STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315279	A. Building B. Wing	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy Manor at Edison Nursing and Rehabilitation	10 Brunswick Avenue Edison, NJ 08817

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37217 Based on observation, interview, and record review, it was determined that the facility failed to a.) provide privacy and promote dignity during podiatry care for 3 of 3 residents observed (Residents #180, #205 and #264) and b.) provide care and services in a dignified and respectful manner during dining in 1 of 4 dining rooms observed. This deficient practice was evidenced by the following: 1. During the initial tour of the 2A unit on 2/21/23 at 11:13 AM, the surveyor observed the facility's podiatrist and his assistant enter Resident #205's room. Resident #205 was awake and seated in their wheelchair. The podiatrist sat on the floor in front of the resident, put on gloves and removed the resident's socks exposing the resident's toe nails. The Podiatrist opened a blue pad, chux (a disposable under pad) and placed it on the floor underneath the resident's feet. The door to the resident's room remained opened as the podiatrist performed toenail care to the resident which was visible to the surveyor in the hallway. The surveyor reviewed the medical records of Resident #205 which revealed the following: Resident #205 was admitted in December 2022 with diagnoses which included but were not limited to: Type 2 diabetes mellitus and cognitive communication deficit. Review of Resident #205's Admission Minimum Data Set (MDS), an assessment tool, dated 12/6/22 revealed that the resident had a Brief Interview for Mental Status (BIMS) of 3 out of 15 which indicated that the resident's cognition was severely impaired. On 2/21/23 at 11:27 AM, the surveyor observed the podiatrist enter Resident #264's room. Resident #264 was awake and in bed. The podiatrist put gloves on and introduced himself to the resident as the foot doctor. The podiatrist removed a blue pad from his bag and placed it under the resident's feet on the bed. The door to the resident's room remained opened as the podiatrist stood at the end of the resident's bed and performed toenail care to the resident which was visible to the surveyor in the hallway. The surveyor reviewed the medical records of Resident #264 which revealed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315279	A. Building B. Wing	03/10/2023

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #264 was admitted in June 2022 with diagnoses which included but were not limited to: Type 2 diabetes mellitus and Alzheimer's disease. Review of Resident #264's Quarterly MDS, dated [DATE], revealed that Resident #264 had short- and long-term memory impairments. On 2/21/23 at 11:31 AM, the surveyor observed the podiatrist enter Resident #180's room. Resident #180 was awake and seated in a wheelchair. The podiatrist sat on floor, put gloves on, unfolded a blue pad from his bag and put it down onto the floor under the resident's feet. The door to the resident's room remained opened as the podiatrist performed toenail care to the resident which was visible to the surveyor in the hallway. The surveyor reviewed the medical records of Resident #180 which revealed the following: Resident #180 was admitted in July 2022 with diagnoses which included but were not limited to Type 2 diabetes mellitus, and dementia. Review of Resident #180's Quarterly MDS dated [DATE], revealed that Resident #180 had BIMS of 3 out of 15 which indicated that the resident's cognition was severely impaired. During an interview with the surveyor on 2/21/23 at 11:36 AM, the podiatrist stated that he usually provided privacy during toenail care by pulling the curtain or sitting in front of the resident to block anyone from seeing, but acknowledged that he did not during those times. During an interview with the surveyor 3/2/23 at 9:40 AM, the Licensed Practical Nurse Unit Manager (LPNUM) #1 stated that the residents should be provided privacy during care, exams, and procedures for dignity of the resident. During an interview with the surveyor on 3/6/23 at 11:38 AM, the Director of Nursing (DON) stated the podiatrist should provide privacy during care. She stated that the Assistant Director of Nursing (ADON) and the Infection Preventionist (IP) had previously spoke to the podiatrist about privacy. 2. On 2/22/23 at 1:21 PM, the surveyor entered the 2A dining room. There were 10 residents present. The surveyor observed a certified nurses aide (CNA) #3 collect two unsampled resident's lunch trays (one after the other) and placed them on the food cart while talking on her cell phone. CNA #3 did not interact with the residents while approaching them to remove their lunch trays. CNA #3 saw the surveyor and put her phone down. At that time, the surveyor interviewed CNA #3 who stated she was on her phone because her son's daycare had called, and she had answered the phone in case it was an emergency. During an interview with the surveyor on 3/2/23 at 10:01 AM, the LPNUM #1 stated that CNAs should not be on their phones in the dining room. If there was an emergency, they should leave the resident area and come back after. During an interview with the surveyor on 3/6/23 at 11:50 AM, the DON stated that staff should not be on their cell phone in front of the resident because it was the resident's home. She added that the staff had been previously in serviced not to use cell phones during care or in the dining room. (continued on next page)

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	315279	A. Building B. Wing	03/10/2023

