility was deficient for CNA staffing on 19 of 21 day shifts and were deficient for total staff for residents on 3 of 21 overnight shifts as follows: 09/26/2021 had 16 CNAs for 155 residents on the day shift, required 20 CNAs. 09/26/2021 had 10 total staff for 155 residents on the overnight shift, required 12 total staff. 09/27/2021 had 18 CNAs for 153 residents on the day shift, required 20 CNAs. 09/27/2021 had 10 total staff for 153 residents on the overnight shift, required 11 total staff. 09/28/2021 had 14 CNAs for 149 residents on the day shift, required 19 CNAs. 09/29/2021 had 16 CNAs for 149 residents on the day shift, required 19 CNAs. 10/01/2021 had 15 CNAs for 149 residents on the day shift, required 19 CNAs. 10/02/2021 had 12 CNAs for 149 residents on the day shift, required 19 CNAs. 10/02/2021 had 10 total staff for 149 residents on the overnight shift, required 11 total staff. 10/03/2021 had 10 CNAs for 144 residents on the day shift, required 18 CNAs. 10/04/2021 had 14 CNAs for 142 residents on the day shift, required 18 CNAs. 10/05/2021 had 15 CNAs for 142 residents on the day shift, required 18 CNAs. 10/06/2021 had 16 CNAs for 141 residents on the day shift, required 18 CNAs. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/07/2021 had 15 CNAs for 141 residents on the day shift, required 18 CNAs. 10/08/2021 had 13 CNAs for 141 residents on the day shift, required 18 CNAs. 10/09/2021 had 14 CNAs for 141 residents on the day shift, required 18 CNAs. 10/10/2021 had 14 CNAs for 141 residents on the day shift, required 18 CNAs. 10/11/2021 had 14 CNAs for 141 residents on the day shift, required 18 CNAs. 10/12/2021 had 15 CNAs for 143 residents on the day shift, required 18 CNAs. 10/14/2021 had 16 CNAs for 142 residents on the day shift, required 18 CNAs. 10/15/2021 had 16 CNAs for 142 residents on the day shift, required 18 CNAs. 10/16/2021 had 15 CNAs for 142 residents on the day shift, required 18 CNAs. The surveyor reviewed the staffing during the re-certification survey from 10/18/2021 through 10/27/2021 which revealed the following concerns: Monday, October 18, 2021. Census (number of residents who resided in the facility) was 142. 7:00 AM - 3:00 PM, 14 CNAs worked. 142 (census) / 14 (divided by the number of CNAs working = 10.1 (number of resident's the CNAs had on their direct care assignments). 3:00 PM - 11:00 PM, 8 CNAs worked. 142/8 = 17.75 Tuesday, October 19, 2021. Census was 141. 7:00AM - 3:00 PM, 15 CNAs worked. 141/15 = 9.4 Wednesday, October 20, 2021. Census was 141. 11:00 PM - 7:00 AM, 10 CNAs worked. 141/10 = 14.1 Thursday, October 21, 2021. Census was 142. 7:00AM - 3:00 PM, 17 CNAs worked. 142/17 = 8.3 11:00 PM - 7:00 AM, 13 CNAs worked. 142/13 = 14.1 Sunday, October 24, 2021. Census was 140. 7:00AM - 3:00 PM, 15 CNAs worked. 140/15 = 9.3 Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum . NJAC 8:39-5.1(a)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33106 Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to operate in a manner to limit the spread of infectious disease by failing to ensure: a.) effective housekeeping, environmental services, and pest control program were provided for 5 of 5 units (Atrium Unit, Pavilion Unit, Court 1 Unit, Court 2 Unit, and Ventilator Unit). b.) a system for communication was followed to inform the Dialysis Center prior to transferring two residents who had a contagious infectious disease (Candida Aureus-a multidrug-resistant organism), for 2 of 2 residents (Resident #28 & Resident #127) who were transferred from the facility Ventilator Unit to the Dialysis Center. c.) staff wore appropriate personal protective equipment (PPE) upon entering residents' rooms who were on transmission-based precautions (TBP) for 3 staff (Respiratory Therapist, Certified Nurse Aide and Housekeeping Staff), on 2 of 5 units (Pavilion and Ventilator Unit). d.) the Certified Nursing Assistant (CNA) went from a person under investigation (PUI) for COVID -19 to a non-PUI resident room wearing inappropriate PPE. Part A The facility's failure to identify the housekeeping and environmental hazards posed a serious and immediate threat to the safety and well-being of all residents who resided on the Court 2 Unit. A serious adverse outcome was likely to occur as the identified non-compliance occurred on a unit identified by the facility as having 58 residents diagnosed with dementia, and 33 out of the 58 residents that resided on the Court 2 Unit ambulated independently. This resulted in an Immediate Jeopardy (IJ) situation that began on 10/08/21 and continued during an on-site re-visit on 10/12/21. The facility was notified of the continued IJ situation after further investigation on 10/14/21 at 1:30 PM. On 10/18/21, during an on-site survey, the survey team determined the IJ situation continued. The facility submitted an acceptable removal plan via electronic mail (email) on 10/22/21 at 5:38 PM. The IJ removal plan was verified as implemented during an on-site re-visit on 10/29/21. The non-compliance remained on 10/29/21 for no actual harm with the potential for more than minimal harm that is not immediate jeopardy based on the following; reference F880 The evidence was as follows: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Two surveyors (Surveyor #1 and #3) conducted a tour of the Court 2 Unit on 10/08/21 at 9:15 AM. Surveyor #1 interviewed a staff member sitting at the nursing station and identified herself as the Licensed Practical Nurse Unit Manager (LPN/UM). The LPN/UM stated the Court 2 Unit comprised residents with Dementia (a cognitive impairment) and residents with behavioral disturbances related to dementia. She stated that the unit census was 58, and 33 of the residents ambulated independently. The LPN/UM identified the two hallways as A and B hallway. The surveyors observed the following: 1. The hallway floors located in front of the nurse's station and on the A and B hallways had debris scattered throughout, and a sticky feel underfoot was noted, with dried brown substances throughout, that was identified by the Certified Nurse Aides, the Licensed Practical Nurse, and unit housekeeper as feces. The surveyors observed that it had appeared as if someone had walked through feces and tracked it throughout the floors of the unit. There were pieces of trash, orange-colored plastic-type needle covers, tissues, and plastic cups on the floors throughout the hallways. 