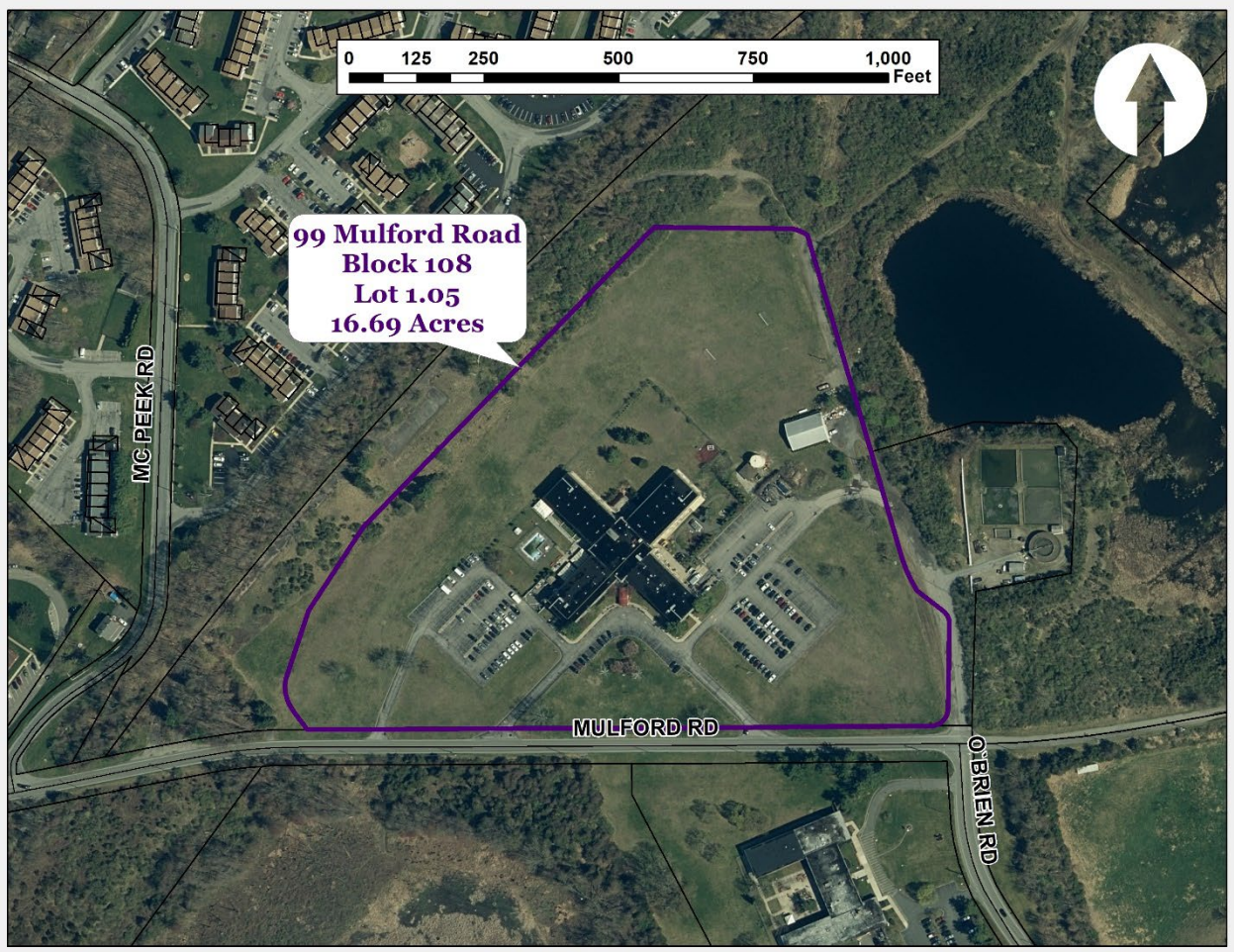
AREA IN NEED OF REDEVELOPMENT STUDY

Woodlands Behavioral and Nursing Center at Andover

99 Mulford Road, Andover Township

Block 108, Lot 1.05



ANDOVER TOWNSHIP, SUSSEX COUNTY

J Caldwell & Associates, LLC
Community Planning Consultants

February 1, 2023

Acknowledgments

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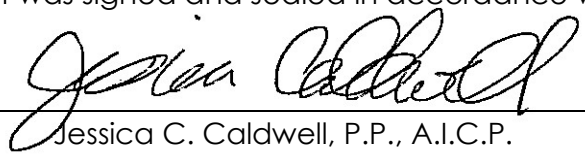

Jessica C. Caldwell, P.P., A.I.C.P.

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Figure 1. Overview of Study Area.

1.2 BACKGROUND

On September 20, 2022, the Governing Body of the Township of Andover authorized the Andover Township Land Use Board via Resolution R2022-119, to conduct a Condemnation Area in Need of Redevelopment Study for the area identified as Block 108, Lot 1.05 on the official tax maps of the Township of Andover (the "Study Area"). The Study Area is located in Block 108, Lot 1.05, at 99 Mulford Road, Andover Township, Sussex County, New Jersey.

The Study Area includes one tax parcel, Block 108, Lot 1.05, and is 16.692 acres in size, located in the northeastern section of the Township along Mulford Road, where the nearest intersection is with O'Brien Road. The Study Area consists of the former Woodland Behavioral and Nursing Center at Andover, a 543-Bed Subacute Nursing Home, which closed in August 2022. The Study Area is developed with one main building, a garage/storage building, water tower, ancillary parking and loading and outdoor yard areas. The main building has a 40,000 square foot footprint and is three (3) stories, for an overall building area of approximately 120,000 square feet. The main building has four (4) wings on each floor which meet in the center of the structure. The garage/storage building is approximately 4,000 square feet (80' x 50').

The purpose of this Study is to determine whether the Governing Body should designate all, or a portion, of the Study Area as a Condemnation Area in Need of Redevelopment under the Redevelopment Law. The Governing Body requested, via Resolution R2022-119 that the Land Use Board conduct a study of the Area to determine if the Study Area meets the criteria to be determined a Condemnation Area in Need of Redevelopment pursuant to Local Redevelopment and Housing Law (Redevelopment Law), N.J.S.A 40A:12A-1 et seq.

Township Resolution R2022-119 also requires that the preliminary investigation of the Study Area be undertaken within the context of a "Condemnation" Redevelopment Area, meaning that if the Study Area is determined to be an Area in Need of Redevelopment under the Redevelopment Law, it shall be given a redevelopment designation. Due to the condemnation designation, the municipality will have the statutory authority to exercise the power of eminent domain to acquire property in the designated area.

The following Study will determine whether the Study Area qualifies as an "Area in Need of Redevelopment" pursuant to the requirements set forth by the Redevelopment Law. The analysis presented in this Study is based upon an examination of existing conditions, site inspections, review of tax data and available government records, a history of the site pertaining to land use and pertinent reporting on the site, zoning ordinances, master plan goals and objectives, and an evaluation of the statutory "area in need of redevelopment" criteria.

2. LOCAL REDEVELOPMENT AND HOUSING LAW

The Local Redevelopment and Housing Law (Redevelopment Law) was designed by the New Jersey State Legislature to provide a process for addressing underutilized, untenable, vacant, and abandoned properties:

"There exist, have existed and persist in various communities of this State conditions of deterioration in housing, commercial and industrial installations, public services and facilities and other physical components and supports of community life and improper or lack of proper, development which result from forces which are amenable to correction and amelioration by concerted effort of responsible public bodies, and without this public effort are not likely to be corrected or ameliorated by private effort."

The Legislature has by various enactments empowered and assisted local governments in their effort to revitalize communities through programs of redevelopment, rehabilitation, and incentives to provide for the expansion and improvement of commercial, industrial, residential, and civic facilities.

2.1 PROCESS

The following process must be followed in order to designate an area in need of redevelopment (N.J.S.A. 40A:12A-6):

a) The Governing Body adopts a resolution authorizing the Planning Board to undertake a preliminary investigation of a proposed area to determine if the area is in need of redevelopment. The resolution must designate whether the area being considered is proposed as a "Condemnation Redevelopment Area" or a "Non-Condemnation Redevelopment Area". The Condemnation Redevelopment Area permits the Governing Body to use the power of eminent domain in a designated redevelopment area. The Governing Body forwards a map of the proposed study area to the Planning Board.

b) The Planning Board "prepares" a map and appends a statement setting forth the basis for the investigation. This must be on file with the Municipal Clerk.

c) A study of the proposed area in need of redevelopment is prepared for review by the Planning Board's planner.

d) The Planning Board sets a date for a public hearing on the study and provides notice and opportunity for the public and those that would be affected by the determination to provide input on the study. The hearing notice must identify the general boundaries of the area and a map is on file with the municipal clerk. The hearing notice must also identify whether the area is being considered as a condemnation or non-condemnation area. The notice must be published for two weeks prior to the hearing in the newspaper of record. The notice must also be mailed to all property owners in the study area and anyone who has expressed interest in the designation.

e) After completing the hearing, the Planning Board makes a recommendation to the Governing Body whether the area, in whole or in part, should be designated as an area in need of redevelopment.

f) The Governing Body, after receiving a recommendation from the Planning Board, may adopt a resolution determining that the delineated area, in whole or in part, is designated as an area in need of redevelopment.

g) The Clerk must transmit a copy of the resolution to the Commissioner of the State Department of Community Affairs (NJDCA) for review and approval. NJDCA has 30 days to approve or disapprove of the area. If NJDCA does not respond in 30 days, the area is approved.

h) Notice of the determination must be provided to all property owners within the delineated area within 10 days of the determination. If the area was determined to be a condemnation area the following language must be in the notice:

   i. The determination operates as a finding of public purpose and authorizes the municipality to exercise the power of eminent domain to acquire property in the redevelopment area, and

   ii. Legal action to challenge the determination must be commenced within 45 days of receipt of notice and that failure to do so shall preclude an owner from later raising such challenge.

i) Following the 45-day appeal period and approval or no comment from NJDCA, then the area is designated as a redevelopment area and the municipality may exercise all of the powers set forth in the Redevelopment Law.

j) In order to carry out a redevelopment of the site, a redevelopment plan must be adopted by the Governing Body. The plan may be prepared by the Governing Body and adopted pursuant to an ordinance with a referral to the Planning Board. Alternatively, the Governing Body may ask the Planning Board to prepare the plan, after which the Governing Body may adopt the plan pursuant to an ordinance.

k) The Redevelopment Plan, once adopted, acts as the zoning on the site.

2.2 BENEFITS OF REDEVELOPMENT

The Redevelopment Law provides for planning and financial benefits for development within an area deemed to be in need of redevelopment to incentivize development as follows:

a. Adopt a redevelopment plan that will identify the manner in which an area will be developed, including its use;

b. Clear an area, install, construct or reconstruct streets, facilities, utilities, and site improvements;

c. Negotiate and enter into contracts with private redevelopers or public agencies for the undertaking of any project or redevelopment work;

d. Issue bonds for the purpose of redevelopment;

e. Acquire property (only for condemnation areas in need of redevelopment);

f. Lease or convey property without having to go through the public bidding process; and

g. Grant long term tax exemptions and abatements (PILOTS).

2.3 CRITERION FOR AN AREA IN NEED OF REDEVELOPMENT

Before an area can be deemed an area in need of redevelopment, each parcel must be reviewed against the statutory criteria to determine if at least one criterion is met pursuant to N.J.S.A 40A:12A-5 listed below:

A. The generality of buildings are substandard, unsafe, unsanitary, dilapidated, or obsolescent, or possess any of such characteristics, or are lacking in light, air, or space, as to be conducive to unwholesome living or working conditions.

B. The discontinuance of the use of a building or buildings previously used for commercial, retail, shopping malls or plazas, office parks, manufacturing, or industrial purposes; the abandonment of such building or buildings; significant vacancies of such building or buildings for at least two consecutive years; or the same being allowed to fall into so great a state of disrepair as to be untenantable.

C. Land that is owned by the municipality, the county, a local housing authority, redevelopment agency or redevelopment entity, or unimproved vacant land that has remained so for a period of ten years prior to adoption of the resolution, and that by reason of its location, remoteness, lack of means of access to be developed through the instrumentality of private capital.

D. Areas with buildings or improvements which, by reason of dilapidation, obsolescence, overcrowding, faulty arrangement or design, lack of ventilation, light and sanitary facilities, excessive land coverage, deleterious land use or obsolete layout, or any combination of these or other factors are detrimental to the safety, health, morals or welfare of the community.

E. A growing lack or total lack of proper utilization of areas caused by the condition of the title, diverse ownership of the real properties therein or other similar conditions which impede land assemblage or discourage the undertaking of improvements, resulting in a stagnant and unproductive condition of land potentially useful and valuable for contributing to and serving the public health, safety, and welfare, which condition is presumed to be having a negative social or economic impact or otherwise being detrimental to the safety, health, morals or welfare of the surrounding area or the community in general.

F. Areas, in excess of five contiguous acres, whereon buildings or improvements have been destroyed, consumed by fire, demolished or altered by the action of storm, fire, cyclone, tornado, earthquake or another casualty in such a way that the aggregate assessed value of the area has been materially depreciated.

G. In any municipality in which an enterprise zone has been designated pursuant to the "New Jersey Urban Enterprise Zones Act, "P.L.1983, c303 (C.52:27H-60 et seq.) the execution of the actions prescribed in that act for the adoption by the municipality and approval by the New Jersey Urban Enterprise Zone Authority of the zone development plan for the area of the enterprise zone shall be considered sufficient for the determination that the area is in need of redevelopment pursuant to sections 5 and 6 of P.L.1992, C.79 (C.40A:12A-5 and 40A:12A-6) for the purpose of granting tax exemptions within the enterprise zone district pursuant to the provisions of P.L.1991, c.431(C.40A:20-1et seq.) or the adoption of a tax abatement and exemption ordinance pursuant to the provisions of P.L.1991, c441(C.40A:21-1 et seq.). The municipality shall not utilize any other redevelopment power within the urban enterprise zone unless the municipal governing body and planning board have also taken the actions and fulfilled the requirements prescribed in the P.L. 1992, C.79 (C.40A:12A-1 et al.) for determining that the area is in need of redevelopment or an area in need of rehabilitation and the municipal governing body has adopted a redevelopment plan ordinance including the area of the enterprise zone.

H. The designation of the delineated area is consistent with smart growth planning principals.

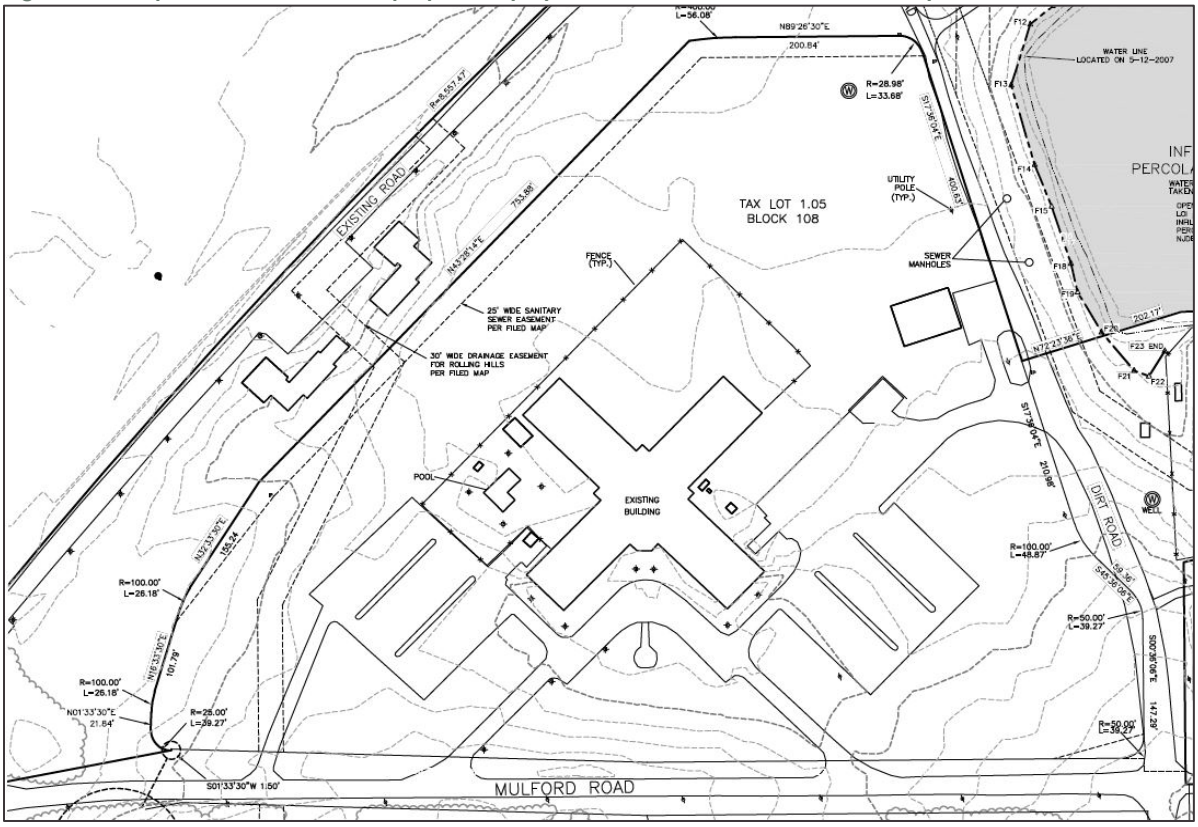
In addition to the above criteria, Section 3 of the Redevelopment Law allows the inclusion of parcels necessary for the effective redevelopment of the area, by stating "a redevelopment area may include land, buildings, or improvements, which of themselves are not detrimental to the health, safety or welfare, but the inclusion of which is found necessary, with or without change in their condition, for the effective redevelopment of the area in which they are a part."

3. OVERVIEW OF THE STUDY AREA

3.1 DESCRIPTION

The Study Area, Block 108, Lot 1.05, is comprised of one (1) parcel that occupies 16.692 acres according to the official tax maps of Andover Township. The Study Area contains a 543-bed nursing home facility, which closed in August 2022, and was known as the Woodlands Behavioral and Nursing Center at Andover. The Study Area does not have any waterways or wetland areas on the subject property. There are no known contaminated sites, steep slopes, or groundwater contamination within the Study Area. A survey below shows all the existing buildings which are on site including all accessory structures. The facility consists of a three (3) story building, with four (4) building wings which is approximately 120,000 square feet. Also on the property is a storage shed/garage which is approximately 80 feet by 50 feet (4,000 square feet). The Woodland Nursing Home paid $1.4 Million in property taxes in 2021, of which 27% went into the $10 million municipal budget, 57% went to fund schools, and 16% went to county services.[1]

Figure 2. Survey of Block 108, Lot 1.01 prepared by Dykstra Associates, Inc. and dated May 31, 2007.

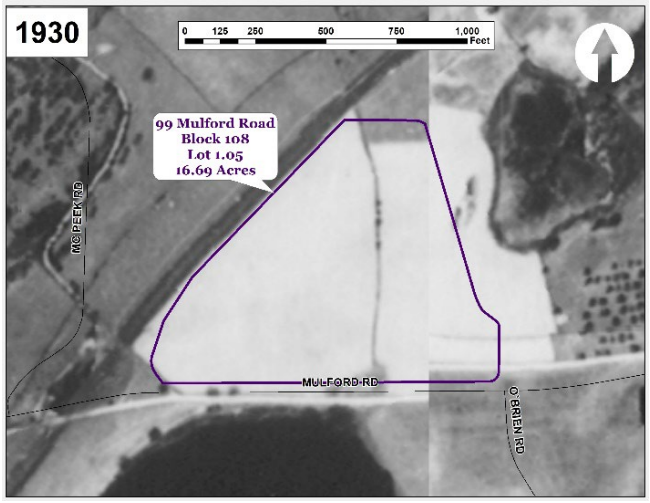


[1] Scruton, Bruce A. "Andover: If Woodland nursing home is shut down township will suffer. Murphy asked to help" New Jersey Herald June 15, 2022 https://www.njherald.com/story/news/2022/06/15/woodland-nursing-home-andover-nj-financial-aid-murphy/7623945001/ Accessed December 20, 2022

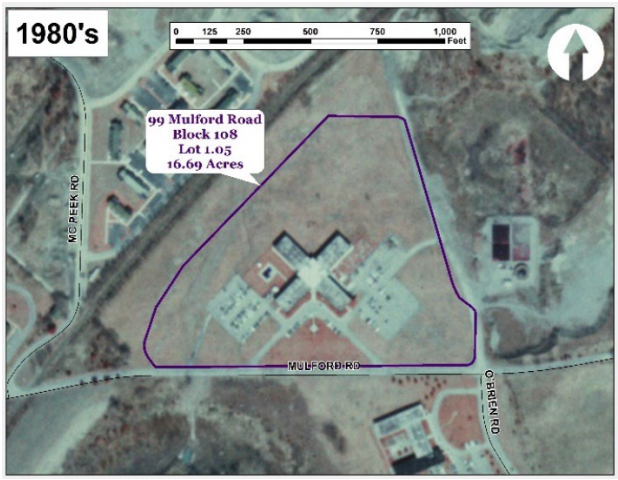
3.2 SITE DEVELOPMENT HISTORY

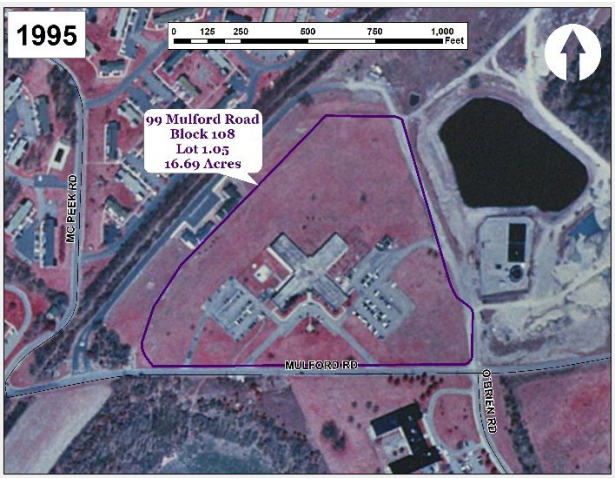
Historic aerials of the site indicate that as of 1930, the Study Area was cleared of trees, potentially for agricultural purposes. Mulford Road existed but few other roadways around the subject property existed. By 1971, it appears as if the site was cleared for development. By 1984, the existing three-story, four-wing facility was constructed, as were the pool and parking areas. This is consistent with the deed from 2004 which states that the property, identified as Andover Intermediate Care Center, was deeded to a joint venture trade between Jeryl Industries and Andover Nursing and Convalescent Home, Inc., dated December 20, 1978 and recorded December 26, 1978 in Deed Book 1021, Page 1159. The property was likely constructed between 1979 and 1982. Based on the aerial imagery, it appears that the storage shed/garage was constructed sometime between 1995 and 2002.

1930

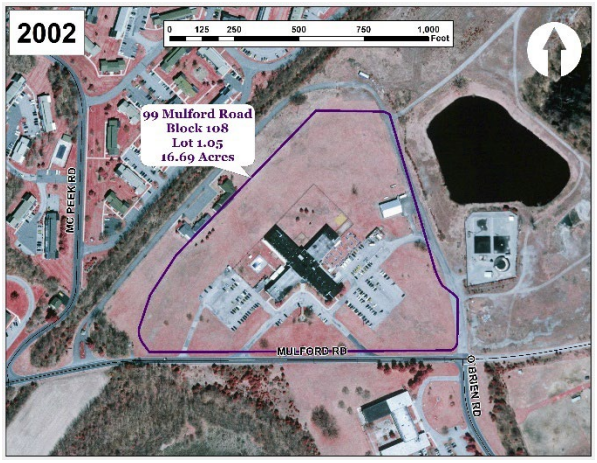


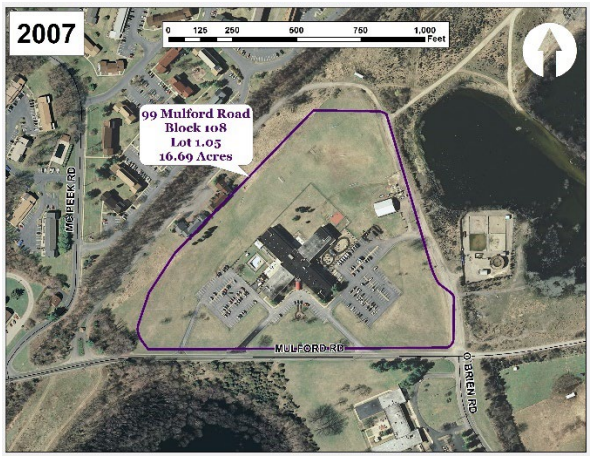
1971

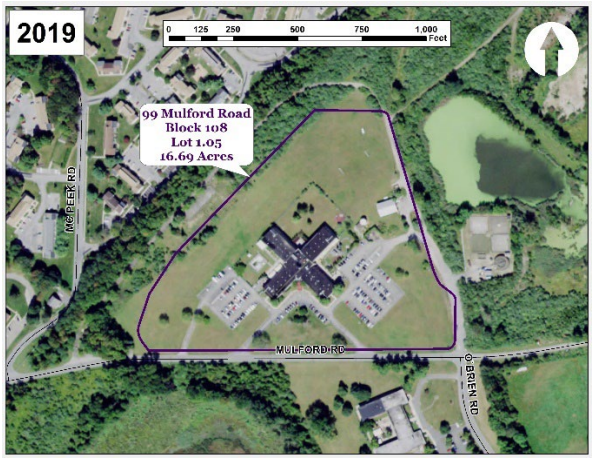


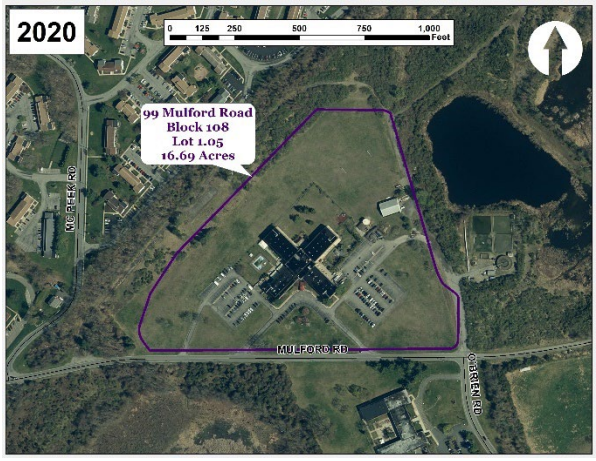


Overview of the Study Area







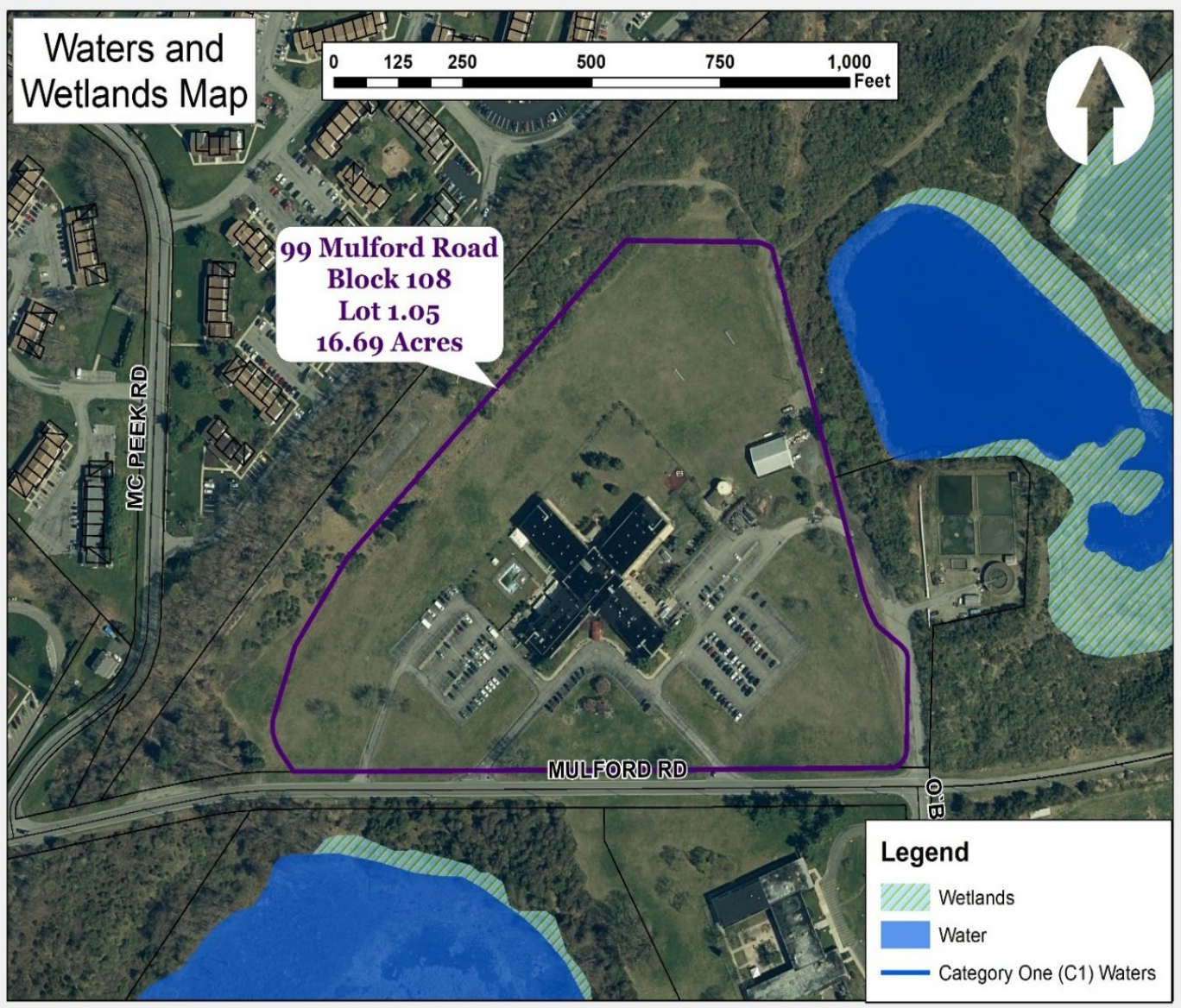


Overview of the Study Area

3.3 ENVIRONMENTAL HISTORY

The Study Area is relatively flat with no known State Open Waters or wetlands present. There are also no known contaminated sites that are located on site. The map below shows where the nearest State Open Waters and wetlands are in relation to the Study Area.

Figure 3. Waters and Wetlands.



Overview of the Study Area

3.4 EXISTING LAND USE

The Study Area includes one (1) tax lot covering an area comprised of New Jersey Department of Environmental Protection (NJDEP) Land Use Land Cover designations including Commercial/Services, Urban and Coniferous Brush/Shrubland. A detailed breakdown of the Land Use Land Cover categories is shown below.

Table 1. Land Use / Land Cover.

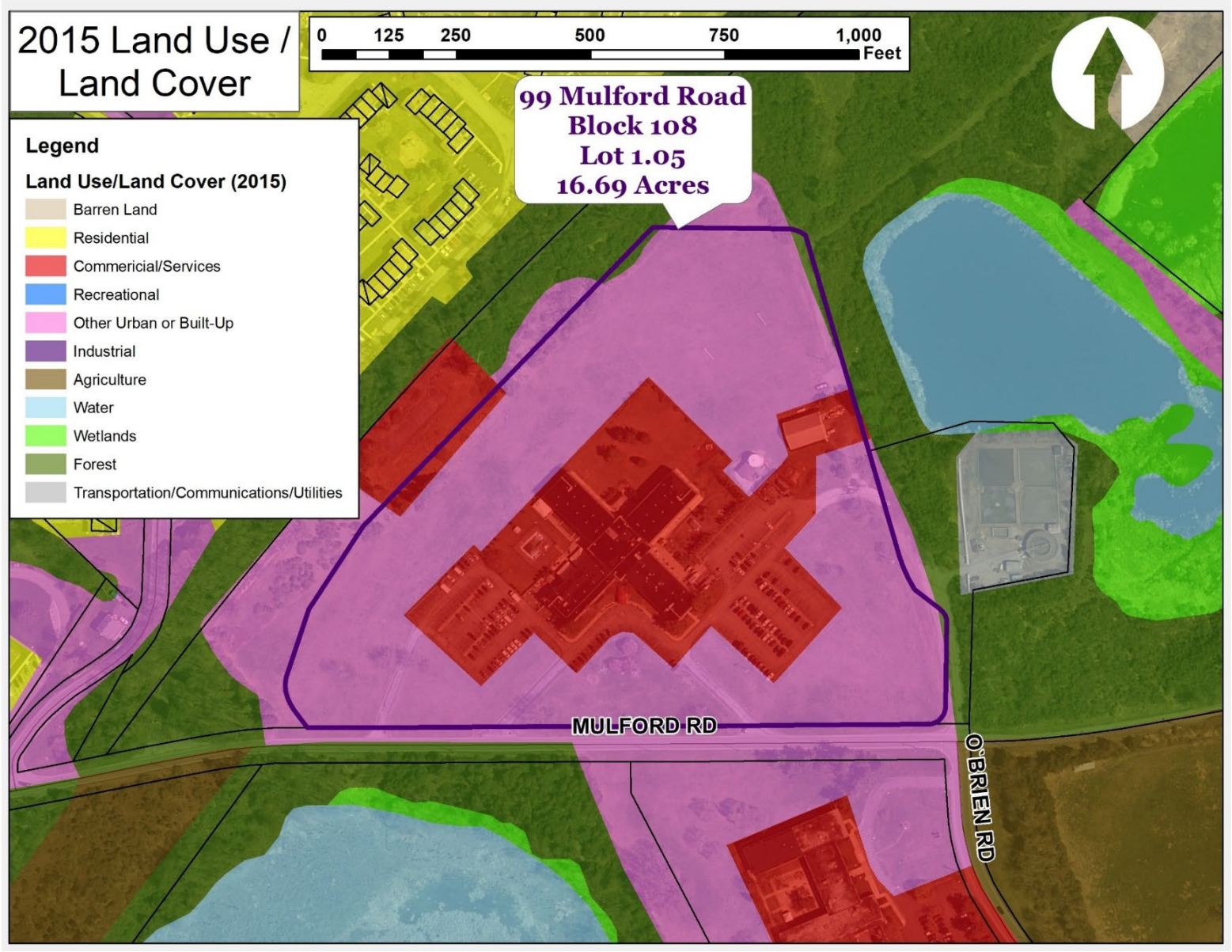
#	Block	Lot	Acreage (ac.)	Land Use
1	108	1.05	5.84	Commercial / Services
2	108	1.05	10.69	Other Urban or Built-Up Land
3	108	1.05	0.16	Coniferous Brush / Shrubland
		Total Acreage	16.692 Acres	

NJDEP Land Use Land Cover Designations within the Study Area are as follows:

1. Approximately 35% of the Study Area is designated as Commercial / Services Land Use;
2. Approximately 64% of the property is designated as Other Urban or Built-Up Land; and
3. The remaining 1.0% of the property is Coniferous Brush/Shrubland Land Use.

