STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315455	A. Building B. Wing	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avant Rehabilitation and Care Center	1314 Brunswick Avenue Trenton, NJ 08638

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Based on observation, interview, record review and review of documentation, it was determined that the facility failed to promote dignity by failing to ensure: a.) a resident who required assistance at meals and foods in bowls was provided , and b.) a resident was provided with priviacy during dressing. This deficient practice occurred for 2 of 19 residents reviewed (Resident #7) and (Resident #54) and was evidenced by the following: a.) During observation of the lunch meal on 09/23/22 at 12:30 PM, the surveyor observed Resident #7 seated at a table eating lunch. Resident #7 spilled all the food on his/her shirt and was observed picking up the food with his/her hands from the shirt to eat. Two staff members (TNA #1 and CNA #2) were observed in the dayroom assisting the residents. The surveyor observed TNA #1 who poured the remaining food from Resident #7's shirt on their plate and was about to serve the resident the food collected when the surveyor stopped her and asked her to call the kitchen for more food. On 09/23/22 at 1:43 PM, during an interview with the surveyor, TNA #1 stated that Resident #7 was always messy during meals and would attempt to eat from other resident trays. She stated that resident #7 should be presented with one food item at a time. She could not comment on why the process was not being followed today. On 09/23/22 the surveyor reviewed Resident #7's medical record. According to the Admission Face Sheet, Resident #7 was admitted to the facility with diagnoses which included but not limited to vascular dementia and schizoaffective disorder. The Quarterly Minimum Data Set (MDS) dated [DATE], indicated Resident #7 was cognitively impaired, Resident #7 received a score of 3 for cognitive skills for daily decision-making problems. The MDS also indicated Resident #7 required set up with eating. A review of the Physician Order Sheet 06/14/22, indicated that Resident #7 was on a soft mechanical diet with instructions to provide food in a bowl. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/23/22 at 2:00 PM, the surveyor interviewed CNA #2 who was sitting at the same table where Resident #7 was eating. CNA #2 expressed her frustration over the lack of oversight and follow up. She stated that the food spillage and attempt to eat from other resident's trays was a common behavior for Resident #7. CNA #2 stated she and other staff reported the behavior several times and nothing had been done about it. The surveyor reviewed Resident #7's Plan of care and could not find any directive written for the direct care staff to follow during meals. On 10/04/22 at 8:30 AM, the surveyor returned to the locked unit to observe the breakfast meal. The surveyor observed Resident #7 in bed. The bed was anchored at a 25-degree angle. The resident was on a low bed. There was no staff in the room to assist the resident with the breakfast meal. Resident #7 spilled the food on the plastic tray and was observed eating with his/her hands from the spillage on the tray. The surveyor left the room and alerted a staff who then entered the room and removed the tray from the resident. On 10/04/22 at 9:30 AM, the surveyor interviewed the CNA #3 assigned to Resident #7 regarding how the resident's needs were communicated to staff. CNA #3 stated in the morning they received report for new residents only. CNA #3 acknowledged that she did not receive any report from the nurse that morning. The surveyor then asked the CNA if there was a care card, or system to follow while providing care, she stated that prior to the transition to electronic medical records, the care cards were in the patient's room and were easily accessible. On 10/04/22 at 10:10 AM, the surveyor then interviewed the Unit Manager (RN #1) in charge of the 300's Unit. RN #1 confirmed that she did not give report to the CNA's. RN #1 stated she was here to help and did not have much knowledge of the resident's needs on the 300's Unit. The surveyor further reviewed the medical record and noted there was no referral for Occupational Therapy to provide guidance and assistance with the above concerns. A review of Resident #7's Care Plan initiated 04/28/22, had a Focus for Nutrition. Etiology: I have a nutritional problem related to nutrition, need for mechanical soft diet, Adaptive equipment (food in bowl). The goals: I will receive adequate nutrition to maintain fairly stable weight. Interventions implemented: We will monitor and encourage your oral intake. We will honor your preferences and offer substitutions within your dietary restrictions. During the two above observations, Resident #7 was not provided with adaptive equipment nor being assisted by staff. It was only on 10/06/22, after the surveyor brought it to the staff's attention, that Resident #7 was provided with assistance during meals. On 10/05/22 at 11:00 AM, the surveyor interviewed the Director of Nursing (DON) regarding the observed meal experience. The DON stated that she was not aware that Resident #7 had been eating with his/her hands until 10/03/22 when she observed the same. The DON stated that if she were made aware she would have referred Resident #7 to Occupational Therapy for evaluation. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/06/22 at 8:45 AM, the surveyor observed CNA #3 assist Resident #7 with the breakfast meal. CNA #3 stated she had been trained to assist with meals but was not aware that eating with your hands was considered a dignity issue. During a follow up interview on 10/06/22 at 2:29 PM, the DON stated Temporary Nursing Assistants (TNAs) and CNAs knew what needed to be done for each resident in the care guide that was transitioned to the electronic medical record. The DON also stated during orientation and at least once a year, information regarding assisting resident with meals was reviewed in training and they do quarterly in-services on Activities of Daily Living (ADLs). The DON further stated her expectations were for staff to be sitting down during a meal, talking and trying to encourage a resident to eat and assist residents with meals as needed. On 10/11/22 at 8:51 AM, CNA# 3 revealed that Resident #7 could not hold a spoon and liked to grab objects. When allowed to feed himself/herself, Resident #7 would spill all the food on the tray and on their clothing. The Licensed Nursing Home Administrator (LNHA) and the DON informed the survey team last week that Resident #7 had to be fed. b. On 09/21/22, the surveyor toured the 300's locked unit assigned to residents with behaviors. The surveyor observed Resident #54 seated in a wheelchair in the hallway. A strong odor of urine permeated in the hallway while approaching Resident #54's room. The surveyor entered the room and observed the linen which included the incontinence pad, and the sheets were soaked with urine. Some clothing was observed on the radiator in the room. A review of Resident #54's medical record revealed the resident was admitted to the facility with diagnoses which included but were not limited to: Dementia, hypertension and coronary artery disease. The Annual MDS, a resident assessment tool used by the facility to prioritize care dated 10/01/21 revealed that Resident #54 was moderately cognitively impaired. Resident #54 scored 9 out of 15 on the Brief Interview for Mental Status (BIMS). Section E of the MDS which addressed behavior indicated that Resident #54 had behaviors of screaming and threatening. Section E 0600 impact on behavior subpart c was coded as Zero for disruption of care in the living environment. On 09/22/22 at 9:55 AM, the surveyor observed Resident #54 sitting in the hallway undressed. Resident #54 had on a disposable brief only. The surveyor observed several staff ambulating in the hallway entering and exiting other resident's room. No staff approached and asked if Resident #54 needed assistance. At 10:00 AM, the surveyor observed a staff member walking toward Resident #54 with some clothing in her hands. The staff greeted the resident and proceeded to dress Resident #54 in the hallway. On 09/22/22 at 1:06 PM, the surveyor interviewed TNA #1 assigned to Resident #54. TNA #1 stated that Resident #54 was self-sufficient with care, was incontinent of urine, wore pull-ups and changed himself/herself. Resident #54 would remove his/her clothing when they were wet and placed them on the floor, sometimes would attempt to wash them from the sink in the room and placed them on the vent in the room to dry. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/23/22 at 10:47 AM, the surveyor interviewed the Behavior Aid (BA #1) regarding Resident #54 observed being dressed in the hallway. The BA stated when she reported to the 300's locked unit around 9:00 AM and almost every day, Resident #54 would be seated in the hallway undressed. BA #1 revealed that she was not trained to provide care, however she would assist when they were short-handed. BA #1 stated that the proper way would be to escort Resident #54 to the room and assist with dressing. When asked for the rationale, she added for privacy. BA #1 stated, I know for sure you have to have the resident in the room. She could not comment why she did not escort Resident #54 to the room. The administrative staff was made aware of the above incident on 10/11/22 and again on 10/12/22. On 10/12/22 at 2:00 PM, the corporate liaison told the survey team that she identified that the facility had some concerns that needed to be addressed and told the survey team that the facility did not have any additional information to provide. A review of the facility's undated policy for Resident Rights indicated under policy statement, Employees shall treat all residents with kindness, respect and dignity. N.J.A.C. 8:39-4.1(a)12

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38080 Based on interview, record review, and other pertinent facility documentation, it was determined that the facility failed to a.) notify in writing of residents' room changes for cognitively impaired residents and b.) develop facility policy for room changes in accordance with federal and state regulations. This deficient practice was identified for 2 of 3 residents reviewed for room changes (Resident #10 and #47) and was evidenced by the following: On 09/26/22 at 2:52 PM, the surveyor interviewed the Director of Social Services (DSS) who stated the process for a resident room change was the nurse or nurse's aide would inform her the resident's room needed to be changed. The DSS stated if a room was available, she talked to the resident directly as well as the roommate and then let the Director of Nursing (DON) or Assistant Director of Nursing (ADON) know a room would be changed. At this time, the surveyor requested a list of resident room changes from the past two months. On 09/27/22 at 12:35 PM, the surveyor re-interviewed the DSS regarding the resident room change procedure, who confirmed that she would speak to the resident and roommate if there was a request for a room change. Then she spoke with the DON or the Licensed Nursing Home Administrator (LNHA) regarding the situation and the need or request for a room change. The DSS stated she called the resident's family to notify of the room change and documented in the electronic Medical Record (eMR) a Progress Note for why the room was changed. The DSS confirmed she did not notify residents or their representatives in writing about a room change. The DSS stated that some residents had been moved due to their COVID-19 outbreak response to mitigate the spread of the virus, which would be a temporary move. At this time, the surveyor and the DSS reviewed the Admission, Discharge, Transfer Activity Detail Report from 07/26/22 to 09/26/22. The surveyor asked the DSS to provide the reason for the room changes for Resident #10 on 08/25/22, Resident #35 on 09/25/22, and Resident #47 on 09/07/22. The DSS looked in the Progress Notes for each resident and stated the following: For Resident #10, the DSS confirmed that there were no Progress Notes for this resident regarding the room change. The DSS stated the DON was responsible for this room change and she thought the resident's room was changed because they were initially on a locked nursing unit which was not an appropriate placement for the resident. For Resident #35, there was a Progress Note dated 09/25/22 that the resident tested positive for COVID-19 so was moved. For Resident #47, the DSS confirmed there were no Progress Notes for the resident regarding the room change. The DSS stated she was not involved in this room change and she thought the resident's room was changed because they were initially on a locked nursing unit which was not an appropriate placement for the resident. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DSS informed the surveyor since the DON started at the facility in August of 2022, the DON had been looking at the residents who were on the locked nursing unit and if the resident needed to be there. The DSS stated that both Resident #10 and #47 did not have behaviors or wandered so they did not need to be on that unit, so the facility was in the process of moving these residents as rooms became available. The DSS confirmed she did not notify in writing the resident or their representative of these changes. The surveyor reviewed the medical record for Resident #10. A review of the Resident Face Sheet (an admission summary) reflected the resident was admitted to the facility in July of 2019 with diagnoses which included cerebral palsy (a congenital disorder of movement, muscle tone, or posture), epilepsy (seizure disorder), and unspecified convulsions. A review of the most recent annual Minimum Data Set (MDS), an assessment tool dated 08/12/22, reflected a brief interview for mental status (BIMS) score unable to be determined with a long and short-term memory problem with severely impaired cognitive skills. There was no documentation regarding the resident's room change or that the resident or their representative was notified in writing. The surveyor reviewed the medical record for Resident #47. A review of the Resident Face Sheet reflected the resident was admitted to the facility in November of 2021 with diagnoses which included bipolar disorder, pain, and schizoaffective disorder. A review of the most recent annual MDS dated [DATE], reflected a BIMS score of unable to be determined with short and long-term memory problems with severely impaired cognitive skills. There was no documentation regarding the resident's room change or that the resident or their representative was notified in writing. On 10/06/22 at 12:59 PM, the surveyor interviewed the DON regarding the facility's process for room changes. The DON stated if a room change was requested, staff notified social services and admission departments. The DSS notified the resident or their representative, and when the facility received the okay for the change, the resident was moved. The resident's representative was notified by the DSS via telephone and documented in the Progress Notes. The DON stated resident representatives received only a telephone call and residents were verbally spoken to, no one received anything in writing. On 10/12/22 at 9:07 AM, the Regional LNHA who was overseeing the facility's LNHA and the facility, confirmed there was no documentation for the room changes as well as nothing provided in writing to the resident or their representative regarding the room changes for both residents. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Room Change Policy and Procedure dated effective 01/24/14 and reviewed 01/20/22, included the Social Worker will .give the resident, designated representative/family member notification prior to changing room .provide notice to designated representative, legal guardian and/or family member of the need or intent to transfer the resident to another room .will document room changes and transfers in the resident's medical record. The policy did not indicate the notice to residents and their representatives must be in writing. N.J.A.C. 8:39-4.1(a)(13)

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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. 38079 Based on observation, interview, and document review, it was determined that the facility failed to maintain a clean and sanitary environment in the shower room on 1 of 3 units (second floor unit) and was evidenced by the following: On 09/21/22 at 11:55 AM, the surveyor in the presence of two other surveyors were touring the second floor of the facility. The surveyors entered the resident shower room and observed the following: Shower labeled C1 had a visibly stained blanket being used as a shower curtain and tied in a knot on the shower rod. The blanket was wet and lying on the base of the shower. The grout on the floor was blackened. There was an area below the shower handrail which was blackened and chipped. Shower labeled C2 had visibly darkened grout below the shower chair. There was an area below the shower handrail which was blackened and chipped. There was a blanket being utilized as a shower curtain. There was a dried washcloth left on the shower chair rail. On 09/21/22 at 12:04 PM, the surveyor asked the second floor Registered Nurse Unit Manager (RN UM) to join the surveyors in inspecting the shower room. The RN UM observed both shower rooms. The RN UM stated that both showers were used daily. She further stated she had recently started at the facility and had not had a chance to inspect the showers yet. The RN UM acknowledged C1 looks like it needs quite a bit of attention, it is mucky and it was stained as well. She commented that C2 should not have a washcloth drying on the shower chair rail. She further stated C2 was gross. The RN UM stated that the nursing staff was responsible to sanitize the showers before the next use. She stated she would find out who the appropriate people were to get the showers clean. On 09/21/22 at 12:10 PM, during an interview with the surveyor, the second floor Certified Nursing Assistant (CNA) confirmed that she had used the shower room twice so far that day. On 10/07/22, the above concern was presented to the administrative staff. As of exit day on 10/12/22, the facility had no additional information to provide. A review of the facility provided, Certified Nursing Assistant job description undated, included but was not limited to Purpose of Job Position: provide each of your assigned residents with routine daily nursing care and services , Personal Nursing Care Functions: assist residents with bath functions, Safety and Sanitation: keep floors dry .notify housekeeping if equipment needs cleaning .report hazardous conditions and equipment to management or nursing supervisor immediately. A review of the facility provided, Environmental Services-Cleaning Resident Rooms, undated included but was not limited to Purpose: to provide guidelines for cleaning and disinfecting residents' rooms and environmental surfaces to break the chain of infection., General Guidelines: 2. All environments/areas (. shower rooms) will be disinfected (or cleaned) daily and when surfaces are visibly soiled. 3. when there is an outbreak, residents' rooms will be disinfected and/or cleaned more often. Definitions: cleaning: removal of visible soil from surfaces through the physical action of scrubbing with a surfactant or detergent and water. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	N.J.A.C. 8:39-31.4(a)(b); 31.8(e)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38080 Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined the facility failed to ensure vulnerable residents were: a.) free from sexual abuse, and b.) protected from verbal abuse from staff. This deficient practice occurred for 3 of 6 residents reviewed for abuse (Resident #10, Resident #56, and Resident #63) and was evidenced by the following: Part A On 08/10/22, multiple staff members observed on the locked nursing unit, Resident #63, a registered sex offender, exit Resident #10's room. Resident #10 had intellectual disabilities and was dependent completely on staff for Activities of Daily Living (ADLs). Resident #63 was reported to be happy, bobbing their head side to side while smiling with feces on both of their hands. Certified Nursing Aide (CNA #1) reported this observation was alarming and reported it to a Licensed Practical Nurse (LPN #1). CNA #1, LPN #1, and Behavioral Aide (BA #1) entered Resident #10's room and observed the bed curtain was open, the resident was lying in bed with the blanket pulled down, their hospital type gown was pulled up, and their incontinence brief was twisted and opened to one side with feces coming outside of the brief. Resident #10 was reported to be shaking and appeared nervous while saying, mommy, rape, and doctor. LPN #1 reported the incident to the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) who both failed to investigate and report the situation. Resident #10 remained on the locked nursing unit for two weeks with Resident #63, until Resident #10's room was changed on 8/25/22 by the DON, since the resident reportedly did not need to be on a locked unit. Resident #63 remained on the locked unit with no additional monitoring and was free to roam around the unit and into other resident rooms. An interview with the LNHA revealed that the facility observed Resident #63 exit Resident #10's room on video surveillance footage, that was unable to be provided to the survey team. The LNHA stated that Resident #63 was only in Resident #10's room for six to seven minutes, and upon interview, Resident #63 stated he/she was in Resident #10's bathroom by mistake, the LNHA stated that was determined as plausible since LPN #1 was at some point inside Resident #10's room while administering medication and did not observe Resident #63. The LNHA concluded that no abuse had occurred, therefore, no investigation was required. The facility's failure to ensure all residents were free from abuse including sexual, verbal, and physical by failing to investigate the abuse, reporting to the appropriate authorities, and implementing interventions regarding an allegation of sexual abuse to Resident #10 by Resident #63, after staff and administration confirmed Resident #63, who was a registered sex offender was observed exiting Resident #10's room, posed a serious and immediate threat for abuse which can cause serious physical and emotional harm, impairment, or death that resulted in an Immediate Jeopardy (IJ) situation that began on 08/10/22, after Resident #63 was observed exiting Resident #10's room, and Resident #63 continued to remain on the locked unit for 15 days with no monitoring. The facility administration was notified of the IJ on 09/28/22 at 2:55 PM. The facility submitted an acceptable Removal Plan (RP) on 09/29/22 at 2:25 PM. The survey team verified the implementation of the RP during the continuation of the on-site survey on 10/03/22. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 09/26/22 at 1:43 PM, Temporary Nursing Aide (TNA #1) informed the surveyor (#1) that she had concerns about an event that occurred on the third-floor locked nursing unit involving Resident #10 who had intellectual disabilities. TNA #1 stated she observed Resident #63 exit Resident #10's room with their hands soiled in feces. When TNA #1 went to check Resident #10, the resident was observed in bed with their incontinent brief twisted and opened on one side with feces all over. The resident was reportedly saying mommy and rape. TNA #1 stated Resident #10's assigned aide, CNA #1 was not at the facility today, but she could corroborate the incident as well as BA #1. TNA #1 stated LPN #1 was informed of the incident. On 09/27/22 at 8:38 AM, the surveyor re-interviewed TNA #1 who stated Resident #63 was independent and did not need assistance from staff for Activities of Daily Living (ADLs), while Resident #10 had the mindset of a five-or six-year-old and required total assistance from staff for ADLs. When Resident #63 was observed leaving Resident #10's room with feces on their hands and staff observed Resident #10 in bed with their incontinent brief twisted and feces coming out, LPN #1 told staff not to touch the resident. The DON had come to the floor and asked questions but she did not take a formal statement from TNA #1 or have TNA #1 sign a formal statement. TNA #1 reported the DON informed staff she would move Resident #10's room, but the resident was not moved until two weeks later. There was no monitoring of Resident #63 who still had access to all the residents in the locked unit. TNA #1 stated the LNHA was aware of this incident, and the police never came to the facility and Resident #10 was never sent to the hospital to be examined for possible rape. TNA #1 stated she had the date of when the incident occurred with a photo of the nursing staff sheet from that day. (continued on next page)

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Avant Rehabilitation and Care Center	1314 Brunswick Avenue Trenton, NJ 08638

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 09/27/22 at 9:00 AM, the surveyor interviewed CNA #1 who confirmed she was Resident #10's aide on the date in question, and stated she had clearly recalled observing Resident #10 in bed in their hospital type gown with a blanket covering them, watching television with their bed curtain in the open position prior to her taking a morning break. CNA #1 stated that upon her return from her break, around 9:00 AM or 10:00 AM, she stated she observed Resident #63 exiting Resident #10's room and he/she appeared happy and was bobbing their head side to side with a smile which alarmed me and seemed weird. CNA #1 went into Resident #10's room and observed their roommate (Resident #56) who was lying in the first bed, and was alert but in their own world and was unable to be interviewed. CNA #1 stated she then observed Resident #10's curtain was now drawn closed as if someone was in there with them, and she knew the resident was unable to close the curtain themselves. When CNA #1 opened the curtain, Resident #10's sheet was pulled off of them, their legs were spread open, their incontinent brief was opened on one side, and their face looked disoriented. When CNA #1 asked Resident #10 what Resident #63 did to them, they were crying asking for their mother and said [he/she] raped [him/her]. CNA #1 reported the incident to LPN #1 who was an Agency nurse and LPN #1 assessed the resident in the presence of multiple aides. CNA #1 stated after that, she went to see Resident #63 to ask what they did, but she observed feces under their fingernails and that was all she needed to see since there was feces in Resident #10's brief. CNA #1 stated LPN #1 called downstairs, and it took twenty minutes for the DON and LNHA to come to the floor. The DON and LNHA were back and forth between Resident #10 and #63's rooms. Resident #10 was assessed by LPN #1 but never sent to the hospital for an evaluation and the police were not called, and LPN #1 told me to clean [Resident #10] up which I was not comfortable doing. CNA #1 stated she asked LNHA what the facility was doing and if they needed her to write a statement and the LNHA responded to CNA #1 to let him handle it. CNA #1 stated Resident #63 was a registered sex offender and did not receive special monitoring. CNA #1 stated that Resident #63 usually stayed in his/her room, which was another reason that seeing them exiting out of Resident #10's room was weird. CNA #1 stated Resident #63 was able to self-propel in their wheelchair as well as get out of their wheelchair. CNA #1 stated I still haven't written a statement and confirmed that no one has asked her to write one. On 09/27/22 at 9:22 AM, the surveyor accessed the United States Department of Justice National Sex Offender Public registry and confirmed Resident #63 was a registered sex offender for aggravated criminal sexual abuse for a victim under thirteen years old. The surveyor reviewed the medical record for Resident #63 which revealed the following: Resident #63's Face Sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included, but were not limited to; bipolar disorder, current episode manic without psychotic features (mental condition with extreme mood swings), and Diabetes Mellitus. The most recent quarterly Minimum Data Set (MDS), an assessment tool dated 07/08/22, reflected a brief interview for mental status (BIMS) score of 7 out of 15, which indicated a severely impaired cognition. The resident's Comprehensive Care Plan (CP) included a focus area dated effective 04/28/22, for at risk for loneliness, boredom and isolation due to the Pandemic (Coronavirus). Interventions included to bring to activities that you enjoy; to arrange phone calls or video chats with your family; to ensure you have activities of your choosing available; and to provide you with tools you need to do your favorite activity if applicable. The care plan failed to include the resident's history of sexual offense. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of the all Progress Notes did not include the incident with Resident #10. The surveyor reviewed the medical record for Resident #10 which revealed the following: A review of the Admission Record face sheet reflected the resident was admitted to the facility with diagnoses which included; cerebral palsy (a congenital disorder of movement, muscle tone, or posture), history of seizure, developmental delay, and [intellectual disabilities]. A review of the most recent annual MDS, dated [DATE], reflected a BIMS score unable to be determined with a long and short-term memory problem with severely impaired cognitive skills. A review of the resident's CP included a focus area dated effective 07/07/22, for ADL Function/ [Rehabilitation] Potential. Interventions included to provide total dependence of staff for bathing, bed mobility, dressing, eating, personal hygiene, toilet use, transfer with a mechanical lift of two people from bed to chair and chair to bed, and turn and reposition. The care plan did not include the incident with Resident #63. A review of the Progress Notes did not include documentation regarding the incident with Resident #63. On 09/27/22 at 9:57 AM, the surveyor interviewed TNA #2 who stated about two months ago, she observed Resident #63 exit Resident #10's room and was told he/she touched Resident #10. TNA #2 stated that Resident #63 should not have been in Resident #10's room. TNA #2 stated LPN #1 was informed of the incident which occurred either the end of July or August; it was two months ago. TNA #2 confirmed that there was no monitoring completed for Resident #63. On 09/27/22 at 10:30 AM, the surveyor interviewed TNA #3 who stated Resident #63 could be aggressive with other residents such as trying to lure a wandering resident of the opposite sex into his/her room. TNA #3 stated she only witnessed it happen one time, and that the wandering resident had only made it to Resident #63's door before the aide then redirected the resident, and told Resident #63 that they were not allowed into the other resident's room. TNA #3 stated that she felt it was not safe for any resident in general to be alone in the room of resident of the opposite sex and that Resident #63 had not done anything in particular that she had been aware of to make her feel extra concerned about it. TNA #3 when asked, stated she was unaware of Resident #63 ever being inside another resident's room. On 09/27/22 at 10:38 AM, TNA #1 informed the surveyor that her cell phone battery was dead and she needed to charge the phone first to provide the surveyor with the information regarding the date of the incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 09/27/22 at 10:46 AM, the surveyor interviewed the DON who stated she had worked at the facility since 08/01/22, and was in charge of investigations. The DON stated the facility investigated falls, anything unwitnessed, bruises, skin tears, any kind of abuse including physical, verbal, and misappropriation of property. The DON stated the process for an investigation was to collect statements from all staff who saw the resident or took care of the resident; interview the resident if able to, even if the resident was confused. Then the facility notified the family or representative and the physician. The DON stated that abuse and/or neglect was investigated with the LNHA, and abuse was reported to the New Jersey Department of Health (NJDOH). At that time, the DON provided the surveyor with all investigations and incidents, which totaled five, that the facility conducted from 08/01/22 through the present. The DON stated the facility was searching for additional investigations, and if they could find any, they would give them to the surveyor. On 09/27/22 at 11:02 AM, the surveyor reviewed the five investigations provided by the DON. None of which did included the incident alleged by staff that occurred between Resident #10 and Resident #63. On 09/27/22 at 11:09 AM, the LNHA stated and confirmed that the surveyor had all of the facility investigations. The LNHA, upon inquiry, stated that he did not keep any soft files, but then stated there may be one or two reportables (mandatory facility reporting) and he would check. On 09/27/22 at 11:23 AM, the surveyor attempted to interview Resident #10's Power of Attorney (POA) via telephone, however, the POA did not answer. The surveyor left a message to call back. On 09/27/22 at 11:25 AM, the surveyor attempted to interview Resident #10's Emergency Contact via telephone, but the number was not in working service. On 09/27/22 at 12:10 PM, the LNHA confirmed that the surveyor had been provided with all investigations, incidents, and grievances from the past three months. This did not include any investigation regarding the alleged incident between Resident #10 and Resident #63. On 09/27/22 at 12:12 PM, the surveyor attempted to interview LPN #1 via telephone, but there was no answer. The surveyor left a message to call back. On 09/27/22 at 12:14 PM, the surveyor called the POA again on the telephone, and there was no answer. On 09/27/22 at 12:34 PM, the surveyor attempted to interview Resident #63 who spoke minimal English and stated that he/she was in pain, and mostly stayed in bed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 09/27/22 at 12:35 PM, the surveyor interviewed the Director of Social Services (DSS) who stated she was the only social worker at the facility. The DSS stated she was involved in the grievance process as well as room changes. If a resident wanted a room change she would speak to the LNHA or DON and change their room if one was available. The DSS stated she would document in the electronic medical record (eMR) under Progress Notes as to why a room change was occurring. When asked why Resident #10 changed their room on 08/25/22, the DSS responded she was not involved in that room change but thought it was because Resident #10 was not appropriately placed on a locked unit. The DSS stated Resident #10 was a younger resident who had cerebral palsy and was wheelchair bound. The DSS stated the resident spent time in the dayroom, had stuffed animals and toys, and had minimal speech with the communication skills of a child. The DSS confirmed the room change was not documented in the eMR. On 09/27/22 at 1:31 PM, the surveyor attempted to interview Resident #10 in the presence of CNA #1, but was unable to tell the surveyor their name or how long they lived in their room. The resident was watching cartoons on the television, and holding a stuffed animal and kept pointing to the surveyor's manilla folder saying book and book yellow. On 09/27/22 at 1:34 PM, the surveyor attempted to interview Resident #10's previous roommate, Resident #56. When asked about Resident #10, Resident #56 stated he/she really liked that roommate who was young and did not talk. The surveyor asked if Resident #10 ever had visitors, and Resident #56 stated that Resident #10 left something here and he/she wanted it returned to them. At that time, Resident #56 went to the empty bed that Resident #10 had previously occupied and provided the surveyor with a Christmas card. When the surveyor opened the card, the card was written to Resident #63's name from [name redacted], an unknown person. On 09/27/22 at 1:41 PM, the surveyor showed LPN #2 the Christmas card, and she could not speak to why Resident #63's card would have been inside Resident #10's previous room. LPN #2 confirmed that was not Resident #63's room, and could not speak to if Resident #63 had ever been inside Resident #10's room. On 09/27/22 at 1:49 PM, the surveyor accompanied by a Laundry Aide interviewed Resident #63 in their native language. Resident #63 looked at the Christmas card, and confirmed it was theirs. Resident #63 did not speak to why the Christmas card was in Resident #10's former room, and told the surveyor that they could keep the Christmas card. On 09/27/22 at 2:23 PM, TNA #1 informed the surveyor that she was able to retrieve the nurse staffing reports and reviewed the nursing staff reports from 08/10/22 through 08/24/22. TNA #1 confirmed the incident had occurred on 08/10/22. On 09/27/22 at 2:23 PM, the LNHA presented the surveyor team with an undated document entitled Summary of Events. The document included the following (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [no date] I received a call from unit [unnamed unit] a staff member [unnamed] was yelling in the hall. When I arrived I saw staff outside [Resident #63's] room and when asked the nurse [unnamed] what was going on that a patient had just come out of [Resident #10's] room who was [an opposite sex] patient. The report continued that the nurse [unnamed] and I immediately went into both Resident A [Resident #63] and Resident B's [Resident #10] rooms. Resident #10 was observed playing with his/her stuffed animal and we spoke with the resident for a few minutes, then spoke to Resident #63 who stated that he/she was confused and went into Resident #10's room to use the bathroom and when realized it was the wrong bathroom he/she was embarrassed. There were a couple of staff members [unnamed] expressing themselves about the resident's [Resident #63's] history, and I pulled staff aside and educated them on the importance of HIPAA (HIPAA; Heath Insurance Portability and Accountability Act; a law created to protect patient health information) and staff [unnamed] were concerned [Resident #63] was in [Resident #10's] room. We reviewed the camera footage [no date or time] and observed Resident #63 was in Resident #10's room for 6-7 minutes. The report continued that Resident #63 entered Resident #10's room at 9:43 AM after [LPN #1] walked away from her medication cart and we could see LPN #1 came back to her cart 1.5 minutes later that was outside of Resident #10's room and she went into the room [unnamed room] and gave medications to the patients [unnamed] and left the room. Then [He/she] moved on from that room towards Resident room [ROOM NUMBER] and as she was walking away, Resident #63 came out of Resident #10's room. Since LPN #1 was in the room and Resident #63 was in the bathroom, that was why we did not see [Resident #63 in the room]. The timeline and event details supported [Resident #63] went into the bathroom and left as suggested. Met with all staff on sensitivity, behavior, and HIPAA. State Agency [name redacted] came to the facility after an anonymous call, and she had nothing further to share because wrong date and wrong time [date and time not included], furthermore no detail on anything. We went over the situation from that day, shared our video footage/pictures from video and timeline. She spoke with some staff [unnamed] and suggested she was closing the case and left. In addition to the statement, there were three dark grainy pictures of surveillance video on an unidentifiable nursing unit. The first picture revealed a nursing unit hallway with a medication cart, a grainy picture of an unidentifiable resident self-propelling in a wheelchair into a resident room, and another person possibly in a wheelchair behind the medication cart. Viewing the picture, the sex of the people or the room could not be determined. The picture was undated and the time stamp was Tue 09:43:51 (S). The second picture was a grainy picture of a nursing unit hallway with the only identifiable object being a medication cart, and an unidentifiable person. There was no date and the timestamp only included 48:08 (S). The third grainy picture showed a nursing unit hallway with an unidentifiable nurse at a medication cart, a possible staff member walking up the hallway towards the nurse and the rest of the picture was unidentifiable. There picture was undated, and the timestamp indicated 9:53:12 (S). The packet also contained Resident #10's admission record Face Sheet dated generated by the LNHA on 09/27/22 at 1:11 PM, and Resident #63's admission record Face Sheet dated generated by the LNHA on 09/27/22 at 2:04 PM. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 09/27/22 at 2:23 PM, the surveyor interviewed the LNHA who stated he found the undated Summary of Events, stuck in a drawer in his desk even though he previously informed the surveyors earlier that he kept no soft files, and he confirmed that the surveyors had been provided all the investigations since he had been at the facility. The LNHA stated this event was immediately dismissed, there was no concern. When asked why there was no concern, the LNHA stated it was no concern because Resident #63 immediately came out of the room. According to the undated Summary of Events Resident #63 was in Resident #10's room for 6-7 minutes. The LNHA stated that the event could have occurred on 8/23/22 because that was my statement to self not provided to the surveyors. The LNHA continued, there were staff a CNA, maybe an activity aide, do not recall the names saying Resident #63 was a sexual predator who came to this facility from our sister facility. The LNHA stated he did not know if Resident #63 was a sexual predator, but has a history of their background as a sexual predator. The LNHA confirmed staff was upset, but he never followed up on it. The LNHA also stated that the sexual predator status was not followed up on. The LNHA stated that staff members refused to write statements and he did not memorialize that. The LNHA stated the first picture was Resident #63 entering Resident #10's room, the second picture was the nurse in Resident #10's room, and the third picture was Resident #63 exiting Resident #10's room (that could not be corroborated by the photos provided by the LNHA). On 09/27/22 at 2:37 PM, the surveyor asked the DSS if she was aware of any allegations of sexual abuse at the facility. The DSS responded she was out of the office on 08/23/22, and was informed by the DON and LNHA on 08/24/22, that Resident #63 went into Resident #10's room, and based on video surveillance footage, there was no need to take it any further. The DSS continued she was under the impression everything had been taken care of. When asked if the incident would be a concern, the DSS responded, definitely a huge concern no resident should be discussed regarding, HIPAA. At this time, the surveyor reviewed the facility's abuse policy with the DSS who confirmed she was familiar with policy. When asked what she would have done if there was an allegation of sexual abuse, the DSS stated I am an advocate and that the police would be called, the resident would be interviewed, and interview the residents and staff. When inquired to the DSS if the staff were interviewed, she stated no. The DSS stated the LNHA closed this investigation after viewing the video surveillance footage, and speaking with the residents, and she confirmed there was no documentation to ensure the residents were okay. On 09/27/22 at 3:03 PM, the surveyor interviewed LPN #3, who stated she was unaware why Resident #10's room was changed on 8/25/22, when she arrived for shift, the resident was in a new room. LPN #3 stated that she changed the resident's room number in the eMR only. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 9/27/22 at 3:16 PM, the surveyor interviewed the DON who stated she was not at the facility on the morning the incident occurred when Resident #63 was observed exiting Resident #10's room by a behavioral aide. When the DON went upstairs, two behavioral aides that she cannot recall their names said Resident #63 came out of Resident #10's room and they reported they did not see what occurred in the room, just Resident #63 exited quickly. The DON stated that Resident #63 had a history of sexual abuse and discussed this with the LNHA. The DON stated she asked staff for statements, but none were provided, and she had no documentation to corroborate that. The DON stated she checked Resident #10, and their incontinent brief and clothing was in place and believed the incident occurred on 8/23/22. The DON stated she did not feel this situation was an allegation of abuse because no one saw anything. Resident #63 stated he/she went to use the bathroom and there was no evidence on the resident. The DON acknowledged there was no documented assessment of either resident as well as there were no documented statements from the residents, staff, or herself. The DON stated she changed Resident #10's room maybe, a day or two later since Resident #10 was not appropriately placed on the locked nursing unit. The DON stated that since Resident #63 was a sex offender, she should have interviewed other residents and looked into another facility placement for Resident #63. The DON stated if the facility policy was followed, the police should have been called, and Resident #10 should have been sent to the hospital for an assessment, as well as a thorough investigation conducted, and Resident #63 should have been monitored. The DON then confirmed none of that was completed. On 09/27/22 at 5:27 PM, the surveyor conducted a telephone interview with LPN #1. LPN #1's first asked if she would lose her job due to speaking with the surveyor. When asked if there had been any incident/s that occurred with Resident #10, LPN #1 stated yes, but the incident was resolved. LPN #1 stated that another resident (Resident #63) was in their bathroom, and she could not recall the date, maybe occurred sometime in August. LPN #1 stated that she had administered Resident #10's medication and then was down the hall with her medication cart when she heard CNA #1 hollering in the hallway saying get out of the room, this was not your room. The resident who CNA #1 hollered at, was Resident #63. The LPN #1 then called downstairs to the LNHA and DON to let them know what occurred. LPN #1 stated she was down a ways in the hallway and when CNA #1 was heard hollering, she then observed Resident #63 exit Resident #10's room. LPN #1 stated she went into Resident #10's room with the LNHA and DON, and at that time observed Resident #10 in bed partially covered with their legs bent. The LPN #1 could not recall if they were bent and open or bent and closed. LPN #1 stated the resident had on a cloth diaper that was soaked, and she could not recall if the resident had a bowel movement since she did not check, but the diaper was fastened at one side but could not recall the other side. LPN #1 could not recall if this was how the resident looked when she administered his/her medications. When asked what the resident's demeanor was, LPN #1 first responded the resident's usual demeanor. When asked what that was, LPN #1 stated laughing. When asked if Resident #10 was laughing, LPN #1 stated no, the resident was saying doctor. When asked why the resident would say doctor, LPN #1 responded she was unsure, maybe the resident thought she was a doctor. LPN #1 stated that she asked Resident #63 why they were in Resident #10's room, and the resident stated he/she was in the bathroom. LPN#1 stated she did not see Resident #63 in Resident #10's room when she was in there, he/she could have been in the bathroom since the bathroom door was closed. When asked if the door opened into the room or into the bathroom, LPN #1 stated the door opened into the room and she confirmed the door could be closed to move towards the exit. LPN #1 stated she assessed Resident #10, but did not complete documented assessment, or provide any information to the surveyor regarding the type of assessment completed. The LPN #1 stated the DON also entered Resident #10's room, but then stated she was not present for that. LPN #1 stated she was unsure how long Resident #63 was in the room, but believed there was camera footage, but the footage would not have shown inside the room. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38080 Based on observation, interview, record review, and review of pertinent facility documentation, the facility failed to implement their abuse policy to report a.) an allegation of sexual abuse between two residents, b.) verbal abuse between a staff member and a resident, c.) physical abuse by a resident against two other residents, and d.) an injury of unknown origin for two residents. This deficient practice was identified for 5 of 6 residents reviewed for abuse (Resident #10, #56, #63, #65, and #72) and 1 of 1 resident reviewed for hospitalization (#193), and was evidenced by the following: Refer to F600 and F684 a.) On 08/10/22, multiple staff members observed on the locked nursing unit, Resident #63, a registered sex offender, exit Resident #10's room. Resident #10 had intellectual disabilities and was dependent completely on staff for Activities of Daily Living (ADLs). Resident #63 was reported to be happy, bobbing their head side to side while smiling with feces on both of their hands. Certified Nursing Aide (CNA #1) reported this observation was alarming and reported it to a Licensed Practical Nurse (LPN #1). CNA #1, LPN #1, and Behavioral Aide (BA #1) entered Resident #10's room and observed the bed curtain was open, the resident was lying in bed with the blanket pulled down, their hospital type gown was pulled up, and their incontinence brief was twisted and opened to one side with feces coming outside of the brief. Resident #10 was reported to be shaking and appeared nervous while saying, mommy, rape, and doctor. LPN #1 reported the incident to the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) who both failed to investigate and report the situation. Resident #10 remained on the locked nursing unit for two weeks with Resident #63 until Resident #10's room was changed on 8/25/22 by the DON since the resident reportedly did not need to be on a locked unit. Resident #63 remained on the locked unit with no additional monitoring and was free to roam around the unit and into other resident rooms. An interview with the LNHA revealed that the facility observed Resident #63 exit Resident #10's room on video surveillance footage, footage that was unable to be provided to the survey team. The LNHA stated that Resident #63 was only in Resident #10's room for six to seven minutes, and upon interview, Resident #63 stated he/she was in Resident #10's bathroom by mistake, the LNHA stated that was determined as plausible since LPN #1 was at some point inside Resident #10's room while administering medication and did not observe Resident #63. The LNHA concluded that no abuse had occurred, therefore, no investigation was required. The facility did not report the allegation to the police or Department of Health (DOH) for review. Resident #10 was not sent to the hospital for examination of possible rape. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avant Rehabilitation and Care Center	1314 Brunswick Avenue Trenton, NJ 08638