2. The resident bathroom in the B hallway had dried feces on the toilet and cups and trash on the floor. 3. Resident room [ROOM NUMBER], with an unsampled resident lying on the bed closest to the door, had a puddle of liquid on the floor with an unknown black substance between the resident's bed and nightstand. The resident did not respond to the surveyor at that time. Debris and tissues were on the floor. The unsampled resident's bedside table, directly adjacent to the wall, was covered with the black substance throughout the lower metal part of the table. The lower baseboard area of the wall that met the floor was lifted with an unknown black substance coming out of the seam, and the lower portion of the nightstand, adjacent to the floor, had the black substance on the area that touched the floor at the base of the nightstand. The resident was confused and was lying in bed. The surveyor was unable to conduct an interview. 4. Resident room [ROOM NUMBER] had black marks and scuffs throughout the floor's entire surface and under both beds. There were multiple smears of a brown substance, identified by the CNA, as feces located on the floors and walls and trash located on the floor. The mattress on the bed by the door was uncovered, faded, and ripped at the side seams with foam coming out of the seams. As identified by the CNA, dried feces was smeared on the wall to the left side of the bed. 5. Resident room [ROOM NUMBER] and 223, with two unsampled residents in the beds, had missing air conditioning unit covers, and the inner workings of both air conditioning units were exposed and imbedded with dust and debris. 6. Resident room [ROOM NUMBER] had a brownish beige splatter that extended from one wall to the other and had dried drips running down the wall to the floor, which was located next to the resident's occupied bed by the door. The entire floor was covered in brownish beige dried debris, food particles, and red stains. The unsampled resident from the door bed was ambulating in the room at the time and did not respond to the surveyor's interview. 7. Resident room [ROOM NUMBER] was soiled with debris, discolored with scuff marks, smears of feces, identified by the CNA at that time, were located on the floor in multiple areas and on the wall near the door. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	8. Resident room [ROOM NUMBER] A had a resident's wheelchair soiled, covered with dust, had a torn seat cushion and armrest with foam sticking outside of the torn areas. 9. Resident rooms [ROOM NUMBERS] had bedsheets utilized as window coverings. 10. The privacy curtains in all the A hallway rooms were soiled, with visible stained areas throughout. 11. room [ROOM NUMBER] had smeared feces on the toilet seat and throughout the exterior of the toilet. 12. On 10/8/21 at 10:15 AM, Surveyor #1 observed that the air conditioning units in room [ROOM NUMBER] and #211 covers were missing, and the inner part of the units were exposed and covered with dust and debris. On 10/08/21 at 9:30 AM, Surveyor #1 interviewed a Certified Nursing Assistant (CNA) regarding the observations made on B hallway. The CNA acknowledged that the unit was unclean and unsanitary regarding the condition of the B hallways floors and resident bathroom. The CNA stated that the housekeeper's responsibility was to clean those areas and identified the brown dried substance located throughout the hallway floor as dried feces. She reported it to the nurse and maintenance and could not offer specifics as to when she reported it. During this interview, the housekeeper for the Court 2B hallway approached the surveyor, and the surveyor conducted an interview at that time. The Court 2B housekeeper confirmed that the hallway floors were dirty and had food debris and dried feces. She accompanied the surveyor to the resident's hallway bathroom on the B hallway and confirmed that the toilet had dried feces all over the seat and trash was on the floor. She stated that she came into work late and did not have a chance to clean the unit. The Court 2B housekeeper added that she used a string mop to clean the floors. The floor technician's responsibility was to deep clean the floor with an electric floor scrubber and stated the facility currently did not have a floor scrubber. She stated that any staff member could have wiped up the dried feces that was located throughout the halls. During this interview, the surveyor observed multiple staff members walking throughout the hallway and directly past the dried feces that was located throughout the hallway floors. The Court 2B housekeeper did not provide an explanation about the cleanliness of the unit. On 10/08/21 at 10:15 AM, Surveyor #1 conducted a tour of the A and B hallways of the Court 2 Unit with the Court 2B housekeeper and the Housekeeping Director (HD). The HD could not locate the housekeeper from the A hallway at that time. During the tour, the HD stated that the hallways and the resident room floors were very, very