The Study Area is developed with two (2) structures: the main nursing home / subacute building; and the garage/storage building, which are categorized as Commercial/Services Land Uses. Other small accessory structures are included in the Other Urban or Built-Up Land Use category.

Figure 4. 2015 Land Use / Land Cover.



Overview of the Study Area

3.5 RELATIONSHIP TO SURROUNDING NEIGHBORHOOD

The Study Area is in the northeastern section of Andover Township. The property is bordered to the north and northwest by the Rolling Hills Condominium Multi-family residential development. To the west of the property is the Ascot Park Apartment complex; south of the property is the Limecrest Subacute and Rehabilitation Center and Howells Pond; east of the property is Lifecare Mews Wastewater Treatment Facility and an infiltration percolation lagoon. Further to the east is a combination of forested and wetland areas. Development near the Study Area is located primarily along Mulford Road and O'Brien Road. Other uses in the broader surrounding areas consist of: a single family residential neighborhood to the south and a small commercial area along Newton Sparta Road; a single-family residential neighborhood beyond the apartments to the east; the Farmstead Golf and Country Club beyond the apartments to the north; single family residential properties and farm properties to the east; and some industrial uses to the east along Limecrest Road heading into Sparta and LaFayette.

3.6 ZONING ANALYSIS

The Study Area is located within the SR Special Residential Zone. The following are permitted uses within the SR Special Residential Zone:

Principal Permitted Uses

A. Agriculture, farm and horticulture (§ 190-42)
B. Community shelters for victims of domestic violence.
C. Community shelters for the developmentally disabled.
D. Family day-care centers.
E. Nursing homes (§ 190-37).
F. Public parks, playgrounds, conservation areas and municipal facilities.
G. Single-family detached dwellings (as regulated in the R-2 Zone District).

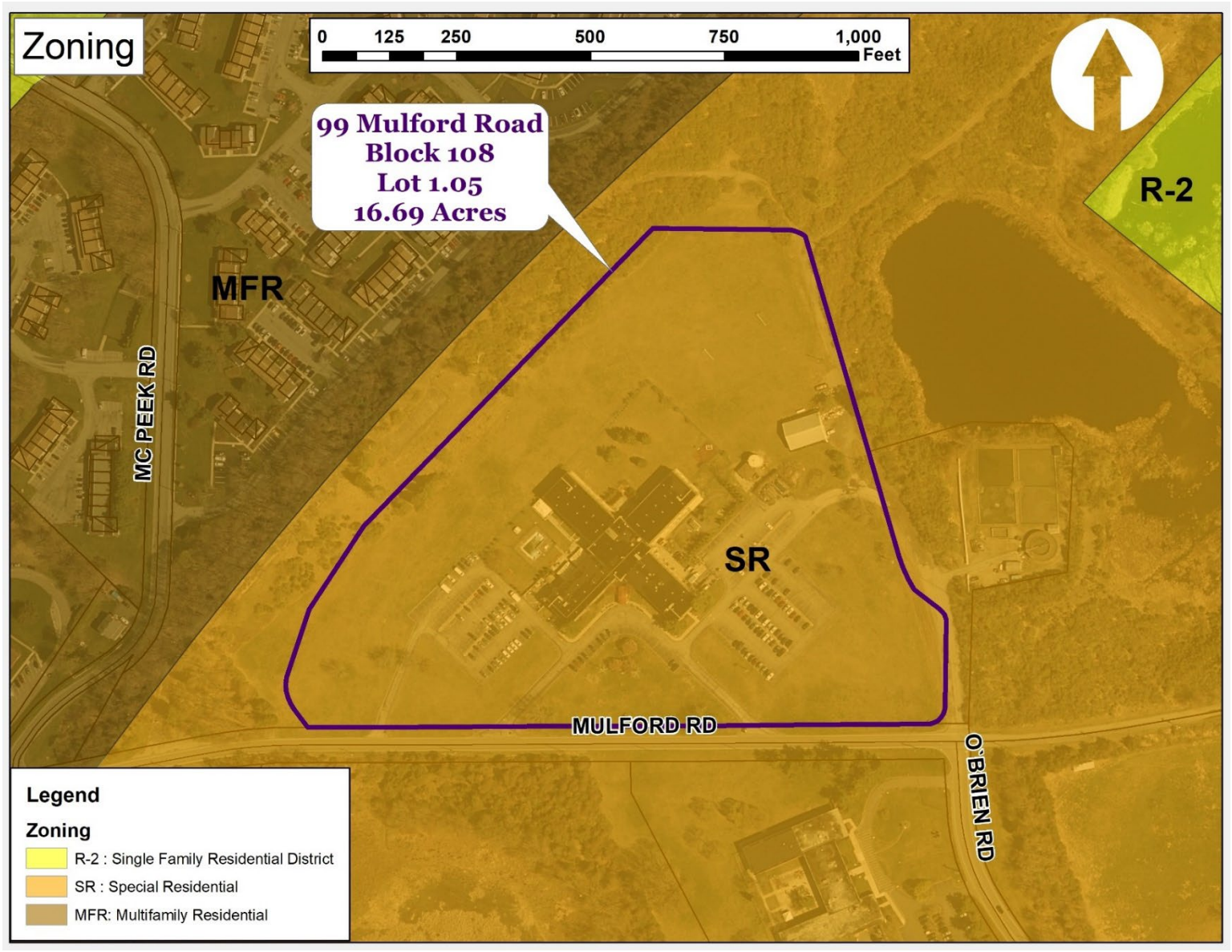
Accessory Uses Permitted

A. Fences (Art. XII).
B. Private garages and carports.
C. Private recreational facilities for project residents.
D. Signs (Art. XI).
E. Uses customarily incidental to principal use.

Conditional Uses Permitted

A. Essential services (§ 190-46).
B. Places of worship and religious institutions (§ 190-48).

Figure 5. Zoning Map.



Overview of the Study Area

3.7 RELATIONSHIP TO MASTER PLAN

The Township's most recent Master Plan was adopted in 1992. Since then, Master Plan Reexamination Reports were adopted in 2007, 2008, 2010 and 2011. The 2011 Zoning Map identifies the Zoning for the Study Area as Special Residential.

The Special Residential Zone District consists of properties on both sides of Mulford Road in the vicinity of Howell's Pond. This Zone District was established to specifically address the needs of senior citizens. The permitted uses in the Special Residential Zone District include senior citizen housing, nursing homes, congregate care facilities and customary and incidental support facilities for such uses. The uses are supported by existing infrastructure capacity available from the Lifecare Mews Wastewater Treatment Facility located on Block 108, Lot 1.04, directly east of the Study Area.

The general lack of new development and investment within the Study Area points to the need for utilization of the opportunities afforded by and pursuant to the Redevelopment Law. Designation as an Area in Need of Redevelopment provides for several benefits and incentives to promote development and redevelopment in a coordinated and planned manner to implement the Township Master Plan, support infrastructure investment in the Study Area and promote the more efficient use of the local infrastructure. Implementation of the Master Plan contributes to the general welfare of both the Township and the Sussex County region.

Land Use Goals

The following Land Use Goals from the Master Plan support the undertaking of this Redevelopment Area Study:

- To exercise stewardship over the lands and waters of Andover Township to ensure that these resources are available for the sustenance and enjoyment of present and future generations.
- To protect and maintain the prevailing rural character and unique sense of place of the Township, which includes diverse residential neighborhoods, attractive non-residential uses, scenic landscapes that result from the natural topography, agricultural lands, woodlands, and watercourses.
- To establish development densities and intensities at levels that do not exceed the carrying capacity of the natural environment and available infrastructure, both existing and planned.
- To establish development densities and intensities at levels that do not exceed the carrying capacity of the natural environment and available infrastructure, both existing and planned.
- To promote cooperation with neighboring municipalities in the region to advance consistent development and open space goals, policies and plans.
- To promote the goals and objectives of Andover Township through the incorporation of local policies and strategies that respond to the basic premises,

intent, and purposes of the State Development and Redevelopment Plan and the Sussex County Strategic Growth Plan.

- To provide a future land use pattern that serves the needs of the community for housing, community services, and a safe and healthful environment.
- To provide for a reasonable balance among various land uses that respect and reflect the interaction and synergy of community life.
- To offer flexibility in developing techniques that recognize new approaches and technologies which are responsive to evolving demographic, economic and environmental needs.

Community Design Goals

The following Community Design Goals from the Master Plan support the undertaking of this Redevelopment Area Study:

- To develop standards to ensure good visual quality and design for all land use categories.
- To ensure that new development is visually and functionally compatible with the physical characteristics of the Township.
- To provide for a proactive approach to physical design and community planning so that adjacent land uses function compatibly and harmoniously in terms of scale and location.
- To improve the visual and physical appearance of developed areas while protecting residential neighborhoods from encroachment by incompatible uses.
- To retain to the greatest extent practicable attractive vistas from public rights-of-way, including views of hills, valleys, ridgelines, woodlands, farmlands, hedgerows, stream corridors, flood plains, and other natural areas.

Housing

The following Housing Goals from the Master Plan support the undertaking of this Redevelopment Area Study:

- To provide for a variety of housing types that respond to the needs of households of varying size, age, and income, persons with disabilities and emerging demographic characteristics.
- To promote and support the development and redevelopment of affordable housing intended to address the Township's fair share obligation.
- To provide a range of housing opportunities within the Township, with densities and lot sizes that respond to the capabilities and limitations of natural systems and available infrastructure.

4. REDEVELOPMENT CRITERIA ANALYSIS

An analysis of the Study Area's existing land use, site layout, and physical characteristics was conducted in addition to using tax records, a physical inspection of the Study Area, a review of aerial photographs, maps, and other government records and reports. The following summarizes those findings that the Study Area meets the following criteria from N.J.S.A 40A:12A-5 to be deemed as an Area in Need of Redevelopment:

Criterion "a": Substandard Buildings (N.J.S.A. 40A:12A-5.a) *The generality of buildings are substandard, unsafe, unsanitary, dilapidated, or obsolescent, or possess any of such characteristics, or are lacking in light, air, or space, as to be conducive to unwholesome living or working conditions.*

The Study Area consists of the former Woodland Behavioral and Nursing Center at Andover, a 543-bed subacute nursing home facility which was closed in August 2022. The facility consists of a 120,000-square-foot, three (3) story building, with four (4) building wings which convene in the center of the structure. Additionally, there is a storage shed which is approximately 80 feet by 50 feet (4,000 square feet).

Upon inspection of the property on November 11, 2022, the property displayed numerous instances of substandard, unsafe, unsanitary and dilapidated conditions. The building, use and grounds also met conditions of obsolescence, including spaces which were so lacking in light, air, or space, as to be conducive to unwholesome living and working environments. These conditions can be divided into the following categories:

- Substandard facilities due to building layout, size and improper retrofitting;
- Deterioration from lack of maintenance and water damage;
- Unsanitary facilities due to lack of maintainence, cleaning and sanitation; and
- Obsolecence of the site and facilities including functional, physical and economic.

BUILDING FACILITIES ARE SUBSTANDARD

Appendix A.1-4 provides photographs taken on November 11, 2022 which illustrate the generality of the buildings. Inside the facility, there are numerous locations where pipes used for fire suppression are exposed and were installed after the construction of the building as a retrofit. There are different types of air conditioners in use including ductless units as and wall units utilized to supplement the existing HVAC systems.

Office areas for staff are located in small closets or storage areas with no windows resulting in a lack of light and ventilation. Offices are also built into existing hallways and retrofitted into exisitng spaces within the structure to provide divided work spaces where the layout and design is cramped and crowding conditions are apparent. Cleaning rooms located at the ends of each hallway are small, dilapidated and deteriorated, making cleaning and maintenance of each floor challenging. There are networking

servers located in small offices, networking wires are haphazardly placed throughout the ceiling tile areas.

Rooms are crowded with several beds located in each room. Vents for the HVAC system are small and there is an overall lack of ventilation due to the improper retrofitting of the facility, which causes a persistent odor in the facility. Also present are exposed phone wires, internet wires and lighting wires run along the baseboards in rooms. Shower facilities are small and crowded with one facility per wing for each gender. Based on the number of beds, this would account for approximately 20-25 people allocated to share shower facilities built for 5-6 people at a time. Closets within each room are small with very few spaces for residents to keep any personal items. Recreation areas for residents are small and cramped with one small lounge area per floor.

The hodling facility or morgue was constructed to hold one to two deceased persons. During COVID-19, the facility was overwhelmed and there was insufficient space to store the deceased persons in the facility. During the weekend of Easter 2020, police were called to investigate complaints of the building improperly storing deceased residents. Upon further investigation, five deceased residents were found being stored in a room configured as a morgue and 12 more being stored in other areas of the site[2]. After a review by the Centers for Medicare and Medicaid Services (CMS), the nursing home was issued $220,235 in fines and penalties for failures in infection control practices in a facility where COVID-19 claimed at least 66 lives. The substandard size of the morgue lead to unwholsome living and working conditions in the facilities where deceased persons were stored in appropriate locations throughout the facility rather than in the morgue in the facility.

The building is substandard and attempts to retrofit the building expose the numerous issues relative to providing residents of the facility with the proper facilities to meet modern heatlhcare standards. The lack of light, air and open space, and substandard nature of the building as a modern health care facility is conducive to unwholesome living and working conditions.

DETERIORATION FROM LACK OF MAINTENANCE AND WATER DAMAGE

A drone flight was conducted on November 28, 2022, which indicated that the building's flat roof had a significant amount of ponding. The ponding appeared on all four wings of the building as well as the interior section of the building. During the inspection on November 11, 2022, water damage was observed throughout the building (**Appendix A.2**). Specifically, water damage was observed as dark stains on the outside of the building, water stains on the ceiling tiles of the interior of the building, drip stains along

[2] Torrejon, Rodrigo "N.J. nursing home with makeshift morgue given citations, must make changes, state says" NJ.com April 18, 2020, https://www.nj.com/coronavirus/2020/04/nj-nursing-home-with-makeshift-morgue-given-citations-must-make-changes-state-says.html I Accessed November 29, 2022

the directional maps inside the building, sagging paint evident of water damage in bathroom areas including shower areas, rust stains around portions of the ceiling near metal that encountered water and stained wall boards which could have resulted from water leaks running down the wall areas. The lack of maintenance of the building has led to a state of deterioration due to water damage that has not been rectified. This dilapidated state has lead to unwholesome living and working conditions within the building.

UNSANITARY FACILITIES DUE TO LACK OF MAINTENANCE

When inspecting the building, there were numerous observations (**Appendix A.3**) of holes in the walls and ceilings, missing and broken ceiling tiles with exposed wires, signs of pest traps that were exposed in corners of the buildings, stained tiles in bathrooms and broken bathroom facilities, misaligned windows which could not close, rooms and storages areas filled with clutter and refuse, broken and rusted cabinetry, damaged drywall, broken and neglected lighting, dirt and grime on floors and walls, dirt and grime in the kitchen and eating areas, peeling wall paper, peeling floor moldings, stained walls and floors, cracks in indoor tiles, and broken door knobs, including on a fire exit. The lack of cleaning and maintenance of the faciltiy lead to a pervasive odor throughout most of the living and working areas.

On the building's exterior, the following issues were observed: broken and/or crumbling concrete and pavement in parking and loading areas; rust on railings by the loading areas; sidewalk cracks with vegetation growing through; lack of curb ramp accessibility and ADA compliance; and a dilapidated and abandoned swimming pool with vegetation growing through the concrete swimming deck. The facilities and grounds are unsanitary and unsafe due to a lack of maintenance which has lead to unwholsome living and working conditions in the Study Area.

FUNCTIONAL, ECONOMIC AND PHYSICAL OBSOLESCENCE

In order to determine if the Study Area displays evidence of obsolescence, this Study reviews the three types of commercial real estate obsolescence according to industry standards generally accepted by real estate professionals: **functional obsolescence, economic obsolescence, and physical obsolescence**[3]**.**

Functional obsolescence occurs when the form (either design or layout of the building and site) or function (the ability to use the building or site) no longer meets the needs or expectations of modern tenants. Examples of functional obsolescence include: out of date plumbing, heating and electrical fixtures; inadequate insulation; unsuitable

[3]Graham, P. (2021, May 28). "Three Types of Commercial Real Estate Obsolescence." Property Metrics. https://propertymetrics.com/blog/physical-economic-functional-obsolescence/

architectural style; construction materials that require excessive maintenance; and undesirable location.

The substandard characteristics of the building listed above point to the functional problems facing the facility due to crowded living spaces, small office spaces lacking in light and air, and faulty layout and design of the building. A primary issue when considering functional obsolesence is the sheer size of the facility as a 543 bed subacute facility. According to Laurie Facciarossa Brewer, New Jersey's Long-Term Care Ombudsman, the size of the facility is no longer conducive to proper care of residents because of the sheer size of the facility. She states that a facility of this size is difficult to staff properly to provide the proper care for residents, which results in inhumane conditions for the residents. Facciarossa Brewer also notes that the current trend in long-ter care is towards smaller, more person-centered care facilities[4]. The comments from the Long-Term Care Ombudsman indicate that there has been a change in industry standards and requirements for long-term care facilities from when the Study Area facility was constructed, effectively rendering the facility unable to meet modern tenant care standards and rendering the use functionally obsolete.

This change in the industry focus is evident in reviewing the size of the facilities in New Jersey as referenced from the Medicaid Website. In reviewing the Long-Term Care Hospitals within New Jersey there is a trend towards fewer beds within a facility, with the average bed count being significantly less than existed at the Woodland Behavioral and Nursing Center (543 beds). The average number of beds located within the Long-Term Care Hospitals in New Jersey is 62 beds. The largest long-term care hospital is located in Peapack and contains 102 beds, which is a fifth of the size of the Woodland Behavioral and Nursing Center.

Table 2. Long-Term Care Hospitals[5].

Facility Name	Location	Number of Beds
Acuity Specialty Hospital	Atlantic City	30
Care One at Trinitas	Elizabeth	75
Kindred Hospital New Jersey	Dover	45
Matheny School & Hospital	Peapack	102
Select Specialty Hospital	Rochelle Park	62
Select Specialty Hospital	Willingboro	69
Silver Lake Hospital	Newark	63
Specialty Care Hospital	Lakewood	50
Average Number of Beds		**62**

[4] Sherman, Ted.& Susan Livio "It was once the largest nursing home in N.J., now just 15 residents remain in a facility soon to close" *NJ.com* August 4, 2022, https://www.nj.com/news/2022/08/it-was-once-the-largest-nursing-home-in-nj-now-just-15-residents-remain-in-a-facility-soon-to-close.html Accessed November 29, 2022

[5] "Long Term Care Hospital Providers" Medicare.gov https://www.medicare.gov/care-compare/results?searchType=LongTermCare&page=1&state=NJ&sort=alpha&tealiumEventAction=Result%20Page%20-%20Search&tealiumSearchLocation=search%20bar Accessed December 20, 2022

Among the top ten rated nursing home facilities in New Jersey, according to the Medicaid Website, the average number of beds in the facility is also significantly less than Woodland Behavioral with 133 Beds.

Table 3. Highest Rated Nursing Homes in New Jersey[6].

Facility Name	Location	Number of Beds
Broadway House for Continuting	Newark	78
United Methodist Communities	Collingswood	60
Arbor Glen Center	Cedar Grove	122
Merry Heart Nursing Home	Succasunna	113
Atrium Post Acute Care	Wayne	170
Atrium at Navesink Harbor	Red Bank	43
Atlas Healthcare at Daughters of Miriam	Clifton	210
Arnold Walter Nursing & Rehabilitation	Hazlet	202
Elmora Hills Health & Rehabilitation	Elizabeth	200
Gardens at Monroe Healthcare	Monroe Twp	136
Average Number of Beds		***133***

The Study Area's facility size and remote geographic location also faced significant difficulties regarding staffing nurses and health aides to work in the facility. The facility was cited by the New Jersey Department of Health surveyors for inadequate staffing on all 14 day-shifts during a two-week observation period in late December 2021 into January 2022.[7]

This was also not the first time that staffing issues were identified. In 2019, a state investigation found that staff members failed to respond to a door alarm after a 76-year old resident deemed at risk of leaving the building walked out undetected in minus 4-degree temperatures[8]. Many of these issues were also evidenced by multiple violations which were observed from Department of Health surveys obtained from the New Jersey Department of Health and Human Services (attached as **Appendix B**) which date back to March of 2019 and were brought to light due to the COVID-19 pandemic.

Some of the violations included in the report included the improper administration of medicines before the pandemic. During the pandemic, there were a multitude of violations which included the following:

- Improper documentation of transferring patients and trip fall incidents;

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[6] "Nursing Homes sorted by Highest Rated" Medicare.gov https://www.medicare.gov/care-compare/results?searchType=NursingHome&page=1&state=NJ&sort=highestRated Accessed December 20, 2022

[7] Livio, Susan and Ted Sherman "Understaffed and Overwhelmed N.J. nursing homes lack the staff required by landmark legislation. Is the law being enforced?" NJ.com May 15, 2022 https://www.nj.com/politics/2022/05/understaffed-and-overwhelmed.html Accessed November 29 Accessed November 29, 2022`

[8] Livio, Susan and Ted Sherman "'Somebody should care about these patients...' It was called one of the worst nursing homes in N.J, why did it take so long to shut it down?" NJ.com December 18, 2022 https://www.nj.com/politics/2022/12/somebody-should-care-about-these-patients.html Accessed December 20, 2022

- Improper notice with regards to patients who passed away to their next of kin or powers of attorney;
- Overall failures to separate COVID positive patients from COVID negative patients and the difficulty in enforcing regulations for doctors coming in and off-site during the pandemic; and
- Insufficient compliance with COVID regulations based on Centers for Medicare and Medicaid Services (CMS) and Center for Disease Control and Prevention's recommended practices for COVID-19.

Overall, the function of the industry is changing in its focus from institutional care in nursing homes to home- and community-based services, which can consist of everything from home health aides to assistance prepping meals. Much of this has occurred as a result of over 130,000 nursing home residents passing away during the COVID-19 pandemic, which is roughly one-quarter of the nation's coronavirus deaths despite comprising less than one percent of the population. The combination of the facility being too large to operate effectively, combined with the industry shift towards smaller facilities and other types of care, is demonstrative of the functional obscolescence of this facility.

Economic obsolescence, also known as external obsolescence, is an impact to the value or usefulness of a property due to external factors such as traffic pattern changes, zoning changes, a major construction project nearby, high crime rates in the area, etc.

The COVID-19 pandemic caused at least 66 deaths in the facility and brought to light many of the already-existing deficiencies of this facility in terms of its ability to operate according to state and federal health and safety regulations. For example, during the weekend of Easter 2020, police were called to investigate complaints that the facility was improperly handling and storing deceased residents. Upon further investigation, five deceased residents were found being stored in a room configured as a morgue and 12 more being stored in other areas of the site[9]. After a review by the Centers for Medicare and Medicaid Services (CMS), the nursing home was issued $220,235 in fines and penalties for failures in infection control practices. In 2019, the Study Area facility, along with Andover I (Limecrest Subacute and Rehabilitation Center) received $22.3 million in State Medicaid [10] payments.

As of January 31, 2022, it became clear that the Study Area facility was teetering on the edge of bankruptcy, with journalist Ted Sherman noting in his May 26, 2022 article on NJ.com that the facility had a negative cash flow, limited borrowing capacity and the threat of loss of federal funding. The Study Area facility's balance sheet showed total

[9] Torrejon, Rodrigo "N.J. nursing home with makeshift morgue given citations, must make changes, state says" NJ.com April 18, 2020, https://www.nj.com/coronavirus/2020/04/nj-nursing-home-with-makeshift-morgue-given-citations-must-make-changes-state-says.html I Accessed November 29, 2022

[10] Sherman, Ted and Rodrigo Torrejon "N.J. nursing home where 17 bodies were discovered in makeshift morgue hit with $220K in federal fines" *NJ.com* May 7, 2020, https://www.nj.com/coronavirus/2020/05/nj-nursing-home-where-bodies-were-discovered-in-makeshift-morgue-hit-with-220k-in-federal-fines.html Accessed November 29, 2022

assets of approximately $15.8 million and total liabilities of approximately $19.8 million. As a result, there was doubt as to the facility's ability to pay its debts as they became due[11].

In February 2022, the Department of Health and State regulators began the process of revoking the facility's license and began relocating the 450 people living at Woodland Behavioral and Nursing Center.[12] On March 9, 2022 the State Health Department selected Atlantic Health System to send a team into the Woodland Behavioral and Nursing Center for up to 90 days to assess the operations, infrastructure and business practices at the facility[13]. The facility was turned over to a receiver in May 2022 to ensure that employee paychecks were processed and that staff retention policies would be implemented. The primary concern was over the health and safety of the residents still remaining at the facility. A hearing was held on July 7, 2022[14]. After the hearing, as no buyer was found, the facility was closed on August 11, 2022, when federal funding was terminated for the facility[15]. The facility could not operate without federal funding as 92 percent of the facility's revenue came from the Centers for Medicare and Medicaid Services[16]. Economic obsolescence of the facility is clear as it was not self-supporting through its services and requires a significant investment to bring the facility up to health and safety standards in order to continue operating.

Physical obsolescence occurs when a property is in decline because of the physical deterioration of the buildings and/or site. Uncurable physical obsolescence occurs when the costs to cure the maintenance issues are higher than can be sustained by the profit produced on the property and/or when the cost to cure the deterioration is in excess of the cost to replace the structures on the property.

Several items are noted above with regard to the overall deterioration of the building including a lack of maintenance, evidence of water damage and a general lack of sanitation within the building all contribute to the building's physical obsolescence.

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[11] Sherman, Ted " In extraordinary move, N.J. finally seeks to take control of state's most troubled nursing home" May 26, 2022 https://www.nj.com/coronavirus/2022/05/in-extraordinary-move-nj-finally-seeks-to-take-control-of-states-most-troubled-nursing-home.html Accessed November 29, 2022

[12] Sherman, Ted.& Susan Livio "It was once the largest nursing home in N.J., now just 15 residents remain in a facility soon to close" *NJ.com* August 4, 2022, https://www.nj.com/news/2022/08/it-was-once-the-largest-nursing-home-in-nj-now-just-15-residents-remain-in-a-facility-soon-to-close.html Accessed November 29, 2022

[13] Fallon, Scott "NJ to send monitors into troubled nursing home that stacked bodies in makeshift morgue" New Jersey Herald March 10, 2022 https://www.njherald.com/story/news/health/2022/03/09/sussex-county-nj-nursing-home-monitors-covid-morgue/9447243002/ Accessed November 29, 2022

[14] Comstock, Lori "Judge hands over operations of Woodland nursing home, for now" New Jersey Herald May 31, 2022 https://www.njherald.com/story/news/2022/05/31/woodland-behavioral-nursing-center-receiver-andover-nj/7453286001/ Accessed November 29, 2022

[15] Sherman, Ted.& Susan Livio "It was once the largest nursing home in N.J., now just 15 residents remain in a facility soon to close" *NJ.com* August 4, 2022, https://www.nj.com/news/2022/08/it-was-once-the-largest-nursing-home-in-nj-now-just-15-residents-remain-in-a-facility-soon-to-close.html Accessed November 29, 2022

[16] Comstock, Lori "Last of Woodland's residents leave as embattled Andover nursing home shutters" New Jersey Herald, August 23, 2022 https://www.njherald.com/story/news/healthcare/2022/08/23/andover-nj-woodland-behavioral-nursing-center-final-residents-move-out/65413680007/ Accessed November 29, 2022

In addition, the documented issues relative to deterioration and lack of maintenance are illustrated in the multiple violations based on records obtained from the New Jersey Department of Health and Human Services (**Appendix B**) which date back to March of 2019.

On March 1, 2019 a Department of Health survey was completed which cited multiple violations including a lack of compliance with the Emergeny Preparedness Program. The non-compliance in this case was for not meeting Minimum Life Safety Code Requirements for the existing elevators which failed to comply with annual inspection requirements. The building's elevators were not certified for operation in 2018 and last certified on August 24, 2017.

On March 5, 2020, another survey was completed which cited multiple violations including providing for a safe/clean/homelike environment where based upon observation, interviews and records review on February 26, 2020 and February 27, 2020, the facility failed to proved a clean and comfortable physical environment in multiple resident sleeping units. What was observed included a darkened substance on the floors of resident rooms, which was determined by the surveyor to be dirt. An old floor finish that had accumulated at the bottom corners of each doorframe of the residents' rooms due to ineffective floor maintenance was also observed.

During a tour on February 27, 2020, the protective lens cover for overbed lights were missing in resident rooms. The Maintenance Director indicated that the lens covers were discontinued and no longer available and while the maintenance director provided a brochure for the new lighting, the Facility Administrator noted that there was no purchase order for said lighting.

As noted in the economic obsolescence section above, due to the size of the operation and the existing available assets, the operation could not manage the ongoing costs of maintenance and repair and, as a result, much of the ongoing maintenance required to operate the facility was not completed leaving the facilitiy to deteriorate over time. The facility was operating at a loss and the ownership did not have the financial means to cure the basic maintenance deficiencies related to the property let alone larger long-term building maintenance. As result, the physical obsolecence is uncurable because the cost of the maintenance and repairs necessary to bring the buildling up to health and safety standards cannot be supported by the business operation of the facility.

A described above, the generality of buildings in the Study Area are substandard, unsafe, unsanitary, dilapidated and obsolescent so as to be conducive to unwholesome living and working conditions, meeting Criterion "a".

Criterion "d": Dilapidation (N.J.S.A. 40A:12A-5.d) *Areas with buildings or improvements which, by reason of dilapidation, obsolescence, overcrowding, faulty arrangement or design, lack of ventilation, light and sanitary facilities, excessive land coverage, deleterious land use or obsolete layout, or any combination of these or other factors are detrimental to the safety, health, morals or welfare of the community.*

The Study Area consists of the former Woodland Behavioral and Nursing Center at Andover, which was a 543-bed subacute nursing home facility that was closed in August 2022. The facility consists of a 120,000-square-foot, three (3) story building with 4 wings as well as a storage shed which is approximately 80 feet by 50 feet (4,000 square feet).

The facility faced multiple health code violations from the Department of Health and Human Services Centers for Medicare & Medicaid Services that were exacerbated by the COVID-19 pandemic which led to its eventual closure in August 2022. Many of the factors which culminated in the closure of the site can be attributed to the size and age of the structure, physical condition of the building both before and after its closure, the external economic factors faced by the most recent operator, and the State's takeover and eventual closure of the facility.

Upon inspection of the property on November 11, 2022, the property displayed numerous instances of dilapidation, obsolescence, overcrowding, faulty arrangement and design, lack of ventilation, light and sanitary facilties and obsolete layout and design, which have resulted in factors that are detrimental to the health, safety, morals and welfare of the community. These conditions can be divided into the following categories:

- Substandard facilities due to obsolete layout, overcrowding and faulty arrangement and design;
- Unsanitary and dilapidated facilities due to lack of maintainence, cleaning and sanitation; and
- Functional, economic and physical obsolescence.

BUILDING FACILITIES ARE OVERCROWDED; LACK VENTILATION, LIGHT & SANITARY FACILITIES; DISPLAY FAULTY ARRANGEMENT AND DESIGN

Appendix A.1-4 provides photographs taken on November 11, 2022 which illustrate the overcrowded nature of the facility, which lacks air, light and displays a faulty arrangement and design.

The building lacks proper ventilation. There are several types of air conditioners in use including ductless units and wall units utilized to supplement the existing HVAC systems. There are broken windows that can't be closed or opened. Many operaable windows are small and don't provide ventilation sufficient to reach internal to the hallways or center of the building. This causes poor ventilation throughout the facility.

The working conditions are overcrowded. Office areas for staff are located in small closets or storage areas with no windows resulting in a lack of light and ventilation. Offices are also built into existing hallways and retrofitted into exisitng spaces within the structure to provide divided work spaces where the layout and design is cramped and crowding conditions are apparent. Cleaning rooms located at the ends of each hallway are small, dilapidated and deteriorated, making cleaning and maintenance of each floor challenging. There are networking servers located in small offices and networking wires haphazardly placed throughout the ceiling tile areas. Working conditions are crowded and cluttered due to faulty arrangement and design and obsolete layout.

Residents rooms are overcrowded with several beds located in each room, where 3-4 beds are present in rooms typically constructed for two residents. Vents for the HVAC system are small and there is an overall lack of ventilation due of the facility, which causes a persistent odor in the facility. Also present are exposed phone wires, internet wires and lighting wires run along the baseboards in rooms or exposed in the ceiling via missing ceiling tiles. Beds and furniture are dilapidated, worn and in desirepair. Closets within each room are small with limited space for residents to keep any personal items. Recreation areas for residents are small and cramped with one approximately 400 square foot lounge area per floor, which would be allocated to approximately 180 residents. Shower facilities are small and crowded with one facility per wing for each gender. Based on the number of beds, this would account for approximately 20-25 people allocated to share shower facilities built for 3-4 people at a time. The living conditions are overcrowded due to faulty arrangement and design and obsolete layout.

The holding facility or morgue was constructed to hold one to two deceased persons. During COVID-19, the facility was overwhelmed and there was insufficient space to store the deceased persons in the facility. During the weekend of Easter 2020, police were called to investigate complaints of the building improperly storing deceased residents. Upon further investigation, five deceased residents were found being stored in a room

configured as a morgue and 12 more being stored in other areas of the site[17]. After a review by the Centers for Medicare and Medicaid Services (CMS), the nursing home was issued $220,235 in fines and penalties for failures in infection control practices in a facility where COVID-19 claimed at least 66 lives. The substandard size of the morgue lead to unwholsome living and working conditions in the facilities where deceased persons were stored in appropriate locations throughout the facility rather than in the morgue in the facility.

The overcrowded nature of the facility, which lacks air, light and displays a faulty arrangement and design as described above, is detrimental to the safety, health, morals or welfare of the community.

DILAPIDATED FACILITIES DUE TO LACK OF MAINTENANCE

When inspecting the building, there were numerous observations (**Appendix A.3**) of dilapidation in and around the building. This included holes in the walls and ceilings, signs of pest traps that were exposed in corners of the buildings, stained tiles in bathrooms and broken bathroom facilities, misaligned windows which could not close, rooms and closets filled with clutter and refuse, broken and rusted cabinetry, damaged drywall, broken and neglected lighting, dirt and grime on floors and walls, dirt and grime in the kitchen and eating areas, peeling wall paper, peeling floor moldings, stained walls and floors, cracks in indoor tiles, and broken door knobs, including on a fire exit. The lack of cleaning and maintenance of the faciltiy lead to a pervasive odor throughout most of the living and working areas. Signs of mold and water damage were also present throughout the building.