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/27/22 at 10:46 AM, Surveyor #1 interviewed the DON who stated she had been at the facility since 08/1/22 and was in charge of investigations. The DON stated the facility investigated falls, anything unwitnessed, bruises, skin tears, any kind of abuse including physical, verbal, and misappropriation of property. The DON stated the process for an investigation was to collect statements from all staff who saw the resident or took care of the resident; interview the resident if able to, even if the resident was confused. Then the facility notified the family or representative and the physician. The DON stated that abuse and/or neglect was investigated with the LNHA, and abuse was reported to the New Jersey Department of Health (NJDOH). At this time, the DON provided the surveyor with all investigations and incidents (five) the facility conducted from 08/1/22 through present time. On 09/27/22 at 11:09 AM, the LNHA stated and confirmed that the surveyor had all of the facility investigations. The LNHA, upon inquiry, stated that he did not keep any soft files, but then stated, there may be one or two reportable events (mandatory facility reporting) and he would check. On 09/27/22 at 3:16 PM, the surveyor interviewed the DON who stated she was not at the facility on the morning the incident occurred when Resident #63 was observed exiting Resident #10's room by a behavioral aide. The DON stated that Resident #63 had a history of sexual abuse and discussed this with the LNHA. The DON stated she asked staff for statements, but none were provided, and she had no documentation to corroborate that. The DON stated she did not feel this situation was an allegation of abuse because no one saw anything. The DON acknowledged there was no documented assessment of either resident as well as there were no documented statements from the residents, staff, or herself. The DON stated if facility policy had been followed, the police should have been called and Resident #10 should have been sent to the hospital for an assessment as well as a thorough investigation conducted, and Resident #63 should have been monitored. The DON also stated the NJDOH would have been informed. The DON acknowledged none of this was done. Refer F600 27193 b.) On 09/23/22 around 7:20 AM, while in the hallway, Surveyor #2 heard a loud verbal exchange near the nursing station. While approaching the nursing station, the surveyor observed a resident standing in the hallway facing the nursing station and talking loudly. Then a female staff member exited the nursing station and was yelling, screaming, and pointing a finger in the resident's face. The surveyor stood by the nursing station and observed the night nurse facing the hallway where the verbal argument was taking place, a Certified Nursing Assistant (CNA #3) sitting at the desk, a laundry staff member in the hallway, the medication nurse, and a Registered nurse who all witnessed the incident, yet none intervened. The resident was identified by staff as Resident #56. Resident #56 approached Surveyor #2 and stated, Can you help me, all I want is a diaper. The one that I had on would be wet in 2 hours. The surveyor informed TNA #4 of the Resident #56's request for the disposable incontinence brief. TNA #4 continued to argue and remained in the hallway near the linen cart. TNA #4 did not provide the disposable incontinence brief to the resident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/23/22 at 7:30 AM, Surveyor #2 interviewed TNA #4 who was involved in the above incident. TNA #4 informed the surveyor that she had been working at the facility for the last 4 months. The surveyor inquired about any in-service education received on Dementia care, she acknowledged receipt of in-service education. The surveyor asked her to comment on the observed behavior witnessed in the hallway. TNA #4 stated, Resident #56 pointed their fingers at her first because she stopped Resident #56 from obtaining a disposable incontinence brief from the linen cart parked in the hallway. In return TNA #4 pointed the fingers back at him/her (Resident #56). TNA #4 stated there were no disposable briefs on the floor. She stated she would have to get a key and go to the first floor to get some disposable incontinence brief. On 09/26/22 at 12:06 PM, Surveyor #2 met with the LNHA and the DON and requested the investigation. The LNHA stated that there was no investigation. The DON walked in and stated that they were not aware of the incident. Therefore, the incident had not been reported to the DOH. The facility did not report the allegation of abuse until 09/30/22, after surveyor inquiry. c.1.) Surveyor #2 reviewed Resident #63 clinical notes dated 01/04/22, and noted the following: 01/04/22, Resident #63 was involved in a physical altercation with his/her roommate. Resident #63 threw the roommate on the floor when he/she observed the roommate laying on his/her bed. During the physical altercation, Resident #63 sustained a laceration to the lower lip. The surveyor reviewed the clinical Notes with the DON. The DON stated that she was not employed by the facility during the incident. She admitted that documentation was lacking, and that the incident should have been entered in the clinical record. She was unable to locate any investigation or provided any incident report that was generated. The physical altercation by Resident #63 was not reported to the state agency. c.2) Surveyor #2 reviewed the nurse's notes dated 01/06/22 timed 2:00 PM, which documented, Resident #63 slapped a resident in the face. When asked why he/she assaulted the resident, Resident #63 replied, I slapped [him/her] in the face because [he/she] walked past me too many times and talked too much. The facility did not generate an incident report nor report the incident to the State Agency. 41858 d.1.) On 09/21/222 at 10:37 AM, during the initial tour of the second-floor, Surveyor #3 observed Resident #65 in bed. Review of Nursing Progress Note, dated 07/2/22 at 1:29 PM, revealed: CNA (Certified Nursing Assistant) brought to my attention that patient was complaining of pain to right foot during am care and donning (putting on) socks. Examination reveals slight swelling to right ankle as compared to the left ankle skin warm to touch skin color normal for patient no redness or bruising noted no open areas noted MD made aware. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/27/22 at 10:46 AM, Surveyor #1 interviewed the DON, who stated she had been at the facility since 08/1/22 and was now in charge of investigations. She stated that there should be an investigation on falls, anything unwitnessed, bruises, skin tears, any kind of abuse verbal or physical, and misappropriation of property. She stated they get statements from all staff who took care of the resident, if they saw anything. If it was a bruise of unknown origin, they would get a statement from the resident, if they were able to give one. Then the facility would call the family and physician to notify them of the incident. She stated anything that warranted such as abuse or neglect, would be called in to the New Jersey Department of Health (NJDOH). On 10/05/22 at 09:44 AM, Surveyor #3 interviewed the DON about the incident involving Resident #65. The DON confirmed that she was unable to locate incident report and stated that it would have been reported to the NJDOH if they did not know the cause. On 10/05/22 at 11:13 AM, Surveyor #3 interviewed the LNHA, who stated that if there was an injury of unknown origin, staff tells the nurse, who tells the DON or the supervisor. They look to see what caused the injury, ie bruise. He stated written statements would be taken from all staff that took care of resident for the last 72 hours and from all the unit aides to find out what happened because they help each other out. The LNHA acknowledged that the facility was unable to provide an incident report/investigation for the incident. Surveyor #3 asked the LNHA If there is not a report or an investigation how can you show it was investigated? The LNHA stated I can't. On 10/06/22 at 2:45 PM, in the presence of the survey team and the Interim Infection Preventionist Licensed Practical Nurse (IIPLPN), LNHA, DON, and RA, Surveyor #3 presented the concern of not being provided with an incident report/investigation for Resident # 65 and that it was not reported to the NJDOH. d.2.) On 9/21/22 at 9:45 AM, during the initial tour of the 2nd floor unit, Surveyor #3 observed resident #72 sitting in a wheelchair in his/her room. The resident was pleasant and agreed to be interviewed. The resident did not speak to any concerns to the bruising on his/her extremities. A review of the nursing progress note dated 09/5/22 at 09:06 PM, revealed Resident was noted with bruising and discoloration to his upper and lower extremities. Skin is flat, cool to touch. Denies pain. Doppler from last week is negative for DT (deep vein thrombosis). Resident is on Eliquis. Anti-coagulant monitoring is ordered Q shift. On 09/27/22 at 10:46 AM, Surveyor #1 interviewed the DON, who provided the surveyor with all investigations and incidents (five) the facility conducted from 08/1/22 through present time. The DON stated the facility was searching for additional investigations and if they could find any, they would give to the surveyor. Review of these investigations by Surveyor #3 did not reveal an investigation regarding the incident from 09/5/22 with Resident #72. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/05/22 at 11:13 AM, Surveyor # 3 interviewed the LNHA, who stated that if there was an injury of unknown origin, staff told the nurse, who told the DON or the supervisor. They looked to see what caused the injury, ie bruise. They would, try to make an educated decision of how something happened, if unable to find a cause, it would be reported to the NJDOH within 2 hours especially with a new bruise. He stated an investigation must be completed as soon as possible while it was fresh in everyone's mind, usually within 3 days. He further stated that the family and physician would be notified at the time of discovery by the nurse, but the DON would usually notify the family with the investigation results. The LNHA stated that the purpose of doing an investigation was to find root cause. He stated that there cannot be an assumption, there must still be a complete investigation and administration must be made aware. At that time, Surveyor #3 reviewed the incident involving Resident #72 on 09/5/22 with the LNHA, who stated, the DON or admin (administrator) should have been made aware, an investigation should have been done. He stated a root cause analysis should have been done and if not able to determine the cause, it should have been reported to the NJDOH. The LNHA confirmed he was unaware of the incident with #72. On 10/06/22 at 2:45 PM, in the presence of the survey team and the IIPLPN, LNHA, DON, and RA, Surveyor #3 presented the concern of not being provided with an incident report/investigation for Resident #72 and that it was not reported to the NJDOH. On 10/12/22 at 12:40 PM, in the presence of the survey team, the RN and the RA confirmed that there was no additional information or evidence to provide besides what was already given to the surveyors throughout the survey process. 31654 Refer to F684 d.3) A review of the closed medical record revealed an Admission Record that Resident #193 had admitting diagnoses that included, but were not limited to, Dysarthria (a speech disorder from neurological injury), CVA, Malignant Hypertension (sudden spike in blood pressure), and Type 2 Diabetes Mellitus. The closed medical record also included a hospital record dated 07/25/21 for Resident #193. The hospital record revealed a Computer Aided Tomography of the Head or Brain without contrast was completed on 07/20/21 and revealed, There are no acute findings. On 10/04/22 at 11:16 AM, the surveyor reviewed the entirety of the closed medical record for Resident #193 which was provided by the facility on 09/26/22 at 3:00 PM and revealed the following conclusion. Resident #193 had sustained four falls including two falls that occurred on 08/20/21, and two falls that resulted in transfer to the emergency roiagnom on [DATE] and 09/24/21, which resulted in an acute, traumatic right subdural hematoma, which required an emergent craniotomy and neuro intensive care. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/04/22 at 4:18 PM, the surveyor, in the presence of another surveyor, inquired to the Licensed Nursing Home Administrator (LNHA) and Regional Licensed Nursing Home Administrator (RLNHA) if there were any investigations for Resident #193. The RLNHA stated no there were no investigations that the facility was aware of. On 10/05/22 at 9:56 AM, the surveyor interviewed the DON regarding what the process was if a resident sustained an injury of unknown origin. The DON stated it should be investigated and reported to the State. There was no reference to being found on the floor. On 10/05/22 at 10:49 AM, the surveyor interviewed the LNHA, regarding what the process was for injuries of unknown origin. The LNHA stated there should be an investigation for injuries of unknown origin. On 10/05/22 at 4:05 PM, the surveyor inquired to the DON regarding any incidents, investigations or reportable events (events that require the facility to report to the DOH) for Resident #193. The DON stated, I have nothing on Resident #193 and the DON stated that she and the LNHA could not locate any incidents or reportable events. 10/06/22 at 10:31 AM, the RLNHA stated to the surveyor that with any injury of unknown origin, an incident report with statements and a full head to toe investigation should have been completed. The RLNHA stated that the falls, possibly the first three, but definitely the last fall, if there were injuries it should have been reported to the Department of Health. The following facility provided policies were reviewed: Accidents-Occurrence Investigation, dated 01/2022 revealed All accidents will be investigated, documented and reported to the New Jersey Department of Health as appropriate. Definitions: Accident refers to any unexpected or unintentional incident, which may result in injury or illness to a resident . Fall: refers to unintentionally coming to rest on the ground, floor or other lower levels, but not as a result of an overwhelming external force (i.e. resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for staff intervention, is considered a fall. A fall without an injury is still a fall unless there is evidence suggesting otherwise when a resident is found on the floor, a fall is considered to have occurred . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procedure: Responsibility Person responsible for area in which the accident occurred (Initiator). Action: Initiated the accident report and enters required information. Notifies RN/Clinical Care Manager; RN/Clinical Care Manager: Action: Investigates the situation and assesses the resident/patient, completes the nurse section of the Accident Report, Determines/implements immediate corrective action. Licensed Nurse RN/LPN: Notifies M.D. & Clinical Care Manager, Identifies relevant environmental risk factors, Notifies Plant Operations and/or housekeeping as appropriate, Documents the accident event and notification of family in the progress notes, Place resident/patient on 24 hour report x 72 hours, Documents resident/patient status in the progress notes X 72 hours, RN/CCM: Initiates/updates CCP with a new intervention, Clinical Care Manager: Reviews the accident report and other pertinent information with the interdisciplinary Team at morning report the following business day, RN/Clinical Care Manager: Initiates Incident report, Obtains statements from all staff, residents, visitors, volunteers present at the time of the accident, by the end of the shift, Obtains statements until a determination can be made as to the time of the accident, Clinical Care Manager: Reviews accident report, statements occurrence report, clinical record and surveillance data as indicated. Completes Summary of Findings and Determination regarding Abuse, Neglect, and Mistreatment, Initiates Corrective Action Plan, Notifies family/significant others of the findings of the Occurrence Investigation, Submits all documents to the A.D.N./D.N.S., D.N.S./A.D.N.: Reviews each case, relevant documents and the clinical record to validate findings and determine results, Forwards original accident reports to the Education Dept., DNS/ADN: Reviews significant injuries and injuries of unknown origin with the Administrative Team (Administrator/Associate Administrator/ Medical Director/Associate Medical Director), Administrative Team: Conducts root cause analysis, as needed, DON/Designee: Notifies DOH and other regulatory agencies as per regulations if: reasonable cause to suspect abuse, neglect and mistreatment has been determined, failure to follow the CCP, which resulted in resident injury, injuries of unknown origin. A review of facility policy, Abuse Prevention & Reporting revised 5/20/22, Policy: 1. Residents of [redacted] for Rehabilitation and Nursing will be protected from abuse, neglect, mistreatment, or misappropriation of property in accordance with State and Federal Regulations. 2. All alleged or suspected incidents of abuse, neglect, mistreatment, or misappropriation of residents' property will be thoroughly investigated, and findings documented in report format. 3. Any case in which abuse, neglect, mistreatment, or misappropriation of resident's property has been identified via the investigation, or a conclusion cannot be drawn will be reported promptly to the State Department of Health. 4. Allegations of abuse will be investigated in accordance with abuse and reporting guidelines. Identification: 2. The facility will investigate all unusual incidents and all injuries of unknown origin. Clues to help Identify Abuse: A. Physical Abuse Clues: Resident denies physical abuse however physical exam reveals .fractures. Responsibility: All non-licensed employees, Actions: 1. reports complaints and/or evidence of suspicion of abuse neglect injury of unknown origin or mistreatment to their supervisor immediately, 2. will complete written statements to aid in investigation. All licensed employees, Actions: 1. Notifies their supervisor immediately, 2. Notifies Administration of same. 3. Will complete written statement to aid in investigation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Nursing Supervisor/Social worker, Actions: 1. Obtains a statement from the resident in question, 2. Takes immediate necessary precautions/management pending complete investigation, 3. Interim case conference is held to develop interventions to ensure resident physical harm, pan, and/or anguish is minimized. Administrator/DNA/Designee, Actions: 1. Will ensure that all alleged violations involving mistreatment, neglect or abuse including injuries of unknown source . are reported immediately to the administrator and/or representative and to other officials in accordance with State law through established procedures (including to the State survey and certification agency), 2. Will ensure that the results of all investigations are reported to the administrator .within 24 hours of the incident. Allegation of Abuse, neglect, exploitation or mistreatment and injuries of unknown source, Action: 1. All alleged violations of abuse are to be reported immediately but no later than 2-hours if the alleged violation involve abuse or results in serious bodily injuries. A review of the facility provided, Rehabilitation and Care Center Abuse Prevention & Reporting policy dated revised 5/20/22, included all residents of [name of another facility] will be protected from abuse, neglect, mistreatment, or misappropriation of property in accordance with State and Federal Regulations; all alleged suspected incidents of abuse, neglect .will be thoroughly investigated and findings documented in a report format; any case of abuse, neglect .has been identified via the investigation, or a conclusion cannot be drawn will be reported to the State Department of Health; allegations of abuse will be investigated in accordance with abuse and reporting guideline .Administrator/DON will ensure all alleged violations of mistreatment, neglect, or abuse .are reported immediately to the administrator and/or representative and to other officials in accordance with State law through established procedures .law enforcement to be notified no later than twenty-four hours. A review of the facility's policy indicated the following: Any case in which abuse, neglect, mistreatment, or misappropriation of resident's property has been identified via the investigation, or a conclusion cannot be drawn will be reported promptly to the State Department of Health. The facility did not follow their own policy. N.J.A.C. 8:39-13.4(c)(2)(v), 27.1(a)(b)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 39885 Based on interview, record review and review of other pertinent facility documents, it was determined that the facility failed to provide the resident and or the resident's representative written notification of the reason for transfer to the hospital and also send a copy to a representative of the Office of the State Long-Term Care Ombudsman for 2 of 2 resident's (Residents #86 and #193) reviewed for hospitalization . This deficient practice was evidenced by the following: On 09/22/22 at 09:49 AM, the surveyor reviewed Resident #86's medical record which revealed a Progress Note (PN), dated 8/4/22, that indicated that the resident was transferred to the hospital. A PN, dated 8/10/22, indicated that Resident #86 returned to the facility from the hospital on that date. There was no documented evidence of written notification to the resident or resident's representative and the Ombudsman of the reason for transfer to the hospital. On 09/28/22 at 01:16 PM, during surveyor interview, the Director of Social Services (DSS) stated that the nurse would notify the family when a resident was transferred to the hospital. She added that she did not know who would provide the written notification to the family. She then stated that she was not sure who would notify the Ombudsman. On 09/30/22 at 11:00 AM, during surveyor interview, the Regional Admissions (RA) stated that the facility had not been sending a written notification to the resident or resident's representative and the Ombudsman of the reason for transfer to the hospital. She added that the DSS was not aware that she was the person that was supposed to send out the notification. The surveyor had previously asked the RA if there was a policy regarding the notification. The RA stated that the facility did not have a policy. On 09/30/22 at 11:23 AM, during surveyor interview in presence of the RA, the DSS confirmed that she had not sent written notification to the resident or family or the Ombudsman of the reason for transfer to the hospital. On 10/04/22 at 11:16 AM, the surveyor reviewed Resident #193's closed medical record which revealed a PN, dated 9/24/22, that the resident was transferred to the hospital. Resident #193 did not return to the facility. There was no documented evidence of written notification to the resident or resident's representative and the Ombudsman of the reason for transfer to the hospital. The facility was unable to provide the survey team any documented evidence that written notification to the resident or resident's representative and the Ombudsman for Resident #86 and Resident #193. On 10/07/22 at 10:49 AM, during surveyor interview, the Licensed Nursing Home Administrator (LNHA) stated that there was no written notification to the resident or family and ombudsman and that there should have been. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	On 10/07/22 at 11:29 AM, during surveyor interview, the Regional Licensed Nursing Home Administrator (RLNHA) stated that there should have been written notification to the resident or family and ombudsman. On 10/07/22 at 01:36 PM, in the presence of the survey team and the LNHA, the RLNHA confirmed that the facility did not have a policy regarding written notification of the reason for transfer to the hospital or notification of the Office of the State Long-Term Care Ombudsman. N.J.A.C. 8:39-4.1(a)31,32

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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 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 39885 Based on interview, review of the medical record and review of other pertinent facility documentation, it was determined that the facility failed to provide the resident or resident representative written notification of the facility's bed hold policy prior to transfer to the hospital for 2 of 2 resident's (Resident #86 and #193) reviewed for hospitalization s. This deficient practice was evidenced by the following: On 9/22/22 at 09:49 AM, the surveyor reviewed Resident #86's medical record which revealed a Progress Note (PN), dated 8/4/22, that indicated that the resident was transferred to the hospital. A PN, dated 8/10/22, indicated that Resident #86 returned to the facility from the hospital on that date. There was no documented evidence of written notification to the resident or resident's representative of the facility's bed hold policy prior to transfer to the hospital. On 09/28/22 at 01:16 PM, during surveyor interview, the Director of Social Services (DSS) stated that the admissions department would provide the notification of the bed hold policy. On 09/28/22 at 01:19 PM, during surveyor interview, the Regional Admissions (RA) stated that she was not aware that the admissions department provided the bed hold notification. She added that she would try to find out who provided it. On 09/29/22 at 10:42 AM, during surveyor interview, the RA stated that upon admission the bed hold policy is reviewed. She added that when a resident is transferred to the hospital, the written notification should be sent out by the Social Services department. On 09/30/22 at 11:00 AM, during surveyor interview, the RA stated the facility had not been sending written notification of the bed hold policy prior to transfer to the hospital. She added that the DSS was not aware that she was the person that was supposed to send out the notification. On 09/30/22 at 11:23 AM, during surveyor interview in the presence of the RA, the DSS confirmed that she had not sent written notification of the bed hold policy prior to hospitalization . On 10/04/22 at 11:16 AM, the surveyor reviewed Resident #193's closed medical record which revealed a PN, dated 9/24/22, that the resident was transferred to the hospital. Resident #193 did not return to the facility. There was no documented evidence of written notification to the resident or resident's representative of the facility's bed hold policy prior to transfer to the hospital. The facility was unable to provide the survey team any documented evidence that written notification to the resident or resident's representative of the facility's bed hold policy prior to transfer to the hospital for Resident #86 and Resident #193. On 10/07/22 at 10:49 AM, during surveyor interview, the Licensed Nursing Home Administrator stated that there was no written notification to the resident or family about the bed hold policy prior to transfer to the hospital and that there should have been. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	On 10/07/22 at 11:29 AM, during surveyor interview, the Regional Licensed Nursing Home Administrator stated that there should have been written notification to the resident or family of the bed hold policy prior to transfer to the hospital. A review of the facility provided policy titled, Bed Hold Policy, with a reviewed date of 5/26/22, included the following: Medicaid Residents Medicaid recipients who reside in the facility and who require hospitalization on a physician's order the Should said resident return within 30 days the facility will continue the use of the previous chart. Private Residents Private paying residents or their responsible parties may authorize the facility to retain their beds pending their return from the hospitalization . By authorizing the bed hold the responsible party assumes the financial responsibility until the resident returns to the facility or the responsible party gives 14 days discharge notice. Upon admission to the hospital, the responsible parties of private paying residents shall be informed by telephone and will be asked to authorize a bed hold. If authorized, the bed hold will remain in effect until the resident returns or until appropriate notice is given. A facility representative will follow up with the resident or resident representative via a telephone conversation in regards to the bed hold policy. The policy did not contain information regarding written notification of the facility's bed hold policy prior to transfer to the hospital. N.J.A.C. 8:39-5.1 (a)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 36419 Based on interview and record review, it was determined that the facility failed to complete a comprehensive Minimum Data Set Assessment (MDS), an assessment tool, as required for 2 of 20 residents (Resident #10 and #248), system selected for MDS over 120 days and was evidenced by the following: On 9/27/22 at 11:52 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the MDS coordinator resigned about three weeks ago and that the Regional MDS coordinator was now responsible for completing the MDS assessments. The DON further stated that the Regional MDS coordinator was only in the facility, once in a while but usually communicated via email. The surveyor asked the DON how often the MDS assessments should be completed. The DON replied, quarterly, annually and for changes in the resident's condition. On 9/28/22 at 1:02 PM, the surveyor interviewed the Regional MDS Coordinator who stated that she had been the facility's Regional MDS coordinator since August 1, 2021, and the in-house facility MDS coordinator for about five weeks. The MDS coordinator stated that she was in the facility once weekly and that she completed the MDS for all the residents upon admission, quarterly, annually, and if there was a significant change. The MDS Coordinator stated that each assessment had an assessment reference date (ARD) and the facility completed a seven-day look-back period from that date. The facility had fourteen days to complete the assessment from the ARD and then they had an additional seven days to submit the assessment. At this time, the MDS Coordinator stated that not all of the MDS assessments were completed because the in-house facility MDS coordinator resigned so she was trying to play catch up. The Regional MDS coordinator acknowledged that as the Regional MDS coordinator, it was her responsibility to ensure that the facility's MDS coordinator completed the MDS assessments within the requirements of the Centers for Medicare and Medicaid Services. The MDS coordinator stated that there were late and incomplete MDS assessments, and she was trying to put everything in order. At this time, the surveyor and MDS coordinator reviewed the Electronic Medical Record (EMR) for the twenty-system selected MDS assessments over 120 days not completed for each of the system-selected MDS which revealed that two residents did not have a completed comprehensive MDS as follows: 1.) Resident # 10's last completed MDS was a quarterly dated 5/28/22. The next comprehensive annual ARD was 8/12/22, which was not completed. 2.) Resident # 248's Admission ARD was 8/29/22, which was not completed. At this time, the MDS coordinator acknowledged the above MDS assessments were not completed, and that the facility was behind on MDS assessments. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Facility Policy, Resident Assessment Instrument (RAI) Process, reflected that the facility complies with the existing federal and state regulations governing the implementation of the RAI process as a basis for the provision of quality care to its residents. The purpose is to outline the procedure of identifying and addressing residents' strengths and needs through the RAI process. The MDS department will schedule MDS assessments, Care Area Assessment, and Care Planning in accordance with the current requirements of the Centers for Medicare and Medicaid Services. Members of the Interdisciplinary Care Team shall endeavor to complete their respective MDS sections on or before the End Date. On 10/12/22 at 12:40 PM, the Regional Licensed Nursing Home Administrator (LNHA) acknowledged the facility was behind on MDS assessments. No further information was provided by the facility. N.J.A.C. 8:39-11.1

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident’s assessment is updated at least once every 3 months. 36419 Based on interview and record review, it was determined that the facility failed to complete a quarterly Minimum Data Set Assessment (MDS), an assessment tool, as required for 6 of 20 residents (Resident #8, #12, #13, #14, #26 and #34) system selected for MDS over 120 days and was evidenced by the following: On 9/27/22 at 11:52 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the MDS coordinator resigned about three weeks ago and that the Regional MDS coordinator was now responsible for completing the MDS. The DON further stated that the Regional MDS coordinator was only in the facility, once in a while but usually communicated via email. The surveyor asked the DON how often the MDS should be completed. The DON replied, quarterly, annually, and for changes in the resident's condition. On 9/28/22 at 1:02 PM, the surveyor interviewed the Regional MDS Coordinator who stated that she had been the facility's Regional MDS coordinator since August 1, 2021, and the in-house facility MDS coordinator for about five weeks. The MDS coordinator stated that she was in the facility once weekly and that she completed the MDS for all the residents upon admission, quarterly, annually, and if there was a significant change. The MDS Coordinator stated that each assessment had an assessment reference date (ARD) and the facility completed a seven-day look-back period from that date. The facility had fourteen days to complete the assessment from the ARD and then they had an additional seven days to submit the assessment. The MDS Coordinator further stated that not all of the MDS assessments were completed because the in-house facility MDS coordinator resigned, and the facility had not hired another MDS coordinator, so she was trying to play catch up. At this time, the MDS coordinator acknowledged that it was her responsibility to ensure that the facility MDS coordinator completed the MDS assessments in accordance with current Centers for Medicare and Medicaid Services requirements. The MDS coordinator stated that there were late and incomplete MDS assessments, and she was trying to put everything in order. At this time, the surveyor and MDS coordinator reviewed the Electronic Medical Record (EMR) for the twenty-system selected MDS assessments over 120 days not completed for each of the system-selected MDS which revealed that six residents did not have a completed quarterly MDS as follows: 1. Resident #12's last completed MDS was a quarterly dated 5/13/22. The next ARD was 7/28/22, which was not completed. 2. Resident #8's last completed MDS was a quarterly dated 5/28/22. The next ARD was 8/12/22, which was not completed. 3. Resident #26's last completed MDS was a quarterly dated 6/3/22. The next ARD was 8/12/22, which was not completed. 4. Resident #13's last completed MDS was a quarterly dated 6/3/22. The next ARD was 8/19/22, which was not completed. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Resident #14's last completed MDS was a quarterly dated 6/12/22. The next ARD was 8/29/22, which was not completed. 6. Resident #34's last completed MDS was a quarterly dated 6/17/22. The next ARD was 9/2/22, which was not completed. At this time, the MDS coordinator acknowledged the above MDS assessments were not completed, and that the facility was behind on MDS assessments. A review of the Facility Policy, Resident Assessment Instrument (RAI) Process, reflected that the facility complies with the existing federal and state regulations governing the implementation of the RAI process as a basis for the provision of quality care to its residents. The purpose is to outline the procedure of identifying and addressing residents' strengths and needs through the RAI process. The MDS department will schedule MDS assessment, Care Area Assessment, and Care Planning in accordance with the current requirements of the Centers for Medicare and Medicaid Services. Members of the Interdisciplinary Care Team shall endeavor to complete their respective MDS sections on or before the End Date. On 10/12/22 at 12:40 PM, the Regional Licensed Nursing Home Administrator (LNHA) acknowledged the facility was behind on MDS assessments. No further information was provided by the facility. N.J.A.C. 8:39-11.1