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility policy titled, Quality of life, dignity dated February 1, 2021, revised January 3, 2023, included but was not limited to; 1. Residents should be treated with dignity and respect at all times. 6. Resident's private space and property should be respected at all times. 10. Staff shall promote, maintain and protect resident privacy during assistance with personal care and during treatment procedures. Review of a facility policy titled, Cell Phone Usage (including texting, headsets, handsfree, IPADS, tablets, and any other electronic communication devices) dated February 1, 2021 and reviewed on January 26, 2023, included but was not limited to: 1. Employees are not permitted to use cell phones while on their individual work units. Incoming calls to employees should not be answered. If there is an emergency, the employee's family and friends should be instructed to call the main number to the facility. NJAC 8:39-4.1(a)(12)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315279	A. Building B. Wing	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 37547 Based on observation, interviews, review of the medical record and other facility documentation, it was determined that the facility failed to ensure that a resident's mattress was maintained in a clean, sanitary, and homelike manner on 1 of 8 nursing units (Memory Care Unit). This deficient practice was evidenced by: During the initial tour of the facility on 02/21/21 at 11:08 AM, the surveyor observed Resident #108 seated in a wheelchair at the bedside beside his/her bed which was stripped. The mattress was heavily stained and soiled, with deep creases noted to the upper portion of the mattress. There was a strong smell of urine in the resident's room. The resident appeared well groomed and dressed and was not able to be interviewed due to his/her cognitive status. The surveyor inspected the bathroom and trash cans in the room which did not contain any waste products that would have contributed to the odor in the room. During an interview with the surveyor on 03/01/23 at 11:39 AM, Certified Nursing Assistant (CNA) #2 stated that Resident #108 sometimes did not make it to the restroom in time and was incontinent. CNA #2 stated that the resident would remove the sheets off of the bed if they were wet and even attempted to place them in the soiled laundry. CNA #2 stated that housekeeping wiped the bed down prior to the CNA making the bed. During an interview with the surveyor on 03/02/23 at 12:49 PM, CNA #2 stated that she reported the condition of the resident's mattress and ensured that it was replaced with a new one as the old mattress was stained despite being sanitized daily by housekeeping. During an interview with the surveyor on 03/06/23 at 11:41 AM, Registered Nurse Unit Manager (RNUM) #1 stated that the CNA or Housekeeping should have told the nurse or called housekeeping who would switch out the resident's mattress. RNUM #1 stated that everything was done verbally by phone, but there was a book where staff could document concerns for maintenance to address. RNUM #1 reviewed the book in the presence of the surveyor and stated that she did not see that the soiled mattress was referenced for replacement. During an interview with the surveyor on 03/06/23 at 11:49 AM, Housekeeper #1 stated that she notified the [NAME] about the condition of Resident #108's mattress and requested that it be replaced. Housekeeper #1 stated that there was a brand new mattress in the resident's room now. During an interview with the surveyor on 03/06/23 at 12:17 PM, the [NAME] stated that he discarded Resident #108's soiled mattress in the garbage and replaced it with a new one. During an interview with the surveyor on 03/07/23 at 11:51 AM, the Infection Preventionist (IP) stated that Resident #108's mattress should have been discarded if it were stained and smelled of urine. The IP stated that the Housekeeper should have been notified and the mattress should have been discarded. The IP stated, the mattress was a harbor for bacteria. (continued on next page)

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	315279	A. Building B. Wing	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 03/10/23 11:24 AM, the District Manager (DM) and the Administrator were present. The DM stated that she had documentation to demonstrate that Resident #108's mattress was inspected in January and February. The surveyor presented the DM and the Administrator with a photograph of the resident's mattress for review. DM confirmed that there was visible staining and a white, chalky, raised residue was noted on the bottom portion of the mattress. The DM also stated that there was a visible crease on the mattress which could retain odors and harbor bacteria. The Administrator stated that the mattress was brown in color and the remainder of the mattresses at the facility were blue, so he was unable to determine the age of the mattress. The Administrator stated that he was unable to provide the surveyor with documented evidence that a staff member had reported a concern with the condition of the mattress prior to surveyor inquiry. The Administrator viewed the photo of the mattress once more and stated, That was a good call, that was a bad mattress. The Administrator was in agreement that the mattress should have been replaced for sanitary reasons. Review of the facility policy titled, Mattress Care (Reviewed 01/11/23) revealed the following: Policy: It is the policy of Embassy Manor to provide its residents with clean and comfortable bedding experience. Procedure: 1. C.N.A. (Certified Nursing Assistant) will strip the bed of any/all soiled linen 2. Housekeeper will remove the mattress from the bed and spray the frame down with a disinfectant. Housekeeper will allow for proper dwell time. 3. Spray the mattress front and back with proper disinfectant. Housekeeper will allow for the proper dwell time. 4. Housekeeper will wipe the mattress down with a clean rag from front to back. 5. Then spray the mattress again with the disinfectant and wipe again. 6. If there are any holes or worn indications please report to the Housekeeping Supervisor for replacement. NJAC 8:39-31.4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315279	A. Building B. Wing	03/10/2023

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45209 Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to develop a person-centered comprehensive care plan to address a resident's contracture for 1 of 3 Residents (Resident #77) reviewed for range of motion. This deficient practice was evidenced by the following: On 2/21/23 at 11:52 AM, Resident #77 was observed in wheelchair with their right hand contracted and bent at wrist with downward flexion. The resident was unable to follow commands. A review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate care, dated 1/22/23, identified the resident as severely impaired and with impairments on both sides of the upper and lower extremities. A review of the medical record indicated that Resident #77 was admitted to the facility with diagnoses which included, but not limited to: Hemiplegia (severe or complete loss of strength) and Hemiparesis (mild loss of strength) following nontraumatic subarachnoid hemorrhage (bleeding in the space that surrounds the brain) affecting the right dominant side. A review of Resident #77 care plan on 2/23/23 did not reflect this resident's contracture. During an interview with the surveyor on 3/2/23 at 11:51 AM, Licensed Practical Nurse (LPN) #1 confirmed that contractures should be identified on the care plan. During an interview with the surveyor on 3/2/23 at 12:09 PM, Registered Nurse Unit Manager (RNUM) #1 stated that contractures should be identified on the care plan, especially on the baseline care plan. Upon reviewing the Resident's electronic medical record, RNUM#1 confirmed that there was no care plan for contractures. During an interview with the surveyor on 3/8/23 at 1:05 PM, Assistant Director of Nursing (ADON) confirmed that Resident #77's contracture and interventions should have been identified on the care plan. A review of the facility's policy titled Care Planning for Long Term Care, with a reviewed date of 1/26/23, revealed under Policy that, The care plan is designed to ensure that residents receive appropriate care and treatment to address problems and needs on an ongoing basis. The goal of the care plan is to implement interventions that help achieve optimal outcomes, and to communicate and coordinate the support of resident needs and goals. (continued on next page)