On the building's exterior, the following issues were observed: broken and/or crumbling concrete and pavement in parking and loading areas; rust on railings by the loading areas; sidewalk cracks with vegetation growing through; lack of curb ramp accessibility and ADA compliance; and a dilapidated and abandoned swimming pool with vegetation growing through the concrete swimming deck.

The Study Area facilities and improvements are dilapidated due to a lack of ongoing maintenance which created ongoing concerns with respect to safety, health, morals and the general welfare of residents causing the facility to be detrimental to the community.

[17] Torrejon, Rodrigo "N.J. nursing home with makeshift morgue given citations, must make changes, state says" NJ.com April 18, 2020, https://www.nj.com/coronavirus/2020/04/nj-nursing-home-with-makeshift-morgue-given-citations-must-make-changes-state-says.html I Accessed November 29, 2022

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In order to determine if the Study Area displays evidence of obsolescence, this Study reviews the three types of commercial real estate obsolescence according to industry standards generally accepted by real estate professionals: **functional obsolescence, economic obsolescence, and physical obsolescence**[18]**.**

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The substandard characteristics of the building listed above point to the functional problems facing the facility due to crowded living spaces, small office spaces lacking in light and air, and faulty layout and design of the building. A primary issue when considering functional obsolesence is the sheer size of the facility as a 543 bed subacute facility. According to Laurie Facciarossa Brewer, New Jersey's Long-Term Care Ombudsman, the size of the facility is no longer conducive to proper care of residents. The large size of the facility make it difficult to staff properly, which results in inhumane conditions for the residents. Facciarossa Brewer also notes that the current trend in long-ter care is towards smaller, more person-centered care facilities[19]. The comments from the Long-Term Care Ombudsman indicate that there has been a change in industry standards and requirements for long-term care facilities from when the Woodlands Facility was constructed, effectively rendering the facility unable to meet modern health care standards.

This change in the industry focus is evident in reviewing the size of the facilities in New Jersey as referenced from the Medicaid Website. In reviewing the Long-Term Care Hospitals within New Jersey there is a trend towards fewer beds within a facility. The average number of beds in other facilities in the State was significantly less than at the Woodland Behavioral and Nursing Center (543 beds). The average number of beds located within Long-Term Care Hospitals is 62 beds with the largest facility in Peapack containing 102 beds.

[18]Graham, P. (2021, May 28). "Three Types of Commercial Real Estate Obsolescence." Property Metrics. https://propertymetrics.com/blog/physical-economic-functional-obsolescence/

[19] Sherman, Ted.& Susan Livio "It was once the largest nursing home in N.J., now just 15 residents remain in a facility soon to close" *NJ.com* August 4, 2022, https://www.nj.com/news/2022/08/it-was-once-the-largest-nursing-home-in-nj-now-just-15-residents-remain-in-a-facility-soon-to-close.html Accessed November 29, 2022

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Average Number of Beds		***62***

Among the top ten rated facilities in New Jersey, according to the Medicaid Website, the average number of beds in each facility is also significantly lower than the Study Area at 133 Beds. The largest facilty noted contained 210 beds, less than half of the facility in the Study Area.

Table 3. Highest Rated Nursing Homes in New Jersey[21].

Facility Name	Location	Number of Beds
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United Methodist Communities	Collingswood	60
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The Study Area's facility size and remote geographic location also faced significant difficulties regarding staffing nurses and health aides to work in the facility. The facility was cited by New Jersey Department of Health surveyors for inadequate staffing on all 14 day-shifts during a two-week observation period in late December 2021 into January 2022.[22]

[20] "Long Term Care Hospital Providers" Medicare.gov https://www.medicare.gov/care-compare/results?searchType=LongTermCare&page=1&state=NJ&sort=alpha&tealiumEventAction=Result%20Page%20-%20Search&tealiumSearchLocation=search%20bar Accessed December 20, 2022

[21] "Nursing Homes sorted by Highest Rated" Medicare.gov https://www.medicare.gov/care-compare/results?searchType=NursingHome&page=1&state=NJ&sort=highestRated Accessed December 20, 2022

[22] Livio, Susan and Ted Sherman "Understaffed and Overwhelmed N.J. nursing homes lack the staff required by landmark legislation. Is the law being enforced?" NJ.com May 15, 2022 https://www.nj.com/politics/2022/05/understaffed-and-overwhelmed.html Accessed November 29 Accessed November 29, 2022`

This was also not the first time that staffing issues were identified. In 2019, a state investigation found that staff members failed to respond to a door alarm after a 76-year old resident deemed at risk of leaving the building walked out undetected in minus 4-degree temperatures[23]. Many of these issues were also evidenced by multiple violations which were observed from Department of Health surveys obtained from the New Jersey Department of Health and Human Services (attached as **Appendix B**) which date back to March of 2019 and were brought to light due to the COVID-19 pandemic.

Some of the violations included the improper administration of medicines before the pandemic. During the pandemic, there were a multitude of violations which included the following:

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- Overall failures to separate COVID positive patients from COVID negative patients and the difficulty in enforcing regulations for doctors coming in and off site during the pandemic; and
- Insufficient compliance with COVID regulations based on Centers for Medicare and Medicaid Services (CMS) and Center for Disease Control and Prevention's recommended practices for COVID-19.

Overall, the long-term health care industry is changing its focus from institutional care in nursing homes to home- and community-based services, which can consist of everything from home health aides to assistance prepping meals. Much of this has occurred as a result of over 130,000 nursing home residents passing away during the COVID-19 pandemic, which is roughly one-quarter of the nation's coronavirus deaths despite comprising less than one percent of the population. The combination of the facility being too large to be run effectively and the industry shift towards smaller facilities and home health care, is demonstrative of the functional obscolescence of this facility.

Due to the severe life and safety impacts of the functional obsolescence of the facility on its residents, this obsolescence is detrimental to the safety, health, morals and welfare of the community.

[23] Livio, Susan and Ted Sherman "'Somebody should care about these patients...' It was called one of the worst nursing homes in N.J, why did it take so long to shut it down?" NJ.com December 18, 2022 https://www.nj.com/politics/2022/12/somebody-should-care-about-these-patients.html Accessed December 20, 2022

Economic obsolescence, also known as external obsolescence, is an impact to the value or usefulness of a property due to external factors such as traffic pattern changes, zoning changes, a major construction project nearby, high crime rates in the area, etc.

The COVID-19 pandemic caused at least 66 deaths in the facility and brought to light many of the already-existing deficiencies of this facility in terms of its ability to operate according to state and federal health and safety regulations. For example, during the weekend of Easter 2020, police were called to investigate complaints that the facility was improperly handling and storing deceased residents. Upon further investigation, five deceased residents were found being stored in a room configured as a morgue and 12 more being stored in other areas of the site[24]. After a review by the Centers for Medicare and Medicaid Services (CMS), the nursing home was issued $220,235 in fines and penalties for failures in infection control practices. In 2019, the Study Area facility, along with Andover I (Limecrest Subacute and Rehabilitation Center) received $22.3 million in State Medicaid [25] payments.

As of January 31, 2022, it became clear that the Study Area facility was teetering on the edge of bankruptcy, with journalist Ted Sherman noting in his May 26, 2022 article on NJ.com that the facility had a negative cash flow, limited borrowing capacity and the threat of loss of federal funding. The Study Area facility's balance sheet showed total assets of approximately $15.8 million and total liabilities of approximately $19.8 million. As a result, there was doubt as to the facility's ability to pay its debts as they became due[26].

In February 2022, the Department of Health and State regulators began the process of revoking the facility's license and began relocating the 450 people living at Woodland Behavioral and Nursing Center.[27] On March 9, 2022 the State Health Department selected Atlantic Health System to send a team into the Woodland Behavioral and Nursing Center for up to 90 days to assess the operations, infrastructure and business practices at the facility[28]. The facility was turned over to a receiver in May 2022 to ensure that employee paychecks were processed and that staff retention policies would be implemented. The primary concern was over the health and safety of the residents still

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[24] Torrejon, Rodrigo "N.J. nursing home with makeshift morgue given citations, must make changes, state says" NJ.com April 18, 2020, https://www.nj.com/coronavirus/2020/04/nj-nursing-home-with-makeshift-morgue-given-citations-must-make-changes-state-says.html I Accessed November 29, 2022

[25] Sherman, Ted and Rodrigo Torrejon "N.J. nursing home where 17 bodies were discovered in makeshift morgue hit with $220K in federal fines" *NJ.com* May 7, 2020, https://www.nj.com/coronavirus/2020/05/nj-nursing-home-where-bodies-were-discovered-in-makeshift-morgue-hit-with-220k-in-federal-fines.html Accessed November 29, 2022

[26] Sherman, Ted " In extraordinary move, N.J. finally seeks to take control of state's most troubled nursing home" May 26, 2022 https://www.nj.com/coronavirus/2022/05/in-extraordinary-move-nj-finally-seeks-to-take-control-of-states-most-troubled-nursing-home.html Accessed November 29, 2022

[27] Sherman, Ted.& Susan Livio "It was once the largest nursing home in N.J., now just 15 residents remain in a facility soon to close" *NJ.com* August 4, 2022, https://www.nj.com/news/2022/08/it-was-once-the-largest-nursing-home-in-nj-now-just-15-residents-remain-in-a-facility-soon-to-close.html Accessed November 29, 2022

[28] Fallon, Scott "NJ to send monitors into troubled nursing home that stacked bodies in makeshift morgue" New Jersey Herald March 10, 2022 https://www.njherald.com/story/news/health/2022/03/09/sussex-county-nj-nursing-home-monitors-covid-morgue/9447243002/ Accessed November 29, 2022

remaining at the facility. A hearing was held on July 7, 2022[29]. After the hearing, as no buyer was found, the facility was closed on August 11, 2022, when federal funding was terminated for the facility[30]. The facility could not operate without federal funding as 92 percent of the facility's revenue came from the Centers for Medicare and Medicaid Services[31]. Economic obsolescence of the facility is clear as it was not self-supporting through its services and requires a significant investment to bring the facility up to health and safety standards in order to continue operating.

Due to the severe life and safety impacts of the economic obsolescence of the facility on its residents, this obsolescence is detrimental to the safety, health, morals and welfare of the community.

Physical obsolescence occurs when a property is in decline because of the physical deterioration of the buildings and/or site. Uncurable physical obsolescence occurs when the costs to cure the maintenance issues are higher than can be sustained by the profit produced on the property and/or when the cost to cure the deterioration is in excess of the cost to replace the structures on the property.

Several items are noted above with regard to the overall deterioration of the building including a lack of maintenance, evidence of water damage and a general lack of sanitation within the building all contribute to the building's physical obsolescence.

In addition, the documented issues relative to deterioration and lack of maintenance are illustrated in the multiple violations based on records obtained from the New Jersey Department of Health and Human Services (**Appendix B**) which date back to March of 2019.

On March 1, 2019 a Department of Health survey was completed which cited multiple violations including a lack of compliance with the Emergeny Preparedness Program. The non-compliance in this case was for not meeting Minimum Life Safety Code Requirements for the existing elevators which failed to comply with annual inspection requirements. The building's elevators were not certified for operation in 2018 and last certified on August 24, 2017.

On March 5, 2020, another survey was completed which cited multiple violations including providing for a safe/clean/homelike environment where based upon

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[29] Comstock, Lori "Judge hands over operations of Woodland nursing home, for now" New Jersey Herald May 31, 2022 https://www.njherald.com/story/news/2022/05/31/woodland-behavioral-nursing-center-receiver-andover-nj/7453286001/ Accessed November 29, 2022

[30] Sherman, Ted.& Susan Livio "It was once the largest nursing home in N.J., now just 15 residents remain in a facility soon to close" *NJ.com* August 4, 2022, https://www.nj.com/news/2022/08/it-was-once-the-largest-nursing-home-in-nj-now-just-15-residents-remain-in-a-facility-soon-to-close.html Accessed November 29, 2022

[31] Comstock, Lori "Last of Woodland's residents leave as embattled Andover nursing home shutters" New Jersey Herald, August 23, 2022 https://www.njherald.com/story/news/healthcare/2022/08/23/andover-nj-woodland-behavioral-nursing-center-final-residents-move-out/65413680007/ Accessed November 29, 2022

observation, interviews and records review on February 26, 2020 and February 27, 2020, the facility failed to proved a clean and comfortable physical environment in multiple resident sleeping units. What was observed included a darkened substance on the floors of resident rooms, which was determined by the surveyor to be dirt. An old floor finish that had accumulated at the bottom corners of each doorframe of the residents' rooms due to ineffective floor maintenance was also observed.

During a tour on February 27, 2020, the protective lens cover for overbed lights were missing in resident rooms. The Maintenance Director indicated that the lens covers were discontinued and no longer available and while the maintenance director provided a brochure for the new lighting, the Facility Administrator noted that there was no purchase order for said lighting.

As noted in the economic obsolescence section above, due to the size of the operation and the existing available assets, the operation could not manage the ongoing costs of maintenance and repair and, as a result, much of the ongoing maintenance required to operate the facility was not completed leaving the facilitiy to deteriorate over time. The facility was operating at a loss and the ownership did not have the financial means to cure the basic maintenance deficiencies related to the property let alone larger long-term building maintenance. As result, the physical obsolecence is uncurable because the cost of the maintenance and repairs necessary to bring the buildling up to health and safety standards cannot be supported by the business operation of the facility.

Due to the severe life and safety impacts of the physical obsolescence of the facility on its residents, this obsolescence is detrimental to the safety, health, morals and welfare of the community.

A described above, the buildings and improvements within the Study Area, by reason of dilapidation, obsolescence, overcrowding, faulty arrangement and design, lack of ventilation, light and sanitary facilities, and obsolete layout, are detrimental to the safety, health, morals and welfare of the community, meeting Criterion d.

Criterion "h": Smart Growth Consistency (N.J.S.A. 40A:12A-5.h) *The designation of the delineated area is consistent with smart growth planning principals adopted pursuant to law or regulation.*

Smart growth is defined as a planning principle that directs new growth to locations where infrastructure and services are available, limits sprawl development, protects the environment, and enhances and rebuilds existing communities. The New Jersey Office for Planning Advocacy identifies the following as smart growth principles:

- Mixed Land Uses;
- Compact, Clustered Community Design;
- Walkable Neighborhoods;
- Distinctive, Attractive Communities Offering a "Sense of Place";

- Open Space, Farmland and Scenic Resource Preservation;
- Future Development Strengthened and Directed to Existing Communities Using Existing Infrastructure;
- A Variety of Transportation Options;
- Community and Stakeholder Collaboration in Development Decision Making;
- Predictable, Fair and Cost-Effective Development Decisions; and
- A Range of Housing Choices.

Designating the Study Area as an Area in Need of Redevelopment will encourage the development of an area of existing infrastructure and existing disturbance that can better serve the needs of the greater Andover community and beyond. Designating the Study Area as a redevelopment area of 16.92 acres with a significant amount of impervious coverage that contains no significant environmental constraints will allow for a variety of redevelopment options and opportunities to promote Smart Growth principals. Therefore, the Study Area meets criterion "h".

5. CONCLUSION

The Study Area meets at least three (3) of the eight (8) redevelopment criteria. Criterion "a" is met because the generality of buildings in the Study Area are substandard, unsafe, unsanitary, dilapidated, and obsolescent, and are so lacking in light, air, and space, as to be conducive to unwholesome living or working conditions. Criterion "d" is met because the Study Area buildings and improvements, by reason of dilapidation, obsolescence, overcrowding, faulty arrangement and design, lack of ventilation, light and sanitary facilities, and obsolete layout, are detrimental to the safety, health, morals and welfare of the community. Criterion "h" is met as designation of the delineated area is consistent with smart growth planning principals adopted by the State Office for Planning Advocacy and the State Development and Redevelopment Plan.

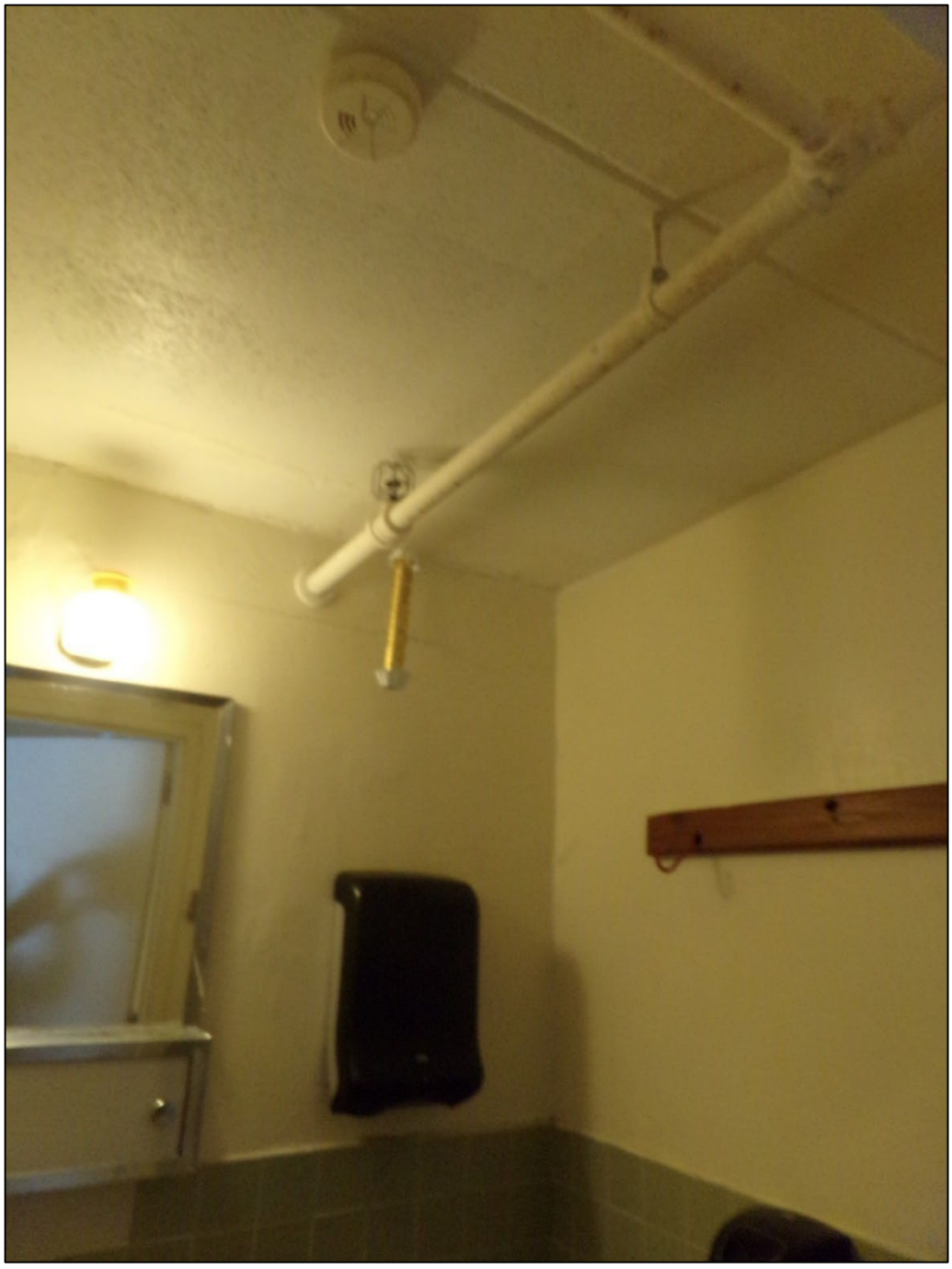
The investigation finds that the Study Area as delineated herein meets the statutory criteria to qualify as an Area in Need of Redevelopment and recommends that the Study Area be designated by the Township Committee as a Condemnation Area in Need of Redevelopment pursuant to N.J.S.A. 40: A-12A-1 et seq.

APPENDIX A: SITE PHOTOGRAPHS

Two site visits were completed for this preparation of this study. A site visit was completed on November 11, 2022, which included a comprehensive interior inspection of the buildings and exterior inspection of buildings and grounds. A second site visit included a drone flight which was conducted on November 28, 2022 to provide an overview of the exterior of the buildings and the overall site.

A.1 IMPROPER RETROFITTING

Fire protection system retrofits.



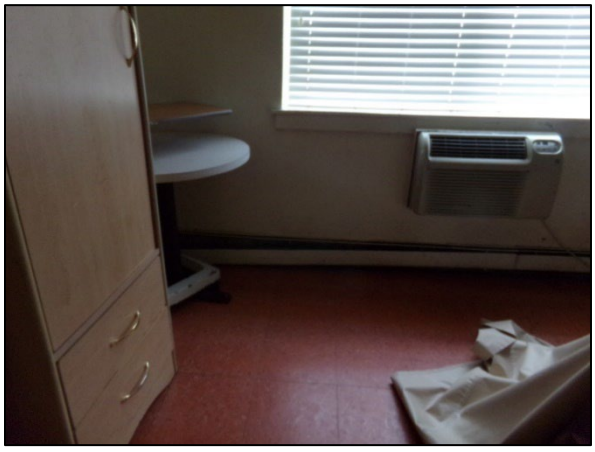
A.1 Improper Retrofitting

Fire protection system retrofits (continued).

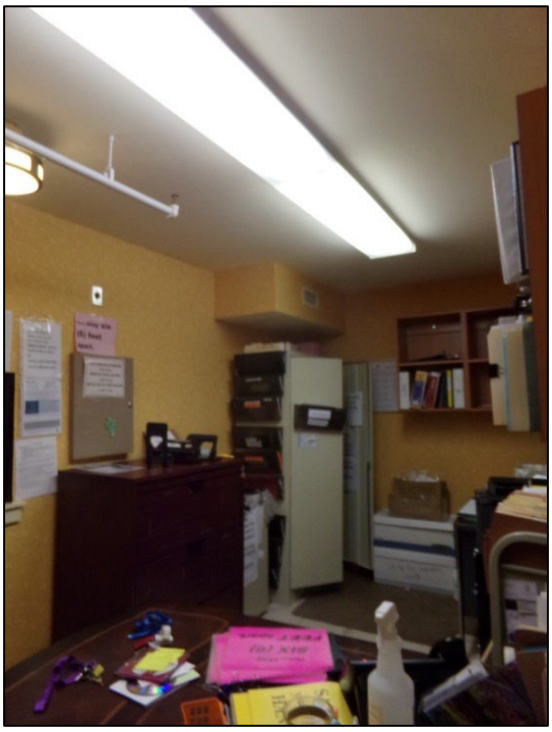
A.1 Improper Retrofitting

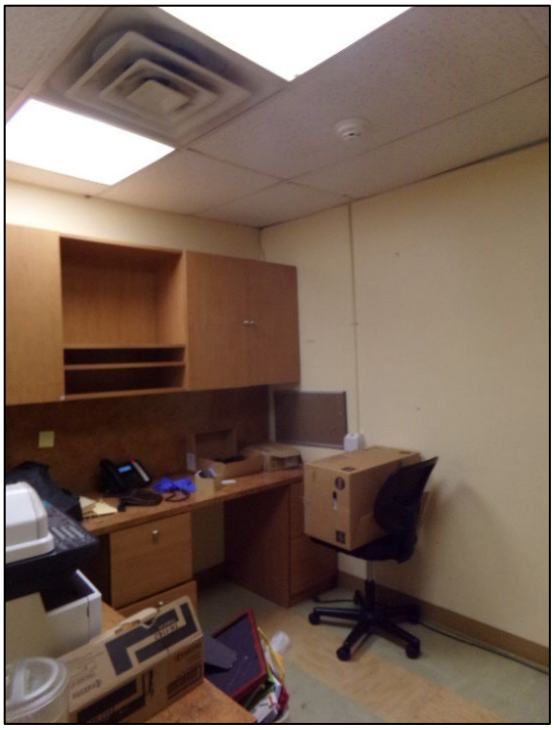
Air conditioning units supplementing existing HVAC system.

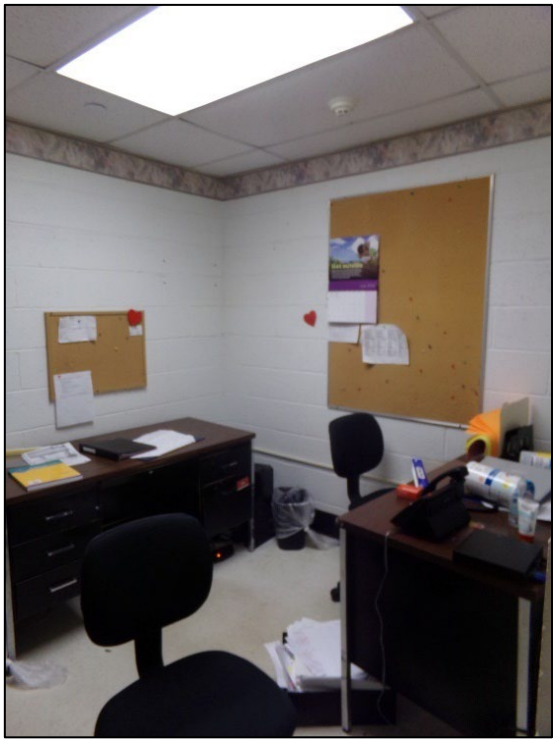





Office spaces in closet areas with no windows.



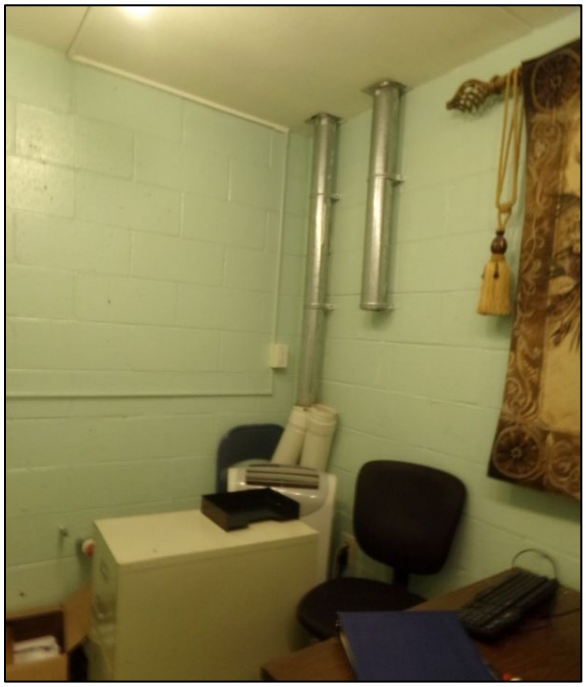




Office spaces in closet and storage areas with no windows (continued).

Office modifications constructed in hallway.

Exposed heating pipes.

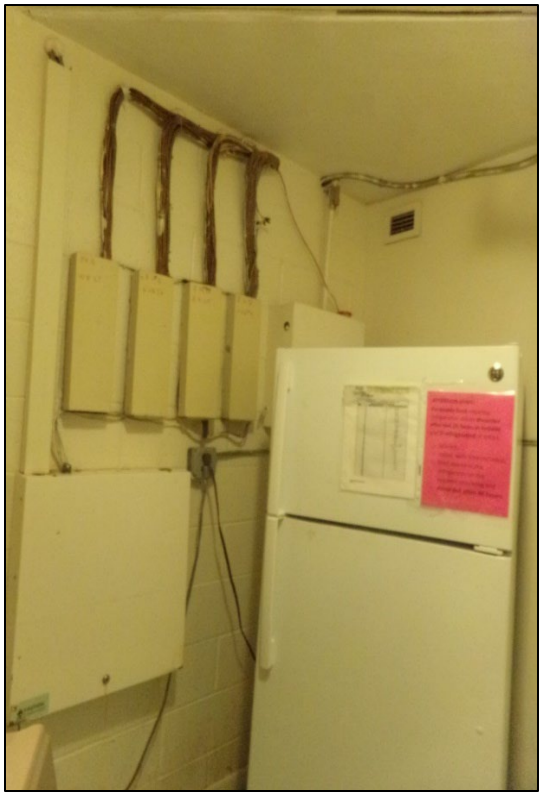


A.1 Improper Retrofitting

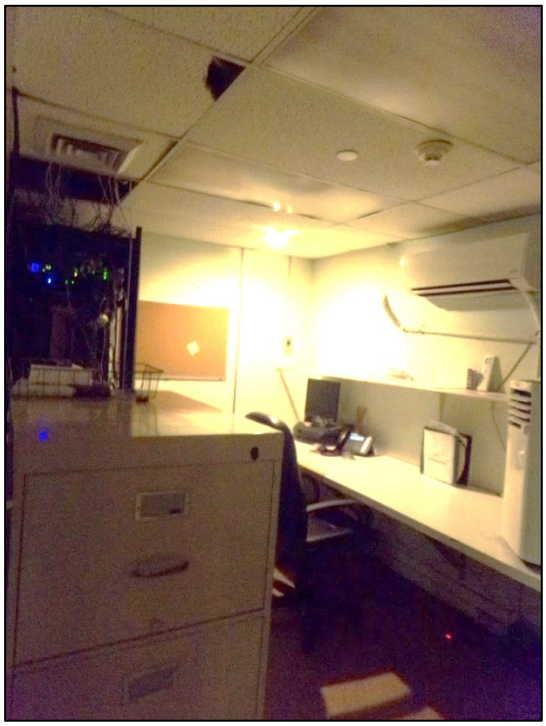
Exposed insulation in closets.

Small vents for HVAC.

Exposed phone wires.



Network servers in small, cramped offices.



Network wires in ceiling.

Refrigerator and freezers on loading dock.

A.2 WATER DAMAGE

Ponding on roof and water damage.

Ponding on roof and water damage (continued).

Ponding on roof and water damage (continued).

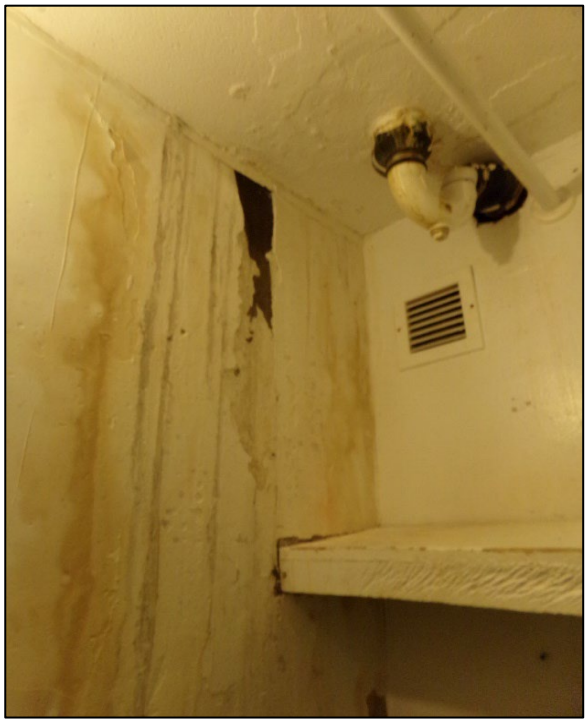
Exterior water damage.

A.2 Water Damage

Interior water damage.



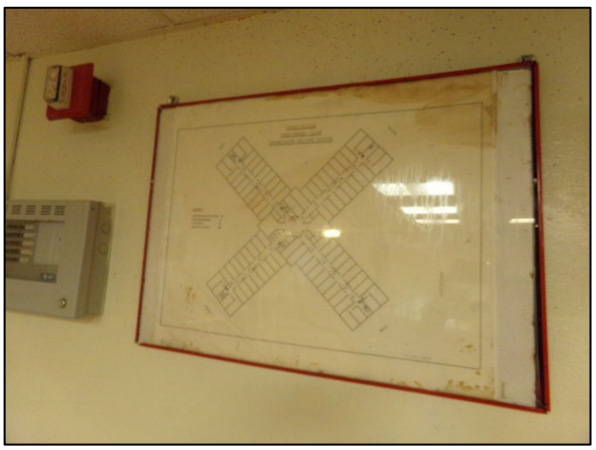





Interior water damage (continued).



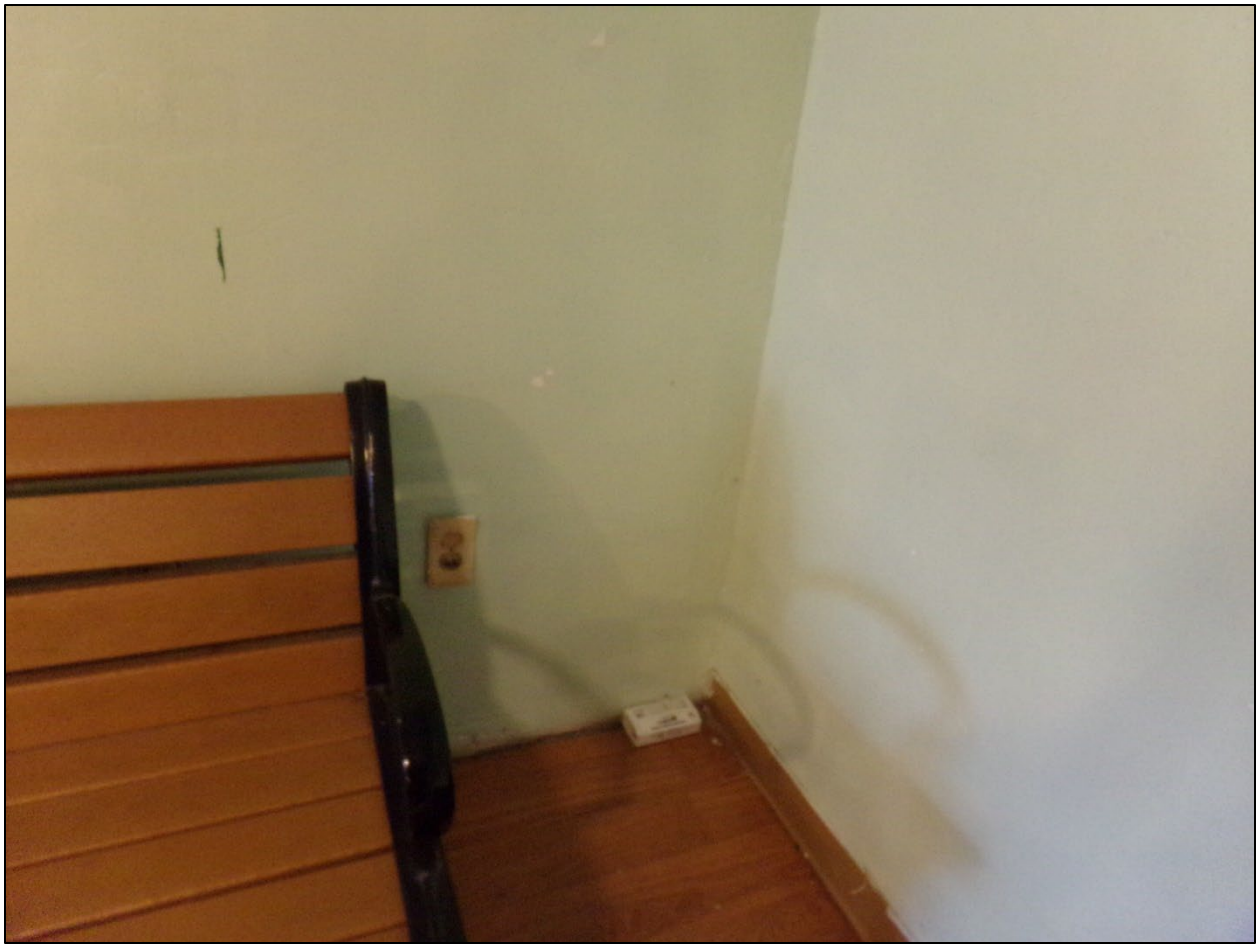





A.3 OVERALL DEGRADATION AND LACK OF MAINTENANCE

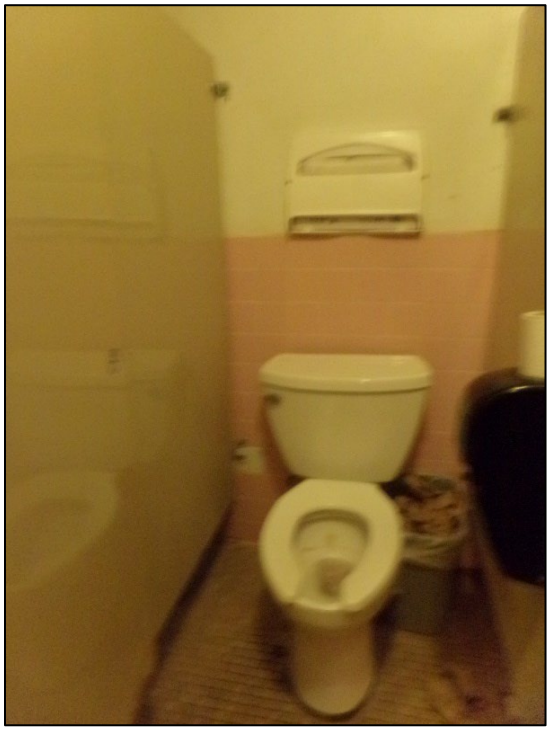
Holes in walls.