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to develop and revise a person-centered comprehensive care plan to: a.) address a resident's aggressive and inappropriate behavior (Resident #63); b.) specify supervision required for residents at risk for falls (Resident #24 and #13); and c.) update the care plan, identify steps to be implemented to manage the behavior of residents with history of sexual assault and prevent them from attempting to engage in inappropriate sexual behavior (Resident #63 and #8), for 4 of 35 residents reviewed for person-centered care plans. Findings included: Refer F600 a. On 09/21/22 at 10:40 AM, Surveyor #1 toured the 300's locked unit and observed Resident #63 lying in bed; he/she was awake and alert. He/she reported to the surveyor that he/she had a headache, the surveyor left the room and informed the nurse. Surveyor #1 reviewed Resident #63's medical record on 09/27/22 which revealed the following: According to the Admission Face Sheet, Resident #63 was admitted to the facility with diagnoses which included Major Depression and diabetes mellitus. The Admission Minimum Data Set (MDS) a resident assessment document dated 01/10/22, included that Resident #63 had displayed some aggressive and inappropriate sexual behavior. The Quarterly MDS dated [DATE], revealed that Resident #63 scored 7 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident had severe cognitive impairment. Section E which addressed behavior indicated that Resident #63 had no behaviors. On 09/21/22 at 11:45 AM, an interview with the Temporary Nursing Assistant (TNA #1) who cared for Resident #63 revealed, that Resident #63 required minimum assistance with care, was able to walk short distance but at times would use the wheelchair to self-propel in the hallway. On 09/22/22 at 12:45 PM, Surveyor #1 observed Resident #63 in bed, awake and alert and did not have any complaints. On 09/23/22 at 1:30 PM, Surveyor #1 reviewed Resident #63's Baseline Care Plan dated 12/28/21, which identified Resident #63 as a fall risk and having behaviors of engaging in physical altercation with others. The intervention was to separate and place on one-to-one (1:1) observation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #63's Comprehensive Care Plan initiated on 04/28/22 was reviewed. The Comprehensive Care Plan did not include a focus nor interventions in place for the management of aggression or sexually inappropriate behavior. There was no identified focus, goals or interventions related to the maladaptive behavior of being sexually inappropriate with male/female residents and being aggressive with other residents. The behavior was not addressed in the care plan. There was no directive in place for the staff to manage the behavior. The inappropriate sexual behavior was not addressed as a concern. There were no specific interventions in place to supervise Resident #63. Four direct care staff confirmed that Resident #63 displayed inappropriate sexual behavior toward confused male/female residents on the locked unit. None of the observed behaviors reported were documented or addressed in the plan of care. On 09/26/22 at 1:43 PM, TNA #1 reported that on 08/10/22 Resident #63 was involved in sexual inappropriate behavior with Resident #10. Resident #63 was observed to have exited Resident #10's room. Resident #10 was an intellectually disabled resident. On 09/27/22 at 8:38 AM, another surveyor interviewed (CNA #2) who recounted the same story and informed the survey team that the administrative staff was aware of the incident and did not ask staff to provide statements. On 09/27/22 at 11:04 AM, an interview with CNA #1 who worked the 300's unit the day of the incident, confirmed the alleged sexually inappropriate behavior. On 09/27/22 at 12:30 PM, Surveyor #1 reviewed Resident #63's electronic Progress Notes (PN) and could not identify any entry pertaining to the above incident. There was no entry regarding the incident in Resident #63's medical record. The Care Plan was not revised to include the incident. On 09/27/22 at 12:45 PM, Surveyor #1 reviewed the PN (not clinical notes) On top of the pages it said (clinical Notes) dated 01/04/22, which documented, Resident # 63 was involved in a physical altercation with the roommate. Resident #63 found the roommate laying in his/her bed, threw the roommate on the floor. The staff heard noise emerging from the room, the CNA attempted to separate the two residents, Resident #63 fell on the floor and sustained laceration to the lower lip. Resident #63 continued to be aggressive with staff. The physician and the nursing supervisor were notified. No documentation of any follow up done after the incident was entered in the Progress Notes. The documentation did not indicate that Resident #63 was being monitored after the incident, or that 1:1 observation was initiated as reflected in the Baseline Care Plan. Surveyor #1 continued to review the PNs and noted another entry dated 01/06/22, which documented that Resident #63 slapped a female resident in the face. When asked what had happened, Resident #63 stated, I slapped her in the face because she walked past me too many times and talked to much. The aggressive behavior was not addressed in the plan of care. There was no indication that the Interdisciplinary Team convened and discussed with the direct care staff measures to prevent Resident #63 from being aggressive toward other residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/29/22 at 10:15 AM, Surveyor #1 reviewed the above PNs with the Director of Nursing (DON) and requested the investigative reports for review. The DON stated that she was not aware of the above incidents and would look for the investigative reports. The surveyor then requested the Care Plan policy for review. On 9/29/22 at 10:46 AM. the DON stated she could not locate any investigation and no additional information was provided. The DON provided the care plan policy for review. The facility did not revise and implement any interventions in the Care Plan after the above incidents. b. Surveyor #1 reviewed Resident #24's medical record on 09/26/22 which reflected that Resident #24 had diagnoses which included but were not limited to: Vascular dementia without behavioral disturbances, anxiety disorder vitamin deficiency. The Quarterly MDS assessment dated [DATE], reflected that Resident #24 was severely cognitively impaired. Resident #24 was totally dependent on staff for all Activities of Daily Living (ADL's). A review of the plan of care dated 07/08/22, included a focus for Fall and documented the following: I am at risk for falls based on score risk of 10. The goal was for Resident #24 to be free from significant injury related to falls. Resident #24 fall interventions included: We will maintain a clutter free environment. We will bring you to the dayroom during the day for closer supervision. We will not leave you in the room and on toilet. We will place you in high visibility area while you are awake. On 09/23/22 at 10:30 AM, an interview with TNA #4 who cared for Resident #24, stated that Resident #24 was confused and totally dependent on staff for care. The CNA stated that Resident #24 was a wanderer. On 09/24/22 at 9:47 AM, surveyor #1 further reviewed the PNs which revealed that Resident #24 fell at the facility on the following dates: 09/09/22 and 09/16/22. The following were documented: 09/09/2022 at 4:36 PM, patient fell to the floor during the last part of day shift. No injury noted. The physician was notified. Neuro check implemented. Patient is resting comfortably. 09/16/2022 at 3:07 PM, Resident #24 attempted to walk between the mechanical lift and wet floor sign, then lost his/her balance and fell . No injuries noted. Family and Nurse Practitioner notified. On 09/22/22 at 9:49 AM, surveyor #1 observed Resident #24 wandering on the locked unit very confused. No staff attempted to redirect him/her into the dayroom for activities. On 09/26/22 at 11:35 AM, surveyor #1 observed Resident #24 wandering aimlessly in the hallway, entering other resident's room. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/28/22 at 10:30 AM, surveyor #1 requested the incident reports for the falls from the DON. The DON stated that she was not aware of the falls. The surveyor reviewed the PNs with the DON who stated she would locate the incident reports. On 10/04/22 at 1:45 PM, the DON stated that she could not locate the incident reports. A review of the Care Plan with the DON lacked evidence that the care plan was revised, and meaningful interventions were implemented to keep Resident #24 safe. c. On 09/27/22 at 11:00 AM, surveyor #1 reviewed the clinical record of Resident #13 which reflected that Resident # 13 was admitted to the facility with diagnoses which included but were not limited to major depressive disorder, hypertension, and dementia with behavioral disturbances. The Quarterly MDS with an assessment Reference date of 08/19/22, revealed that Resident #13 was severely cognitively impaired. Resident #13 received a score of 3 on the cognitive skills for daily decision making. Resident #13 was fully dependent on staff to meet his/her needs in bed mobility, transfer, toilet use, eating and dressing. The clinical record further revealed that Resident #13 sustained falls at the facility on 09/10/22, 09/13/22, and 09/23/22. Resident #13 was identified as being at high risk for falls. Resident #10 received a score of 10 on the Fall Risk Assessment. The causal factor identified: Resident rolled out of the bed. The Care Plan was not revised to implement specific interventions and provide directives to the direct care staff on how to keep Resident #13 safe. Resident #13 sustained another fall on 9/13/22. Resident #13 was found on the floor in the room, sustained a facial laceration and had to be transferred to the hospital for evaluation. 45449 d. On 09/27/22 at 10:45 AM, Surveyor #2 observed Resident #08's room closed. The surveyor knocked on the Resident's door and was invited to enter by Resident #08. The surveyor observed Resident #08 lying in bed and conversational. At that time, during an interview with Surveyor #2, Resident #08 stated he/she was arrested, jailed and the charges were dropped. Resident #08 also stated that the reason for the transfer to this facility was because the previous facility was for mental patients. On 9/29/22 at 2:23 PM, the surveyor verified the https://www.nsopw.gov/ website which revealed Resident #08 was a registered sex offender. On 09/30/22 at 10:20 AM, during an interview with the survey team, the Regional Nurse and Regional Licensed Nursing Home Administrator (LNHA) stated the family representative for Resident #08 had informed them (the facility) that Resident #08 was expunged and was in search of the verifiable documents. The Regional LNHA informed the surveyors that she would reach out to the Resident's parole officer. The Regional LNHA stated that Resident #08 was not being transferred to a different facility but was monitored. The Regional LNHA could not further define the parameters of monitored for Resident #08. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Admission Record revealed the resident was admitted from [redacted] Nursing Home on 11/10/21. The nearest relative reflected no visitors listed/county should be contacted and the address listed was [redacted] correctional facility. A review of the Nursing Admission assessment dated [DATE], revealed the resident was independent with mobility using a wheelchair and had no risk for wandering or elopement on previous admission/home. Further review of the form under section Long Term Memory Check reflected 0 errors which indicated the resident had intact mental function. A review of the Physician Order Activity Detail Report (PO) for May 17, 2022 to October 3, 2022, reflected that the resident had diagnoses which included chronic kidney disease, diabetes mellitus, hypertension, major depressive disorder, insomnia, and chronic obstructive pulmonary disease. On 10/04/22 at 10:10 AM, Surveyor #2 requested all of the admission documents from the Interim Infection Preventionist Licensed Practical Nurse (IILPN). On 10/04/22 at 12:41 PM, during an interview Surveyor #2, the Social Services Director (SSD) stated that Social Services Psychosocial Assessments (SS-PA) were completed the next day and weekend admissions were completed the following Monday. The SSD informed the surveyor that for existing residents, their Psychosocial Annual/Reassessments were completed quarterly along with the Resident's Care Plan. At that time, the SSD stated she had known that Resident #08 was a registered sex offender since 05/22 which she learned from the previous Director of Nursing. SSD admitted to doing nothing with the information she received. The SSD stated she was concerned for Resident #08's privacy and acknowledged she should have been equally concerned with the other Resident's safety. The SSD stated she should have informed her Superiors, informed the clinical team and care planned Resident #08. On 10/04/22 at 12:47 PM, Surveyor #2 requested for all the documents pertaining to all social worker assessments [SS-PA] from the SSD. On 10/5/22 at 9:38 AM, Surveyor #2 requested for all of Resident #08's SS-PA and care plans from the Regional Licensed Nursing Home Administrator (Regional LNHA). On 10/05/22 at 1:50 PM, during an interview with Surveyor #2, the Regional LNHA stated she was unable to locate the Admission/Initial SS-PA and Admission care plan. A review of the SS-PA revealed -Admission/Initial assessment, was not provided, lost. -First quarter/Reassessment after admission, was not provided, lost. -06/21/22 no Psychosocial Assessment that addressed Resident was a registered sex offender. -8/06/22 -06/21/22 no Psychosocial Assessments that addressed Resident was a registered sex offender. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avant Rehabilitation and Care Center	1314 Brunswick Avenue Trenton, NJ 08638

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Care Plan (CP) Activity Report marked with a status of active, printed on 09/30/22 did not include a focus, goals and interventions for Resident #08's Psychosocial History as a registered sex offender. On 10/06/22 at 10:25 AM, during an interview with Surveyor #2, the Regional LNHA informed the surveyor that Resident #08 should have been care planned from admission under social history or social services assessment. On 10/06/22 at 11:37 AM, during an interview with Surveyor #2, the DON stated that the social worker was responsible for obtaining Resident #08's psychosocial history assessment during admission on 11/21, which should have triggered the inclusion of a focus on history of sex offense within the care plan. The DON confirmed that the resident should have been care planned and was not. The DON acknowledged that there were at least four opportunities to have developed, revised and/or updated Resident #08's care plan. On 10/12/22 at 12:40 PM, in the presence of the survey team the Regional Nurse and Regional Licensed Nursing Home Administrator (LNHA) confirmed no additional information could be provided. The facility policy dated 01/05/22 and titled, Policy and procedure for Care Planning reflected that the policy of the facility is to provide an individualized comprehensive care plan for each resident based on assessments done at the time of admission, quarterly, annually and when there is a change in condition. Purpose: To ensure that the residents plan of care is reflective of the current condition and needs of the resident. The facility failed to develop and implement meaningful interventions to care for the residents based on their assessed needs. The policy was not being followed. The facility was made aware of the above findings on 10/04/22 and 10/11/12 and no additional information was provided on the exit day. A review of the facility provided, Care Planning last reviewed 5/26/22 include but was not limited to the following: Policy: It is the policy of ___ [redacted] Rehabilitation and Care Center __to provide an individualized comprehensive care plan (CCP) for each resident based on assessments done at the time of admission, quarterly, annually, and when there is a significant change in condition. Purpose: To ensure that the residents plan of care is reflective of the current condition and needs of the resident. General Information: -A comprehensive care plan will be written for all new admission. -A new care plan will be initiated for significant change if the current care plan is more than 12 months old OR if the CCP does not reflect the current needs of the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Care plan will be listed on the front cover of the CCP sheet with the initiation and discontinuation date of each care plan. Procedure: Individual, Registered Nurse Responsibility 2. Based on the above assessment, will initiate or update the care plan to reflect raps that were triggered by the initial assessments. Individual, All disciplines Responsibility 9. Formulates care plan for specific discipline on Admission, quarterly, significant change, return from the hospital and as needed with change in condition. N.J.A.C. 8:39-11.2 (e) 1 (h)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31654 Based on interview, record review and document review it was determined that the facility failed to implement revised interventions to prevent recurrent falls for a resident who had a history of falls and sustained a fall without injury on 01/11/23. The deficient practice occurred for 1 of 4 Residents reviewed for incidents (Resident #9) during a re-visit survey conducted on 01/26/23 and was evidenced by the following: On 01/26/23 at 8:43 AM, the Director of Nursing (DON) informed the surveyor team that there had been four investigations/ Reportable Events since 12/05/22. The surveyor reviewed the medical record for Resident #9 which revealed: A Resident Face Sheet which indicated the resident had diagnoses which include, but were not limited to, vascular dementia, unspecified severity, with behavioral disturbance, essential hypertension and chronic ischemic heart disease. An Nursing Progress Note, dated 01/17/23 at 11:12 AM, revealed 01/22/2023 CNA approached writer stating resident is on the floor on the floor mat. I observed resident laying on [his/her] side on the right side of [his/her] bed on the floor mat. Vitals were taken within normal limits. Resident assessed: no apparent injuries noted. M.D., Unit manager and [family member] notified. No new orders. Will continue to monitor. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan Activity Report for Resident #9 revealed an Active Care Plan Focus for Falls with an Etiology: polypharmacy; cognitive impairment; incontinence; seizure disorder with an Effective Date 04/28/2022. Goals included I will be free from significant injury related to falls, Effective: 07/11/2022, Review: 02/09/2023; My safety will be maintained in the least restrictive environment., Effective: 11/30/2022, Review: 03/01/2023; and I will have reduced frequency of falls., Effective: 12/08/2022, Review: 03/08/2023. The Active Interventions, with an Effective date 07/11/2022, included: We will orient you to your surrounding and routine on the unit; We will ensure you have the proper footwear or socks with non-skid bottoms; We will maintain a clutter free environment; We will bring you to the dayroom during the day for closer supervision; We will toilet you every 2 to 4 hours and PRN (as needed), We will offer toileting on hourly rounds.; We will change you every 2-4 hours and PRN. We don't want you to be uncomfortable and try to get up by yourself.; We will take you out of bed when wakeful because you get very restless and want to get up right away. We don't want you to fall.; We will apply anti-skids socks on you prior to sleep so you don't slip if you get up during the night.; We will not leave you alone in room or on toilet (when awake),; We will encourage your compliance with plan of care. We will involve your family in promoting compliance. We will send a PT/OT (therapy) referral if needed, Effective 09/20/22; We will place you in high visibility areas while you're awake, Effective: 11/20/2022. A Notes section of the Falls Care Plan revealed: Plan of care still applicable. POC continues, Created on: 09/20/2022, During rounds from change of shift CNA observed resident sitting upright on the floor at bedside at 3:30 PM, Created on 12/01/2022., NN (nursing note) on 11/30/2022, resident found on the floor on the left side of [his/her] bed. MD, ADON and [family] notified. Neuro check started, Created on 12/05/2022, On 11/30, Resident was found on floor with no apparent injury, Created on 12/08/2022, NN on 01/03/2022 Shift Note: CNA doing rounds found resident on floor on the left side of his bed. Resident's vitals were taken. Skin assessment done. MD, ADdon, and [family] notified. Neuro check started. (There were no additional interventions added to Resident #9's Care Plan after the 01/03/2022 fall. On 01/26/23 at 9:48 AM, the surveyor interviewed the Corporate Administrator (CA) regarding what should be done after a resident falls. The CA stated there should be a new intervention and revised interventions added to the Care Plan. On 01/26/23 at 12:48 PM, the surveyor interviewed the CA and DON, in the presence of the Licensed Nursing Home Administrator (LNHA) and survey team regarding any interventions that were added after Resident #9 sustained a fall on 01/11/23. The DON and CA confirmed that there we no new interventions added. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/26/23 at 1:50 PM, the DON provided the surveyor with an Accident/Incident (A/I) Investigation for Resident #9, for an A/I dated 01/11/23 at 9:30 AM. Description of A/I: Writer was informed by CNA that resident is on the floor. Writer observed resident on his right side on right side of bed on the floor mat. Vitals were within normal limits. Resident assessed. No apparent injuries at this time. Resident placed back in bed, wedges re-secured. MD, Sister, Unit Manager made aware. Fall Risk: At Risk and Fall Score: (left blank). Nurse's Signature: Signed by Licensed Practical Nurse, (LPN #1). Immediate Interventions Taken (Check and complete if applicable): Adaptive Device, Monitoring, Issues Alarm, Floor Mat, Get OOB (out of bed) earlier, Environmental Change, Provide Naps, Resident Teaching , Staff Counseling, Staff Training, Therapy Evaluation, Environmental [NAME] Describe, Medication Change Describe, and Other (all left blank). Based on your investigation, do you suspect abuse, neglect, mistreatment or that a crime may have occurred, no was checked. The Investigation Completed by: LPN #2 (Undated). An attached Interdisciplinary Team Care Plan Conference Summary dated 01/11/23 revealed Resident alert, has [history] vascular dementia, chronic ischemic heart disease, overactive bladder, on 01/11/23 Resident on the mat observed by staff, full assessment done by staff, no sx (symptom) of pain or distress noted. Staff continue to round. Mat on the floor, bed in lowest position. A CNA accident statement dated 01/11/23 revealed that the CNA witnessed the resident on the floor mat, and yes was checked that the bed was in the lowest position and the floor mats had been used. (There we no new interventions added to Resident #9's Care Plan to prevent falls.) Review of the Falls and Fall Risk, Managing Policy Reviewed 0/30/22 revealed: Policy Statement, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling; Resident-Centered Approaches to managing Falls and Fall Risk, 1. the staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 5. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. 7. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling.; Monitoring Subsequent Falls and Fall Risk; 2. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions . Review of the Comprehensive Care Plan Policy Effective Date: 02/02/22 revealed: Policy Statement: A. A comprehensive care plan for each resident shall be developed and initiated on admission at this facility utilizing an interdisciplinary team approach. the comprehensive care plan will be individualized, define the problems/needs identified from each discipline's assessment, attainable goals and interventions. C. Each resident's comprehensive care plan shall be reviewed and updated by the interdisciplinary team as per MDS 3.0 schedule: quarterly, annually, significant change in condition and if the resident's condition warrants it., Purpose: A. To provide a system for all disciplines involved to direct resident care to: Identify and assess each resident's problems/needs. Develop, document and implement a coordinated plan of care. Evaluate the effectiveness of the plan of care and modify plan as needed. NJAC 8:39-11.2 (e)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 27193 Based on observation, interview, and record review, it was determined that the facility failed to provide residents with the care needed to meet the resident's assessed needs. This deficient practice was identified for 2 of 19 residents reviewed for care, (Resident #48 and #54) was evidenced by the following: On 09/21/22 at 10:20 AM, during the initial tour of the locked 300's unit, the surveyor observed Resident #48 in their room, the room had a strong odor of urine. Flies were noted in the room, the mattress was yellow stained. On 09/21/22 at 11:00 AM, an interview with LPN # 6 assigned to the 300's unit low side, revealed that all residents on the low side were confused, they defecated and urinated on the floor and wandered from room to room. The LPN could not comment if Resident #48 was on a toileting program or what had been done to address the behavior. On 09/21/22 at 11:01 AM, the surveyor interviewed the Housekeeping staff assigned to the 300's Unit, she stated that she reported to work at 7:00 AM daily, her role was to remove the trash, clean the dining room, the nursing station, and the shower rooms. She stated that she would clean the rooms (resident) after breakfast. She stated she was not informed of any particular room that needed to be cleaned and disinfected daily. On 09/21/22 at 11:55 AM, an interview with a Temporary Assistant (TNA #2) revealed that they did not have enough linen, towels, wash cloths to care for the residents. TNA #2 stated that she discussed the concern with the Licensed Nursing Home Administrator (LNHA). TNA #2 stated that she had been employed at the facility since October. On 09/23/22 at 7:01 AM, during an interview with the 11:00 PM-7:00 AM Licensed Practical Nurse (LPN #4) who cared for the residents on the 11:00 PM-7:00 AM shift, she stated that her role was to ensure that all residents that were incontinent were up and changed during the shift. LPN #4 confirmed that the pads and sheet were stained and wet. When asked if incontinence care was provided, she did not have any comment. On 09/23/22 at 7:19 AM, the surveyor interviewed CNA #3 assigned to the 300's Unit, she stated that some days when she reported to work in the morning, incontinence care was not provided for incontinent residents if they were short handed. On 09/26/22 at 8:38 AM, the surveyor observed Resident #48 in the elevator going out to smoke. The surveyor went to the room and noted flies all over the room. The sheet and the blanket were yellow stained and wet. The surveyor observed the gown and the linen on the floor, all were visibly wet. On 09/26/22 at 10:07 AM, the surveyor escorted the Licensed Practical Nurse (LPN#5 in the room where we both observed the linen on the floor, flies on the bed and the sheets and incontinence pads were visibly wet. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed Resident #48's clinical record on 09/26/22 at 12:30 PM. The Admission Face Sheet (an admission summary) reflected that Resident #48 had diagnoses which included but were not limited to: Paranoid schizophrenia, anxiety disorder and other schizo-affective disorder. The Annual Minimum Data Set (MDS) an assessment tool used by the facility to prioritize care dated 06/17/22, reflected that Resident #48 was cognitively impaired and received a score of 8 on the Brief Interview For Mental Status (BIMS). Normal score 15. Section E 008 which addressed rejection of care was coded as Zero indicative of being in compliance with care. The resident plan of care dated 04/28/22 last revised 07/08/22, revealed a focus for ADL and Elimination. The goal was for Resident #48 to maintain current level of functioning. The interventions implemented included: I want you to assist me with toileting and dressing. For toilet use Resident #48 was assessed as being incontinent. The goal was Resident #48 to be changed every 2-4 hours and PRN (as needed). Another intervention was to provide Resident #48 with a urinal at the bedside. On 09/21/22 at 10:20 AM and 09/26/22 at 8:38 AM, the surveyor looked and could not locate a urinal in the room. On 09/26/22 at 10:30 AM, the surveyor and the LPN #5 assigned to the desk, went to the room, looked and could not locate a urinal in the room or the bathroom. On 09/28/22 at 11:30 AM, the surveyor reviewed the electronic medical record and noted a Progress Notes dated 07/23/22 which addressed non compliance with care. The Progress Notes indicated the following: Resident was found in the room in bed by this nurse with the bed soaked with urine and so were his/her clothes. This nurse asked CNA for assistance in cleaning up resident, and changing his/her bed and clothes. Resident refused. There was no documentation in the clinical record regarding approaches attempted regarding resident behavior of urinating on the bed and on the floor. The facility was aware of Resident #48's behavior of being non-compliant with care and failed to implement measures to address the behavior. The care plan had not been revised to provide directives to the direct care staff regarding the behavior. There was no measures in place to disinfect the room. 2.) Resident #54 was admitted to the facility with diagnoses which included but were not limited to: Dementia, hypertension and coronary artery disease. The Annual MDS, a resident assessment tool used by the facility to prioritize care dated 10/01/21, revealed that Resident #54 was moderately cognitively impaired. Resident #54 scored 9 on the Brief Interview for Mental Status (BIMS). Normal score 15. Section E of the MDS which addressed behavior indicated that Resident #54 had behavior of screaming and threatening. Section E 0600 impact on behavior subpart c was coded as Zero for disruption of care in the living environment. On 09/21/22 at 9:52 AM, the surveyor toured the 300's locked unit assigned to residents with behavior. The surveyor observed Resident #54 seated in a wheelchair in the hallway. A strong odor of urine was permeated in the hallway while approaching Resident #54's room. The surveyor entered the room and observed the linen included the incontinence pad, and the sheets were soaked with urine. Some clothing was observed on the radiator in the room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/21/22 at 10:12 AM, the surveyor observed the Licensed Nursing Home Administrator (LNHA) in the hallway and escorted him to the room. The LNHA entered the room with the surveyor and we both observed the bedding included the incontinence pads were soaked and yellow stained with urine. The LNHA stated he made rounds every day and had not identified concerns with incontinence care. After seeing the sheet stained yellow with dry urine the administrator stated that his expectations would be that incontinence care would be provided every 2 hours for residents that were On 09/23/22 at 6:53 AM, the surveyor observed Resident #54 seated in a wheelchair in the doorway. The surveyor entered Resident #54's room, the incontinence pads (2) were soaked with urine, strong urine odor noted in the room, bedding, included fitted sheet and blanket were soaked and yellow stained, roach noted crawling on the floor. On 09/23/22 at 6:57 AM, the surveyor interviewed Resident #54. Resident #54 stated that he/she had not been changed during the night. The surveyor escorted the night nurse to the room where we both observed the same. Resident #54 had 2 pads on the bed, both pads wet and stained with urine. The bedding linen was wet and stained with urine, the mattress was also wet and yellow stained. On 09/23/22 at 6:58 AM, the surveyor interview CNA #4 who cared for Resident #54 on the 11:00 PM-7:00 AM shift. CNA #4 stated that Resident #54 would not get up to be changed during the night, she had to wait until the morning to change Resident #54. The CNA did not indicate that she asked either the nurse or another CNA to assist with care. CNA #4 confirmed that Resident #54 had not been changed during the 11:00 PM-7:00 AM shift. She did not indicate that she attempted to change the resident and the resident refused. On 09/23/22 at 7:01 AM, the surveyor interviewed LPN #4 who cared for Resident #54. The LPN stated all residents that are incontinent were to be changed every 2 hours. When asked if incontinence care was provided during the shift for Resident #54, she did not have any comment. On 09/23/22 at 7:19 AM, CNA #3 confirmed stated that incontinence care would not be provided during the 11:00 PM-7:00 AM shift when the facility was short handed. She stated that Resident #54 had to be changed but could be combative with care. On 09/27/22 at 10:14 AM, a TNA#1 assigned to the 300's Unit stated that Resident #54 had a behavior of urinating on the floor and required two person assist with incontinent care. This information was not entered in the Plan of Care. A review of Resident #54's Plan of Care dated 07/11/22, indicated the following: I want you to encourage me to participate to the best of my ability in all aspects of ADL,s. I want to assist me with my ADL,s in the following areas: eating-set up dressing bathing (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	toileting transfers Resident #56 plan of care had a focus for Elimination. The goal was for Resident #54 to maintain adequate urinary functioning as demonstrated by quantity sufficient urination each shift. Interventions included: We will toilet you every 2-4 hours and PRN (as needed) We will provide incontinent care every 2-4 hours and PRN. We will keep your urinal at the bedside for ease of use. Resident #54 did not have a urinal at the bedside when observed from 09/21/22 to 10/03/22. A urinal was noted at the bedside on 10/03/22. A review of the facility's policy for ADL,s dated 07/09/20 last revised 04/02/2022, documented the following: Policy: It is the policy of the facility to provide ADL care to all residents based on assessment of needs. Procedure : Review plan of care for each resident before care. In accordance with the plan of care, provides the necessary assistance resident requires with each ADL,s. If Resident refused care, notify the charge nurse and social service for intervention. There was no documentation in the medical record that the Social Worker or the Director of Nursing were aware of the above concerns with Resident #48 and #54. The facility was made aware of the above concerns on 09/21/22 and 11/12/22 during the exit conference, no additional information was provided. N.J.A.C. 8:39-27.2(d) (h) (j)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 39885 Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to provide appropriate services for a resident with contractures by failing to ensure: a.) appropriate interventions were in place for a resident with contractures, and b.) a resident with limited range of motion received appropriate services in accordance with person centered care plan to prevent further contractures, and c.) interventions were appropriately documented as administered for resident with limited range of motion for 1 of 4 residents (Resident #20) reviewed for position/mobility. This deficient practice was evidenced by the following: On 09/22/22 at 12:43 PM, the surveyor observed Resident #20 seated in a chair. Resident #20 had contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of both hands. The surveyor did not observe any devices including a hand roll in either of Resident #20's hands. The surveyor attempted to interview Resident #20 and the resident was unable to verbalize. On 09/27/22 at 10:29 AM, the surveyor observed Resident #20 lying in bed. The surveyor did not observe any devices in either of Resident #20's contracted hands. On 09/27/22 at 11:38 AM, the surveyor reviewed Resident #20's electronic medical record. A review of the Resident Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included, but were not limited to; chronic pancreatitis (inflammation of the pancreas), essential hypertension (high blood pressure) and contracture, unspecified joint. A review of the resident's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 05/28/2022 reflected that the resident had no speech and that the resident's cognitive skills for decision making were severely impaired. A further review of the resident's MDS, Section G - Functional Status indicated that the resident had functional limits in range of motion on both upper extremities and Section O- Special Treatments, Procedures and Programs indicated that the resident did not receive any range of motion techniques or a splint or brace assistance. The surveyor reviewed Resident #20's individualized, comprehensive care plan (CP) which did not include a care concern related to Resident #20's limited range of motion or contractures. The surveyor reviewed Resident #20's September 2022 electronic Treatment Administration Record (TAR) which included the following: An order, with a start date of 09/2/22, for Bilateral hand palm roll application, on in the morning and off in the evening. Off for ADL's and Skin Checks. There was not a diagnosis listed for the order. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An order, with a start date of 08/6/22, for Bilateral hand roll application. On in the morning and off at bedtime. Off during ADL's and Skin Check. Protocol: Monitor effectiveness in 60 minutes. DX (diagnosis) Contracture, unspecified joint. Both orders were signed by a nurse on 09/22/22 and 09/27/22 to indicate that the hand rolls were administered. There were two orders for hand roll application. The facility had not contacted the physician to clarify the orders. On 09/28/22 at 01:37 PM, the surveyor interviewed Resident #20's assigned Temporary Nurses Aide (TNA) regarding the resident's contracted hands. The TNA stated that she only cleaned Resident #20's hand. She added that Resident #20's hands had been contracted since she had started at the facility in October, 2021. The surveyor then asked the TNA if she had seen hand rolls placed in Resident #20's hands. The TNA stated that she had not seen any hand rolls. She added that she had seen other residents that had splints. On 09/28/22 at 01:40 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) assigned to Resident #20, in the presence of LPN #2, regarding the resident's order for hand rolls. LPN #1 stated that today was her first day that she had Resident #20 and that she made the Therapy department aware that she could not place the hand rolls in Resident #20's hands. Then LPN #2 stated that when she had Resident #20 that the Therapy department was aware that Resident #20's hand constriction was so far contracted that she could not place a hand carrot. She added that since she had been at the facility for three weeks that she had not seen Resident #20 with hand rolls and that the Therapy department was aware. The surveyor then asked LPN #2 why the nurses were signing that the hand rolls were being administered if they were not being administered. LPN #2 stated that they were getting used to the computer system. She added that the nurses have to sign their initials but that there was a drop down that you could write the reason why an order was not administered. On 09/29/22 at 10:32 AM, the surveyor interviewed the Director of Rehabilitation (DR), who was an Occupational Therapist, regarding the process for a resident who had contractures. The DR stated that nursing would refer the resident to them either verbally or written on a form. The therapist would then screen (evaluate) the resident and determine the appropriate recommendation and then get an order from the physician. The surveyor then asked the DR how long Resident #20 had hand contractures and if Resident #20 had been evaluated for hand rolls or other devices. The DR stated that the present therapy group had been at the facility since January 2022 and that he had been at the facility since March 2022. He added that he would try to get the information but that he may have to reach out to the previous therapy company. On 09/29/22 at 10:52 AM, the DR provided the surveyor with a Progress Note, dated 08/3/22, written by Occupational Therapy for Resident #20, which included the following: Screen requested re: contracture management of b/l (bilateral) wrists hands and digits. Pt (patient) p/w hard end feel of b/l wrist in flexion, no active movement in digits or hands and resting in protective position. B/L hand carrots (a device that is thin on one side and gradually gets larger) were trialed with pt, pt resistive to device by pulling back when digits are attempted to be stretched. Pt visibly refuses b/l hand carrots. No skin breakdown is noted at this time, management of skin integrity should continue w/ nursing interventions. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DR also provided the surveyor with a Screen/Referral Form, dated 02/11/19, for Resident #20 which included the following: Decreased ROM/contracture-indicated yes with the comment B/L hands (Baseline as per nursing) Need for splint/orthotic/prosthetic-indicated no with the comment unable to tolerate secondary to contracture On 09/29/22 at 11:32 AM, the surveyor interviewed the DR regarding the 08/3/22 screen done for Resident #20. The DR stated that the recommendation was not to put any hand roll in the resident's hand and to maintain resident's skin integrity. He added that we would communicate to the nurse and that the nurse would contact doctor. On 09/29/22 at 1:05 PM, the surveyor reviewed Resident #20's Medication Administration Records and TARs for January 2022 to May 2022, which were provided by the Director of Nursing (DON). There were no orders for hand rolls to be applied. On 09/30/22 at 9:53 AM, the surveyor interviewed the DR regarding handrolls versus hand carrots and Resident #20. The DR stated that if a resident cannot tolerate hand carrots in their hands, then there is not much of anything else that can be used. The DR stated that he had spoken to the therapist that evaluated the resident on 08/3/22 and that the therapist stated that Resident #20 was wincing and pulling back when the therapist was trying to move the resident's fingers to insert the trial hand carrots. He then added that he would not say that hand rolls were appropriate for Resident #20 and that in his opinion the resident should not have an order for handrolls. On 10/04/22 at 12:35 PM, during surveyor interview, LPN #3 stated that when she was hired almost 2 years ago that Resident #20 had the contractures of both hands but that she did not know when the contractures first started. On 10/6/22 at 8:40 AM, the surveyor reviewed the facility provided September 2022 TAR for Resident #20 which included the following: The order with the start date of 09/2/22 was signed by a nurse indicating that the hand rolls were administered during the 7:00a-3:00p shift all the days of September except for two days, 09/19/22 and 09/30/22, which had a comment as to the reason why they were not applied and three days, 09/17/22, 09/26/22 and 09/29/22 which had a dash which indicated that a nurse did not sign or document the order for those days. The order also was signed by a nurse indicating that the hand rolls were removed during the 3:00p-11:00p shift all the days of September except for 09/24/22. The order with the start date of 08/6/22 was signed by a nurse indicating that the hand rolls were administered during the 7:00a-3:00p shift all the days of September except two days, 09/28/22 and 09/30, which had a comment as to the reason why they were not applied and three days, 09/17/22, 09/26/22 and 09/29/22 which had a dash which indicated that a nurse did not sign or document the order for those days. The order also was signed by a nurse indicating that the hand rolls were removed during the 3:00p-11:00p shift all the days of September except for two days, 09/23/22 and 09/24/22. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/06/22 at 11:25 AM, the surveyor interviewed LPN#2 regarding the orders for handrolls for Resident #20. LPN #2 stated that she did not know why a new order for hand rolls was ordered by the physician. She added that she thought that when therapy does an evaluation, that they will try to get a contracture to loosen up but that they were not successful. LPN #2 then stated that she met with the therapist yesterday and that she told the therapist to discontinue the hand roll order for Resident #20. The surveyor then asked LPN #2 if she would expect documentation by the physician or a nurse to indicate the reason a new order was written. LPN #2 stated that there should be documentation. The surveyor then asked LPN #2 if there should be two of the same order. LPN #2 stated that there should not be two orders but that they just recently transferred to a new computer system. She added that she thought someone should have called the physician to clarify the orders. The surveyor asked LPN #2 if a nurse should have signed that the handrolls were administered when they were not. LPN #2 stated that a nurse should put in a comment the reason it was not placed, that they should not document that it was administered if it was not. The surveyor then asked LPN #2 if Resident #20 should have had a care plan related to the resident's contractures and management of the contractures. LPN #2 stated that the resident should have had a care plan related to contractures and range of motion. Lastly, the surveyor asked LPN #2 how long it should take before a physician is notified of an order that has not been able to be administered. LPN #2 stated that yesterday the therapist told her that she would take care of discontinuing the hand roll order. She added that she thought the therapy department would take care of the discontinue but that she could be wrong. On 10/06/22 at 01:16 PM, the surveyor interviewed the DON regarding Resident #20 and the reason that the new order for hand rolls was ordered in August 2022. The DON stated that she did not know. The surveyor asked the DON to review the 08/3/22 screen done by Occupational Therapy and if Resident #20 should have an order for hand rolls. The DON then reviewed the screen and stated that there should not be an order for hand rolls for Resident #20. The surveyor then asked the DON if the nurses should have been signing that the order was administered. The DON stated that the nurses should not be signing since obviously they were not [applying it]. The surveyor asked the DON if there should have been two of the same order and how long before the physician should be notified if an order is not able to be carried out. The DON stated that there should not be two orders and that it should not be long before the nurse should contact the physician. She added 2-3 days at max. The surveyor then asked the DON what the difference between the hand rolls and the hand carrot were. The DON stated that if the hand carrot could not be placed in the hand then the handroll would never be able to be placed. On 10/07/22 at 11:04 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding Resident #20's concerns about the hand roll orders. The LNHA stated that he would expect that they would search for something effective. He added that if they could not find something effective then the nurses should not have signed for anything that was not administered. He then stated that he did not know the facility policy but that the nurse should have notified the physician after 3 days which he thought was a reasonable amount of time. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/07/22 at 11:34 AM, during surveyor interview, the Regional Licensed Nursing Home Administrator (RLNHA) stated that for a resident that had limited range of motion a screen from occupational therapy should be done and that their recommendation should be followed. She then stated that if a nurse was unable to place the physician ordered handrolls in the resident's hands that the nurse should not be signing that the order was administered. The surveyor then asked how long it should be before the nurse would contact the physician. The RLNHA stated that it should be three days and then the nurse should contact the physician that the order is unable to be carried out. The surveyor then asked the RLNHA if a resident with contractures or limited range of motion should have had a care plan for that concern. The RLNHA stated that they should have had a care plan for that. A review of the facility provided policy titled, Range of Motion Exercises with a reviewed date of 5/2/22, did not include information regarding physician orders for handrolls or care plan for contractures. N.J.A.C. 8:39-27.1(a);27.2(m)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 27193 Based on observation, interview, and record review, the facility failed follow the facility policy for fall prevention, and to ensure: a.) interventions in place to prevent accidents were consistently implemented, and b.) residents at risk for falls received adequate supervision to prevent falls. This deficient practice was identified for 2 of 5 of five residents (Resident #13 and #24) reviewed for accidents and was evidenced by the following: On 09/21/22 at 10:15 AM, the surveyor observed Resident #13 in a low bed and his/her face was discolored. Resident #13 had bruises on the facial area. Resident #13 was alert and was calling out mommy continuously. On 09/21/22 at 11:30 AM, the surveyor returned to the room and observed that Resident #13 remained in bed. Resident #13 was able to hold a conversation for a brief period of time and denied being in pain. On 09/22/22 at 1:02 PM, the surveyor observed Resident #13 in bed. A Certified Nursing Assistant (CNA #1) was in the room assisting Resident #13 with the lunch meal. Resident #13 was screaming and calling out mommy during the meal. On 09/22/23 at 1:30 PM, the surveyor interviewed CNA #1 who stated that Resident #13 required extensive assistance from staff with all activities of daily living (ADL's). All needs must be anticipated, does not use the call light. Resident #13 continuously calling out mommy. CNA #1 stated that Resident #13 sustained a fall last week and the facility placed a concave mattress on the bed after the fall. She declined to comment further on the fall and she stated that the fall occurred early in the morning on the 11:00 PM-7:00 AM shift. On 09/23/22 at 7:08 AM, the surveyor entered the room and observed Resident #13 in bed calling out mommy. The bed was in a high position, the bed rail on the right side was elevated with a bumper pad in place. The bed rail on the left side was lowered and the bumper pad was not adjusted. The Registered Nurse Registered Nurse (RN #1) entered the room, administered medication to Resident #13, and then left the room. On 09/23/22 at 7:14 AM, the surveyor returned to the room and observed the bed was in the same position. The surveyor escorted the Licensed Practical Nurse Licensed Practical Nurse (LPN #4) to the room where we both observed the resident's bed in high position, the bumper pad not adjusted. The nurse stated that all staff who provided care were aware that the bed had to be in the lower position. On 09/27/22 at 11:00 AM, the surveyor reviewed the clinical record of Resident #13 which reflected that Resident #13 was admitted to the facility with diagnoses which included but were not limited to major depressive disorder, hypertension, and dementia with behavioral disturbances. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Quarterly Minimum Data Set (MDS) with an assessment Reference date of 08/19/22 revealed that Resident #13 was severely cognitively impaired. Resident #13 received a score of 3 on the cognitive skills for daily decision making (section c1000). Resident #13 was fully dependent on staff to meet his/her needs in bed mobility, transfer, toilet use, eating and dressing. The surveyor reviewed Resident #13's care plan and noted a fall care plan initiated on 04/28/22. The Care plan received from the Charge Nurse on 09/26/22, did not indicate that Resident #13 was at risk for falls. The Care plan received from the Director of Nursing dated 10/04/22, identified that Resident #13 was at risk for falls based on score of 10. The Fall Risk Assessment was not provided. The goal was for Resident #13's safety to be maintained in the least restrictive environment. Further review of the care plan revealed that Resident #13 was at risk for falls related to polypharmacy, cognitive impairment and Alzheimer's dementia. Interventions included but were not limited to: Staff will answer your call bell promptly. We will maintain a clutter free environment. Will place all personal belongings within reach We will place you in high visibility areas while you are awake We will not leave you alone in the room or on toilet. On 09/27/22 at 10:30 AM, the surveyor further reviewed the clinical record of Resident #13 and noted that Resident #13 sustained falls at the facility on the following dates: 09/10/22, 09/13/22 and 09/23/22. The following information were entered in the electronic medical records: 09/10/22, Resident noted in bed at 09:00 AM, Awake, alert and oriented to name only. yelling out mommy. No distress noted. PRN (as needed) Klonopin given with little effect. At 9:45 am, resident was still yelling out, then he/she started yelling, help me help me mommy. Noted resident laying on the floor by the bed. Appeared to have rolled out of his/her bed. Noted laying on the left side. Causal factor: Resident rolled off the bed and was noted on the floor by the bed. Steps taken to prevent recurrence: keep bed in lowest position. 09/13/22 at 7:15 AM, an entry in the Progress notes indicated, Resident found at 7:15 AM lying in prone position on floor next to bed. Small cut on the left cheek, Left cheek swollen and red, left eye starting to turn ecchymotic, Resident unable to say what happened, continued to scream mommy. Assist back to bed, physician notified, sent to the hospital for evaluation.The causal factor was not identified. The hospital record indicated the following under diagnosis: Fall from standing Facial laceration. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/23/22 at 3:45 PM, Resident was found by CNA face down in the room close to the bed about 3:43 PM. When asked what happened, he/she replied I don't know. Steps taken to prevent recurrence: Educated to call for help or use the call bell. The facility identify Resident #13 as being cognitively impaired totally dependent on staff. On 09/23/22 at 7:15 AM, the surveyor interviewed the 11:00 PM -7:00 AM Licensed Practical Nurse (LPN #4) regarding the 09/13/22 fall that happened on her shift. She stated, it did not happened like that, and declined to comment. The surveyor attempted to call the nurse several times, she did not return the call. On 09/26/22 at 11:30 AM, the surveyor reviewed the electronic Progress Notes and noted an entry dated 08/30/22 timed 12:41 PM, which documented, It is recommended that Resident #13 is out of the bed everyday to hallway, dayroom/ downstairs activity room to increase environmental stimulation and tolerance to positioning in chair, lean should subside as tolerance to mechanical wheelchair improves but 1 pillow may be used to keep patient in midline . The facility did not follow the above recommendations. Staff could not identify what measures could be implemented to keep Resident #13 from calling and yelling out when left alone in the room. On 09/27/22 at 9:30 AM, the surveyor observed Resident #13 in bed, calling out mommy. Denied being in pain. On 09/28/22 at 10:00 AM, the surveyor requested the New Jersey Universal Transfer Form (NJUTF) for review. The DON indicated she could not locate the NJUTF. On 09/28/22 at 10:30 AM, the surveyor interviewed CNA #3 who was familiar with Resident #13's routine. CNA#3 stated that Resident #13 was always restless, continuously calling out. Resident #13 used to be able to feed himself/herself but now had to be assisted with meals. She added that Resident #13 could be verbally abusive. On 10/05/22 at 10:30 AM, the surveyor showed to the DON the Emergency Department Documentation which stated the following under diagnosis: Fall from standing. Facial laceration. The DON declined to comment on the discrepancy. The incident report provided documented that Resident #13 was found face down in the room close to the bed. On 10/06/22 at 3:36 PM, during an interview with the DON regarding the falls, she stated that if she had known about the incident more closely, she would have called an Interdisciplinary meeting and would implement more meaningful interventions. The surveyor then asked if any in-service education had been done, the DON stated that the night nurse did not report that Resident #13's bed was in a high position the morning of 09/23/22. No in service was done. There was no documentation in the clinical record that an Interdisciplinary meeting was called, discussed the falls and implemented meaningful interventions to keep Resident #13 safe. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #13 was found on the floor in the room on 09/10/22, the facility indicated that he/she rolled from the bed. The facility did not take any action to prevent recurrence. The Resident was not provided with a floor mat or a scoop mattress as indicated in the policy. The care plan was not updated. Resident #13 sustained another fall in the room on 09/13/22 at 7:15 AM and and was sent to the hospital for evaluation. Resident #13 sustained a laceration to the facial area. b.) The surveyor reviewed Resident #24's medical record on 09/26/22 which reflected that Resident #24 had diagnoses which included but not limited to: Vascular dementia without behavioral disturbances, anxiety disorder and vitamin deficiency. The Quarterly MDS assessment dated [DATE], reflected that Resident #24 was severely cognitively impaired. Resident #24 was totally dependent on staff for all ADLs. A review of the plan of care dated 07/08/22 included a focus for Fall and documented the following: I am at risk for falls based on score risk of 10. The goal was for Resident #24 to be free from significant injury related to falls. Resident #24's fall interventions included: We will maintain a clutter free environment. We will bring you to the dayroom during the day for closer supervision. We will not leave you in the room and on toilet. We will place you in high visibility area while you are awake. On 09/23/22 at 10:30 AM, an interview with the Certified Nursing Assistant (CNA #2) who cared for Resident #24, revealed that Resident #24 was confused and totally dependent on staff for care. CNA #2 stated that Resident #24 was a wanderer. On 09/24/22 at 9:47 AM, the surveyor further reviewed the Progress Notes which revealed that Resident #24 fell at the facility on the following dates: 09/09/22 and 09/16/22. The following entries were entered in the electronic medical record: 09/09/2022 4:36 PM, patient fell to the floor during the last part of day shift. No injury noted. The physician was notified, Neuro check implemented. Patient is resting comfortably. 09/16/2022 3:07 PM, Resident attempted to walk between the [mechanical lift] and wet floor sign, then lost his/her balance and fell . No injuries noted. Family and Nurse Practitioner notified. On 09/22/22 at 9:49 AM, the surveyor observed Resident #24 wandering on the locked unit. Very confused. No staff attempted to redirect him/her in the dayroom for activities. On 09/26/22 at 11:35 AM, the surveyor observed Resident #24 wandering in the hallway and entering other residents room. No staff were observed to redirect Resident #24. On 09/28/22, the surveyor requested the investigative reports for the falls. The DON stated that she was not aware of the falls. The surveyor reviewed the Progress notes with the DON, the DON stated she would locate the investigative reports. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/04/22 at 1:45 PM, the DON provided the fall facility's policy and stated that she could not locate the investigative reports. No additional information was provided on the exit day. A review of the facility's fall prevention Policy and Procedure dated 01/05/22 last revised 05/26/22 revealed the following: Policy: It is the policy of the facility to identify specific risk factors that may indicate the resident is at risk for falls upon admission, readmission, quarterly annually, and with any significant change. Based upon the assessment the resident will have a preventative plan of care initiated as well as be revised, and evaluated throughout their stay at the facility. The interdisciplinary team will collaborate in developing, evaluating, and revising fall prevention plan of care to prevent falls/ injury, or to minimize injury and/ or complications if a fall should occur. The policy also indicated that beds should remain in a low position and brakes on at all times. Call bell and personal belongings should be within the resident's reach. Utilize a floor mattress or scoop mattress as indicated and needed. Include in falling star program as indicated. N.J.A.C. 8:39-27.1 (a)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avant Rehabilitation and Care Center	1314 Brunswick Avenue Trenton, NJ 08638