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	315279	A. Building B. Wing	03/10/2023

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled Comprehensive Care Plan, with a reviewed date of 1/26/23, revealed under Policy that, The Comprehensive Care Plan includes the instructions needed to continue to provide effective and person-centered care that meets the professional standard of quality care. Each patient will have a person-centered comprehensive care plan that is developed and implemented to meet all of their preferences, goals and addresses all clinical, physical, mental and psychosocial needs. NJAC 8:39-11.2(d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315279	A. Building B. Wing	03/10/2023

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37217 Based on observation, interviews, and record review, it was determined that the facility failed to revise and update the care plan (CP) in a timely manner for residents who had falls. This deficient practice was identified for 2 of 35 residents reviewed for comprehensive care plans, (Residents #130 and #264) and was evidenced by the following: 1. On 2/21/23 at 11:22 AM, Resident #130 was observed sleeping in bed. According to the Admission Record, Resident #130 was admitted to the facility in July 2022 with diagnoses which included but were not limited to; unspecified dementia. Review of the Quarterly Minimum Data Set (MDS), an assessment tool dated, 2/13/23, revealed that the resident had a Brief Interview for Mental Status (BIMS) of 5 out of 15 which indicated that the resident had severely impaired cognition. Additional review revealed that the resident had a diagnosis of dementia, required extensive assist of one staff with transfers, and had two falls since the prior assessment. Review of an incident report (IR) dated, 1/11/23 at 8:25 AM, revealed that Resident #130 was observed lying on the floor next to their bed. Neurological checks were initiated, the resident denied pain and there were no visible injuries. The resident was seen by the Nurse Practitioner and orders were obtained for laboratory work, and bilateral hip and knee X-rays. Further review of the IR indicated an investigation was completed on 1/12/23. The investigation summary did not indicate if the care plan was revised or if an intervention was put into place after the fall. Review of the resident's CP included a focus dated 5/19/22 which indicated that the resident was at risk for falls due to confusion, gait/balance problems, incontinence, poor comprehension, unaware of safety needs and a history of falls. The goal was for the resident to be free from falls for 90 days. The care plan included interventions dated, 5/19/22, to anticipate and meet the resident's needs, ensure the resident was wearing appropriate footwear, encourage the resident to participate in activities, the call light was within reach, follow facility fall protocol, safe environment, referral to rehab. Additional interventions for rehab referral for post fall screening were dated 8/9/22, 10/10/22 and 11/28/22. There was no documented evidence that Resident #130's care plan was revised or updated with an intervention for the fall that occurred on 1/11/23. 2. On 2/21/23 at 11:27 AM, Resident #264 was observed awake and in bed. According to the Admission Record, Resident #264 was admitted to the facility in June 2022 with diagnoses which included but were not limited to; Alzheimer's disease. (continued on next page)

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	315279	A. Building B. Wing	03/10/2023

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Quarterly MDS dated [DATE], revealed that the resident had short and long term memory impairments, required extensive assist of one staff for bed mobility and transfers. Further review revealed that the resident did not have any falls since the last assessment. Review of an IR dated 1/4/23 at 5:30 AM, revealed the resident was observed sitting on the floor in their room with active bleeding from an opened area to the resident's left hand. A pressure dressing was applied, and the resident was transferred to the emergency room . A referral was made to rehab for a post fall evaluation upon return from the emergency room . Review of the Progress notes dated 1/5/23 at 5:37 PM, revealed the family had requested a bed alarm. Review of the resident's January 2023 Treatment Administration Record (TAR) revealed, bed alarm check for function every shift with a start date of 1/5/23. Review of Resident #264's CP revealed a focus dated 6/3/22 that the resident was at risk for falls related weakness of bilateral lower extremities. The goal date 6/3/22 was that the resident would not sustain serious injury through next review date. Interventions dated 6/3/22, included but were not limited to: anticipate and meet the resident's needs, call light within reach, ensure the resident is wearing appropriate footwear. Additional review of the CP revealed that the intervention for a rehab referral was added to the CP on 1/28/23 (24 days after the 1/4/23 fall) and the bed alarm was added to the CP on 2/9/23 (over a month after the 1/4/23 fall). During an interview with the surveyor on 3/2/23 at 09:40 AM, the Licensed Practical Nurse Unit Manager (LPNUM) #1 stated that the staff had a fall meeting after every fall to discuss interventions, and what could be done to prevent another fall. She stated the CP would be updated by the Assistant Director of Nursing (ADON), unit managers, or nurses. During a follow up interview with the surveyor on 3/3/23 at 11:49 AM, the surveyor reviewed Resident #130 and Resident #264's CP with the LPNUM #1. The LPNUM #1 stated there should be a CP intervention on Resident #264's 1/4/23 fall care plan. She stated Resident #130 may have had the same interventions in place. She stated resident falls were discussed in morning meeting to see if there were new interventions for the CP. She stated the CP may not be updated during the meeting, but would updated when interventions were in place. During an interview with the surveyor on 3/6/23 at 11:30 AM, the Director of Nursing (DON) stated that falls were discussed daily at morning meetings. Physical therapy would look at every fall and would do a screen and evaluation. She stated that the ADON was responsible for review of every fall investigation and update of interventions. She stated the ADON called staff to determine what happened and would put in the summary of the IR. The DON stated that every fall should have an intervention on the care plan. During an interview with the surveyor on 3/7/23 at 11:03 AM, the ADON stated falls were thoroughly discussed in the morning meeting, and that the Rehab Director would be present. She further stated falls were discussed to determine the cause, and then the resident's care plans were updated. The ADON stated she reviewed falls, and made sure the CP's were updated. (continued on next page)

