STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315522	A. Building B. Wing	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accelerate Skilled Nursing and Rehab Piscataway	10 Sterling Drive Piscataway, NJ 08854

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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 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** 37217 Based on observation, interview, and record review it was determined that the facility failed to develop and/or implement a person-centered comprehensive care plan that addressed all of the resident's medical needs and diagnosis for 6 of 14 residents (Residents #52, #235, #14, #21, #56 and #50) reviewed for comprehensive care plans. The deficient practice was evidenced by the following: 1. On 1/3/23 at 11:05 AM, the surveyor observed Resident #52 lying in the bed, alert and awake. Resident #52 stated they were admitted to the facility to receive intravenous (IV) antibiotic therapy and showed to the surveyor the IV access site to the right arm. The surveyor reviewed the hybrid medical record of Resident #52 which revealed the following: The Admission Minimum Data Set (MDS) assessment, dated 12/7/22, which indicated the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored a 15 out of 15 which indicated that that the resident was cognitively intact. The MDS assessment also indicated the resident had active diagnoses of chronic frontal sinusitis and other local infections of the skin and subcutaneous tissue. Physician's orders for Resident #52, dated 12/10/22, which read: Ertapenem [an antibiotic medication] Sodium Solution Reconstituted 1 GM Use 1 gram intravenously one time a day for Sinus Infection until 01/11/2023. A review of the resident's progress notes, dated 12/16/22, indicated the resident had a midline [a long, thin flexible tune that is inserted into a large vein in the upper arm to give IV treatments] access site to the right upper arm. A review of the resident's care plans, revealed there was no care plan related to the resident's sinus infection diagnosis or receiving an antibiotic medication. (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/9/23 at 12:49 PM, the surveyor interviewed Registered Nurse #3 (RN #3) about care plans and Resident #52. RN#3 stated care plans were initiated by nurses upon admission and triggered on the resident's admission assessment. RN# 3 stated residents on antibiotics should have care plans based on their infection. The surveyor with RN #3 reviewed the care plans for Resident #52. There was no care plan for the resident's antibiotic treatment or primary diagnosis of sinusitis (sinus infection). RN#3 acknowledged Resident #52 should have had a care plan for their antibiotic treatment. RN# 3 further stated the Director of Nursing (DON), managers, and charge nurses were responsible for reviewing and updating care plans. On 1/12/23 at 10:46 AM, the surveyor interviewed the Infection Preventionist (IP) about care planning and Resident #52. The IP stated it would be expected for residents receiving antibiotic treatment to have a care plan. The surveyor informed the IP of discussion with RN#3 and that there was no care plan for Resident #52 who was receiving IV antibiotic treatment. On 1/12/23 at 1:54 PM, the surveyor informed the Administrator, Quality Assurance Consultant #1 (QAC #1), QAC #2, and Regional Director of Operations of the care plan concerns for Resident #52. There was no verbal response provided. On 1/13/23 at 10:44 AM, the surveyor met with the Administrator, Medical Director, QAC #1, and IP. QAC #1 stated the resident was discharged home that morning and no further information could be presented. 2. On 1/3/23 at 12:32 PM, the surveyor observed Resident #235 sitting at the bedside, alert and awake. Resident #235 was on Transmission-Based Precautions (TBP) [for known or suspected individuals with infectious agents which require additional measures to prevent transmission] for COVID-19. Resident #235 was aware they had been quarantined on TBP for a couple of days due to testing positive for COVID-19. The surveyor reviewed the electronic medical record (EMR) of Resident #235 which revealed the following: The Admission Minimum Data Set (MDS) assessment, dated 12/7/22, which indicated the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored a 10 out of 15 which indicated that the resident had moderate cognitive impairment. The MDS assessment also indicated the resident had active diagnoses that included: Diabetes Mellitus with foot ulcer, coronary artery disease, and heart failure. Physician's order for Resident #235, dated 1/2/23, which read: Paxlovid Tablet Therapy Pack 20 x 150 MG & 10 x 100 MG (Nirmatrelvir &Ritonavir) Give 3 tablet by mouth two times a day for COVID infection for 5 Days. There was no physician order for TBP for the resident. A review of the resident's progress notes indicated the resident had tested positive for COVID-19 on 1/2/23 after reporting symptoms that included chills, muscle aches, and cough. The resident was placed on TBP and started on Paxlovid medication treatment. A review of the resident's care plans, revealed there was no care plan related to the resident's COVID-19 diagnosis and having TBP in place. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/09/23 11:08 AM, the surveyor interviewed RN #3 about care plans. RN#3 stated care plans were initiated by nurses upon admission and triggered on the resident's admission assessment. RN# 3 stated residents should have care plans based on their infection and treatment. RN#3 acknowledged residents who were COVID positive or who were on TBP should have a care plan in place. On 1/11/23 at 12:53 PM, the surveyor informed the DON of the interview with RN#3 and that there was no COVID-19 care plan for Resident #235. The DON stated there should be a care plan for COVID-19 positive residents and residents on TBP. The surveyor informed the DON that there were no care plans found for Resident #235 related to COVID-19 positive diagnosis or TBP. The DON acknowledged the resident should have had a care plan and would review. On 1/12/23 at 1:54 PM, the surveyor informed the Administrator, Quality Assurance Consultant #1 (QAC #1), QAC #2, and Regional Director of Operations of the care plans concerns for Resident #235. There was no verbal response. On 1/13/23 at 10:44 AM, the surveyor met with the Administrator, Medical Director, QAC #1, and IP. QAC #1 stated no further information could be presented as the resident was already discharged home. 3. During the initial tour of the facility on 01/03/23 at 10:03 AM, the surveyor observed Resident #14 sitting in the wheelchair with oxygen administered by nasal tubing. The oxygen tubing was dated 01/03/23. According to the Admission Record, Resident #14 was admitted to the facility with diagnoses which included, but were not limited to, Atherosclerotic Heart Disease (buildup of plaque in arteries causing reduced blood flow), muscle weakness, and reduced mobility. The resident's most recent Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 10/31/22, reflected that Resident #14 was confused. A review of the Electronic Medical Record physician orders on 01/06/23 at 10:02 AM, did not include a physician order for oxygen administration. A review of the January 2023 Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not include orders for oxygen administration. A review of the resident's Care Plan did not identify that Resident #14 used oxygen. The Director of Nursing (DON) provided Resident #14's Care Plan which revealed a Creation Date of 01/09/23 that the resident requires oxygen, with interventions that included, encourage resident positioning upright, and maintain oxygen use as ordered. During an interview with the surveyor on 01/09/23 at 12:03 PM, the assigned Licensed Practical Nurse (LPN) #1, reported that the unit manager was responsible for creating and updating care plans. LPN #1 further advised, There isn't one (a unit manager). If something needs to be added, I try to do it myself. But I don't have time. When asked if oxygen is a common care planned topic, LPN #1 reported, Yes, how long, when, how much. Upon reviewing the resident's care plan LPN #1 confirmed, I don't see it on the care plan. During an interview with the surveyor on 01/09/23 at 12:55 PM, the DON identified that oxygen should be identified on the care plan. Upon reviewing Resident #14's care plan, the DON confirmed, Yes, I don't see it on the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #56's Admission Minimum Data Set (MDS), an assessment tool dated 12/13/22, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated that the resident was fully, cognitively intact. The Functional Status portion of the MDS indicated that the resident required extensive assistance for bed mobility of one person and total dependence of one person for toileting. Review of Resident 56's care plan revealed an entry that was initiated on 12/16/22, Focus: The resident was at risk for ADL (activities of daily living) self-care deficit as evidenced by impaired mobility related to physical limitations/left BKA (below knee amputation), Goal: Resident to receive assistance necessary to meet ADL needs, Interventions: included: resident to have paired care (initiated on 12/16/22). The entry was revised by both the DON and the Infection Preventionist (IP). Further review of Resident #56's care plan revealed that on 01/04/23, the IP created an entry which revealed: Focus:Verbal agitation/aggression towards staff AEB (as evidenced by) using profanity and yelling to get out of his/her room. Goal: Will not be verbally aggressive towards others. Interventions included but were not limited to paired care. On 01/04/23 at 12:38 PM, the DON provided the surveyor with an investigation that was dated 12/22/22 at 6:00 PM, that was sent to the New Jersey Department of Health (NJDOH). Review of the investigation revealed that Resident #56 alleged that a nurse aide was rough while care was provided after the resident had diarrhea and felt that the aide had a bad attitude. The DON specified that the resident was placed on paired care going forth and a toileting schedule. The DON documented that the Certified Nursing Assistant (CNA) was suspended until the investigation was completed. Further review of the investigation revealed that the conclusion which included review of statements, and follow-up with the resident, the allegation was unsubstantiated, and the resident stated, I am receiving good care and I feel safe. Seven residents were interviewed, and no concerns were noted. During an interview with the surveyor on 01/11/23 at 11:41 AM, the surveyor interviewed the DON who stated that Paired Care was implemented after the resident's first allegation which occurred on 12/22/22. The DON stated that when the second allegation occurred on 01/02/22, the CNA admitted that she had not looked at the Kardex (a medical patient information system) prior to providing resident care, and went into the resident's room alone, instead of with another CNA as required in accordance with the resident's care plan. The DON stated that she had given the aides an in-service about paired care, but hand not provided them with any reference materials. On 01/11/23 at 12:35 PM, the surveyor observed Resident #35 lying in bed awake. The resident complained that his/her belly had not felt good but the nurse, Licensed Practical Nurse (LPN #3) checked the resident's vitals and performed a COVID test which was negative. The surveyor asked if the nurse attended to the resident alone or with another staff member. The resident stated that one nurse or one aide responded when the call bell was pressed. The resident stated that he/she had only seen the nurse today and the person who delivered the lunch tray. The resident further stated that everything had been great and there had been no further issues. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the surveyor on 01/11/23 at 12:45 PM, CNA #2 stated that she cared for Resident #56 quite a few times before. She described the resident as independent with care and stated that the resident required set up for care and transfers. She stated that when the resident had to get out of bed, she just locked the wheels on the chair and stood there for supervision. CNA #2 stated that she worked for an agency and floated throughout the facility where needed. CNA #2 stated that she had not reviewed Resident #56's Kardex since she began working at the facility on 01/03/23, as she had not gained access to the system. CNA #3 stated that she looked through other staff's access and did not see anything special noted for Resident #56. CNA #2 stated that they did not give any type of report at the facility otherwise. During an interview with the surveyor on 01/11/23 at 12:49 PM, LPN #3 stated that Resident #56 had behaviors and depression. LPN #3 stated the DON stated that two CNAs and two nurses must respond to the call bell when the resident called. When LPN #3 was asked if she went into the resident's room with another nurse she stated, I never had problems with the resident, I just help him/her right away. When the surveyor asked LPN #3 if she delegated to CNA #2 that two staff were required to respond to Resident #56's call bell, she stated that she did not think that CNA #2 who was assigned to the resident, knew that two aides were supposed to respond to the resident. LPN #3 stated that one day, she was unsure of the date, a CNA on the night shift was rude to the resident and she had reported it to the DON. LPN #3 stated that the DON did an in-service and told us to answer the light with two people after the incident. During an interview with the surveyor on 01/12/23 at 11:24 AM, the IP stated that Resident #56 was placed on paired care after an incident was called into the NJDOH. The Administrator who was present stated that the facility could not substantiate the resident's allegations and implemented the care plan. The facility was unable to provide the surveyor with documented evidence that care paired care was implemented as described within the resident's care plan. 6. During the initial tour of the facility on 01/03/23 at 11:45 AM, the surveyor observed Resident #50 seated in a wheelchair at the bedside. The resident had a left upper extremity dialysis access site that was covered with a 4 x 4 dressing that was not dated. The resident stated that he/she attended dialysis treatments on Monday, Wednesday and Friday from 11 AM to 3 PM. The resident stated that he/she was unsure if the facility staff monitored the access site post-treatment. According to the Admission Record Report (an admission summary), Resident #50 was admitted to the facility in November of 2022 with diagnosis which included but were not limited to: Type 2 Diabetes Mellitus (condition in which the body does not produce enough insulin or resists insulin), essential hypertension (high blood pressure) and depression. Review of Resident #50's Admission Minimum Data Set (MDS), an assessment tool dated 11/24/2022, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident was fully cognitively intact. Active diagnosis included but were not limited to: Amputation, renal insufficiency, renal failure or End-Stage Renal Disease (ESRD). Review of Section O of the MDS, Special Treatments, Procedures, and Programs included Dialysis. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #50's care plan revealed an initial entry that was dated 11/21/22, three days after the resident was admitted to the facility, with a Focus aimed at: Renal insufficiency related to kidney disease. Goals included: Will be free from infection and resident will have no signs or symptoms of complications related to fluid deficit. Interventions included: Assist resident with ADLS (activities of daily living) and ambulation as needed. Watch for SOB (shortness of breath) and match level of assistance to resident's current energy level, Encourage rest periods as resident requires. Monitor and report changes in mental status: lethargy, tiredness, fatigue, tremors and seizures. The entry failed to specify the resident's scheduled dialysis days and time, method of transport, the type of dialysis access site that the resident had and related required interventions to ensure the dialysis access remained patent and free from specific signs and symptoms of infection. Review of Resident #50's Admission/Re-admission Evaluation, assessment dated [DATE], revealed that the resident required dialysis while a patient, but failed to specify whether the resident received Peritoneal (completed daily through a catheter in the abdomen) or Hemodialysis (completed three to five times per week through an access in the arm). Further review of the evaluation revealed that a Base Line Care Plan-Dialysis which was available for selection was not initiated, which provided the following options for selection: Focus: The resident needs dialysis (specify type hemo/peritoneal), Goal: The resident will have no s/sx (signs and symptoms) of complications from dialysis, Some of the Interventions that were available for selection included but were not limited to: Do not draw blood or take b/p (blood pressure) in arm with graft, Encourage resident to go for the scheduled dialysis appointments, monitor/report to MD s/sx of infection to access site: Redness, swelling, warmth or drainage, Monitor/report to MD s/sx of the following: Bleeding/Hemorrhage. Review of Resident #50's Order Summary Report (OSR) revealed that on 12/06/22, an order was placed for the resident to be NPO (nothing permitted orally) post-midnight Sunday 12/5/22, for procedure of revision of AV fistula (arteriovenous fistula, a connection created between an artery and a vein to form a dialysis access graft) on 12/6/22 at 7:00 AM. Further review of the OSR revealed that an order was placed on 12/13/22 for the resident to attend dialysis on Monday, Wednesday, Friday at 11 AM p/u (pick up) time 10 AM. Review of Resident #50's PN dated 12/5/22 at 12:44 PM, which was written by Licensed Practical Nurse/Charge Nurse (LPN/CN #1) and revealed that she received a call from a Physician's Group regarding the resident having an upcoming procedure scheduled on 12/12/22 at 7 AM, due to issues with his/her AV Fistula (possible clog). Further review of the PN revealed that on 12/13/22, the Nurse Practitioner (NP) documented that the resident underwent angioplasty and stent placement of left subclavian vein after he/she was found to have almost complete vascular occlusion per vascular evaluation yesterday during a fistulogram (an x-ray study of fistula to detect a clot or narrowing) of the left upper extremity .Left upper extremity swelling unchanged, S/P angioplasty, stent placement of left subclavian vein by vascular surgery yesterday. During an interview with the surveyor on 01/10/23 at 11:47 AM, the Registered Nurse Supervisor (RNS) stated that whoever served in the role of Supervisor initiated the care plans which included dialysis care plans. The RNS explained that a dialysis care plan should have included the dialysis location and scheduled days, and fistula check which included assessment for bleeding, bruit and thrill. The RNS stated that nurses were responsible to update the care plan in response to a new event such as a fall or skin tear. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the surveyor on 01/13/23 at 9:50 AM, the Infection Preventionist (IP) stated that the dialysis care plan should have been implemented upon admission to the facility and should have included site, inspection, monitor for signs and symptoms of bleeding, and note any fluid intake or dietary restrictions. During an interview with the surveyor on 01/13/23 at 10:45 AM, the Quality Assurance Consultant (QAC #1) stated that the dialysis care plan for Resident #50 was implemented on 01/12/23 at 11:51 AM, into the Electronic Health Record (EHR), but it should have been implemented upon admission to the facility and should have included the dialysis site location. The surveyor reviewed the facility policy titled, Care plan preparation, long term care, with a reviewed date of 5/20/2022. Under Introduction, it read: A care plan is an individualized, written action plan for a resident's care, treatment, and services that is based on the resident's medical, nursing, physical, mental, and psychosocial needs and preferences. The care plan must include: interventions that describe the services the interdisciplinary team employs to attain or maintain the resident's highest practicable, physical, mental, and psychosocial well-being. Under Documentation, it read: Document all pertinent resident problems, expected outcomes, interventions, and evaluations of expected outcomes. Both the DON and Administrator provided the surveyor with the same copy of an undated facility policy titled, Dialysis Guidelines. Review of the policy revealed that the Purpose: To provide guidelines for centers providing dialysis services in house. This includes hemodialysis and peritoneal dialysis. When the surveyor inquired to see if there was a specific policy for residents whose dialysis treatments were completed at an off-site dialysis center, the Administrator stated that was the only policy she had. Further review of the policy revealed the following: If a center provides dialysis services, there is collaboration between the center and a Medicare certified dialysis facility. The center remains responsible for the overall quality of care the patient receives. A coordinated comprehensive care plan for dialysis treatments is developed with input from both the interdisciplinary team (IDT) and dialysis facility staff. The patient's plan of care identifies the patient specific parameters ordered by the medical practitioner for nutritional and fluid needs, lab results, blood pressure, weights, and other vial signs as well as who to notify of concerns and which medications should be given or not given. In order to assure that the dialysis needs of the patient are met in the case of an emergency, the care plan should identify acute care settings that would be able to meet the patient's need for dialysis Both the center and dialysis facility are responsible for shared communication regarding patients receiving dialysis services, either offsite or onsite .Collaborative communication includes information regarding: .dialysis adverse reaction/complications and/or recommendations for follow up observations and monitoring including those related to the vascular access site or peritoneal dialysis catheter . NJAC 8:39-27.1 (a), 11.2 (d) NJAC 8:39-11.2 (f)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 46049 Based on observations, interviews, review of medical records and other facility documentation, it was determined the facility failed to consistently follow standards of professional clinical practice with regard to: a) accurately documenting medication administration for 1 of 1 residents (Resident #52) reviewed for antibiotic use, b) adhering to physician's orders for blood pressure medication parameters, clarification of physician's orders and adherence to the facility Medication Administration policy for 3 of 4 residents observed during medication administration pass (Residents #185, #186 and #187), and c. administering oxygen to a resident without physician orders for 1 of 3 residents (Resident # 14) reviewed for oxygen. This deficient practice was identified as follows: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. The deficient practice is evidenced by the following: 1.) The surveyor reviewed the hybrid medical records of Resident #52 which revealed the following: The Admission Minimum Data Set (MDS) assessment, dated 12/7/22, which indicated the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored a 15 out of 15 which indicated that that the resident was cognitively intact. The MDS assessment also indicated the resident had active diagnoses of chronic frontal sinusitis and other local infections of the skin and subcutaneous tissue. A review of the Order Summary Report and the electronic Medication Administration Record (eMAR) indicated Resident #52 had a physician order, dated 12/10/22, which read: Ertapenem [an antibiotic medication] Sodium Solution Reconstituted 1 GM Use 1 gram intravenously one time a day for Sinus Infection until 01/11/2023. The eMAR also had a physician order entry, discontinued date on 12/10/22 that read: Ertapenem [an antibiotic medication] Sodium Solution Reconstituted 1 GM Use 1 gram intravenously one time a day for Sinus Infection until 01/11/2023. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the December 2022 eMAR for Resident #52 revealed that on 12/9/22, the Ertapenem antibiotic medication scheduled for 2000 and on 12/21/22 the Ertapenem antibiotic medication scheduled for 0600, there were no nurse signatures for those entries. On 1/12/23 at 10:46 AM, the Infection Preventionist (IP) was informed about concern that there were no nurse signatures documented for days identified on the Ertapenem entry in the December 2022 eMAR. The IP stated she would follow up and provide further information. On 1/12/23 at 1:32 PM, the IP informed the surveyor that the Ertapenem medication entries identified were not signed and that the physician was notified. The IP further stated she contacted RN#1 who worked on 12/9/22 and RN#1 stated she would have to look at her notes when she came into work to see what happened. The IP stated the other nurse, who did not sign the eMAR no longer worked at the facility. On 1/12/23 at 1:54 PM, the surveyor informed the Administrator, Quality Assurance Consultant #1 (QAC #1), QAC #2, and Regional Director of Operations of the above concerns for no nurses' signatures on the eMAR for Ertapenem medication on 12/9/22 and 12/21/22. On 1/13/23 at 9:40 AM, the surveyor interviewed the IP on the above concerns. The IP stated if the nurses could not administer a medication, or a dose was missed that the physician would be made aware. The IP further stated the nurses were expected to review their eMAR assignment at the end of the shift to ensure all medications were administered and signed for. On 1/13/23 at 10:24 AM, the surveyor interviewed RN #1 about missed signature for Ertapenem on the December 2022 eMAR. RN#1 stated she spoke with the IP yesterday (1/12/23), who asked her about the missing signatures for the Ertapenem. RN #1 stated she could not recall what happened since it was, so long ago. RN #1 stated she tried to check her documentation when she came into work last night but still wasn't sure what happened on 12/9/22. RN #1 acknowledged it would be expected for the physician to be notified if there were any changes with a resident's medication, such as a missed dose, delayed medication, or need to change the time for a medication. On 1/13/23 at 10:44 AM, the surveyor met with the Administrator, Medical Director, QAC #1, and IP. QAC #1 stated an incident report was to be done and they would reach out to the nurses to provide re-education. The surveyor reviewed the undated facility policy titled, Medication and Treatment Administration Guidelines, Long-Term Care. Under Documentation, it read: Medications and treatments administered are documented immediately following administration or per state specific standards, Medications not administered according to medical practitioner's orders are reported to the attending medical practitioner and documented on the clinical record including the name and dose of the medication and reason the medication was not administered, and The licensed nurse is responsible for validating documentation is completed for any medication administered during the shift. NJAC 8:39-11.2 (b); 29.2(d) 37547 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 11:00 AM, LPN #3 concluded signing out Resident #186's medications that were administered which included Polyethylene Glycol 3350 Oral Powder 17 GM/Scoop, Give 1 (one) scoop by mouth one time a day for constipation. LPN #3 stated that she was required to advise the NP that the Polyethylene Glycol was administered late, as the medication that was scheduled for administration at 9:00 AM, turned red on the computer screen of the EMAR when she attempted to sign the medication out as administered at 11:00 AM. At 11:01 AM, The surveyor interviewed LPN #3 post-medication administration observation. LPN #3 stated that she obtained the resident's blood pressures at 8:00 AM and utilized the readings for blood pressure medication administration during the medication pass observation. When the surveyor asked LPN #3 what the facility policy was for the timing of blood pressure reading values used for blood pressure medication administration based on physician ordered parameters LPN #3 stated, I do not know what the policy allowed for. During a later interview with the surveyor on 01/05/23 at 3:07 PM, LPN #3 stated that at 9:00 AM, Resident #185 had an order to hold the dosage of Diltiazem HCL ER 180 mg to be held for a SBP less than 105, and the resident had a SBP of 103 and the medication was not held as indicated. LPN #3 stated that she instead waited until the resident returned from therapy and rechecked the resident's blood pressure which was 122/70's and both HTN medications (Diltiazem HCL ER and Isosorbide Mononitrate ER) were administered. LPN #3 further stated that she notified the NP before that, about 30 minutes ago. LPN #3 stated that she feared the resident's blood pressure would drop too low during physical therapy LPN #3 stated that she should have gotten an order to change the medication administration time to be given when the resident returned from physical therapy. LPN #3 further stated that the order for Resident #187's Potassium Chloride 20 mEq, did not specify how to the medication was required to be prepared for administration and the order should have been clarified prior to administration to ensure that it was ok to mix the medication in applesauce. LPN #3 further stated that Resident #186's administration time for Voltaren, ordered twice daily, should have been adjusted so that the medication could have been administered after AM care had been completed after 11 AM. LPN #3 further stated that she obtained resident blood pressure readings at 8 AM, and it was better if she repeated the blood pressure reading at the time of blood pressure medication to ensure accuracy. During an interview with the surveyor on 01/06/23 at 10:53 AM, the Licensed Practical Nurse/Charge Nurse (LPN/CN #1) stated that blood pressure medications were required to be held according to physician ordered parameters at the time the medication was due as you only had one hour before or one hour after the medication time was scheduled to administer it and are not permitted to administer the medication beyond that time frame because it interfered with the medication schedule. LPN/CN #1 stated that LPN #3 should have notified the NP that the Resident #185's blood pressure medications interfered with physical therapy and documented the conversation, and checked for new orders. LPN/CN #1 explained blood pressures should be rechecked if it had been more than one hour since the value was obtained and scheduled blood pressure medications were due to ensure that there had not been any blood pressure fluctuations. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN/CN #1 further stated that a request for a time change should have been requested to change Resident #186's order for Voltaren administration to coordinate with the resident's care. LPN/CN #1 further stated that, An order for KCL (potassium chloride) 20 mEq should have specified to administer the medication in 8 (eight) ounces of water and should have been clarified prior to administration in applesauce as it was never assumed. During an interview with the surveyor on 01/11/23 at 11:00 AM, the Infection Preventionist (IP) who stated she was also responsible for Staff Development, stated that LPN #3 should have decided not to administer medications one hour after the scheduled administration time. The IP stated that the residents blood pressures should have been repeated prior to medication administration as it had been approximately 90 minutes and vital signs (blood pressure readings) should have been obtained prior to blood pressure medication administration to ensure accuracy. The IP further stated that LPN #3 should have obtained an order to change the time of administration of Voltaren if she was concerned about giving it prior to AM care or administered the medication within parameter guidelines of a one-hour window (one hour before scheduled due time, or one hour after scheduled due time). The IP concluded the interview by stating that the order for KCL should have been clarified with the physician prior to administration in applesauce. The surveyor requested to view a copy of LPN #3's medication pass observation competency at that time which was not provided by the facility. During an interview with the surveyor on 01/13/23 at 10:45 AM in the presence of the survey team, the Administrator stated that. She had nothing further to provide regarding medications that were administered to residents outside of the scheduled parameters during the medication pass observation at this point. Review of the facility policy titled, Medication Administration: Medication Pass (06//21) revealed the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.Procedure: .If medication is new for resident, or if medication is unfamiliar or physician order is questioned: Read original physician order, Compare original physician order with MAR (Mediation Administration Record) for accuracy, Remove medication from cart, Compare MAR with medication label for accuracy, verify allergy status, Contact physician for clarification, if needed, Read special medication administration instructions, Obtain vital signs, if applicable, and record results on MAR (Medication Administration Record), Prepare medications for administration Medications are administered in accordance with standards of practice and state specific and federal guidelines.Communities are responsible for establishing a community medication time schedule and communicating the standard schedule for the center with attending medical practitioners. Licensed nurses and medication aides are oriented upon hire and evaluated annually in medication and treatment administration techniques and medication and treatment documentation requirements. Medication and Treatment Orders: A complete medication order includes: Date and time, Name of resident, Name of medication, Form, formula, and route of administration, Dosage or strength, Frequency, including end date orders if applicable, Directions for use including the reason for use, diagnosis, or clinical indication, Medication specific parameters if applicable .Orders are transcribed then noted by the licensed nurse. The licensed nurse noting an order is responsible for accurate transcription and initiation of orders . Documentation: Medications and treatments administered are documented immediately following administration or per state specific standards. Vital signs are taken and recorded prior to the administration of vital sign dependent medications in accordance with medical practitioner's orders .Medications not administered according to medical practitioner's orders are reported to the attending medical practitioner and documented in the clinical record including the name and dose of the medication and reason the medication was not administered The licensed nurse or medication aide is responsible for validating documentation is completed for any medication administered during the shift. NJAC 8:39-11.2(b), 17.2 (g), 27.1 (a) 45209 3.) During the initial tour of the facility on 01/03/23 at 10:03 AM, the surveyor observed Resident #14 sitting in the wheelchair with oxygen administered by nasal tubing. The oxygen tubing was dated 01/03/23. On 01/06/23 at 10:15 AM, the surveyor observed Resident #14 sitting in a reclining chair with oxygen being administered by nasal tubing. The oxygen tubing was dated 01/03/23. According to the Admission Record, Resident #14 was admitted to the facility with diagnoses which included, but were not limited to, Atherosclerotic Heart Disease (buildup of plaque in arteries causing reduced blood flow), muscle weakness, and reduced mobility. A review of the physician orders in the Electronic Medical Record on 01/06/23 at 10:02 AM, did not include physician orders for oxygen administration. A review of the January 2023 Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not include orders for oxygen administration. A review of the documentation provided by the Director of Nursing (DON) on 01/11/23, reflected Resident #14's physician orders were updated on 01/06/23 at 10:27 AM to include O2 (oxygen) @ 2 liters per minute via nasal cannula as needed for dyspnea (shortness of breath) or Sp02 (amount of oxygen in the blood) < 92% maintain Sp02 >92% call MD if Sp02 <88% for further orders. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the surveyor on 01/09/23 at 11:00 AM, Certified Nursing Assistant (CNA) #1 confirmed that the administration of oxygen required a physician order. CNA #1 also confirmed that the oxygen tubing should not be dated prior to the physician's order date. During an interview with the surveyor on 01/09/23 at 12:03 PM, the assigned Licensed Practical Nurse (LPN) #1 reported that oxygen required a physician's order. Upon reviewing Resident #14's orders, LPN#1 confirmed that the order was placed on 01/06/23. LPN #1 verified that the oxygen tubing was dated 01/03/23. LPN#1 stated, It should be dated that day (the order date) and changed every 7 days. During an interview with the surveyor on 01/09/23 at 12:55 PM, the DON identified that Resident #14's oxygen tubing should not be dated 01/03/23 unless that is the date the order is placed . Let me look if there was a previous one [order]. There is no order. The surveyor reviewed an undated Facility Procedure titled, Medication and Treatment Administration Guidelines. Under the heading General, the procedure revealed Centers are to follow the Orders Management Matrix for initiation of non-medication or treatment orders. All orders are to be prescribed by a medical practitioner. The surveyor reviewed the facility procedure titled, Oxygen Administration, long term care, with a revised date of 11/28/22. Under the heading Implementation, the procedure reflected to Verify the practitioner's order for oxygen therapy. NJAC 8:39-11.2 (b); 29.2(d)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 36000 Based on observation, interview, and record review, it was determined that the facility failed to a.) evaluate and complete a wound assessment for one resident's wound in a timely manner, b.) complete weekly skin assessments for one resident and c.) discontinue a wound treatment when resolved. This deficient practice was identified for 1 of 1 resident (Resident #29) reviewed for pressure ulcers and was evidenced by the following: On 01/03/23 at 10:05 AM, the surveyor observed Resident #29's legs were contracted, and the resident was lying supine in bed on an air mattress with the head of the bed elevated. The resident stated that he/she had a wound on the shin. According to the Admission Record Report, the resident was admitted with diagnoses which included, but were not limited to, contracture of muscle. Review of the 10/14/22 Quarterly Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care, reflected that the resident was cognitively intact and required total care by staff for activities of daily living. The MDS further reflected that the resident had an active diagnosis of an unspecified open wound to the right lower leg. Review of the ongoing Care Plan revealed a focus that Resident #29 had an actual right shin pressure ulcer with the goal to decrease/minimize skin breakdown risks times 90 days. The Care Plan reflected the interventions to observe skin condition with ADL care daily and report abnormalities, administer treatment per physician orders, and wound consult and treat. Review of the Order Summary Report for Order Date Range: 10/01/22-01/11/23 reflected an order dated 10/27/22 to apply skin prep to the periwound (outside perimeter), then clean the right inner leg/shin wound with Skin Integrity Cleaner, apply Medihoney and silver alginate to the wound and cover with border gauze every day shift for wound care. Further review of the January 2023 Treatment Administration Record (TAR) reflected that the 10/27/22 treatment order to the right inner leg/shin wound was discontinued on 01/06/23. Review of the Skin & Wound Evaluation V5.0 dated 10/27/22 reflected that the resident had an unstageable (obscured full-thickness skin and tissue loss) wound to the right shin. The wound had a length of 3.0 cm and width of 1.6 cm. The surveyor observed there were no Skin & Wound Evaluation V5.0 completed for the right inner leg/shin after 10/27/22 until after surveyor inquiry. On 01/13/23 at 9:00 AM, the facility provided the Skin & Wound Evaluation V5.0 dated 11/03/22, completed by the Advanced Practice Wound Nurse (APWN) reflected that the wound to the right shin had resolved. This Skin & Wound Evaluation V5.0 dated 01/09/23 was not completed until after surveyor inquiry. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the November 2022 TAR reflected that the nurses signed that the treatment to the right inner/leg shin was completed daily on 11/05/22, 11/06/22, 11/07/22, 11/08/22, 11/09/22, 11/10/22, 11/11/22, 11/13/22, 11/14/22, 11/15/22, 11/16/22, 11/17/22, 11/19/22, 11/20/22, 11/22/22, 11/23/22, 11/24/22, 11/25/22, 11/26/22, 11/28/22, 11/29/22, and 11/30/22. Review of the December 2022 TAR reflected that the nurses signed that the treatment to the right inner/leg shin was completed daily on 12/01/22, 12/08/22, 12/12/22, 12/14/22, 12/15/22, 12/18/22, 12/20/22, 12/21/22, 12/22/22, 12/24/22, 12/25/22, 12/27/22, 12/28/22, 12/29/22 and 12/31/22. Review of the January 2022 TAR reflected that the nurses signed that the treatment to the right inner/leg shin was completed daily on 01/01/23, 01/02/23, 01/04/23 and 01/05/23. The surveyor further observed that Resident #29's Electronic Medical Record (EMR) revealed the following: - the physician orders did not include an order for weekly skin assessments; and - the nurses continued to sign the 10/27/22 treatment orders to the right inner leg/shin after the wound had resolved on 11/03/22. On 01/11/23 at 11:10 PM, the surveyor, Director of Nursing (DON) and LPN #1 observed that Resident #29's right inner leg/shin wound was healed. During an interview with the surveyor on 01/11/23 at 12:08 PM, the APWN stated that she was following the right inner leg/shin wound weekly and she believed it resolved in November 2022. The APWN further stated that her documentation of the wound would be found in the progress notes. During an interview with the surveyor on 01/11/23 at 01:08 PM, the DON stated there were no Skin & Wound Evaluation V5.0 completed for the right inner leg/shin wound after 10/27/22 up to the date the wound treatment was discontinued on 01/06/23. The facility could not provide further documentation to indicate when the wound had resolved. During a follow up interview with the surveyor on 01/11/23 at 2:03 PM, LPN #1 reviewed Resident #29's orders and confirmed there was no order for a skin assessment. LPN #1 stated that the physician puts in the order for the skin assessment and we follow that. On the second floor, we complete skin assessments on shower days. Surveyor inquired, if there was no skin assessment order, when are the skin assessments completed. LPN #1 stated that the skin assessments were usually documented in the EMR under Assessments. LPN #1 verified that the skin assessment was unavailable for him to complete for this resident under the Assessment tab in the EMR. LPN #1 further stated that we also had a paper assessment which could have been completed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the surveyor 01/12/23 at 11:46 AM, Quality Assurance Consultant (QAC) #1 and QAC #2 discussed Resident #29's right inner leg/shin wound. At that time, QAC #2 reviewed Resident #29's right inner leg/shin wound pictures. QAC #2 showed the surveyor a picture of the right inner leg/shin wound dated 11/03/22, which reflected that the wound was resolved. The surveyor further discussed with QAC #1 and QAC #2 the concern that the resident did not have an order for weekly skin assessments. QAC #1 stated that the skin assessments were usually completed on shower days and she he would get back to the surveyor. The surveyor further discussed with QAC #1 and #2 that the nurses continued to sign the TAR after the right shin healed. QAC #1 stated that the nurses should have notified the physician that the wound had healed for new orders. During an interview with the surveyor on 01/12/23 at 12:01 PM, Certified Nursing Assistant (CNA) #2 stated that if she observed something different about a resident's skin, she would immediately alert the nurse to look at the resident's skin. CNA #2 stated that some examples would be a skin tear, skin opening, redness or anything different from their prior skin condition. During a follow up interview with the surveyor on 01/12/23 at 12:13 PM, LPN #1 stated that he usually goes in on shower days to assess Resident #29's skin and he would document on the Body Audit in the EMR. For Resident #29, the CNA sees the skin during care and he observed the skin during dressing changes daily. LPN #1 further stated that if a resident's wound healed, he would tell the Advanced Practice Nurse, physician, or APWN and she would come and assess the wound and give me a direction to discontinue the treatment order. During a follow up interview with the surveyor on 01/13/23 at 09:50 AM, the surveyor discussed with the APWN that the facility provided the right inner leg/shin Skin & Wound Evaluation V5.0 dated 11/03/22 which the APWN completed on 01/09/23. The APWN stated that the shin wound healed on 11/03/22 and she monitored the resident's wounds weekly. The APWN further stated that if a wound heals, she will discontinue the treatment. The surveyor inquired, why did the treatment continue. The APWN stated that there was a clarification by the nurse and she discontinued the treatment on 01/06/23, as it had healed. The APWN stated, It could be my mistake as a provider. During a follow up interview with the surveyor on 01/13/23 at 10:10 AM, the QAC #1, in the presence of the Infection Preventionist, stated that she expected the wound nurse to complete weekly rounds, document in the progress notes, put orders in the medical record and discontinue orders when a wound healed. The APWN obviously knew that the wound had healed. The QAC #1 further stated that she expected the nurses, if a wound healed, to communicate with the physician and get an order to discontinue the treatment. The facility did not provide further information about the weekly skin assessments. Review of the facility's Skin Management Guidelines, dated 03/2022, reflected that body audits were completed by the licensed nurse daily for patients with pressure injuries and documented in the TAR. The Guidelines further reflected that skin alterations and pressure injuries were evaluated and documented by the licensed nurse whenever there was a significant change in condition or clinically indicated. Review of the facility's Skin Quick Reference document, dated 02/2022, reflected that the facility should document in the TAR daily body audit for patients, including but not limited to, with pressure injury, treatment completion, and weekly wound rounds. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accelerate Skilled Nursing and Rehab Piscataway	10 Sterling Drive Piscataway, NJ 08854

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NJAC 8:39-27.1(e)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 45209 Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to ensure that a resident with limited range of motion of the right hand received appropriate services to prevent further decrease in range of motion. This deficient practice was identified for 1 of 1 residents (Resident #21) reviewed for positioning and mobility and was evidenced by the following: During the initial tour of the facility on 01/03/23 at 10:03 AM, the surveyor observed Resident #21 with a contracture to the right hand. The surveyor observed a hand roll located on the resident's bedside table. Resident #21 stated that he/she can apply and remove the hand roll without assistance. On 01/06/23 at 11:00 AM, the surveyor observed Resident #21 with a contracture to the right hand. The resident's hand roll was observed on the bedside table. When asked how often the resident used the hand roll, he/she responded, I wear it at night. I don't want it to get it dirty during the day. On 01/09/23 at 11:17 AM, the surveyor observed resident #21 asleep in bed with the contracture to the right hand. The resident's hand roll was observed on the bedside table. According to the Admission Record, Resident #21 was admitted to the facility with diagnoses which included, but were not limited to, Atherosclerotic Heart Disease (buildup of plaque in arteries causing reduced blood flow), and muscle weakness. Review of Resident #21's most recent Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 12/15/22, identified Resident #21 as cognitively intact with functional limitation in range of motion on one side of the upper and lower extremity. The MDS also revealed that Resident #21 required extensive assistance and was dependent on staff for most activities of daily living. During the resident's Record Review on 01/06/23 at 10:02 AM, it was observed that Resident #21's ongoing Care Plan did not identify the right-hand contracture and hand roll intervention. A review of the January 2023 physician orders, Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not address the resident's contracture or any interventions. During an interview with the surveyor on 01/09/23 at 11:00 AM, Certified Nursing Assistant (CNA) #1 confirmed that splinting/orthotic devices required physician orders and they are trained from the therapists on how to apply and remove the device. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the surveyor on 01/09/23 at 12:03 PM, the assigned Licensed Practical Nurse (LPN) #1 reported that the unit manager was responsible for creating and updating care plans. LPN #1 further advised, There isn't one (a unit manager). If it something that needs to be added, I try to do it myself but I don't have time. When asked if splinting/devices are common care planning topics, LPN #1 responded, Yes. When asked to identify what would be documented, LPN #1 stated, The interventions to prevent worsening condition, how long for splinting, how often. The surveyor inquired if staff received any training as to donning and doffing the splint. LPN #1 explained, Therapy will come up and train. Everything [documentation] would be with them. Upon reviewing the resident's physician orders, LPN #1 confirmed, Well, that would be night shift; but no, I do not see any. During an interview with the surveyor on 01/09/23 at 12:55 PM , the Assistant Director of Rehabilitation (ADDR) reported that upon discharge from rehabilitation, the nursing staff is trained on the application and removal of a device. The ADDR stated that nursing was responsible for ensuring that the resident wore the device, provided skin checks, and notified Rehabilitation of any changes, including the resident's refusal to wear the device or questions regarding the device. Upon review of documentation provided by the ADDR on 01/09/23 at 1:04 PM, the Therapy Communication Form revealed, Under Splint Wear Section that the handroll was identified with the instruction checked off to apply roll to right (circled) upper extremity. Handwritten next to the entry identified as tolerated every day. The surveyor also reviewed the Therapy Discharge Summary signed on 9/26/2022 at 12:42 PM revealed, Nursing range of motion (ROM) and activities of daily living (ADL) assistance as requested by patient. Therapy follow up established/trained. Restorative Splint and Brace Program Splint and Brace Program Established/Trained. Passive range of motion (PROM) and Gentle stretching right upper extremity (RUE) as tolerated followed by (f/b) right hand roll throughout the day/evening (as tolerated) and removed for hygiene and ROM. Physical Therapy (PT) educated and able to remove and apply splint on her own as well. During an interview with the surveyor on 01/09/23 at 12:55 PM, the Director of Nursing (DON) identified that splinting/orthotics/palm guards require physician's orders. When asked by the surveyor if the Resident has any physician's orders the DON responded, No I don't see them. When asked if the Resident is Care Planned for the device the DON stated, I don't see it. It should be on there. The surveyor reviewed the undated facility procedure titled, Facility Braces/Splints, Under Purpose revealed: To maintain function range of motion, decrease muscle contractures and provide support and alignment for weakened limbs through use of braces and/or splints. Under Procedure, it documented: #1 Verify medical practitioner's order. Order should specify what type of brace/splint should be used as well as wearing schedule. #9 Carefully inspect skin and appearance of body part during and between applications. The surveyor reviewed an undated Facility Procedure titled, Medication and Treatment Administration Guidelines. Under General, it revealed Centers are to follow the Orders Management Matrix for initiation of non-medication or treatment orders. All orders are to prescribed by a medical practitioner. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NJAC 8:39-27.2(m)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 37217 Based on interview and review of facility documentation, it was determined that the facility failed to provide evidence that Certified Nursing Assistants (CNAs) received annual performance evaluations and 12 hours of mandatory in-service training as required. This deficient practice was identified for 5 of 5 CNAs and was evidenced by the following: On 1/4/23 at 11:40 AM the surveyor reviewed the facility's list of CNAs and requested the in-service training and performance evaluations for 5 randomly selected who had been hired on 4/1/2021. On 1/5/23 at 10:00 AM, the Human Resources (HR) director provided the surveyor with a printout of a document titled, Transcript Report-Nurse Aide Completions with Training Hours. A review of the Transcript Report-Nurse Aide Completions with Training Hours included CNA #5, #6, and #7, but did not include CNA #8 or #9. Additionally, there was no evidence on the transcript provided that ensured that CNAs #5, #6, and #7 received 12 hours of in-service training. On 1/9/23 at 9:27 AM, the surveyor reviewed the transcript report with the HR director. The HR director confirmed that the transcript report did not include tracking of hours of education for the CNAs. When asked about the other two CNAs that were not on the transcript, the HR director stated that corporate had provided what was handed to the surveyor and she was unable to determine how many hours of education each CNA completed. During an interview with the surveyor on 1/10/23 at 8:42 AM, the Director of Nursing (DON) stated that there were no performance evaluations completed for the CNAs. During an interview with the Administrator, and HR director in the presence of the survey team on 01/13/23 at 10:43 AM, the HR director could not provide additional information. She stated she was responsible to monitor the CNA in-service hours to ensure each CNA receives twelve hours of training and also to ensure performance evaluations were done annually, but the DON did not have them completed. A review of an undated facility policy titled, Employee Development included; Performance Appraisal .your job performance will be reviewed 90 days after hire, transfer or promotion and annually thereafter .In-service Training; Ongoing training is necessary to provide the highest level of quality care to our patients/residents. You will be responsible for participating in training related to your position. You will be paid for participating in mandatory training. Your supervisor and/or the HR designee will communicate those requirements to you. NJAC 8:39-43.17(b)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 36000 Based on interview and record review, it was determined that the facility failed to a.) act on or respond to, recommendations made by the Consultant Pharmacist (CP) in a timely manner. This deficient practice was identified for 1 of 5 residents reviewed for medication regimen review (Resident #5) and was evidenced by the following: The surveyor reviewed the progress notes (PN) from 06/01/22 through 01/12/23 and observed that the CP generated Medication Regimen Review (MMR) PNs dated 06/29/22, 08/01/22, 09/30/22, 10/31/22, 11/20/22 and 12/31/22 with his recommendations to be completed by the physician. The surveyor observed that the physician did not address the CP MMR Progress Notes. During an interview with the surveyor on 01/10/23 at 10:36 AM, the surveyor asked the Director of Nursing (DON) for the physician's response to the CP recommendations for Resident #5. The DON stated that her date of hire was 12/14/22. The DON further stated that the CP reviewed each resident's medications monthly and generated a report which was emailed to the Medical Director and DON. The DON then printed out the recommendations, gave them to the physician to complete and the physician returned the completed CP recommendations to the DON within 30 days. On 01/11/23 at 1:30 PM, the DON provided the following CP Medication Regimen Review (MMR) Progress Notes (PN) for Resident #5: - MMR PN dated 06/29/22 reflected irregularities were noted. The CP recommended please evaluate the benefit/risk of use for Oxybutynin [a medication used to treat an overactive bladder] and to please evaluate the benefit/risk of use for Sliding Scale Insulin order (is it still needed)? The MMR PN further reflected a handwritten X for the Physician Response Accept the recommendation(s) above, please implement as written. The MMR PN further contained a handwritten signature of the APN. The surveyor observed that the signature was not dated. - MMR PN dated 08/01/22 reflected irregularities were noted. The CP recommended please evaluate if a Clonazepam [a medication used to prevent and control seizures] dosage reduction could be attempted at this time. The MMR PN further reflected a handwritten X for the Physician Response Decline the recommendation(s) above and do not wish to implement any changes due to the reasons(s) below. The surveyor observed the Rationale portion of the MMR PN was blank. The MMR PN further contained a handwritten notation *See Psych [psychotherapy] note 8/10/22* and a signature of the APN. The surveyor observed that the signature was not dated. - MMR PN dated 09/30/22 reflected No irregularities were noted. No action required. The surveyor observed the form was blank and did not contain a handwritten signature or date. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- MMR PN dated 10/31/22 reflected irregularities were noted. The CP recommended Is Esomeprazole [a medication used to treat heartburn] still needed? The MMR PN further reflected a handwritten X for the Physician Response Decline the recommendation(s) above and do not wish to implement any changes due to the reasons(s) below. The surveyor observed the Rationale portion of the MMR PN was blank. The MMR PN further contained a handwritten notation *See Diagnosis List* and a signature of the APN. The surveyor observed that the signature was not dated. - MMR PN dated 11/30/22 which reflected irregularities were noted. The CP recommended please evaluate if a Clonazepam dosage reduction could be attempted at this time. The MMR PN further reflected a handwritten X for the Physician Response Decline the recommendation(s) above and do not wish to implement any changes due to the reasons(s) below. The surveyor observed the Rationale portion of the MMR PN was blank. The MMR PN further contained a handwritten notation *See CRNP (APN) note* 12/4/22 and a signature of the APN. The surveyor observed that the signature was not dated. - MMR PN dated 12/31/22 which reflected No irregularities were noted. No action required. The surveyor observed the form was blank and did not contain a handwritten signature or date. During an interview with the surveyor on 01/11/23 at 11:25 AM, the surveyor reviewed the MMR PNs with the APN and she acknowledged that she reviewed and signed the MMR PNs yesterday, 01/10/23. The APN stated that the CP came monthly, reviewed each resident's medications, and made recommendations. The CP provided the recommendations to the Director of Nursing (DON) and she provided these forms to the physician and the physician would address them. If the physician was not available, their APNs would complete the task. Once the recommendations were completed, they were returned to the DON. At that time, the surveyor and APN reviewed each CP MMR PN as follows: - For the 06/29/22 MMR PN, the APN reviewed the PN dated 07/04/22 which reflected that the resident had a chronic/labile (readily or frequently changing) overactive bladder. The APN further stated that the 07/04/22 PN further reflected that Resident #5 had a history of chronic/labile diabetes mellitus without complications with blood sugars between 113-283 for the last two days. The APN acknowledged that she did not fill in this rationale on the MMR PN. - For the 08/01/22 MMR PN, the APN reviewed the 08/10/22 Psychotherapy PN and acknowledged she did not fill in the rationale on the MMR PN. - For the 09/30/22 MMR PN, the APN confirmed that the form was incomplete. - For the 10/31/22 MMR PN, the APN stated that Resident #5 had pain in the abdomen and confirmed that she did not fill in this rationale. The APN further reviewed the progress notes and confirmed that the CP recommendations were not addressed after 10/31/22. - For the 11/30/22 MMR PN, the APN reviewed the 12/04/22 PN and confirmed that she did not fill in the rationale. - For the 12/31/22 MMR PN, the APN confirmed that the form was incomplete. At that time, the APN stated that the CP recommendations should be completed right away and voiced an understanding of completing the CP recommendations. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the surveyor on 01/13/23 at 10:48 AM, the Quality Assurance Consultant #1 acknowledged that the MMR PNs were not completed in their entirety. Review of the facility's Medication Regimen Review policy dated 08/2018 reflected the following: - CPs perform MMR for patients and will generate recommendations with the overall goal of promoting positive outcomes and minimizing adverse consequences. - The CP conducts review of the medical record. The findings and/or recommendations are entered in the electronic health record assessment. - The CP generates three copies of the MRR recommendations with one copy provided to the DON and retained in the MRR binder as the master tracking system, one copy provided to the Medical Director and one copy provided to the attending physician or prescriber. - The DON, or designee reviews the MRR and contacts the attending physician to review and obtain orders as warranted. The DON, or designee documents on the MRR and in the patient's clinical record, the physician order(s) and forwards the completed MRR to the DON within 30 days of the CP's review. - The attending physician documents the review and any resulting actions or orders on the MRR. - Once validated as complete, the paper copy of the MRR is filed in the patient's clinical record - Legal/Miscellaneous tab. The copy from the master tracking binder is removed and securely disposed of by placing in the secure document shred box. NJAC 8:39 - 29.3 (a)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 36000 Based on observation, interview, and record review, it was determined that the facility failed to a.) ensure that expired medications and supplies were removed from the medication rooms and unit emergency carts where other current in use items were stored, b.) ensure that each medication room refrigerator was maintained and locked, c.) ensure that each medication room refrigerator contained a secured/locked narcotics box and d.) consistently document medication room refrigerator temperatures. This deficient practice was identified for 2 of 2 units and was evidenced by the following: On 01/10/23 at 10:46 AM, surveyor #1 inspected the medication room on the second floor with the Registered Nurse Supervisor (RNS) and observed the following: 1. The RNS and surveyor #1 reviewed the medications stored in the large refrigerator and the RNS confirmed the following items were expired: one Pneumovax 23 syringe expired 11/22/22, one Famotidine Injection 40 mg/4 ml expired 09/2022 and one IV Daptomycin 500 mg/100 mg expired 01/02/23. 2. Surveyor #1 reviewed the lower cabinet to the right of the sink, in the presence of the RNS, and the RNS confirmed, that the following items were expired: one bottle of Vitamin B-6 50 mg tablets expired 12/22 and four bottles of Aspirin 325 mg expired 12/22. 3. Surveyor #1 observed that the small black refrigerator did not have a lock affixed to the refrigerator. 4. Surveyor #1 observed that both refrigerators had a Medication/Vaccine Refrigerator Temperature Log (Temp Log) affixed to each refrigerator that was incomplete. Review of the Temp Log reflected the Month, Year and Location, an area checked to record the Refrigerator temperatures only, the Day, Time (AM and PM), Refrigerator (temperature), Freezer (temperature), and Initials. Surveyor #1 reviewed the Temp Log affixed to the large refrigerator was dated January 2023. The Temp Log reflected the staff did not complete the refrigerator temperatures on 01/01/23 AM and PM, 01/02/23 AM, 01/03/23 PM, 01/04/23 AM and PM, 01/05/23 PM, 01/06/23 AM and PM, 01/07/23 AM, 01/08/23 AM, and 01/09/23 AM and PM. Surveyor #1 reviewed the Temp Log affixed to the small refrigerator was dated January 2023. The Temp Log reflected the staff did not complete the refrigerator temperatures on 01/01/23 AM and PM, 01/02/23 AM, 01/03/23 PM, 01/04/23 PM, 01/05/23 PM, 01/06/23 AM and PM, 01/07/23 AM, 01/08/23 AM, and 01/09/23 AM and PM. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When interviewed at the time of the observations, the RNS stated that the refrigerators were reviewed for expired items when a resident was discharged from the facility and every two weeks. The RNS further stated that it was the nurses' responsibility and sometimes the Director of Nursing (DON) or the supervisors to review the refrigerators for expired items. The RNS confirmed there was no lock on the small refrigerator and that the large and small refrigerator Temp Logs were incomplete. The RNS stated that it was the responsibility of the day supervisor to check the refrigerator temperatures daily. On 01/10/23 at 11:51 AM, two surveyors inspected the third floor medication room with the RNS and observed the following: 1. Surveyor #1 observed the small refrigerator was not locked and did not contain a secured, locked box inside of the refrigerator for narcotic medications. The small refrigerator contained the following items: three sealed boxes of one vial of Humalog, one sealed bottle of Latanoprost Ophthalmic 2.5 ml solution, three prefilled Basaglar insulin pens, two prefilled Humulin insulin pens, two prefilled Lantus insulin pens, and five prefilled Glargine pens. The surveyor #1 further observed that the ice compartment of the small refrigerator contained a thick layer of ice. At that time, the RNS confirmed the observations. 2. Surveyor #1 reviewed a storage cabinet to the right of the refrigerator and observed six 3 ml Syringe with hypodermic safety needles with an expiration date of 03/28/22. At that time, the RNS confirmed the observation. 3. Surveyor #2 reviewed the lower shelf of the bottom counter cabinet and observed the following expired medications: 19 individually wrapped Heparin Lock Flush Syringe expired 05/31/22, one sealed box of 50 individually wrapped Heparin Lock Flush Syringes expired 04/30/22 and one individually wrapped and sealed 0.9 Sodium Chloride Flush expired 09/30/22. 4. Surveyor #1 observed the Temp Log affixed to the small refrigerator was dated January 2023 and reflected the staff did not complete the refrigerator temperatures on 01/01/23 AM, 01/02/23 PM, 01/04/23 PM, 01/05/23 PM, 01/06/23 AM and PM, 01/07/23 AM and PM, 01/08/23 AM and PM, 01/09/23 AM and PM. At that time, the RNS acknowledged that the Temp Logs were incomplete and stated that she was nurse supervisor and it was her responsibility to check the refrigerator temperatures daily on both floors. The two surveyors reviewed the third floor crash cart, situated near the nurses' station, and observed the following expired items: Twenty-one 0.09 oz lubricating jelly expired 12/19, and six 0.09 oz lubricating jelly expired 01/20. The surveyors further observed to the right of the crash cart, affixed to the wall, was a container which housed two Biohazard Spill Kits with an expiration date of 10/31/22. (continued on next page)

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Accelerate Skilled Nursing and Rehab Piscataway	10 Sterling Drive Piscataway, NJ 08854

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/10/23 at 12:09 PM, the two surveyors reviewed the second floor crash cart, situated near the nurses' station, and observed the following expired items: nine packets of E-z lubricating Jelly expired 3/2021, eight packets of E-z lubricating Jelly expired 1/2020, two packets of Petroleum Jelly expired 02/21, one Non-Conductive Connecting Tubing expired 11/01/21, one Inner Cannula expired 06/30/21, and one Yankauer expired 11/28/21. The surveyors observed to the right of the crash cart, affixed to the wall, was a container which housed two Biohazard Spill Kits with an expiration date of 10/31/22. During a follow up interview with surveyor #1 on 01/10/23 at 12:39 PM, the RNS stated, I believe the night supervisor checked the crash cart. During a follow up interview with surveyor #1 on 01/10/23 at 1:06 PM, the RNS verified that there was no locked/secured narcotics box in the third floor refrigerator. She stated that if there was a new admission, who had a narcotic that needed to be refrigerated, that it would be stored in the second floor medication room. During an interview with surveyor #1 on 01/11/23 at 11:10 AM, the DON stated that night shift was responsible to review the medications in the medication storage rooms and return the expired medications and discontinued medications of residents to the pharmacy. It was important to review the medications for expiration dates so that we don't give expired medications to the residents. The DON expected her nurses to keep the medication rooms clean, check for expired medications, and return expired/discontinued resident medications to the pharmacy. At that time, the DON and surveyor #1 reviewed the crash cart on the second floor. The DON stated that there was a binder, which the night shift filled out to check the crash cart and the AED. The DON reviewed the crash cart and could not locate the binder. She stated that the binder was kept from survey to survey. The DON stated that she would have medical records locate the completed forms. She stated that it was important to review the crash cart for expired items because if there was a code, all items should be in date and available. The DON further stated that she expected night shift to maintain the binder, check the crash carts daily and complete the Basic Crash Cart Checklist daily. While at the crash cart, surveyor #1 and DON reviewed the Biohazard Spill Kit expiration dates. The DON confirmed the spill kits were expired and removed them from their basket on the wall. The DON was not sure if the spill kits were reviewed by the night nurse when she reviewed the crash cart and was uncertain if the spill kits were included on the Basic Crash Cart Checklist. The DON reviewed the second floor medication room with surveyor #1. The DON confirmed there was a large and small refrigerator in the medication room and stated the small refrigerator did not require to be locked because it only housed flu vaccines. The DON stated that it was the responsibility of the Nursing Supervisors to monitor the refrigerator temperatures daily and she expected that the temperatures will be monitored daily so that the medications are kept at correct temperatures. At that time, surveyor #1 and DON discussed that the third floor refrigerator did not contain a secured, locked narcotics box. The DON further stated that the narcotics could be stored in the second floor narcotics box unless the narcotic was resident specific. During an interview with surveyor #1 on 01/13/23 at 10:48 AM, the Quality Assurance Consultant #1 stated that the facility could not locate the binders for the crash carts. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Basic Crash Cart Checklist did not include the Biohazard Spill Kits. Review of the facility's undated Medication and Treatment Administration Guidelines, Long-Term Care reflected that medications and biologicals are securely stored in a locked cabinet, cart, or medication room. The guidelines further reflected that controlled substances are securely stored using a double-lock system (medication cart, medication room, refrigerator, controlled substance lock box, and/or separately keyed controlled substance drawer in medication cart). The guidelines further reflected that medications are stored in accordance with standards of practice. Review of the facility's undated Emergency Management document reflected to use a crash cart check sheet and signature form daily to verify the contents of the crash cart. One sheet is used per cart per month. The document further reflected to check emergency care items and equipment stored in the crash cart against the crash cart checklist once a month and whenever the cart is opened to validate contents and expiration dates. The licensed nurse or designee: replaces items with expired dated, secures the cart with break-away lock and covers, signs and dates crash cart checklist. The document further reflected that checklists and signature logs are submitted to the Quality Assurance Performance Improvement committee for review and follow-up upon completion. NJAC 8:39-29.4 (c)(e)(h), 29.7(b)

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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** 37547 Based on observations, interviews, and record reviews, it was determined that the facility failed to a.) handle potentially hazardous foods, and maintain equipment and sanitation in a safe, consistent manner to prevent foodborne illness and b.) consistently document refrigeration temperatures for 3 out of 3 resident rooms. This deficient practice was evidenced by the following: On [DATE] from 9:52 AM to 10:36 AM, the surveyor observed the following in the kitchen in the presence of the Dining Services Director (DSD). 1. In a food preparation area, the surveyor observed that two of four five-pound packages of ground hamburger that were being thawed inside of a stock pot under running water within the sink, protruded halfway out of the stock pot and were not fully submerged beneath the water. The DSD stated that each package of ground beef was required to be submerged beneath the running water to ensure that they defrosted at the same time. She then proceeded to push the packages down into the stock put so that they were fully covered by the running water. Cook #1 returned to the food preparation area and acknowledged that the ground beef was not fully submerged beneath the running water as it was required to be to ensure a safe thawing process. Cook #1 further stated that he intended to defrost the meat to be utilized to make meat loaf to be served the next day. 2. In the walk-in refrigerator: a) On the second shelf of a three-tiered wired rack, there was a clear, plastic bin which contained one cucumber that had multiple areas of a white plaque substance, a second cucumber that appeared to have been cut in half, was not covered, and had begun to decay. There was a head of cabbage with yellow and brown outer leaves. The DSD removed the items from the bin and placed them within a smaller bin. The DSD proceeded to remove the outer leaves from the cabbage, discarded them, and stated that the cabbage was still good. She then returned the cabbage to the storage bin. The DSD stated that the cucumbers should have been discarded and removed them from storage. The surveyor noted a received date of [DATE] on the produce bin which failed to contain a use by date. The DSD stated that she did not know why the use by date was not specified on the produce bin as required. She further stated that produce was normally used within a week of receipt. b) On the bottom rack of a free-standing wired rack, there was an opened five-pound box of chicken thighs that were marked with a received by date of [DATE], the packing label failed to contain an opened date or use by date in the space provided. The DSD stated that there was another sticker on the box which contained a use by date, but it must have fallen off. When the surveyor asked the DSD why it was important to ensure that an opened date and a use by date were written on an opened package of chicken, a potentially hazardous food, she stated that the chicken would be cooked today and served tomorrow and failed to provide a rationale. c) In a food preparation area: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The surveyor observed a can opener that was mounted on the front of the table in the food preparation area. The DSD removed the can opener from the holder upon request and the blade of the can opener was visibly soiled and had a dried, black substance on the anterior blade and a single strand of an orange substance was noted on the upper portion of the blade cover. The DSD stated that she personally cleaned the can opener in the dishwasher on Saturday, [DATE]. The DSD stated that a soiled can opener could cause contamination. The DSD stated that the PM Cook should have cleaned it. The DSD stated that there was no cleaning schedule in place to ensure that the can opener was cleaned. d) In the presence of the DSD and Cook #2 in the galley of the kitchen: The surveyor observed that the cooking surface of a six-burner stove had a thick layer of a black, shiny substance encrusted on the interior and exterior surfaces of all six of the burners and there was also a moderate amount of a thick, yellow dried substance that was also noted on the burners. The DSD stated that the stove was last cleaned on [DATE] and was required to be cleaned every 15 days. The DSD further stated that the stove would be cleaned this Friday, [DATE]. The surveyor requested that the DSD open the oven door that was beneath the six-burner stove. The DSD stated that the oven was not utilized by the facility. When the DSD opened the oven door, a cloth rag was noted on the top rack of the oven, and a cleaning utensil (scraper) was noted on the bottom rack of the oven. Both the inside of the oven door and the floor of the oven were heavily soiled with dried white and yellow food particles. The DSD removed the cloth rag and stated that it posed a potential fire hazard. Cook #2 who was present at that time, stated that she cleaned the inside of the oven on [DATE], and the rag was not there at that time. On [DATE] from 12:25 PM to 1:05 PM, during a follow-up visit to the kitchen, the surveyor observed the following in the presence of the DSD: The surveyor observed Dietary Aide (DA) #1, who wore a hair net that only covered her ponytail and left the top and anterior portion of her hair uncovered as she approached the food service line that was in process. When interviewed, DA #1 stated that her hair was covered, but the hair net must have slipped off. The DSD who was present, stated that DA #1's hair should have been completely covered by the hair net to prevent contamination on the food service line. During an interview with the surveyor on [DATE] at 9:46 AM, the Infection Preventionist (IP) stated that if DA #1's hair was not fully covered by the hair net, hair could end up in the food or an entire container of food could become contaminated. During an interview with the surveyor on [DATE] at 11:17 AM, the Dining Services District Manager (DSDM) stated that the six-burner stove top should have been cleaned daily. The Administrator who was present at that time stated, It was dirty. The DSDM then agreed to furnish the surveyor with the kitchen cleaning schedule. At 11:57 AM, in a later interview with the DSDM, he stated that, There was no process in place for a cleaning schedule in the kitchen previously, but there should have been. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled, Food: Preparation (Revised ,d+[DATE]) revealed the following: Procedures: .Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination. All utensils, food contact equipment, and food contact surfaces will be cleaned and sanitized after every use .The Cook(s) thaws frozen items that requires defrosting prior to preparation using one of the following methods: . Completely submerging the item under cold water (at a temperature of 70 degrees F or below) that is running fast enough to agitate and float loose ice particles; Review of the facility policy titled, Use By Dating Guidelines (Rev. [DATE]) revealed the following: Ready to eat*, Time/Temperature Control for Safety Foods included but were not limited to: .Produce Date With: Use by date seven days after opening .Meats, eggs, and other frozen items that are placed in the refrigerator to thaw: Poultry Use by date ,d+[DATE] days . Review of the facility policy titled, Equipment (Revised ,d+[DATE]), revealed the following: Policy Statement: All foodservice equipment will be clean, sanitary, and in proper working order. Procedures: All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials. All staff members will be properly trained in the cleaning and maintenance of all equipment. All food contact equipment will be cleaned and sanitized after every use. All non-food contact equipment will be clean and free of debris. The Dining Services Director will submit requests for maintenance or repair to the Administrator and/or Maintenance Director as needed . Review of the facility policy titled, Staff Attire (Revised ,d+[DATE]) revealed the following: All employees wear approved attire for the performance of their duties. Procedure: All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained . 36000 2. During the initial tour on [DATE], the surveyor observed the small refrigerators in rooms [ROOM NUMBER]. Attached to each refrigerator was a Refrigerator/Freezer Temperature Log (Temp Log) dated [DATE]. The Temp Log reflected columns for the Date, Time, Internal Temp, Other Temp, and Initials to record the temperatures of the refrigerators daily. The Temp Logs further reflected that the forms were not completed for each day of the month as follows: - The Temp Log from room [ROOM NUMBER] reflected the following dates were blank: [DATE], and [DATE]. - The Temp Log from room [ROOM NUMBER] reflected the following dates were blank: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] reflected the Time of 11:, [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- The Temp Log from room [ROOM NUMBER] reflected the following dates were blank: [DATE], and [DATE]. During an interview with the surveyor on [DATE] at 1:25 PM, Resident #31 stated that the staff cleaned out the refrigerator yesterday. During an interview with the surveyor on [DATE] at 10:49 AM, the Administrator stated that the in-room resident refrigerator logs are to be completed daily and I know they are not being done. The night shift was assigned to monitor the temperatures, and the Maintenance Department will place new temperature logs on each refrigerator monthly. The Certified Nursing Assistants (CNA) will check the temperatures daily on night shift. The Administrator stated, I am well aware that it is not happening and I talk about it all the time. I just hired a new Maintenance Director; and I hope it will be up and running soon. The Administrator stated that it was important to make sure that the food holds the correct temperature so that the residents do not get sick. During an interview with the surveyor on [DATE] at 12:29 PM, CNA #3 stated that he worked on the , d+[DATE] shift and that he was instructed to take the temperature of the refrigerators in resident rooms and make sure they are clean and nothing was spoiled. CNA #3 stated that the temperature should be recorded on the door of the refrigerator; and that normally, the ,d+[DATE] shift was assigned to do this task, but we help each other out. During an interview with the surveyor on [DATE] at 10:26 AM, Registered Nurse (RN) #1 stated that she worked three days per week on night shift. She was instructed that the CNAs were to monitor the temperatures of the in-room refrigerators, to check the refrigerators for expired items and to make sure the refrigerators were clean. RN #1 stated that the temperature logs were maintained in a binder for a month or two months. RN #1 further stated, I don't see the CNAs doing it. During an interview with the surveyor on [DATE] at 10:47 AM, Quality Assurance Consultant #1 stated that the in-room refrigerator logs were inconsistent. The surveyor requested to review the refrigerator log binder. The facility could not provide the binder. Review of the facility's Food From Outside Sources and In-Room Refrigerators, with an Original Date of , d+[DATE], reflected: If personal in-room refrigerators are used: - A staff member designated by the administrator monitors the condition, temperature and maintenance with regard to food safety in the refrigerator. - A temperature log is kept and responsibility for checking and recording temperatures is assigned by the administrator or director of nursing. 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. 37217 Based on observation, interviews, medical record review and other pertinent facility documentation, it was determined that the facility's Administrator failed to ensure that the facility was in compliance with the following regulatory requirements, which affected the safety of all the residents in the facility. The Administrator failed to ensure: 1.) immediate action was taken to initiate contact tracing upon the identification of a COVID positive staff member, Registered Nurse #1 (RN #1), who was symptomatic and provided care to 9 residents on 1 of 2 units and tested positive for COVID-19 while at work on 12/24/22, 2) conduct contact tracing to identify residents and staff who had close contact with symptomatic COVID-19 positive residents (Resident #33 and #235), 3.) a process was in place to conduct immediate resident and staff testing upon identification of a COVID-19 positive staff and residents, 4.) COVID-19 surveillance and monitoring were completed for the residents, 5.) the facility followed the relevant Centers for Disease Control and Prevention (CDC), Federal, and State guidance for infection control, and 6.) the facility's Outbreak Plan and COVID-19 policies were followed to prevent exposure and mitigate the spread of COVID-19, a deadly highly transmissible infectious disease. The Administrator's failure to ensure facility wide infection control prevention standards, policies and procedures were implemented and immediately conduct contact tracing and testing upon the identification of COVID-19-positive staff and residents to prevent the spread of COVID-19, a contagious infectious and potentially deadly virus, posed a serious and immediate risk to the health and well-being of all staff and residents for contracting COVID-19. A serious adverse outcome was likely to occur as the identified non-compliance resulted in an Immediate Jeopardy (IJ) situation that was identified on 1/11/23. The removal plan was accepted and verified as implemented by the survey team during an onsite visit conducted on 1/12/23. The IJ began on 11/15/22 when the former Director of Nursing (DON) who was primarily responsible for infection control left the facility without notice. On 12/24/22 at 7:00 PM, RN #1 reported to work while sick with fever and cough, proceeded to provide care for 9 residents in 1 of 2 resident units, and tested positive for COVID-19 on 12/24/22 at 10:00 PM. The Infection Preventionist (IP) stated that the contact tracing policy was never initiated for the 9 residents on the RN's assignment. Three residents on the RN's assignment were immunocompromised and had a diagnosis of Human Immunodeficiency Virus (HIV) with prednisone (a glucocorticoid medication used to suppress the immune system and decrease inflammation) use, Sickle Cell Anemia (an inherited disease in which the red blood cells have an abnormal crescent shape, and block small blood vessels), Chronic Obstructive Pulmonary Disease (COPD, a condition involving constriction of the airways), 1 of the 3 immunocompromised residents was not vaccinated for COVID-19. Three additional residents were not vaccinated for COVID-19. Additionally, two symptomatic residents tested positive in the facility on 1/1/23 and 1/2/23. There was no contact tracing or subsequent resident testing performed. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	There were no consistent COVID-19 surveillance/assessments completed for the residents. The IP stated that she did not have a line list or notify the local health department of the positive cases. There was no screening or education provided to visitors entering the facility. The IP stated she was following the direction and guidance of the Administrator. The Administrator stated that she assumed that the IP was aware of her responsibilities and fulfilling her role as the IP. Refer to F880L and F886L as it pertains to the facility's failure to ensure the implementation of infection control practices and precautions during an identified COVID-19 outbreak. This deficient practice was evidenced by the following: A review of the Administrator's job description provided by the facility revealed the following: Manages all business related activity to achieve the organization's vision and supporting strategies and assures that the company image as an ethical and high quality provider of health services is maintained. Communicates new Policy and Procedures and regulations to staff to ensure compliance. Ensures that facility operations comply with local, state, and federal standards, laws, and licensing and certifying bodies. Understands and uses company policies, procedures and compliance program to promote quality of care. Develops all facility policies consistent with corporate guidelines. During the entrance conference on 1/3/23 at 11:00 AM, the Infection Preventionist (IP), along with the DON, informed the surveyors there were two COVID-19-positive residents (Resident #33 and Resident #235) in the facility on the 2nd-floor unit. The IP stated she started in the facility in November and was responsible for staff development and infection control. The IP stated that the Administrator was currently on vacation. On 1/4/23 at 9:18 AM, Surveyor #2 asked the DON for the facility line list (a table that contains key information about each case in an outbreak). The DON stated that there was no line list and that it had not been done since the prior DON had left. She stated she had started at the facility in December and was not aware there wasn't a line list until yesterday (1/3/23). On 1/4/22 at 10:00 AM, Surveyor #1 reviewed the facility's COVID tracker (an internal tool that documents COVID-19 positive staff) titled COVID-19 Employee Detail, which revealed RN #1 was positive for COVID-19 on 12/24/22. An additional review revealed that the onset of symptoms was on 12/22/22 and the last day RN #1 worked was 12/24/22. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Surveyor #1 reviewed the COVID Tracker that included RN #1 with the DON and IP. The DON stated RN #1 tested positive for COVID-19 at work on 12/24/22 and had allergy symptoms that included sinus symptoms and headache, for a couple of days before. The DON stated RN #1 did not work on 12/22/22 and 12/23/22 and worked on 12/24/22 for the 7 pm to 7 am shift on the 2nd-floor unit. The DON further stated RN #1 should not have come in sick to work and should have tested before her shift. The DON stated she did not do contact tracing and would have to check the documentation for residents tested . The surveyor asked the IP about the line list for COVID-19 cases in the facility. The IP stated she was new, did not have access to everything, and was not sure of the line list. The IP confirmed the line list was not completed and was following up with the LHD about it. The IP stated the previous DON was completing the line list and was not sure of the date the previous DON had left. During a telephone interview with Surveyor #1 On 1/4/23 at 11:57 AM, RN #1 stated she started feeling sick on 12/22/22 and called out sick to the Registered Nurse Supervisor (RNS) on 12/22/22 and 12/23/22. RN #1 stated she was running temperatures, had a cough, and reported to the RNS that she was not feeling well. She stated the RNS stated, ok and did not ask any further questions. RN #1 stated it was holiday time and if you call out before the holiday, you don't get time and a half. RN #1 stated she went back to work on 12/24/22 and thought she was ok since she called her primary doctor who gave her antibiotics, and she also took Tylenol. RN #1 stated she still had a fever and cough symptoms when she went to work. RN #1 said she received report from the outgoing nurse, checked on her residents, and did her first medication administration pass before testing herself at 10:00 PM and tested positive for COVID-19. The surveyor asked if she had told anyone that she was not feeling well or about her symptoms on 12/24/22. RN #1 stated, Who was I gonna tell .there was no one . only nurses and she had called the DON at 10:00 PM after testing positive. RN#1 stated the DON told her that she had to go home and could not work as she tested positive for COVID-19. RN #1 said she gave report to the other nurse and went home. The surveyor asked RN #1 why she tested herself at 10:00 PM and not before that time. RN #1 replied that the outgoing nurses wanted to give report to go home, and she did not want to keep them waiting. RN #1 stated that no one from the facility had called her to ask about contact tracing including residents she had contact with. RN #1 stated she had education about COVID-19 in 2020 and 2021 and acknowledged that the facility had stated if a staff member had symptoms or was COVID-19 positive that the staff member should not come to work. On 1/4/23 at 11:54 AM, the IP provided the surveyor RN#1's timecard which revealed RN #1 worked on Saturday 12/24/22, clocked in at 7:00 PM, and clocked out at 10:45 PM. On 1/4/23 at 12:38 pm, the IP provided the surveyor with the assignment of RN #1 on 12/24/22, which included 9 residents (Resident #236, #69, #239, #47, # 80, #63, #240, #238 and #52). The IP stated that the residents who were exposed were not tested and there was no documentation that the residents were tested . The IP stated she was new in training, but that she was responsible to ensure they were doing the correct thing and the residents should have been tested . Additionally, the IP stated that the contact tracing policy was not initiated. A review of the medical records for the 9 residents that were assigned to RN #1 on 12/24/22, included three immunocompromised residents: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accelerate Skilled Nursing and Rehab Piscataway	10 Sterling Drive Piscataway, NJ 08854

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #236 who had a diagnosis that included HIV, was receiving dialysis, and prednisone (a corticosteroid medication that suppresses the immune system and decreases inflammation) treatment; Resident #240 who had a diagnosis that included Sickle Cell Anemia; and Resident #238, who had a diagnosis that included COPD. Four of the residents (Resident #236, #69, #239, and #47) were unvaccinated and 5 residents (Resident # 80, #63, #240, #238, and #52) were fully vaccinated according to the facility's resident COVID-19 vaccination matrix. The COVID-19 Surveillance Assessment and progress notes relating to COVID-19 surveillance and monitoring for the 9 residents' electronic medical records were not consistent and were not completed every shift as per the facility's COVID-19 Clinical Monitoring and Measures Plan policy. The policy indicated a Screening UDA [User Defined Assessment] which included vital signs was to be completed every shift for residents in the affected unit (where a resident tested positive or positive employee worked). On 1/4/23 at 12:53 PM, the IP provided to the surveyor a copy of the facility's Contact Tracing Worksheet, dated 10/05/2022, and COVID-19 Outbreak and Contact Tracing Tool, dated 10/19/22. The IP confirmed this was not initiated after positive staff and resident cases in the facility. The Contact Tracing Worksheet indicated the process for contract tracing when a positive COVID-19 case was identified, which included recording COVID-19 positive demographic and exposure data on the COVID-19 Outbreak and Contact Tracing Tool, identifying the first day of symptoms, determining where the symptomatic individual visited and others who were in close contact with the COVID-19 positive individual. The COVID-19 Outbreak and Contact Tracing tool was to be completed for staff and residents, included the COVID-19-positive individual's date of symptom onset, assignment for staff, room number for resident, potentially exposed individuals, if they were in close contact, for how long, and PPE (personal protective equipment, clothing or equipment worn to protect the person from infection) used during contacts. On 1/4/23 at 1:05 PM, Surveyor #1 and Surveyor #2 interviewed the IP and the DON about the process of testing residents and staff, after a positive case. The IP stated testing should be twice a week, positive COVID results are logged in the computer's COVID tracker and there was a surveillance log in which results were written for staff testing. The IP stated there was no log for residents, positive results were found on the resident's medical record, and was not sure where negative results would be documented. The DON stated resident testing, whether positive or negative results, should be documented in the electronic medical record's progress notes. The surveyor requested from the DON and IP documentation of any resident testing conducted. On 1/4/23 at 1:55 PM, Surveyor #1 interviewed the IP about the two COVID-19-positive residents in the facility. The IP stated the two residents were tested because they had symptoms. The IP stated she would check and provide information on contact tracing and resident testing. A review of the progress notes provided by the IP revealed that Resident #235 had chills, muscle aches, cough, and tested positive for COVID-19 on 1/1/23, and Resident #33 had a sore throat with post-nasal drip and tested positive for COVID-19 on 1/2/23. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a follow-up interview with Surveyor #2 on 1/5/23 at 10:58 AM and 12:03 PM, the IP stated there was no process in place to ensure resident testing was done. The IP stated contact tracing should have been done for COVID-19-positive residents and testing of residents in contact but was not done. The surveyor asked for the contact information of the LHD, and the IP handed an email address to the surveyor and stated that she did not have a phone number for the LHD and had not notified the LHD of any of the positive cases. She stated after the former DON left the facility, she was pulled into so many directions and was following the direction and guidance of the Administrator. On 1/11/23 at 9:35 AM, the surveyor interviewed the DON who provided the infection control policy. The policies for isolation precautions, PPE, Infection Surveillance, outbreak investigations, and antibiotic stewardship had a review date of 7/2021. The DON stated she could not find the policy reviewed for the year 2022 and that the infection control policy was reviewed and approved in January 2023. The DON provided policies with an Annual Review page signed by the DON, Administrator, IP, and Medical Director, dated 1/9/2023. During an interview with the surveyors on 1/11/23 at 10:05 AM, the Administrator stated that the former DON had left without notice in November and the IP had a solid week of training and spent a day with the Quality Assurance Consultant. She stated when the DON left, she had assigned the IP to be a Unit Manager on one of the units for oversight and she (the IP) should have been juggling everything. The Administrator stated she would let the IP know if something needed to be addressed and the IP was responsible for in-services, following up with tracking of covid positive residents, ensuring testing was being done, completing surveillance after a positive case, and checking the residents on the assignment after a positive staff case. The Administrator stated she could not recall a positive staff case on 12/24/22. The surveyor informed the Administrator of RN #1, COVID-19 surveillance, and contact tracing concerns. The Administrator stated after a positive COVID-19 case, it was expected for the residents to be tested for COVID-19 and that staff was instructed not to come in to work when sick and to test before starting their shift. The Administrator further stated the LHD should have been notified after the first positive COVID-19 case and that the IP had a contact in the LHD but was not sure who. The Administrator acknowledged the facility's infection control policies and procedures should be reviewed annually and could not recall if the policy was reviewed in 2022. The Administrator stated the DON and herself were responsible for ensuring policies were reviewed. The Administrator stated she was not aware that there was no line list and that there was no contact with the LHD. The Administrator stated she assumed the IP was doing what she was supposed to do and was not following up with her. She stated there was no team meeting held to discuss RN #1 testing positive on 12/24/22. The Administrator stated that she and the DON would be responsible for ensuring the IP was carrying out her responsibilities. During an interview with Surveyor #1 on 1/13/23 at 8:45 AM, the Human Resource Director confirmed that the last day of the prior DON was on 11/15/22. The surveyor reviewed the IP's competency checklist, a twelve page document, titled Infection Preventionist Orientation Plan and Skills Competency Checklist which was dated 11/4/22. Review of the checklist revealed 84 out of 92 tasks were not completed. (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 Job Description provided for the IP with a date of hire of 10/22/22 did not indicate her role and responsibilities as an IP. A review of an undated facility's policy titled Outbreak Plan included the following: Under Testing, Refusal of Testing & Isolation/Cohorting, it read ProMedica Piscataway will continue to test healthcare personnel and residents for Covid-19 in accordance with CDC, CMS, and LHD guidelines.; Under Reporting Requirements, it read Any resident or staff suspected or diagnosed according to State-specific criteria shall be promptly reported to appropriate local and/or state health department officials, included but not limited to NHSN. The policies provided did not further address COVID-19 surveillance. A review of the facility's policy titled COVID-19 Clinical Monitoring and Measures Plan, dated 10/10/22, indicated that when any employee tests positive or a resident (who was not previously being cared for in transmission based precautions [TBP]) tests positive for COVID-19, enhanced measures should be implemented. Enhanced measures included but were not limited to, a Screening UDA (User Defined Assessment) consisting of vital signs every shift for residents in the affected unit (where a resident tested positive or positive employee worked), identifying potential staff, visitor, and other resident prolonged exposure, notification to local department of health of any positive COVID-19 test results, and to refer to CDC Work Restrictions for HCP with SARS-CoV-2 Infection and Exposures to determine status of employee. A review of the Centers for Medicare and Medicaid Services (CMS) directive QSO-20-38-NH, dated revised 09/23/22, included but was not limited to the definition of Close contact refers to someone who has been within 6 feet of a COVID-19 positive person for a cumulative total of 15 minutes or more over a 24-hour period. Guidance - 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 forth by the HHS Secretary. The testing summary included that for newly identified COVID-19 positive staff or resident in a facility that can identify close contacts, the facility should, regardless of vaccination status, test all staff that had a higher-risk exposure with a COVID-19 positive individual and test all residents who had a close contact with a COVID-19 positive individual. Testing during an outbreak revealed that upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately (but not earlier than 24 hours after the exposure, if known). Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based (e.g. facility-wide) testing. Documentation of testing revealed that upon identification of a new COVID-19 case in the facility, document the date the case was identified, the date that other residents and staff are tested , the dates that staff and residents who tested negative are retested , and the results of all tests. (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 CDC guidance Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, revised 9/23/22, indicated if healthcare-associated transmission is suspected or identified, facilities might consider expanded testing of HCP and patients as determined by the distribution and number of cases throughout the facility and ability to identify close contacts. The guidance further indicated the following: A single new case of SARS-CoV-2 infection in any healthcare personnel (HCP) or resident should be evaluated to determine if others in the facility could have been exposed; The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission; Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status; Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5 NJAC 8:39- 19.1(a); 19.2(a)(c),8:39-27.1(a)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. 46049 Based on observation, interview, and record review, it was determined that the facility failed to ensure: 1.) immediate action was taken to initiate contact tracing upon the identification of a COVID positive staff member, Registered Nurse #1 (RN #1), who was symptomatic and provided care to 9 residents on 1 of 2 units and tested positive for COVID-19 while at work on 12/24/22 2. 2) conduct contact tracing to identify residents and staff who had close contact with symptomatic COVID-19 positive residents (Resident #33 and #235) 3.) COVID-19 surveillance and monitoring were completed for the residents, 4.) the facility followed the relevant Centers for Disease Control and Prevention (CDC), Federal, and State guidance for infection control, and 5.) the facility's Outbreak Plan and COVID-19 policies were followed to prevent exposure and mitigate the spread of COVID-19, a deadly highly transmissible infectious disease. The facility's system-wide failure to immediately conduct contact tracing upon the identification of COVID-19-positive staff and residents to prevent the spread of COVID-19, a contagious infectious and potentially deadly virus, posed a serious and immediate risk to the health and well-being of all staff and residents for contracting COVID-19. A serious adverse outcome was likely to occur as the identified non-compliance resulted in an Immediate Jeopardy (IJ) situation that was identified on 1/5/23 at 3:35 PM. The removal plan was accepted and verified as implemented by the survey team during an onsite visit conducted on 1/6/23. The IJ situation began on 12/24/22 at 7:00 PM, when RN #1 reported to work while sick with fever and cough, proceeded to provide care for 9 residents in 1 of 2 resident units, and tested positive for COVID-19 on 12/24/22 at 10:00 PM. The Infection Preventionist (IP) stated that the contact tracing policy was never initiated for the 9 residents on the RN's assignment. Three residents on the RN's assignment were immunocompromised and had a diagnosis of Human Immunodeficiency Virus (HIV) with prednisone (a glucocorticoid medication used to suppress the immune system and decrease inflammation) use, Sickle Cell Anemia (an inherited disease in which the red blood cells have an abnormal crescent shape, and block small blood vessels), Chronic Obstructive Pulmonary Disease (COPD, a condition involving constriction of the airways). 1 of the 3 immunocompromised residents was not vaccinated for COVID-19. Three additional residents were not vaccinated for COVID-19. Additionally, two symptomatic residents tested positive in the facility on 1/1/23 and 1/2/23. There was no contact tracing or subsequent resident testing performed. There were no consistent COVID-19 surveillance/assessments completed for the residents. The IP stated that she did not have a line list or notify the local health department of the positive cases. There was no screening or education provided to visitors entering the facility. The IP stated she was following the direction and guidance of the Administrator. This deficient practice was evidenced by the following: Refer to F 886L (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Reference: Centers for Medicare & Medicaid Services (CMS), QSO-20-38-NH, revised 9/23/22, 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 (CDC) guidance, Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, revised 9/23/22. During the entrance conference on 1/3/23 at 11:00 AM, the Infection Preventionist (IP), along with the Director of Nursing (DON), informed the surveyors there were two COVID-19-positive residents (Resident #33 and Resident #235) in the facility on the 2nd-floor unit. The IP stated she started working in the facility in November and was responsible for staff development and infection control. The IP stated that the Administrator was currently on vacation. On 1/4/23 at 9:18 AM, Surveyor #2 asked the DON for the facility line list. The DON stated that there was no line list and that it had not been done since the prior DON had left. She stated she had started at the facility in December and was not aware there was not a line list until yesterday (1/3/23). On 1/4/23 at 10:00 AM, Surveyor #1 reviewed the facility's COVID tracker (an internal tool that documents COVID-19 positive staff) titled COVID-19 Employee Detail, which revealed RN #1 was positive for COVID-19 on 12/24/22. An additional review revealed that the onset of symptoms was on 12/22/22 and the last day RN #1 worked was 12/24/22. During an interview with Surveyor #1 and Surveyor #2 on 1/4/23 at 11:05 AM, the IP, in the presence of the DON, stated the facility's infection control practice was based on the infection control manual and facility policies based on corporate, CDC guidelines and guidance from the Local Health Department (LHD). The IP stated COVID-19 testing was conducted twice a week and in between that time if someone was symptomatic. The IP stated the residents and staff were tested twice a week on Mondays and Thursdays. Surveyor #1 reviewed the COVID Tracker that included RN #1 with the DON and IP. The DON stated RN #1 tested positive for COVID-19 at work on 12/24/22 and had allergy symptoms that included sinus symptoms and headache, for a couple of days before. The DON stated RN #1 did not work on 12/22/22 and 12/23/22 and worked on 12/24/22 for the 7 pm to 7 am shift on the 2nd-floor unit. The DON further stated RN #1 should not have come in sick to work and should have tested before her shift. The DON stated she did not do contact tracing and would have to check the documentation for residents tested . The surveyor asked the IP about the line list (a table that contains key information about each case in an outbreak) for COVID-19 cases in the facility. The IP stated she was new, and did not have access to everything, and was not sure of the line list. The IP confirmed the line list was not completed and was following up with the LHD about it. The IP stated the previous DON was completing the line list and was not sure of the date the previous DON had left. Surveyor #2 requested the contact information for RN #1, timecards, and residents assigned to RN #1 on 12/24/22. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The COVID-19 Surveillance Assessment and progress notes relating to COVID-19 surveillance and monitoring for the 9 residents' electronic medical records were not consistent and were not completed every shift as per the facility's COVID-19 Clinical Monitoring and Measures Plan policy. The policy indicated a Screening UDA [User Defined Assessment] which included vital signs was to be completed every shift for residents in the affected unit (where a resident tested positive or positive employee worked). On 1/4/23 at 12:53 PM, the IP provided Surveyor #2 a copy of the facility's Contact Tracing Worksheet, dated 10/05/2022, and COVID-19 Outbreak and Contact Tracing Tool, dated 10/19/22. The IP confirmed this was not initiated after positive staff and resident cases in the facility. The Contact Tracing Worksheet indicated the process for contract tracing when a positive COVID-19 case was identified, which included recording COVID-19 positive demographic and exposure data on the COVID-19 Outbreak and Contact Tracing Tool, identifying the first day of symptoms, determining where the symptomatic individual visited and others who were in close contact with the COVID-19 positive individual. The COVID-19 Outbreak and Contact Tracing tool was to be completed for staff and residents, included the COVID-19-positive individual's date of symptom onset, assignment for staff, room number for resident, potentially exposed individuals, if they were in close contact, for how long, and PPE used during contacts. On 1/4/23 at 1:05 PM, Surveyor #1 and Surveyor #2 interviewed the IP and the DON about the process of testing residents and staff, after a positive case. The IP stated testing should be twice a week, positive COVID results are logged in the computer's COVID tracker and there was a surveillance log in which results were written for staff testing. The IP stated there was no log for residents, positive results were found on the resident's medical record, and was not sure where negative results would be documented. The DON stated resident testing, whether positive or negative results, should be documented in the electronic medical record's progress notes. Surveyor #1 requested from the DON and IP documentation of any resident testing conducted. On 1/4/23 at 1:55 PM, Surveyor #1 interviewed the IP about the two COVID-19-positive residents in the facility. The IP stated the two residents were tested because they had symptoms. The IP stated she would check and provide information on contact tracing and resident testing. A review of the progress notes provided by the IP revealed that Resident #235 had chills, muscle aches, cough, and tested positive for COVID-19 on 1/1/23, and Resident #33 had a sore throat with post-nasal drip and tested positive for COVID-19 on 1/2/23. During an interview with Surveyor #1 on 1/5/23 at 10:42 AM, the RNS stated if someone said they were calling out sick or not feeling well, she would ask about their symptoms, how long, and when they last worked. The RNS could not recall if she received any callouts when working on 12/22/22 and 12/23/22. The surveyor asked the RNS if she was aware of a positive COVID-19 staff case on 12/24/22. The RNS stated she knew they had a case but does not know who it was. The RNS stated there was a schedule logbook where callouts are written. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a follow-up interview with Surveyor #2 on 1/5/23 at 10:58 AM and 12:03 PM, the IP stated there was no process in place to ensure resident testing was done. The IP stated contact tracing should have been done for COVID-19-positive residents and testing of residents in close contact but was not done. The surveyor asked for the contact information of the LHD, and the IP handed an email address to the surveyor and stated that she did not have a phone number for the LHD and had not notified the LHD of any of the positive cases. She stated after the former DON left the facility, she was pulled into so many directions and was following the direction and guidance of the Administrator. On 1/5/23 at 1:30 PM, the DON provided Surveyor #1 with the call-out log for December 2022. The call-out log was in calendar format, which included the employee's name written on the day the employee called out. RN #1's name was documented on the December 2022 call-out log for 12/22/22 and 12/23/22. There was no further information documented on the call-out log. During an interview with the surveyors on 1/11/23 at 10:05 AM, the Administrator stated that the former DON had left without notice in November and the IP had a solid week of training and spent a day with the Quality Assurance Consultant. She stated when the DON left, she had assigned the IP to be a Unit Manager on one of the units for oversight and she (the IP) should have been juggling everything. The Administrator stated she would let the IP know if something needed to be addressed and the IP was responsible for in-services, following up with tracking of covid positive residents, ensuring testing was being done, completing surveillance after a positive case, and checking the residents on the assignment after a positive staff case. The Administrator stated she could not recall a positive staff case on 12/24/22. The surveyor informed the Administrator of RN #1, COVID-19 surveillance, and contact tracing concerns. The Administrator stated after a positive COVID-19 case, it was expected for the residents to be tested for COVID-19 and that staff was instructed not to come in to work when sick and to test before starting their shift. The Administrator further stated the LHD should have been notified after the first positive COVID-19 case and that the IP had a contact in the LHD but was not sure who. The Administrator stated she was not aware that there was no line list and that there was no contact with the LHD. The Administrator stated she assumed the IP was doing what she was supposed to do and was not following up with her. She stated there was no team meeting held to discuss RN #1 testing positive on 12/24/22. The Administrator stated that she and the DON were responsible for ensuring the IP was carrying out her responsibilities. During an interview with Surveyor #1 and Surveyor #2 on 1/13/23 at 9:13 am, the Medical Director, stated he was made aware of the COVID-19 tracking and testing concerns. The Medical Director stated that the facility followed CDC and CMS guidelines for policies and was unaware they were not being followed. The Medical Director stated he was always made aware of positive COVID-19 cases in the facility and testing of residents should be based on contact tracing. The surveyor reviewed the IP's competency checklist, a twelve page document, titled Infection Preventionist Orientation Plan and Skills Competency Checklist which was dated 11/4/22. Review of the checklist revealed 84 out of 92 tasks were not completed. A review of the Job Description provided for the IP with a date of hire of 10/22/22, did not indicate her role and responsibilities as an IP. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of an undated facility's policy titled Outbreak Plan included the following: Under Testing, Refusal of Testing & Isolation/Cohorting, it read ProMedica Piscataway will continue to test healthcare personnel and residents for Covid-19 in accordance with CDC, CMS, and LHD guidelines.; Under Reporting Requirements, it read Any resident or staff suspected or diagnosed according to State-specific criteria shall be promptly reported to appropriate local and/or state health department officials, included but not limited to NHSN. The policies provided did not further address COVID-19 surveillance. A review of the facility's policy Infection Control Manual, 07/10/2021 included the following: Under Surveillance, Section 4: Outbreak Investigations read, An epidemic or outbreak is an excess over the expected or usual level of a disease within a geographic area. One case may constitute an epidemic and warrant an outbreak investigation .The Infection Preventionist or DON, under the direction of the Medical Director, manages an outbreak investigation. Under Outbreak Strategies, it read Upon identification of a potential outbreak, conduct an outbreak investigation. The objectives of any outbreak investigation are to describe the situation (what is happening), determine the etiology (where did the infection start), what is the agent, where is the source and what is the method of spread. It is important to identify the incubation period (interval between exposure and onset of symptoms). A review of the facility's policy titled COVID-19 Clinical Monitoring and Measures Plan, dated 10/10/22, indicated that when any employee tests positive or a resident (who was not previously being cared for in transmission based precautions [TBP]) tests positive for COVID-19, enhanced measures should be implemented. Enhanced measures included but were not limited to, a Screening UDA [User Defined Assessment] consisting of vital signs every shift for residents in the affected unit (where a resident tested positive or positive employee worked), identifying potential staff, visitor, and other resident prolonged exposure, notification to local department of health of any positive COVID-19 test results, and to refer to CDC Work Restrictions for HCP with SARS-CoV-2 Infection and Exposures to determine status of employee. A review of the Centers for Medicare and Medicaid Services (CMS) directive QSO-20-38-NH, dated revised 09/23/22, included but was not limited to the definition of Close contact refers to someone who has been within 6 feet of a COVID-19 positive person for a cumulative total of 15 minutes or more over a 24-hour period. Guidance - 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 forth by the HHS Secretary. The testing summary included that for newly identified COVID-19 positive staff or resident in a facility that can identify close contacts, the facility should, regardless of vaccination status, test all staff that had a higher-risk exposure with a COVID-19 positive individual and test all residents who had a close contact with a COVID-19 positive individual. Testing during an outbreak revealed that upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately (but not earlier than 24 hours after the exposure, if known). Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based (e.g. facility-wide) testing. Documentation of testing revealed that upon identification of a new COVID-19 case in the facility, document the date the case was identified, the date that other residents and staff are tested , the dates that staff and residents who tested negative are retested , and the results of all tests. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of CDC guidance Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, revised 9/23/22, indicated if healthcare-associated transmission is suspected or identified, facilities might consider expanded testing of HCP and patients as determined by the distribution and number of cases throughout the facility and ability to identify close contacts. The guidance further indicated the following: A single new case of SARS-CoV-2 infection in any healthcare personnel (HCP) or resident should be evaluated to determine if others in the facility could have been exposed; The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission; Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status; Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. Part B F880 remains a deficiency at a scope and severity of an F based on the following: Based on observations, interviews, and review of other facility documentation, it was determined that the facility failed to: 1) conduct screening or education for visitors entering the facility, 2) review annually the facility's infection control and infection prevention plan and policies, and 3) maintain proper infection control practices identified during the: a) tour of the kitchen b) dining observation, and c) medication administration observation identified on 1 of 2 Nursing Units (Second Floor), and for 1 of 2 nurses (Licensed Practical Nurse #2) observed during the medication pass. This deficient practice was evidenced by the following: 1) On 1/3/23 at 9:05 AM, six surveyors entered the facility and were greeted by the front desk receptionist, who was not wearing a mask. The receptionist after greeting the surveyor applied a surgical mask. The receptionist instructed the surveyors to sign in with their names and date. There was no COVID-19 screening or education. Surveyor #2 interviewed the receptionist about the process of visitor check-in. The receptionist stated visitors sign in who they are visiting, they do not check temperatures anymore, and was not sure if there were COVID-19-positive residents in the facility. The receptionist stated there was no COVID-19 screening of visitors since November 2022. The receptionist further stated previously they would check temperatures and had a form for visitors to fill out. There was a sign on the reception desk for all visitors to always wear a mask in the facility. There was no signage about COVID-19 observed by the main entrance or reception area. On 1/3/23 at 10:29 AM, Surveyor #2 used the elevator, where there was signage observed for visitors about COVID-19, signs and symptoms, and signage that indicated a mask and face shield was required for the 2nd and 3rd-floor units. Signs were also observed in front of the elevators for visitors about COVID, its signs and symptoms, and a small sign was noted behind the reception area that was not visible. On 1/4/23 at 8:59 AM, the surveyors entered the facility, there were no visible signs posted about COVID-19 by the main entrance. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 1/4/23 at 11:05 AM, Surveyors #1 and #2 interviewed the infection preventionist (IP) and the Director of Nursing (DON) about visitor education and screening. The IP stated they did not conduct visitor screening since before she started working there and that the facility cannot close to visitors. The surveyor asked about any COVID-19 education for visitors. The IP stated signs were posted, though she was not sure if any were posted by the main entrance. On 1/4/23 at 11:50 AM, Surveyor #3 interviewed Guest Services/Recreation Director about visitor screening, who stated there used to be a Visitors/Staff Attestation. The Visitor/Staff had their temperature taken, they answered questions about COVID-19 signs and symptoms and then the second form had contact information and verified that the person was aware that the building had Covid positive residents. The Guest Services/Recreation Director stated the Administrator informed the staff in November they would not be using COVID-19 attestation forms and that she sent out an email to staff on November 4, 2022. A copy of the email was provided to the surveyor. During an interview with the surveyors on 1/11/23 at 10:05 AM, the Administrator stated in November 2022, the policy of screening visitors changed based on a zoom meeting with the corporate level nurse who provided an update on CDC guidance. The Administrator further stated visitors were given masks and were informed of proper PPE (personal protective equipment, protective clothing or equipment used to protect the body from injury or infection) to use when coming into the facility. A review of an undated facility's policy titled Outbreak Plan included the following: Under Screening & Protective Measures, it read Healthcare personnel and permitted visitors entering ProMedica Piscataway will be screened for COVID-19 illness; Under Notification Plan, it read Signage is posted at entrance doors to alert visitors to Covid-19. A review of the facility's Infection Control Manual policy with a revised date of 07/2021 included the following: Section 2: Precaution Systems, under Visitor Management, it read, Visitor management is the control of access and actions of people visiting for the safety and prevention of disease transmission. The policies provided did not further address COVID-19 visitor screening and education. 2) On 1/11/23 at 9:35 AM, the surveyor interviewed the DON who provided the infection control policy. The policies for isolation precautions, PPE, Infection Surveillance, outbreak investigations, and antibiotic stewardship had a review date of 7/2021. The DON stated she could not find the policy reviewed for the year 2022 and that the infection control policy was reviewed and approved in January 2023. The DON provided policies with an Annual Review page signed by the DON, Administrator, IP, and Medical Director, dated 1/9/2023. During an interview with the surveyor on 1/11/23 at 10:05 AM the Administrator acknowledged the facility's policies and procedures should be reviewed annually and could not recall if the policy was reviewed in 2022. The Administrator stated the DON and herself were responsible for ensuring policies were reviewed. During an interview with the surveyor on 1/13/23 at 9:13 AM, the Medical Director stated he was not sure exactly, but believed the policies were reviewed at the last QAPI meeting in December. The surveyor informed the Medical Director that the DON and the Administrator could not find an annual infection control policy review for 2022. The Medical Director provided no direct response and further stated the interdisciplinary team discussed protocols in morning meetings. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	37547 3) On 01/03/23 at 9:52 AM, during the initial tour of the kitchen, the surveyor observed the Dining Services Director (DSD) who touched the lid of a trash can with her bare hands as she attempted to open the lid after the foot pedal feature malfunctioned. The DSD then proceeded to wash her hands for 14 seconds before she began the tour of the kitchen. During an interview with the surveyor on 01/04/23 at 8:40 AM, the DSD stated that when she washed her hands yesterday in the presence of the surveyor, she sang the happy birthday song once to ensure that she washed her hands for what she thought was the appropriate length of time of 20 seconds. The DSD further stated that if she did not wash her hands for at least 20 seconds prior to the tour of the kitchen there was a concern of contamination. During an interview with the surveyor on 01/11/23 at 10:46 AM, the Administrator stated that if the DSD had not washed her hands for at least 20 seconds prior to the tour of the kitchen, She could have passed germs onto the food and all around the kitchen. During an interview with the surveyor on 01/12/23 at 11:35 AM, the Infection Preventionist (IP) stated that the DSD should have washed her hands for 20 seconds prior to the tour of the kitchen to prevent the spread of infectious agents or bacteria. On 01/12/23 at 12:25 PM, during a follow-up visit to the kitchen, the surveyor observed Dietary Aide (DA #1) who washed her hands for 32 seconds at the handwashing sink, left the water running in the sink, dried her hands on a paper towel, removed her hair net, and replaced it with a larger one that provided full coverage, as the one she wore only covered her ponytail, and not the front or top of her head. DA #1 then proceeded to turn off the faucet with her bare hands. When interviewed at that time, DA #1 stated that she knew that she should have used a paper towel to turn off the faucet, but she had forgotten to. The DSD who was present stated that there was a potential for contamination since DA #1 touched her hair, then touched the faucet with her bare hands. The DSD stated that DA #1's responsibilities included plating food on the food service line, which was in process during the time of the observation. During an interview with the surveyor on 01/13/23 at 9:46 AM, the IP stated that DA #1 should have used a paper towel to turn off the faucet after she washed her hands because she re-contaminated her hands and that could have transferred to the faucet which had a potential for the spread of infection. 4) On 01/03/23 at 12:10 PM, the surveyor observed that a Dietary Aid (DA) delivered the food truck to Hall A of the Second Floor Nursing Station and proceeded to leave the unit. At 12:11 PM, the surveyor observed Certified Nursing Assistant (CNA #4) as she approached the food truck and removed the first meal tray without first performing hand hygiene before she delivered the tray to Unsampled Resident #1. The resident requested a plastic cup. CNA #4 returned to the food truck, obtained a plastic cup, and provided it to the resident as requested. CNA #4 then exited the resident's room without first performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	At 12:12 PM, the surveyor observed CNA #4 as she approached the food truck and reviewed Unsampled Resident #2's meal ticket before she poured coffee from a carafe into a coffee cup and placed it on the resident's tray. CNA #4 then proceeded to deliver the meal tray to the resident without first performing hand hygiene. The surveyor observed that CNA #4 did not offer to assist the resident with hand hygiene prior to the meal service. CNA #4 then exited the resident's room without first performing hand hygiene. At 12:13 PM, the surveyor observed CNA #4 who removed Unsampled Resident #3's tray from the food truck without first performing hand hygiene. The resident was asleep when she entered the room and she attempted to wake the resident by calling the resident's name without success. CNA #4 left the tray at the bedside and exited the resident's room without first performing hand hygiene. At 12:15 PM, the surveyor observed CNA #4 who removed Unsampled Resident #4's tray from the food truck without first performing hand hygiene and delivered it to the resident. CNA #4 offered the resident assistance and opened[TRUNCATED]

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46049 Based on observation, interview, and record review of facility documentation, it was determined that the facility failed to implement their protocol to monitor and track resident antibiotic use for the month of December 2022. This deficient practice was identified for 1 of 1 resident (Resident #52) reviewed for antibiotics and was evidenced by the following: On 1/9/23 at 9:10 AM, the surveyor asked the DON and IP to provide information on Antibiotic Stewardship tracking and surveillance. On 1/10/23 at 9:25 AM, the DON provided the surveyor with the facility's Antibiotic Stewardship Report (an automated report generated from the information entered about initial resident infection trends). A review of the provided Antibiotic Stewardship Report, dated 1/9/23, indicated the monthly data for antibiotic use and infections from 12/1/22 to 12/31/22. The report did not detail any further information regarding specific residents, type of organisms, diagnostic tests, treatments, or durations of antibiotics. The surveyor asked the DON to provide further information regarding their Antibiotic and Infection tracking. The surveyor reviewed the hybrid medical records of Resident #52 who was being reviewed for antibiotic medication use, which revealed the following: The Admission Minimum Data Set (MDS) assessment, dated 12/7/22, which indicated the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored a 15 out of 15 which indicated that that the resident was cognitively intact. The MDS assessment also indicated the resident had active diagnoses of chronic frontal sinusitis and other local infections of the skin and subcutaneous tissue. A review of the Order Summary Report and the electronic Medication Administration Record (eMAR) indicated Resident #52 had a physician order, dated 12/10/22, which read: Ertapenem [an antibiotic medication] Sodium Solution Reconstituted 1 GM Use 1 gram intravenously one time a day for Sinus Infection until 01/11/2023. The eMAR also had a physician order entry, discontinued date on 12/10/22 that read: Ertapenem [an antibiotic medication] Sodium Solution Reconstituted 1 GM Use 1 gram intravenously one time a day for Sinus Infection until 01/11/2023. On 1/10/23 at 9:45 AM, the DON provided the surveyor with the facility's Infection Detail Report for Excel (a report that provides comprehensive information on residents with infections), which was dated 1/9/23. A review of the Infection Detail Report listed residents with infections from 12/1/22 to 12/31/22, which included documentation of their symptoms, diagnostic tests (if any completed), antibiotic medications and other treatments administered, and duration of the prescribed treatment. Resident #52, who was being reviewed for antibiotic medication use, was not listed on the report. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/10/23 at 10:33 AM, the surveyor interviewed the DON about antibiotic stewardship and that Resident #52 was not listed on the report. The DON stated the IP was educated yesterday about the Antibiotic Stewardship tracking and the Infection Detail Report for December 2022 was completed yesterday. On 1/10/23 at 1:08 PM, the surveyor interviewed the IP about Antibiotic Stewardship. The surveyor asked the IP about antibiotic surveillance and tracking process. The IP stated during morning interdisciplinary meetings new admissions and residents with changes in conditions are reviewed to determine residents with infections or antibiotic treatment. The IP acknowledged the [DATE] Antibiotic Stewardship reports were completed yesterday (1/9/23). The IP stated the December 2022 tracking report was updated to include Resident #52 and the report for January 2023 was currently in progress. The IP stated she was aware it had to be done and that it was her responsibility as IP. The IP further stated that she did not finish her orientation and was not aware how to complete it until she was trained yesterday by the Interim DON. On 1/12/23 at 1:54 PM, the surveyor informed the Administrator, Quality Assurance Consultant (QAC) #1, QAC #2, and Regional Director of Operations of the concerns for the Antibiotic Stewardship tracking for December 2022 not being completed. The facility provided no additional information. A review of the facility's Infection Control Manual policy, dated 07/10/2021 included the following: Under Surveillance, Section 2: Monthly Surveillance, Monthly Infection Surveillance Tracking and Trending read, Information about infections is gathered, monitored and tracked throughout the month .The data entered generates surveillance reports which are reviewed by the Infection Preventionist for trend identification including trends that may require initiating outbreak investigations .The Infection Preventionist monitors types of infections, symptoms, location, onset date, cultures, swabs and X-rays taken including dates and results, the type of precautions, treatment interventions initiated and the date the infection is resolved. Any patient/resident placed on antibiotics for reasons other than prophylactic i.e., pre-surgical, pre-dental procedures or non-transmissible disease conditions, should be counted on Surveillance Tracking. A review of the facility titled, Antibiotic Stewardship, dated 07/2021, indicated under Leadership Commitment, QMS trend reports submitted by Infection Preventionist to Antibiotic Stewardship Committee and/or QAPI/Infection Control Committees for review and consideration include: Antibiotic Stewardship Report, Infection Rate Report, Infection Detail Report, Question Response Drill Down Report and Monthly Infection Control Analysis Report. NJAC 8:39-19.4(d)(g)