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 38079 Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to document the amount of fluid administered by nursing for 1 of 2 residents (Resident #69) reviewed for fluid restriction while on hemodialysis (HD -the process of purifying the blood of a person whose kidneys are not working normally). This deficient practice was evidenced by the following: On 09/21/22 at 10:41 AM, the surveyor observed Resident #69 sitting in a chair by the window in his/her room. Resident #69 stated he/she was on HD and there was an access in their right arm. On 09/26/22 at 11:03 AM, the surveyor observed Resident #69 in their room eating ice chips out of a pink water pitcher. Resident #69 stated that he/she had HD that day and would be picked up at 1 PM. The resident further stated he/she was not on any fluid restrictions. He/she stated they would eat before he/she would leave. The surveyor asked again if anyone ever told him/her to restrict fluids. The resident stated, I don't have any fluid restrictions, I can have what I want. A review of the Resident Face Sheet revealed Resident #69 was admitted to the facility June 2022 with diagnoses which included but were not limited to pneumonia and renal osteodystrophy (abnormal development of bone due to chronic kidney disease and renal failure). The Admission Minimum Data Set (MDS-an assessment tool) dated 07/10/22, revealed Resident #69 had a Brief Interview for Mental Status (BIMS) score of 9/15 indicating moderately impaired cognition. Section I1500 revealed an active diagnosis Renal insufficiency, Renal Failure, or End-Stage Renal Disease. Section K0510 revealed Resident #69 was on a therapeutic diet. Section O0100 J. revealed Resident #69 was on HD. A review of the Physician Order Activity Detail Report revealed an order dated 07/09/22 for Diet: special instructions: nursing 480 milliliter (ml) 7AM to 3PM = 240 ml; 3PM to 11PM = 180 ml; and 11PM to 7 AM = 60 ml. A review of Resident #69's on-going Care Plan revealed a focus area effective 07/07/22 will comply with therapeutic diet restrictions and fluid restrictions and a focus area effective 10/03/22, fluid restriction 1200 ml (720 ml dietary and 480 ml nursing). A review of the September 2022 Medication Administration Record (MAR) revealed the fluid restriction = 1200 ml/day order with a start date of 09/30/22 and a protocol to document intake every shift. A review of the July 2022 and August 2022 MARs failed to display the fluid restriction order for the nursing staff to document the amount of fluid per shift the resident was administered. A review of the Progress Notes revealed a note entered by the Registered Dietitian (RD) dated 08/10/22. The RD noted that she had a conversation with the RD at Resident #69's HD center. The note revealed the fluids restriction of 1200 ml (720 ml dietary and 480 ml nursing). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/30/22 at 11:08 AM, during an interview with the surveyor, the Licensed Practical Nurse (LPN) caring for Resident #69 stated if a resident was on fluid restrictions, it would show up in the orders. The LPN accessed Resident #69's electronic medical record (eMR) but was unable to provide any documentation of fluid restrictions. The LPN stated the amounts documented should be in the MAR so that nursing could check it (fluid restriction) off. On 10/04/22 at 09:21 AM, during an interview with the surveyor, the RD stated if a resident was on a fluid restriction, the amount would be split between dietary and nursing. The RD stated the order would be put it in the eMR and be sent into [computerized menu software] to determine how much fluid would be provided for dietary and nursing. The RD accessed Resident #69's eMR and was unable to provide any documentation of the fluid restriction in the MAR starting in July 2022 when the order was given. The RD acknowledged the fluid restriction order was given 07/09/22. The RD further stated she had no way to know if nursing was administering the correct amount of fluids because it was not documented anywhere that she was aware of. The RD stated if a resident on fluid restrictions was provided extra fluid, it could be detrimental to the resident's health. On 10/04/22 at 9:32 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that dietary would notify the nursing staff of any fluid restriction amount they were responsible to administer. The DON stated the fluid amount would be split between nursing and dietary and that she would be ultimately responsible to ensure the fluid restrictions were in place and being followed. The DON stated it was important for the nurses to monitor the amount of fluid so the resident would not become (fluid) overloaded. A review of the facility provided, Fluid Restrictions policy last reviewed 08/07/22, included but was not limited to Policy: to maintain fluid restrictions as per orders and /or in accordance with the recommendations from nephrology or dialysis. Purpose: to maintain fluid restrictions and allow resident to exchange fluids as desired for quality of life. Procedure: 2. the dietitian communicates with nursing and dietary their respective daily allotted fluid amount. 6. Nursing to review fluids consumed during medication pass. 8. Document fluid restriction and updates care plans. On 10/07/22, the above concern was presented to the administrative staff. As of exit day on 10/12/22, the facility had no additional information to provide. N.J.A.C. 8:39-27.1(a)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 38079 Based on observation, interview, record review, and document review, it was determined that the facility failed to provide sufficient nursing staff to ensure resident's highest practical wellbeing by failing to: a.) provide incontinence care on 1 of 3 units (unsampled resident), b.) provide psychiatric consultation per physician order for a resident who expressed suicidal ideation and feelings of loneliness for 1 of 3 residents reviewed for mood and behavior (Resident #63), c.) schedule a resident's appointment with their preferred cardiologist after a hospital visit for 1 of 5 residents who attended a Resident Council Meeting (unsampled resident), and d.) maintain the required minimum direct care staff-to-shift ratios as mandated by New Jersey State requirement, CHAPTER 112 (An Act related to staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes). The deficient practice was evidenced as follows: Refer to: F584, F740, F636, F638, and F882 a.) On 09/23/22 at 6:53 AM, Surveyor #1 went to the locked unit and observed the following: Resident #54, pads on the bed were soaking wet, strong urine odor in the room, and a roach was noted crawling on the floor. During an interview at that time with the surveyor, the resident indicated that he/she had not been changed during the night. Surveyor #1 escorted the 11:00 PM - 7:00 AM Licensed Practical Nurse (LPN) #1 to the room where they both observed the same. The resident had 2 pads on the bed, both pads were wet and stained with urine, and the fitted sheet was also stained with urine. On 09/23/22 at 6:58 AM, during an interview with Surveyor #1, the 11:00 PM - 7:00 AM Certified Nursing Assistant (CNA) revealed that the resident would not get up to be changed during the night and that she had to wait until the resident got up. Surveyor #1 went to Resident #54's room and observed that the mattress was also wet with urine. On 09/23/22 at 7:01 AM, Surveyor #1 interviewed LPN #1 who worked the 11:00 PM -7:00 AM shift, LPN#1 stated that her role was to ensure that all incontinent residents were up and changed every 2 hours and as needed. Surveyor#1 escorted LPN #1 into Resident #48's where we both observed the same, the pads were wet. LPN#1 confirmed the unsampled resident did not receive incontinence care during the shift. When asked if incontinence care was provided, she did not have any comment. On 09/23/22 at 7:19 AM, the surveyor interviewed CNA #3 assigned to the 300's Unit, she stated that some days when she reported to work in the morning, incontinence care was not provided for incontinent residents if they were short handed. b.) On 09/27/22 at 12:34 PM, Surveyor #2 observed Resident #63 lying in bed. The resident spoke little English but informed the surveyor they were in pain and had received medicine for the pain. The resident stated that he/she mainly stayed in bed because of the pain. The surveyor reviewed the medical record for Resident #63. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the Resident Face Sheet (an admission summary) reflected the resident was admitted to the facility in December of 2021 with diagnoses which included bipolar disorder, current episode manic without psychotic features (mental condition with extreme mood swings), and diabetes mellitus. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 07/8/22, reflected a brief interview for mental status (BIMS) score of 7 out of 15, which indicated severely impaired cognition. A review of the Physician Order Activity Detail Report reflected the resident had a physician's order (PO) dated 05/14/22 for psychological evaluation and treatment as needed. A review of the Clinical Notes included a Nurses Note dated 04/20/22 at 3:00 PM, reflected the resident stated, I am lonely, I want to kill myself. Resident will have a room change to be with his/her friend. Staff instructed to monitor closely, and psychiatric consultation ordered. A review of an additional Nurses Note dated 04/20/22 at 8:40 PM, reflected the resident was seen by [name redacted psychiatric screening center] and screening staff today at 5:10 PM, recommended follow-up with psychiatrist. On 10/5/22 at 9:39 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA), Regional Nurse, and Regional LNHA stated Resident #63 was never seen by a psychiatrist while at this facility. The Director of Nursing (DON) stated the Regional LNHA called the previous psychiatrist who confirmed the resident was not seen because they were unaware the resident needed to be seen. The Regional LNHA confirmed the nurse should have informed the psychiatrist. On 10/05/22 at 12:01 PM, during surveyor interview, the facility staffing coordinator stated she had been at the facility almost 90 days. She stated she did not know the CNA staffing ratios off the top of her head, but she believed the ratio was met most days. She further stated that sometimes staffing was difficult on the weekend. c.) During a Resident Council meeting conducted on 09/28/22, 1 of 5 residents (unsampled) stated that 5 or 6 months ago he/she passed out and was transferred to the hospital and upon return he/she had to wear a heart monitor for a while. The resident stated that his/her cardiologist sent a letter because he was unable to reach anyone in the facility. The resident showed the surveyor another letter from his/her cardiologist that revealed they had made 3 attempts to contact him/her at the numbers provided. Unable to reach and no call back. Trying to schedule testing or f/u appointment. On 09/28/22 at 1:25 PM, the resident stated that he/she told the LPN unit manager, who was out with COVID, took her cardiology letter and lost it. The resident stated he/she was still waiting for an appointment. On 10/07/22 at 10:52 AM, during surveyor interview, the LNHA stated he was aware of the CNA ratios as 1-8 (7 AM - 3 PM), 1-10 (3 PM - 11 PM) and 1-14 (11 PM - 7 AM) and that to his understanding the facility had been meeting the ratios. d.) Per the New Jersey 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/30/22, 2 weeks of staffing had been calculated (09/04/2022 to 09/10/2022 and 09/11/2022 to 09/17/2022) for the 10/12/2022 Standard survey at the facility and the results were as follows: The facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -09/04/22 had 11 CNAs for 103 residents on the day shift, required 13 CNAs. -09/05/22 had 10 CNAs for 103 residents on the day shift, required 13 CNAs. -09/06/22 had 11 CNAs for 103 residents on the day shift, required 13 CNAs. -09/07/22 had 11 CNAs for 102 residents on the day shift, required 13 CNAs. -09/08/22 had 11 CNAs for 101 residents on the day shift, required 13 CNAs. -09/10/22 had 10 CNAs for 100 residents on the day shift, required 13 CNAs. -09/11/22 had 11 CNAs for 100 residents on the day shift, required 12 CNAs. -09/12/22 had 11 CNAs for 99 residents on the day shift, required 12 CNAs. -09/13/22 had 11 CNAs for 102 residents on the day shift, required 13 CNAs. -09/14/22 had 11 CNAs for 102 residents on the day shift, required 13 CNAs. -09/15/22 had 12 CNAs for 102 residents on the day shift, required 13 CNAs. -09/16/22 had 11 CNAs for 104 residents on the day shift, required 13 CNAs. N.J.A.C. 8:39-5.1(a)(c); 25.2 (a); 27.1(a)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 39885 Based on interviews and review of pertinent facility provided documentation, the facility failed to ensure that staff had appropriate competencies and skill sets to provide nursing and related services to assure resident safety, and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This deficient practice was evidenced by the following: On 10/07/22 at 11:48 AM, the surveyor interviewed the Interim Infection Preventionist (IIP) who had been the facility Educator prior to becoming the IIP regarding staff competencies. The IIP stated that she was only the Educator for a month and that she had been implementing the new computer system during that time. She added that the Director of Nursing (DON) and the Assistant DON (ADON) were the facility's educators and that the competency book would possibly be located in the DON's office. On 10/07/22 at 11:57 AM, the surveyor interviewed the second floor Unit Manager (UM) regarding staff competencies. The UM stated that she had occasionally given in-services to staff but that she had not done any staff competencies. She added that she had thought the Educator or the ADON were responsible for staff competencies. On 10/07/22 at 11:59 AM, the surveyor interviewed the DON regarding staff competencies and requested to view the facility's documentation of staff competencies. The DON stated that if there were staff competencies done that she did not know where they were. She stated that the educator would be responsible for staff competencies. The DON then stated that she had not done any competencies with staff but that she was not saying that they were not done. She added that she believed that the former Infection Preventionist had done an in-service on donning (to put on) and doffing (remove) of personal protective equipment but that she was not aware if the former Infection Preventionist had done any competencies. On 10/12/22 at 09:53, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding staff competencies. The LNHA stated that the expectation would be to follow what the current policy was but that he did not know what the policy was in detail. He then stated that after orientation, the expectation was a competency which was the ability for them to perform the task. The surveyor then asked the LNHA who was responsible for staff competencies. The LNHA stated that the department heads should have done their staff competency. He then added that the Unit Managers should have done their staff competencies. The surveyor then asked who would do the third floor staff competencies since there was not a Unit Manager on the third floor. He stated that the ADON or DON should then do them. He added that there was a good chance the policy was not updated. He then stated that he was trying to get things on track before this survey and that was why we have survey to get back on track. The facility was unable to provide the survey team any documented evidence that staff competencies were completed. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility provided policy titled, Competency of Nursing Staff, with a reviewed date of 2/2/22, included the following: Under Policy Statement 1. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by State law. 2. In addition, licensed nurses and nursing assistants employed (or contracted) by the facility will: a. participate in a facility-specific, competency-based staff development and training program; and b. demonstrate specific competencies and skill sets deemed necessary to care for the needs of resident, as identified through resident assessments and described in the plans of care. Under Policy Interpretation and Implementation 1. The staff development and training program is created by the nursing leadership, with input from the medical director, and is designed to train nursing staff to deliver individualized, safe, quality care and services for the residents . 3. The facility assessment includes an evaluation of the staff competencies that are necessary to provide the level and types of care specific to the resident population . 5. Facility and resident-specific competency evaluations will be conducted upon hire, annually and as deemed necessary based on the facility assessment. 6. Facility and resident-specific competency evaluations will include: a. Lecture with return demonstration for physical activities; b. A pre- and post-test for documentation issues; c. Demonstrated ability to use tools, devices, or equipment used to care for residents; d. Reviewing adverse events that occurred as an indication of gaps in competency; or e. Demonstrated ability to perform activities that are within the scope of practice an individual is licensed or certified to perform. 7. competency demonstrations will be evaluated based on the staff member's ability to use and integrate knowledge and skills obtained in training, which will be evaluated by staff already deemed competent in that skill or knowledge. 8. Inquires concerning staff competency evaluations should be referred to the Director of Nursing Services or to the Personnel Director. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	N.J.A.C. 8:39-9.3(a)2,3