dirty and unsanitary. He stated that he relayed his concerns to the corporate office that he needed the proper supplies and assistance to sanitize and scrub the floors in the hallways and the resident rooms. He stated that he only had string mops instead of microfiber mops. The HD stated that the microfiber mops were more effective at preventing cross-contamination. He also added that resident rooms were to be carbolized (deep cleaned) but had not been done for months. He stated that when a resident's room was carbolized, all the furniture from the resident's room was removed, bedside curtains were cleaned, and floors were stripped and re-waxed. He revealed that this had not been done in months because he didn't have the staff to do the work, and he didn't have a floor scrubber to be able to clean the floor properly. He added that the floor scrubber broke a few months ago and that he has been asking the corporate office for a new one, but it has not been provided. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/08/21 at 10:25 AM, the Director of Nursing (DON), the Infection Preventionist (IP), the LPN/UM, and the Maintenance Director (MD) accompanied the surveyors to tour the Court 2-unit, A and B hallways. They all agreed and voiced that they were very concerned about the cleanliness of the hallway floors and floors in the resident's rooms. They confirmed that the cleanliness of the floors and walls in the hallways and resident rooms were unacceptable. The MD confirmed to the surveyors that the facility had not had a floor scrubber but it was ordered. The IP stated that it was an infection control issue because of the excessive amount of fecal matter and urine on the floor within the resident's environment posed an infection control issue. The IP stated that the condition of the Court 2 was an infection control issue because of the excessive amount of fecal matter present and stated the urine on the floor within the resident's environment posed an infection control issue. On 10/08/21 at 11:30 AM, the surveyor interviewed a CNA who stated that maintenance issues were reported through a computer system. The maintenance department was supposed to check the system and fix the concerns. The CNA stated that she was unsure how to enter the concerns into the computer system but would report it to the nurse to notify maintenance. She added that the environmental conditions on Court 2 were horrible and that even when issues were reported, nobody did anything about it. On 10/8/21 at 11:35 AM, Surveyor #1 interviewed the Licensed Practical Nurse (LPN) who had been employed in the facility for 7 years and who worked on the Court 2 Unit. The LPN stated that she reported concerns to the maintenance staff directly about the broken handrails; however, they don't fix them. The LPN also revealed that the resident rooms have not been carbolized for months. On 10/08/21 at 2:30 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA). The LNHA stated that he and the staff member who identified himself as the Regional Directors of Operations conducted an environmental round together on 10/04/21. The LNHA stated that a few dirty rooms were identified but admitted that they did not go into all the resident rooms. The LNHA provided the surveyor with an email dated 10/05/21 at 11:13 AM from the Regional Director of Operations (RDO) and titled, Housekeeping Rounds. The email contained the following information: 1.) room [ROOM NUMBER] needs better floor cleaning. 2.) room [ROOM NUMBER] needs cleaning. 3.) room [ROOM NUMBER] needs to be carbolized ASAP (as soon as possible) 4.) room [ROOM NUMBER] needs to be carbolized ASAP 5.) room [ROOM NUMBER] needs to be carbolized ASAP 6.) Vent hallway needs to be stripped. 7.) room [ROOM NUMBER] needs to be carbolized ASAP 8.) room [ROOM NUMBER] needs to be carbolized ASAP (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	9.) room [ROOM NUMBER] needs to be carbolized ASAP The email further indicated that the work needed to be done by the end of the week. The LNHA admitted that the environmental and housekeeping concerns he identified along with the RDO were not rectified because the facility did not have the proper floor scrubber. The LNHA then provided the surveyor with a receipt dated 10/06/21 for a floor scrubber. The LNHA could not provide the surveyor with any documentation as to when the residents' rooms on the Court 2 Unit were last carbolized. On 10/12/21 at 8:30 AM, Surveyor #3 observed the following on the Pavilion Unit: room [ROOM NUMBER] toilet soiled with feces. room [ROOM NUMBER] with smeared feces on the toilet seat, and the toilet remained clogged with feces as observed on 10/8/21. On 10/12/21 at 9:30 AM, the surveyor interviewed the LNHA, who stated that he did not have the staffing to carbolize resident rooms and stated that he was not a slum lord. He then stated that it would be important to ensure that resident rooms were carbolized and deep cleaned to prevent the spread of germs and stated that the rooms were dirty but did not provide a detailed explanation as to why. The surveyor interviewed the RDO on 10/12/21 at 9:42 AM, who stated that when environmental rounds were conducted on 10/05/21, he provided the LNHA with a list of concerns. He could not answer as to why the environmental concerns were not addressed. He then stated that the rooms should have been carbolized and cleaned as per the carbolization schedule and that a lack of staff was a huge factor as to why the environment was not clean or sanitary. He then added that there was no excuse and that a lot of work needed to be completed in the facility. On 10/18/21, from 10:05-12:57 PM, during a tour of the Pavilion unit, Surveyors #3 and #4 observed the following: On the Pavilion unit in room [ROOM NUMBER] soiled sink with brown stains. A black fly was observed on Resident #31 while the resident was lying in bed in the resident's room, the floor was stained with dark substances, and the toilet was filled with feces. Multiple flies were observed on Resident #17's hands, shoulder, and arms while seated in a recliner chair in the Pavilion side 2 day room. The room also had debris on the floor and a plastic cup on the floor which looked as if it contained feces with smears of the same in several areas of the floor. The walls and molding of the room was soiled with various debris. An unoccupied resident room, room [ROOM NUMBER], had a mattress on the floor, and the toilet was filled with feces in the bow and on the seat. An unsampled resident's room, room [ROOM NUMBER], had a stained floor, had a urine odor, and multiple black flies were in the room. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #4's room had trash strewn on the floor, and the toilet was soiled with a dark substance. In room [ROOM NUMBER], an unsampled resident, had a torn floor mat on the floor, the floor was soiled with various colored debris, black flies were in the room, there was no blinds for the window. Resident #442's room had broken blinds and had a stained floor. Resident #101's room had a stained floor, feces were on the bathroom floor, and the toilet bowl. Resident #95 was sitting in a chair on the Pavilion side 1 day room. The back cover of the chair was missing, and the resident had a fly on his/her head. On 10/18/21 at 10:41 AM, Surveyor #5 observed: An unsampled resident's room on the Pavilion unit, room [ROOM NUMBER]. The resident was in bed, with a ripped, uncovered bed pillow on the bed, and the stuffing of the pillow was exposed. There was debris, including paper towels and other debris on the floor, and multiple black flies were in the room. The floor was soiled with embedded marks of a dark substance, and the walls and baseboard were stained and soiled with various colored debris throughout. The surveyor then observed Resident #40's room, with garbage and debris strewn about the entire floor. There were wet areas throughout the floor, and the floor had a sticky feel. The surveyor brought the Unit Manager Licensed Practical Nurse (UMLPN) to observe the resident rooms. During the observation of room [ROOM NUMBER], the UMLPN stated, I don't think it is clean. I am not gonna lie. During Resident #40's room observation, the UMLPN stated, it is bad. On 10/18/21 at 8:28 AM- 9:20 AM, Surveyors #1, #3, and 4 observed the following on Court 2: A large, approximately 200-gallon fish tank was located by the nursing station. The fish tank was not filtering, and there was brown, blackish-colored water in the tank with the top of the tank open to the air. There was a large fish observed at the bottom of the tank. At that time, the Maintenance Director and Surveyor #14 were present. Surveyor #1 interviewed the MD about the fish tank. The MD stated, The facility is not taking care of the fish tanks, and the facility had no food for the fish. He stated, I guess they are just letting the fish die. room [ROOM NUMBER] had debris was on the floor, and the floor was very sticky with splatters. room [ROOM NUMBER] had debris on the floor, the floor underneath the bed was stained with a dark-colored substance. room [ROOM NUMBER] had a stained, discolored floor with various trash strewn about the entire floor. Resident #114 was observed lying in bed with a fly on the resident. There was a strong odor of urine in the room and brown stains on the floor. On 10/18/21 at 12:16 PM, surveyor #3 observed Resident #140 on the Atrium unit with flies on their pillow while the resident was lying in bed. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/18/21, during a tour of Court 1, from 10:50 AM to 1:00 PM, Surveyors #1 and # 5 observed the following: Both air conditioning units were visibly broken in the small sitting room in front of the nurse's station, and debris was embedded inside both units. A large, approximately 200-gallon fish tank was located by the nursing station. The fish tank was not filtering, and there was brown, blackish-colored water in the tank with the top of the tank open to the air. There was a large fish observed at the bottom of the tank. Resident #104 stated the toilet did not flush correctly, and they were manually pouring water down the toilet so that it would flush. At 12:45 PM, the dining room closest to the front of the unit was observed, with two unsampled residents consuming the lunch meal. There was a loosened piece of wallpaper a few feet away from the resident's table, and the loose piece of wallpaper exposed a wall covered with blackened areas under the wallpaper. There was a large cob-web and a water-type stain on the wall and ceiling tile, where the blackened area was located under the exposed wallpaper. There was a visibly broken air conditioning unit that was visibly soiled with embedded debris inside the unit's vents. Resident #99 was observed eating lunch with an unsampled resident in the second dining area. Resident #99 stated there was bugs all over the place, the bathroom clogged, and the call bells did not work. The surveyors observed many flies in the day room where the residents were consuming lunch. At 12:55 PM, Resident #12 was observed watching television in their room and stated the call bell hasn't worked for over a year, very, very uncomfortable, and there were flies all over the place. At that time, the surveyor observed flies in the resident's room. On 10/19/21, Surveyor #5 observed the following environmental concerns on Court 1 Unit: At 