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Report COVID19 data to residents and families. 46049 Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure resident representatives were informed of a newly confirmed COVID-19 diagnosis of a staff member in the facility by 5 PM the next calendar day. This deficient practice was identified for 1 of 1 staff who tested positive for COVID-19 (Registered Nurse #1) and was evidenced by the following: During the entrance conference on 1/3/23 at 11:00 AM, the surveyor requested the process of notification of confirmed and suspected COVID-19 cases to residents and resident representatives. On 1/4/22 at 10 AM, Surveyor #1 reviewed the facility's COVID tracker (an internal tool that documents COVID-19 positive staff) titled COVID-19 Employee Detail, which revealed RN #1 was positive for COVID-19 on 12/24/22. On 1/5/23 at 10:01 AM, the DON informed Surveyor #2 that COVID-19 positive results for staff and residents were entered into the facility's COVID tracker and would trigger automated (robo) calls to resident representatives. The DON further stated they started making flyers to notify the residents in the facility. On 1/9/23 at 12:30 PM, the IP provided the surveyor a report of automated calls made to resident representatives about the COVID case on 12/24/22. A review of the untitled report of automated calls for the notification of resident representatives regarding the 12/24/22 COVID-19 positive case revealed the automated calls were dated as assigned on 12/27/22. The report included the resident's name their resident representative and indicated if a call was answered. On 1/11/23 9:35 AM, the surveyor interviewed the DON about the automated call report that was dated 12/27/22 for notification to residents' representatives about the COVID-19 case on 12/24/22. The DON was unable to provide any additional documentation that resident representatives were notified by 12/25/22 at 5 PM when the new COVID-19 positive case was confirmed on 12/24/22. The DON stated the most recent report for automated calls was on 12/27/22. The DON further stated it was the holiday and the automated calls go out once results were submitted to the facility's COVID tracker. During an interview with the surveyor on 1/11/23 at 10:05 AM, the Administrator stated resident representatives would be notified of COVID-19 cases in the facility by automated calls. The Administrator stated it was expected for resident representatives to be notified by the next day. The surveyor informed the Administrator of the concern that the report of the automated calls indicated that resident representatives were notified on 12/27/22 about the COVID-19 case on 12/24/22. The Administrator acknowledged notification was delayed and stated it was because of the holiday. (continued on next page)

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 1/12/23 at 10:46 AM, IP stated once COVID-19 cases were entered into the COVID tracker, it triggered automated calls for notification. The IP stated she was responsible for entering COVID-19 positive cases into the COVID tracker. The IP confirmed the COVID-19 case was entered into the COVID tracker on 12/27/22, after the holiday weekend when she returned to work. On 1/12/23 at 1:54 PM, the surveyor informed the Administrator, Quality Assurance Consultant (QAC) #1, QAC #2, and Regional Director of Operations about the concern of timely notification of COVID-19 cases in the facility and notification for COVID-19 case on 12/24/22 was on 12/27/22. No further information was presented to the surveyor. The surveyor reviewed the facility policy titled, Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff, dated 1/27/2021. Under Procedure, 3. Positive COVID test results must be entered into the COVID Tracker as soon as received, seven days a week, to meet the requirement of calls being made by 5 pm the next calendar day following the occurrence. NJAC 8:39-5.1 (a)

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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. 46049 Based on interview, medical record review, and review of facility documents, it was determined that the facility failed to ensure: 1.) a symptomatic Registered Nurse #1 (RN #1) notified the supervisor, prior to the start of her shift on 12/24/22 that she was ill, 2.) a process was in place to conduct immediate resident and staff testing upon identification of a COVID-19 positive staff member (RN #1) who provided care to 9 residents on 1 of 2 units while working on 12/24/22, and for two residents who tested positive for COVID-19 (Residents #33 and #235) 3.) the facility followed the relevant Centers for Disease Control and Prevention (CDC), Federal, and State guidance for infection control, and 4.) the facility's Outbreak Plan and COVID-19 policies were followed to prevent exposure and mitigate the spread of COVID-19, a deadly, highly transmissible infectious disease. The facility's system-wide failure to immediately conduct COVID-19 testing upon the identification of COVID-19-positive staff and residents to prevent the spread of COVID-19, a contagious infectious and potentially deadly virus, posed a serious and immediate risk to the health and well-being of all staff and residents for contracting COVID-19. A serious adverse outcome was likely to occur as the identified non-compliance resulted in an Immediate Jeopardy (IJ) situation that was identified on 1/5/23 at 3:35 PM. The removal plan was accepted and verified as implemented by the survey team during an onsite visit conducted on 1/6/23. The IJ situation began on 12/24/22 at 7:00 PM, when RN #1 reported to work while sick with fever and cough, proceeded to provide care for 9 residents in 1 of 2 resident units, and tested positive for COVID-19 on 12/24/22 at 10:00 PM. The Infection Preventionist (IP) stated there was no process in place to test the residents and staff. There was no evidence that the facility tested the 9 residents the RN had on her assignment. Three residents on the RN's assignment were immunocompromised and had a diagnosis of Human Immunodeficiency Virus (HIV) with prednisone use, Sickle Cell Anemia, and Chronic Obstructive Pulmonary Disease (COPD). 1 of the 3 immunocompromised residents was not vaccinated for COVID-19. Three additional residents were not vaccinated for COVID-19. Additionally, two symptomatic residents tested positive in the facility on 1/1/23 and 1/2/23. There was no subsequent resident testing performed. This deficient practice was evidenced by the following: Refer to 880L Reference: Centers for Medicare & Medicaid Services (CMS), QSO-20-38-NH, revised 9/23/22, 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 During the entrance conference on 1/3/23 at 11:00 AM, the IP, along with the Director of Nursing (DON), informed the surveyors that there were two COVID-19-positive residents (Resident #33 and Resident #235) in the facility on the 2nd-floor unit. The IP stated she started in the facility in November and was responsible for staff development and infection control. The IP stated that the Administrator was currently on vacation. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 1/4/22 at 10:00 AM, Surveyor #1 reviewed the facility's COVID tracker (an internal tool that documents COVID-19 positive staff), titled COVID-19 Employee Detail which revealed RN #1 was positive for COVID-19 on 12/24/22. An additional review revealed that the onset of symptoms was on 12/22/22 and the last day the RN #1 worked was 12/24/22. During an interview with Surveyor #1 and Surveyor #2 on 1/4/23 at 11:05 AM, the IP, in the presence of the DON, stated the facility's infection control practice was based on the infection control manual and facility policies based on corporate, CDC guidelines and guidance from the Local Health Department (LHD). The IP stated COVID-19 testing was conducted twice a week and in between that time if someone was symptomatic. The IP stated the residents and staff were tested twice a week on Mondays and Thursdays. Surveyor #1 reviewed the COVID Tracker which included RN #1 with the DON and IP. The DON stated RN #1 tested positive for COVID-19 at work on 12/24/22 and had allergy symptoms that included sinus symptoms and headache, for a couple of days before. The DON stated RN #1 did not work on 12/22/22 and 12/23/22 and worked on 12/24/22 for the 7 pm to 7 am shift on the 2nd-floor unit. The DON further stated RN #1 should not have come in sick to work and should have tested before her shift. The DON stated she did not do contact tracing and would have to check the documentation for residents who were tested . During a telephone interview with Surveyor #1 On 1/4/23 at 11:57 AM, RN #1 stated she started feeling sick on 12/22/22 and called out sick to the Registered Nurse Supervisor (RNS) on 12/22/22 and 12/23/22. RN #1 stated she was running temperatures, had a cough, and reported to the RNS that she was not feeling well. She stated the RNS stated, ok and did not ask any further questions. RN #1 stated it was holiday time and if you call out before the holiday, you don't get time and a half. RN #1 stated she went back to work on 12/24/22 and thought she was ok since she called her primary doctor who gave her antibiotics, and she also took Tylenol. RN #1 stated she still had a fever and cough symptoms when she went to work. RN #1 stated she received report from the outgoing nurse, checked on her residents, did her first medication administration pass before testing herself at 10:00 PM, and tested positive for COVID-19. The surveyor asked if she had told anyone that she was not feeling well or about her symptoms on 12/24/22. RN #1 stated, Who was I gonna tell .there was no one .only nurses and she had called the DON at 10:00 PM after testing positive. RN#1 stated the DON told her that she had to go home and could not work as she tested positive for COVID-19. RN #1 said she gave report to the other nurse and went home. The surveyor asked RN #1 why she tested herself at 10:00 PM and not before that time. RN #1 replied that the outgoing nurses wanted to give report to go home, and she did not want to keep them waiting. RN #1 stated that no one from the facility had called her to ask about contact tracing including residents she had contact with. RN #1 stated she had education about COVID-19 in 2020 and 2021 and acknowledged that the facility had stated if a staff member had symptoms or was COVID-19 positive that the staff member should not come to work. On 1/4/23 at 11:54 AM, the IP provided the surveyor RN #1's timecard which revealed RN #1 worked on Saturday 12/24/22, clocked in at 7:00 PM, and clocked out at 10:45 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 1/4/23 at 12:38 PM, the IP provided the surveyor with the assignment of RN #1 on 12/24/22, which included 9 residents (Resident #236, #69, #239, #47, # 80, #63, #240, #238 and #52). The IP stated that the residents who were exposed were not tested and that there was no documentation that the residents were tested . The IP stated she was new in training, but that she was responsible to ensure they were doing the correct thing and the residents should have been tested . A review of the medical records for the 9 residents that were assigned to RN #1 on 12/24/22, included three immunocompromised residents: Resident #236 who had a diagnosis that included HIV, was receiving dialysis, and prednisone (a corticosteroid medication that suppresses the immune system and decreases inflammation) treatment; Resident #240 who had a diagnosis that included Sickle Cell Anemia; and Resident #238, who had a diagnosis that included COPD. Four of the residents (Resident #236, #69, #239, and #47) were unvaccinated and 5 residents (Resident # 80, #63, #240, #238, and #52) were fully vaccinated according to the facility's resident COVID-19 vaccination matrix. On 1/4/23 at 1:05 PM, Surveyor #1 and Surveyor #2 interviewed the IP and the DON about the process of testing residents and staff, after a positive case. The IP stated testing should be twice a week, positive staff COVID results are logged in the computer's COVID tracker and there was a surveillance log in which results were written for staff testing. The IP stated there was no log for residents, positive results were found on the resident's medical record, and she was not sure where negative results would be documented. The DON stated resident testing, whether positive or negative results, should be documented in the electronic medical record's progress notes. The surveyor requested from the DON and IP documentation of any resident testing conducted. On 1/4/23 at 1:55 PM, Surveyor #1 interviewed the IP about the two COVID-19-positive residents in the facility. The IP stated the two residents were tested because they had symptoms. The IP stated she would check and provide information on contact tracing and resident testing. A review of the progress notes provided by the IP revealed that Resident #235 had chills, muscle aches, and cough, and tested positive for COVID-19 on 1/1/23, and Resident #33 had a sore throat with post-nasal drip and tested positive for COVID-19 on 1/2/23. During an interview with Surveyor #1 on 1/5/23 at 10:42 AM, the RNS stated if someone said they were calling out sick or not feeling well, she would ask about their symptoms, how long, and when they last worked. The RNS could not recall if she received any callouts when working on 12/22/22 and 12/23/22. During a follow-up interview with Surveyor #2 on 1/5/23 at 10:58 AM and 12:03 PM, the IP stated there was no process in place to ensure resident testing was done. The IP stated contact tracing should have been done for the COVID-19-positive residents and testing of residents in contact but was not completed. She stated after the former DON left the facility, she was pulled into so many directions and was following the direction and guidance of the Administrator. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview with the surveyors on 1/11/23 at 10:05 AM, the Administrator stated that the former DON had left without notice in November and the IP had a solid week of training and spent a day with the Quality Assurance Consultant. She stated when the DON left, she had assigned the IP to be a Unit Manager on one of the units for oversight and she (the IP) should have been juggling everything. The Administrator stated she would let the IP know if something needed to be addressed and the IP was responsible for in-services, following up with tracking of covid positive residents, ensuring testing was being done, completing surveillance after a positive case, and checking the residents on the assignment after a positive staff case. The Administrator stated she could not recall a positive COVID-19 staff case on 12/24/22. The surveyor informed the Administrator of RN #1, COVID-19 surveillance, and contact tracing concerns. The Administrator stated after a positive COVID-19 case, it was expected for the residents to be tested for COVID-19 and that staff was instructed not to come in to work when sick and to test before starting their shift. The Administrator stated she assumed the IP was doing what she was supposed to do and was not following up with her. She stated there was no team meeting held to discuss RN #1 testing positive on 12/24/22. The Administrator stated that she and the DON would have been responsible for ensuring the IP was carrying out her responsibilities. During an interview with Surveyor #1 and Surveyor #2 on 1/13/23 at 9:13 AM, the Medical Director stated he was made aware of the COVID-19 tracking and testing concerns. The Medical Director stated that the facility followed CDC and CMS guidelines for policies and was unaware they were not being followed. The Medical Director stated he was always made aware of positive COVID-19 cases in the facility and testing of residents should be based on contact tracing. The surveyor reviewed the IP's competency checklist, a twelve page document, titled Infection Preventionist Orientation Plan and Skills Competency Checklist which was dated 11/4/22. Review of the checklist revealed 84 out of 92 tasks were not completed. A review of the Job Description provided for the IP with the date of hire of 10/22/22, did not indicate her role and responsibilities as an IP. (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 Centers for Medicare and Medicaid Services (CMS) directive QSO-20-38-NH, dated revised 09/23/22, included but was not limited to the definition of Close contact refers to someone who has been within 6 feet of a COVID-19 positive person for a cumulative total of 15 minutes or more over a 24-hour period. Guidance - 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 forth by the HHS Secretary. The testing summary included that for newly identified COVID-19 positive staff or resident in a facility that can identify close contacts, the facility should, regardless of vaccination status, test all staff that had a higher-risk exposure with a COVID-19 positive individual and test all residents who had a close contact with a COVID-19 positive individual. Testing during an outbreak revealed that upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately (but not earlier than 24 hours after the exposure, if known). Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based (e.g. facility-wide) testing. Documentation of testing revealed that upon identification of a new COVID-19 case in the facility, document the date the case was identified, the date that other residents and staff are tested , the dates that staff and residents who tested negative are retested , and the results of all tests. A review of an undated facility's policy titled Outbreak Plan included the following: Under Evidence-Based Outbreak Response Measures, it revealed, if a new/reemergence of an infectious disease is detected, ProMedica Piscataway will follow its Infection Control policies and the measures and procedures set forth by the CDC, CMS, and LHD for guidelines and directives. Under Testing, Refusal of Testing & Isolation/Cohorting, it read ProMedica Piscataway will continue to test healthcare personnel and residents for Covid-19 in accordance with CDC, CMS, and LHD guidelines.; Under Reporting Requirements, it read Any resident or staff suspected or diagnosed according to State-specific criteria shall be promptly reported to appropriate local and/or state health department officials, included but not limited to NHSN. The policies provided did not further address COVID-19 surveillance. A review of the facility's policy titled COVID-19 Clinical Monitoring and Measures Plan, dated 10/10/22, indicated that when any employee tests positive or a resident (who was not previously being cared for in transmission based precautions [TBP]) tests positive for COVID-19, enhanced measures should be implemented. Enhanced measures included but were not limited to, a Screening UDA [User Defined Assessment] consisting of vital signs every shift for residents in the affected unit (where a resident tested positive or positive employee worked), identifying potential staff, visitor, and other resident prolonged exposure, notification to local department of health of any positive COVID-19 test results, and to refer to CDC Work Restrictions for HCP with SARS-CoV-2 Infection and Exposures to determine status of employee. A review of the facility's policy titled Testing Criteria Summary, dated 10/05/22, for newly identified COVID-19 positive staff or resident (not in TBP) in a facility/community that can identify close contacts included: For newly identified COVID-19 positive staff or resident in a facility that can identify close contacts, the facility should, regardless of vaccination status, test all staff that had a higher-risk exposure with a COVID-19 positive individual and test all residents who had a close contact with a COVID-19 positive individual and testing frequency should be performed Day 1, 3, and 5 unless a positive result is obtained. NJAC 8:39- 19.1(a); 19.2(a)(c)