Pest traps exposed in building.



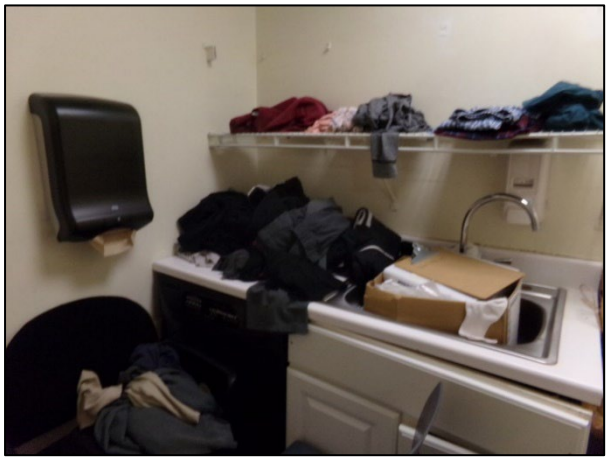
A.3 Overall degradation and lack of maintenance

Stained tiles in bathrooms.



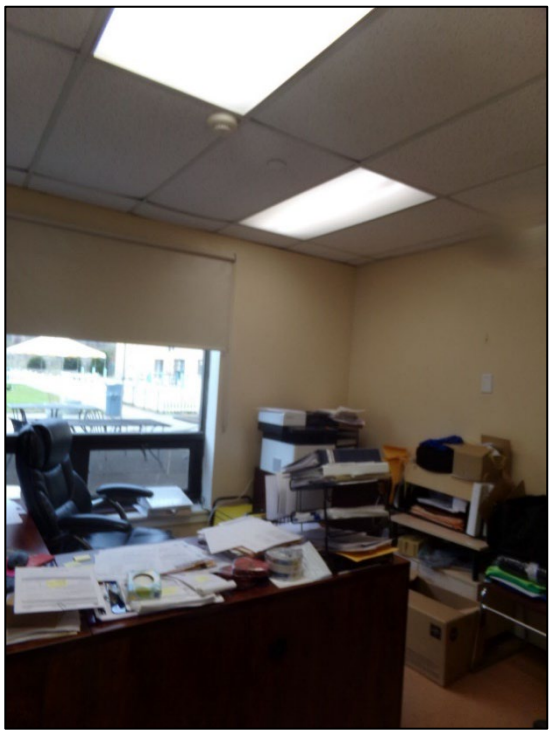
Misaligned windows.

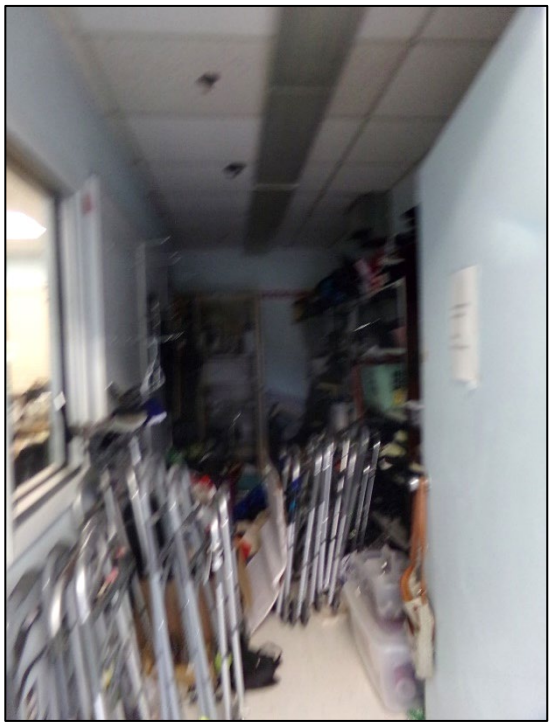
Clutter in various rooms.



A.3 Overall degradation and lack of maintenance

Clutter in various rooms (continued).

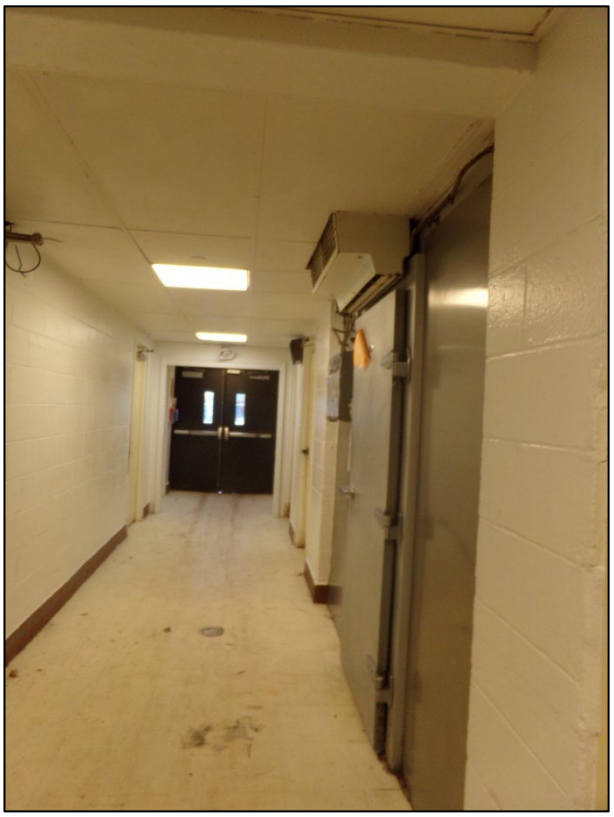


Damaged and rusted cabinetry.

A.3 Overall degradation and lack of maintenance

Damaged and neglected lights in dining area.

Dirt on floors outside of freezer area.



A.3 Overall degradation and lack of maintenance

Peeling wall paper.

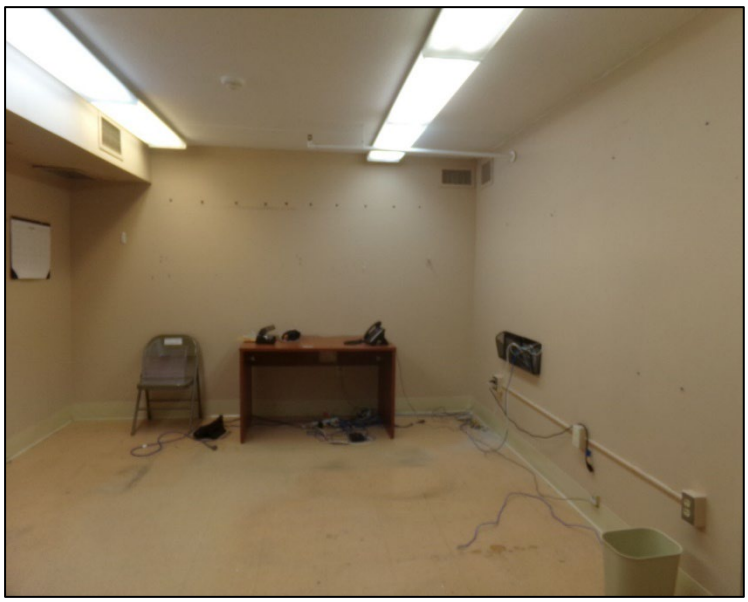
Peeling floorboard moldings.

A.3 Overall degradation and lack of maintenance

Stained walls and floors.

A.3 Overall degradation and lack of maintenance

Stained walls and floors (continued).



Cracks on indoor tiles.

Broken handle on fire exit.

A.3 Overall degradation and lack of maintenance

Broken concrete and pavement, and rusted railings in loading area.

A.3 Overall degradation and lack of maintenance

Sidewalks and pavement with cracks; vegetation growing through.

A.3 Overall degradation and lack of maintenance

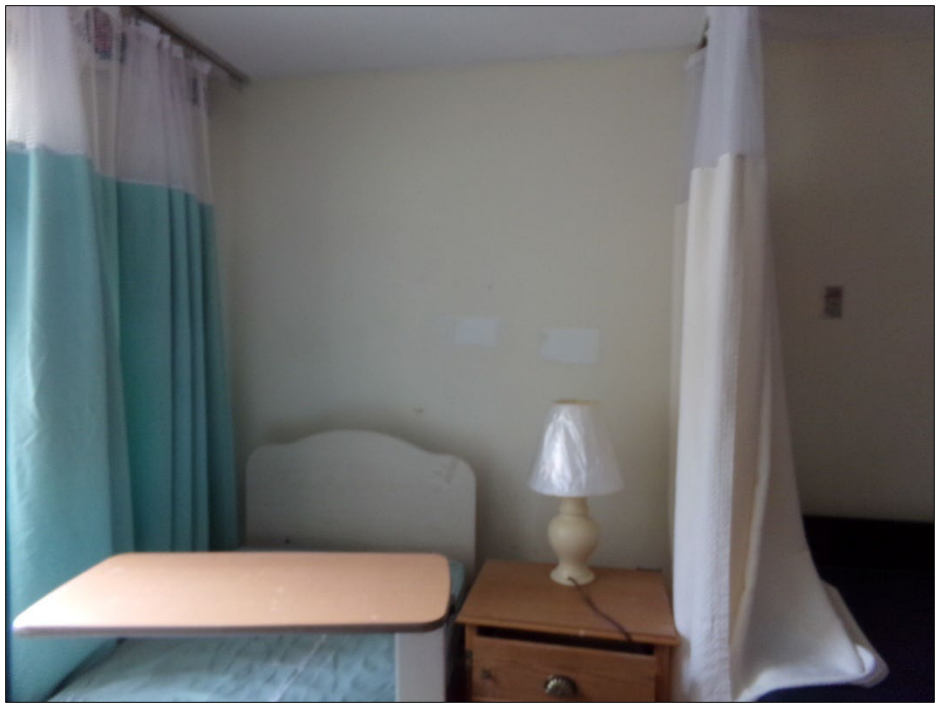
Deteriorating parking areas.

A.3 Overall degradation and lack of maintenance

Deteriorating parking areas (continued).

Improperly winterized pool; deteriorating concrete patio.

A.4 PHOTOS OF ROOMS – CROWDING & DILAPIDATION



A.4 photos of rooms – CROWDING & DILAPIDATION

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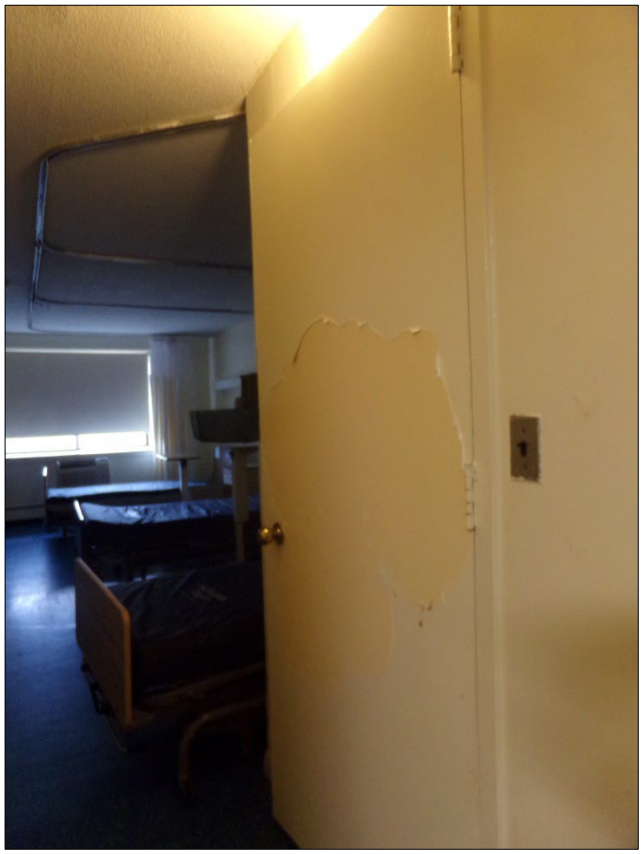

A.4 photos of rooms – CROWDING & DILAPIDATION

APPENDIX B: WOODLAND BEHAVIORAL AND NURSING CENTER SURVEY

Attached as Appendix B is the document of redacted surveys completed by the Department of Health and Human Services Centers for Medicare and Medicaid Services for the Woodland Behavioral and Nursing Center at Andover from March 1, 2019 through January 24, 2022,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315248	A. BUILDING _____ B. WING _____	01/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND BEHAVIORAL AND NURSING CENTER	99 MULFORD ROAD ANDOVER, NJ 07821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 884 SS=F	Reporting - National Health Safety Network CFR(s): 483.80(g)(1)(i)-(viii)(2) §483.80(g) COVID-19 reporting. The facility must-- §483.80(g)(1) Electronically report information about COVID-19 in a standardized format specified by the Secretary. This report must include but is not limited to— (i) Suspected and confirmed COVID-19 infections among residents and staff, including residents previously treated for COVID-19; (ii) Total deaths and COVID-19 deaths among residents and staff; (iii) Personal protective equipment and hand hygiene supplies in the facility; (iv) Ventilator capacity and supplies in the facility; (v) Resident beds and census; (vi) Access to COVID-19 testing while the resident is in the facility; (vii) Staffing shortages; and (viii) Other information specified by the Secretary. §483.80(g)(2) Provide the information specified in paragraph (g)(1) of this section at a frequency specified by the Secretary, but no less than weekly to the Centers for Disease Control and Prevention's National Healthcare Safety Network. This information will be posted publicly by CMS to support protecting the health and safety of residents, personnel, and the general public. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to report complete information about COVID-19 to the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) during a seven-day period that reporting was required by regulation.	F 884		1/24/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/24/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315248	A. BUILDING _____ B. WING _____	01/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND BEHAVIORAL AND NURSING CENTER	**99 MULFORD ROAD ANDOVER, NJ 07821**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 884	Continued From page 1 The CDC submitted data from the NHSN to the Centers for Medicare and Medicaid Services (CMS). Based on review of that data, CMS determined that between 01/17/2022 and 01/23/2022, the facility did not report complete information to NHSN about COVID-19 in the standardized format and frequency as specified by CMS and the CDC. This failure to report has the potential to cause more than minimal harm to all residents residing in the facility.	F 884		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315248	A. BUILDING _____ B. WING _____	C 10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND BEHAVIORAL AND NURSING CENTER	**99 MULFORD ROAD ANDOVER, NJ 07821**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ148293, #NJ149475, #NJ149034 Census: 456 Sample size: 4 Survey date: 10/21/2021 - 10/22/2021 The facility is in compliance with the requirements of 42 CFR part 483, Subpart B, for Long Term Care Facilities based on this complaint survey. In addition to the complaint survey, a COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.	F 000		

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

Electronically Signed | 11/04/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315248	A. BUILDING _____ B. WING _____	05/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND BEHAVIORAL AND NURSING CENTER	**99 MULFORD ROAD ANDOVER, NJ 07821**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Survey date: 05/18/2021 Census: 248 Sample: 7 A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000		

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

Electronically Signed | 05/18/2021

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	315248	A. BUILDING _____ B. WING _____	02/24/2021

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F 000	INITIAL COMMENTS Survey date: 2/24/21 Census: 400 Sample: 4 A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found not to be in compliance with 42 CFR §483.80 infection control regulations as it relates to the implementation of the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		3/26/21

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

Electronically Signed | 03/02/2021

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.

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F 880	Continued From page 1 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its	F 880		

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F 880	Continued From page 2 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documents, it was determined that the facility failed to implement infection control measures consistently to prevent the transmission of [redacted]. This deficient practice was identified for [redacted] units ([redacted]- a 14-day quarantine unit) and, was evidenced by the following: On 2/24/21 at 11:00 AM, the surveyor toured the [redacted] Wing (a unit where the facility cohorted new/re-admissions from the hospital). Prior to entering the unit, the surveyor observed a sign that listed the required Personal Protective Equipment (PPE) to don (put on) before entering the unit; N95 mask, and goggles or face shield outside of resident rooms and if entering a residents room, required the addition of a gown and gloves. There was also signage with the same information outside of each room. The surveyor observed and interviewed 2 Certified Nursing Assistants (CNAs), a Housekeeper, a Security Guard, a Licensed Practical Nurse (LPN) Supervisor, a Recreation Supervisor, and an LPN, all wearing the appropriate PPE. The surveyor also observed a Physician in the chart room sitting at a table writing in charts. The surveyor asked the Physician why he was not wearing an N95 mask and goggles or a face shield. The Physician said, "I saw a study that people who wear eyeglasses get Covid 50% less." The Physician was wearing eyeglasses. The surveyor asked the Physician what he wore when he went into the rooms on the yellow wing to see the residents. The Physician said, "What should I wear? I wear this mask, and that's it." The Physician said, "If someone would tell me, I	F 880	1. Residents affected by the deficient practice: Residents on [redacted] a [redacted] (PUI) wing, are affected by the deficient practice. 2. Identify other residents who could be affected by the deficient practice: All other residents in the facility could be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficiency would not recur: a. The Physician identified was immediately re-educated on the use (including donning and doffing) of appropriate personal protective equipment (PPE) on the [redacted] Wing (PUI unit); b. The attending physicians and nurse practitioners were provided with copy of the facility policy and procedure on appropriate PPE in accordance with the cohorting guidelines; c. COVID monitors will weekly check PPE use by staff on the units. Omissions or deficient PPE use will be immediately addressed by re-educating the individual concerned; d. Per Directed Plan of Correction,	

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F 880	Continued From page 3 would wear it, but no one did." The Physician was wearing a surgical mask, not the required N95 mask, eyeglasses, no face shield or goggles. The LPN Supervisor was present and told the Physician that she would get him the required PPE. On 2/24/21 at 11:30 AM, the surveyor interviewed the In-Service Director/Compliance Liaison. The surveyor asked how often the facility provided infection control training related to Covid-19. She said that it was monthly and on-going. She further stated that there were "Covid monitors" who were in management, and whenever they saw something that needed correcting related to Covid, they would provide training on the spot. The surveyor asked if they invited the Physicians to the in-services for Covid-19. She said, "No." On 2/24/21 at 11:55 AM, the surveyor spoke to the Physician again, in the chart room on the [redacted] Wing. The Physician said he had not gone to any other units in the building and showed the surveyor a paper bag that contained PPE; The Physician said the LPN Supervisor gave it to him. He further stated that he would put it on as soon as the LPN Supervisor showed him how. On 2/24/21 at 1:34 PM, the surveyor interviewed the Infection Preventionist (IP) and asked about Covid-19 in-servicing and if the Physicians were included. The IP stated, "we routinely in-service the staff but exclude the doctors." The surveyor asked about the observation of the Physician not wearing the required PPE on the Yellow Wing. The IP said that she was not aware of any Physician not wearing the appropriate PPE. She added, if brought to her attention, she would have made sure the Physician had PPE. She further stated that signs were posted before entering the	F 880	the Facility conducted a root cause analysis and identified the reason the physician did not wear the appropriate PPE, because he was not instructed on what PPE was required on the PUI unit despite signage posted on the entry to the unit door. He was subsequently instructed on proper PPE on PUI units; and e. Per Directed In-Service Training, the Facility mandated and conducted in-service training by video to staff as follows: i. Topline staff (Directors) were trained on Infection Control and Prevention Program- Module 1 (from Nursing Home Infection Preventionist Training Course) (http://www.train.org/main/course/1081350); ii. All staff were trained on CDC COVID-19 Prevention Messages for Frontline Long-Term Care Staff: Keep COVID-19 Out! (https://youtu.be/7srwrF9MGdw); and iii. Frontline staff were trained on Use PPE Correctly for COVID-19 (https://youtu.be/YYTATw9yav4). 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: a. The Director of Nursing (DON) or designee will weekly audit for a period of sixty (60) days the in-service/re-education	

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F 880	Continued From page 4 unit and on the unit that showed what PPE was required. The surveyor asked the IP what the testing procedure was on the Yellow Wing. She said the residents were swabbed on admission then weekly. She further stated they had to have a negative Covid test 3-5 days before admission. On 2/24/21 at 1:55 PM, the surveyor interviewed the Medical Director (MD). The surveyor asked if he was aware of the Physician not wearing the required PPE on the Yellow Wing. He said the IP just told him. He further stated, "As an aside, I just want you to know that he had Covid 2 months ago, but we'll address it. I know you get that 3-month window, so I think he was just banking on that. I've never known this to be an issue. We will address it." The MD acknowledged that the Physician should have been wearing the appropriate PPE. On 2/24/21 at 2:10 PM, the surveyor reviewed the facility's Covid-19 Outbreak Plan updated on 1/14/21. Number 3. read; "Mitigating actions to prevent or reduce the risk of transmission include the following:" p. read: Signage on PPE, hand hygiene, and physical distancing will be posted throughout the building. Signage on PPE shall include the following information. ii. read: Yellow wing-N95 mask if available-KN95 mask if N95 is not available, face shield or eye protection, and while in the resident room, isolation gown and gloves." On 2/24/21 at 2:20 PM, the surveyor asked the Administrator about the KN95 instruction in their outbreak plan. He said they only use N95 on the [redacted] unit because they have plenty of them. The Administrator provided the most recent Covid-19 tests for all the residents the Physician saw that day, as well as the Physician's Covid-19	F 880	documents to ensure that identified omissions or deficient PPE use was immediately corrected. b. The Facility□s QAPI plan sets forth the basis and goals of its overall Quality Improvement Program. The QAPI Committee meets quarterly to monitor that solutions are sustained.	

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F 880	Continued From page 5 test from 2/22/21. They were all negative. NJAC 8:39-19.4 (a)	F 880		

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E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on April 18, 2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6).	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on April 16-21, 2020. The facility was not in substantial compliance with 42 CFR §483.80 (Infection Control), Subpart-B-Requirements for Long Term Care Facilities. The facility was not following infection control safety practices and guidance recommended by CMS and the Centers for Disease Control and Prevention (CDC), during a COVID-19 pandemic. The census was 419. Immediate Jeopardy was identified at: CFR 483.80 at tag F880 at a scope and severity of "K." The Immediate Jeopardy situation began on April 6, 2020 and was removed on April 21, 2020. The Medical Director, Director of Nursing and Administrative Assistant were made aware that Immediate Jeopardy existed on April 17, 2020 at 12:25 PM. The Nursing Home Administrator was not present onsite during the survey due to illness. COVID-19 (Coronavirus Disease 2019), is a disease caused by the coronavirus SARS -CoV-2. COVID-19 is thought to spread mainly from person to person, mainly through respiratory droplets produced when an infected person coughs or sneezes.	F 000		
F 580	Notify of Changes (Injury/Decline/Room, etc.)	F 580		

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F 580 SS=D	Continued From page 1 CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		

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F 580	Continued From page 2 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, record reviews and staff interviews, it was determined the facility failed to notify a resident representative (R[redacted]) and a resident's physician (R[redacted]) of a significant change of condition [redacted] of [redacted] sampled residents. The findings include: Review of facility policy titled, "Change of Condition," last revised 08/01/17, read in part "The Facility will promptly inform the resident, consult with the resident's Attending Physician, and notify the resident legal representative when the resident endures a significant change in their condition ..." R[redacted] was admitted to the facility on [redacted] with a past medical history that included [redacted] Per copy of court documents found in R1[redacted] chart, [redacted] was appointed their legal guardian on [redacted] On 03/30/20, it was documented on the Interdisciplinary Progress Notes sheet, "MD was made aware that residents Roommate in hospital and tested positive for [redacted]" The progress note further mentioned to order for "COVID and move to [redacted])." R[redacted] was swabbed for	F 580		

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F 580	Continued From page 3 [redacted] and moved to [redacted] that same day. Further review of R[redacted]s medical record revealed that the test results for [redacted] came back positive on [redacted] Per nursing progress note on [redacted] at 11:00 AM, [redacted] NP ... made aware ..." On [redacted] at 09:40 AM, it was documented on the Interdisciplinary Progress Notes sheet, "Rc'd (received) telephone call from POA (power of attorney) ...updated on Residents DX (diagnosis) [redacted] Resident is afebrile at this time no [redacted]) noted MD verified/assessed on [redacted] POA wants to be updated on [change] in health status. Requesting to speak with DON (director of nursing). DON notified." On [redacted] 9:50 AM, it was documented on the Interdisciplinary Progress Notes sheet, "Spoke (POA) about [redacted] - apologized for not informing [redacted] On 04/12/20 at 1:00 PM, it was documented on the Interdisciplinary Progress Notes sheet by nursing, [redacted] Not able to eat or take medication. Continue to Monitor." There was no evidence found in the record that R[redacted]s POA was notified of this change in condition. On 04/13/20 at 4:00 AM, it was documented on the Interdisciplinary Progress Notes sheet, "Responded to nurse call on the floor ...no [redacted] to both [redacted] and [redacted] . [redacted] and [redacted] R[redacted] was pronounced dead at 5:00 AM per	F 580		

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F 580	Continued From page 4 nurse's progress note. On [redacted] at 7:02 PM in an interview with the DON, she confirmed that the notification in change of condition was delayed regarding notifying the resident's POA of the [redacted] results. She stated she spoke with the resident's POA and wrote the note on [redacted] at 9:50 AM. On [redacted] at 2:53 PM, the surveyor observed R[redacted] lying supine on a [redacted] in the hallway on the [redacted] unit. The surveyor observed R[redacted] wearing an [redacted] and heard R[redacted] making a [redacted]. During that observation, R[redacted] was being wheeled to the elevator by emergency personnel in Personal Protective Equipment that included face masks, gowns and gloves. On 04/16/20 at 2:56 PM Employee (E) 3, standing at the [redacted] nurse's station, stated R[redacted] was being taken to the emergency room for [redacted] stated she did not know how long R[redacted] had been like that. During an interview with the surveyor on 04/16/20 at 2:58 PM, the [redacted] unit supervisor stated R[redacted] started with [redacted] that morning and [redacted] a temperature in the afternoon. Review of the Admission Record revealed R[redacted] was admitted to the facility on [redacted] with diagnoses that included but were not limited to: [redacted] and [redacted]	F 580		

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F 580	Continued From page 5	F 580		

[redacted].

Review of the Annual Minimum Data Set (MDS - an assessment tool), dated [redacted], revealed R[redacted] had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated a [redacted]

Review of the Quarterly MDS, dated [redacted] revealed R[redacted] had a BIMS of [redacted] which indicated a [redacted].

Review of the Physician's Order Form, dated [redacted] revealed a physician's order dated [redacted] for [redacted] l (medication to [redacted] [redacted] milligram (mg) administer [redacted] tablets by mouth every [redacted] hours as needed (PRN) for a [redacted]

Review of the Medication Administration Record for PRN medications, dated [redacted] revealed the physician's order for [redacted] but no documentation that the medication had been administered to R[redacted].

Review of R[redacted]'s Interdisciplinary Progress Notes (IDPN), completed by nursing revealed:

[redacted] at 2:35 PM, a temperature (T) of [redacted] F, pulse (P) [redacted], blood pressure (BP) [redacted] oxygen level (SPO2) of [redacted] on room air (RA), R[redacted] was [redacted] and [redacted] were administered as needed (PRN). There was no documentation that a follow up [redacted] was obtained to determine the effectiveness of the [redacted] There was no other documented clinical assessment or follow-up documentation.

04/15/20 at 2:15 AM, T [redacted] F, BP [redacted], pulse (P) [redacted]), respirations (R)

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[redacted] and SPO2 [redacted]% RA. [redacted] was administered. The T was rechecked at 3 AM and noted to be [redacted] There was no other documented clinical assessment or follow-up documentation.

[redacted] at 8:00 AM, "slept fairly the whole night." There was no other documented clinical assessment or follow-up documentation.

[redacted] at 3:00 PM, the latest T was [redacted] F "post [redacted]" that was administered for a T of [redacted] during the shift. There was no other documented clinical assessment or follow-up documentation.

[redacted] at 6:00 PM, T of [redacted] F, [redacted] administered and "will monitor." There was no other documented clinical assessment or follow-up documentation.

[redacted] at 9:45 PM, T[redacted] F, BP [redacted], P [redacted], R [redacted] SPO2 [redacted] on RA.

[redacted] at 2:30 PM, "Resident noted to be [redacted], O2 Sat [redacted] s..." call to physician to send to hospital emergency room for evaluation and treatment. There were no previous documented calls to the physician regarding R[redacted] temperature readings, vital signs, or changes in condition over the [redacted] days from [redacted]

[redacted] (no time written), SPO2 of [redacted] on RA, T [redacted] change in status, increased and [redacted]

[redacted] at 7:00 PM, report from hospital emergency room that Resident [redacted] was admitted

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F 580	Continued From page 7 with [redacted] and possible [redacted] Review of the facility provided, "Temperature Check [redacted] monitoring)" logs for the [redacted] units revealed the following: [redacted] 7am - 3pm shift: T [redacted] blank "other symptoms", blank "comments", and signed "checked by wing-nurse signature" [redacted] 11pm - 7 am shift: T [redacted] blank "other symptoms", blank "comments", blank "checked by wing-nurse signature" 3pm - 11pm shift: T [redacted] blank "other symptoms", blank "comments", and signed "checked by wing-nurse signature" 7am - 3pm shift: T [redacted], blank "other symptoms", blank "comments", and signed "checked by wing-nurse signature" [redacted]: 7am - 3pm shift: T [redacted] blank "other symptoms", blank "comments", blank CNA signature and signed "checked by wing-nurse signature." During an interview with the surveyor on 04/17/20 at 2:32 PM, E4 stated the staff does not always call the physician when a resident had a temperature and that the PRN [redacted] would be tried first and if that didn't work, the staff should call the physician. E4 stated that she would have to monitor the symptoms and that any changes should be documented in the notes. E4 stated they would not ask for a [redacted] test right away and confirmed no test was ordered for R[redacted] E4 stated the staff would communicate symptoms and the temperatures would be on the	F 580		

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F 580	Continued From page 8 temperature logs for the staff to monitor but that she was unaware of anything until yesterday when R[redacted] "just wasn't himself." E4 also stated that as of today, R[redacted] had to be [redacted] at the hospital. On 04/17/20 at 4:08 PM, the surveyor requested the missing "Temperature Check [redacted] monitoring)" logs [redacted] unit from [redacted] the 11pm - 7am and 3pm - 11pm shifts and [redacted] 11pm - 7am shift from the DON. The surveyor also requested any policies or procedures on the Temperature Check [redacted] monitoring logs, Monitoring Residents for [redacted] or related topics. The facility was given opportunity and could not provide additional policies/procedure, information or documentation regarding any of the above.	F 580		
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		

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providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

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F 880	Continued From page 10 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record reviews, and review of facility documents, the facility failed to ensure: 1) appropriate transmission based precautions were ordered and implemented (immediate isolation from asymptomatic roommates) for suspected [redacted] residents (R[redacted], R[redacted], R[redacted] R[redacted] and R[redacted]), [redacted]) a system of surveillance to prevent the spread of infection (screening, tracking, monitoring and/or reporting of fever and other signs/symptoms of [redacted] for [redacted] residents (R[redacted], R[redacted] ,R[redacted], R[redacted], R[redacted] R[redacted]), 3) staff properly used personal protective equipment (PPE) when caring for [redacted] or [redacted] suspected residents, 4) staff were properly trained to use the infrared forehead thermometer on staff, visitors and residents, 5) implementation of hand washing practices consistent with CDC (Centers for Disease Control and Prevention) guidelines to reduce the spread of infections and prevent cross-contamination during the COVID-19 pandemic, and 6) posting of contact/droplet precaution signage throughout the facility. These failures in proper infection control practices had the potential to affect all residents in the facility through the development and transmission of [redacted] and other communicable diseases. It was determined the provider's non-compliance with one or more requirements of participation has caused, or was likely to cause, serious injury, harm impairment or	F 880		

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death to residents. The Immediate Jeopardy (IJ) was related to §480.80 Infection Control. The Director of Nursing (DON), Medical Director and the Administrative Assistant were made aware the IJ existed for the 405 residents in the facility on April 17, 2020 at 12:25 PM. The sample size was 25 residents (R).

An acceptable action plan was received on April 17,2020 at 8:45 PM. The Immediate Jeopardy was removed on April 21, 2020 at 4:30 PM, after onsite verification on April 21,2020.

The findings include:

Review of the facility's March 2020 policy and procedure "CARING FOR RESIDENTS WITH A SUSPECTED OR A CONFIRMED CASE OF COVID-19," revealed the following procedures:

"Patients testing positive for COVID-19 or suspected of COVID-19 will be evaluated by PMD to determine the need for hospitalization. If hospitalization is not medically necessary, the resident is to remain in the facility.

Patients with known or suspected COVID-19 will be transferred to the designated unit and when feasible provided with a private room.

On admission, a resident with known or suspected COVID-19 will be provided with a private room when available.

Residents that have a confirmed case of COVID-19 can cohort with other residents who have a confirmed COVID-19.

Residents with suspected or confirmed

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COVID-19 will have the door in their room kept closed at all times.

All efforts will be made to have consistent caregivers assigned to residents with suspected or confirmed COVID-19. These staff members will not float to other units.