10:21 AM, Surveyor #5 conducted an interview with Resident #141 while the resident was seated in their wheelchair by the Court 1 nursing station. Surveyor #5 observed the resident's wheelchair was soiled with embedded soiled areas throughout the exterior of the wheelchair. At 10:25 AM, during an observation of Resident #18's room with the resident's attending physician. The surveyor interviewed the physician regarding the cleanliness of the building, and the physician stated it was lacking a little bit, and all you would have to do is look at the floor. At that time, the physician pointed to the floor located at the end of the resident's bed. The surveyor observed brown stains on the floor, and what appeared to be white and orange crushed pill debris, the physician indicated that is what it looked like it was crushed pill debris. At that time, a fly landed on Resident #18, and the physician stated, this is the type of thing, and shooed the fly away. On 10/19/21, Surveyor #3 observed the following environmental concerns on the Pavilion Unit: At 11:30 AM, Resident #98 had a stained privacy curtain. Surveyor #3 again observed Resident #98's room on 10/21/21 at 10:51 AM, and the privacy curtain remained in the same condition. On 10/20/21 at 8:45 AM, Surveyor #3 observed the following on the Pavilion unit: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #39's bed was covered with flies, and the bathroom had dried feces on the toilet and the floor. In room [ROOM NUMBER], there was a strong odor of urine in the room. room [ROOM NUMBER], flies were covering the bed, and the bathroom had dried feces on the floor and the toilet. On 10/21/21 at 8:50 AM- 9:08 AM, Surveyor #9 observed the following on Court 1: Surveyor #9 interviewed Resident #99 in the resident's room while the resident consumed the breakfast meal. The resident stated their toilet was clogged. The Surveyor observed feces in the toilet with multiple flies around the toilet. Flies were flying around the resident while the resident was consuming the meal and flies were observed on the resident's water cup. Resident #21 was interviewed in the resident's room, and a fly landed on the resident's head. The resident stated that every time the toilet was fixed, it only worked for a day or two and overflows on the floor and stated the odor was terrible. The resident further stated that the flies have been bad all summer, there was no pest control. Resident #12 was interviewed in the resident's room while they were sitting up in bed. Resident #12 (resided in the same room as Resident #21) stated the toilet was broken and could not be used, and they needed to use the bathroom across the hall, which was very inconvenient. The resident stated the flies were a pain in the [exploitive] and didn't know why the flies were there, and they never saw anyone from pest control spraying. On 10/21/21 at 9:14 AM, Surveyor #9 interviewed a CNA who stated she had been employed at the facility since September. The CNA stated the floor had an issue with flies mainly within the last few weeks. She stated that pest control was here the week before last, and there was a pest control book at the nurses' station. At that time, the surveyor reviewed the pest control book as directed by the CNA. The log for October 5th and 12th had No Reports. On 10/21/21 at 11:26 AM, Surveyor #9 interviewed the MD, who stated he worked at the facility for 7 months. The surveyor inquired as to how are issues were reported to maintenance. The MD stated there was a computer system, and anytime something was reported, it went to the maintenance phone, and staff were not supposed to report it any other way. The MD stated the computer system was used for three months, and staff were taught not to use the books. The surveyor inquired about the state of the toilets on Court 1 and for Resident's #12, #21, and #99. The MD stated Resident's #12, #21, and #99's toiled would be replaced soon and that the toilets jet had been corroded. The MD stated the Court 1 unit had not been used in over one year, and it was just opened two months ago. The Surveyor requested the computer maintenance logs from the MD at that time, and he stated he would print them tomorrow. On 10/21/21 at 9:30 AM through 10:30 AM, Surveyor #3 observed the Pavilion unit and observed: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #17 was in bed on the Pavilion Unit. The resident was screaming and was covered with flies. The Surveyor accompanied the Director of Nursing (DON) to the room to observe the flies on the resident. The DON stated to the surveyor that she had never seen anything like that. The surveyor observed that Resident #17 sitting on a unit chair that was visibly soiled, and feces were observed on the floor. room [ROOM NUMBER] was observed with flies on the bed and in the room. The day room was observed with brown substances on the floor. On 10/18/2021 at 10:30 AM, Surveyor #3 toured the Ventilator Unit and observed that the curtain in room [ROOM NUMBER] was visibly soiled and stained. The surveyor inquired about the soiled curtain on the Ventilator Unit. The nurse told the surveyor that she reported it to housekeeping staff six months ago, and nothing had been done about it. The surveyor requested the housekeeping log for review. The nurse informed the surveyor that there was no book on the floor. An interview with the Housekeeping Director (HD) on 10/19/2021 at 12:30 PM revealed that all housekeeping issues/work orders were documented in the QAPI book. The HD further stated that the QAPI book was replaced by an electronic version: TELS one month ago. The surveyor reviewed the QAPI book and could not find any documentation regarding a schedule to