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	315279	A. Building B. Wing	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy Manor at Edison Nursing and Rehabilitation	10 Brunswick Avenue Edison, NJ 08817

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the IR and careplans for Resident #130 and Resident #264 with the ADON. The ADON confirmed she did not see the interventions on the printed copy of the CP. The ADON went on the computer to review the CPs and stated the interventions for #264's fall on 1/4/23 was a referral to rehab but she did not click save on the CP so it did not go on to the CP timely. The ADON continued to look on the computer for interventions for Resident #130's 1/11/23 fall and confirmed she did not see that the CP was updated. She stated,interventions were aspirin on hold, reeducate immediately, kept in line of site, when in room increase supervision, and increased group activity. The ADON confirmed that those interventions were not on the CP or on the investigation summary and should have been. She stated the purpose of the investigation summary was to discuss what was done to prevent further falls. During a follow up interview with the surveyor on 3/8/23 at 11:02 AM, the ADON stated she was supposed to ensure that interventions were updated on the resident's CP timely. Review of the facility's Fall Prevention and Post Fall Management Policy, dated February 1, 2021 with a revised date of February 1, 2022 revealed, The Interdisciplinary Team (IDT) would review on admission, and update the resident's fall prevention care plan at least quarterly, whenever a significant change occurs and after a fall occurrence. Review of the facility's Care planning for Long Term Care Policy, dated February 1, 2021 with a reviewed date of January 26, 2023, revealed, Purpose: the care plan provides a systematic, comprehensive, and interdisciplinary method for the resident to identify treatment and care. Policy: The care plan is designed to ensure that residents receive appropriate care and treatment to address problems and needs on an ongoing basis. The goal of the care plan is to implement interventions that help achieve optimal outcomes, and to communicate and coordinate the support of resident needs and goals. NJAC 8:39-11.2(e)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315279	A. Building B. Wing	03/10/2023

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45209 Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to: a.) accurately transcribe a physician's order for enteral flushes for 1 of 2 residents reviewed for tube feeding (Resident #23), b.) accurately transcribe a physician's order for contractures for 1 of 3 residents reviewed for range of motion (Resident #77), c.) follow a physician's order for weekly weights for 1 of 5 residents reviewed for weights (Resident #183), d.) ensure urinary output was accurately documented in the medical record for 1 of 3 residents reviewed for foley catheters (Resident #199), and e.) ensure neurological assessments neuro checks were completed for 2 of 4 residents reviewed for accidents (Residents #130 and #264). This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1. On 2/24/23 at 9:33 AM, the surveyor observed Resident #23 in bed as staff entered room to perform morning care. A review of the Annual Minimum Data Set (MDS), an assessment tool used to facilitate care, dated 12/8/22, identified Resident #23 as severely impaired and dependent on staff for all aspects of care. A review of the medical record indicated that Resident #23 was admitted to the facility with diagnosis which included, but not limited to: Severe Intellectual Disability, Dysphagia (difficulty in swallowing) and Gastronomy Status (a tube inserted through the abdomen that brings food directly to the stomach). A review of the Order Summary Report (OSR) revealed an order to Flush GT/PEG Tube with 500mL of water every six hours. Flush GT/PEG Tube with an additional 100mL every shift, with a start date of 10/1/2021. The order was implemented with the specific administration times of 0900, 1200, 1700, 2100. A review of the corresponding February and March 2023 Medication Administration Record (MAR) revealed the above order with a check mark and the administrating nurse's initials. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315279	A. Building B. Wing	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy Manor at Edison Nursing and Rehabilitation	10 Brunswick Avenue Edison, NJ 08817