The IDT will limit the number of caregivers that enter the room over the course of the shift to limit exposure.

The following measures will be implemented for residents with known or suspected COVID-19:

A facemask will be placed on the resident and worn as tolerated

Transmission based precautions will be instituted to include placement of isolation cart at entrance of room and signage on the door

Caregivers will don appropriate personal protective equipment (PPE) - gown, mask, face/eye shield, gloves

Dedicated equipment to included BP machine, stethoscope, thermometer, and when needed glucose finger stick monitoring supplies will be provided and stored inside the room

Vital signs will be taken twice per shift and this will be aligned with medication administration and AOL care

When respirator face masks are available, they will be utilized by caregivers...

When residents with known or suspected COVID-19 require transfer to an acute care hospital setting...,

The IDT will take all necessary measures to identify resident preferences and goals for care while at the same time adhere to the CDC guidelines to prevent transmission of the disease.

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Residents and representatives will be provided with education on Advanced Directives and MOLST. Education will focus on current information with regards to recovery and mortality.

The Resident's representative will receive a daily update on the resident's condition via phone at a prearranged time..." IDT stands for Interdisciplinary Team.

1) Appropriate Transmission Based Precautions

Review of the facility's COVID-19 binder on 04/18/20, revealed a document from the CDC, titled, Flowchart to Identify and Assess 2019 Novel Coronavirus. The following recommendations were under the section Upon Arrival (to the facility): "Take steps to ensure all persons with symptoms of suspected COVID-19 or other respiratory infection {e.g., fever, cough) adhere to respiratory hygiene and cough etiquette, hand hygiene, and triage procedures.

Post visual alerts (e.g., signs, posters) at the facility entrance and in strategic places (e.g., waiting areas, elevators} to provide Residents and HCP with instructions (in appropriate languages)
about hand hygiene, respiratory hygiene, and cough etiquette.

Instructions should include how to use face masks or tissues to cover nose and mouth when coughing or sneezing, to dispose of tissues and contaminated items in waste receptacles, and how and when to perform hand hygiene.

Ensure that Residents with symptoms of

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F 880	Continued From page 14 suspected COVID-19 or other respiratory infection (e.g., fever, cough) are not allowed to be among other Residents. Identify a separate, well-ventilated space that allows residents to be separated by 6 or more feet, with easy access to respiratory hygiene supplies. Ensure rapid triage and isolation of Residents with symptoms of suspected COVID-19 or other respiratory infection (e.g., fever, cough): Implement triage procedures to detect persons under investigation (PUI) for 2019-nCoV (Novel Coronavirus) during or before Resident admission and ensure that all Residents are asked about the presence of symptoms of a respiratory infection and history of travel to areas experiencing transmission of COVID-19 or contact with possible COVID-19 Residents. Implement respiratory hygiene and cough etiquette (i.e., placing a facemask over the Resident's nose and mouth if that has not already been done) and isolate the PUI for 2019-nCoV in an Airborne Infection Isolation Room (AIIR), if available." On 04/17/20 at 9:25 AM, an observation of the [redacted]) room assignments for room [redacted] revealed that R1[redacted] (awaiting [redacted] test results since the resident was symptomatic) was placed in the same room with R[redacted], who was not suspected of having [redacted]. A review of the medical record for R[redacted] revealed	F 880		

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F 880	Continued From page 15 the resident was admitted on [redacted] with a diagnosis of [redacted]. A review of the medical record for R[redacted] revealed the resident was admitted on [redacted] with a diagnosis of [redacted]. Interview with E14 on 04/17/20 at 9:30 AM, revealed confirmation that R[redacted] did show symptom which included [redacted] and this was reason for resident being tested for [redacted]. When asked about R[redacted]'s status. E14 did reveal that R[redacted] did not have any symptoms of [redacted] and was not suspected of having [redacted]. She explained that they did not move R[redacted] because they are awaiting for the [redacted] test result to come back. Review of "[redacted]" (a lab report) dated [redacted] revealed that R[redacted] was [redacted]" for [redacted]). R[redacted] was admitted to the facility on [redacted] with a past medical history that included [redacted]. Per the IDT Progress Notes review, R[redacted] was noted to have a [redacted] on [redacted] R[redacted] was seen by her provider that same day and an order for "Swab [redacted]-PUI" was written at 9:30 AM. Per nursing progress note on [redacted] at 12:25 PM, the [redacted] swab was obtained. The results for the test came back [redacted] on [redacted]0. R[redacted] was transferred to [redacted], the designated [redacted] isolation unit, that same day. R[redacted] was admitted to the facility on [redacted] a past medical history that included [redacted]. On [redacted], R[redacted] was moved to the	F 880		

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F 880	Continued From page 16 [redacted] unit. R[redacted] was admitted to the facility on [redacted] with a past medical history that included [redacted]. R[redacted] was R[redacted]s and R[redacted]s roommate before R[redacted] was moved to [redacted] During an observation on the [redacted] Unit on 4/16/20 at approximately 2:45 PM, it was revealed a sign outside of room for R[redacted] and R[redacted], which indicated there was a [redacted] resident in the room. Per record review, R[redacted] was noted to have a [redacted] on [redacted]. R[redacted] was seen by her provider and an order for "Swab [redacted]-PUI" was written on [redacted] at 9:30 AM. Per nursing progress note on [redacted] at 12:25 PM, the [redacted] swab was obtained. The results for the test came back [redacted] on [redacted] During an interview with E8 on 04/16/20 at approximately 2:50 PM, when asked if there was a [redacted] person in room with the [redacted] signage in [redacted] unit, E8 stated that R[redacted] had been moved to the [redacted] isolation wing on [redacted] E8 then took down the sign. On 04/16/2020 at approximately 2:55 PM, the HR (human resource) director also confirmed R[redacted] was moved to [redacted] unit on [redacted]. R[redacted] and R[redacted] roomed with R[redacted] for [redacted] days from [redacted] to [redacted] when R[redacted] was a person under investigation for [redacted], until subsequently moved to the [redacted] isolation wing. 2) System of surveillance Record review during the [redacted] days R[redacted] was	F 880		

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F 880	Continued From page 17 suspected [redacted] and cohorting with R[redacted] and R[redacted] revealed no indication of an assessment or additional monitoring for [redacted] symptoms that include in part: cough, shortness of breath or difficulty breathing, and chills aside from temperature checks. Review of the facility documentation, "Temperature Check [redacted] monitoring)" logs for [redacted] unit from [redacted] to [redacted] revealed several monitoring sheets missing. Of the [redacted] days reviewed, there were 18 out of 48 shifts missing temperature logs. The dates were: 04/01, 04/02, 04/05 to 04/09, and 04/11 to 04/16. On the provided temperature check logs, there were also columns for "Other Symptoms" and "Comment." Review of the temperature logs on [redacted] for R[redacted], R[redacted] and R[redacted], did not reveal any documentation in those columns. Review of R[redacted]s Interdisciplinary Progress Notes also did not reveal any additional monitoring of signs and symptoms of [redacted] while on [redacted] from [redacted] to [redacted] Review of R[redacted]s Interdisciplinary Progress Notes also did not reveal any additional monitoring of signs and symptoms of [redacted] while on [redacted] from [redacted] to [redacted] Review of R[redacted]'s Interdisciplinary Progress Notes did not reveal any additional monitoring of signs and symptoms of [redacted] while on [redacted] from [redacted] to [redacted] A review of the medical record for R[redacted]s revealed the resident was admitted on [redacted] with a diagnosis of [redacted].	F 880		

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Record review of the Progress Notes dated [redacted] at 7:00 PM revealed R[redacted] had a high T of [redacted]. The next T of [redacted] was documented at 11:22 PM on that same day.

A physician order, dated [redacted], ordered [redacted] test and labs to be drawn. Orders were carried out, and results were pending.

Further review of the Medication Administration Record (MAR) for [redacted] revealed that there were no medications given/charted that addressed the high temperature of [redacted]

Review of the Temperature log dated [redacted] revealed that R[redacted] temperature was not documented at all. This was the day after he had a temperature of [redacted]

Review of the Progress Notes dated [redacted] at 5:30 AM, stated resident was [redacted] and was pronounced dead at 6:09 AM.

No documentation of [redacted] monitoring was found regarding the [redacted] symptoms which included [redacted] or [redacted] assessment of R[redacted] from [redacted] to [redacted]

In an interview with the Administrative Assistant (AA) on 04/17/2020 at 6:00 PM, she was asked about the lack of documentation regarding assessment notes and medications or nursing interventions given for the fever. The AA attempted to find documentation, but no further documentation could be provided.

Review of [redacted] (a lab report) dated [redacted] revealed that R1[redacted] s [redacted] ([redacted]) was [redacted]".

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F 880	Continued From page 19 On 04/16/20 at 2:53 PM, the surveyor observed R[redacted] lying supine on a [redacted] in the hallway on the [redacted] floor unit. The surveyor observed R[redacted] wearing an [redacted] and heard R[redacted] making a [redacted]. During that observation, R[redacted] was being wheeled to the elevator by emergency personnel in PPE that included face masks, gowns and gloves. During an interview with the surveyor on 04/16/20 at that time, E3 at the [redacted] nurse's station stated R[redacted] was being taken to the emergency room for [redacted] and stated she did not know how long R[redacted] had been like that. During an interview with the surveyor on 04/16/20 at 2:58 PM, E4, stated R[redacted] started with [redacted] that morning and [redacted]" a temperature in the afternoon. Review of the Admission Record revealed R[redacted] was admitted to the facility on [redacted] with diagnoses that included but were not limited to: [redacted]. Review of the Annual Minimum Data Set (MDS - an assessment tool), dated [redacted] revealed R8 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated a [redacted]. Review of the Quarterly MDS, dated [redacted] revealed R8 had a BIMS of [redacted] which indicated a	F 880		

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F 880	Continued From page 20 [redacted]	F 880		

Review of R[redacted]'s Physician's Order Form, dated [redacted], revealed an order dated [redacted] for [redacted] (medication to [redacted]) [redacted] milligram (mg) administer[redacted] by mouth every [redacted] hours as needed (PRN) for a temperature above [redacted]

Review of the Medication Administration Record for PRN medications, date[redacted], revealed the physician's order for [redacted] but no documentation that the medication had been administered to R[redacted].

Review of R8's Interdisciplinary Progress Notes, completed by nursing revealed:

[redacted] at 2:35 PM, a temperature (T) of [redacted] F, pulse (P) [redacted], blood pressure (BP) [redacted], oxygen level (SPO2) of [redacted] % on room air (RA), R[redacted] was [redacted] and two [redacted] were administered as needed (PRN). There was no documentation that a follow up temperature was obtained to determine the effectiveness of the [redacted]. There was no other documented clinical assessment or follow-up documentation.

[redacted] at 2:15 AM, T [redacted] F, BP [redacted], pulse (P) [redacted] beats per minute (bpm), respirations (R) [redacted] and SPO2 [redacted] RA. [redacted] was administered. The T was rechecked at 3 AM and noted to be [redacted] F. There was no other documented clinical assessment or follow-up documentation.

[redacted] at 8:00 AM, "slept fairly the whole night." There was no other documented clinical assessment or follow-up documentation.

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F 880	Continued From page 21 [redacted] at 3:00 PM, the latest T was [redacted] F "post [redacted]" that was administered for a T of [redacted] during the shift. There was no other documented clinical assessment or follow-up documentation. [redacted] at 6:00 PM, T of [redacted] F, [redacted] administered and "will monitor." There was no other documented clinical assessment or follow-up documentation. [redacted] at 9:45 PM, T [redacted] F, BP [redacted], P [redacted], R [redacted] and SPO2 [redacted] % on RA. [redacted] at 2:30 PM, "Resident noted to be in [redacted], O2 Sat [redacted] .." call to physician to send to hospital emergency room for evaluation and treatment. There were no previous documented calls to the physician regarding R [redacted] temperature readings, vital signs, or changes in condition over the [redacted] days from [redacted] to [redacted] [redacted] (no time written), SPO2 of [redacted] on RA, T [redacted] F, change in status, increased and [redacted] [redacted] at 7:00 PM, report from hospital emergency room that Resident [redacted] was admitted with [redacted] and possible [redacted] Review of the facility provided, "Temperature Check [redacted] monitoring)" logs for the third-floor units revealed the following: [redacted] 7am-3pm shift: T [redacted], blank "other symptoms", blank "comments", and signed "checked by wing-nurse signature"	F 880		

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F 880	Continued From page 22 [redacted] 11pm -7am shift: T[redacted], blank "other symptoms", blank "comments", blank "checked by wing-nurse signature" 3pm -11pm shift: T[redacted], blank "other symptoms", blank "comments", and signed "checked by wing-nurse signature" 7am -3pm shift: T 1[redacted] blank "other symptoms", blank "comments", and signed "checked by wing-nurse signature" [redacted] 7am-3pm shift: T[redacted] blank "other symptoms", blank "comments", blank CNA signature and signed "checked by wing-nurse signature." During an interview with the surveyor on 04/17/20 at 2:32 PM, E4 stated the staff does not always call the physician when a resident had a temperature and that the PRN[redacted] would be tried first and if that didn't work, the staff should call the physician. E4 stated that she would have to monitor the symptoms and that any changes should be documented in the notes. E4 stated they would not ask for a [redacted] test right away and confirmed no test was ordered for R8. E4 stated the staff would communicate symptoms and the temperatures would be on the temperature logs for the staff to monitor but that she was unaware of anything until yesterday when R8 just wasn't themselves. E4 also stated that as of today, R[redacted] had to be [redacted] at the hospital. On 04/17/20 at 4:08 PM, the surveyor requested the missing "Temperature Check ([redacted]" logs [redacted] unit from [redacted] the 11pm - 7am and 3pm - 11pm shifts and [redacted]	F 880		

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F 880	Continued From page 23 11pm - 7am shift from the DON. The surveyor also requested any policies or procedures on the Temperature Check [redacted] monitoring logs, Monitoring Residents for [redacted] or related topics. The facility was given opportunity and could not provide additional policies/procedure, information or documentation regarding any of the above. R[redacted] was admitted to the facility on [redacted] with diagnoses of [redacted] Review of the facility's New Jersey Universal Transfer Form revealed on [redacted] R[redacted] was transferred to the hospital emergency room (ER) for a T of [redacted] degrees Fahrenheit (F) and being [redacted]. The ER After Visit Summary, dated [redacted], revealed discharge instructions for [redacted]. These included: call 911 for a seizure, if resident cannot be woken, chest pain or trouble breathing, stiff neck, bad headache, sensitivity to light, feeling weak, dizzy, or confused, stop urinating or urinate is less than normal, coughing up of blood or thick, yellow or green mucus, severe abdominal pain or abdomen is larger than usual. R[redacted] " End of Visit Vitals" were blood pressure(BP) -[redacted] T-[redacted] F, pulse (P)-[redacted] respirations (R)-[redacted] and oxygen saturation (SaO2)[redacted] percent (%). The discharge instructions also included to follow-up with the attending physician in [redacted] days [redacted] and to call the physician for a T of [redacted] F or higher. Review of the IDT on [redacted] at 7:30 AM, documented R[redacted] had returned to the facility with a discharge diagnoses of "[redacted]" and [redacted] screening completed. At 8:00 AM the nursing note documented the following vitals:	F 880		

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F 880	Continued From page 24 BP[redacted], [redacted] (T) P-76 and SaO2-[redacted] "Continue to monitor." The next documented IDT nursing note was on[redacted] at 9:00 PM. It revealed "Resident in bed[redacted], no fever or pain noted on this shift. Resident cooperates well regarding care..." On[redacted] at 6:40 PM, a late entry nursing note revealed on[redacted] R[redacted] was found on the floor by[redacted] bed, had fell on the wet floor and obtained a[redacted] on the[redacted] of[redacted]. The resident's vitals were taken, range of motion assessed and pupils (eyes) were found to be equal, round and reactive to light and accommodation (PERRLA). The next IDT note was on[redacted] at 7:15 AM. It read "Entered room, Resident (with symbol) eyes open,[redacted] no[redacted], no[redacted] response, no[redacted], no[redacted] R[redacted] physician and registered nurse pronounced the resident deceased at 7:35 AM. Review of the facility's Internal Medicine Monthly Visit/Acute visit/Readmission form dated[redacted] revealed the following hand written notes from[redacted] physician: "Found dead this am,[redacted]) not performed Physica[redacted] test was done?...[redacted] for the last few days-that was not brought to my attention.[redacted], likely[redacted]." On 04/16/20 at 3:15 PM, the[redacted] surveillance monitoring and tracking was discussed with the DON. The DON stated all working staff temperatures were checked at the beginning of each shift upon entering the facility. If any staff person's temperature was equal or greater than[redacted], they are sent home. In regards to the residents' temperatures, the DON stated they were checked by the CNA's at the	F 880		

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beginning of each shift every eight (8) hours. The CNA's recorded the temperatures on a Temperature List form. This form could be found at the Nurses' Station on each floor. If there were other [redacted] symptoms such as shortness of breath, coughing, weakness, etc. this information would be documented by the nurse and found in the progress (IDT) notes.

On 4/17/20 at 7:30 PM, the DON was asked for the facility's practice on assessment and monitoring after an unwitnessed fall. The DON stated the nurses perform [redacted]) checks every four (4) hours for 72 hours. It was also stated the [redacted] checks should have been performed after R[redacted] fall . This surveyor was unable to locate the [redacted] checks or the resident's Advanced Directive/ MOLST (Provider Orders for Life Sustaining Treatment) information on the clinical chart. Later the DON confirmed R [redacted] was a full code, the Advanced Directive/ MOLST information were never provided.

The facility's Temperature Check (Coronavirus monitoring) form was composed of eight columns, titled, Resident Name, Rm No.(room number) ,Date, Time, Temp.(temperature), Other Symptoms, Comment and CNA (Certified Nursing Assistant) Signature.

On 04/18/20 at approximately 10:40 AM, the Temperature Check form was reviewed with the DON . A request for temperature checks and [redacted] monitoring was requested for R[redacted]. The facility presented the [redacted] List for Temperature Check, dated [redacted], 11-7 (11:00 PM- 7:00 AM) Shift. R[redacted] name was on the list in room [redacted] with a Temp reading of [redacted] All other columns were blank. The facility was unable to provide the requested temperature

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F 880	Continued From page 26 checks for [redacted] days in [redacted] ([redacted] and [redacted] [7-3 and 3-11 shift]). On 04/20/20 the facility emailed R[redacted]s [redacted] Flow Sheet, which revealed [redacted] assessments were only assessed for [redacted] hours, with the last documented time of 3:15 PM on [redacted]. 3) PPE Usage On the [redacted] ([redacted]) unit, an observation with the HR Director on 4/16/20 at approximately 3:30 PM, E7 was seen not wearing a gown upon entering resident room [redacted] E7 was then observed walking out of resident room [redacted] and exited the unit through the closed double doors. On 04/16/20 at 5:51 PM in an interview with the DON, when asked what personal protective equipment (PPE) staff were currently required to wear on [redacted] units, the DON stated they were to wear a face mask (currently N95) and a gown. The CDC recommendation from [redacted]. "...In addition to the actions described above, these are things facilities should do when there are [redacted] cases in their facility or sustained transmission in the community Healthcare Personnel Monitoring and Restrictions: Because of the higher risk of unrecognized infection among residents, universal use of all recommended PPE for the care of all residents on the affected unit (or facility-wide depending on the situation) is recommended when even a	F 880		

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single case among residents or HCP is identified in the facility; this should also be considered when there is sustained transmission in the community. The health department can assist with decisions about testing of asymptomatic residents."

On 04/16/20 at 2:56 PM, the surveyor observed the [redacted] unit nurse's station. The surveyor observed a staff member standing on the outside perimeter of the round, nurse's desk with their face mask positioned below their nose. The staff member was talking to and in close proximity to five other staff members behind and around the nurse's station. The staff member was identified as E1. The surveyor observed one of the other staff members had been within arm's length from E1.

On 04/16/20 at approximately 3:00 PM, E1 stated she had lowered her face mask because it was "change of shift." E1 stated she had no excuse for the improper use of the face mask and that she had been in-serviced the beginning of March 2020 on the proper use of PPE. E1 stated she should have positioned the face mask "the right way" over her nose "to protect everyone."

On 4/16/20 at 3:24 PM, the surveyor observed, on the [redacted] floor between the nurse's station and the [redacted] hall, a staff member with her face mask positioned below both her nose and mouth, down below her chin. The staff member was in close proximity to eight other staff members and was loudly projecting her voice and was calling out assignments and instructions. The staff member was identified as E2. The surveyor observed three other staff members had been within arm's length from E2.

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F 880	Continued From page 28 On 04/16/20 at approximately 3:30 PM, E2 stated her mask was positioned below her nose and mouth because sometimes it was hard to breathe with the mask fully on the face. E2 stated she knew that was not the correct way to don the face mask and that the purpose of the face mask was important to prevent the spread of the [redacted] During an interview with the surveyor on 04/16/20 at 2:58 PM, E4 stated the staff had been in-serviced on the use of PPE by the facility educator who was now out sick. E4 stated it was everyone's responsibility to check that their own PPE and "each other's" PPE was on correctly. During an interview with the surveyor on 04/16/20 at 3:50 PM, the DON stated that all staff had been trained on how to use and wear their PPE. The DON stated face masks should always be worn correctly and cover the nose and mouth. The DON identified E2 as a staff member who worked in the Quality Assurance position at the facility. Review of E1's, "Personal Protective Equipment (PPE) Competency Validation, dated 03/26/20, revealed a competent, "Return verbal demonstration" to prevent cross contamination between staff. The PPE Competency Validation also revealed, 4. Don Mask/Respirator - secure ties/elastic bands at middle of head and neck; 5. fit flexible band to nose bridge and 6. fit snug to face and below chin. The competency also included to correctly identify the appropriate PPE to be worn based on anticipated level of exposure. Review of the facility handout addressed to the employees, dated [redacted] revealed that with the [redacted] outbreak in the facility, staff may have	F 880		

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been exposed. Staff may continue to work provided the included but not limited to 1. Healthcare Personnel (HCP) should report temperature and absence of symptoms each day prior to starting work for the 14-day period after their exposure and 2. HCP wears a facemask while at work for the same 14-day period.

Review of the facility, "PPE Strategies for LTCFs during Cluster of [redacted] Infections:", not dated, revealed when there are cases in the facility universal masking of HCP while in the facility.

During an interview with the surveyor on 04/17/20 at 2:40 PM, the DON stated there was no record of an in-service regarding PPE for E2. The DON stated E2 "never showed up for it (the in-service)" because E2 mostly worked the 3pm - 11pm shift. The DON acknowledged that all staff should have been in-serviced.

4) Infrared Thermometers

On 04/16/20 at 2:30 PM surveyor entered the front door of the facility into the reception area. Upon observation, surveyor's temperatures were checked immediately on the forehead area. One reading obtained on a surveyor read "91 Fahrenheit (F)" and another temperature reading was taken again but it was lower than normal finding, again at "91 F." No further test was done and the surveyor was directed to go inside the facility.

Review of the Medical Infrared forehead thermometer manufacturer's information provided by the facility, revealed an illustration that indicated the area to obtain the temperature was

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in the middle of the forehead. The instructions also revealed after entering the room from a low or high temperature outside, to wait for 20 minutes until the temperature of the "subject" is adjusted to the temperature environment; before measurement, please be sure there is no hair, sweat, makeup or hat covering and that the ambient (relating to the immediate surroundings) temperature should be stable and not tested in places with large airflow.

On 04/17/20 at 8:50 AM entered the front door of the facility into the reception area. Upon observation, surveyor's temperatures were checked on the neck, and not the appropriate area of the forehead. One reading obtained on a surveyor read "94.7 Fahrenheit (F)."

During an interview with the surveyors on 04/16/20 at 4:10 PM, the Central Supply manager stated he handled the ordering of the digital thermometers and that they "were starting to break down." The Central Supply manager also stated that the facility had three digital thermometers on order. He also stated, "I don't know how or if the thermometers are calibrated because we never had to do that before." The facility was unable to present information regarding the calibration requirements for the thermometers being used during the survey.

During an interview with the surveyors on 04/16/20 at 4:12 PM, the Medical Director stated the Certified Nursing Assistants (CNA) were taking the temperatures and were trained just as part of their CNA training and not specifically in-serviced by the facility.

5) Hand Washing Practices

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F 880	Continued From page 31 An observation on the [redacted] unit at 2:50 PM on 04/16/20, E11 was observed handling soiled linen at the doorway in room [redacted] She discarded it in the soiled linen cart and did not change her gloves. She then went to another room without performing any hand hygiene. At 3:05 PM E11 was observed at the doorway of the [redacted] unit removing and discarding her gloves first. She then removed her contaminated PPE gown with ungloved hands and discarded the gown. She did not perform hand hygiene before leaving the unit. At 3:10 PM E12, was observed removing her soiled PPE at the doorway of the [redacted] unit. She did not perform hand hygiene before leaving the unit. There was only one large trash bin at the main entrance of the unit. A used PPE gown was not thrown in the proper receptacle but instead was thrown into a smaller size trash bin which was overflowing. It was noted that the door could only be opened with a turn handle knob. There was no place designated at the entry in which staff could perform hand hygiene measures. Upon opening the door, there was a hallway with still no place to perform hand hygiene. The hand sanitizer was not close by, and it was found on top of the nursing medication cart two rooms away. It was not easily accessible to the staff who needed to perform hand hygiene. At 3:15 PM, E13 was observed at the doorway of the [redacted] unit, wiping her face shield with ungloved hands. She was using the [redacted] wipes to clean and disinfect the face shield. After cleaning, she did not do hand hygiene. An interview with E10 on 04/16/20 at 3:15 PM revealed E11 and E12 should have performed hand hygiene before leaving the unit. On 04/17/20 at 9:55 AM, two physical therapy staff members (E15 and E16) were observed	F 880		

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	315248	A. BUILDING _____ B. WING _____	C 04/21/2020

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F 880	Continued From page 32	F 880		

walking in the hallway. They were still wearing gloves as they opened the door to exit the [redacted] unit [redacted] floor). They removed their gloves after exiting and did not perform hand hygiene afterwards. An interview with E15 04/17/20 at 10:00 AM, revealed that he was not aware he should wash his hands before leaving the closed unit. He stated he will wash his hands downstairs in the therapy room. Both staff members stated that they will wash their hands downstairs in the therapy room.

In an observation on 04/17/20 at approximately 9:30 AM, E6 was observed on [redacted] unit, entering and exiting rooms [redacted] and [redacted]. E6 failed to sanitize hands before donning new gloves and entering in room [redacted] Finally, E6 failed to perform hand hygiene after exiting room [redacted] after removal of gloves.

Further observation of [redacted] unit at approximately 9:49 AM revealed E5 perform hand hygiene using a hand sanitizer but subsequently contaminated her left hand by touching the door handle when she exited the unit (double doors were closed). E5 failed sanitize hands again after contamination.

In an observation on 04/16/20 at approximately 3:55 PM while on [redacted] it was revealed that the linen cart at the end of the hallway was left uncovered. An 8 oz. used plastic water bottle was also observed to be on one of the shelves.

In an observation on 04/18/20 at approximately 9:35 AM while on [redacted] it was revealed that the linen cart at the end of the hallway was left uncovered.

On 04/16/20 an observation of the environment

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F 880	Continued From page 33 on the [redacted] unit, revealed the floor was sticky and visibly soiled with stains on the unit hallway. Per facility policy from Healthcare Services Group titled, "Infection Control Overview & Policy," last updated 03/24/20, read in part "Implement hand hygiene (hand washing) practices consistent with accepted standards of practice, to reduce the spread if infections ..." It also indicated, "hand hygiene should be performed ...after removing gloves." 6) Posting of Signage Review of the facility's policy "Guidelines on Isolation Rooms, last updated April 7, 2020, "revealed the following: "Isolation Unit: South 2 has been designated the wing for isolation for COVID -19 positive residents... 2. A sign stating, "Residents SUSPECTED OF [redacted] (PUI) (tested but results not yet available) in the room - observe [redacted] PRECAUTIONS" or "[redacted] positive resident in the room - observe [redacted] PRECAUTIONS." will be posted on the door of the resident room. 10. All staff working on the isolation wing will use total personal protective equipment ("PPE") equipment, namely, disposable gown, gloves, eye protection, and mask. Signs will be posted on the isolation wing to remind staff of correct donning and doffing of PPE." An observation of the [redacted] on 04/16/20 at	F 880		

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F 880	Continued From page 34 3:15 PM was completed. The unit had one entry which was also the exit. There was one isolation sign at the point of entry. The sign did not specify the PPE to be worn for that unit. It was not clear what kind of PPE should be worn (such as gowns, gloves, goggles, N95 respirators, surgical masks). It also was not specified what type of transmission based precautions (TBP) should be implemented. For example contact, droplet, or airborne. At approximately 3:30 PM, revealed Rooms [redacted] did not display signage by the door designating what PPE needed to be worn and the type of transmission based precautions needed. Only rooms [redacted] had the [redacted] signage present. When Nurse (E10) was questioned why only certain rooms had the signage, she could not indicate why. She admitted that the sign should be on all the rooms since it was the [redacted] section. She explained that the census is [redacted], and all [redacted] residents are on isolation precautions for testing positive for [redacted] She said they needed to wear PPE such as gowns, gloves, goggles and N95 respirators. The transmission-based precautions are [redacted] and [redacted] Onsite verification of the removal plan was completed on [redacted], at 4:30 PM. The surveyor verified that the plan of removal & corrective actions taken by the facility had been fully implemented to prevent the serious adverse outcome from occurring or recurring. The decision was based on observations, staff interviews, review of education, in-services, and training provided by the facility to the staff and monitoring logs to verify the immediate corrective actions were in place.	F 880		

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S 000	Initial Comments Survey Date 04/17/20 Census 419 Sample 25 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. On 04/18/2020, in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations, a Directed Plan of Correction (DPOC) was issued. The DPOC included a curtailment of admissions and the hiring of a consultant Registered Nurse for the Director of Nursing position; a consultant Administrator; and a consultant Infection Control Preventionist.	S 000		
S1340	8:39-19.4(a)(1-6) Mandatory Infection Control and Sanitation (a) The facility shall develop, implement, comply with, and review, at least annually, written policies and procedures regarding infection prevention and control which are consistent with the most up-to-date Centers for Disease Control and Prevention publications, incorporated herein by reference, including, but not limited to, the following: 1. Guidelines for Handwashing and Hospital Environmental Control; 2. Guidelines for Isolation Precautions in	S1340		5/18/20

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

Electronically Signed | 05/18/20

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S1340	Continued From page 1 Hospitals; 3. Prevention and Control of Tuberculosis in Facilities Providing Long-term Care to the Elderly; 4. Prevention of Nosocomial Pneumonia; 5. Prevention of Catheter Associated Urinary Tract Infections; and 6. Prevention of Intravascular Infections. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure: 1.) appropriate transmission-based precautions were ordered and implemented (immediate isolation from asymptomatic roommates) for suspected [redacted] residents (R[redacted], R[redacted], R[redacted], R[redacted] and R[redacted]; 2.) a system of surveillance to prevent the spread of infection (screening, tracking, monitoring and/or reporting of fever and other signs/symptoms of [redacted]) for six residents (R[redacted], R[redacted],R[redacted] R[redacted]R[redacted], R[redacted]); 3) staff properly used personal protective equipment (PPE) when caring for [redacted] positive or [redacted] suspected residents; 4.) staff were properly trained to use the infrared forehead thermometer on staff, visitors and residents; and 5.) implementation of hand washing practices; and 6.) posting of contact/droplet precaution signage throughout the facility, in accordance with CDC (Centers for Disease Control and Prevention) guidelines to reduce the spread of infections and prevent	S1340	S 1340 Element One – Corrective Actions 1. Transmission Based Precautions R[redacted] and R[redacted] were immediately separated and properly cohorted based on assessment of symptoms and test results which were documented in the medical record. Staff were re-educated about the facility cohort protocol on April 20. Residents [redacted] and [redacted] were separated and properly cohorted based on assessment of symptoms and test results which were documented in the medical record. Staff were re-educated about the facility cohort protocol April 20. On April 17, 2020, the Director of Nursing obtained the number of residents asymptomatic or negative for [redacted] as well as the number of residents	

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S1340	Continued From page 2	S1340		

cross-contamination during the [redacted] pandemic.

The deficient practice was evidenced by the following:

1.) On 04/17/20 at 9:25 AM, an observation of the [redacted] Unit ([redacted] floor) room assignments for room [redacted] revealed that R[redacted] (awaiting [redacted] test results since the resident was symptomatic) was placed in the same room with R[redacted], who was not suspected of having [redacted].

Interview with E14 on 04/17/20 at 9:30 AM, revealed confirmation that R[redacted] did show symptom which included fever of [redacted], and this was reason for resident being tested for [redacted]. When asked about R[redacted]'s status. E14 did reveal that R[redacted] did not have any symptoms of [redacted] and was not suspected of having [redacted] She explained that they did not move R[redacted] because they are waiting for the [redacted] test result to come back.

A review of the medical record for R[redacted] revealed the resident was admitted on [redacted] with a diagnosis of [redacted].

A review of the medical record for R[redacted] revealed the resident was admitted on [redacted] with a diagnosis of [redacted].

Review of [redacted]" (a lab report) dated [redacted] revealed that R[redacted] was "[redacted]" for [redacted]).

During an observation on the [redacted] Unit on

symptomatic or under observation for [redacted] on each wing on each floor.

Based on the above information, [redacted] out of [redacted] room changes were done on [redacted], [redacted] to cohort residents who are asymptomatic and/or negative for [redacted] from those residents who were symptomatic or under observation for [redacted] to prevent the continued spread of [redacted] in the facility. The last [redacted] room changes were completed on April 18, 2020.

Residents with change in status were moved and cohorted accordingly on [redacted]. Residents who are negative or asymptomatic that begin to show symptoms of [redacted], were moved to a unit for symptomatic residents and placed under observation.

Room changes continued post [redacted] as residents continued to be cohorted following the Infectious Disease and DON consultant's direction. To better utilize space units were consolidated and Residents and staff were cohorted according to the cohort protocol to prevent the transmission of the virus.

Name plates by the door to the resident rooms were updated to reflect the room changes.