clean the resident's care equipment, including cleaning/ replacing curtains in the resident's room as needed. The HD was also asked to download any communication from the TELS that addressed all issues observed in the resident's environment during the tour, for example, resident's care equipment such as wheelchair cleaning, IV poles, room cleaning and carbolization schedule, none was provided. On 10/21/21 at 09:59 AM, Surveyor #2 observed in room [ROOM NUMBER]-W on the Ventilator Unit that the resident's privacy curtain was soiled with a large amount of dried brown liquid splatter marks. The Registered Nurse (RN) stated it was pointed out yesterday that the privacy curtain needed to be changed. It has probably been here a while. It's dark and looks old. The RN indicated that she did not report it to anyone. The RN also stated that since the unsampled resident in that room had a ventilator that it could cause mold and respiratory issues. She again revealed that she did not report it to housekeeping or maintenance. On 10/21/21 at 10:05 AM, Surveyor #2 interviewed a Respiratory Therapist (RT) who stated she personally did not report that the curtain was heavily soiled and stated that the former Unit Manager (UM) contacted the HD. She also added that the former floor guy used to change and wash curtains, but he left a long time ago. On 10/21/21 at 10:11 AM, Surveyor #2 interviewed the CNA, who stated she reported the soiled curtains in rooms: #251, #252, #253, #255, #257, #259. She stated that she reported it to the RN/UM maybe twenty times. On 10/21/21 at 10:17 AM, Surveyor #2 interviewed the RN, who stated that the rooms on the Ventilator Unit were not terminally cleaned. To her knowledge and that room [ROOM NUMBER] and 255 were observed to have soiled curtains. The CNA stated that she just thought the other rooms should have the curtains washed even though they were not visibly soiled. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/21/21 at 10:33 AM, the CNA reported that room [ROOM NUMBER] had a soiled privacy curtain. She also revealed that the resident who resided in that room was positive for Candida Auris. The surveyor observed that the privacy curtain had dried, brown, splattered debris. On 10/21/21 at 10:25 AM, Surveyor #2 interviewed the housekeeper who worked in the facility for 9 yrs. The housekeeper stated that she had worked on the ventilator unit 2 yrs. She added that the HD usually took the curtains down and washed them. Once I report it and let them know, it is up to him to get it done. She stated that she reported that the privacy curtain in room [ROOM NUMBER] needed to be cleaned because the resident went to the hospital and had Candida Auris. She then revealed that the room should have been carbolized after the resident was discharged to the hospital. On 10/21/21 at 11:09 AM, Surveyor #2 interviewed the who stated that last Friday, he was made aware and that he must have overlooked the soiled curtains on environmental grounds. I must have overlooked it. He stated that the curtains have not been washed since August. He said that he thought the debris on the curtains were either tube feeding or possibly respiratory secretions. He confirmed that it was a health risk and created an environment for pests. On 10/22/21 at 9:00 AM, Surveyor #9 conducted a follow-up interview with Resident #21 in the resident's room while the resident was in a wheelchair next to the bed. The surveyor observed two flies on the resident's bed and one on the resident's privacy curtain. On 10/22/21 at 10:51 AM, Surveyor #5 interviewed the DON in the presence of the survey team regarding the presence of the flies observed in the resident's food. The DON stated that flies were not acceptable to be on the resident's food because it was not hygienic. The DON stated it was an infection control issue. On 10/22/21 at 9:08 AM, Surveyors #3 and #4 observed Resident #60 sitting in the dayroom [ROOM NUMBER] on the Pavilion unit eating breakfast. Both surveyors observed flies on their food and drink. There were flies on the resident's coffee cup, on the spoon inside the oatmeal, and on top of the oatmeal. In addition, there were flies on the resident's shoulder and the chair they were sitting in. On 10/22/21 at 10:51 AM, in the presence of the survey team, the Director of Nursing (DON) stated it was not acceptable for flies to be in the resident's food because it is not hygienic. She acknowledged it posed an infection control issue but was unable to elaborate on it further. On 10/22/21 at 1:15 PM, Surveyor #3 conducted an interview with the facility Infection Preventionist Nurse (IPN) regarding the flies observed at mealtime throughout the survey. The IP stated that since she had started here, the flies were discussed with the former administrator, and it was a major concern. She stated, nothing is being done, it was unacceptable to have staff swatting flies while feeding residents. She stated that flies could lay eggs, and that can cause maggots. On 10/25/21 at 8:40 AM, Surveyors #3 and 4 observed the following on the Pavilion Unit: Flies were flying around an unsampled resident while the resident consumed the breakfast meal in the dining room. The flies were on the resident's tray, the spoon located in the coffee, and the chair. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #3 was observed in the common area. Surveyor #3 accompanied the resident's CNA to Resident #3's room. The CNA applied gloves to remove the sheets from the resident's bed, and the resident's mattress had a rip by the zipper. The CNA turned the mattress over, and it was stained/discolored and had holes. On 10/25/21 at 1:26 PM, the Licensed Nursing Home Administrator (LNHA) stated the facility had fly zappers but was unsure of the current number. The LNHA acknowledged since he started, the flies have been a big issue. The LNHA stated he felt the main issue was the soiled utility rooms having soiled linens and trash, especially during the off shift. He concluded, there was currently no housekeeping schedule, but he was working with the HD. On 10/26/21, Surveyors #3 and 4 observed the following on the Pavilion Unit: On 10/26/21 at 9:40 AM, HD stated the nursing staff were supposed to put in the maintenance/housekeeping application (app) any issues. The HD concluded he conducted six (6) weeks of quality assurance rounds for the entire facility. On 10/26/21 at 9:50 AM, Surveyor #3 observed an unsampled resident eating at the dining room table with flies on the table, on the resident's plate, and the resident's toast. The surveyor asked the LPN to come and observe, and the LPN confirmed the same. On 10/26/21 at 9:51 AM, Surveyors #3 and #4 observed Resident #95 sitting at a table in the dayroom [ROOM NUMBER] on the Pav

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37218 Complaint # NJ149075 Based on observation, interview, and record review it was determined that the facility failed to a.) maintain a functioning call-bell system and provide residents with an alternate means of a call bell (i.e tap bell) when the system was only functioning intermittently which was identified on 2 of 5 resident care units (Court 1 and Atrium), and for 1 of 1 residents (Resident #342) reviewed for call bells b.) have a preventive maintenance program in place to monitor failures in the call bell system and to make necessary corrections for 2 of 5 care units. This deficient was evidenced by the following: 1. On 10/18/2021 at 12:31 PM, Surveyor #1 and Surveyor #5 toured Court 1 and observed the call bell system was not functioning in residents' rooms and bathrooms. The rooms the call bells were not functioning in were rooms 105, 106, 107, 108, 112, and 116B. The surveyors observed that there were residents residing in the rooms the call bells were not functioning in. At 12:55 PM, Surveyor #5 interviewed an unsampled alert and oriented resident in his/her room who stated that the call bell hadn't worked in over a year. At 1:00 PM, Surveyor #5 interviewed the Registered Nurse (RN) who worked on Court 1 who confirmed that the residents call bells did not work. The RN stated that the unit was shut down during COVID and then re-opened back up about one or two months ago. The RN stated that on other units where the call bells weren't working the residents had tap bells, but she had not seen any tap bells on the unit. At 1:57 PM, Surveyor #1 interviewed the Maintenance Director (MD) who stated that the call bell system was down in Court 1 and had been broken for about a month due to faulty wiring in the walls. The MD further stated that the Administration knew that the call bell system was not working on the unit and they were supposed to supply the residents with tap bells, but never did, and doesn't know why. 37547 2. On 10/21/2021 at 11:01 AM, during a tour of the Ventilator Unit, Surveyor #2 observed Resident #342 who was lying in bed and was unable to communicate verbally due to a tracheostomy (an incision in the windpipe to relieve an obstruction to breathing) and mechanical ventilation (an appliance for artificial respiration) and utilized a communication board (white board with dry erase markers) to communicate. The resident wrote on the communication board and informed the surveyor that he/she needed a call bell and had not had one since he/she returned from the hospital. The resident demonstrated that he/she banged loudly on the table with the television remote to alert staff when needed. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Transfer/Discharge Report revealed that Resident #342 was readmitted to the facility on [DATE] with diagnoses which included but were not limited to: Dependence on a ventilator, tracheostomy, acute and chronic respiratory failure, anxiety disorder, chronic obstructive pulmonary disease (acute exacerbation), pneumonia, and morbid obesity. Review of the admission Minimum Data Set (MDS), an assessment tool dated 9/20/2021, revealed that Resident #342 had a Brief Interview for Mental Status (BIMS) score of 11 which indicated that the resident was moderately cognitively impaired and was totally dependent on two staff members for bed mobility and transfers. Review of Resident #342's Care Plan revealed an entry that was dated 9/20/2021, which focused on adequate airway and O2 (oxygen delivery) r/t (related to) impaired breathing mechanics and the goal was for resident to have breath sounds bilaterally (both sides) through the next review date. Interventions included but were not limited to: Keep call bell within easy reach (initiated 09/20/21) and monitor/document for restlessness, agitation, confusion, increased heart rate, (tachycardia) (an abnormally rapid heart rate) and bradycardia (abnormally slow heart action). At 11:04 AM, the surveyor interviewed the Registered Nurse (RN) who stated that Resident #342 had a tap bell for communication before he/she went to the hospital and it must have been misplaced. She immediately went to the nurse's station and obtained a metallic, manual, non-wired tap bell and placed it within reach of the resident on the resident's nightstand. The RN stated that the resident's wired call bell (a call bell that when pressed caused a light to go on outside of the resident's room and alarmed through a call system box located at the central nurse's station) had been broken for a while, so we used this type instead. At 2:35 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and requested a copy of the work orders that were placed for the Ventilator Unit. He stated that the RN should have reported the broken call bell right away once identified and stated that he would speak with her. The LNHA failed to provide documented evidence that a work order was placed to alert the Maintenance Department of a need to repair Resident # 342's call bell system. 