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the surveyor on 03/06/23 at 10:45 AM, Licensed Practical Nurse (LPN) #2 confirmed that medication orders should not be combined into one order but separate. During an interview with the surveyor on 03/06/23 at 10:50 AM, Licensed Practical Nurse Unit Manager (LPNUM) #1 stated that everyone had the responsibility of reviewing orders for accuracy when you give meds you review them. LPNUM #1 also confirmed that 24 hours chart checks were completed by the night shift. Upon reviewing the MAR, LPNUM #1 confirmed that the orders should be separated, and the identified hours were not spaced correctly to correlate every 6 hours. When asked what the dietitian's impression would be upon reviewing the MAR, LPNUM #1 stated, she would be under the impression that the nurses were giving all the hydration. When asked why having two separate orders for the flushes would be important LPNUM #1 responded, there is no way to determine if each flush was given. During an interview with the surveyor on 3/6/23 at 11:30 AM, the Registered Dietitian (RD) reported that she used the nurse's documentation in the progress notes and the MAR for her nutritional assessment. When asked how she determined if the residents received their hydration, the RD reported that she contacted the nurse and they confirm with the MAR. Upon reviewing Resident #23's MAR, the RD confirmed that she was under the impression that the resident was receiving both flushes. The RD also stated that hydration flushes are very specific, and this incorrect order was something that should have been brought to her attention. During an interview with the surveyor on 3/8/23 at 1:05 PM, the Assistant Director of Nursing (ADON) stated that the night shift was responsible for completing 24-hour chart checks and the unit manager was responsible for completing chart reviews. Upon reviewing Resident #23's MAR, the ADON confirmed that the orders should be separated. The ADON also confirmed it was not possible to determine if the resident had received the ordered hydration based on how it was transcribed on the MAR. 2. On 2/21/23 at 11:52 AM, Resident #77 was observed in the wheelchair with right their hand contracted and bent at the wrist with downward flexion. The resident was unable to follow commands. A review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate care, dated 1/22/23, identified the resident as severely impaired and with impairments on both sides of the upper and lower extremities. A review of the medical record indicated that Resident #77 was admitted to the facility with diagnosis which included, but not limited to: Hemiplegia (severe or complete loss of strength) and Hemiparesis (mild loss of strength) following nontraumatic subarachnoid hemorrhage (bleeding in the space that surrounds the brain) affecting right dominant side. A review of the Order Summary Report (OSR) revealed an order to separate digits at all times with gauze, with an order date of 1/26/23. A review of the corresponding February and March 2023 Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not reflect this order. On 2/24/23 at 9:54 AM, Resident #77 was observed without gauze between the fingers of either hand. On 2/28/23 at 10:25 AM, Resident #77 was observed without gauze between the fingers of either hand. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/2/23 at 10:07 AM, Resident #77 was observed without gauze between the fingers of either hand. On 3/6/23 at 11:44 AM, Resident #77 was observed without gauze between the fingers of either hand. On 3/8/23 at 11:16 AM, Resident #77 was observed without gauze between the fingers of either hand. During an interview with the surveyor on 3/6/23 at 10:45 AM, Licensed Practical Nurse (LPN) #1 confirmed that she did not have any orders for Resident #77 regarding contractures. During an interview with the surveyor on 3/2/23 at 12:09 PM, Registered Nurse Unit Manager (RNUM) #1 confirmed that the order was received to use gauze to separate the fingers. When asked if this order could be located on the MAR or TAR, the RNUM#1 responded, no. During an interview with the surveyor on 3/8/23 at 1:05 PM, the Assistant Director of Nursing (ADON) stated that the night shift was responsible for completing 24-hour chart checks and the unit manager was responsible for completing chart reviews. Upon reviewing Resident #77's MAR and TAR, the ADON reported that the orders were located on the OSR, so it will never transcribe over. When asked if this order should have been clarified, the ADON responded, yes, it should have. When asked if this order should have been transcribed to the MAR or TAR the ADON stated, yes . A review the facility Policy Titled Physician Orders, with Reviewed Date of 2/1/2023, revealed under Procedure that: 1.The discipline requesting the order will complete the appropriate request in its entirety in the electronic orders Portal and submit on behalf of the resident. 2.The nurse will notify the attending physician or physiatrist to ask for an order based on the disciplines request and then Confirm the orders in the Orders Pending Confirmation Tab. If the physician chooses not to give the order, the nurse must inform the discipline that requested the order. 4.Verbal telephone orders may only be received by licensed personnel (e.g RN, LPN, Physician, etc). Orders must be reduced to writing by the person receiving the order and recorded in the resident's medical electronic record. The entry must contain the instructions from the physician, date, time and the signatures and title of the person transcribing the information. 5.Upon receiving the telephone order, the nurse will transcribe the order in the electronic record, read the order back to the physician, sign with his/her name and document ordered by the physician's name, date, and time the order. 37217 3.On 2/22/2023 at 10:40 AM, Resident #183 was observed in bed sleeping. According to the Admission Record, Resident #183 was readmitted to the facility in 10/2022 with diagnoses which included but were not limited to; Type 2 diabetes mellitus and hypothyroidism. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Quarterly MDS dated [DATE], revealed that the resident had a Brief Interview for Mental Status (BIMS) of 15 out of 15, which indicated that the resident's cognition was intact. The MDS also revealed that the resident had a weight loss and weighed 146 pounds (lbs). Review of Resident #183's care plan, created on 3/30/22, revised 2/22/23, included that the resident was at risk for altered nutrition/hydration status related to abnormal labs and significant weight loss. An intervention created on 3/30/22 and revised on 2/22/23, included to monitor weights monthly and that the resident had a history of refusing weights despite encouragement and education. Review of the Registered Dietician's (RD) progress notes (PN) dated 11/18/22 included, to initiate weekly weights for four weeks to monitor. Review of a physician's order dated 11/18/22 with a start date of 11/22/22, revealed weekly weight for four weeks, one time a day, every Tuesday, for monitoring. Review of the Resident's November and December MAR did not reflect the 11/18/22 order for weekly weights. Review of Resident #183's weight summary report revealed a weight of 146.2 lbs documented on 12/9/23. There were no weekly weights documented as ordered for 11/22/22, 11/29/22, 12/6/22, and 12/13/22. During an interview with the surveyor on 3/2/23 at 9:50 AM, the LPNUM #1 stated the RD would recommend weekly weights, and would put an order in the computer. She stated the Certified Nurses Aides (CNAs) would obtain the weight, document the weight on paper and the RD would enter the weight in the computer. During an interview with the surveyor on 3/2/23 at 10:43 AM, the RD stated she would put in the order for weekly weights and provided a list to the CNAs and the unit managers. In the presence of the surveyors, the RD reviewed Resident #183's weights and progress notes. She stated that the resident's appetite improved, and the resident's weights were trending up. She confirmed that she did not see the November 2022 ordered weekly weights documented and would follow up. During an interview with the surveyor on 3/3/23 at 10:59 AM the Director of Nursing (DON), in the presence of the RD, stated that there was a documentation error when the RD put the order for weekly weights in the computer. The RD selected no documentation required which was why the order was on the physician order sheet (POS) only and not on the MAR where the nurses would see the order. The DON and RD confirmed there was no documentation of weights based on the order. The DON stated that there should have been documentation if resident refused to be weighed, but the order was only on the POS, it was an error, and the RD clicked the wrong thing. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Physicians Orders, revised on February 1, 2022, reviewed on February 1, 2023, included that it was the policy of Embassy Manor to receive requests/recommendations through electronic medical record, orders portal from dietary departments for patient/resident physician orders. Procedure: the discipline requesting the order will complete the appropriate request in it's entirety in the electronic Orders Portal and submit on behalf of the resident .A 24 hour check will be conducted so any transcription errors will be picked up, clarified and then corrected. Upon receiving the telephone order, the nurse will transcribe the order on the electronic record .It is the responsibility of the discipline requesting the order to assure that the order they have requested has been obtained in a timely manner. Review of a facility policy titled, Weights/Weight loss revised January 3, 2023, included Policy: In order to ensure an ongoing and accurate record of a resident's weight as part of the medical record .Procedure: 2. A monthly weight shall be obtained by the assigned certified nurses aide, under the supervision of the licensed nurse or RD. The certified nurses aide shall record the weight on the units monthly tracking sheet. The dietician shall then transcribe the weight on the electronic medical record. 3. A resident may be reweighed for various reasons, i.e significant changes in weight. This shall be recorded in the same manner as procedure #2. 4. On 2/28/23 at 10:35 AM, Resident #199 was observed sleeping in bed. The resident's foley catheter was draining amber colored urine. According to the Admission Record, Resident #199 was admitted to the facility in December 2022 with diagnosis which included but were not limited to: urinary tract infection. Review of the resident's Admission MDS dated [DATE], revealed that the resident had short and long term memory impairments, and had an indwelling catheter. Review of the resident's care plan dated 12/8/22, revealed that the resident had an indwelling catheter related to obstructive uropathy due to benign prostatic hyperplasia (enlarged prostate). Interventions included to monitor and document intake and output per facility policy. Review of the resident's Order Summary report included an order dated 12/15/22 to monitor urine output every shift for foley catheter. Review of the resident's February 2023 Medication Administration Record (MAR) included the aforementioned order. Additional review of the MAR revealed that 0 was coded as the output for the shift on the following dates and times: 2/6/23 night shift, 2/7/23 day and evening shift, 2/15/23 evening and night shift, 2/17/23 evening and night shift, 2/23/23 evening shift, 2/25/23 night shift, and 2/27/23 night shift. During an interview with the surveyor on 2/28/23 at 10:44 AM, Licensed Practical Nurse (LPN) #4 stated that the nurses entered the resident's output every shift in the Treatment Administration Record (TAR), and Resident #199 had urine output every shift. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the surveyor on 3/7/23 at 12:17 PM, Registered Nurse (RN) #2 stated nurses monitored and assessed foley catheters, and the urine in the urine bag. The CNAs emptied the urine from the foley bags and notified the nurses of the resident's output. The nurses then documented the output on the MAR. If there was 0 output, the nurse would notify the physician and obtain an order. During an interview with the surveyor on 3/7/23 at 01:03 PM, LPNUM #1 stated nurses observed the resident's foley catheter to make sure it was patent, flowing and there was a certain amount of urine each shift. She stated the CNA's emptied the urine and report the output to the nurse who would document the output on the MAR. The surveyor reviewed Resident #199's February 2023 MAR with LPNUM #1. LPNUM #1 stated, that no one should have a 0 documented, and that she would ask the nurse if the foley was already emptied prior to the documentation on the MAR or if the foley catheter was flushed. During an interview with the surveyor on 3/8/23 at 10:41 AM, the DON stated that nurses should monitor foley catheter output and document the output every shift. She stated the CNAs emptied the foley catheter, measured the output and notified the nurse who would document on the MAR. The DON stated Resident #199 always had urine output and was disappointed that the nurses did not document correctly. The DON stated LPNUM #1 was contacting the nurses for clarification. During an interview with the surveyor on 3/9/23 at 11:30 AM, LPN #5 stated Resident #199 always had urine output on the days she worked, but she inadvertently clicked 0 on the MAR. She stated it was a human error and if there was no output, she would have called the physician. Review of an employee statement form written by LPN #6, dated 3/8/23, revealed that LPN#6 was the assigned nurse for Resident #199 on 2/6/23 and that the resident's foley catheter was patent and draining urine. LPN #6 wrote that the resident had an output of 300 milliliters at the end of the shift, and LPN #6 mistakenly entered 0. Review of a facility's policy titled, Intake and output, effective February 1, 2021, with a reviewed date of January 26, 2023, included but was not limited to; Policy: Accurate intake and output shall be documented, when indicated by a resident's medical condition .Measure and record the amount of each voiding. If the resident has a catheter or other drainage collection device, empty at the end of each shift and record the amount. 