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 39885 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that the posted 24-hour staffing report was completed in its entirety and provided accurate information. This deficient practice was evidenced by the following: On 09/30/22 at 11:24 AM, the surveyor observed the facility's version of the Nursing Home Resident Care Staffing Report, dated 09/30/22, posted near the receptionist desk, which included the following: On 09/30/22 Day Shift, the Staffing Report omitted the Current Resident Census, the number of Staff for each staff category and the Staff to Resident Ratios for each staff category. The Total Hours Worked for Registered Nurse (RN) was 3; for Licensed Practical Nurse (LPN) was 4; and Certified Nurses Aide (CNA) was 10. On 09/30/22 Evening Shift, the Staffing Report omitted the Current Resident Census, the number of Staff for each staff category and the Staff to Resident Ratios for each staff category. The Total Hours Worked for RN was 2; for LPN was 4; and CNA was 9. On 09/30/22 Night, the Staffing Report omitted the Current Resident Census, the number of Staff for each staff category and the Staff to Resident Ratios for each staff category. The Total Hours Worked for RN was 0; for LPN was 4; and CNA was 4. On 10/05/22 at 12:01 PM, the surveyor interviewed the Staffing Coordinator (SC) regarding posting the 24-hour staffing report. The SC stated that she posts the number of employees that work that shift that day. The surveyor then asked the SC if the posted information had to include the number of hours worked and the SC stated no. On 10/06/22 at 12:05 PM, during surveyor interview, the SC stated that she was never told to write the census on the form when she was trained at this facility. She added that when she worked at another facility, she had put the census on the form. On 10/6/22 at 01:15 PM, during surveyor interview, the Director of Nursing (DON) stated that she looked at the 24-hour staffing report. The DON stated that the information that was to be posted was the number of nursing staff, census, actual hours worked and the ratio of staff to number of residents. On 10/07/22 at 10:52 AM, during surveyor interview, the Licensed Nursing Home Administrator stated that the 24-hour staffing report should have the census, how many nursing staff each shift, the actual hours worked and the ratio of staff to number of residents. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	On 10/07/22 at 11:34 AM, during surveyor interview, the Regional Licensed Nursing Home Administrator stated the 24-hour staffing report should have the census, how many nursing staff each shift, the actual hours worked and the ratio of staff to number of residents. She added that usually the facility would print the form from the state. Review of the facility provided policy titled, Posting Direct Care Daily Staffing Numbers with a reviewed date of 2/5/22 included the following: Under Policy Statement Our facility will post, on a daily basis for each, the number of nursing personnel responsible for providing direct care to residents. Under Policy Interpretation and Implementation 1. Within two (2) hours of the beginning of each shift, the number of Licensed Nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format . 3. Shift staffing information shall be recorded on the Nursing Staff Directly Responsible for Resident Care form for each shift. The information recorded on the form shall include: a. The name of the facility. b. The date for which the information is posted. c. The resident census at the beginning of the shift for which the information is posted. d. Twenty-four (24)-hour shift schedule operated by the facility. e. The shift for which the information is posted. f. Type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift. g. The actual time worked during that shift for each category and type of nursing staff. h. Total number of licensed and non-licensed nursing staff working for the posted shift . 5. Within two (2) hours of the beginning of each shift, the shift supervisor shall compute the number of direct care staff and complete the Nursing Staff Directly Responsible for Resident Care form. The shift supervisor shall date the form, record the census and post the staffing information in the location(s) designated by the Administrator. 6. The form may be typed or handwritten . N.J.A.C. 8:39-41.2 (a)(b)(c)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 38080 Based on observations, interviews, and review of other pertinent facility documentation, it was determined that the facility failed to provide psychiatric consultation for a resident who expressed suicidal ideation and feelings of loneliness as ordered by the physician in April of 2022. This deficient practice was identified for 1 of 3 residents reviewed for mood and behavior (Resident #63) and was evidenced by the following: On 09/27/22 at 09:57 AM, the surveyor interviewed Temporary Nursing Aide (TNA) #1, who stated the facility's locked unit was for residents who had a tendency to wander off of a unit, had dementia, and more aggressive behaviors. TNA #1 continued Resident #63 was a resident on the unit who usually stayed in their room or in the hallway and went outside to smoke cigarettes. TNA #1 stated the resident had no behaviors, but there was an incident last month where Resident #63 was observed exiting a resident of the opposite sex's room. Resident #63 had not had a tendency to wander, and the incident was reported to the nurse. On 09/27/22 at 10:30 AM, the surveyor interviewed TNA #2, who stated Resident #63 was confused and liked to be aggressive and liked to fight staff when they tried to shower them. TNA #2 reported the resident could also be aggressive with residents and could try to lure residents of the opposite sex into their room. TNA #2 stated she witnessed the incident occur once and removed the other resident from Resident #63's room. On 09/27/22 at 12:34 PM, the surveyor observed Resident #63 lying in bed. The resident spoke little English, but informed the surveyor they were in pain and had received medicine for the pain. The resident stated that he/she mainly stayed in bed because of the pain. The surveyor reviewed the medical record for Resident #63. A review of the Resident Face Sheet (an admission summary) reflected the resident was admitted to the facility in December of 2021 with diagnoses which included bipolar disorder, current episode manic without psychotic features (mental condition with extreme mood swings), and diabetes mellitus. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 07/8/22, reflected a brief interview for mental status (BIMS) score of 7 out of 15, which indicated severely impaired cognition. A review of the Physician Order Activity Detail Report, reflected the resident had a physician's order (PO) for divalproex (an anticonvulsant medication used to treat bipolar) dated 12/29/21; to administer one 125 milligrams (mg) delayed release tablets every morning for bipolar disorder and current episode of bipolar disorder. The resident had an additional PO for divalproex extended release dated 12/29/21; to administer one 250 mg tablet every morning for bipolar disorder and current episode manic. The resident also had a PO dated 5/14/22 for psychological evaluation and treatment as needed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avant Rehabilitation and Care Center	1314 Brunswick Avenue Trenton, NJ 08638

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a Social Service Progress Note dated 04/20/22, reflected a Housekeeper (HK) reported resident was depressed and said to her, I want to kill myself. HK stated other staff members reported hearing similar statements. A certified nursing aide suggested the resident be moved to another room with his/her friend so they would not be lonely. Called [name redacted] crisis line requesting an evaluation on Resident #63 for their suicidal statements. Social Worker told nurses to make sure resident stayed in hallway and they removed any sharp objects from resident's room that could be used to hurt themselves. A review of the Clinical Notes included a Nurses Note dated 04/20/22 at 03:00 PM, reflected the resident stated, I am lonely, I want to kill myself. Resident will have a room change to be with his/her friend. Staff instructed to monitor closely, and psychiatric consultation ordered. A review of an additional Nurses Note dated 04/20/22 at 08:40 PM, reflected the resident was seen by [name redacted psychiatric screening center] and screening staff today at 05:10 PM, recommended follow-up with psychiatrist. A review of the Physician's Orders reflected a telephone physician's order dated 04/20/21 for a psychiatric consultation from Physician #1, and a telephone physician's order dated 04/21/22 for a psychiatric consultation from Physician #2. A review of Psychiatric Screening dated 04/20/22, recommended a follow-up with psychiatrist. The surveyor was unable to locate any psychiatrist follow-up in the medical record. A review of the resident's comprehensive care plan included a focus area dated effective 04/28/22, for at risk for loneliness, boredom and isolation due to the Pandemic (Coronavirus). Interventions included to bring activities that you enjoy; to arrange phone calls or video chats with your family; to ensure you have activities of your choosing available; and to provide you with tools you need to do your favorite activity if applicable. The care plan did not include the resident's suicidal ideation, behaviors or aggressions, or the resident's diagnoses of bipolar disorder and current episode manic. On 09/28/22 at 10:44 AM, the surveyor interviewed the Registered Nurse (RN), who stated she was a per diem nurse who worked mostly on the locked nursing unit for the 7:00 AM to 3:00 PM shift. The RN stated the resident was okay and did not have behaviors on her shift. The RN continued the resident was able to make his/her needs known and had not been unpleasant towards her. The RN also stated since she was per diem, she really would not know if the resident had been in any fights or altercations with other residents. When the surveyor asked who created or updated the care plan, the RN responded any nurse could. The RN stated they care planned for behaviors, certain medications, safety, Activities of Daily Living (ADLs). The RN stated care plans were updated every ninety days or as soon as an issue arises that would be care planned for. On 09/28/22 at 12:48 PM, the surveyor interviewed the Psychiatric Nurse Practitioner (Psych NP) who stated he came to the facility weekly and touched base with the nursing staff to determine the residents who needed to be seen. The Psych NP stated this company had only started at the facility this June, and he had only been coming to this facility for about two months. The Psych NP stated he did not recall seeing Resident #63 ever, but the resident was scheduled to be seen today and could not speak to why the resident needed to be seen. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/29/22 at 11:54 AM, the Regional Nurse in the presence of the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and the Regional LNHA who was currently overseeing the facility LNHA, informed the surveyor that Resident #63 was transferred from the facility last night for appropriate placement. On 10/4/22 at 12:56 PM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated if the resident had a physician's order for a psychiatric consultation, it was the nurse's responsibility to let the Psych NP, or the Psychiatrist know a resident needed to be seen. If after the resident was seen and there were new orders, it was the nurse's job to communicate the recommendation to the resident's physician and transcribe any new physician's orders. The LPN stated she was unfamiliar with Resident #63. On 10/4/22 at 01:04 PM, the surveyor interviewed the DON who stated if a resident had a psychiatrist consultation, the physician documented either on a consultation sheet that was uploaded to the electronic Medical Record (eMR), or they documented directly into the eMR. The DON stated it was the nurses' responsibility to read all consultations and communicate any recommendations to the physician and carry out any new physician's orders. The nurse should document in the eMR that they spoke to the physician and any new orders, which is a nursing standard of practice. At this time, the surveyor reviewed with the DON the [name redacted psychiatric screening] dated 04/20/22 with the recommendation for a psychiatrist follow-up. The surveyor then reviewed the Nurse's Note dated 04/20/22 at 08:40 PM, the resident was seen today by [name redacted psychiatric screening] with a recommendation to follow-up with psychiatrist. The surveyor then reviewed with the DON the telephone physician's orders from 04/20/22 and 04/21/22 for a psychiatric consultation which the DON confirmed the resident should have seen the psychiatrist. The surveyor requested all psychiatric consultations the resident had at this facility. The DON stated the facility had a new psychiatric company that started this summer, but she would look for the information. On 10/5/22 at 09:39 AM, the DON in the presence of the LNHA, Regional Nurse, and Regional LNHA stated Resident #63 was never seen by a psychiatrist while at this facility. The DON stated the Regional LNHA called the previous psychiatrist who confirmed the resident was not seen because they were unaware the resident needed to be seen. The Regional LNHA confirmed the nurse should have informed the psychiatrist. On 10/7/22 at 10:16 AM, the DON informed the surveyor that Resident #63 was not seen by the Psych NP on 09/28/22, because the resident was transferred out of the facility before the Psych NP saw them. A review of the facility's Change of Condition policy dated effective 1/5/22 and reviewed 7/1/22, included it is the policy of the facility to identify and communicate changes in condition to the physician and other team members to implement interventions to prevent further deterioration and possibly to prevent hospitalization . the resident will be monitored until condition significantly improves .a care plan will be initiated and/or updated based on the reason for the change, goals and interventions . (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Care Planning policy dated effective 1/5/22 and reviewed 5/26/22, included care planning will be based on the MDS triggers as well as the medical diagnoses and complex medical conditions noted upon assessment .the comprehensive care plan will be reviewed and revised as needed upon re-admission, return bed hold, quarterly and upon significant change .care plans will be updated to reflect interval problems as they arise . N.J.A.C. 8:39-27.1(a)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45449 Based on observation, interview, and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure: a.) a medication was removed from active inventory after being discontinued in July 2022 for one (1) of three (3) medication carts inspected; and b.) expired medications were removed from emergency (back-up) supply box for 1 of 1 back up supply box. This deficient practice was evidenced by the following: 1.) On 09/26/22 at 11:58 AM, the surveyor inspected the Low side medication cart on the third floor in the presence of the Licensed Practical Nurse (LPN #1). The surveyor found one bingo card (a multidose card containing individually packaged medication) of Divalproex sodium (Depakote) extended release (ER; used for epilepsy and, or acute bipolar mania) 250 milligrams (mg) with Unsampled Resident #393's name crossed off with a marker and Resident #48's name had been handwritten in. The bingo card was dated 07/19/22, labeled 1 of 1. The bingo card found was opened with 13 tablets remaining. At that time, LPN #1 stated she did not know why Unsampled Resident #393's name was crossed off and Resident 48's name was handwritten in. She also stated that a Resident's bingo card should not be relabeled with another resident's name because it can result in a medication administration error. A review of the Resident Face Sheet (an admission summary) revealed that Unsampled Resident #393 was admitted to the facility with diagnoses which included but were not limited to; other seizures, schizoaffective disorder (mood disorder) and bipolar type. A review of the July 2022 electronic Medication Record (eMR) for Unsampled Resident #393 revealed that Divalproex ER 250 mg was discontinued on 07/21/22. A review of the Physician's Orders (PO) generated on 10/03/22 at 12:21 PM for Unsampled Resident #393 did not reveal an active order for Divalproex ER 250 mg. A review of Unsampled Resident #393's electronic Medication Administration Record (eMAR) from 07/01/22 to 07/31/22, revealed Divalproex ER 250 mg was last administered on 07/21/22. A review of the Resident Face Sheet revealed that Resident #48 was admitted to the facility with diagnoses which included but were not limited to paranoid schizophrenia, anxiety disorder and other seizures. A review of the PO generated on 10/03/22 at 1:21 PM for Resident #48 revealed an active order for Divalproex ER 250 mg with an original order date of 03/25/22. A review of Resident #48's eMAR for 10/22, revealed Divalproex ER 250 mg was last administered on 10/03/22. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Consultant Pharmacist (CP) unit inspection report in the past three months for the Third floor, low side medication cart revealed the following: September 2022 -All expired and discontinued medication out of cart, N - not in compliance August 2022 - All expired and discontinued medication out of cart, Y- in compliance July 2022 - All expired and discontinued medication out of cart, Y-in compliance A review of the back-up box reorder form revealed no listing for medication Divalproex ER 250 mg. 2. On 09/26/22 at 12:17 PM, the surveyor, in the presence of the second floor Registered Nurse/Unit Manager (RN/UM), observed the following items in the locked back-up box located in the Director of Nursing's (DON) office on the second floor: -Amoxicillin 250 mg quantity of two (2) expired on 09/07/22 -Amoxicillin/Clavulanate 250 mg/125 mg quantity of two (2) expired on 9/21/22 -SMZ/TMP double strength 800 mg/160 mg quantity of two (2) expired on 5/11/22 quantity of two (1) expired on 5/28/22 quantity of two (1) expired on 7/27/22 -Back-Up medication utilization declining inventory sheet for Ceftin (cefuroxime) 250 mg reflected a recordedending balance quantity of 10. quantity of zero (0) was found in the back-up box -Missing Back-Up medication utilization declining inventory sheet for Keflex (cephalexin) 250 mg quantity of ten (10) was found (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/26/22 at 12:26 PM, during an interview with surveyor, the DON stated the facility's par levels (minimum quantity limits) were low. She explained that the nurses signed out the medication by deducting the medication from the par level, wrote the Resident's name, signed their [the nurse's] name and was replenished by the pharmacy. The pharmacy was alerted by the nurse that signed out the back-up medication. The DON also stated that she started 7 weeks ago and the task of ensuring medications were not expired and reconciled had not been assigned to anyone. At that time, the DON stated she had no process for replenishing, reconciliation or ensuring back-up medications were not expired. The DON acknowledged that the reconciliation task was important to avoid diversion and the replenishment task was equally important since it ensured medications listed on the back-up list were available for administration to residents in an emergency. The DON also stated that medications in the back-supply should be checked for expiration to avoid administration of expired medication to residents. The DON stated emergency delivery from the pharmacy was available within four to five hours of the same day. On 10/05/22 at 09:36 AM, the surveyor requested for any policy relating to discontinued medications and/or expired medications from the Regional Nurse. On 10/06/22 at 11:06 AM, during an interview with the surveyor, the DON stated that discontinued and expired medications should be pulled from the cart or storage and returned to the pharmacy if returnable and destroyed in the facility if not returnable. The DON also stated that all nurses on all shifts were responsible to pull the discontinued and expired medications. At that time, the concern regarding Unsampled Resident #393's name crossed off on the bingo card and Resident 48's name handwritten on the bingo card was brought to the attention of the DON. The DON stated that writing another person's name on a bingo cart is not an acceptable practice. On 10/06/22 at 2:38 PM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA), and the Regional LNHA, the surveyor presented the above concerns and requested any additional information. On 10/12/22 at 12:40 PM, in the presence of the survey team, the Regional Nurse and Regional LNHA confirmed no additional information could be provided. A review of facility policy provided, 5.0 Reordering, Changing & Discontinued Medication Orders revised on 10/01/18, included but was not limited to the following: Policy: The facility will communicate any medication reorders, changes or discontinuation to the pharmacy in accordance with pharmacy guidelines and state/federal regulations; thus ensuring standardized process of communication. Communications may be transmitted through verbal or electronic orders. Procedure D. Discontinuation of Orders 1. All orders that are discontinued must be indicated on the POS/EMAR and either faxed, sent electronically or provided verbally to the pharmacy for profile update. The POS & MAR/TAR should be marked indicating the discontinuation of order with date and nurse's signature. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility policy provided, 7.0 Back-Up Box/Stat/Emergency Kit Supply of Medications revised on 10/01/18, included but was not limited to the following: Procedure E) 1. Back-Up Boxes (d) Facility staffs are responsible for replacing the medication in the box/kit. (e) Consultant Pharmacist or designee review the Back-Up Box/stat/emergency supply for correct quantity and expiration. Any discrepancies determined in quantity or expiration are communicated to the pharmacy immediately. A review of facility policy provided, Medication Storage last reviewed on 05/26/22, included but was not limited to the following: Purpose: To make sure all medications and medical supplies are checked before using meds or supplies on a patient. Procedure: Individual, Licensed Nurse/NM [Nurse Manager] Responsibility 1. Checks medication storage at least monthly to ensure all meds [medication] and supplies are checked for labels, expiration dates and to ensure the labels are legible. 2. Any meds expiring should be removed before the expiration date. If pending expiration, will determine if supply will be completed before expiration date. A review of facility policy provided, 4.0 Medication Disposal/Destruction revised on 10/01/18, included but was not limited to the following: Policy: The facility will adhere to all federal, state, and local regulations related to medication destruction/disposal when discarding any medication and medical waste. N.J.A.C. 8:39- 29.2 (d); 29.4 (a) (f) (g)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45449 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to properly label, date and discard expired biologicals in 2 of 3 medication carts, and 1 of 2 medication rooms inspected on the second floor unit. This deficient practice was evidenced by the following: On 09/26/22 at 10:10 AM, the surveyor, in the presence of the second floor Registered Nurse/Unit Manager (RN/UM), observed the following items in the High side unit medication cart (second floor): -one unlabeled inhaler [no Resident's name and unmarked with open date] of Ventolin HFA (albuterol oral inhaler; a medication used to help in breathing) 90 micrograms (mcg) per actuation. -one unlabeled bottle [no Resident's name] of Linzess (linaclotide; a medication used to treat chronic constipation or chronic irritable bowel syndrome) 145 milligrams (mg). During an interview with the surveyor at that time, the RN/UM stated that each medication should have been in a bag or a box and labeled with the Resident's name on the medication to avoid medication administration to the wrong resident. On 09/26/22 at 11:01 AM, the surveyor, in the presence of the RN/UM, observed the following item in the Low side unit medication cart (second floor): -one opened and unlabeled [no Resident's name, unmarked with an open date] nebulizer solution foiled package of Ipratropium bromide and Albuterol inhalation solution (a medication used to help in breathing) 0.5mg/3mg. During an interview with the surveyor at that time, the RN/UM stated that the medication should have been labeled with the Resident's name on the medication package to avoid medication administration to the wrong resident. On 09/26/22 at 11:07 AM, the surveyor, in the presence of the RN/UM, observed the following within the medication room on the Second floor Unit: -one open box of Mantoux Test (a tuberculin skin test performed to check if a person has been infected with tuberculosis), containing one vial of medication in the refrigerator. The opened box was dated 08/25/22. At that time, the surveyor and RN/UM reviewed the manufacturer's package that indicated Discard opened product after 30 days. The RN/UM stated she would discard the expired biological. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/06/22 at 11:06 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that discontinued and expired medications should be pulled from the cart or storage room and returned to the pharmacy if returnable and destroyed in the facility if not returnable. The DON also stated that all nurses on all shifts were responsible to pull the discontinued and expired medications. On 10/6/22 at 11:25 AM, during the continuation of an interview with the surveyor, the DON stated that all medications should have been labeled and kept in the proper container or bag received from the pharmacy. The DON also stated that medications without labels should have been thrown away to avoid medication administration errors [given to the wrong resident] which could lead to adverse events (unwanted side effects). The DON stated that all nurses on all shifts were responsible to ensure all medications were labeled properly. On 10/12/22 at 12:40 PM, in the presence of the survey team, the Regional Nurse and Regional Licensed Nursing Home Administrator (LNHA) confirmed no additional information could be provided. Review of the facility provided, Medication Storage policy last reviewed 5/26/22, included but was not limited to the following: Procedure: Individual, Licensed Nurse/NM Responsibility 1. Checks medication storage at least monthly to ensure all meds [medications] and supplies are checked for labels, expiration dates and to ensure the labels are legible. 2. Any meds that will be expiring should be removed before the expiration date. If pending expiration, will determine if supply will be completed before expiration date. N.J.A.C. 8:39-29.4 (a) (f) (h)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31654 Based on observation, interview, and review of documentation, it was determined that the facility failed to store, label, and date potentially hazardous food, and maintain kitchen sanitation in a manner intended to limit the spread of food-borne illnesses. The deficient practice was evidenced by the following: On [DATE] at 9:38 AM to 10:09 AM, the surveyor entered the facility kitchen and toured with the Food Service Director (FSD). On [DATE] at 9:41 AM, the surveyor observed the facility ice machine. The baffle area (the interior back of the basin in direct contact with the ice) located in the bucket with ice, contained black streaked debris, and accumulated debris above it. The FSD confirmed the ice machine was not clean. The FSD stated maintenance would come monthly to clean filters and the cover of the ice machine. On [DATE] at 9:54 AM, the surveyor observed ,d+[DATE] package of meatballs in the freezer, wrapped, but with no label and no use by date. The FSD stated the meatballs were good for 30 days. On [DATE] at 9:55 AM, the surveyor observed two frozen pie shells in plastic wrap and not in the box, both were open to air and on top of the box. The pie shells were not labeled with a use by date. The FSD took the two pie shells, placed them back in the box, and stated that the rest of the pie shells were open in the box. On [DATE] at 9:59 AM, the surveyor observed three bags of sealed frozen collards and one bag of corn inside of an egg crate (a plastic container with holes on all sides) stored directly on the floor. The FSD stated the crate should be elevated. On [DATE] at 10:00 AM, the surveyor observed a bag of 6 frozen hamburgers. The surveyor asked about being dated and when they expired. The FSD stated, no they didn't date (the bag of frozen burgers), and that they are supposed to date everything. The surveyor observed a very soiled can opener with dark caked on debris on the outside, and dark, caked on, sticky sticky in appearance debris on the inside. The base of the can opener base was attached to the stainless steel table and was observed to have brownish colored spots around it. The holder for the can opener was located on the side of the workstation next to the base. The holder had visible black caked on, greasy debris. The cook was present and stated that the can opener had been cleaned two days ago. The surveyor asked the cook to pull out the can opener insert in presence of the FSD. The insert was observed to be very soiled with dark caked on debris. A review of the facility provided policy, Ice Machine Maintenance, dated ,d+[DATE], included but was not limited to; policy: to maintain proper functioning and sanitation of the ice machine schedule sanitizing for the unit ice machines. Procedure: machines will be sanitized/clean with an EPA (Environmental Protection Agency) and manufacturer approved product daily by the food service department and as needed. (continued on next page)

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Avant Rehabilitation and Care Center	1314 Brunswick Avenue Trenton, NJ 08638

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility provided policy, Ice Machine Sanitation Policy, revised [DATE], included but was not limited to; kitchen staff will wash, rinse, and sanitize the ice making machine weekly. Procedure: 11. Record date of sanitation on the ice machine cleaning log. A review of the facility provided policy, Manual Can Opener Policy, undated, included but was not limited to; kitchen will assure safe usage of manual can opener for food preparation. Procedure: 1. Can opener blade will be inspected before opening cans for .cleanliness, 4. Staff will inspect opener blade, clean and sanitize after each usage, and 5. FSD or designee will replace blade each month or as needed. A review of the facility provided policy, Dating and Labeling Policy; revised ,d+[DATE], included but was not limited to; assure food safety by maintaining proper dates and labels to all ready to eat food products. Procedure: 1. Inspect all deliveries for proper labeling and damage, 2. Label products in storage with date the package was opened or expiration date with no more than 48 hours after opening, whichever is appropriate, 4. Use the [redacted] address label dating and labeling system to date all items, 6. Foods marked with manufactures use by date may be used and stored until expiration date, 7. Foods that are marked with manufactures use by date may not be used if opened or prepared including portioning. A review of the facility provided Department of Health inspection dated [DATE], included but was not limited to; the facility was found out of compliance for food protected from potential contamination during preparation, storage, display. NJAC 8:,d+[DATE].2(g)

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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. 31654 Based on interview, record review and document review it was determined that the Licensed Nursing Home Administrator (LNHA) failed to ensure policies, procedures and systems were developed and implemented to ensure immediate action was taken to make certain that the facility operated in a manner to ensure residents' attained or maintained the highest practicable physical, mental and psychosocial well-being of each resident by ensuring that a resident was free of sexual abuse, and the facility maintained an effective infection control program that limited the spread of COVID-19 an infectious deadly virus as was identified during an on-site survey that began on 09/21/22 and was evidenced by the following: Refer to 600L, 880L, 886L This IJ situation began on 9/28/22 and the facility administration was notified of the IJ on 9/28/22 at 2:55 PM. The facility submitted an acceptable removal plan on 09/27/22 at 3:46 PM. The IJ removal plan was verified as implemented during an onsite visit on 10/04/22 at 12:02 PM. Two Immediate Jeopardy (IJ) situations were identified on 09/23/22 at 1:04 PM for 880L and 886L, which began on 09/21/22 at 1:09 PM, when the Licensed Nursing Home Administrator (LNHA) was unable to provide the survey team with requested policies, procedures and documentation required to conduct the survey, and on 10/11/22 at 2:03 PM, the 880L and 886L were revised to incorporate additional IJ findings of deficient practice. A subsequent IJ situation was identified on 09/28/22 at 2:55 PM for 600K, and on 09/30/22 at 1:31 PM was revised to incorporate additional findings which elevated the deficient practice to widespread finding of abuse at 600L. An additional finding of IJ was identified on 10/11/22 at 2:03 PM for 888L. Refer to 880L Based on observation, interview, record review and review of pertinent documentation, it was determined that the facility failed to ensure that Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid Services (CMS) guidance was implemented to limit the spread of COVID-19, infectious disease by failing to ensure: 1.) a process was in place to conduct comprehensive contact tracing upon the identification of a single new case of COVID-19 for 3 of 3 resident care units, and 2.) a process was in place to ensure all required staff were appropriately fit tested for an N-95 respirator for 3 of 3 resident care units which placed all residents and staff at risk for contracting a contagious infectious and potentially deadly virus. Refer to 886L (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Based on interview, record review and document review it was determined that the facility failed to: 1.) conduct immediate resident and staff testing upon the identification of a single COVID-19 positive staff or resident result, and 2.) ensure a system was in place, and the facility Infection Preventionist followed the facility policy to ensure that all staff who required weekly or bi-weekly COVID-19 testing was completed and documented during a COVID-19 outbreak. The facility's failure to take immediate action, follow Centers for Medicare and Medicaid Services (CMS) guidance, Centers for Disease Control and Prevention (CDC) and facility policies to limit exposure risks placed all residents and staff at risk for contracting COVID-19, a contagious potentially deadly virus. Refer to 600L Based on observation, interview, record review, and other pertinent facility documentation, it was determined the facility failed to ensure a.) residents were free from sexual abuse after an allegation of sexual abuse involving (Resident #10), and b.) protect vulnerable residents from being verbally abused by staff (Resident #56). Refer to 888L Based on interview, record review and document review it was determined that the facility failed to: 1.) ensure the facility policy, Centers for Disease Control and Prevention (CDC), and Centers for Medicare and Medicaid Services (CMS) for COVID-19 vaccinations was implemented to ensure that all staff were up to date with COVID-19 vaccinations, or have been granted a qualifying exemption during a COVID-19 outbreak that began on 06/24/22 and 2.) ensure all staff that were not up to date with vaccinations, or had been granted a qualifying exemption were not permitted to work in the facility. The facility's failure to take immediate action, follow Centers for Medicare and Medicaid Services (CMS) guidance, Centers for Disease Control and Prevention (CDC) and facility policies to limit exposure risks placed all residents and staff at risk for contracting COVID-19, a contagious potentially deadly virus. The non-compliance remained on 10/12/22 for no actual harm with the potential for more than minimal harm that is not IJ based on the following: 1. Based on interview and document review during the on-site survey conducted on 10/12/22, multiple Immediate Jeopardy situations were identified, in addition to a subsequent IJ identified on 10/11/22 at 2:03 PM for 888L, multiple deficient practices that were identified that had the potential to affect the health, safety and welfare of all residents who resided at the facility on 3 of 3 resident units. Refer to 609F, 610F, 689H, 865F, 725F, 812F, 843F, 865F, 867F, 882F On 09/21/22 at 9:05 AM, the LNHA informed the survey team that the facility was presently experiencing a COVID-19 outbreak and he would provide the facility line listing. The surveyor requested all of the infection control information, including staff vaccination policies and matrix, information on residents who smoked and times, and Quality Assurance and Performance Improvement (QAPI) information. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 09/21/22 at 1:09 PM, the surveyor conducted a follow-up interview with the LNHA who stated the Infection Preventionist, who had not completed an infection control certification, was responsible for all of the vaccination effort and would be able to provide all the information. On 09/22/22 at 10:06 AM, the Director of Nursing (DON) provided the survey team with a list of smokers, without the corresponding policy. On 09/22/22 at 2:14 PM, the DON and LNHA were unable to provide the survey team with all of the requested entrance conference documents including all infection control policies and procedures, vaccination matrix (document with the vaccination status of all staff) and a current facility line listing. On 09/22/22 at 2:26 PM, the LNHA confirmed that the facility infection control policies and procedures were not available. On 09/23/22 at 10:00 AM, the facility uncertified Infection Preventionist provided the survey team with a copy of the facility line listing two days after the initial request. On 09/23/22 at 11:32 AM, the LNHA informed the survey team that he was unable to provide the QAPI policies and procedures. On 09/23/22 at 11:34 AM, the survey team conducted an interview with the LNHA and DON regarding the National Health and Safety Network information that is required to be submitted regarding the staff vaccination status. The LNHA confirmed he inputted the information and confirmed there was no current employee vaccination list since not all employees were on it. The DON stated I am not making up what I don't have. On 10/06/22 at 2:43 PM, the survey team presented findings to the LNHA, DON, Regional Interim Infection Preventionist Licensed Practical Nurse (RIIPLPN), Regional Administrator and Regional Nurse. On 10/12/22 at 12:41 PM, the survey team met with the Regional Administrator and Regional Nurse who confirmed there was no rebuttal for the findings presented by the survey team and the facility had not additional information to provide. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of the Administrator Job Description, signed by the LNHA on 06/22/2022, revealed the Purpose of Your Job Position; The primary purpose of your position is to direct the day-to day functions of the Facility in accordance with current federal, state and local standards guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times., Delegation of Authority; As Administrator you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties., Administrative Functions; Plan, develop, organize, implement, evaluate, and direct the Facility's programs and activities in accordance with guidelines issues by management, Develop and maintain written policies and procedures and professional standards of practice that govern the operation of the Facility, Assist department directors in the development, use, and implementation of departmental policies and procedures and professional standards of practice, Review the Facility's policies and procedures at least annually and make changes as necessary to assure continued compliance with current regulations, Interpret the Facility's policies and procedures to employees, residents, family members, visitors, government agencies, etc., as necessary, Ensure that all employees, residents, visitors, and the general public follow the Facility's established policies and procedures, Assist the Medical Director in the development and implementation of medical and nursing services policies and procedures and professional standards of practice, Inform the Medical Director of all suspected or known incidents of resident abuse ., Resident Rights; .Review resident complaints and grievances and make written reports of action taken. Discuss such actions with resident and family as appropriate, Ensure that all policies governing the timely notice for resident discharges and/or room or roommate changes are strictly followed by all personnel .; Administrator; .Report all allegations of resident abuse and/or misappropriation of resident property, The Acknowledgement section of the jog description, dated 06/22/2022 and signed by the LNHA revealed I have read this job description and fully understand that the requirements set forth therein have be determined to be essential to this position. I hereby accept the position of Administrator and agree to perform the tasks outlined in this job description in a safe manner and in accordance with the Facility's established procedures. N.J.A.C. 8:39-9.2(a)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 39885 Based on interview and review of pertinent facility provided documents, it was determined that the facility failed to ensure the facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies was reviewed and updated, as necessary, and at least annually. This deficient practice was evidenced by the following: On 09/21/22 at 01:09 PM, during the entrance conference held with the facility administration, another surveyor requested a copy of the Facility Assessment (FA). On 9/22/22 at 2:28 PM, the Licensed Nursing Home Administrator (LNHA) provided the other surveyor with the FA. The FA was not signed or dated to indicate when the FA was conducted or reviewed. On 10/07/22 at 10:49 AM, the surveyor interviewed the LNHA regarding the FA. The LNHA stated that the FA should have been dated and signed. He then stated that it looked like the wrong one was given. He added that the corporate person had given it to him. He then added that it was in the binder for survey (binder which contains documents for recertification survey). The surveyor then asked the LNHA who was responsible for the FA. The LNHA stated that typically the LNHA was responsible but that the binder for survey was already ready to go before he had come to the facility. He added that the FA was done prior to his arrival but he could not say when. On 10/07/22 at 11:29 AM, the surveyor interviewed the Regional Licensed Nursing Home Administrator (RLNHA) regarding the FA process. The RLNHA stated that the FA should be signed and dated. She added that it should done at a minimum once a year but that she would review it every quarter. A review of the facility provided policy titled, Facility Assessment with a reviewed date of 5/2/22, included the following: Under Policy Statement A facility assessment is conducted annually to determine and update our capacity to meet the needs of and competently care for our residents during day-to-day operations. Determining our capacity to meet the needs of and care for our residents during emergencies is included in this assessment. Under Policy Interpretation and Implementation 1. Once a year, and as needed, a designated team conducts a facility-wide assessment to ensure that the resources are available to meet the specific needs of our residents . 6. The facility assessment is intended to help our facility plan for and respond to changes in the needs of our resident population and helps to determine budget, staffing, training, equipment and supplies needed. It is separate from the Quality Assurance and Performance Improvement evaluation . (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9. The facility assessment is reviewed and updated annually, and as needed . 10. The QAPI Committee is responsible for reviewing facility and resident information quarterly to determine if a facility reassessment is warranted. N.J.A.C. 8:39-5.1(a)

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31654 Based on interview and document review it was determined that the facility failed to ensure the Medical Director (MD) duties per the MD Job Description were implemented to ensure resident care policies and services were provided to all residents that were consistent with current professional standards of practice on 3 of 3 resident units. The deficient practice was evidenced by the following: Refer to: F600K, F609F, F610F, F684H, F835L, 838F, 850F, F865F, F867F, F880L, F886L, F888L During a recertification survey conducted on 10/12/22, the survey team identified multiple findings of Immediate Jeopardy which included, but were not limited to: The facility failed to ensure residents were free from sexual abuse after an allegation of sexual abuse involving (Resident #10), and b.) protect vulnerable residents from being verbally abused by staff (Resident #56). The Licensed Nursing Home Administrator (LNHA) failed to ensure policies, procedures and systems were developed and implemented to ensure immediate action was taken to ensure the facility operated in a manner to ensure the facility residents' attained or maintained the highest practicable physical, mental and psychosocial well-being of each resident by ensuring that a resident was free of sexual abuse, and the facility maintained an effective infection control program that limited the spread of an infectious deadly disease. The facility failure to ensure that Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid Services (CMS) guidance was implemented to limit the spread of infectious disease by failing to ensure: 1.) a process was in place to conduct comprehensive contact tracing upon the identification of a single new case of COVID-19 for 3 of 3 resident care units, and 2.) a process was in place to ensure all required staff were appropriately fit tested for an N-95 respirator and documentation was completed for 3 of 3 resident care units which placed all residents and staff at risk for contracting a contagious infectious and potentially deadly virus. (continued on next page)