Hand sanitizer was located at the entrance and the exit doors of the [redacted] unit as well as other locations in the facility to promote proper hand hygiene in addition to hand washing. Staff were re-educated about proper handwashing and use of

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S1340	Continued From page 3 [redacted] at approximately 2:45 PM, it was revealed a sign outside of room for R[redacted] and R[redacted], which indicated there was a [redacted] resident in the room. During an interview with E8 on 04/16/20 at approximately 2:50 PM, when asked if there was a [redacted] person in room with the [redacted] signage in [redacted] unit, E8 stated that R[redacted] had been moved to the [redacted] isolation wing on [redacted] E8 then took down the sign. On [redacted] at approximately 2:55 PM, the HR (human resource) director also confirmed R[redacted] was moved to [redacted] unit on [redacted]. Per record review, R[redacted] was noted to have a [redacted] on [redacted]. R[redacted] was seen by [redacted] provider and an order for "Swab [redacted]-PUI" was written on [redacted] at 9:30 AM. Per nursing progress note on [redacted] at 12:25 PM, the [redacted] swab was obtained. The results for the test came back [redacted] on [redacted]. R[redacted] was admitted to the facility on [redacted] with a past medical history that included [redacted] Per the IDT Progress Notes review, R[redacted] was noted to have a [redacted] (T) on [redacted] R[redacted] was seen by [redacted] provider that same day and an order for "Swab [redacted] PUI" was written at 9:30 AM. Per nursing progress note on [redacted] at 12:25 PM, the [redacted] swab was obtained. The results for the test came back positive on [redacted]. R[redacted] was transferred to [redacted], the designated [redacted] isolation unit, that same day. R[redacted] was admitted to the facility on [redacted] with a past medical history that included [redacted]. On [redacted], R[redacted] was moved to the [redacted] unit.	S1340	hand sanitizer to prevent the spread of infection. 2. System of Surveillance Resident[redacted] was re-assessed on April 18, 2020 and monitored for symptoms of [redacted] with findings documented in the medical record and on the revised [redacted] Symptom Assessment form. Staff were re-educated about the facility assessment and monitoring protocol for [redacted] Resident[redacted] was re-assessed on April 18, 2020 and monitored for symptoms of [redacted] with findings documented in the medical record and on the revised [redacted] Symptom Assessment form. Staff were re-educated about the facility assessment and monitoring protocol for C[redacted]. S 1340 Element One – Corrective Actions Resident[redacted] was re-assessed on April 18, 2020 and monitored for symptoms of [redacted] with findings documented in the medical record and on the revised [redacted] Symptom Assessment form. Staff were re-educated about the facility assessment and monitoring protocol for [redacted]. Resident[redacted] expired. Staff that provided care to Resident[redacted] were counseled and re-educated about the facility assessment and monitoring protocol for [redacted] that included proper documentation of assessment, notifying the physician timely with changes in resident condition and	

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S1340	Continued From page 4 R was admitted to the facility on with a past medical history that included . R was R's and R's roommate before R was moved to R and R roomed with R for days from to when R was a person under investigation for , until subsequently moved to the isolation wing. 2.) Record review during the days R was suspected and cohorting with R and R revealed no indication of an assessment or additional monitoring for symptoms that include in part: cough, shortness of breath or difficulty breathing, and chills aside from temperature checks. Review of the facility documentation, "Temperature Check (monitoring)" logs for unit from to , revealed several monitoring sheets missing. Of the days reviewed, there were out of shifts missing temperature logs. The dates were: , and to . On the provided temperature check logs, there were also columns for "Other Symptoms" and "Comment." Review of the temperature logs on for R, R and R, did not reveal any documentation in those columns. Review of R's Interdisciplinary Progress Notes also did not reveal any additional monitoring of signs and symptoms of while on from to Review of R's Interdisciplinary Progress Notes also did not reveal any additional monitoring of signs and symptoms of while on	S1340	provision of CPR for residents designated as full code. Staff that provided care to Resident were re-educated about the facility assessment and monitoring protocol for . The nurse was counseled and re-educated for failing to document assessment of Resident including the effect of medication provided to alleviate fever and timely notification of the physician. The fall experienced by Resident was re-investigated, and the nursing staff were re-educated about the facility assessment and monitoring protocol for and the assessment of a resident including neuro checks after an unwitnessed fall. Nursing staff that provided care to Resident were counseled and re-educated regarding timely notification of the physician when changes in condition occur with resident and proper documentation of checks following an unwitnessed fall. Presumptive (PUI) residents have their temperature checked every shift and are monitored daily for symptoms of including fever, dry cough, shortness of breath, tiredness, aches and pains, and nasal congestion. 3. Proper Use of PPE Staff were re-educated on proper donning and doffing of PPE and proper hand hygiene via instructional video from the CDC. The completion date for this training was April 21, 2020.	

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S1340	Continued From page 5 [redacted] from [redacted] to [redacted] Review of R[redacted]'s Interdisciplinary Progress Notes did not reveal any additional monitoring of signs and symptoms of [redacted] while on [redacted] from [redacted] to [redacted]. A review of the medical record for R[redacted] revealed the resident was admitted on [redacted] with a diagnosis of [redacted]. Record review of the Progress Notes dated [redacted] at 7:00 PM revealed R[redacted] had a [redacted] T of [redacted] The next T of [redacted] was documented at 11:22 PM on that same day. A physician order, dated 0[redacted], ordered [redacted] test and labs to be drawn. Orders were carried out, and results were pending. Further review of the Medication Administration Record (MAR) for [redacted] revealed that there were no medications given/charted that addressed the high temperature of [redacted] Review of the Temperature log dated [redacted] revealed that R[redacted] temperature was not documented at all. This was the day after [redacted] had a temperature of [redacted] Review of the Progress Notes dated [redacted] at 5:30 AM, stated resident was unresponsive and was pronounced dead at 6:09 AM. No documentation of [redacted] monitoring was found regarding the [redacted] symptoms which included [redacted] or [redacted] assessment of R[redacted] from [redacted] to [redacted]. In an interview with the Administrative Assistant (AA) on 04/17/2020 at 6:00 PM, she was asked	S1340	Employee 1 and Employee 2 received immediate re-education and counseling regarding the proper use of PPE on April 18, 2020. Employees who are out sick or in quarantine are required to complete the PPE training before they return to work. Observations of employees donning, and doffing PPE is completed during supervisor rounds with staff on the spot re-education as needed. 4. Proper Use of Thermometers Thermometers in use at the reception desk were checked for type and model to determine the manufacturer's recommendations for proper usage to effectively take body temperature. Signs showing correct usage of thermometers was posted to remind staff to calibrate thermometers before use. All employees or essential personnel or allowed visitors are screened before entry onto the resident units, including monitoring of the temperature. Thermometers used at the reception area are calibrated to ensure accuracy following the manufacturer directions. S 1340 Element One – Corrective Actions 5.Handwashing Staff providing resident care on the isolation unit, [redacted] were re-educated starting on April 17, 2020 and completed on April 21, 2020 to wash their hands for 20 seconds covering all surfaces, before leaving the resident rooms on [redacted]	

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S1340	Continued From page 6 about the lack of documentation regarding assessment notes and medications or nursing interventions given for the [redacted]. The AA attempted to find documentation, but no further documentation could be provided. Review of [redacted] (a lab report) dated [redacted] revealed that [redacted]) was [redacted] ". On 04/16/20 at 2:53 PM, the surveyor observed R[redacted] lying supine on a stretcher in the hallway on the [redacted] unit. The surveyor observed R[redacted] wearing an [redacted] and heard R[redacted] making a [redacted] during [redacted]. During that observation, R[redacted] was being wheeled to the elevator by emergency personnel in PPE that included face masks, gowns and gloves. During an interview with the surveyor on 04/16/20 at that time, E3 at the third-floor nurse's station stated R[redacted] was being taken to the emergency room for [redacted] and stated she did not know how long R[redacted] had been like that. During an interview with the surveyor on 04/16/20 at 2:58 PM, E4, stated R[redacted] started with [redacted] [redacted] that morning and [redacted] a temperature in the afternoon. During an interview with the surveyor on 04/17/20 at 2:32 PM, E4 stated the staff does not always call the physician when a resident had a temperature and that the PRN [redacted] would be tried first and if that didn't work, the staff should call the physician. E4 stated that she would have to monitor the symptoms and that any changes should be documented in the notes. E4 stated they would not ask for a [redacted] test right away and confirmed no test was ordered for R[redacted]. E4 stated the staff would communicate symptoms	S1340	and/or to sanitize their hands before leaving [redacted] Hand sanitizer units were placed by the entrance and exit doors to the unit. Employees 11, 12, 13, 1, 5, 16, and 6 were counseled and re-educated regarding proper handwashing and sanitizing to prevent the spread of infection. Competency evaluations were completed that required a return demonstration. Nursing staff on [redacted] and [redacted] were re-educated on April 18, 2020 regarding the proper storage of linens to prevent contamination. The hallway floor on the [redacted] unit was immediately swept and mopped clean on April 17, 2020. The Housekeeping District Manager conducted training and retraining of all Porters and Managers on proper floor care. The National Guard deployed to the facility on [redacted] and is assisting housekeeping staff with cleaning and disinfecting floors and rooms. 6. Posting Contact/Droplet Signage Signs reminding staff to “Please SANITIZE your HANDS before leaving the unit” were immediately posted on April 18, 2020 by the exit door of [redacted] Signs reminding staff to “Please SANITIZE your HANDS before leaving the building” were immediately posted on the	

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S1340	Continued From page 7 and the temperatures would be on the temperature logs for the staff to monitor but that she was unaware of anything until yesterday when R[redacted] just wasn't themselves. E4 also stated that as of today, R[redacted] had to be [redacted] Review of the Admission Record revealed R[redacted] was admitted to the facility on [redacted] with diagnoses that included but were not limited to: [redacted]. Review of the Annual Minimum Data Set (MDS - an assessment tool), dated [redacted], revealed R[redacted] had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated a [redacted]. Review of the Quarterly MDS, dated [redacted] revealed R8 had a BIMS of [redacted] which indicated a [redacted]. Review of R[redacted]s Physician's Order Form, dated 03/2020, revealed an order dated [redacted] for [redacted] (medication to [redacted] milligram (mg) administer [redacted] tablets by mouth every [redacted] hours as needed (PRN) for a [redacted] above [redacted] (F). Review of the Medication Administration Record for PRN medications, dated [redacted] revealed the physician's order for [redacted] but no documentation that the medication had been administered to R[redacted].	S1340	table (with a hand sanitizer on top) located at the [redacted] and by the glass doors leading to the [redacted] on April 18, 2020. Signs reminding staff to Please SANITIZE your HANDS before entering the building" were immediately posted on April 18, 2020 by the hand sanitizer stand by the table where staff fill out the screening questionnaire as well as by the glass door leading towards the [redacted] Element Two - Identification of Residents at Risk All residents have the potential to be affected by these infection control practices. All [redacted] residents could be affected by these infection control practices. All presumptive (PUI) [redacted] residents could be affected by these practices. All other residents positive for or presumed to have [redacted] could be affected by these practices. Element Three – Systemic Change The facility retained the consulting services of a Clinical Nurse Practitioner, a DON consultant, an Infectious Disease consultant, and an Administrator consultant to assist the facility with corrective actions and systemic changes. Education is provided daily to re-enforce best practices outbreak to contain to contain and mitigate the COVID outbreak in the facility.	

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S1340	Continued From page 8 Review of R's Interdisciplinary Progress Notes, completed by nursing revealed: [redacted] at 2:35 PM, a temperature (T) of [redacted] F, pulse (P) [redacted] blood pressure (BP) [redacted] oxygen level (SPO2) of [redacted] % on room air (RA), R was alert and two [redacted] were administered as needed (PRN). There was no documentation that a follow up temperature was obtained to determine the effectiveness of the [redacted]. There was no other documented clinical assessment or follow-up documentation. 04/15/20 at 2:15 AM, T [redacted] F, BP [redacted] pulse (P) [redacted] beats per minute (bpm), respirations (R) [redacted] and SPO2 [redacted] % RA. [redacted] was administered. The T was rechecked at 3 AM and noted to be [redacted] F. There was no other documented clinical assessment or follow-up documentation. [redacted] at 8:00 AM, "slept fairly the whole night." There was no other documented clinical assessment or follow-up documentation. [redacted] at 3:00 PM, the latest T was [redacted] F "post [redacted] that was administered for a T of [redacted] during the shift. There was no other documented clinical assessment or follow-up documentation. [redacted] at 6:00 PM, T of 1[redacted] F, [redacted] administered and "will monitor." There was no other documented clinical assessment or follow-up documentation. [redacted] at 9:45 PM, T [redacted] F, BP [redacted], P [redacted], R [redacted] and SPO2 [redacted] on RA. 04/16/20 at 2:30 PM, "Resident noted to be in [redacted], O2 Sat [redacted] .." call to physician to send to	S1340	S 1340 Element Three – Systemic Change Further cohorting of Residents was completed and the designated [redacted] unit was restructured to include a clean room for donning and a soiled room for doffing PPE with staff re-educated about the use of these areas to contain the virus. Staff on all shifts were retrained from April 18 – April 20, 2020 regarding the correct donning of masks and doffing of gowns and hand hygiene via instructional video from the CDC. A subcommittee of the Quality Assurance Compliance Committee ("Compliance Committee") organized the video training, obtaining signatures of staff in attendance, and maintaining on file these attendance sheets. Direct handwashing observations with return demonstrations and completion of competencies were completed for staff in addition to the video training – completion May 15, 2020. Direct observation of staff donning, and doffing PPE was completed during on unit rounds and staff provided with immediate re-education as appropriate. New thermometers were ordered, and manufacturer's recommendations were ascertained, and staff educated re use of the new thermometer. Staff were educated on proper usage of the thermometer to take the body temperature effectively and correctly.	

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S1340	Continued From page 9 hospital emergency room for evaluation and treatment. There were no previous documented calls to the physician regarding R[redacted]'s temperature readings, vital signs, or changes in condition over the[redacted] days from [redacted] to [redacted] [redacted] (no time written), SPO2 of [redacted]% on RA, T[redacted] F, change in status, increased and labored breathing "use of [redacted] (utilized by people [redacted] . [redacted] at 7:00 PM, report from hospital emergency room that Resident [redacted] was admitted with [redacted] and possible [redacted] Review of the facility provided, "Temperature Check ([redacted] monitoring)" logs for the third-floor units revealed the following: On [redacted] 7 AM-3 PM shift: T[redacted], blank "other symptoms," blank "comments," and signed "checked by wing-nurse signature." On [redacted]: 11 PM-7 AM shift: T[redacted], blank "other symptoms," blank "comments," and signed "checked by wing-nurse signature." 3 PM-11 PM shift: T[redacted], blank"other symptoms," blank "comments," and signed "checked by wing-nurse signature." 7 AM-3 PM shift: T[redacted], blank "other symptoms," blank "comments," and signed "checked by wing-nurse signature." On [redacted] 7 AM-3 PM shift: T 1[redacted], blank "other symptoms," blank "comments," blank CNA	S1340	Laundry staff folding clean linen now place the clean linen in clear plastic bags to be handed for distribution. Housekeeping Assistant Manager supervises and checks that clean linens are delivered and stored in a hygienic manner. Staff on [redacted] unit were reeducated on April 18, - April 20, 2020 to wash all surfaces of their hands for 20 seconds after handling dirty linen. [redacted] protocols were reviewed and revised as needed by the DON consultant and Clinical Nurse consultant to ensure compliance with CDC [redacted] guidance. Changes were reviewed with staff at clinical and management meetings held by the consultant Administrator. A CPR protocol for use during [redacted] was developed and staff educated about the procedures to use when administering CPR to a resident with [redacted] The protocol includes identification of code status to assure proper procedures are followed. This protocol is included with the [redacted] Outbreak plan. The code status of each resident was reviewed by the unit manager and properly noted for easy access by staff in case of an emergency. Element Four - Quality Assurance Daily observations of the use of PPE and proper handwashing are completed by Unit Managers and the nursing management team to assure staff properly don and doff PPE. The Quality Assurance Compliance Committee will meet weekly for sixty (60) days and monitor staff	

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S1340	Continued From page 10 signature and signed "checked by wing-nurse signature." On 04/17/20 at 4:08 PM, the surveyor requested the missing "Temperature Check [redacted] monitoring)" logs [redacted] unit from [redacted] the 11 PM - 7 AM and 3 PM - 11 PM shifts and [redacted] 11 PM - 7 AM shift from the DON. The surveyor also requested any policies or procedures on the Temperature Check [redacted] monitoring logs, Monitoring Residents for [redacted] or related topics. The facility was given opportunity and could not provide additional policies/procedure, information or documentation regarding any of the above. The Centers for Disease Control and Prevention (CDC), "The [redacted] Long-Term Care Facility Guidance," dated 04/02/20, revealed the symptoms of C[redacted] in older adults and people who have severe underlying medical conditions, including but not limited to, heart or lung disease or diabetes seem to be at higher risk for developing more serious complications from [redacted] illness. Symptoms reported may range from mild to severe illness. These symptoms may appear 2-14 days after exposure to the virus and may include, but are not limited to: fever, cough, shortness of breath or difficulty breathing, chills and repeated shaking with chills. [redacted] was admitted to the facility on [redacted] with diagnoses of [redacted] Review of the facility's New Jersey Universal Transfer Form revealed on [redacted] R[redacted] was transferred to the hospital emergency room (ER) for a T of [redacted] degrees Fahrenheit (F) and being [redacted] The ER After Visit Summary, dated [redacted], revealed discharge instructions for [redacted]	S1340	proficiency and observance of these infection preventive measures and re-evaluate to determine whether there is a need to continue with the PPE and handwashing education. S 1340 Element Four - Quality Assurance The Quality Assurance Compliance Committee (“Compliance Committee”) will meet weekly for sixty (60) days (or until the outbreak is resolved if longer) to monitor proper cohorting of Residents and Staff in the building as a means of mitigating spread of [redacted]. Findings will be discussed and serve as the basis for additional staff education as required. Daily the Quality Assurance Certified Nursing Assistant (QA-CNA) or designee will monitor light-duty CNA and nurses assigned to take temperatures to check whether temperature-taking is being done correctly. Findings of these audits will serve as the basis for additional education as needed. The QA-CNA or designee will check the thermometers daily to ensure that the thermometers as well as the batteries are working properly and will replace the thermometers and/or batteries when needed. An audit of the code status of residents was completed and resident wishes properly noted for easy access in case of an emergency. The ADON/designee will include review of code status during completion of monthly chart audits. Results will be reported to the Quality Assurance Compliance Committee (“Compliance Committee”) monthly for	

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S1340	Continued From page 11 [redacted]. These included: call 911 for a seizure, if resident cannot be woken, chest pain or trouble breathing, stiff neck, bad headache, sensitivity to light, feeling weak, dizzy, or confused, stop urinating or urinate is less than normal, coughing up of blood or thick, yellow or green mucus, severe abdominal pain or abdomen is larger than usual. R12's " End of Visit Vitals" were blood pressure (BP) -[redacted] T-[redacted] F, pulse (P)-[redacted] respirations (R)-[redacted] and oxygen saturation (SaO2) [redacted] percent (%). The discharge instructions also included to follow-up with the attending physician in three days ([redacted]) and to call the physician for a T of [redacted] F or higher. Review of the IDT on [redacted] at 7:30 AM, documented R[redacted] had returned to the facility with a discharge diagnoses of "[redacted] and [redacted] screening completed. At 8:00 AM the nursing note documented the following vitals: BP-[redacted], [redacted] (T) P-[redacted] and SaO2-[redacted]%, "Continue to monitor." The next documented IDT nursing note was on [redacted] at 9:00 PM. It revealed "Resident in [redacted], no [redacted] noted on this shift. Resident cooperates well regarding care..." On 04/10/20 at 6:40 PM, a late entry nursing note revealed on [redacted] R[redacted] was found on the floor by his bed, had fell on the wet floor and obtained a [redacted] on the [redacted] of [redacted] The resident's vitals were taken, range of motion assessed and [redacted] were found to be equal, round and reactive to light and accommodation (PERRLA). The next IDT note was on [redacted] at 7:15 AM. It read "Entered room, Resident (with symbol) eyes open, [redacted] no verbal response, no painful response, no respiration, no pulse." R[redacted]'s physician and registered nurse pronounced the resident deceased at 7:35 AM. Review of the facility's	S1340	action as appropriate. In addition, QA-CNA or designee will check the screening questionnaire filled out by staff to see that the temperatures have been recorded. The Quality Assurance Compliance Committee (“Compliance Committee”) will meet weekly for sixty (60) days to monitor that body temperatures are indeed correctly taken and recorded, and that the thermometers and batteries are always functioning properly. Daily the Unit Manager/designee will review the Resident unit-based temperature and assessment log tool required during the [redacted] outbreak to ensure compliance with the procedure for completion. The Unit Manager will discuss findings at daily clinical meetings for action as appropriate. The DON/designee will conduct 20 chart audits of residents noted with changes in condition on the 24 hour report and/or discussed at morning meeting monthly for three months and then quarterly on an ongoing basis to ensure compliance with assessment and documentation of vital signs including temperatures and oxygenation levels and notification of POA and physicians with changes in condition in compliance with facility procedures and standards of practice. Findings will be acted upon immediately and will be reported in aggregate to the QAPI committee and Administrator at quarterly meetings. The DON/designee will complete chart	

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S1340	Continued From page 12 Internal Medicine Monthly Visit/Acute visit/Readmission form dated [redacted], revealed the following hand written notes from R[redacted]s physician: "Found dead this am, [redacted] present, [redacted]) not performed Physical-[redacted] test was done?... [redacted] for the last few days-that was not brought to my attention. [redacted] illness, likely [redacted] On 04/16/20 at 3:15 PM, the [redacted] surveillance monitoring and tracking was discussed with the DON. The DON stated all working staff temperatures were checked at the beginning of each shift upon entering the facility. If any staff person's temperature was equal or greater than 100.0, they are sent home. In regard to the residents' temperatures, the DON stated they were checked by the CNA's at the beginning of each shift every eight (8) hours. The CNA's recorded the temperatures on a Temperature List form. This form could be found at the Nurses' Station on each floor. If there were other [redacted] symptoms such as shortness of breath, coughing, weakness, etc. this information would be documented by the nurse and found in the progress (IDT) notes. On 4/17/20 at 7:30 PM, the DON was asked for the facility's practice on assessment and monitoring after an unwitnessed fall. The DON stated the nurses perform [redacted] checks every four (4) hours for 72 hours. It was also stated the [redacted] checks should have been performed after R[redacted]'s fall. This surveyor was unable to locate the [redacted] checks or the resident's Advanced Directive/ MOLST (Provider Orders for Life Sustaining Treatment) information on the clinical chart. Later the DON confirmed R 12 was a full code, the Advanced Directive/ MOLST information were never provided.	S1340	audits of residents' code status monthly for three months and then quarterly on an ongoing basis to ensure code status is current and reflects the resident end-of-life wishes. Findings will be acted upon immediately and will be reported in aggregate to the QAPI committee and Administrator at quarterly meetings. A double-check system will be strictly enforced, with Housekeeping District Manager reviewing the QCI sheets completed by Assistant Managers and verifying that clean linens and other clean laundry are kept clean and unexposed. The Quality Assurance Compliance Committee ("Compliance Committee") will meet weekly for sixty (60) days to monitor the proper storage of clean linen and handling of dirty linen. Housekeeping Assistant Manager will conduct quality care inspection ("QCI"), document on QCI sheets for Floor Technicians, and re-educate if necessary. The Quality Assurance Compliance Committee ("Compliance Committee") will meet weekly for sixty (60) days to monitor the proper cleaning of floors. Completion Date – May 18, 2020	

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S1340	Continued From page 13 The facility's Temperature Check ([redacted]s monitoring) form was composed of eight columns, titled, Resident Name, Rm No. (room number), Date, Time, Temp.(temperature), Other Symptoms, Comment and CNA (Certified Nursing Assistant) Signature. On 04/18/20 at approximately 10:40 AM, the Temperature Check form was reviewed with the DO . A request for temperature checks and [redacted] monitoring was requested for R[redacted] The facility presented the [redacted] Two List for Temperature Check, dated [redacted], 11-7 (11:00 PM- 7:00 AM) Shift. R[redacted] name was on the list in room [redacted] with a Temp reading of [redacted] All other columns were blank. The facility was unable to provide the requested temperature checks for [redacted] days in [redacted] ([redacted] and [redacted] [7-3 and 3-11 shift]). On 04/20/20 the facility emailed R[redacted] [redacted]l Flow Sheet, which revealed [redacted] assessments were only assessed for [redacted] hours, with the last documented time of 3:15 PM on [redacted]. 3.) On the [redacted] ([redacted]) unit, an observation with the HR Director on 4/16/20 at approximately 3:30 PM, E7 was seen not wearing a gown upon entering resident room [redacted]. E7 was then observed walking out of resident room [redacted] and exited the unit through the closed double doors. On 04/16/20 at 5:51 PM in an interview with the DON, when asked what personal protective equipment (PPE) staff were currently required to wear on [redacted] units, the DON stated they were to wear a face mask (currently N95) and a gown.	S1340		

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S1340	Continued From page 14 On 04/16/20 at 2:56 PM, the surveyor observed the [redacted] unit nurse's station. The surveyor observed a staff member standing on the outside perimeter of the round, nurse's desk with their face mask positioned below their nose. The staff member was talking to and in close proximity to five other staff members behind and around the nurse's station. The staff member was identified as E1. The surveyor observed one of the other staff members had been within arm's length from E1. On 04/16/20 at approximately 3:00 PM, E1 stated she had lowered her face mask because it was "change of shift." E1 stated she had no excuse for the improper use of the face mask and that she had been in-serviced the beginning of [redacted] on the proper use of PPE. E1 stated she should have positioned the face mask "the right way" over her nose "to protect everyone." On 4/16/20 at 3:24 PM, the surveyor observed, on the [redacted] floor between the nurse's station and the [redacted], a staff member with her face mask positioned below both her nose and mouth, down below her chin. The staff member was in close proximity to eight other staff members and was loudly projecting her voice and was calling out assignments and instructions. The staff member was identified as E2. The surveyor observed three other staff members had been within arm's length from E2. On 04/16/20 at approximately 3:30 PM, E2 stated her mask was positioned below her nose and mouth because sometimes it was hard to breathe with the mask fully on the face. E2 stated she knew that was not the correct way to don the face mask and that the purpose of the face mask was important to prevent the spread of the virus.	S1340		

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S1340	Continued From page 15 During an interview with the surveyor on 04/16/20 at 2:58 PM, E4 stated the staff had been in-serviced on the use of PPE by the facility educator who was now out sick. E4 stated it was everyone's responsibility to check that their own PPE and "each other's" PPE was on correctly. During an interview with the surveyor on 04/16/20 at 3:50 PM, the DON stated that all staff had been trained on how to use and wear their PPE. The DON stated face masks should always be worn correctly and cover the nose and mouth. The DON identified E2 as a staff member who worked in the Quality Assurance position at the facility. During an interview with the surveyor on 04/17/20 at 2:40 PM, the DON stated there was no record of an in-service regarding PPE for E2. The DON stated E2 "never showed up for it (the in-service)" because E2 mostly worked the 3 PM - 11 PM shift. The DON acknowledged that all staff should have been in-serviced. Review of E1's, "Personal Protective Equipment (PPE) Competency Validation, dated 03/26/20, revealed a competent, "Return verbal demonstration" to prevent cross contamination between staff. The PPE Competency Validation also revealed, 4. Don Mask/Respirator - secure ties/elastic bands at middle of head and neck; 5. fit flexible band to nose bridge and 6. fit snug to face and below chin. The competency also included to correctly identify the appropriate PPE to be worn based on anticipated level of exposure. Review of the facility handout addressed to the employees, dated 04/8/20, revealed that with the [redacted] outbreak in the facility, staff may have been exposed. Staff may continue to work	S1340		

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S1340	Continued From page 16 provided the included but not limited to 1. Healthcare Personnel (HCP) should report temperature and absence of symptoms each day prior to starting work for the 14-day period after their exposure and 2. HCP wears a facemask while at work for the same 14-day period. Review of the facility, "PPE Strategies for LTCFs during Cluster of [redacted] Infections:", not dated, revealed when there are cases in the facility universal masking of HCP while in the facility. [redacted]. "...In addition to the actions described above, these are things facilities should do when there are [redacted] cases in their facility or sustained transmission in the community Healthcare Personnel Monitoring and Restrictions: Because of the higher risk of unrecognized infection among residents, universal use of all recommended PPE for the care of all residents on the affected unit (or facility-wide depending on the situation) is recommended when even a single case among residents or HCP is identified in the facility; this should also be considered when there is sustained transmission in the community. The health department can assist with decisions about testing of asymptomatic residents." 4.) On 04/17/20 at 8:50 AM entered the front door of the facility into the reception area. Upon observation, surveyor's temperatures were checked on the neck, and not the appropriate area of the forehead. One reading obtained on a	S1340		

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S1340	Continued From page 17 surveyor read "94.7 Fahrenheit (F)." On 04/16/20 at 2:30 PM, the surveyor entered the front door into the reception area of the facility. There were three staff members observed at the screening table. One of the staff was identified as a Certified Nursing Assistant and requested to take the surveyors temperature. The CNA pointed the infrared digital thermometer at the center of the surveyor's forehead and received a temperature of 91 degrees Fahrenheit (F). The surveyor requested a confirmation of the temperature. The CNA pointed the infrared digital thermometer above the surveyor's right ear, the temporal area, and received a temperature of 91 degrees F. Review of the Medical Infrared forehead thermometer manufacturer's information provided by the facility, revealed an illustration that indicated the area to obtain the temperature was in the middle of the forehead. The instructions also revealed after entering the room from a low or high temperature outside, to wait for 20 minutes until the temperature of the "subject" is adjusted to the temperature environment; before measurement, please be sure there is no hair, sweat, makeup or hair covering and that the ambient (relating to the immediate surroundings) temperature should be stable and not tested in places with large airflows. During an interview with the surveyors on 04/16/20 at 4:10 PM, the Central Supply staff member stated he handled the ordering of the digital thermometers and that they "were starting to break down." The Central Supply staff member also stated that the facility had three digital thermometers on order. He also stated, "I don't know how or if the thermometers are calibrated because we never had to do that	S1340		

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S1340	Continued From page 18 before." Upon request, the facility was unable to provide information regarding the calibration requirements for the thermometers being used during the survey. During an interview with the surveyors on 04/16/20 at 4:12 PM, the Medical Director stated the CNAs were taking the screening temperatures and were trained just as part of their CNA training and not specifically in-serviced by the facility. The CDC interim guidance included, "Preparing for [redacted]: Long-term Care Facilities, Nursing Homes" which indicated that "given the high risk of spread once [redacted] enters a nursing home, facilities must take immediate action to protect residents, families, and healthcare personnel (HCP) from severe infections, hospitalizations, and death. Visitors and HCP continue to be sources of introduction of [redacted] into nursing homes. To protect the vulnerable nursing home population, aggressive efforts toward visitor restrictions and implementing sick leave policies for ill HCP, and actively checking every person entering a facility for fever and symptoms of illness continue to be recommended." [redacted] The CDC interim guidance included, "Key Strategies to Prepare for [redacted] in Long-term Care Facilities (LTCFs)" which indicated to "Keep [redacted] from entering your facility: ... Actively screen anyone entering the building (HCP, ancillary staff, vendors, consultants) for fever and symptoms of [redacted] before starting each shift... ."	S1340		

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S1340	Continued From page 19 [redacted] On the [redacted] unit, an observation with the HR Director on 4/16/20 at approximately 3:30 PM, E7 was seen not wearing a gown upon entering resident room [redacted]. E7 was then observed walking out of resident room [redacted] and exited the unit through the closed double doors. On 04/16/20 at 2:56 PM, the surveyor observed the [redacted] unit nurses' station. The surveyor observed a staff member standing on the outside perimeter of the round, nurses' desk with her face mask positioned below her nose. The staff member was talking to and in close proximity to five other staff members behind and around the nurses' station. The staff member was identified as a E1. The surveyor observed one of the other staff members had been within arm's length from E1. At that time, the surveyor interviewed E1 who stated she had lowered her face mask because it was "change of shift." E1 stated she had no excuse for the improper use of the face mask and that she had been in-serviced the beginning of [redacted] on the proper use of PPE. E1 stated she should have positioned the face mask "the right way" over her nose "to protect everyone." On 04/16/20 at 3:24 PM, the surveyor observed, on the main floor between the nurses' station and the south hall, a staff member with her face mask positioned below both her nose and mouth, down below her chin. The staff member was in close proximity to eight other staff members and was loudly projecting her voice and was calling out assignments and instructions. The staff member was identified as a E2. The surveyor observed	S1340		

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S1340	Continued From page 20 three other staff members had been within arm's length from E2. At that time, the surveyor interviewed E2 who stated her mask was positioned below her nose and mouth because sometimes it was hard to breathe with the mask fully on her face. E2 stated she knew that was not the correct way to wear the face mask and that the purpose of the face mask was important to prevent the spread of the virus. During an interview with the surveyor on 04/16/20 at 2:58 PM, the third floor E4 Unit Supervisor stated the staff had been in-serviced on the use of PPE by the facility educator who was now out sick. The E4 stated it was everyone's responsibility to check that their own PPE and "each other's" PPE was on correctly. During an interview with the surveyor on 04/16/20 at 3:50 PM, the Director of Nursing (DON) stated that all staff had been trained on how to use and wear their PPE. The DON stated face masks should always be worn correctly and cover the nose and mouth. The DON identified E2 as a staff member who worked in the Quality Assurance position at the facility. During an interview with a surveyor on 04/16/20 at 5:51 PM, when asked what personal protective equipment (PPE) staff were currently required to wear on [redacted] units, the DON stated they were to wear a face mask (currently N95) and a gown. Review of E1's, "Personal Protective Equipment (PPE) Competency Validation, dated 03/26/20, revealed a competent, "Return verbal demonstration" to prevent cross contamination between staff. The PPE Competency Validation	S1340		

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S1340	Continued From page 21 also revealed, 4. Don Mask/Respirator - secure ties/elastic bands at middle of head and neck; 5. fit flexible band to nose bridge and 6. fit snug to face and below chin. The competency also included to correctly identify the appropriate PPE to be worn based on anticipated level of exposure. During an interview with the surveyor on 04/17/20 at 2:40 PM, the DON stated there was no record of an in-service regarding PPE for E2. The DON stated E2 "never showed up for it (the in-service)" because E2 mostly worked the 3 PM-11 PM shift. The DON acknowledged that all staff should have been in-serviced. Review of the facility educational document to the employees, dated 04/08/20, revealed that with the [redacted] outbreak in the facility, staff may have been exposed. Staff may continue to work provided the included but not limited to 1. Healthcare Personnel (HCP) should report temperature and absence of symptoms each day prior to starting work for the 14-day period after their exposure and 2. HCP wears a facemask while at work for the same 14-day period. Review of the facility, "PPE Strategies for LTCFs during Cluster of [redacted] Infections," not dated, revealed when there are cases in the facility: "universal masking of HCP while in the facility." The CDC's, "Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed [redacted] in Healthcare Settings," updated 04/13/19, included, "Minimize Chance for Exposures...Universal Source Control: As part of source control efforts, HCP should wear a facemask at all times while they are in the	S1340		