5. a. On 2/21/23 at 11:22 AM, Resident #130 was observed sleeping in bed. According to the Admission Record, Resident #130 was admitted to the facility in July 2022 with diagnoses which included but were not limited to: unspecified dementia. Review of the Quarterly MDS, an assessment tool, dated 2/13/22, revealed that the resident had a BIMS of 5 out of 15 which indicated that the resident had severely impaired cognition. Additional review revealed that the resident had a diagnosis of dementia, required extensive assist of one staff with transfers, and had two falls since the prior assessment. Review of the resident's CP included a focus dated 5/19/22, that the resident was at risk for falls due to confusion, gait/balance problems, incontinence, poor comprehension, unaware of safety needs and a history of falls (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an incident report (IR) dated 11/26/22 at 4:00 PM, revealed that Resident #130 was observed lying on the floor on their right side, and the resident had a bump on their forehead. A cold compress was applied, vital signs were checked, neurological checks were initiated. The resident was assisted back to bed. Review of an IR dated, 1/11/23 at 8:25 AM, revealed that Resident #130 was observed lying on the floor next to their bed. The resident was unable to provide a description of the fall. Neurological checks were initiated, the resident denied pain and there were no visible injuries. Review the Neurological Flow Sheet indicated the following: Note: This checklist should be completed at the following intervals for follow up for all unwitnessed falls or falls in which head is struck, initial assessment followed by every 15 minutes x 4, every 30 minutes x2, every hour x2, once per shift for 72 hour[s]. Review of Resident #130's neurological assessment flow sheet's dated 11/26/23 and 1/11/23 revealed neurological assessments were completed for the first four hours after each fall, however there was no documented neurological assessments on the flow sheet for the interval of once per shift for 72 hours. b. On 2/21/2023 at 11:27 AM, Resident #264 was observed awake and in bed. According to the Admission Record, Resident #264 was admitted to the facility in 6/2022 with diagnosis which included but were not limited to: Alzheimer's disease. Review of the resident's Quarterly MDS dated [DATE], revealed that the resident had short and long term memory impairments, required extensive assist of one staff for bed mobility and transfers. Further review revealed that the resident did not have any falls since the last assessment. Review of Resident #264's CP revealed a focus dated 6/3/22 that the resident was at risk for falls related to weakness of bilateral lower extremities. Review of an IR dated 1/28/23 at 2:15 PM, revealed that the resident was observed sitting on the floor in front of their wheelchair in the dining room. The resident was unable to provide a description of the fall. Neuro checks were initiated and there were no injuries. The resident was assisted back to the wheelchair. Review of an IR dated 1/28/23 at 10:43 PM, revealed that the resident was observed sitting on the floor by the side of the wheelchair in the activity room. The resident was unable to provide a description of the fall. Neuro checks were initiated and there were no injuries. The resident was assisted to their wheelchair and to their bed. Review of Resident #264's Neurological Assessment Flowsheet dated 1/28/23, revealed that neurological assessments were completed from 2:15 PM though 8:15 PM. There was no further assessments documented on the flow sheet for the interval of once per shift 72 hours. During an interview with the surveyor on 3/2/23 at 10:12 AM, LPNUM #1 stated neurological assessment should be in the resident's chart. The surveyor reviewed Resident #130's and Resident #264's neurological flow sheets with LPNUM #1. The LPNUM #1 was unable to provide additional information. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the surveyor on 3/7/23 at 11:03 AM, the ADON stated neuro checks would be completed for unwitnessed falls and would be completed to identify any deficits. LPNUM #1 would be responsible to ensure completion. The surveyor reviewed Resident #130 and Resident #264's IRs and neurological assessments with the ADON. The ADON confirmed the assessments were incomplete. Review of a facility policy titled, Fall prevention and post fall management, revised February 1, 2021 included, if an unwitnessed fall occurs or there is a suspected head injury, or if ordered by a physician, a neurological evaluation status post fall will be completed. Documentation for neurological evaluation starts with the time of the fall. The neurological form must be completed. Neurological evaluation will be completed by a nurse only and documented as follows: Initial neurological evaluation includes: Vital signs, level of consciousness, orientation, pupillary reflexes, motor and sensory function. NJAC 8:39-11.2(b), 27.1(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37547 Based on observations, interviews, review of medical records and other facility documentation, it was determined that the facility failed to ensure a resident who was dependent on supplemental oxygen via a tracheostomy tube (a surgically created hole (stoma) in the windpipe (trachea)) received supplemental oxygen in accordance with physician orders for 1 of 2 residents reviewed for tracheostomy care (Resident #66). This deficient practice was evidenced by: During the initial tour of the building on 02/21/23 at 12:36 PM, the surveyor observed a stop sign posted outside of Resident #66's room which cautioned that an N 95 mask (filters 95% of particles) was required to enter the resident's room. From the doorway, the surveyor observed Resident #66 lying in bed asleep with the head of bed elevated. The resident had a tracheostomy tube and was noted to have a positive cough. According to the Admission Record (an admission summary) Resident #66 was readmitted to the facility in August of 2022 with diagnoses which included but were not limited to: Cerebral infarction (stroke), aphasia (a language disorder that affects a person's ability to communicate) respiratory failure, tracheostomy, gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), and gastroesophageal reflux disease without esophagitis (occurs when stomach acid repeatedly flows back into the tube connecting the mouth and stomach (esophagus)). Review of