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/07/22 at 11:29 AM, the surveyor conducted a telephone interview with the facility Medical Director (MD). The MD informed the surveyor that she has been the MD for over two years. The surveyor inquired as to how the MD was involved with the facility. The MD stated that the facility had a lot of contracts to provide care for people without insurance, and persons without a home, they have nothing. The MD stated she would admit those residents under her care as the MD. The MD stated that she had reviewed policies in the past and the facility had a great deal of turnover with the Administrator and Director of Nursing position. The MD stated she had just found out yesterday (10/06/22) that there were serious concerns at the facility. The MD stated she had met the Administrator and stated at present I have no contact with the Administrator. The surveyor inquired to the MD if she provided medical care for Resident #65. The MD confirmed that she was responsible for the medical care of Resident #65. The surveyor inquired if she was informed about a delay in Resident #54 receiving an X-ray. The MD stated the facility did not tell her that the X-ray did not occur on 07/02/22 (the day it was ordered) and not until 07/04/22. She stated if she had been told, she may have sent [Resident #65] to the emergency room . The MD confirmed she was also not made aware that there was not an appointment available until 07/20/22 for an orthopedic physician, and that it did not appear that the orthopedic physician was contacted until 07/08/22. She stated I 100 % expect them to call her if they cannot get an appointment, I can send them out. The surveyor asked the MD if she had been involved regarding the facility policies or the facility assessment. The MD stated nothing was in writing. The surveyor reviewed the signed and un-dated Job Description for the Medical Director. The MD stated she was provided a blank job description by the facility and she had crossed out what she was not going to do. The MD stated she was not the person who was going to guide all of the care for all of the patients, or supervise any other doctors and also crossed out the section with the other duties, and that is why she crossed it out on the job description. At that time, the surveyor observed under Duties and Responsibilities, three areas were crossed out and included Involvement at all levels of individualized patient care and supervision, Supervises medical practitioners who provide the direct patient care for the facility, and a crossed out area with error written beside it revealed I further understand that the duties listed above my change at any time either verbally or in writing according to the needs of the facility. I understand that I may be required to work weekends, holidays, and may be temporarily assigned to other positions as needed. The surveyor inquired if the MD was involved with the QAPI or any QAPI projects that she was involved in and the MD stated not really. The MD stated there has been so much change they have not gone over much. When the MD was asked about knowledge of registered sex offenders that resided in the facility or an incident involving sexual abuse allegation, the MD stated no, they should have told me and stated I should have been involved in that, and confirmed she had not been made aware of the Immediate Jeopardy situations or the sexual abuse allegation. (continued on next page)

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The MD Job Description revealed: The Purpose: The Medical Director helps coordinate and evaluate the medical care within the facility by reviewing and evaluating aspects of physician care and practitioner services and helping the facility identify, evaluate and address health care issues related to the quality of care and quality of life of residents. The Medical Director is an important member of the healthcare team in a nursing home, and is responsible for overall coordination of care and for implementation of policies related to care of the residents in a nursing home. The residents in nursing homes are frail, medical-[NAME] complex, and have multiple disabilities., Delegation of Authority: As Medical Director you are delegated as the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. Duties and Responsibilities: (in addition to what was crossed out as referenced above) Serves as the clinician who oversees and guides the care that is provided to residents, Serves as the physician responsible for the overall care and clinical practice carried out at the facility., Applies clinical and administrative skills to guide the facility in providing care., Helps the facility develop and manage both quality and safety initiatives, including risk management., Provided information that helps others (including facility staff, practitioners, and those in the community) understand and provide care. Acknowledgement: I have read this job description and fully understand that the requirements set forth therein have been determined to be essential to this position. I hereby accept the position of Medical Director and agree to perform the tasks outlined in this job description in a safe manner and in accordance with the Facility's established procedures . N.J.A.C. 8:39-23.1(a)1-7

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45449 Complaint #NJ00155999 Based on observation, interview, and other facility documentation, it was determined that the facility failed to maintain complete, accurate, and readily accessible medical records. This deficient practice was identified for (a) 1 of 4 residents closed medical records reviewed (Resident #194), and (b) 1 of 35 Sampled residents reviewed (Resident #8). The deficient practice was evidenced by the following: a) On 09/27/22 at 11:47 AM, the surveyor requested Resident #194's closed records from the Medical Records department. On 09/28/22 at 12:02 PM, the surveyor interviewed the Unit Clerk/ Medical Records (UC/MR) who explained her process. She stated she thinned the paper charts, closed charts, and sent data to other physicians when needed. She informed the surveyor that the electronic Medical Record (eMR) started in May 2022. A review of the eMR under Admission Discharge Transfer (ADT) reflected Resident #194 was admitted to the facility on [DATE] and discharged on [DATE]. On 10/04/2022 at 11:51 AM, the Regional Registered Nurse provided the surveyor with Resident #194's face sheet, the minimum data set and the hospital medical record, which were the only documents the facility had. On 10/03/22 at 12:35 PM, the surveyor followed up on the request made for the paper medical closed record with the UC/MR, who stated she could not locate the documents. She confirmed that the documents within the paper medical charts that were thinned or closed were collected and placed in a filing cabinet in the medical records room by her. She stated she could not locate Resident #194's paper medical records. On 10/06/22 at 02:32 PM, during an interview with the surveyors, the Regional Licensed Nursing Home Administrator (Regional LNHA) stated she was unable to locate Resident #194's paper medical record. On 10/07/22 at 08:35 AM, during an interview with the surveyors, the Regional LNHA confirmed Resident #194's paper medical record was missing. Reference F 656 b) On 10/04/22, the surveyor requested Resident #8's Admission documents, Interdisciplinary notes, progress notes, and MDS from the Interim Infection Preventionist (formerly the facility educator). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/04/22 at 12:47 PM, the surveyor requested all of Resident #8's social worker assessments (Social Services -Psychosocial Assessment; SS-PA) from the Social Services Director. On 10/05/22 at 09:38 AM, the surveyor requested all of Resident # 8's SS-PA and admission care plan from the Regional LNHA. On 10/05/22 at 01:50 PM, during an interview with the surveyor, the Regional LNHA stated she was unable to locate the Admission/Initial SS-PA and the Admission/Initial care plan for Resident #8. On 10/06/22 at 02:38 PM, in the presence of the survey team, LNHA and Director of Nursing (DON), the surveyor presented the above concerns and requested any additional information. On 10/12/22 at 12:40 PM, in the presence of the survey team, the Regional Nurse and Regional LNHA confirmed no additional information could be provided. A review of the facility provided, Medical Records policy reviewed 1/5/2022, included but was not limited to the following: Policy Statement: Our facility shall protect and safeguard all medical records. Policy Interpretation and Implementation: 1. All current medical records are filed in the Medical Records Department and are maintained by the Medical Records Clerk. 2. Medical records are stored in a locked room and protected from fire, water damage, insects, and theft. 3. Archived medical records (those being retained for a specified period beyond the resident's discharge or death) will be clearly identified as archived records and stored appropriately. N.J.A.C. 8:39-35.2 (d)(6)(16)

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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 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. 39885 Based on interview and review of facility provided documentation, it was determined that the facility failed to have a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs. The deficient practice was evidenced by the following: On 10/11/22 at 01:00 PM, the surveyor asked the Regional Licensed Nursing Home Administrator (RLNHA) to view the written transfer agreement that the facility had with one or more hospitals. The RLNHA was unable to provide the surveyor a written transfer agreement. On 10/12/22 at 10:53 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) to view the written transfer agreement that the facility had with one or more hospitals. The LNHA stated that the agreement would be in the Emergency Preparedness (EP) manual. The LNHA then, in the presence of the surveyor, began looking through different binders that were not labeled as the EP manual. He then stated that the previous owner would have had the agreement. He stated that he was unable to locate it at this time. The LNHA then continued to look in a binder labeled EP, and he then provided the surveyor with one unsigned agreement, and three signed agreements that were titled with the names other Nursing Home facilities. The LNHA was unable to provide a written transfer agreement with a hospital for the current facility. On 10/12/22 at 11:13 AM, in the presence of the survey team, the surveyor asked the LNHA about the transfer agreement with the hospital. The LNHA stated that the hospital agreement was with their transport company. The surveyor then asked the LNHA what the purpose of a transfer agreement with a hospital was. The LNHA stated that it was in case the facility needed to relocate residents in the event of any medical emergency. The surveyor then asked the LNHA if he had ever seen the written transfer agreement with a hospital, and he stated no. The facility was unable to provide the survey team with a written transfer agreement. A review of the facility provided policy titled, Transfer Agreement, with a reviewed date of 11/11/2021, included the following: Under Policy Statement Our facility has a transfer agreement in place with a designated hospital should our residents need care that is beyond the scope of our available care and services. Under Policy Interpretation and Implementation 1. The hospital with which we have an agreement is approved for participation under Medicare/Medicaid Certified programs. 2. Our transfer agreement: (continued on next page)

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a. Is in writing and authorized by individuals who are permitted to execute such an agreement on behalf of the institutions; b. Ensure that residents are transferred from the facility to the hospital and admitted in a timely manner when medically appropriate (as determined by the attending physician); c. Ensure that residents are transferred from the facility to the hospital and admitted in a timely manner in an emergency situation by another practitioner, consistent with the state law; . 3. Completed copies of our transfer agreements are on file in the business office. 4. Inquiries concerning transfer agreements should be referred to the Administrator. N.J.A.C. 8:39-11.2(j)

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. 38079 Based on interview and review of documentation, it was determined that the facility failed to employ a Social Worker (SW) with the required experience per facility policy and Centers for Medicare and Medicaid Services (CMS). This was identified for 1 of 1 SW employed and was evidenced by the following: On 09/27/22 at 12:31 PM, during an interview with a surveyor, the SW stated she had been in the position of Social Services Director (SSD) since March 2022. The SW stated some of her responsibilities included initial social services assessments, communication with residents and families, handling concerns such as any investigations, and interviewing anyone involved. The SW reiterated that she had started in March 2022 and added that this was her first job out of school, she had not been educated on this (her job), and had not been provided with clear direction to handle grievances. She stated that the Licensed Nursing Home Administrator (LNHA) had started in June 2022 and had trained her. The SW further stated she could not recall if she was provided a job description but, I'm going to be honest, no. On 09/27/22 at 2:37 PM, during an interview with the surveyors, the SW stated she was not working on 08/23/22 but when she worked on 08/24/22, she was informed of an incident that took place on 08/23/22. The SW stated the incident was regarding one resident that had gone into another resident's room. She stated she was told by the LNHA and the Director of Nursing (DON) that they reviewed the incident and there was no need to take it any further. The SW reviewed the facility Abuse Policy in the presence of the surveyors and commented that if there were an allegation of abuse, she would be responsible to be an advocate, call police if need be, and interview the residents. The SW stated she did not follow up with any staff interviews, or investigations. On 10/04/22 at 2:54 PM, during an interview with the surveyors, the SW stated she had graduated in May 2021, and obtained her SW license in November 2021. She stated she had never officially worked with another social worker and had not met the facility's corporate SW yet. The SW stated she had completed a lot of learning on my own and that the facility had provided some education since the survey started. On 10/05/22 at 12:53 PM, during an interview with the surveyors, the LNHA stated the SW had been hired through the previous administration. The LNHA further stated end of story there was no education, guidance, or training for the SW and that with the switch (change in ownership), the SW was lost in the shuffle. The LNHA stated he was not a SW, but had been trying to work with the SW, and reached out to other facilities for help. He stated there was no regional (corporate) SW, but there were two nice buildings that the facility could team the SW up with. The LNHA stated the plan now was to have the SW work with another SW when possible to be afforded the training she needed. A review of the facility provided resume for the SW revealed she had not been employed as a SW in any health care facility since obtaining her Master of Social Work in May 2021. The SW was noted to have shadowed a Licensed Clinical Social Worker at a behavioral health facility from September 2020 to April 2021, seven months. The SW was also noted as a Social Work Intern in a school system from August 2019 to December 2019, four months. (continued on next page)

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility provided, Social Worker Job Description provided on 09/28/22 and signed on 09/28/22 by the SW, included but was not limited to Experience: must have, as a minimum three (3) years supervised social work experience in a health care setting working directly with individuals. The facility was on record as being licensed for 149 beds. The CMS guidelines implemented 11/28/17, included but were not limited to a qualified SW full-time for a facility with over 120 beds. The qualifications included one year of supervised social work experience in a health care setting working directly with individuals. The SW had not met the experience requirement for a SW and the facility did not have another SW employed to provide supervision. On 10/07/22, the above concern was presented to the administrative staff. As of exit day on 10/12/22, the facility had no additional information to provide. N.J.A.C. 8:39-9.3(a)(1)(3); 39.2; 39.4(i)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 39885 Based on concerns identified during this survey that ended 10/12/2022, interviews and review of pertinent facility provided documentation, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to put forth a good faith attempt to identify and correct their own concerns related to infection prevention and control during an ongoing COVID-19 virus (an acute disease in humans caused by a Coronavirus) outbreak that began on 06/24/22. This deficient practice was identified during the standard survey and was evidenced by the following: Refer to F880L, F886L, F888L On 09/21/22 at 01:09 PM, during the entrance conference held with the facility administration, another surveyor requested information regarding the QAA (Quality assessment and assurance) committee and QAPI plan. The administration informed the survey team that the facility was presently in an outbreak of COVID-19 which began on 06/24/22. On 10/07/22 at 10:00 AM, the surveyor reviewed the facility provided Quality Assurance Meeting August 2022 minutes which included the following: Outbreak Plan: We reviewed the outbreak plan as it effects each and every dept. Since I am new to the team I wanted to bring it to an almost beginning step. We had a question answer session which gave me an idea as to where we are. There was no other documentation in the minutes in relation to infection control or COVID-19. On 10/07/22 at 11:29 AM, another surveyor interviewed the Medical Director regarding the QAPI process. The Medical Director stated that she had been at the facility for more than two years and that she attended the QAPI committee meetings. The other surveyor then asked if there were any QAPI plans that she was involved in. The Medical Director stated, not really. She added that at every QAPI Committee meeting they would go over things, but that there had been so much change in staff that they had not gone over much, and that the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) were very new to the facility. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/12/22 at 09:53 AM, in the presence of another member of the survey team, the surveyor interviewed the LNHA regarding the facility's QAPI program. The LNHA stated that the QAPI committee met on a quarterly basis and that the Interim Infection Preventionist (IIP) was the lead person with the Assistant Director of Nursing. He stated that he had only attended the last meeting which occurred in July 2022 and that it was a reintroduction and went over what he would expect from them. The LNHA stated that the Medical Director would oversee the process and that if she could not attend the meeting, she would get the information and would sign off on it. He added that he had only attended one meeting since he started at the facility and that the Medical Director was not at that meeting and there was not another physician in her place. The surveyor asked the LNHA for an example of what the QAPI committee was working on. The LNHA stated that there were certain topics like infection control that we discuss, the prior deficiencies and what that looks like for the facility. The LNHA then stated that the current focus was residents that were eating with their hands. The surveyor asked if the staff vaccination for COVID-19 status had been presented to the QAPI committee. The LNHA stated that he knew that it had but that he was not sure how deep we went in. He added that he could not recall the conversation but that it should be a daily conversation and that obviously they should have been better with that. The surveyor asked the LNHA if he kept up to date with the current infection control guidelines. The LNHA stated yes. The surveyor then asked the LNHA if he was able to identify any breaches in infection control prior to the survey. The LNHA stated that if he saw staff doing something wrong then he would train them but that once trained there was some forgetfulness. The surveyor then asked the LNHA if the facility had an Infection Control Committee (ICC) and their process. The LNHA stated that the ICC met at the same time that the QAPI committee met. He added that information was discussed monthly and that it was recapped at the QAPI meeting but that he did not think there were formal meeting minutes for the ICC. He then stated that there were a lot of things we need to work on. He added that before the survey the facility was trying to get things on track, but that was the reason we have survey, to get back on track. On 10/12/22 at 10:53 AM, the LNHA showed the surveyor a Quality Assurance Meeting sign in sheet dated 08/2/22 which included the Medical Director's signature. The surveyor then asked about the Medical Director's signature since the LNHA previously stated that the Medical Director had not attended. He then stated that the Medical Director was there and must have entered the meeting maybe at the end or after the meeting began. On 10/12/22 at 11:52 AM, during surveyor interview, the IIP stated that she had been on the QAPI committee since 2008. The surveyor asked the IIP if she was the QAPI committee chair or coordinator. The IIP stated that she was not in charge of the committee and that the LNHA, DON and Medical Director would be in charge. She added that she did not know who the QAPI committee chair or coordinator was. The surveyor then asked the IIP if there were any plans of action to correct identified quality deficiencies. The IIP stated that she did not have any plans in place. The surveyor then asked the IIP if the committee had identified any of the concerns that the survey team had found or had any plans of action to correct them already in place prior to the survey. The IIP stated that she could not recall that they had any QAPI plans going on prior to survey. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/12/22 at 12:41 PM, the surveyor interviewed the Regional Licensed Nursing Home Administrator (RLNHA), in the presence of the Regional Nurse, regarding the QAPI program. The RLNHA stated that the expectation would be that each department team would review monthly that their systems were running to move forward and to meet best practices and would present the information to the QAPI committee. The surveyor then asked the RLNHA if the concerns that were identified by the survey team should have been identified by the facility. The RLNHA stated that the expectation would be that some of the concerns should have been identified and that they should have been working on plans to improve. The surveyor then asked the RLNHA who the QAPI committee chair or coordinator was. The RLNHA stated that it should be the LNHA. The surveyor then asked the RLNHA if the facility had any plans of action to correct identified quality deficiencies already in place prior to the survey. The RLNHA stated that she was not aware of any performance improvement plans that they were working on and that there was none that she could find. The facility was unable to provide any documented evidence that the QAPI Committee attempted to put forth a good faith attempt to identify and correct their own concerns. A review of the facility provided policy titled, Quality Assurance and Performance Improvement (QAPI) Program, dated August 2017, included the following: Under Policy Statement The facility shall develop, implement, and maintain an ongoing, facility-wide Quality Assurance and Performance Improvement (QAPI) program that builds on the Quality Assessment and Assurance Program to actively pursue quality of care and quality of life goals. Under Policy Interpretation and Implementation The primary purpose of the Quality Assurance and Performance Improvement Program is to establish data driven, facility-wide processes that improve the quality of care, quality of life and clinical outcomes of our residents. Under Five Strategic Elements The QAPI program has been developed with five strategic elements in mind: Under Five Strategic Elements 1. Design and Scope: a. The program is ongoing and comprehensive. b. It involves the full range of services and department in the facility. c. It covers all systems of care and management practices, with priority given to quality care, quality of life and resident choice. d. Goals, targets and benchmarks are established and measured based on the best available evidence. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Governance and leadership: . c. Member of the facility leadership are accountable for QAPI efforts. Under QAPI Action Steps The following steps are employed or will be employed to support and enhance the facility QAPI program: . 9. Establishing a QAPI Plan that guides quality efforts and serves as the main document that supports the QAPI program 16. Recognizing patterns in systems of care that can be associated with quality problems. 17. Prioritizing identified quality issues based on risk of harm and frequency of occurrence, and determining which will become the focus of PIPs . 19. Conducting Root Cause Analysis to identify the underlying issues that contribute to recognized problems. A review of the facility provided policy titled, QAPI Committee dated August 2017, included the following: Under Policy Interpretation and Implementation The Administrator shall delegate the necessary authority for the QAPI committee to establish, maintain and oversee the QAPI program. Under Goals of the Committee The primary goals of the QAPI Committee are to : 1. Establish, maintain and oversee facility systems and processes to support the delivery of quality of care and services; . 3. Help identify actual and potential negative outcomes relative to resident care and resolve them appropriately; 4. Support the use of root cause analysis to help identify where patterns of negative outcomes point to underlying systematic problem' 5. Help departments, consultants and ancillary services implement systems to correct potential and actual issues in quality care' 6. Coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals; Under Committee Authority (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. The QAPI Coordinator shall coordinate the activities of the QAPI Committee. Under Committee Reports and Records The committee shall maintain minutes of all regular and special meetings that include at least the following information: -The date and time the committee met; -The names of committee members present and absent; -A summary of the reports and finding; -A summary of any approaches and action plans to be implemented; -Conclusions and recommendations from the committee; and -The time the meeting adjourned. A review of the facility provided policy titled, QAPI Plan, dated August 2017, included the following information: Under Policy Statement This facility shall develop, implement, and maintain an ongoing, facility wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems. Under Policy Interpretation and Implementation The Objectives of the QAPI Plan are to: 1. Provide a means to identify and resolve present and potential negative outcomes related to resident care and services; . 3. Provide structure and processes to correct identified quality and/or safety deficiencies; 4. Establish and implement plans to correct deficiencies, and to monitor the effects of these action plans on resident outcome , 7. Establish systems and processes to maintain documentation relative to the QAPI Program, as a basis for demonstrating that there is an effective ongoing program . Under Authority 2. The Administrator is responsible for assuring that this facility's QAPI Program complies with federal, state, and local regulatory agency requirements. (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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 39885 Based on concerns identified during the survey through interviews, and review of pertinent facility provided documents, it was determined that the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee developed and implemented appropriate plans of action to correct identified quality deficiencies. This deficient practice was identified during the standard survey and was evidenced by the following: On 09/21/22 at 01:09 PM, during the entrance conference held with the facility administration, another surveyor requested information regarding the QAA (Quality assessment and assurance) committee and QAPI plan. On 10/07/22 at 10:00 AM, the surveyor reviewed facility provided Quality Assurance Meeting minutes for the last three meetings. There was no documented evidence in the minutes to confirm plans of action to correct identified quality deficiencies were implemented. On 10/07/22 at 11:29 AM, the other surveyor interviewed the Medical Director regarding the QAPI process. The Medical Director stated that she had been at the facility for more than two years and that she attended the QAPI committee meetings. The other surveyor then asked if there were any QAPI plans that she was involved in. The Medical Director stated, not really. She added that at every QAPI Committee meeting they would go over things, but that there had been so much change in staff that they had not gone over much, and that the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) were very new to the facility. On 10/12/22 at 09:53 AM, in the presence of another member of the survey team, the surveyor interviewed the LNHA regarding the facility's QAPI program. The LNHA stated that the QAPI committee met on a quarterly basis and that the Interim Infection Preventionist (IIP) was the lead person with the Assistant Director of Nursing. He stated that he had only attended the last meeting which occurred in July 2022 and that it was a reintroduction and what he would expect from them. The LNHA stated that the Medial Director would oversee the process and that if she could not attend the meeting, she would get the information and would sign off on it. The surveyor asked the LNHA for an example of what the QAPI committee was working on. The LNHA stated that there were certain topics like infection control that we discuss, the prior deficiencies and what that looks like for the facility. The LNHA then stated that the current focus was residents that were eating with their hands. The surveyor asked if the staff vaccination for COVID-19 status had been presented to the QAPI committee. The LNHA stated that he knew that it had but that he was not sure how deep we went in. He added that he could not recall the conversation but that it should be a daily conversation and that obviously they should have been better with that. The surveyor asked the LNHA if he kept up to date with the current infection control guidelines. The LNHA stated yes. He then stated that there were a lot of things we need to work on. He added that before survey the facility was trying to get things on track, but that was the reason we have survey, to get back on track. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/12/22 at 11:52 AM, during surveyor interview, the IIP stated that she had been on the QAPI committee since 2008. The surveyor asked the IIP if she was the QAPI committee chair or coordinator. The IIP stated that she was not in charge of the committee and that the LNHA, DON and Medical Director would be in charge. She added that she did not know who the QAPI committee chair or coordinator was. The surveyor then asked the IIP if there were any plans of action to correct identified quality deficiencies. The IIP stated that she did not have any plans in place. The surveyor then asked the IIP if the committee had identified any of the concerns that the survey team had found or had any plans of action to correct them already in place prior to the survey. The IIP stated that she could not recall that they had any plans going on prior to the current survey. On 10/12/22 at 12:41 PM, the surveyor interviewed the Regional Licensed Nursing Home Administrator (RLNHA), in the presence of the Regional Nurse, regarding the QAPI program. The RLNHA stated that the expectation would be that each department team would review monthly that their systems were running to move forward and to meet best practices and would present the information to the QAPI committee. The surveyor then asked the RLNHA if the concerns that were identified by the survey team should have been identified by the facility. The RLNHA stated that the expectation would be that some of the concerns should have been identified and that they should have been working on plans to improve. The surveyor then asked the RLNHA who the QAPI committee chair or coordinator was. The RLNHA stated that it should be the LNHA. The surveyor then asked the RLNHA if the facility had any plans of action to correct identified quality deficiencies already in place prior to the survey. The RLNHA stated that she was not aware of any performance improvement plans that they were working on and that there was none that she could find. The facility was unable to provide any documented evidence that the QAPI Committee developed and implemented appropriate plans of action to correct identified quality deficiencies. A review of the facility provided policy titled, Quality Assurance and Performance Improvement (QAPI) Program, dated August 2017, included the following: Under Policy Statement The facility shall develop, implement, and maintain an ongoing, facility-wide Quality Assurance and Performance Improvement (QAPI) program that builds on the Quality Assessment and Assurance Program to actively pursue quality of care and quality of life goals. Under Policy Interpretation and Implementation The primary purpose of the Quality Assurance and Performance Improvement Program is to establish data driven, facility-wide processes that improve the quality of care, quality of life and clinical outcomes of our residents. Under Five Strategic Elements The QAPI program has been developed with five strategic elements in mind: . 2. [G]overnance and leadership: . (continued on next page)

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Avant Rehabilitation and Care Center	1314 Brunswick Avenue Trenton, NJ 08638

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	e. Staff are encouraged to identify and report quality concerns as well as opportunities for improvement . 4. Performance Improvement projects: a. Performance improvement projects (PIPs) are initiated when problems are identified. b. PIPs involve systematically gathering information to clarify issues and to intervene for improvements . 13. Gathering and using QAPI data in an organized and meaningful way. Areas that may be appropriate to monitor and evaluate include: a. Clinical outcomes: pressure ulcers, infections, medication use, pain, falls, etc.; b. Complaints from residents and families; c. Re-hospitalization s; d. Staff turnover and assignments; e. Staff satisfaction; f. Care plans; g. State surveys and deficiencies; and h. MOS assessment data . 16. Recognizing patterns in systems of care that can be associated with quality problems. 17. Prioritizing identified quality issues based on risk of harm and frequency of occurrence, and determining which will become the focus of PIPs. 18. Planning, conducting and documenting PIPs. 19. Conducting Root Cause Analysis to identify the underlying issues that contribute to recognized problems. 20. Taking systematic action targeted at the root causes of identified problems. This encompasses the utilization of corrective actions that provide significant and meaningful steps to improve processes and do not depend on staff to simply do the right thing. A review of the facility provided policy titled, QAPI Committee dated August 2017, included the following: Under Policy Interpretation and Implementation (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Administrator shall delegate the necessary authority for the QAPI committee to establish, maintain and oversee the QAPI program. Under Goals of the Committee The primary goals of the QAPI Committee are to : 1. Establish, maintain and oversee facility systems and processes to support the delivery of quality of care and services; . 3. Help identify actual and potential negative outcomes relative to resident care and resolve them appropriately; 4. Support the use of root cause analysis to help identify where patterns of negative outcomes point to underlying systematic problem' 5. Help departments, consultants and ancillary services implement systems to correct potential and actual issues in quality care' 6. Coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals; Under Committee Authority 5. The QAPI Coordinator shall coordinate the activities of the QAPI Committee. Under Committee Reports and Records The committee shall maintain minutes of all regular and special meetings that include at least the following information: -The date and time the committee met; -The names of committee members present and absent; -A summary of the reports and finding; -A summary of any approaches and action plans to be implemented; -Conclusions and recommendations from the committee; and -The time the meeting adjourned. A review of the facility provided policy titled, QAPI Plan, dated August 2017, included the following information: Under Policy Statement (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	This facility shall develop, implement, and maintain an ongoing, facility wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems. Under Policy Interpretation and Implementation The Objectives of the QAPI Plan are to: 1. Provide a means to identify and resolve present and potential negative outcomes related to resident care and services; . 3. Provide structure and processes to correct identified quality and/or safety deficiencies; 4. Establish and implement plans to correct deficiencies, and to monitor the effects of these action plans on resident outcome , 7. Establish systems and processes to maintain documentation relative to the QAPI Program, as a basis for demonstrating that there is an effective ongoing program . N.J.A.C. 8:39-33.1(a)(b)(c)(e); 8:39-33.2 (a)(b)(c)(d)