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S1340	Continued From page 22 healthcare facility...HCP should have received job-specific training on PPE and demonstrated competency with selection and proper use (e.g., putting on and removing without self-contamination). [redacted] 5.) An observation on the [redacted] unit at 2:50 PM on 04/16/20, E11 was observed handling soiled linen at the doorway in room [redacted]. She discarded it in the soiled linen cart and did not change her gloves. She then went to another room without performing any hand hygiene. At 3:05 PM, E11 was observed at the doorway of the [redacted] unit removing and discarding her gloves first. She then removed her contaminated PPE gown with ungloved hands and discarded the gown. She did not perform hand hygiene before leaving the unit. At 3:10 PM, E12, was observed removing her soiled PPE at the doorway of the [redacted] unit. She did not perform hand hygiene before leaving the unit. There was only one large trash bin at the main entrance of the unit. A used PPE gown was not thrown in the proper receptacle but instead was thrown into a smaller size trash bin which was overflowing. It was noted that the door could only be opened with a turn handle knob. There was no place designated at the entry in which staff could perform hand hygiene measures. Upon opening the door, there was a hallway with still no place to perform hand hygiene. The hand sanitizer was not close by, and it was found on top of the nursing medication cart two rooms away. It was not easily accessible to the staff who needed to perform hand hygiene. At 3:15 PM, E13 was observed at the doorway of	S1340		

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S1340	Continued From page 23 the [redacted] unit, wiping her face shield with ungloved hands. She was using the [redacted] to clean and disinfect the face shield. After cleaning, she did not perform hand hygiene. An interview with E10 on 04/16/20 at 3:15 PM revealed E11 and E12 should have performed hand hygiene before leaving the unit. On 04/17/20 at 9:55 AM, two physical therapy staff members (E15 and E16) were observed walking in the hallway. They were still wearing gloves as they opened the door to exit the [redacted] unit ([redacted]). They removed their gloves after exiting and did not perform hand hygiene afterwards. An interview with E15 04/17/20 at 10:00 AM, revealed that he was not aware he should wash his hands before leaving the closed unit. He stated he will wash his hands downstairs in the therapy room. Both staff members stated that they will wash their hands downstairs in the therapy room. In an observation on 04/17/20 at approximately 9:30 AM, E6 was observed on [redacted] unit, entering and exiting rooms [redacted] and [redacted] E6 failed to sanitize hands before donning new gloves and entering in room [redacted]. Finally, E6 failed to perform hand hygiene after exiting room [redacted] after removal of gloves. Further observation of East 1 unit at approximately 9:49 AM revealed E5 perform hand hygiene using a hand sanitizer but subsequently contaminated her left hand by touching the door handle when she exited the unit (double doors were closed). E5 failed sanitize hands again after contamination.	S1340		

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S1340	Continued From page 24 In an observation on 04/16/20 at approximately 3:55 PM while on [redacted] it was revealed that the linen cart at the end of the hallway was left uncovered. An 8 oz. used plastic water bottle was also observed to be on one of the shelves. In an observation on 04/18/20 at approximately 9:35 AM while on [redacted] it was revealed that the linen cart at the end of the hallway was left uncovered. On 04/16/20 an observation of the environment on the [redacted] unit, revealed the floor was sticky and visibly soiled with stains on the unit hallway. Per facility policy from Healthcare Services Group titled, "Infection Control Overview & Policy," last updated 03/24/20, read in part "Implement hand hygiene (hand washing) practices consistent with accepted standards of practice, to reduce the spread if infections ..." It also indicated, "hand hygiene should be performed ...after removing gloves." 6.) An observation of the [redacted] Unit on 04/16/20 at 3:15 PM was completed. The unit had one entry which was also the exit. There was one isolation sign at the point of entry. The sign did not specify the PPE to be worn for that unit. It was not clear what kind of PPE should be worn (such as gowns, gloves, goggles, N95 respirators, surgical masks). It also was not specified what type of transmission based precautions (TBP) should be implemented. For example contact, droplet, or airborne. At approximately 3:30 PM, revealed Rooms [redacted] to [redacted] did not display signage by the door designating what PPE needed to be worn and the type of transmission based precautions needed. Only rooms [redacted] to [redacted] had the [redacted] signage present.	S1340		

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S1340	Continued From page 25 When Nurse (E10) was questioned why only certain rooms had the signage, she could not indicate why. She admitted that the sign should be on all the rooms since it was the [redacted] section. She explained that the census is [redacted], and all [redacted] residents are on isolation precautions for testing positive for [redacted]. She said they needed to wear PPE such as gowns, gloves, goggles and N95 respirators. The transmission-based precautions are contact and droplet. Review of the facility's policy "Guidelines on Isolation Rooms, last updated April 7, 2020, "revealed the following: "Isolation Unit: [redacted] has been designated the wing for isolation for [redacted] positive residents...2. A sign stating, "Residents SUSPECTED OF [redacted] (PUI) (tested but results not yet available) in the room - observe DROPLET PRECAUTIONS" or "[redacted] positive resident in the room - observe [redacted] PRECAUTIONS." will be posted on the door of the resident room. 10. All staff working on the isolation wing will use total personal protective equipment ("PPE") equipment, namely, disposable gown, gloves, eye protection, and mask. Signs will be posted on the isolation wing to remind staff of correct donning and doffing of PPE."	S1340		
S1720	8:39-27.1(a) Mandatory Quality of Care (a) The facility shall provide and ensure that each resident receives all care and services needed to enable the resident to attain and maintain the highest practicable level of physical (including pain management), emotional and social	S1720		5/18/20

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S1720	Continued From page 26 well-being, in accordance with individual assessments and care plans. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to evaluate and document ongoing clinical assessments to identify and treat a change in condition, and notify the physician of any changes in condition. This deficient practice was identified for Residents [redacted] and [redacted]5, [redacted] of [redacted] residents reviewed for conditions related to [redacted] in a facility experiencing a [redacted] outbreak. The deficient practice was evidenced by the following: R[redacted] was admitted to the facility on [redacted] with a past medical history that included [redacted]. Per copy of court documents found in R[redacted] chart, R[redacted]s [redacted] was appointed their legal guardian on [redacted]. On [redacted] it was documented on the Interdisciplinary Progress Notes sheet, "MD was made aware that residents Roommate in hospital and tested [redacted] for [redacted] The progress note further mentioned to order for "[redacted] and move to [redacted])." R[redacted] was swabbed for	S1720	S 1720 Element One – Corrective Actions Nursing staff that delayed notifying the POA of Resident [redacted] of each change in condition were counseled and received re-education of the notification requirement to the POA whenever changes in condition occur. The requirement to promptly document these notifications in the resident medical record per standards of practice and regulations was also included in the re-education. Nursing staff that failed to accurately assess Resident [redacted] and notify the physician of changes in condition including temperature and oxygen saturation levels and then document changes in the medical record received counseling and re-education. Re-education included notification of the physician when a resident has a change in condition, proper assessment of changes, and required documentation of findings in the medical	

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S1720	Continued From page 27 [redacted] and moved to [redacted] that same day. Further review of R[redacted]'s medical record revealed that the test results for [redacted] came back [redacted] on [redacted] Per nursing progress note on [redacted] at 11:00 AM, "[redacted], NP ... made aware ..." On 04/10/20 at 09:40 AM, it was documented on the Interdisciplinary Progress Notes sheet, "Rc'd (received) telephone call from POA (power of attorney) ...updated on Residents DX (diagnosis) [redacted]. Resident is [redacted] at this time no [redacted]) noted MD verified/assessed on [redacted] POA wants to be updated on [change] in health status. Requesting to speak with DON (director of nursing). DON notified." On [redacted] at 9:50 AM, it was documented on the Interdisciplinary Progress Notes sheet, "Spoke (POA) about ([redacted]- apologized for not informing [redacted] On [redacted] at 1:00 PM, it was documented on the Interdisciplinary Progress Notes sheet by nursing, "Resident has [redacted]! Intake is just composed of fluids small quantity. Not able to [redacted] or take [redacted] Continue to Monitor." There was no evidence found in the record that R[redacted]'s POA was notified of this change in condition. On [redacted] at 4:00 AM, it was documented on the Interdisciplinary Progress Notes sheet, "Responded to nurse call on the floor ...no [redacted] to both [redacted] l and [redacted] stimuli. [redacted] and [redacted]." R[redacted] was pronounced dead at 5:00 AM per nurse's progress note.	S1720	record per standards of practice and regulations. Nursing staff received re-education regarding timely completion of the [redacted] outbreak temperature check logs as required. A copy of the required procedure was reviewed with nursing staff during the education program. Element Two – Identification of Residents at Risk All residents have the potential to be affected by these practices. Element Three – Systemic Change A new [redacted] vital sign and symptom assessment tool was developed by the DON consultant on May 5, 2020 to replace the temperature log and nursing staff were educated about the procedure for tool completion. On May 11, 2020 it was decided to modify the assessment tool and the procedure for completion with staff re-education and implementation of the revised assessment tool implemented effective May 12, 2020. A written procedure for completion of the [redacted] Symptom Assessment Tool which include vital signs and symptoms to be used during the [redacted] outbreak was implemented and nursing staff provided with re-education. A copy of the procedure was placed on each unit in the binder with the tool. Nursing staff receive education about documentation and notification of change in condition procedures on hire as part of the facility orientation program.	

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	061901	A. BUILDING: _____ B. WING _____	04/19/2020

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S1720	Continued From page 28 On 4/17/20 at 7:02 PM in an interview with the DON, she confirmed that the notification in change of condition was delayed regarding notifying the resident's POA of the [redacted] results. She stated she spoke with the resident's POA and wrote the note on [redacted] at 9:50 AM. Review of facility policy titled, "Change of Condition," last revised 08/01/17, read in part "The Facility will promptly inform the resident, consult with the resident's Attending Physician, and notify the resident legal representative when the resident endures a significant change in their condition ..." On 04/16/20 at 2:53 PM, the surveyor observed R[redacted] lying supine on a stretcher in the hallway on the [redacted] unit. The surveyor observed R[redacted] wearing an [redacted] and heard Resident [redacted] making a [redacted]g. During that observation, Resident [redacted] was being wheeled to the elevator by emergency personnel in Personal Protective Equipment that included face masks, gowns and gloves.))))) On 04/16/20 at 2:56 PM, E3, standing at the [redacted] nurse's station, stated Resident [redacted] was being taken to the emergency room for [redacted] and stated she did not know how long Resident [redacted] had been like that. During an interview with the surveyor on 04/16/20 at 2:58 PM, the [redacted] Registered Nurse (RN) unit supervisor stated R[redacted] started with [redacted] that morning and '[redacted]' a temperature in the afternoon.	S1720	Documentation education is also reviewed annually and as needed. Additional nursing education was provided to re-enforce resident assessment, notification of changes and documentation requirements per facility protocols and standards Element Four – Quality Assurance Daily the Unit Manager/designee will review the Resident unit-based temperature logs required during the [redacted] outbreak to ensure compliance with the procedure for completion. The Unit Manager will discuss findings at daily clinical meetings for action as appropriate. The DON/designee will conduct 20 chart audits of residents noted with changes in condition on the 24-hour report and/or discussed at morning meeting monthly for three months and then quarterly on an ongoing basis to ensure compliance with assessment and documentation of vital signs including temperatures and oxygenation levels and notification of POA and physicians in compliance with facility. S 1720 Element Four – Quality Assurance procedures and standards of practice. Findings will be acted upon immediately and will be reported in aggregate to the QAPI committee and Administrator at quarterly meetings. Completion Date – May 18, 2020	

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S1720	Continued From page 29 Review of the Admission Record revealed R was admitted to the facility on 8 with diagnoses that included but were not limited to: [redacted]. Review of the Annual Minimum Data Set (MDS), an assessment tool, dated, revealed R had a Brief Interview for Mental Status (BIMS) score of which indicated a impairment. Review of the Quarterly MDS, dated, revealed R had a BIMS of which indicated a [redacted] Review of the Physician's Order Form, dated, revealed a physician's order dated for (medication to) milligram (mg) administer tablets by mouth every hours as needed (PRN) for a above (F). Review of the Medication Administration Record for PRN medications, dated, revealed the physician's order for but no documentation that the medication had been administered to R Review of R s Interdisciplinary Progress Notes (IDPN), completed by nursing revealed: On at 2:35 PM, a temperature (T) of F, pulse (P), blood pressure (BP), oxygen level (SPO2) of on room air (RA), resident was and were	S1720		

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administered as needed (PRN). There was no documentation that a follow up [redacted] was obtained to determine the effectiveness of the [redacted]. There was no other documented clinical assessment or follow-up documentation.

[redacted] at 2:15 AM, T [redacted] F, BP [redacted], P [redacted], respirations (R) [redacted] and SPO2 [redacted]% on RA. [redacted] was administered. The temperature was rechecked at 3 AM and noted to be [redacted] degrees F. There was no other documented clinical assessment or follow-up documentation.

On [redacted] at 8:00 AM, "slept fairly the whole night." There was no other documented clinical assessment or follow-up documentation.

On [redacted] at 3:00 PM, the latest T was [redacted] degrees F "[redacted]" that was administered for a T of [redacted] during the shift. There was no other documented clinical assessment or follow-up documentation.

On [redacted] at 6:00 PM, T of [redacted] F, [redacted] administered and "will monitor." There was no other documented clinical assessment or follow-up documentation.

On [redacted] at 9:45 PM, T [redacted] F, BP [redacted], P [redacted], R [redacted] and SPO2 [redacted]% on RA.

On [redacted] at 2:30 PM, "Resident noted to be [redacted], [redacted] 's..." call to physician to send to hospital emergency room for evaluation and treatment. There were no previous documented calls to the physician regarding Resident [redacted] temperature readings, vital signs, or changes in condition over the [redacted] days from [redacted] to [redacted]

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S1720	Continued From page 31 On [redacted] (no time written), SPO2 of [redacted] on RA, T [redacted] F, change in status [redacted] and [redacted] "[redacted]" (utilized by people with [redacted] . On [redacted] at 7:00 PM, report from hospital emergency room that R[redacted] was admitted with [redacted] and possible [redacted]. Review of the facility provided, "Temperature Check ([redacted] monitoring)" logs for the [redacted] units revealed the following: On [redacted]: 7 AM-3 PM shift: T[redacted] blank "other symptoms," blank "comments," and signed "checked by wing-nurse signature." On [redacted]: 11 PM-7 AM shift: T[redacted] blank "other symptoms," blank "comments," and signed "checked by wing-nurse signature." 3 PM-11 PM shift: T[redacted], blank"other symptoms," blank "comments," and signed "checked by wing-nurse signature." 7 AM-3 PM shift: T[redacted] blank "other symptoms," blank "comments," and signed "checked by wing-nurse signature." On [redacted]: 7 AM-3 PM shift: T[redacted], blank "other symptoms," blank "comments," blank CNA signature and signed "checked by wing-nurse signature." During an interview with the surveyor on 04/17/20 at 2:32 PM, E4 stated the staff does not always call the physician when a resident had a	S1720		

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temperature and that the PRN [redacted] would be tried first and if that didn't work, the staff should call the physician. E4 stated that she would have to monitor the symptoms and that any changes should be documented in the notes. E4 stated they would not ask for a [redacted] test right away and confirmed no test was ordered for R[redacted] E4 stated the staff would communicate symptoms and the temperatures would be on the temperature logs for the staff to monitor but that she was unaware of anything until yesterday when R8 "just wasn't himself." E4 also stated that as of today, R[redacted] had to be [redacted] at the hospital.

On 04/17/20 at 4:08 PM, the surveyor requested the missing "Temperature Check [redacted] monitoring)" logs f[redacted]r unit from [redacted] the 11 PM-7 AM and 3 PM-11 PM shifts and [redacted] 11 PM-7 AM shift from the DON. The surveyor also requested any policies or procedures on the Temperature Check C[redacted] monitoring logs, Monitoring Residents for [redacted] or related topics. The facility was given opportunity and could not provide additional policies/procedure, information or documentation regarding any of the above.

The Centers for Disease Control and Prevention (CDC), "The [redacted] Long-Term Care Facility Guidance," dated 04/02/20, revealed the symptoms of Coronavirus in older adults and people who have severe underlying medical conditions, including but not limited to, heart or lung disease or diabetes seem to be at higher risk for developing more serious complications from [redacted] illness. Symptoms reported may range from mild to severe illness. These symptoms may appear 2-14 days after exposure to the virus and may include, but are not limited

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S1720	Continued From page 33 to: fever, cough, shortness of breath or difficulty breathing, chills and repeated shaking with chills.	S1720		

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F 000	INITIAL COMMENTS STANDARD SURVEY CENSUS: 491 SAMPLE SIZE: 39 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. Complaint: NJ00133085	F 000		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		5/14/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/15/2020

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F 584	Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review on 2/26/20 and 2/27/20, it was determined that the facility failed to provide a clean and comfortable physical environment in [redacted] of [redacted] resident sleeping units. This deficient practice occurred on the [redacted] & [redacted] the [redacted] floor [redacted] & [redacted] Wing and was evidenced by the following findings: On 2/26/20 from 12:15 PM to 1:45 PM, the surveyor observed, in the presence of the facility's Maintenance Director, a darkened substance on the floors of [redacted] of [redacted] resident rooms on the [redacted] floor [redacted] Wing and [redacted] of [redacted] resident rooms on the [redacted] floor [redacted] Wing. The surveyor determined that the substance was dirt and old floor finish that had accumulated at the bottom corners of each doorframe to the resident's room due to ineffective floor maintenance. The facility's Maintenance Director	F 584	F584 Safe/Clean/Comfortable/Homelike Environment F 584 Element One – Corrective Action The floors on the [redacted] floor [redacted] and [redacted] wings including the identified [redacted] resident rooms on the [redacted] wing and the [redacted] identified resident rooms on the [redacted] wing were deep cleaned with baseboard stripper, stripped of wax and all corners and edges scrubbed and cleaned. The protective lens covers on the overbed lights in resident rooms [redacted] [redacted] & [redacted] on the [redacted] floor [redacted] wing were discontinued. New fixtures have been ordered and will be replaced upon receipt. The protective lens covers on the overbed lights in resident room [redacted] on the [redacted] floor [redacted] wing was discontinued. New	

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F 584	Continued From page 2 acknowledged and confirmed this finding in an interview during the observation and stated that this was a housekeeping concern. The facility provided a monthly project schedule which indicated that floor corners and edges on the [redacted] floor were cleaned every Monday between 11:00 PM and 7:00 AM. According to this schedule, the last project cleaning should have occurred on 2/24/20 11:00 PM to 7:00 AM (2 days prior). The degree of accumulation of dirt and old floor finish observed indicated that the scheduled cleaning did not occur or was not properly done. During a tour of the [redacted] floor [redacted] Wing on 2/27/20 at 10:20 AM, the surveyor observed in the presence of the facility's Maintenance Director, the protective lens cover for the overbed lights in [redacted] of [redacted] resident rooms were missing. This was observed in resident rooms [redacted] and [redacted] An interview with the Maintenance Director at 1:30 PM revealed that the lens covers were discontinued, no longer available and the facility was currently in the process of upgrading all light fixtures. At 2:00 PM, the Maintenance Director provided a brochure from a vendor for new lighting. At 2:15 PM, the facility's Administrator revealed in an interview that the facility was not able to provide a purchase order or sales contract for new lighting. During a tour of the 3[redacted] floor [redacted] Wing on 2/27/20 at 10:40 AM, the surveyor observed in the presence of the facility's Maintenance Director, the protective lens cover for the overbed lights in [redacted] resident rooms was missing. This was observed in resident rooms [redacted] At 10:54 AM on 2/27/20 in the presence of the	F 584	fixtures have been ordered and will be replaced upon receipt. The ceiling tiles in the [redacted] shower room on the [redacted] floor [redacted] wing in all stalls and community areas in the shower were bleached and cleaned immediately including at the wall and floor junctures. In addition, Maintenance re-caulked wall and floor junctures in the perimeter of each shower stall after thorough cleaning. Element Two All residents have the potential to be affected by this practice. Element Three Environmental checks are conducted daily by the Housekeeping staff when cleaning all shower rooms. Housekeeping and Maintenance staff were re-educated about proper cleaning protocols and the process to report any areas in need of deep cleaning or repair or maintenance to their supervisor for immediate action. Environmental rounds are conducted weekly to evaluate the cleanliness and any repairs needed to ensure a clean and safe environment throughout the facility. The Maintenance and Housekeeping logs have been revised to reflect these specific areas and maintenance staff educated about these revisions. Environmental and maintenance rounds were conducted throughout the facility to ensure all other areas not cited were clean and in safe condition.	

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F 584	Continued From page 3 Maintenance Director the surveyor observed an unidentified black substance clinging to the ceramic tile ceiling in [redacted] of [redacted] community shower rooms located on the same wing. This was observed in the [redacted] Shower room. Also, the [redacted] shower stalls in the same shower room was observed by the surveyor to have an unidentified blackened substance on the wall/floor juncture of the perimeter of each stall. The Maintenance Director acknowledged and confirmed this finding in an interview during the observation and stated that the shower room's poor ventilation had caused these issues. NJAC 8:39-31.2(e) and 31.4(a)	F 584	Element Four The Maintenance Director, Housekeeping Director, and Administrator will conduct walking rounds a minimum of weekly to monitor the cleanliness of all resident care areas specifically focused on floors and shower rooms to ensure all areas are maintained in a clean and sanitary manner. The Maintenance Director will report findings monthly to the Quality Assurance Compliance Committee for action as appropriate. The Maintenance Director will monitor the repair log weekly which include checking lens covers of over-the-bed fixtures and discuss findings with the Administrator. The Maintenance Director will report findings monthly to the Quality Assurance Compliance Committee for action as appropriate.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		5/14/20

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§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 5 Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide written notification of an emergency transfer to	F 623	F623 Notice Requirements Before Transfer/Discharge – pp. 4-7, CMS-2567	

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	315248	A. BUILDING _____ B. WING _____	C 03/05/2020

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F 623	Continued From page 6 the resident or resident representative for 2 of 2 residents (Resident # [redacted] and # [redacted]) reviewed. This deficient practice was evidenced by the following: 1. The surveyor reviewed Resident # [redacted] medical record. The Minimum Data Set (MDS) tracking sheet indicated that the resident was transferred out of the facility on [redacted] There was no evidence of written notification identified or provided. 2. The surveyor reviewed Resident [redacted] medical record. The Admission Record indicated the resident was transferred out to the hospital on 1[redacted] There was no evidence of written notification identified or provided. On 3/4/20 at 11:21 AM, the surveyor interviewed the Director of Social Services, who stated that the aforementioned resident's representatives were verbally notified of an emergency transfer, but that this was not done in writing. On 3/4/20 at 1:30 PM, the surveyor discussed the above concerns with the Administrator and the Director of Nursing (DON). The Administrator acknowledged that the aforementioned resident's representatives were verbally notified of an emergency transfer only. There was nothing provided in writing. On 3/5/20 at 1:00 PM, no further information was provided by the facility. NJAC 8:39-27.1 (a)	F 623	1. Residents affected by the deficient practice: a. Resident # [redacted] 's Minimum Data Set ("MDS") tracking sheet indicated that the resident was transferred out of the facility on [redacted]. There was no evidence of written notification provided. b. Resident [redacted] 's Admission Record indicated that the resident was transferred to the hospital on [redacted]. There was no evidence of written notification provided. 2. Identify other residents who could be affected by the deficient practice: All residents could be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficiency would not recur: a. Social Work Department will regularly check the Daily Census for any resident discharge to hospital. b. If a resident has been discharged to hospital, Social Work Department will complete the Letter-Notification re Resident's Hospitalization and mail to the resident's primary contact. i. This notification letter will state the name of the hospital and the date of the	

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F 623	Continued From page 7	F 623	discharge. ii. Copy of the notification letter will be kept in a binder located in the Social Work Department Office. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: a. Social Services Assistant will generate a list of residents who were discharged for the week and the date that the corresponding notification letters were mailed to family or guardian of the resident. b. Director of Social Work will review the list at the end of the week to oversee the notification process. c. The Quality Assurance Compliance Committee (“Compliance Committee”) will meet monthly to monitor and ensure that written notification is made to resident’s family or representative whenever a resident is transferred out of facility (or) to the hospital.	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates.	F 640		5/14/20

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F 640	Continued From page 8 (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced	F 640		

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F 640	Continued From page 9 by: Based on interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set (MDS) in accordance with federal guidelines. This deficient practice was identified for [redacted] of [redacted] resident (Resident #[redacted]) reviewed for resident assessment and was evidenced by the following: On 03/4/20 at 9:30 AM, the surveyor reviewed the facility assessment task that included the Resident's MDS Assessments. The MDS is a comprehensive tool that is a federal mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. Resident #1 was triggered under the survey facility task as "MDS record over [redacted] days old." Review of Resident #[redacted] medical record revealed that the resident expired in the facility on [redacted] The surveyor reviewed the MDS 3.0 assessment tool, including all the completed MDS assessments for the resident. The MDS assessment history revealed that the Death in Facility tracking record for Resident [redacted] was not submitted until 3[redacted]. MDS Death in Facility assessments must be submitted no later than [redacted] days after expiration. On 3/4/2020 at 2:00 PM, the surveyor discussed the above concern with the Administrator and the Director of Nursing (DON). The DON acknowledged that the assessment was not submitted timely in accordance with the federal	F 640	F640 Encoding/Transmitting Resident Assessments □ pp. 7-10, CMS-2567 1. Residents affected by the deficient practice: Resident [redacted]: The Minimum Data Sheet (MDS) assessment history revealed that the Death in Facility tracking record for Resident [redacted] who expired in the facility on [redacted], was not submitted until [redacted] 2. Identify other residents who could be affected by the deficient practice: All residents could be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficiency would not recur: MDS Coordinators will be re-educated and reminded that MDS Death in Facility assessments shall be submitted to the Quality Measure System no later than [redacted] days after resident expiration. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: a. MDS Manager will check the daily	

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F 640	Continued From page 10 regulations. NJAC 8:39-11.2	F 640	census for any resident discharge or expiration to ensure that any and all MDS Death in Facility assessments are submitted to the Quality Measure System no later than [redacted] days after resident expiration. b. The Quality Assurance Compliance Committee ("Compliance Committee") will meet monthly to monitor the MDS Manager in checking and ensuring that MDS Death in Facility assessments for the month are submitted within [redacted] days after resident expiration.	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that the Registered Nurse (RN) assessed the resident after the resident fell, as per the nursing standards of clinical practice. This deficient practice was identified for [redacted] of [redacted] residents (Resident #2[redacted], and [redacted]) reviewed for falls. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, "The practice of nursing as a registered	F 658	F658 Services Provided Meet Professional Standards □ pp. 10-15, CMS-2567 1. Residents affected by the deficient practice: a. Resident #[redacted] fell twice on [redacted] at 3:25 A.M. and 7:20 A.M. Both falls were investigated, and a review of the Occurrence Report showed that the Fall Assessments were both completed by a Licensed Practical Nurse (LPN). b. Resident #[redacted] had been pushed onto	5/14/20

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F 658	Continued From page 11 professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Administrative Code, Title 13, Law and Public Safety, Chapter 37, New Jersey Board of Nursing, under 13:37-6.5 Non-Delegable Nursing Tasks, includes: "A registered professional nurse shall not delegate the physical, psychological, and social assessment of the patient, which requires professional nursing judgment, intervention, referral, or modification of care." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case-finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On [redacted] at 10:01 AM, the Licensed Practical Nurse (LPN) informed the surveyor that Resident #[redacted] was [redacted] and on fall precautions. On 2/28/2020 at 12:09 PM, the surveyor observed the resident seated in a wheelchair in	F 658	the floor by another resident and consequently fell on [redacted]. A review of the Investigation Report dated [redacted] indicated that an LPN assessed Resident [redacted]. c. Resident #[redacted] was observed by a Certified Nursing Assistant to be sitting in the [redacted] with [redacted], according to the Investigative Report dated 1[redacted]. A unit LPN assessed the resident to have a [redacted] of the [redacted] 2. Identify other residents who could be affected by the deficient practice: All residents could be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficiency would not recur: a. Both RNs and LPNs will be reeducated that physical, psychological, and social assessment of the patient shall be done by an RN, and not an LPN. b. The policy and procedure on Fall Risk Assessment will be revised to specify that a Registered Nurse will assess the Resident at the time of admission/readmission and said RN shall complete the Fall Risk Assessment. c. The Occurrence Report form will be revised to specify that an RN will complete	

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F 658	Continued From page 12 front of the nursing station with other residents. On 2/28/2020 at 11:18 AM, the Fall Coordinator/Licensed Practical Nurse (FC/LPN) informed the surveyor that resident [redacted] had fallen twice on [redacted] at 3:25 AM and 7:20 AM. The 3:25 AM fall occurred when the resident slid off the wheelchair while trying to go to the bathroom. The resident sustained no injury from this fall. The second fall at 7:20 AM was documented that the resident was found sitting on the floor in their room. The resident sustained no injury from the second fall. Both falls were investigated, and it was an LPN who assessed the resident at the time of the fall. On that same date and time, the FC/LPN told the surveyor an RN should have completed the fall assessment. The FC/LPN could not speak as to why the RN did not assess the resident at the time of the fall or after the fall. A review of Resident #[redacted] Face Sheet (an admission summary), identified that the resident had diagnoses which included, but were not limited to repeated [redacted] and [redacted] A review of [redacted] Significant Change Minimum Data Set (SMDS), an assessment tool used to facilitate the management of care, indicated a Brief Interview for Mental Status (BIMS) score of [redacted], which reflected that the resident's [redacted] The SMDS also documented that the resident had [redacted] incidents. A review of the Occurrence Report for the fall incident provided by the Director of Nursing	F 658	the form and perform the fall assessment. d. The [redacted] Flow Sheet will likewise be revised to specify that an RN will complete [redacted] assessment and sign the form. e. RNs and LPNs will be educated on the foregoing revised policies and procedures. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: a. The Director of Nursing or RN designee shall review daily any and all Occurrence Reports and Investigation Reports, and ensure that the assessments made have been done by an RN. b. The Quality Assurance Compliance Committee (“Compliance Committee”) will meet monthly to monitor the Director of Nursing or RN designee in checking and ensuring that assessments are done by RNs and not LPNs.	

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F 658	Continued From page 13	F 658		

(DON), reflected that the resident had fall incidents on [redacted] at 3:25 AM and 7:20 AM.

A review of the above Occurrence Report showed that the Fall Assessments were both completed by an LPN.

Further review of the medical records, reflected there was a lack of documentation that the resident was assessed by an RN on 1[redacted] at 3:25 AM or 7:20 AM, after the resident's fall.

On 3/2/2020 at 12:37 PM, the LPN informed the surveyor that Resident [redacted] had a fall incident on [redacted], and he was the assigned nurse at that time of the fall. He stated, "I called [redacted] and the LPN Supervisor came, and we both assessed the resident." The LPN could not speak to why the resident was not assessed by an RN at the time of the fall or post-fall.

On that same date and time, the LPN informed the surveyor that there was no injury at the time of the fall.

2. On 2/26/2020 at 10:30 AM, the surveyor observed Resident #[redacted] independently ambulating in the hallway.

A review of the resident's Face Sheet indicated that the resident had diagnoses which included, but were not limited to, [redacted]

Review the Quarterly MDS, dated [redacted] reflected that the resident had a BIMS score of [redacted], which indicated [redacted]

Review of Resident #1[redacted]s Care Plan revealed that the resident had been pushed onto the floor by another resident on [redacted]

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A review of the Investigation Report dated [redacted] provided by the DON, revealed that a Certified Nursing Assistant (CNA) witnessed another resident push Resident [redacted] who had been walking in the hallway at the time. The Investigation Report indicated that an LPN assessed Resident [redacted]. The report further indicated that Resident [redacted] did not sustain any injuries.

3. On 2/26/20 at 10:17 AM, the surveyor observed Resident [redacted] independently ambulating in and out of the room.

A review of the resident's face sheet indicated that the resident had diagnoses which included but not limited to [redacted].

A review of the Quarterly MDS dated [redacted], reflected that the resident had a BIMS score of [redacted] which indicated [redacted].

A review of the Investigative Report dated [redacted], provided by the DON, revealed that Resident [redacted] was observed by a Certified Nursing Assistant to be sitting in the [redacted] with their [redacted] A unit LPN assessed the resident to have a [redacted] The resident was then sent to the emergency room for treatment. The facility investigation concluded that the resident was unable to explain what had happened due to their [redacted] and that a fall could not be ruled out.

On 3/2/2020 at 1:31 PM, the survey team met with the DON and the Administrator and discussed the above observations and concerns. The DON informed the surveyors that an RN

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F 658	Continued From page 15 should have completed the fall assessment. The DON further stated that the staff "probably" forgot to call the RN at the time of the fall or injury. The DON suggested that this most likely why the RN didn't complete the assessment. A review of the Occurrence Report for Fall Policy with a revised date of 12/11/19, provided by the DON, indicated that a Licensed Nursing Staff would assess a resident for injuries before moving the resident in case of fall. The Occurrence Report for fall Policy did not specify that an RN would be responsible for assessing the resident at the time of the fall or post-fall. NJAC 8:39-11.2 (b); 27.1(a)	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to consistently apply [redacted] prevention boots as ordered by the physician. This deficient practice was identified for [redacted] of [redacted] residents	F 686	F686 Treatment/Services to Prevent/Heal [redacted] □ pp. 15-18, CMS-2567 F686 Element One – Corrective Action	5/7/20

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F 686	Continued From page 16 (Resident #) reviewed for and was evidenced by the following: The surveyor reviewed the medical record for Resident # According to the face sheet (an admission summary), the resident was admitted to the facility on and had diagnoses which included but not limited to; A review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated , reflected that the resident had a brief interview for mental status (BIMS) score of out of which indicated . A review of the Scale (an assessment tool used to determine the dated reflected a score of , indicating the resident was at for the of . A review of the physician's order sheet for reflected an order dated for; on at all times. May remove for hygiene and skin check. A review of the resident's individualized care plan dated reflected that the resident had a potential for y related to The care plan had interventions to maintain skin integrity, which included at all times. The corresponding physician order was transcribed into the resident's Treatment Administration Record (TAR) for and with all three shifts signing as	F 686	CNA #1 and CNA#2 and the RN involved in the care of Resident were counseled and re-educated concerning the proper procedures to follow to ensure residents requiring the use of boots to prevent are provided daily with the as per the MD order. The care plan of this resident was reviewed to ensure it clearly noted the use of the as ordered. Resident # has that are being applied as per the physician order, and the unit manager is monitoring the resident daily for proper use of the This information is clear on the CNA assignment sheet for aides providing care to see and is reviewed daily by the charge nurse. Element Two All residents who require relief devices have the potential to be affected by this practice. Element Three Nursing staff including licensed nurse and nurse aides facility-wide received reeducation about the proper use of relieving devices to prevent At orientation and a minimum of annually, nursing staff receive education concerning the use of devices to prevent skin breakdown. Information will also be communicated to the care team. Daily the unit manager checks for the	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND BEHAVIORAL AND NURSING CENTER	99 MULFORD ROAD ANDOVER, NJ 07821

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F 686	Continued From page 17 applied. On 3/2/20 at 10:09 AM, the surveyor observed the Certified Nursing Assistant #1 (CNA #1-primary CNA for Resident [redacted] and the Registered Nurse (RN) remove the covers from resident to position the resident for a [redacted] care treatment. The [redacted] were not in use when the CNA #1 and RN uncovered the resident. During the conclusion of the [redacted] care treatment observation, CNA #1 and the RN did not apply the Me[redacted] to the resident's [redacted] On 3/3/20 at 10:16 AM, the surveyor observed Resident [redacted] sitting in a [redacted] with both [redacted] exposed and resting on the surface of the [redacted]. There were no [redacted] observed on the resident. On 3/3/20 at 10:18 AM, the surveyor interviewed the unit manager Licensed Practical Nurse (UM/LPN), who confirmed that resident [redacted] should have [redacted] on at all times. She accompanied the surveyor to the resident room and acknowledged that the [redacted] were not applied. On 3/3/20 at 10:19 AM, the surveyor and the CNA#2 (a floater- assigned to different units and not familiar with the resident) entered Resident [redacted] room to search for the [redacted] and found [redacted] hanging on the wall, and [redacted] was in the closet. She stated that she did not see any [redacted] in the room when she provided AM care "this morning" and that she was not aware that the resident had to have [redacted] in place. She further stated that she could have checked the care plan or asked the nurse.	F 686	proper use of ordered [redacted] reduction devices as part of the required rounds. Any concerns are reported to the supervisor/DON as appropriate for action. Element Four The Unit Manager and DON/Designee will conduct walking rounds a minimum of weekly on an ongoing basis to ensure residents have the proper [redacted] reducing devices in use as ordered by the physician. The DON will report findings of these rounds monthly on an ongoing basis to the Quality Assurance Compliance Committee for action as appropriate.	