35642 3. On 10/24/2021 at approximately 11:02 AM, two surveyors walked to the end of the small corner hallway on the Atrium unit. In the same hallway as the housekeeping closet. At that time, there was no evidence of a call light alarm sounding or lit up in the hallway. The surveyors randomly selected the two residents in the room to interview. The surveyors knocked and were invited to enter the room. The surveyor observed Resident #139 sitting in a wheelchair adjacent to the bed. The resident immediately stated to the two surveyors that they had pressed the call bell and wanted to go back to bed because they had been out of bed since 8:30 AM that morning. The resident stated that he/she had pressed the call light and that it was lit up in her room. The surveyor observed that there was a small red light activated where the call light cord connects to the wall, indicating that the call bell had been pressed. The surveyors looked again outside the room where there was a light panel on the ceiling outside the resident's room, but it was not lit up and there was no alarm sound audible outside of the room to indicate that the resident was requesting assistance. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyors also noted that both Resident #139 and his/her roommate did not have tap bells. Resident #139 and his/her roommate confirmed that they did not have a tap bell to alert staff that they needed assistance but believed that the call bell had been working because they had seen the small red light on in the room on the wall. The surveyor asked how long ago he/she had pressed the call light, and Resident #139 replied maybe two minutes before the surveyors had entered. The resident stated that call bell response time varies. The surveyors exited the room to find the resident's assigned CNA after interviewing the resident. At 11:06 AM, the CNA and the LNHA were outside the resident's room, and the surveyor observed the CNA walk into the room of Resident #139. At that time, the surveyor asked the LNHA about how residents communicate their needs if the call bell system was not functioning, and stated in the presence of the two surveyors that he was not aware that the call bell system was not functioning. The LNHA and surveyors then tested a nearby resident room which was vacant in the same hallway, and the light did not turn on. He indicated this may be why it was a vacant room. The surveyor then observed the CNA enter the resident room and went to turn off the call bell light. The surveyor asked the CNA before he turned it off to test the functioning of the call bell. The surveyors observed with the CNA that there was no light and no audible sound to alert staff that a call bell light had been activated for the room belonging to Resident #139 and his/her roommate. The surveyor interviewed the CNA at that time who stated that he doesn't know why the call light doesn't work and that he believed it, was a ghost. Both the CNA and the LNHA confirmed that there was no light and audible sound coming from the room belonging to Resident #139, and that both residents did not have tap bells or a means to summon staff. At approximately 11:15 AM, another CNA tested the call bell system in room [ROOM NUMBER] in the presence of two surveyors and the LNHA. The call bell system lit up and had an audible alarm, indicating that room was functioning properly. The CNA confirmed that the call bell system was old and that some rooms don't always work. The surveyor asked if residents on the unit get tap bells if the bells do not work, and she indicated that, No one has tap bells here. On 10/22/2021 at 9:29 AM, the surveyor interviewed the Lead Maintenance (LM) staff member, who stated that the facility had used TELLS (a computerized system to report building maintenance issues) for the past three months and utilized a logbook prior to that. The surveyor requested to view the TELLS logs that were available. The facility failed to provide the surveyor with documented evidence that the call bell system failure was reported or noted. At 10:50 AM, the surveyor observed Resident #342 who was asleep in his/her bed. The resident had both a tap bell on his/her nightstand and a wired call bell within his/her reach. The surveyor pressed the wired call bell which triggered an audible bell tone sound, and a light was illuminated in the hallway above the doorway outside of the resident's room simultaneously. The RN responded immediately to assess the resident's needs and did not turn the alarm off which caused the alarm to continue to sound. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 10:56 AM, the Respiratory Therapist responded to Resident #342's room to assess the resident's needs and disarmed the alarm which caused the ringing sound to arrest and the light that was lit outside of the resident's room to go out. On 10/26/2021 at 1:13 PM, in a later interview the LNHA stated that staff were expected to report all maintenance issues and they were required to be logged into the TELLS System. He further stated that he did not rely on that. The surveyors requested policies on the call bell system from the MD and they were not provided. No additional documentation was provided to the survey team during the survey to refute the surveyor's findings. NJAC 8:39-31.8 (c) 9