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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** 31654 Based on observation, interview, record review and review of pertinent documentation, it was determined that the facility failed to ensure that Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid Services (CMS) guidance was implemented to limit the spread of infectious disease by failing to ensure: 1.) a process was in place to conduct comprehensive contact tracing upon the identification of a single new case of COVID-19 for 3 of 3 resident care units, and 2.) a process was in place to ensure all required staff were appropriately fit tested for an N-95 respirator and documentation was completed for 3 of 3 resident care units. This deficient practice placed all residents and staff at risk for contracting a contagious infectious and potentially deadly virus and was evidenced by the following: Reference: Centers for Medicare & Medicaid Services (CMS), QSO-20-38-NH, revised 03/10/22, Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements. Reference: Centers for Disease Control and Prevention, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, Updated Sept. 23, 2022 Part 1 The facility's failure to ensure a process was in place to conduct comprehensive contact tracing upon the identification of a single new case of COVID-19 for 3 of 3 resident care units resulted in an Immediate Jeopardy (IJ) situation that began on 09/20/22, when two symptomatic residents (Resident #44 and Resident #52) were not immediately tested for COVID-19 and tested on e day later, on 9/21/22, and both residents were positive for COVID-19. The facility uncertified Registered Nurse Infection Preventionist (URNIP) confirmed contact tracing was not completed to identify any close contacts for Resident #44 and Resident #52, and the URNIP was unable to provide documented evidence of contact tracing that was completed to identify close contacts for both residents. The facility administration was notified of the IJ on 9/23/22 at 1:04 PM. The facility submitted an acceptable removal plan via electronic mail (email) on 09/27/22 at 3:46 PM. The IJ removal plan was verified as implemented during an on-site visit on 10/03/22 at 1:49 PM. 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	On 09/21/22 at 9:18 AM, upon entrance to the building, Surveyor #1 requested information from the Corporate Nurse (CN) regarding any COVID-19 positive residents currently residing in the building. The CN stated there were no COVID-19 positive residents in the building, and there were two persons under investigation (PUI- a person who had been in contact with a person who had an infection, or was awaiting testing for a suspected infection) who resided on the first floor. The Licensed Nursing Home Administrator (LNHA) informed the survey team that the facility was currently in an outbreak of COVID-19 and would provide the survey team with a copy of the current line listing. On 09/21/22 at 1:09 PM, surveyor #1 conducted an entrance conference with the LNHA and Director of Nursing (DON). The LNHA stated the URNIP was the facility Infection Preventionist and confirmed that she did not have an infection control certification since she had not completed infection control training. The LNHA stated that the URNIP was responsible for all of the facility COVID-19 vaccination effort. Surveyor #1 inquired to the number of COVID positive residents and symptomatic residents who currently residend in the facility, and the LNHA confirmed there were currently no COVID-19 positive residents who resided in the facility, and there were two PUI residents. Surveyor #1 requested all the information related to the COVID-19 vaccination status of all residents and staff and all related testing for COVID-19. The LNHA and DON stated that residents and staff were tested twice per week, however, they were unable to provide the documentation, and stated that the URNIP would provide it. On 09/22/22 at 9:55 AM, the DON and LNHA informed the survey team that two residents (Resident #44 and Resident #52) had tested positive for COVID-19 and had been moved to the first floor for isolation. The LNHA stated the positive results were identified during routine COVID-19 testing. On 09/22/22 at 1:46 PM and 2:14 PM, during interviews, the DON and LNHA failed to provide the survey team with the requested documents related to infection control, which included the staff vaccination documentation and staff and resident testing documentation. The LNHA stated the documents were now with the corporate people and he was unable to produce the documents. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 09/22/22 at 3:42 PM, the URNIP was interviewed by Surveyor #1, #2 and #3 regarding the facility COVID-19 testing process. The URNIP stated that not all staff and residents were tested twice weekly. She stated if the resident had not yet received a COVID-19 booster vaccine, they would be tested twice weekly. The survey team inquired as to what was the criteria that was used to determine which staff were tested for COVID-19. The URNIP then proceeded to review her COVID-19 testing log with the surveyors. The URNIP stated if some staff felt like they had a cold, they could be tested , and stated there are no staff members that need to be tested at present. The URNIP presented a log with handwritten COVID retesting employees, Binax Now Test Sign Off and had a handwritten date of 09/20/22, which contained three staff names, each dated 09/20/22, with a negative result. The three staff included a Licenced Practical Nurse (LPN #1), Unidentified Staff, (Staff #1), and the Maintenance Director (MD). The URNIP stated only residents were on her list to receive COVID-19 testing twice per week. A second document provided by the URNIP, revealed a handwritten COVID [sic.] res [NAME], 09/20/22, pt's The handwritten document contained eleven names and had a handwritten date of 09/20/22 with a negative result, and seven names were listed and dated 09/21/22. The URNIP stated the eleven names listed were not tested related to the COVID-19 positive residents, (Resident #44 and Resident #52, that were tested on [DATE]). Resident #52 and Resident #44, were listed with a positive result, and the remaining five names were negative. The survey team inquired to the URNIP regarding why the other names listed received a test, and the URNIP stated three staff requested a test, one resident requested a test, one resident was the Unsampled Resident roommate of Resident #44 who also requested to be tested after the resident had found out that the room mate tested positive. At 3:45 PM, the URNIP confirmed she was responsible for COVID-19 testing, and the two pages that she had provided to the survey team, and reviewed with the survey team was the only facility COVID-19 testing log that was used for residents and staff on 09/20/22 and 09/21/22. On 09/23/22 from 9:42 AM to 10:00 AM, Surveyor #2, #3 and #4 conducted a subsequent interview with the URNIP. The URNIP stated Resident #44 was tested for COVID-19 on 09/21/21, and she confirmed the resident had been symptomatic on 09/20/22. The URNIP stated that Resident #52 was tested for COVID-19 due to also having symptoms on 09/20/22, and she confirmed the resident also had tested positive on 09/21/22. The URNIP stated she had not been made aware until the 09/21/22 that Resident #44 and #52 were symptomatic. When asked if she should have been informed of the symptomatic residents she stated yes, I would think so. When asked who was responsible for completing any contact tracing related to the COVID-19 positive cases, the URNIP stated that is a good question and stated it would be under her jurisdiction. The URNIP stated that she had just found out from the survey team that Resident #52 had attended a funeral, otherwise, she stated she would have tested the resident for COVID-19 before and after attending a funeral outside of the facility. The URNIP stated that she had tried to obtain information from staff and made rounds daily on the resident units. When inquired to the URNIP when the current outbreak began and what the status was, the URNIP stated she did not know when the outbreak started, not the specific date, and as far as she knew the facility had always been in an outbreak. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The Regional Administrator Registered Nurse (RARN) provided the survey team with a copy of the facility Outbreak Plan/Covid-19 Response, revised 03/10/22 which was reviewed in the presence of the URNIP. The document revealed Higher -risk exposure- referred to exposure of an individual's eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if present in the room for an aerosol-generating procedure. This can occur when staff does not wear adequate personal protective equipment during care or interaction with an individual. The document also revealed Upon identification of a single new case of COVID-19 in any staff or residents, testing should begin immediately. Facilities have the option to perform outbreak testing though two approaches, contact tracing or broad-based (e.g., facility-wide) testing. Surveyor #1 inquired to the URNIP regarding what staff were considered exposed to Resident #44 and Resident #52, and were any of the staff tested for COVID-19 in response to the exposure. The URNIP stated everyone could be going into the room, anyone can answer a light [call bell], and stated, I will be honest with you, I didn't test anyone, and stated I tested the two [Resident #44 and #52] that were positive and the immediate roommate. The URNIP then confirmed, in the presence of the survey team, that she did not complete any contact tracing, and stated the book of testing that she had provided to the survey team was the entirety of the facility COVID-19 testing documentation, and confirmed there was no facility wide testing completed in response to the Residents #44 and #52 positive COVID-19 status. She stated any other staff member could have completed a COVID-19 test if they were trained. When inquired if any other staff had been trained to complete COVID-19 testing she stated, not off the top of my head. The survey team inquired to the URNIP regarding what should have been completed at the time a resident was experiencing symptoms of COVID-19. The URNIP stated that the facility has a DON, and testing supplies could be obtained as needed, and the residents should be tested if they were symptomatic. The URNIP stated that unvaccinated and symptomatic residents should be transferred to a COVID-19 isolation room with isolation signs placed outside. The URNIP stated if residents were symptomatic and then tested negative for COVID-19, they should be moved to an isolation room for PUI in the event they became symptomatic. The URNIP stated if there was a room mate to the COVID-19 positive resident, that person would be tested , and Resident #52 did not have a roommate. The URNIP stated that the roommate of Resident #44 was tested for COVID-19 on 09/21/22, and tested negative but was not restricted to the PUI section at this point. The URNIP stated both Resident #44 and Resident #52 had been coughing on 09/20/21 and were very alert. The surveyor inquired to the URNIP if she was aware that Resident #52 had attended a funeral on 09/16/22 outside of the facility, as documented in Resident #52's progress notes. The URNIP stated no, she was not aware. The URNIP was asked if she completed the facility line listing (the spreadsheet of all COVID-19 infections that is transmitted to the Department of Health) and communicated with the local Department of Health (DOH) regarding new COVID-19 cases. The URNIP stated the LNHA was responsible for completing the line listing and contacting the DOH. The URNIP provided the survey team with a copy of the facility line listing which revealed that the symptoms for Residents #44 and #52 had an onset date of 09/21/22. The survey team inquired if that date was correct and the URNIP stated that date should be changed to 09/20/22, when both residents became symptomatic. The surveyors inquired to the URNIP if she had reviewed the staff assignment sheets for Resident #44 and Resident #52 to determine who provided care for the residents. The URNIP confirmed that she had not looked at the assignment sheets to determine who had cared for Resident #44 and Resident #52. When asked how far back would it be reviewed to determine close contacts for the purpose of contact tracing, the URNIP did not specify and stated that she would have to get clarification. The survey inquired if the URNIP received a job description, and she stated, not as of yet. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The survey team inquired to the URNIP regarding a list of all staff vaccination status and the percent vaccinated staff. The URNIP stated she could get that information from the employee files, however, she was not provided with that information for any new hires, and confirmed that she did not enter the information into the National Healthcare Safety Network (NHSN). On 09/23/22 at 11:34 AM, the survey team interviewed the DON regarding who was responsible for completing the NHSN information. The DON stated the LNHA completed it, however, she was unable to provide a staff vaccination list to the survey team, and she did not know what the percent COVID-19 vaccination status was for the staff. The DON stated she did not have a completed vaccination list and I am not making up what I don't have. The survey team inquired to the DON regarding what was the process when a resident became symptomatic for COVID-19. The DON stated as soon as symptoms developed the symptomatic person should be tested for COVID-19, and the Assistant Director of Nursing could complete the testing on the 11:00 PM-7:00 AM shift. The DON stated there was no reason that testing should not be completed. On 09/23/22 at 11:49 AM, Surveyor #1 interviewed the DON and LNHA in the presence of the survey team regarding if contact tracing was completed after Residents #44 and #52 tested COVID-19 positive. Both confirmed that contact tracing was not completed. A review of the facility provided document, Contact Tracing Policy Covid 19 Pandemic undated and provided on 09/26/22, included but was not limited to Purpose: committed to following all state and federal guidance and regulations to prevent the spread of Covid 19 .As per the CDC, contact tracing and close contacts are critical to help slow transmission of COVID-19. Procedure: maintain a continuous log of every person, including staff and visitors, who may have close contact with individuals at the facility. The Administrator or his/her designee will maintain the contact tracing log. If a staff member, resident, or consultant that visited the facility reports testing positive for COVID-19, the facility will immediately notify the local health officials and follow directives. For a new onset of a positive Covid case in a resident or staff member, the Infection Preventionist will document all contacts and conduct contact tracing utilizing Contact Tracing Form. Part 2 The facility's failure to ensure a process was in place to ensure all staff were appropriately fit tested for an N-95 respirator and documentation was complete for 3 of 3 resident care units, resulted in an Immediate Jeopardy situation that began on 09/23/22 at 8:53 AM, when a Licensed Practical Nurse (LPN #2) was observed at a medication cart on the 2nd floor wearing a surgical mask. LPN #2 informed the surveyor that she had not been fit tested for an N-95 mask, she worked on multiple resident units, and that she had not received a COVID-19 booster. The IJ was identified on 10/11/22 at 2:03 PM, when the facility IIPLPN was unable to confirm, and provide documented evidence that all staff who required fit-testing for an N-95 mask (a close facial fitting respiratory protection device for filtration of airborne particles) had been appropriately fit-tested . The facility submitted an acceptable removal plan via email on 10/12/22 at 1:42 PM. The IJ removal plan was verified as implemented on 10/12/22 at 2:35 PM. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 09/23/22 at 9:06 AM, Surveyor #1 interviewed the URNIP, in the presence of the survey team, regarding if staff were currently fit tested for N-95 masks, the URNIP stated that she did not have a test mask to complete the fit testing process. The URNIP stated everybody is not fit tested . When asked if all staff that worked on the COVID-19 unit were required to be fit tested and wear an N-95 mask. The URNIP stated no they can wear either [N-95 or surgical mask], and stated they should wear the N-95 mask. The URNIP stated I did not get to everybody, and I still have to get around to doing the new people. On 09/23/22 at 8:53 AM Surveyor #1 observed LPN #2 on the 2nd floor medication cart wearing a surgical mask. Surveyor #1 interviewed LPN #2 at that time who stated she was a new hire. The surveyor asked LPN #2 if she was vaccinated for COVID-19 and if she had been fit tested for an N-95 mask. LPN #2 stated not fit tested , not boosted, and she stated she was vaccinated for COVID-19 and confirmed that the facility was aware that she was not boosted. LPN #2 stated that she signed a waiver form that was provided by the facility since she did not want a COVID-19 booster. Surveyor #1 inquired to LPN #2 if she had received COVID-19 testing and she stated that the facility would let her know if she needed to take a test, and she could also let the URNIP know if she needed to take a COVID-19 test. Surveyor #1 asked if LPN #2 if she was assigned to a particular unit, and she stated that she floated to different units. Surveyor #1 inquired to LPN #2 if she was responsible for completing any COVID-19 symptom monitoring for her assigned residents. She stated, vitals are taken on everyone usually, if there were new symptoms then she would check vital signs (clinical measurements, specifically pulse rate, temperature respiration rate and blood pressure that indicate essential body functions), and that she would do vital signs if she had to, and stated she had not seen any formal resident monitoring for vital signs. On 10/06/22 at 12:30 PM, Surveyor #1 observed LPN #2 on the 1st floor COVID-19 unit at the nursing station. LPN #2 was observed wearing a NIOSH tc N-95 mask. Surveyor #1 inquired what N-95 mask was she required to wear, the LPN #2 removed two different masks from the bins outside of a resident room, and stated that she could wear either one. LPN #2 stated the mask Surveyor #1 was wearing (N95 # 8210) was very tight, and she stated that she was fit tested for both masks by the IIPLPN. Surveyor #1 inquired if LPN #2 had a medical or religious exemption for the COVID-19 booster. LPN #2 again stated that she had signed a paper waiver provided by the facility that indicated she does not want the booster, and stated no, it was not a medical exemption or a religious exemption and stated it was a document that offered risks and benefits. Surveyor #1 asked LPN #2 if she was fit tested for the mask she was wearing and she stated she could wear both and chose the N-95 that did not hurt her face which was the NIOSH tc N-95. LPN #2 stated if the masks were in the bins that they were okay to wear. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/06/22 at 4:03 PM, Surveyor #1 in the presence of the survey team, interviewed the Interim Infection Preventionist Licensed Practical Nurse (IIPLPN) regarding the N-95 fit testing process. The IIPLPN stated the N-95 fit testing should be done upon hire and annually. Surveyor #1 asked if the IIPLPN had received training or a certification for fit testing. The IIPLPN stated she watched videos and stated that a hood was used over a person's head and there was a solution that would be used to test the person to see if the mask fit. The IIPLPN provided the surveyor with a book of N-95 Respirator Training and Fit Testing Verification Forms (FTVF) for employees, and she stated the papers proved that a person had been fit tested for an N-95 mask. The IIPLPN stated there were certain brands and they fit differently. She stated that the fit testing was completed with the masks that were most prevalent and stated, no there was no shortage of N-95 masks. The IIPLPN stated if the employee needed a special mask, we would order it and some employees medically cannot use the N-95 masks. The IIPLPN stated the staff that were not up to date with their COVID-19 vaccinations were required to wear the N-95 masks, and staff who worked with the COVID-19 positive residents. On 10/06/22 at 4:10 PM, Surveyor #1 reviewed the FTVF form for LPN #2. The document revealed the Training and Fit Date was 09/23/22 for the 8210 N95 model. The IIPLPN was the trainer's name and signature. The Respirator Fit Test Record had a blank in the Respirator Selected and Manufacturer section was blank. The Fit Checks section with Negative Pressure, Positive Pressure, Pass, Fail and Not Done was blank. The Fit Testing section with Fit Factor for Quantitative and Qualitative, Isoamyl Acetate, Sweet, Bitter and Smoke and pass/fail for each was completely blank. The employee acknowledgement of test results was signed on 09/23/22 by LPN #2 and the Test Conducted by section was blank. Surveyor #1 inquired to the IIPLPN if the 8210 N-95 was available at the facility and she stated yes, it is a common mask. Surveyor #1 inquired about the FTVF document and was it completed since there were blanks and stated I don't have an answer for that and confirmed that she was unable to tell if LPN #2 passed or failed her fit test because the form was incomplete. The IIPLPN stated that it was important for all staff to know their results and stated although the document was incomplete that LPN #2 had been fit tested . Surveyor #1 inquired about a waiver that was completed by LPN #2 that stated she could waive the booster and the IIPLPN stated she was unaware of such a document. On 10/06/22 at 4:22 PM, Surveyor #1 asked the Regional Licenced Nursing Home Administrator (RLNHA) if there was a certification needed to conduct fit testing and if the facility allowed staff to waive the COVID-19 vaccine. The RLNHA stated yes a certification was required to provide fit testing and staff were required to be up to date all three were needed (two vaccines and one booster). On 10/07/22 at 10:49 AM, Surveyor #1 asked the IIPLPN if there was any staff that were currently not fit-tested for an N-95 mask. She confirmed that she did not know because she was not doing fit testing prior and was currently putting a list together and stated, it has been started. The IIPLPN stated, I watched the O. S.H.A. [Occupational Safety and Health Administration] video and did the competency back in the pandemic. The IIPLPN was not sure how long the certification was good for. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The IIPLPN provided the survey team with a document on 09/28/22, in a packet with document related to an Occupational Therapy Assistant's (OTA) COVID-19 information. The document revealed the OTA's name handwritten on the document. The document was titled ACCEPTANCE/DECLINATION FORM/VACCINATION RECORD with three areas that can be checked off. The first area revealed a Covid-19 Vaccine Administration Consent, I wish to receive the Covid-19 Vaccine. I read or had explained to me the Covid-19 Vaccine Information. I was given the opportunity to ask questions that were answered to my satisfaction. I understand the health benefits and risks of Covid-19 and the Covid-19 Vaccine. The second area revealed Covid-19 Vaccine Declination, I decline to be vaccinated at this time. I have been given the opportunity to be vaccinated with the Covid-19 Vaccine. I understand that by declining this vaccine, I continue to be at increased risk of acquiring Covid-19, a serious disease, and a risk to others. I understand I can request the COVID 19 vaccine at any time during my employment with this facility, and the third section revealed, and was checked off by the Occupational Therapy Assistant, I have already received the COVID 19 vaccination. Please provide a copy of your COVID 19 vaccination card. (This document reflected what LPN #2 stated she had been offered and signed, however was not provided by the facility) The non-compliance remained on 10/12/22 for no actual harm with the potential for more than minimal harm that is not IJ based on the following: Based on observations, interview, record review and document review it was determined that the facility failed to ensure that CDC and CMS infection control guidance was followed to limit the spread of infections and ensure: a.) staff donned (put-on) the appropriate Personal Protective Equipment (PPE) upon entry into the room of residents who were on transmission-based precautions (TBP) for PUI, a new admission and un-vaccinated for COVID-19, and COVID-19 positive residents (Resident #245 and #249) and one unsampled resident on 1 of 3 units reviewed for TBP, b.) COVID-19 surveillance was conducted and documented for any signs and symptoms of COVID-19 during a COVID-19 outbreak for all facility residents who resided on 3 of 3 units, c.) a resident with a multidrug-resistant organism (an organism resistant to multiple antibiotics) was placed on TBP to prevent the spread of a multi drug resistant organism (MRDO) for 1 of 1 resident (Resident #86) reviewed for urinary catheter/UTI (urinary tract infection), d.) staff disinfected a blood pressure cuff prior to use on multiple residents, on 1 of 3 units observed for nursing care, e.) all staff completed the required COVID-19 entrance screening prior to providing resident care on 1 of 3 units, f.) to maintain a clean and sanitary environment in double occupancy resident room (Resident #7 and an unsampled resident) on 1 of 3 units (third floor unit), and g.) the facility annually reviewed Infection Control Policies and Procedures (ICPC) for 1 of 1 ICPC manuals provided and reviewed. The deficient practice was evidenced by the following: 38079 (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	a.) On 09/21/22 at 11:07 AM, Surveyor #4 observed the COVID-19 PUI unit on the first floor. Surveyor #4 observed room [ROOM NUMBER] with a Stop sign affixed to the door and a plastic bin located next to the door. The plastic bin contained PPE gowns, surgical masks, N95 masks, gloves, hand sanitizer, and eye protection. Surveyor #4 observed another sign on the door Stop Observation-Quarantine Precautions, in addition to standard precautions; only essential personnel should enter this room; everyone MUST: hand hygiene before gloving and after glove removal, wear Mask N95 if fit tested and available or surgical mask if not fit tested or failed fit test, and eye protection; gown and gloves required prior to entering if you anticipate contact with resident or potentially contaminated surfaces in close proximity to resident. Quarantine Precautions: for use during COVID-19 pandemic - newly admitted residents during observation period (14 days); unvaccinated residents with frequent visits outside the facility .personal protective equipment with illustration how to don (put on) and doff (take off). Surveyor #4 then observed a staff member inside of the room without wearing eye protection, or a PPE gown, and the staff was wearing a cloth mask, and gloves. The staff member was handing Resident #245 a bar to exercise with. The staff member was identified as an Occupational Therapy Aide (OTA), and the OTA proceeded to exit the room wearing the same cloth mask and gloves. The OTA stated that PPE was not part of her training when she began at the facility about two weeks prior, and stated she had not been fit tested for the N95 mask. She stated she did see the signage on the door but did not wear any PPE because she had seen the resident before and she did not think it was a problem. The OTA then stated to Surveyor #4 that by not wearing her PPE, she could become contaminated, and possibly spread the COVID-19 infection. The OTA stated she had been trained about a year ago on PPE, but that was with a different company. Surveyor #4 asked the OTA if she was aware why the resident was on isolation. The OTA stated she believed something for COVID-19, but the resident did not have any symptoms that she was aware of. The OTA acknowledged the Stop sign affixed to the door and stated that she had not checked with the nurse prior to entering the room. A review of Resident #245's medical records revealed the resident had been recently admitted with diagnoses which included, but was not limited to; Multiple Sclerosis and pain. A review of the Admission Minimum Data Set (MDS), an assessment tool dated 09/16/22, revealed a Brief Interview of Mental Status (BIMS) of 15/15 indicating the resident was cognitively intact. A review of the Physician's Orders (PO) revealed an order dated 09/13/22, for Occupational Therapy Screen, Evaluate and Treat. A review of the facility provided immunizations for the resident revealed Resident #245 had not been vaccinated for COVID-19. During an interview with Surveyor #4 on 09/21/22 at 11:19 AM, and in the presence of the OTA, the DON stated the therapy department was not new to the facility. The DON stated there would be signs on the doors of isolation rooms to alert the staff of what PPE should be worn inside the rooms, and the DON confirmed there was a sufficient supply of PPE in the bins next to the doors. The DON then informed the OTA that she should not be wearing a cloth mask, and could not wear gloves in the hallway. The OTA at that time placed her gloved hands into her scrub top pockets. The DON stated if staff did not wear the appropriate PPE, they could spread infection (COVID-19). The DON further stated she was not sure who would be responsible for training new therapy staff on PPE. The DON then acknowledged the OTA had not been fit tested and stated the OTA should not be in the COVID-19 isolation room without first being fit tested . At that time, the DON again instructed the OTA to remove her gloves and wash her hands. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 09/23/22 at 9:06 AM, during an interview with Surveyor #4, the acting URNIP stated she had not fit tested everyone working on the PUI/COVID-19 unit with the residents. The RN #1 stated the staff should be wearing N95 masks and that she had not gotten around to check, or work with staffing to see who should be working with the PUI/COVID-19 positive residents. On 09/28/22 at 8:39 AM, Surveyor #4 observed a staff member on the first floor PUI/COVID-19 unit. The staff member was wearing an N95 mask that was not secured around her head and both straps of the N95 mask were sticking out of the sides of a surgical mask she was wearing. The staff member was stepping into the COVID-19 isolation room of Resident #249 with signage on the door. The signage, Stop Observation-Quarantine Precautions, in addition to standard precautions, only essential personnel should enter this room, everyone MUST: hand hygiene before gloving and after glove removal, wear Mask N95 if fit tested and available or surgical mask if not fit tested or failed fit test, and eye protection; gown and gloves required prior to entering if you anticipate contact with resident or potentially contaminated surfaces in close proximity to resident. Quarantine Precautions: for use during COVID-19 pandemic .personal protective equipment with illustration how to don (put on) and doff (take off). At that time Surveyor #4 interviewed the staff member who identified herself as an LPN who worked with a contracted wound care company. The wound care LPN stated she had been in-serviced on PPE before, but not at the facility. She further stated she was not sure if the resident was positive for COVID-19. The wound care LPN stated she had been fit tested for the N95 mask and knew that the straps should be around her head, but my nose is sore, so I anchored the N95 with a surgical mask. Surveyor #4 asked how the N95 should fit. The wound care LPN stated the N95 should be a tight fit and acknowledged that hers was not really a tight seal. She further stated that by wearing the N95 incorrectly, she could become exposed to COVID-19. A review of Resident #249's medical records revealed the reside [TRUNCATED]

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 38079 Based on interview and pertinent documentation, it was determined that the facility failed to employ an Infection Preventionist (IP) who had completed specialized training in infection prevention and control per Centers for Medicare & Medicaid Services (CMS) guidance. This deficient practice was identified for 1 of 1 employees reviewed for IP and was evidenced by the following: On 09/21/22 at 1:08 PM, entrance conference was conducted with the facility Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). At that time, the surveyor was informed that the current position of IP was held by a Registered Nurse (RN) who had not completed the Center for Disease Control and Prevention (CDC) specialized training for infection prevention and control. On 09/22/22 at 1:54 PM, during an interview with the surveyor, the RN stated she had started as IP at the facility in July 2022 and had not completed her CDC training (IP). On 09/23/22 at 9:42 AM, during an interview with surveyors, the RN who was acting as the facility's IP stated she was new to the role of IP. The RN was questioned about the facility line listing regarding recent COVID-19 positive residents. The RN stated the LNHA had been responsible to create and update the facility line listing because she did not know how to do it. The surveyor next questioned the RN about contact tracing in response to the COVID-19 positive residents or staff. The RN stated she believed contact tracing would fall under her jurisdiction, but that she would need to find out for sure. The RN reviewed the facility provided line listing and was not able to inform the surveyors when the current COVID-19 outbreak had begun. When questioned about testing in regard to contact tracing, the RN stated, everyone could be (exposed to COVID-19) going into the room, anyone can answer a light and I will be honest with you I didn't test anyone. The RN informed the surveyors that she had not received a job description and that she got an idea of her responsibilities from the former IP. On 9/23/22 at 10:17 AM, the RN provided the surveyors with the on-line advertisement for the position of IP at the facility. The advertisement included but was not limited to a requirement of having an Infection Prevention Certification. A review of CMS QSO-19-10-NH, dated 03/11/19, included but was not limited to Background: Effective November 28, 2019, the final requirement includes specialized training in infection prevention and control for the individual(s) responsible for the facility's IPCP (infection prevention and control program). Specialized Training for Infection Prevention and Control: In order to receive a certificate of completion, learners must complete all modules and pass a post-course exam . Completion of this course will provide specialized training in infection prevention and control. On 10/07/22, the above concern was presented to the administrative staff. As of exit day on 10/12/22, the facility had no additional information to provide. N.J.A.C. 8:39-20.2