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F 686	Continued From page 18 On 3/4/20 at 10:32 AM , the surveyor interviewed the CNA#1, who stated that she had forgotten to apply the [redacted] the day she was observed in [redacted] care and that she always applies the [redacted] after AM care. On 3/5/20 at 9:09 AM, the survey interviewed the Director of Nursing, who stated that if there was a physician order for [redacted], then they should have been applied as ordered. The facility provided no further information.	F 686		
F 695 SS=D	NJAC: 8:39.27(a) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to maintain the necessary [redacted] care and services of a resident who was receiving [redacted] according to the standard of practice. This deficient practice was identified for [redacted] of [redacted] residents (Resident [redacted]) and evidenced by the following: A review of the resident's Face Sheet (an admission summary), reflected that the resident was admitted to the facility with diagnoses which	F 695	F695 Respiratory/Tracheostomy Care and Suctioning □ pp. 18-21, CMS-2567 F695 Element One – Corrective Action Nursing staff that provided care to Resident [redacted] received counseling and reeducation regarding the need to properly monitor and document the resident's [redacted] level as ordered by the physician following standards of practice. The physician	5/14/20

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F 695	Continued From page 19 included but not limited to [redacted] A review of the [redacted] Quarterly Minimum Data Set, an assessment tool used to facilitate the management of care, indicated that the resident's [redacted] skills for [redacted] were [redacted], which meant that the resident's [redacted]. The QMDS indicated that the resident was on [redacted] therapy. On 2/27/2020 at 8:55 AM, the surveyor observed Resident [redacted] seated in bed awake and with [redacted] in use at [redacted]) attached to [redacted]. There were [redacted] in use at [redacted] attached to [redacted] via [redacted] going to the [redacted] machine. The resident informed the surveyor that the facility used [redacted] (both [redacted] set [redacted] for a long time and said, "I'm comfortable, and I need it." On 2/28/2020 at 12:15 PM, two surveyors observed the resident in their room utilizing [redacted] with the same set up observed on 2/27/2020. On that same date and time, the surveyors interviewed the Licensed Practical Nurse (LPN). The LPN informed the surveyors that the resident was on [redacted], and tolerating it well. The LPN further stated that the resident should have been monitored for [redacted] Resident [redacted] was using an [redacted]	F 695	orders were clarified, and the monitoring included on the MAR/TAR for this resident. Element Two All residents who require [redacted] have the potential to be affected by this practice. Element Three Licensed Nursing staff facility-wide received reeducation about the proper monitoring and documentation of [redacted] levels for all residents requiring [redacted] per the physician order. Records were reviewed of all current residents requiring [redacted] to ensure their [redacted] levels are monitored in compliance with physician orders and standards of practice. MARs/ TARs were updated to reflect this requirement. The facility policy entitled [redacted] Therapy via [redacted] was updated to include the process to monitor [redacted] levels of residents receiving [redacted]. Element Four The ADON/ designee will audit medical records of residents using [redacted] on a weekly basis for six months to ensure documentation of the [redacted] levels is properly documented n the MAR/TAR. Thereafter the ADON/designee will conduct random audits bi-weekly on a sample of two MAR/TAR books per week. Findings will be aggregated and discussed with the DON. The DON/designee will report findings at the Quality Assurance Compliance meeting	

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F 695	Continued From page 20 [redacted] machine. The [redacted] manual indicated that "appropriate patient monitoring must be used at all times." The surveyor reviewed the [redacted] Physician's Orders, which revealed a physician's order dated [redacted], for [redacted] The corresponding physician order was transcribed into the resident's Treatment Administration Record (TAR) for [redacted] Further review of the resident's medical records showed that there was no documented evidence that the resident's [redacted] was monitored and documented. On 3/2/2020 at 1:31 PM, the survey team met with the Administrator and the Director of Nursing (DON) and discussed the above observations and concerns. On that same date and time, the DON stated that the [redacted] of the resident should have been monitored and documented every shift in the Medication Administration Record (MAR). She further stated that the resident tolerated the [redacted] treatment and that there were no adverse effects. On 3/4/2020 at 1:29 PM, the survey team met with the Administrator and the DON. There was no additional information provided. A review of the [redacted] Therapy [redacted] Policy, having an update date of 3/2/2020, provided by the DON did not contain information about monitoring of [redacted]	F 695	monthly on an ongoing basis.	

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F 695	Continued From page 21 NJAC 8:39-11.2 (b); 27.1(a)	F 695		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		5/14/20

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F 880	Continued From page 22 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility staff failed to: a.) adhere to accepted standards of infection control practices for the proper storage of a [redacted] for [redacted] resident (Resident [redacted] reviewed for [redacted] treatment; b.) proper handling and storage of indwelling [redacted] for [redacted] residents (Resident [redacted] and [redacted]) reviewed for a [redacted] and, c.) use the required personal protective equipment (PPE) and perform handwashing to prevent the	F 880	F880 Infection Prevention & Control □ pp. 21-28, CMS-2567 Element One – Corrective Action LPN #1, LPN #2, and the CNA that provided care to Resident [redacted] received counseling and reeducation regarding the proper changing of the [redacted] according to facility policy and the proper storage of the [redacted] in a bag when not in use to prevent contamination	

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F 880	Continued From page 23 spread of infection on a resident with transmission-based precautions for [redacted] resident (Resident [redacted] This deficient practice was evidenced by the following: 1. On 2/27/2020 at 8:36 AM, the surveyor observed Resident [redacted] seated in bed with a [redacted] directly touching the top of the nightstand. The [redacted] was dated [redacted] A review of Resident [redacted] Face Sheet (an admission summary), reflected that the resident was admitted to the facility with diagnoses which included but not limited to [redacted] and [redacted] A review of the [redacted] Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, indicated a Brief Interview for Mental Status (BIMS) score of [redacted] which reflected that the resident's [redacted]. The QMDS indicated that the resident was on [redacted] treatment and had an [redacted]. On 2/27/20 at 8:36 AM, the Certified Nursing Assistant (CNA) was inside the resident's room and informed the surveyor that the resident was [redacted]. The CNA stated that the resident was "probably" on a [redacted] treatment as needed. On 2/28/2020 at 8:36 AM, the surveyor observed Resident [redacted] lying in a [redacted] with an [redacted] directly touching the floor	F 880	and cross contamination. The CNA who failed to put the [redacted] of Resident [redacted] in a [redacted] bag was counseled and re-educated regarding the rationale for the use of the [redacted] bag and proper placement of the floor to prevent contamination. Staff that provided care to Resident [redacted] received counseling and re-education regarding proper placement of the [redacted], and proper storage of the [redacted] bag in a [redacted] bag with the [redacted] and the [redacted] bag placed on the bed [redacted] of the residents [redacted] to prevent backflow of [redacted] and prevent [redacted] Staff that provided care to Resident [redacted] received counseling and re-education regarding proper placement of the [redacted] the [redacted] and proper storage of the [redacted] in a [redacted] bag with the [redacted] and the [redacted] bag placed on the bed [redacted] the [redacted] resident's [redacted] to prevent backflow of [redacted] and prevent [redacted] CNA#1, the RN who assisted the [redacted] LPN with [redacted] care were counseled and reeducated about proper handwashing and use of PPE when assisting with [redacted] care. Both staff members performed a return demonstration of handwashing and a handwashing competency was completed. The [redacted] LPN who provided the [redacted]	

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F 880	Continued From page 24 without a [redacted] bag. Also, the [redacted] dated [redacted] was observed directly touching the nightstand table. On 2/28/2020 at 8:38 AM, the Licensed Practical Nurse #1 (LPN#1) informed the surveyor that the resident was [redacted], required total assistance with activities of daily living (ADLs), and unable to move without staff assistance. On that same date and time, LPN#1 and the surveyor went inside the resident's room. LPN#1 stated, "I don't know why the [redacted] bag was on the floor, and it should be inside a [redacted] bag for infection control." He further stated that the [redacted] should also be inside a plastic bag for infection control when not in use. At that same time, the surveyor observed LPN#1 grab the [redacted] that was directly on the top of the nightstand and placed it inside a plastic bag. He told the surveyor that [redacted] was the date this particular [redacted] was first used. On that same date at 8:50 AM, the CNA had no answer to why the [redacted] bag was directly touching the floor. She stated that the [redacted] bag should not be on the floor as that is an infection control issue. On 3/2/2020 at 8:52 AM, LPN#2 informed the surveyor that she was the 11-7 shift nurse who was responsible for changing the [redacted] every [redacted] and [redacted] for Resident [redacted] She further stated, "We nurses are not perfect. I probably missed and forgot to change the [redacted] of the resident." She indicated that the [redacted] bag should be inside a [redacted] bag for infection control.	F 880	care treatment to Resident [redacted] was counseled and reeducated about proper handwashing and use of PPE when providing [redacted] care, including proper setup of a clean field prior to [redacted] care, proper handwashing throughout the [redacted] care procedure, proper use of PPE and handwashing when donning and doffing PPE and proper use of PPE and handwashing when cleaning after [redacted] treatment when caring for a resident with [redacted] precautions. The [redacted] LPN performed a return demonstration of handwashing, donning and doffing PPE and setting up and cleaning up after [redacted] care with a handwashing and a [redacted] care treatment competency completed. Element Two All residents who have [redacted] have the potential to be affected by these practices. All residents who have [redacted] treatments have the potential to be affected by these practices. All residents who receive [redacted] care have the potential to be affected by these practices. Element Three Licensed Nursing staff facility-wide received infection control reeducation in the following areas: 1. Proper changing of [redacted] according to facility infection control policies; 2. Proper handwashing; 3. Procedures for [redacted] care treatment including those where [redacted] precautions	

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F 880	Continued From page 25 2. On 2/26/2020 at 10:12 AM, the surveyor observed Resident [redacted] lying in bed and that the resident had an [redacted] bag. The [redacted] bag was hung on the left, lower side of the bed rail, and was not contained in a [redacted] bag. The CNA informed the surveyor that the resident was cognitively impaired, required extensive assistance with ADLs, and preferred to stay in bed. She further stated that the resident had a [redacted] for a long time. A review of the resident's Face Sheet reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted]. A review of the [redacted] QMDS indicated a BIMS score of [redacted] which reflected that the resident's [redacted]. The QMDS indicated that the resident had a [redacted] On 2/27/2020 at 8:38 AM, the surveyor observed Resident [redacted] lying in bed. The [redacted] and the [redacted] bag were in direct contact with the floor. On 2/28/2020 at 8:40 AM, the surveyor observed Resident [redacted] in bed with an [redacted] bag layered over the bed, directly touching the bed linen. The [redacted] bag was above the [redacted] of the resident's [redacted]. This position allowed the [redacted] in the [redacted] to [redacted] into the [redacted], which increased the possibility of a [redacted] Infection. The resident stated, "I don't know" when the surveyor asked who placed the [redacted] bag on top of the bed.	F 880	are in effect; 4. Proper positioning of [redacted] in a [redacted] bag, positioned with [redacted] off the floor [redacted] the [redacted] of the resident [redacted] Nursing staff receive infection control education during initial orientation and a minimum of annually that includes areas 1-4 above. Transmission-based precautions are also addressed during this training as is handwashing with return demonstrations and treatment competencies to decrease the risk of infections. The facility infection control policies addressing handwashing, contact precautions, [redacted] care, [redacted] control and [redacted] care procedure were reviewed with nursing staff during the re-education. Element Four The ADON/ designee will observe the WCCLPN perform one treatment biweekly for six months to ensure the [redacted] care treatment was completed in compliance with all infection control procedures for contact precautions, handwashing and use of PPE. Findings of these audits will be discussed with the DON and reported at the Quality Assurance Compliance Committee meeting monthly by the DON on an ongoing basis. After six months the QA committee will determine if additional observations are required. The ADON/ designee will conduct weekly care rounds on an ongoing basis to	

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F 880	Continued From page 26 On 2/28/2020 at 8:48 AM, the surveyor showed the Director of Nursing (DON) the [redacted] bag and discussed the above concerns and observations. The DON stated that the [redacted] should have been hung on the bed rail with a [redacted] bag for infection control. 3. On 2/26/2020 at 9:47 AM, the surveyor observed Resident [redacted] seated in a wheelchair in their room. The resident was unable to remember what they had for breakfast and did not know the date and time. On 2/27/2020 at 8:42 AM, the surveyor observed the resident lying in a low bed with an [redacted] directly touching the [redacted]. The [redacted] bag was not contained in a [redacted] bag. A review of the resident's Face Sheet reflected that Resident [redacted] was admitted to the facility with diagnoses which included but not limited to; [redacted] A review of the [redacted] MDS indicated a BIMS score of [redacted] which reflected that the resident's cognition was [redacted] The SMDS indicated that the resident had a [redacted] with a diagnosis of [redacted]. On 2/27/20 at 8:43 AM, the [redacted] CNA informed the surveyor that the resident was cognitively [redacted], required total assistance	F 880	monitor infection control procedures for bagging and replacement of [redacted] per facility policy, proper placement of [redacted] in a [redacted] bag with [redacted] off the floor and the bag placed below the [redacted]. Findings of these audits will be discussed with the DON and reported at the Quality Assurance Compliance Committee meeting monthly by the DON on an ongoing basis. After six months the QA committee will determine if additional observations are required.	

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F 880	Continued From page 27 with ADLs, and had a [redacted]. On that same date and time, the [redacted] CNA and the surveyor went to the resident's room, and both observed the [redacted] lying on top of the [redacted]. The [redacted] CNA stated, "sometimes I see the [redacted] bag on top of the mat when I come in." She further stated, "the [redacted] bag should be in a [redacted] bag." The [redacted] CNA could not answer if the [redacted] on the [redacted] was or wasn't appropriate. On 3/2/2020 at 1:31 PM, the surveyor spoke to the Administrator and DON regarding the above concerns. The DON informed the surveyors that the [redacted] bag should be in a [redacted] bag and not be directly touching the floor due to infection control. The DON stated, "the nurses were provided a warning and written up with regards to the problem." She further stated that LPN#1 should have discarded the [redacted] because it was considered contaminated because it touched the surface of the nightstand. On 3/5/2020 at 9:29 AM, the Infection Control Nurse/RN (ICN/RN) informed the surveyors that the [redacted] bag should not be directly touching the floor and should be in a [redacted] bag for infection control. On that same date and time, the ICN/RN informed the surveyors that the [redacted] should not be directly touching the surface and should be inside the plastic bag when not in use for infection control. She stated that the [redacted] should be changed twice a week, and it was the 11-7 shift nurse responsible for changing the [redacted]. She further stated that when the [redacted] touches a surface, it should be discarded and considered contaminated.	F 880		

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	315248	A. BUILDING _____ B. WING _____	C 03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND BEHAVIORAL AND NURSING CENTER	99 MULFORD ROAD ANDOVER, NJ 07821

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F 880	Continued From page 28 A review of the [redacted] Policy and Procedure with a review date of 2/26/16, provided by the DON, indicated, "Always place [redacted] bags in a [redacted] bag; Keep [redacted] off the floor." A review of the Use of [redacted] and Disposable [redacted] Equipment Policy with a review date of 11/11/16, provided by the DON, indicated, "Professional nursing staff on 11-7 shall routinely change units every [redacted] and [redacted] night; when temporarily not in use, the mask, cannula or [redacted] is covered lightly with non-airtight covering." 4. Review of the face sheet (an admission summary) for Resident # [redacted] reflected the resident was admitted to the facility on [redacted] with diagnoses which included but not limited to; [redacted]. Review of the QMDS, dated [redacted], reflected that the resident had a brief interview for mental status (BIMS) score of [redacted] out of [redacted], which indicated [redacted]. Review of section [redacted] of the MDS indicated the resident was coded for [redacted]. On 3/2/20 between 10:09 AM and 10:37 AM, the surveyor observed Resident [redacted] care treatment with the following staff: Certified Nursing Assistant #1 (CNA #1), Registered Nurse (RN) and [redacted] Licensed Practical Nurse [redacted] LPN). The CNA#1 and RN positioned the resident for the treatment, and the [redacted] LPN	F 880		

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F 880	Continued From page 29 performed the actual [redacted] treatment. A review of the physician's order sheet for [redacted] reflected an order dated [redacted] to the [redacted], apply [redacted] then cover with dressing. Change once daily for [redacted] care. The surveyor observed the [redacted] LPN prepare the over-bed table with the needed [redacted] care supplies. The [redacted] LPN did not wash her hands or don gloves before the preparation of the over-bed table. The surveyor then observed the [redacted] LPN wash her hand for thirteen seconds. After washing her hands, she pushed the lever on the paper towel dispenser to get a towel. She dried her hands and wiped the sink surface with the same towel. The [redacted] LPN then donned gloves and removed Resident [redacted] dressing and proceeded to rewash her hands. The surveyor observed the WCCLPN wash her hands for sixteen seconds. She then touched the paper towel dispenser lever to dispense the paper towel. The [redacted] LPN donned gloves and cleansed the [redacted]. Afterward, she removed her gloves and washed her hands for seven seconds. She then touched the paper towel dispenser lever to dispense the paper towel. The RN who was assisting the [redacted] LPN had to leave the room to get [redacted] (a medication ointment used to [redacted]). The RN removed her gown and gloves in the room but did not wash her hands before exiting the room. She returned with the [redacted] donned a clean gown, and did not don gloves. She opened the [redacted] for the [redacted] LPN and then donned gloves to	F 880		

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F 880	Continued From page 30 assist with the repositioning of the resident. The [redacted] LPN applied the [redacted] to the [redacted], removed the absorbent pad under the resident, and removed her gown and gloves, and washed her hands for seven seconds. After washing her hands, she touched the lever of the paper towel dispenser with her wet clean hands to dispense the paper towel. The surveyor then observed the [redacted] LPN clean up the dirty treatment supplies on the over-bed table with un-gloved hands and placed the dirty treatment supplies in the garbage receptacle inside the resident's room. She exited the room without washing her hands and stated she was done. She did not wash her hands after she left the room. On 3/2/20 at 10:39 AM, the surveyor interviewed the [redacted] LPN, who stated that she usually washed her hands for 30 seconds and sang "Happy Birthday." She stated she was nervous and maybe did not wash her hands long enough. She also stated that she should have worn gloves to remove the treatment supplies from the over-bed table and then wash her hands. Lastly, she stated that she should not have touched the paper towel dispenser for the paper towels after washing her hands. On 3/2/20 at 10:55 AM, the surveyor interviewed the DON, who stated that all staff was expected to wash their hands for 20 seconds and not touch the paper towel dispenser when getting a towel to dry their hands. She also stated that the [redacted] LPN should have washed her hands before she left the resident's room and should have had gloves on to clean up the treatment supplies. Lastly, the DON stated that the RN who left the	F 880		

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F 880	Continued From page 31 room to get the [redacted], should have washed her hands before leaving the room. Review of the "Hand Hygiene" policy and procedure dated 4/2016 revealed the following: Purpose: to decrease the risk of transmission of infection by appropriate hand hygiene; Handwashing: Wash hands for twenty seconds; wash hands before and after the care of each resident and during care procedures as necessary. Review of the [redacted] precautions" policy and procedure dated 7/2015 revealed the following: Contact precautions shall be used in addition to Standard Precautions (used for all residents) for residents with infections that can be easily transmitted by direct and indirect contact; gloves should be removed before leaving the resident's room, and hands should be washed immediately. Review of the undated [redacted] policy and procedure indicated the following: gloves should be worn to enter a room of a resident who is [redacted] infected; gowns and gloves should be removed before leaving the resident's room, and hands must be washed immediately with an antiseptic soap. NJAC 8:39-19.4 (a) (1, 2)	F 880		

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	315248	A. BUILDING **01** B. WING _____	**03/05/2020**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS LIFE SAFETY CODE 101:2012 THIS FACILITY IS IN COMPLIANCE WITH THE MINIMUM LIFE SAFETY CODE REQUIREMENTS AS SURVEYED USING CMS-2786R.	K 000		

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

Electronically Signed | 03/20/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315248	A. BUILDING _____ B. WING _____	03/01/2019

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F 000	INITIAL COMMENTS STANDARD SURVEY: 03/01/19 CENSUS: 485 SAMPLE SIZE: 38 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to maintain a medication error rate below 5%. The surveyor observed on [redacted] of [redacted] units, 3 nurses administer [redacted] doses of medication to [redacted] residents, and there were [redacted] errors which resulted in a medication error rate of 16 %. The deficient practice was evidenced by the following: Error 1 and 2: On 2/20/19 starting at 8:55 a.m., the surveyor observed the [redacted] floor Licensed Practical Nurse (2LPN) prepare medication for Resident [redacted]. The 2LPN placed 3 medications, [redacted] 20 mg, [redacted] 5 mg and [redacted] 25 mg in a medication cup along with chocolate pudding. The 2LPN placed and administered the	F 759	Error 1 and 2 1. Resident affected by the deficient practice: Resident [redacted] whose 3 medications – [redacted] 20 mg, [redacted] 5 mg, and [redacted] 25 mg – along with chocolate pudding in a cup were administered with a spoon. The LPN threw into the garbage bin the medication cup with visible leftover chocolate pudding along with two of the medications stuck in the cup. The Surveyor alerted the LPN and thereafter, the Surveyor and LPN extracted the cup from the garbage, examined the cup, and found in the cup 2 tablets, [redacted] 20mg and [redacted] 25 mg.	3/15/19

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

Electronically Signed | 03/14/2019

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F 759	Continued From page 1 medication in a spoon. The 2LPN then threw the medication cup with visible chocolate pudding along with medication into the garbage attached to the medication cup. The surveyor alerted the 2LPN to the medication left in the cup and thrown in the garbage. The 2LPN along with the surveyor removed the cup and once examined, found 2 tablets left in the cup, [redacted] 20 mg and [redacted] 25 mg. Error 3: On 2/20/19 starting at 9:20 a.m., the surveyor observed the [redacted] floor Licensed Practical Nurse (3LPN) prepare medication for Resident [redacted]. The 3LPN placed the resident's 10 medications in a medication cup. One of the medications administered was [redacted] 20 mg with directions, [redacted] capsule by mouth once daily for [redacted]. Do not chew or crush. Take 30-60 minutes before a meal." printed on the Medication Administration Record (MAR). The 3LPN informed the surveyor that Resident [redacted] had eaten breakfast at 8:30 a.m. Error 4 and 5: On 2/20/19 starting at 10:02 a.m., the surveyor observed the [redacted] floor Registered Nurse (RN) prepare medication for Resident [redacted]. The RN placed the resident's 8 medications in a medication cup. Two of the medications prepared and administered to Resident #[redacted] were [redacted] 2.5 mg and [redacted] mg. The directions documented on the MAR included [redacted] 2.5 mg once daily with a printed cautionary, "Take with breakfast." [redacted] mg twice daily was documented	F 759	The LPN who committed the foregoing error gave another [redacted] 20 mg and [redacted] 25 mg from Resident #[redacted]s bingo card in the presence of Surveyor to ensure that resident received the two medications. 2. Identify other residents who could be affected by the deficient practice: All the residents on the unit could be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficiency would not recur: a. The LPN received from the Director of Nursing a verbal one-on-one in-service/reeducation on February 20, 2019 and a one-on-one in-service/reeducation in writing on February 25, 2019. b. Nurses will be reeducated via monthly Nurses' Meetings, starting on March 12, 2019, to ensure that residents whose medications are administered with pudding or apple sauce have taken all their medications by checking the medication cup, and to make certain that the cup is empty before discarding it in the trash bin. c. Nurses will be subject to monthly med pass observation and randomly checked by consultant pharmacist.	

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F 759	Continued From page 2 on the MAR with a printed cautionary, "Take with food or meal." The RN informed the surveyor that Resident [redacted] had eaten breakfast at 8:30 a.m. NJAC 8:39-29.2 (d)	F 759	4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: a. Assistant Director of Nursing will randomly monitor weekly the nurses on med pass to ensure that when passing medications to residents who take their pills with pudding and applesauce in a cup, the residents have in fact taken the medication(s) and the cup is indeed empty of medication(s). b. The Consultant Pharmacist will do monthly observation/ monitoring of nurses' med pass. The observation/monitoring shall include checking cups to make sure that pills administered with pudding or applesauce were taken by resident and that the cup is actually devoid of medication(s). c. Assistant Director of Nursing and/or Director of Nursing, Consultant Pharmacist, and QAPI Nurse will meet monthly to monitor med pass performance of nurses to make sure that solutions are sustained. Error 3 1. Resident affected by the deficient practice: Re Resident [redacted] – At 9:20 A.M., the LPN placed the resident's 10 medications in a medication cup. One of the	

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F 759	Continued From page 3	F 759		

medications administered was [redacted] 20 mg with directions, “1 capsule by mouth once daily for [redacted]. Do not chew or crush. Take 30-60 minutes before a meal.” printed on the Medication Administration Record (MAR). LPN informed Surveyor that Resident [redacted] had eaten breakfast at 8:30 A.M.

MD was notified that the medication was not given before breakfast but fifty (50) minutes after Resident [redacted] had eaten.

2. Identify other residents who could be affected by the deficient practice:

All the residents on the unit could be affected by the deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficiency would not recur:

a. The LPN who committed the error received from the Director of Nursing a one-on-one reeducation both verbally and in writing on February 20, 2019.

b. Nurses will be reeducated via monthly Nurses’ Meetings, starting on March 12, 2019, to read carefully and follow all cautionaries written on the Physician Order Sheet (POS) and MAR.

c. Nurses on 11-7 during monthly recap will read all orders on the POS and cautionaries on the MAR, make correction(s) if printout is incorrect or has

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F 759	Continued From page 4	F 759	discrepancy, and inform Pharmacy to make the necessary correction as well. d. Nurses on 11-7 shift during monthly recap will place sticker on each resident's MAR to serve as reminder for nurses, indicating information on who has medications that must be given before breakfast or before meals or with food or with breakfast. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: a. Consultant pharmacist will randomly check on a monthly basis all nurses on med pass observation and make sure that nurses are following the cautionaries. b. Assistant Director of Nursing / Director of Nursing will monitor monthly the consultant pharmacists' documented observations and other records kept at DON's Office for nurse's file, and will reeducate nurses when indicated. c. Assistant Director of Nursing and/or Director of Nursing, Consultant Pharmacist, and QAPI Nurse will meet monthly to monitor nurses' med pass performance and make sure that solutions are sustained. Error 4 and 5 1. Resident affected by the deficient	

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F 759	Continued From page 5	F 759		

practice:

Re Resident [redacted] – At 10:02 A.M., the Registered Nurse ("RN") placed the resident's eight (8) medications in a medication cup. Two of the medications prepared and administered to Resident [redacted] were [redacted] mg and [redacted] mg. The directions documented on the MAR included [redacted] 2.5 mg once daily with a printed cautionary, "Take with breakfast." [redacted] mg twice daily was documented on the MAR with a printed cautionary, "Take with food or meal." The RN informed the surveyor that Resident [redacted] had eaten breakfast at 8:30 A.M. The physician was notified that Resident [redacted] did not take the [redacted] mg with food or meal.

2. Identify other residents who could be affected by the deficient practice:

All the residents on the unit could be affected by the deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficiency would not recur:

a. The RN who committed the error received from the Director of Nursing a one-on-one reeducation both verbally and in writing on February 20, 2019.

b. Nurses will be reeducated via monthly Nurses' Meetings, starting on March 12,

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F 759	Continued From page 6	F 759	2019, to read carefully all cautionaries written on the POS and MAR, and to follow them. c. Nurses on 11-7 shift during monthly recap will place a sticker-reminder on every resident's MAR, with the sticker indicating that meds are to be given at time specified and/or with food and meals. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: a. Consultant pharmacist will randomly check monthly nurses on med pass observation and make sure that nurses are following the cautionaries. b. Assistant Director of Nursing / Director of Nursing will monitor monthly consultant pharmacists' documented observations and other records kept at DON's Office for nurse's file, and will reeducate nurses when indicated. c. Assistant Director of Nursing and/or Director of Nursing, Consultant Pharmacist, and QAPI Nurse will meet monthly to monitor nurses' med pass performance and to make sure that solutions are sustained.	

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E 000	Initial Comments E000 Emergency Preparedness This facility is not in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilitites. The facility must submit a plan of correction to address the following concerns that pose no greater risk to resident health and safety than potential for causing minimal harm.	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or	E 004		3/15/19

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

Electronically Signed | 03/14/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315248	A. BUILDING **01** B. WING _____	**03/01/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND BEHAVIORAL AND NURSING CENTER	**99 MULFORD ROAD** **ANDOVER, NJ 07821**

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E 004	Continued From page 1 CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: A review of the facility's Emergency Preparedness Plan and Program (EPP) and interview, revealed that the facility failed to ensure the EPP was reviewed and updated at least annually as evidenced by the following: On 02/22/19 at 11:00 a.m., the facility's Maintenance Director stated in an interview that the EPP review/update was just done. At 12:30 p.m., the surveyor review of the facility's EPP and related documentation, revealed that there was no documented evidence that the facility's EPP was reviewed and updated in 2018. This issue was confirmed in an interview with the facility's Administrative Assistant at 1:00 p.m., in the presence of the facility's Maintenance Director, who indicated that this problem would be corrected. On 02/26/19, the facility provided	E 004	1. Resident affected by the deficient practice: The Emergency Preparedness Plan and Program was not reviewed and updated in and for the year of 2018. 2. Identify other residents who could be affected by the deficient practice: Non-review and update of the Emergency Preparedness Plan and Program could affect all residents. 3. What measures will be put into place or systemic changes made to ensure that	

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E 004	Continued From page 2 signed documentation which indicated the EPP was reviewed and updated in February 2019 but not in 2018. NJAC 8:39-31.2(e)	E 004	the deficiency would not recur: a. Review and assess periodically the Emergency Preparedness Plan and Program components including but not limited to the Facility Resource Directory, the Incident Response Guide, and the Job Action Sheets (“JAS”), and modify if needed. b. In-Service Department, in coordination with all departments, shall provide individual and team training on the Emergency Preparedness Plan and Program. c. In addition, the facility is to conduct an exercise on a quarterly basis. i. Establish an Exercise Committee and choose a chairperson. ii. Choose an incident from the facility’s Hazard Vulnerability Assessment. iii. Become familiar with the types of exercises and select one. iv. Establish the exercise objectives. v. Consider a disaster drill. vi. Incorporate Nursing Home Incident Command System (“NHICS”) forms. vii. Develop an evaluation strategy. viii. Conduct the drill/exercise. ix. Conduct an After Action Report and Improvement Plan. d. Make needed changes based on lessons learned.	

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E 004	Continued From page 3	E 004	4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: a. The Quality Assurance and Performance Improvement (“QAPI”) Committee will meet quarterly to oversee the implementation of the Emergency Preparedness Plan. b. Further, the QAPI Committee will review quarterly the results of the exercise / drill conducted and the recommended changes based on lessons learned. c. The Administrator, Chief Compliance Officer, Maintenance Director as well as Director of Nursing will annually review and sign the reviewed (and updated) Emergency Preparedness Plan and Program.	
K 000	INITIAL COMMENTS KOOO LIFE SAFETY CODE 101:2012 The facility is not in substantial compliance with the Minimum Life Safety Code requirements as surveyed under CMS-2786R.	K 000		
K 531 SS=D	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record.	K 531		3/15/19

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K 531	Continued From page 4 Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to comply with the annual inspection requirements of ASME A17.1 as evidenced by the following: On 02/22/18 at 11:00 a.m., a review of the facility elevator annual elevator Certificates of Operation for 2018, revealed that the buildings 3 elevator cars were not certified for operation in 2018. The elevators were last certified in 2017 as noted on the Certificate of Operation provided by the facility and dated 08/24/17. On 02/26/18 at 11:45 a.m., the facility Maintenance Director indicated in an interview, that the elevators were inspected by the Department of Community Affairs (DCA) code officials in November 2018 and that the Certificate of Operation was held-up due to an unpaid bill. On 02/26/18 at 12:35 p.m., the surveyor conducted a telephone interview with the DCA elevator code official who could not verify that an elevator inspection was done in 2018. The facility was unable to provide any evidence of annual inspection by DCA Code Officials. However, the facility did provide an elevator notice record that indicated that their	K 531	1. Resident affected by the deficient practice: The facility failed to comply with the annual inspection requirement of ASME A17.1 as it was revealed that the building's three (3) elevator cars were not certified for operation in 2018. 2. Identify other residents who could be affected by the deficient practice: All residents could be affected by the non-certification of the three (3) elevators. 3. What measures will be put into place or systemic changes made to ensure that the deficiency would not recur: The elevators will be inspected and certified yearly as noted on the Certificate of Operation by the Department of Community Affairs. Inspection fees will be	

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K 531	Continued From page 5 contracted vendor inspected the elevators on 11/25/18. NJAC 8:39-31.2(e)	K 531	paid in a timely manner to ensure that the requisite annual certification is obtained. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: a. The Director of Maintenance will provide the Administrator a copy of the paid bill and Certification of Inspection annually. b. Also, in addition to the minimum monthly inspection by the elevator service provider, the Q.A. Coordinator will quarterly ask the Maintenance Director for inspection reports and a certification that the minimum monthly inspection is being conducted to ensure that elevator inspection is in fact being completed and up to date.	