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45449 Based on interview, medical record review, and review of other pertinent facility documents, it was determined that the facility failed to offer a resident a Pneumococcal Vaccine. This deficient practice was identified for 1 of 5 residents reviewed for immunization status (Resident #11). The deficient practice was evidenced by the following: On 09/26/22 at 9:18 AM, the surveyor reviewed Resident #11's medical record which revealed the following information: Review of the Resident Face Sheet Record (an admission summary) revealed that Resident # 11 had been admitted to the facility with diagnoses which included but were not limited to dementia, acute embolism, thrombosis of lower extremities and an International Classification of Diseases, 10th Revision (ICD-10; a diagnostic and procedure coding system) of Z28.39 other under immunization (is for reporting when a patient is not current on other, non-COVID vaccines). Review of the most recent quarterly Minimum Data Set (MDS - an assessment tool), dated 08/12/22, revealed a Brief Interview for Mental Status (BIMS) of 5 out of 15 which indicated the resident was severely cognitively impaired; and under section O, O0300 Pneumococcal Vaccine revealed 0 not received and reason of 3 not offered. Review of the admission MDS, dated [DATE], revealed a BIMS of 5 out of 15 which indicated the resident was severely cognitively impaired; and under section O, O0300 Pneumococcal Vaccine revealed 0 not received and reason of 3 not offered. Review of Resident #11's Medication Orders from admission 05/06/22 reflected a standing order for Pneumococcal Vaccine upon initial admission pending family/resident consent was not marked for yes or no. Review of Resident #11's active Care Plan (CP) printed on 10/03/22 did not reveal any focus, goals or interventions for vaccinations. Review of Resident #11's electronic Medical Record (eMR) under Preventative Health did not reveal a Pneumococcal Vaccine administered recorded. Review of Resident #11's Immunization Record from Resident #11's paper medical record did not reveal a Pneumococcal Vaccine administered recorded. On 09/28/22 at 12:58 PM, the concern regarding Resident #11's Pneumococcal Vaccine status, where there was not documentation that it was offered, administered, refused and there was not any education provided was brought to the attention of the second floor Unit Manager Registered Nurse (UM/RN) and the Director of Nursing (DON) and any additional information was requested. On 09/29/22 at 11:08 AM, during an interview with the surveyor, Resident #11 stated he/she had not been offered any vaccinations but if his/her doctor or nurse recommended it, I will do it. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/04/22 at 10:46 AM, during an interview with the surveyor, UM/RN stated she did not find additional information regarding Pneumococcal Vaccine for Resident #11. She acknowledged that the immunization should have been care planned since the Resident did not have all the vaccination as documented on the resident's face sheet. On 10/06/22 at 02:32 PM, the concern regarding Resident #11's Pneumococcal Vaccine status, where there was not any documentation that it was offered, administered, refused and no education provided was brought to the attention of the DON in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA), and the Regional LNHA and any additional information was requested. On 10/12/22 at 12:40 PM, in the presence of the survey team, the Regional Nurse and Regional LNHA confirmed that no additional information could be provided. Review of the facility provided, Pneumococcal Vaccine policy reviewed 1/2022, included but was not limited to the following: Policy: All residents will be offered pneumococcal vaccines to aid on preventing pneumonia/pneumococcal infections. Policy Interpretation and Implementation: 1. Prior to or upon admission residents will be assessed for eligibility to receive the pneumococcal vaccine series and when indicated, will be offered the vaccine series within thirty days (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. 3. Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine .Provision of such education shall be documented in the resident's medical record. 4. Pneumococcal vaccines will be administered to residents (unless medically contraindicated, already given or refused) . 5. Residents/representative have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the pneumococcal vaccination. 6. For Residents who receive the vaccines, the date of the vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record. N.J.A.C. 8:39-19.4(h), (i), (j)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Perform COVID19 testing on residents and staff. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31654 Based on interview, record review and document review it was determined that the facility failed to: 1.) conduct immediate resident and staff testing upon the identification of a single COVID-19 positive staff or resident result, and 2.) ensure a system was in place, and the facility Infection Preventionist followed the facility policy to ensure that all staff who required weekly or bi-weekly COVID-19 testing was completed and documented during a COVID-19 outbreak. The facility's failure to take immediate action, follow Centers for Disease Control and Prevention (CDC) , Centers for Medicare and Medicaid Services (CMS) guidance, and facility policies to limit exposure risks placed all residents and staff at risk for contracting COVID-19, a contagious deadly virus. Reference: Centers for Medicare & Medicaid Services (CMS), QSO-20-38-NH, revised 03/10/22, Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements. Reference: Centers for Disease Control and Prevention, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, Updated Sept. 23, 2022 Refer to 880L, 888L Part 1 The failure to conduct immediate resident and staff testing upon the identification of a single COVID-19 positive staff or resident result. This resulted in an Immediate Jeopardy (IJ) situation which began on 09/20/22 and was identified on 09/23/22 at 1:04 PM. The facility's COVID-19 outbreak began on 06/24/22. Two residents (Resident #44 & #52) were symptomatic, coughing and sneezing on 09/20/22, and the facility's uncertified Infection Preventionist Registered Nurse (UIPRN) confirmed testing was not immediately performed on 09/20/22. The facility administration was notified of the IJ on 9/23/22 at 1:04 PM. The facility submitted an acceptable removal plan on 09/27/22 at 3:46 PM. The IJ removal plan was verified as implemented during an onsite visit on 10/03/22 at 1:49 PM. The evidence was as follows: On 09/21/22 at 9:18 AM, upon entrance to the building, Surveyor #1 requested information from the Corporate Nurse regarding if there were any COVID-19 positive residents in the building. The Corporate Nurse stated there was no COVID-19 positive resident in the building, and there were two persons under investigation (PUI- a person who had been in contact with a person with an infection or awaiting testing for a suspected infection) who resided on the first floor. At 9:05 AM, the Licensed Nursing Home Administrator (LNHA) informed the survey team that the facility was currently in an outbreak of COVID-19 and would provide the survey team with a copy of the current line listing. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 09/21/22 at 1:09 PM, Surveyor #1 held an entrance conference with the LNHA and Director of Nursing (DON). The LNHA stated the UIPRN was not certified since she had not yet completed the infection control training. The LNHA stated that the UIPRN was responsible for all of the facility vaccination effort. Surveyor #1 inquired to the number of COVID-19 positive residents and symptomatic residents who were currently residing in the facility and the LNHA stated there were currently no COVID-19 positive residents who resided at the facility, and there were two residents who were considered persons under investigation. Surveyor #1 requested all the information related to the current COVID-19 vaccination status of all residents and staff and all related testing for COVID-19. The LNHA and DON stated that residents and staff were tested twice per week, however, they were unable to provide the documentation and stated that the UIPRN would be able to provide the testing information. On 09/22/22 at 9:43 AM, the DON and LNHA informed the survey team that two residents (Resident #44 & Resident #52) had tested positive for COVID-19 and now resided on the first floor after being transferred from the third floor due to testing COVID-19 positive. The LNHA stated the positive results were identified during routine COVID-19 testing. On 09/22/22 at 9:55 AM, the DON and LNHA failed to provide the survey team with the requested documents related to infection control, which included staff vaccination and staff and resident testing documentation. The LNHA stated the documents were with the corporate people and he was unable to produce the documents. On 09/22/22 at 3:42 PM, the UIPRN was interviewed by Surveyor #1, #2, and #3, regarding the facility testing process. The URNIP stated that not all staff and residents were tested twice weekly. She stated if the resident had not yet received a COVID-19 booster vaccine, they would be tested twice weekly. Surveyor #1 inquired as to what was the criteria that was used to determine what staff were tested for COVID-19. The UIPRN reviewed her COVID-19 testing log with the surveyors and stated if some staff felt like they had a cold, they could be tested . The URNIP then stated there is no staff members that need to be tested at present. The UIPRN presented a log with handwritten COVID retesting employees, [brand name rapid COVID-19 test] Test Sign Off dated 09/20/22, and contained three staff names, dated 09/20/22, with a negative result documented for a Licence Practical Nurse (LPN #1), Maintenance Director (MD) and Staff #1. The UIPRN stated only residents were on her list to receive COVID-19 testing twice per week. A second document provided by the UIPRN, revealed a handwritten COVID testing, 09/20/22, pt's The handwritten document contained eleven names, dated 09/20/22, with a negative result and seven names were listed and dated 09/21/22. The UIPRN stated the eleven names that were listed did not receive a COVID-19 test due to the COVID-19 Positive residents identified on 09/21/22. Resident #52 and Resident #44 were also listed on the document, with a positive result, and the remaining five names were listed with a negative result. Surveyor #1 inquired to the UIPRN regarding why the other names listed had received a COVID-19 test. The UIPRN stated three staff requested a test, one resident requested a test, one resident was the Unsampled Resident roommate of Resident #44 who also requested to be tested . At 3:45 PM, the UIPRN confirmed the two pages that were provided to the surveyors, and reviewed with the surveyors, was the only COVID-19 testing log for employees or staff on 09/20/22 and 09/21/22, with no other testing dates provided. (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 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of the Electronic Nursing Progress Notes (EPN) for Resident #44 revealed on 09/21/22 at 10:51 PM a nurse documented that Resident has been coughing and sneezing since yesterday. MD [doctor] made aware and ordered COVID test. Resident tested positive for COVID 19 .Resident Transferred to the 1st floor room . The Care Plan Activity Report for Resident #44 revealed, The COVID-19 Actual or suspected Care Plan, As Evidenced By: Confirmed positive for COVID 19 09/21/22, Effective: 09/21/22, Goals revealed, I will recover from COVID 19, Effective 09/21/22, Interventions included; We will place you in isolation form droplet and contact precautions until the virus is resolved. Effective:09/21/22, We will confine you to your room during your illness to prevent the spread of the virus, Effective:09/21/22, We will monitor your temp [temperature], vital signs, pulse ox [blood oxygen level] and symptoms to see if you are responding to treatment, Effective 09/21/22. A review of the EPN for Resident #52 revealed on 09/21/22 at 3:50 PM, Licence Practical Nurse #1 (LPN #1) documented covid swab requested., and at 10:50 PM, another nurse documented Resident has been coughing since yesterday. MD made aware and ordered COVID test. Resident tested positive for COVID 19 . Resident Transferred to the 1st floor . (This represented a seven hour delay from the documented request for the Covid swab at 3:50 PM) (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 09/23/22 from 9:42 AM to 10:00 AM, Surveyor #1 again interviewed the UIPRN in the presence of Surveyor #2, #3, and #4. The URNIP stated Resident #44 was tested on [DATE], and confirmed the resident was symptomatic on 09/20/22. The UIPRN stated that Resident #52 was tested due to also having symptoms on 09/20/22, and the resident tested positive on 09/21/22. The UIPRN stated she was not made aware until 09/21/22, that Resident #44 and #52 were symptomatic on 09/20/22. When asked if she should have been informed of the symptomatic residents she stated yes, I would think so. When asked who is responsible for completing any contact tracing related to the COVID-19 positive cases, the UIPRN stated that is a good question and stated it would be under her jurisdiction. The surveyor inquired to the UIPRN if she was aware that Resident #52 had attended a funeral on 09/16/22, as documented in Resident #52's progress notes. The URNIP stated no, she was not aware. The UIPRN stated that she had just found out from the survey team that Resident #52 had left the facility out on pass, otherwise, she stated she would have tested the resident for COVID-19 before and after having left the facility out on pass. The UIPRN stated that she tried to get information from staff and made rounds daily. When inquired to the URNIP when the current outbreak started and what the status was, the UIPRN stated she did not know when the outbreak started, not the specific date, and as far as she knew they were always in an outbreak. The Regional Licensed Nursing Home Administrator (RLNA) provided the survey team with a copy of the facility Outbreak Plan/Covid-19 Response, revised 03/10/22, which was reviewed in the presence of the UIPRN . The document revealed a Higher -risk exposure- refers to exposure of an individual's eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if present in the room for an aerosol-generating procedure. This can occur when staff does not wear adequate personal protective equipment during care or interaction with an individual. The document also revealed Upon identification of a single new case of COVID-19 in any staff or residents, testing should begin immediately. Facilities have the option to perform outbreak testing though two approaches, contact tracing or broad-based (e.g., facility-wide) testing. Surveyor #1 inquired to the UIPRN regarding what staff were considered exposed to Resident #44 and Resident #52 and were any of the staff tested for COVID-19 in response to the exposure. The UIPRN stated everyone could be going into the room, anyone can answer a light, and stated, I will be honest with you, I didn't test anyone and stated I tested the two [Resident #44 and #52] that were positive and the immediate roommate. The UIPRN then confirmed, in the presence of the survey team, that she did not complete any contact tracing and the book of testing that she had provided to the survey team was in it;s entirety, no other COVID-19 testing documentation was available and confirmed there was no facility wide testing completed in response to the Residents #44 and #52 positive COVID-19 status. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The UIPRN stated any other staff member could complete a COVID-19 test if they were trained. When inquired if any other staff had been trained to do COVID-19 testing she stated, not off the top of my head. Surveyor #3 inquired to the UIPRN regarding what should be done when a resident was experiencing symptoms of COVID-19. The UIPRN stated that the facility had a DON and testing supplies can be obtained as needed and the residents should be tested if they are symptomatic and unvaccinated, the resident should be transferred to a COVID-19 isolation room with isolation signs placed. The UIPRN stated if residents were symptomatic and then tested negative for COVID-19, they should be moved to an isolation room for PUI in the event they became COVID-19 positive. The UIPRN stated if there was a room mate to the COVID-19 positive resident, that person would be tested , and Resident #52 did not have a roommate. The UIPRN stated that the roommate of Resident #44 was tested for COVID-19 on 09/21/22, and tested negative, but was not restricted to the PUI section at this point. The URNIP stated both Resident #44 and #52 were both coughing on 09/20/21, and were very alert. The URNIP was asked if she completed the facility line listing (the spreadsheet of all COVID-19 infections that is transmitted to the Department of Health) and communicated with the local Department of Health (DOH) regarding new COVID-19 cases. The URNIP stated the LNHA was responsible for the line listing and contacting the DOH. The UIPRN provided the survey team with a copy of the facility line listing which revealed that the symptoms for Residents #44 and #52 had an onset date of 09/21/22, and the survey team inquired if that date was correct, and the UIPRN stated that date should be changed to 09/20/22. On 09/24/22 at 9:30 AM, Surveyor #1 toured the third floor unit and observed a Certified Nursing Aide (CNA #1), who was wearing a black surgical mask and was making the bed in Resident #44's room. The surveyor inquired to CNA #1 where Resident #44 was at present and CNA #1 stated that the Resident #44 was in physical therapy. Surveyor #1 interviewed Licensed Practical Nurse #1 regarding where Resident #44 was at present. The nurse stated that Resident #44 had tested COVID-19 positive and had been transferred to the 1st floor COVID-19 unit and CNA #1 was not made aware. CNA #1 was not tested for COVID-19 on 09/21/22, when she had been assigned to provide care for Resident #44 while the resident was symptomatic for COVID-19 on 09/20/22, and had tested COVID-19 positive on 09/21/22. Part 2 The facility infection preventionist failed to ensure a system was in place, and was followed to ensure the all staff who required weekly, or bi-weekly COVID-19 testing was implemented and documented during a COVID-19 outbreak. This resulted in an IJ situation that was identified on 10/11/22 at 2:03 PM, when the facility failed to complete required COVID-19 testing which placed all residents and staff at risk for contracting a contagious and potentially deadly virus. The facility submitted an acceptable removal plan on 10/12/22 at 1:42 PM. The survey team verified the removal plan as implemented during an onsite survey on 10/12/22 at 2:35 PM. The deficient practice was evidenced by the following: On 09/23/22 at 9:42 AM, Surveyor #2 conducted an interview with LPN #1 who stated she was not vaccinated, had a medical exemption, and was not fit tested . (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 09/26/22 at 12:02 PM and 2:18 PM, the Director of Nursing (DON) and Interim Infection Preventionist Licence Practical Nurse (IIPLPN), respectively provided the staff vaccination matrix and both did not include LPN #1. The DON confirmed at 12:05 PM, that the facility vaccination matrix had not been completed until the past weekend. On 10/04/22 at 11:19 AM, Surveyor #1 conducted an interview with the IIPLPN, in the presence of the survey team regarding what the frequency was for testing staff that were not up to date with COVID-19 vaccines. She stated it depended on the county rate and the staff should be tested on ce or twice per week, and we are low, so we are testing everyone every three to five days because of the outbreak. The IIPLPN stated that staff that was not up to date with COVID vaccinations should also have been wearing N-95 respirator masks when they provided care. At that time, Surveyor #1 requested that the IIPLPN review the facility Outbreak Response Plan regarding any guidance for facility testing for information regarding testing. The IIPLPN stated testing was once or twice per week, she did not write the facility policy, and she had reviewed it. On 10/06/22 at 1:46 PM, Surveyor #1 interviewed the IIPLPN in the presence of the team regarding the staff COVID-19 vaccination requirements. The facility had been informing staff that they must receive a COVID-19 booster. The surveyor inquired regarding if the staff that are not fully vaccinated are being tested for COVID-19. The IIPLPN stated I am going to say no, and stated the facility was in an outbreak and they were tested for that. Surveyor #3 inquired to what testing frequency should have been completed. The IIPLPN stated that everyone should have been tested twice per week due to the current COVID-19 outbreak, and confirmed the facility testing lists were not consistent and were not updated. On 10/06/22 at 2:09 PM, Surveyor #3 conducted an interview with the IIPLPN in the presence of the survey team. The IIPLPN acknowledged that all staff were currently not up to date with their COVID-19 vaccinations, and the vaccination staff tracking was not current. The IIPLPN stated this was not known until she assumed the role of IIPLPN. The IIPLPN was unable to provide any documentation and confirmed staff that were currently not up to date or exempted from receiving the COVID-19 vaccination, were not being tested for COVID-19 the way they should be tested , which was twice per week during an outbreak which began on 06/24/22. On 10/07/22 at 11:52 AM, Surveyor #2 observed LPN #1 providing care on 09/21/22, 09/22/22, 09/24/22, 09/26/22, 09/28/22, 09/29/22, 09/30/22, 10/03/22, 10/04/22 and 10/06/22. During all observations, LPN #1 was observed wearing a black surgical mask. The LPN #1 stated she had cared for the Unsampled third floor Resident who was symptomatic, and then tested COVID-19 positive on 10/06/22. LPN #1 stated she had been working at the facility for four months, and confirmed to the survey team that she had not been fit tested for an N95 respirator mask. On 10/11/22 10:51 AM, the IIPLPN, in the presence of the LNHA, provided an updated vaccination list to the survey team. Surveyor #1 inquired to the LNHA and IIPLPN why the list was provided today and the IIPLPN stated I did it yesterday and I don't have an answer why it was not done earlier. The IILPN stated there are a lot of components to this program and I cannot fix it in a week or two. The LNHA stated I was aware, when asked if he knew the vaccination list was incomplete, and the IILPN stated she was not aware that the vaccination list was incomplete. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of the facility's policy, Update to COVID Vaccination and Testing dated 04/06/22 and facility reviewed on 9/2/2022, revealed Policy: It is the policy of [redacted] Rehabilitation and Care Center to offer COVID-19 vaccination and testing as per CDC and DOH guidance as a preventative health measure to reduce the risk of infection from COVID 19. Based on the above definitions, CMS has set the requirement that if staff have not received a COVID booster they are not considered up to date and will require routine testing in accordance with CDC community transmission rates. A review of the facility's policy, COVID 19 Management (All Policies), revised on 5/31/2022, revealed; Staff COVID 19 Vaccination and Testing Requirements, Procedure: Employee Vaccinations for COVID 19 (per DOH order summary action). This facility will track and securely document the COVID 19 vaccination and/or testing status of all staff including vaccination booster doses. 3. All employees of this facility must be fully vaccinated including booster vaccinations as they are mandated or have an approved medical exemption. 4. For Staff whom are partially vaccinated (one dose for multi-dose vaccine schedule or those who are eligible for the booster vaccines as it is mandated): at minimum perform weekly testing and use of NIOSH N95 or equivalent for source control, 12. All employees, contract staff and medical staff will be tested for COVID-19 as per the most current guidelines. A review of the facility's policy, Outbreak Plan/COVID-19 Response, revised 3/10/22, revealed Guidelines: Testing of Nursing Home Staff and Residents to enhance efforts to keep COVID-19 from entering and spreading through nursing homes, facilities are required to test residents and staff based on parameters and a frequency set for the the HHS Secretary. 41858 The non-compliance remained on 10/12/22, for no actual harm with the potential for more than minimal harm that was not IJ evidenced by the following: 1. Based on interview and review of facility documentation, it was determined that the facility failed to test unvaccinated staff for Coronavirus Disease 2019 (COVID-19) at a frequency based on the facility's policy, COVID 19 Management (All Policies). This deficient practice was identified for 3 of 3 staff members reviewed for COVID-19 testing and was evidenced by the following: On 09/26/22 at 12:02 PM, the DON provided the Staff Vaccination Matrix (SVM) to the survey team, she confirmed it was completed over the weekend because they did not have staff vaccination cards prior to that time. On 09/26/22 at 2:18 PM, the IIPLPN provided an updated SVM to the survey team. On 10/05/22 at 9:37 AM, after a review of the SVM in the presence of the survey team, the RLNHA, the LNHA, the Regional Nurse (RN) and the DON, Surveyor #3 requested 9 weeks of testing from August 1, 2022 for the two staff members identified by the facility as having COVID-19 vaccination exemptions, and one partially vaccinated staff member as listed on the SVM. A review of the testing from August 1,2022 provided by the Regional Administrator (RA) on 10/5/22 at 10:53 AM, revealed the following: A. The Staffing Coordinator tested negative on 9/28/22 and 10/4/22. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	B. LPN # 3 tested negative 8/17/22. C. Temporary Nurses Aide (TNA) #1 tested negative on 8/17/22 and 9/28/22. On 10/05/22 at 1:18 PM, in the presence of the survey team, the RLNHA confirmed that the above provided testing was the only COVID-19 testing that could be located for the prior nine weeks beginning August 1, 2022 and confirmed that the facility's Outbreak started 06/24/22. On 10/06/22 at 1:50 PM, in the presence of the survey team, Surveyor #3 interviewed the IIPLPN. The IIPLPN reviewed the facility's policy COVID 19 Management (All Policies), and confirmed that all staff who are exempt or not up to date with the COVID-19 vaccine should be tested for COVID-19 at least once a week but they are not. Surveyor #3 reviewed the testing for the above listed staff members with the IIPLPN. She then stated that staff with an exemption or partially vaccinated should be tested twice a week during an outbreak. She stated LPN #3 works per diem (as needed). Surveyor #1 confirmed LPN #3 worked on 9/16/22, the IIPLPN confirmed that there was not testing provided for 9/16/22, but she should have been tested that day. She further stated, if staff with an exemption work per diem they should test when they come to work. She stated that the Staffing Coordinator was here every day so she should have been tested twice a week and TNA #1 is not fully vaccinated and should have been tested twice a week. The IIPLPN acknowledged that staff that are exempt and/or not up to date were not being tested the way that they should be during an outbreak, which was twice a week and according to the facility's policy, which was once a week. On 10/06/22 at 02:45 PM, in the presence of the survey team, Surveyor #3 made the IIPLPN, the LNHA, the DON, and the RA aware of the above concerns with testing of employees that were not up to date with their vaccination. A review of the facility's policy, COVID 19 Management (All Policies) revised on 5/31/2022, revealed; Staff COVID 19 Vaccination and Testing Requirements, Procedure: 3. All employees of this facility must be fully vaccinated including booster vaccinations as they are mandated or have an approved medical exemption. 4. For Staff whom are partially vaccinated (one dose for multi-dose vaccine schedule or those who are eligible for the booster vaccines as it is mandated): at minimum perform weekly testing, 12. All employees, contract staff and medical staff will be tested for COVID-19 as per the most current guidelines. N.J.A.C. 8:39-5.1(a)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 45449 Based on interview, medical record review, and review of other pertinent facility documents, it was determined that the facility failed to offer a resident a COVID-19 Immunization. This deficient practice was identified for 1 of 5 residents reviewed for immunization (Resident #11). The deficient practice was evidenced by the following: On 09/26/22 09:18 AM, the surveyor reviewed Resident #11's medical record which revealed the following information: Review of the Resident Face Sheet Record (an admission summary) revealed that Resident # 11 had been admitted to the facility with diagnoses which included but were not limited to dementia, acute embolism, thrombosis of lower extremities and an International Classification of Diseases, 10th Revision (ICD-10; a diagnostic and procedure coding system) of Z28.39 other under immunization (is for reporting when a patient is not current on other, non-COVID vaccines). Review of Resident #11's active Care Plan (CP) printed on 10/03/22 did not reveal any focus, goals, or interventions for vaccinations. Review of Resident #11's electronic Medical Record (eMR) under Preventative Health did not reveal a Covid-19 Immunization administration record. Review of Resident #11's Immunization Record from Resident #11's paper medical record did not reveal a Covid-19 Immunization administration record. On 09/28/22 at 12:58 PM, the concern regarding COVID-19 Immunization status, where no documentation that it was offered, administered, refused and no education provided was brought to the attention of the Unit Manager Registered Nurse (UM/RN) and the Director of Nursing (DON) and any additional information was requested. 09/29/22 at 11:08 AM, during an interview with the surveyor, Resident #11 stated he/she had not been offered any vaccinations but if his/her doctor or nurse recommended it, I will do it. On 10/04/22 at 10:46 AM, during an interview with the surveyor, UM/RN stated she did not find additional information regarding Covid-19 Immunization for Resident #11. She acknowledged that the immunization should have been care planned since the Resident did not have all the vaccinations as documented on the resident's face sheet. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/06/22 at 2:32 PM, the concern regarding Resident #11's Covid-19 Immunization status, where no documentation that it was offered, administered, refused and no education provided was brought to the attention of the DON in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA), and the Regional LNHA and any additional information was requested. On 10/12/22 at 12:40 PM, in the presence of the survey team, the Regional Nurse and Regional LNHA confirmed that no additional information could be provided. Review of the facility provided, Vaccination of Residents/COVID-19 policy reviewed 1/5/2022, included but was not limited to the following: Policy Statement: All residents will be offered COVID-19 vaccines to aid on preventing infectious disease unless the vaccine is medically contraindicated, or the resident has already been vaccinated. Policy Interpretation and Implementation: 1. Prior to receiving vaccination, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations . 2. Provisions if such education shall be documented in the resident's medical record. 5. If vaccines are refused, the refusal shall be documented in the resident's medical record. 6. If the resident receives a vaccine, at least the following information shall be documented in the resident's medical record: a. Site of administration b. Date of administration c. Lot number of the vaccine (located on the vial); d. Expiration date e. Name of the person administering the vaccine. N.J.A.C. 8:39-19.4(a)

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F 0888 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure staff are vaccinated for COVID-19 31654 Based on interview, record review and document review, it was determined that the facility failed to: a.) ensure the facility policy, Centers for Disease Control and Prevention (CDC), and Centers for Medicare and Medicaid Services (CMS) for COVID-19 vaccinations was implemented to ensure that all staff were up to date with COVID-19 vaccinations, or have been granted a qualifying exemption during a COVID-19 outbreak that began on 06/24/22; and, b.) ensure all staff that were not up to date with vaccinations, or had been granted a qualifying exemption were not permitted to work in the facility. The facility's failure to take immediate action, follow Centers for Medicare and Medicaid Services (CMS) guidance, Centers for Disease Control and Prevention (CDC), and facility policies to limit exposure risks placed all residents and staff at risk for contracting COVID-19, a deadly contagious virus. Reference: Centers for Disease Control and Prevention, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, Updated September 23, 2022 Refer to F880 and F886 The failure to ensure all staff were up to date with COVID-19 vaccinations or granted a qualifying exemption during a COVID-19 outbreak were not permitted to work in the facility placed all residents and staff at risk for contracting a contagious, potentially deadly virus. This situation resulted in an Immediate Jeopardy (IJ), which began on 06/24/22 when a Licensed Practical Nurse (LPN #1), who was unvaccinated for COVID-19, without having a qualifying exemption, proceeded to work forty-seven shifts from the start of the facility outbreak on 06/24/22 until 10/10/22. The IJ was identified on 10/11/22 at 2:03 PM. The facility administration was notified of the IJ on 10/11/22 at 2:03 PM. The facility submitted an acceptable removal plan on 10/12/22 at 01:42 PM. The IJ removal plan was verified as implemented during an onsite visit on 10/12/22 at 02:35 PM. The evidence was as follows: On 09/21/22 at 9:09 AM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA) stated that the facility was currently in outbreak status for COVID-19, and the outbreak was three days from ending. (continued on next page)

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F 0888 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 09/21/22 at 1:09 PM, Surveyor #1 conducted an entrance conference with the LNHA and the Director of Nursing (DON). During the entrance conference, Surveyor #1 requested the facility infection control policies related to COVID-19 and the COVID-19 Staff Vaccination Matrix. The LNHA and DON confirmed the Uncertified Registered Nurse Infection Preventist (URNIP) did not have an infection control certification and that she was responsible for all of the COVID-19 vaccination efforts. The LNHA stated that the URNIP has all of the documents and noted that there was currently no symptomatic resident in the facility. On 09/22/22 at 3:42 PM, in the presence of the survey team, the URNIP stated that not everyone was tested twice weekly. When the survey team asked the criteria for the staff to be tested , she said, if some people feel like they have a cold, they would be tested and that currently, there were no staff members that needed to be tested . The URNIP confirmed that her log was the only facility testing document at that time. The survey team inquired to the URNIP regarding the staff vaccination list, and the URNIP stated that she did not have a completed list for the staff's COVID-19 vaccination status. On 09/23/22 at 11:34 AM, the survey team interviewed the LNHA and DON regarding the National Health and Safety Network information that is required to be submitted. The LNHA confirmed that he inputted the data and that there was no current employee vaccination list since not all employees were on it. The DON stated, I am not making up what I don't have. On 09/22/22 at 9:43 AM, the DON and LNHA informed the survey team that two residents (Resident #44 & Resident #52) had tested COVID-19 positive and had been moved to the first floor for isolation. The LNHA stated the positive results were identified during routine COVID-19 testing. On 09/22/22 at 9:55 AM, the DON and LNHA failed to provide the survey team with the requested infection control documents, which included the staff vaccination and staff and resident testing documentation. The LNHA stated the documents were now with the corporate people, and he could not produce the documents. On 09/23/22 at 8:53 AM, Surveyor #1 observed LPN #2 on the second-floor medication cart wearing a surgical mask. Surveyor #1 then interviewed LPN #2, who stated she was a new hire. The surveyor asked LPN #2 if she was vaccinated for COVID-19 and if she had been fit tested for an N-95 mask. LPN #2 replied, not fit tested , not boosted (a test to determine if a respirator mask appropriately fits to protect the wearer). She stated she was vaccinated for COVID-19 and confirmed that the facility was aware that she was not boosted. LPN #2 said that she signed a waiver form that the facility provided since she did not want a COVID-19 booster. Surveyor #1 inquired to LPN #2 if she had received COVID-19 testing, and she stated that the facility would let her know if she needed to take a test and that she could also let the URNIP know if she needed to take a COVID-19 test. Surveyor #1 asked LPN #2 if she was assigned to a particular unit. LPN #2 replied that she floated to different units. (continued on next page)

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F 0888 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/06/22 at 12:30 PM, Surveyor #1 observed LPN #2 on the 1st floor COVID-19 unit at the nursing station wearing a National Institute of Occupational Safety and Health (NIOSH) N-95 mask. Surveyor #1 further inquired about what N-95 mask she was required to wear. LPN #2 removed two different masks from the bins outside a resident room and told the surveyor that she could wear either one. LPN #2 stated the mask Surveyor #1 was wearing (N95 #8210) was very tight, and she said that she was fit tested for both masks by the Interim Licensed Practical Nurse Infection Preventist (ILPNIP). Surveyor #1 inquired if LPN #2 had a medical or religious exemption for the COVID-19 booster. LPN #2 reiterated that she had signed a paper waiver provided by the facility, which indicated she did not want the booster and stated no; it was not a medical or a religious exemption, only that it was a document that offered risks and benefits. On 10/06/22 at 1:46 PM, surveyor #3 interviewed the ILPNIP in the presence of the survey team. The ILPNIP stated that the facility had been telling staff they must get boosted for COVID-19. The ILPNIP said the facility should have a list of all the employees, a copy of the vaccination cards, and a spreadsheet to track when everyone was due. When asked about the new hire process, the ILPNIP stated the new hires should have received a booster or provided proof of COVID-19 Vaccination status. She then said, I mean, anyone can decline, and they shouldn't be employed in healthcare [if the COVID-19 vaccines are declined]. The ILPNIP stated it was mandated to be up to date with COVID-19 vaccines, per the federal government, Centers for Disease Service (CDC), and the state government. At that time, the ILPNIP confirmed that all staff were not up to date with COVID-19 vaccines and stated, I am acknowledging now since she had not been aware of all staff not being up to date with COVID-19 vaccines and she also confirmed that the staff were not being tested twice per week. On 10/07/22 at 11:01 AM, Surveyor #1 interviewed the Regional Licensed Nursing Home Administrator (RLNHA) regarding agency staff's vaccination status before working at the facility. The RLNHA confirmed there was no system in place to ensure that the staffing agencies were sending fully vaccinated staff who had been fit tested for N-95 masks. On 10/07/22 at 11:52 AM, surveyor #2 had observed LPN #1 providing care on 09/21/22, 09/22/22, 09/24/22, 09/26/22, 09/28/22, 09/29/22, 09/30/22, 10/03/22, 10/04/22 and 10/06/22. LPN #1 was wearing a black surgical mask during all observations. LPN #1 stated she had cared for the unsampled third-floor resident, who was symptomatic and tested COVID-19 positive on 10/06/22. LPN #1 stated she had worked at the facility for four months and confirmed she had not been fit tested for an N95 mask. On 10/07/22 at 12:58 PM, the ILPNIP provided the facility line listing, which revealed a symptomatic unsampled COVID-19-positive resident was identified on the third floor on 10/06/22. On 10/07/22 at 1:01 PM, the ILPNIP confirmed that LPN #2 was not up to date with her COVID-19 vaccines, and the ILPNIP confirmed she had been unaware. The ILPNIP stated, I will be honest with you she did not know why LPN #2 got through the system. The ILPNIP said there was no form she was aware of that the facility provided to staff for declining a COVID-19 vaccination. The ILPNIP stated, from my understanding, everyone needs to be up to date on their vaccines. The ILPNIP noted that once she had a complete list of the unvaccinated staff, the staff would have to find another place to work if the staff refused to vaccinate. (continued on next page)

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F 0888 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/11/22 at 8:49 AM, the ILPNIP provided a copy of the Resident/Employee Contact Tracing Record dated 10/11/22. The document revealed that LPN #1 was identified as the nurse who cared for eight residents who tested COVID-19 positive, including Residents # 44 and #52, who tested COVID-19 positive on 09/21/22 and the unsampled resident on 10/6/22; All eight residents resided on the third floor. LPN #2 was identified as a close contact for two residents, Resident #10 and an unsampled resident, on 10/03/22, who resided on the third floor. On 10/11/22 at 12:53 PM, the facility Human Resources Manager (HRM) provided the survey team with Time Card detail for LPN #1 and LPN #2. LPN # 1 worked forty-seven shifts since the facility outbreak began on 06/24/22, which was revealed in the Time Card detail from 06/21/22 through 10/11/22. LPN #2 worked twenty shifts from 09/19/22 through 10/11/22. 41858 The non-compliance remained on 10/12/22 for no actual harm with the potential for more than minimal harm that is not IJ based on the following: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to: a.) develop and implement a policy to track and document facility staff vaccination status to ensure all eligible staff were vaccinated by the required dates; and, b.) follow the facility policy for contingency plans by failing to ensure unvaccinated staff wore an N95 respirator mask (a tight-fitting mask that protected the wearer from air particles) to mitigate the potential spread of COVID-19. This deficient practice was evidenced by the following: On 09/26/22 at 12:02 PM, five days after the survey began on 09/21/22, the DON provided the Staff Vaccination Matrix (SVM) to the survey team. She confirmed it was completed over the weekend because they did not have staff vaccination cards. On 09/26/22 at 2:18 PM, the ILPNIP provided an updated SVM to the survey team. A review of the SVM revealed that there were 94 total staff, 85 completely vaccinated staff, four partially vaccinated staff, two staff granted an exemption, and three staff temporary delay/new hires. Of the 94 total staff, 29 staff did not receive the booster dose. The SVM revealed that 62 staff of the 94 were up to date (received all recommended COVID-19 vaccines, including any booster dose (s) when eligible) with the vaccination requirement. A review was completed of the National Healthcare Safety Network (NHSN) data regarding the facility's reported percentage of fully vaccinated staff for the week ending 09/04/22. The facility reported the ratio of staff fully vaccinated was 100%. A review of the facility-provided SVM revealed that 95.7% of staff were vaccinated. On 10/04/22 at 2:10 PM, Surveyor #3 interviewed the Staffing Coordinator (SC), who stated she had a medical exemption. When asked what PPE she had to wear in the building, she said she wore a surgical mask, but she was told she had to wear an N95 if she had to go into a COVID-positive room. (continued on next page)

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F 0888 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/05/22 at 11:26 AM, Surveyor #3 observed the SC, wearing a surgical mask, on the 3rd floor at the nurses' station, conversing with one resident and one staff member. On 10/05/22 at 1:00 PM, Surveyor #3 requested testing for LPN#3, who was listed as a temporary delay per CDC/new hire on SVM from the Regional Administrator (RA). The RA gave the surveyor a copy of LPN #3's vaccination card, which showed she was fully vaccinated and boosted. Therefore, no testing was required. On 10/06/22 at 8:40 AM, the ILPNIP provided an updated SVM to the survey team. On 10/06/22 at 9:34 AM, Surveyor #3 observed the Maintenance Director (MD) (listed on the SVM as completely vaccinated but had not received the booster dose) touring the facility on the 2nd floor with the Life safety surveyor. The Maintenance Director wore a surgical mask. On 10/06/22 at 12:15 PM, Surveyor #4 interviewed CNA #1 while working on the 2nd floor. CNA #1 stated she received two doses of the COVID-19 vaccination. She wore a surgical mask and stated that this was what she had to wear in the building unless she cared for residents with COVID, then she would wear goggles, an N95, and a gown. A review of the SVM revealed CNA#1 was listed on the SVM as completely vaccinated but had not received the booster dose. On 10/06/22 at 12:42 PM, Surveyor #4 interviewed TNA #1, who stated she had two vaccinations but needed a booster that was due in July and was going to get the booster soon. She wore a surgical mask, and she stated that she could wear a surgical mask. She said she would need to wear an N95, a gown, gloves, and a face shield with Covid residents. TNA# 1 stated that right now, on the third floor, it was okay for her to wear a surgical mask. A review of the SVM revealed TNA#1 was listed on the SVM and was listed as partially vaccinated. On 10/06/22 at 1:50 PM, in the presence of the survey team, Surveyor #3 interviewed the ILPNIP. The ILPNIP reviewed the facility's policy, COVID-19 Management (A Policies), and confirmed that all staff who are exempt or not up to date should be wearing an N95, but they are not. She stated that staff is being told that they must be up to date and that it is mandated. The ILPNIP noted that staff would be removed from the schedule if they refused and did not have an approved exemption. At that time, the ILPNIP stated that they should have a list of all employees, copies of their vaccination cards, and a spreadsheet to track how many doses staff had received. She stated that new hires should have had to show their vaccination card. Surveyor #3 asked if employees could decline the COVID vaccine without an approved exemption. The ILPNIP stated that if that was the case, they should not be employed in healthcare . She said employees could not sign a declination form for the COVID-19 vaccine. She further stated that the Centers for Disease Control mandated at the Federal and State levels that everybody in healthcare must be up to date. Surveyor #3 reviewed the SVM and the vaccination cards with the ILPNIP, who acknowledged that there were inconsistencies. (continued on next page)

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F 0888 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/06/22 at 2:09 PM, in the presence of the survey team, the ILPNIP stated, I totally acknowledge staff are not up to date, tracking employees was not current, but we weren't aware until I took over the Infection Preventionist role. She then acknowledged that staff that was exempt or were not up to date were not being tested the way they should be during a COVID-19 outbreak, which was twice weekly. On 10/06/22 at 02:45 PM, in the presence of the survey team, Surveyor #3 made the ILPNIP, the LNHA, the DON, and the RA aware of the above concerns with employees not being boosted, employee vaccination not being tracked, and with employees that are exempt or not up to date wearing proper personal protection equipment according to the facility policy. A review of the SVM received on 10/06/22 from the ILPNIP which revealed the vaccination list, who is not up to date (IP List) received 10/10/22, staff vaccination cards and interviews revealed the following: 1. The LNHA was listed on the SVM as up to date, on the ILPNIP list as needing booster, vaccination card #1 (name redacted) lot #EN5318 02/03/21 hamilton; (name redacted) lot # EN5318 02/03/21 [another facility name] post-acute vaccination card # 2 1st (name redacted) [pharmacy name] and 2nd dose (name redacted) [pharmacy name], no date, boosted (name redacted) 03/31/22 generation pharmacy. On 10/11/22 at 10:52 AM, in the presence of the survey team, the LNHA stated he was up to date on his vaccines and provided proof. 2. Unit Secretary (US) #1 was listed on the SVM as up to date, on the ILPNIP list as needing a booster, vaccination card: (name redacted), 4/22/21, 5/20/21, 11/15/21. On 10/12/22 at 9:46 AM, Surveyor #3 interviewed US#1, stating she was up to date on her vaccines. 3. Housekeeper (HSK) #1 was listed on the SVM as completely vaccinated and needs a booster dose. On the IP list, nothing was recorded. Vaccination card: (name redacted) 06/28/22, 07/18/22, on 10/12/22 at 9:51 AM. Surveyor #3 interviewed HSK #1, who stated he was up to date on his vaccines. 4. LPN #4 was listed on the SVM as up to date, on the ILPNIP list as needing booster, vaccination card: (name redacted) 07/16/21, 08/06/2. On 10/12/22 at 9:53 AM, Surveyor #3 interviewed LPN #4, who stated she was up to date on her vaccines. 5. Behavior Aide (BA) #1 was listed on the SVM as partially vaccinated, on the ILPNIP list as needing a booster, vaccination card: (name redacted), 06/31/22. On 10/05/22 at 11:28 AM, Surveyor #3 interviewed BA #1, who stated she was up to date on her vaccines and gave the facility a copy of her vaccination card. On 10/12/22 at 9:56 AM, Surveyor #3 observed CNA#1 on the 2nd floor wearing a surgical mask. During an interview at that time, CNA#1 stated, I was told yesterday I need to get the booster today. On 10/12/22 at 1:46 PM, Surveyor #3 observed the SC on the 2nd floor wearing a surgical mask. (continued on next page)

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F 0888 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/12/22 at 2:00 PM, in the presence of the survey team, Surveyor #3 made the RA and Regional Nurse aware that CNA#1 and the SC were observed wearing only surgical masks, as mentioned above. They both acknowledged that the facility's policy was if not up to date or exemptions, staff should have been wearing an N95. A review of the facility's policy, COVID-19 Management (All Policies), revised on 5/31/2022, revealed it is the policy of this facility to follow CDC and DOH [Department of Health] guidelines for the management of the COVID-19 (Sars-COV-2). The policy addressed Staff COVID-19 Vaccination and Testing Requirements, Procedure: Employee Vaccinations for COVID-19 (per DOH order summary action). This facility will track and securely document the COVID-19 vaccination and/or testing status of all staff, including vaccination booster doses. Staff who need an exemption form can request it from Human Resources or their Department Head. Procedure: 3. All employees of this facility must be fully vaccinated, including booster vaccinations, as they are mandated or have an approved medical exemption. 4. For Staff who are partially vaccinated (one dose for multi-dose vaccine schedule or those who are eligible for the booster vaccines as it is mandated): Use of NIOSH-approved N95 or equivalent for source control. 5. Providing all personnel who decline to be vaccinated a written affirmation for their signature, which signifies that they were offered the opportunity for a COVID-19 vaccination but declined. For employees, the reason for declination must fall into a medical reason or religious reason. 7. Upon request from the DOH, the following must be presented: a. number and percentage of personnel that have been vaccinated for COVID-19, b. Number and percentage of personnel for which medical exemptions have been granted, c. The total number of covered personnel. 8. For staff who are not vaccinated do not fall into the exemption or are temporarily delayed in obtaining the vaccine as it is mandated and staffing is in crisis levels. a. This facility will communicate the staffing crisis to the appropriate government agency and will attempt to place identified staff members who aren't fully vaccinated in non-resident areas and to duties that can be performed remotely (i.e., telework), or to duties which limit exposure to those most at risk (e.g. assigning to residents who are not immunocompromised, unvaccinated). 9. This facility will require staff who have not completed their primary vaccination series (including .been granted an exemption or who have a temporary delay) to follow addition CDC-recommended precautions, such as adhering to universal source control and physical distancing measures in areas that are restricted from resident access, even if the facility or service site is located in a county with low to moderate community transmission. 10. Any employee who refuses testing and is not fully vaccinated per the current guidelines will not be permitted to work in this facility. N.J.A.C. 8:39-9.3(c);19.1(b); 19.4(a)

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Put firmly secured handrails on each side of hallways. 38079 Based on observation, interview, and document review, it was determined that the facility failed to ensure corridors were equipped with firmly secured handrails on 1 of 3 floors (second floor) and was evidenced by the following: On 09/21/22 at 12:21 PM, the surveyor in the presence of a second surveyor was touring the second floor and observed the handrails from the elevator door located in front of the second floor conference room to be unsecure. The surveyors observed the handrail from the elevator to the corner of the low side corridor was visibly leaning outward. The surveyor was able to touch the handrail and it was observed to have almost completely separated from where it was screwed into the wall. The surveyors observed the attached corner handrail, that was meant to hold two handrails together, which was visibly partially separated from the two handrails causing another handrail on the low side corridor to become unsecured. The surveyors next observed the handrail from the elevator towards the high side corridor was visibly leaning outward with a corner handrail piece which was partially unattached to the loose handrail. On 09/21/22 at 12:23 PM, the Licensed Nursing Home Administrator (LNHA) was observed on the second floor. The two surveyors showed the handrails to the LNHA. At that time, the LNHA confirmed the handrails were loose. He stated all handrails should be secured so no one gets hurt. He further stated he performed walking rounds daily and he had not identified the loose handrails earlier that day. A review of the Centers for Medicare and Medicaid Services (CMS) Reference S&C-07-07 dated 12/21/06, included but was not limited to the purpose of the handrail requirements is to assist residents with ambulation and/or wheelchair navigation. They are a safety device as well as a mobility enhancer for those residents who need assistance. On 10/07/22, the above concern was presented to the administrative staff. As of exit day on 10/12/22, the facility had no additional information to provide. N.J.A.C. 8:39-31.2(e)