Resident #66's Annual Minimum Data Set (MDS), an assessment tool dated 02/25/23, revealed that the resident was rarely/never understood, had a memory problem and never/rarely made decisions. Further review of the MDS revealed that the resident was totally dependent with the assistance of two persons for both bed mobility and transfers and was totally dependent with assistance of of one person for feeding assistance. Further review of the MDS revealed that the resident received nutrition via a feeding tube and also received a mechanically altered diet (e.g. purred food, thickened liquids). The MDS specified that the resident received special treatments which included oxygen therapy, suctioning and tracheostomy care. Review of Resident #66's Care Plan (CP) revealed an entry initiated on 07/27/22 which detailed that the resident had a tracheostomy related to respiratory failure. Further review of the CP revealed an intervention that was also initiated on 07/27/22 for oxygen settings of eight liters per minute (lpm) via tracheostomy, humidified, suction as necessary and trach care every shift. Review of Resident #66's Order Summary Report revealed an entry dated 08/05/22 for O2 (oxygen) at eight lpm via trach collar continuously every shift for chronic respiratory failure. On 02/23/23 at 9:36 AM, the surveyor observed Resident #66 lying in bed awake with the head of bed elevated. The resident had a portable concentrator (medical device that delivers continuous, concentrated oxygen) that was set to deliver oxygen at 10 lpm. The resident was able to speak in short, simple sentences when spoken to and voiced no concerns. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/24/23 at 10:13 AM, the surveyor observed Resident #66 lying in bed asleep with the head of bed elevated. The oxygen concentrator was set at seven lpm via trach collar. On 02/28/23 at 11:21 AM, Resident #66 was observed lying in bed with the head of bed elevated and the resident's oxygen concentrator was set at seven lpm via trach collar. On 03/01/23 at 12:30 PM, Resident #66 was observed lying in bed asleep with the head of bed elevated and the resident's oxygen concentrator was set at seven lpm via trach collar. During an interview with the surveyor on 03/03/23 at 10:55 AM, Licensed Practical Nurse (LPN) #4 stated that Resident #66 was ordered continuous oxygen at eight lpm delivered via the concentrator. LPN #4 looked at the concentrator setting and agreed that the concentrator was set to deliver seven lpm instead of eight lpm of oxygen as ordered. LPN #4 then attempted to turn the dial to increase the oxygen setting from seven liters to eight but was unable to do so. LPN #4 stated that she would obtain a new concentrator. During an interview with the surveyor on 03/03/23 at 1:29 PM, the Director of Nursing (DON) stated that there was an order for Resident #66 to have oxygen at eight lpm and nursing was responsible to check the rate and ensure accuracy. During an interview with the surveyor on 03/06/23 at 11:15 AM, Registered Nurse Unit Manager (RNUM) #1 stated that oxygen orders were based on physician orders and nurses were required to round and ensure that the settings were maintained. RNUM #1 stated that she thought that Resident #66's oxygen order was changed to five lpm via concentrator after the weekend supervisor phoned the primary physician. On 03/06/23 at 12:09 PM, the surveyor observed Resident #66 lying in bed asleep with the head of bed elevated. The surveyor observed that the concentrator was placed in the corner of the room and was not in use. The resident had an air compressor (device used to deliver compressed air) on the night stand to the left of the resident that was set at 35% humidification and there was no concentrator beside the resident to deliver oxygen as described by RNUM #1. During an interview with the surveyor on 03/06/23 at 12:14 PM, LPN #4 stated that they had to change Resident #66's concentrator, so she changed it. LPN #4 stated that the resident's current oxygen order was for five lpm with 35% humidification. When the surveyor asked LPN #4 to demonstrate how the oxygen was delivered to the resident if the concentrator was not utilized she was unable to answer the question and instead stated, A technician set it up for us. During an interview with the surveyor on 03/06/23 at 12:48 PM, RNUM #1 accompanied the surveyor into Resident #66's room to view and clarify the resident's respiratory equipment against the current physician's order for five lpm of oxygen via trach collar continuously via compressor with 35% FIO2 (fraction of inspired oxygen). The RNUM #1 viewed the equipment and stated, I do not know why they set it up like that. RNUM #1 stated that she was unable to tell if the resident received five liters of oxygen as ordered. RNUM #1 stated that she would find out and report back to the surveyor. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 03/07/23 at 12:39 PM, RNUM #1 stated that when she saw Resident #66's order for five lpm of oxygen which did not match the respiratory equipment that was set up in the room she spoke with LPN #4 who informed her that a respiratory supply company technician came in and set it up that way. RNUM #1 stated that she informed LPN #4 that the resident had not received five liters of oxygen because the concentrator was in the corner of the room. RNUM #1 stated that the Assistant Director of Nursing (ADON) had the respiratory supply technician come back out to the facility last night (3/6/23). RNUM #1 explained that when the respiratory supply technician came to the facility initially, they did not bring the adapter (blue piece) that was required to connect the tubing from the concentrator to the compressor and they did not have the attachment either. RNUM #1 further stated the respiratory supply technician should have spoke with the nursing staff and confirmed the oxygen order prior to delivery and set up. RNUM #1 stated that a new concentrator was ordered because the oxygen level would rise and fall on its own and needed to be fixed. RNUM #1 stated, It was important that the resident received the right amount of oxygen because it helped you to breathe and without it, you could stop breathing. On 03/07/23 at 1:03 PM, Resident #66 was observed lying in bed awake with the head of bed elevated. The concentrator was set to deliver 5 lpm of oxygen and the compressor was set to deliver 35% humidification as described by RNUM #1 in accordance with the physician's order that was written on 03/05/23. During an interview with the surveyor on 03/08/23 at 11:16 AM, RN #1 stated that when he cared for Resident #66 over the weekend he was told in report that the resident had new equipment, a compressor, which delivered oxygen to the resident and had replaced the concentrator. RN #1 stated that he was unsure why the resident's equipment was changed. He stated that you could check the dial on the humidification bottle to determine if the settings were correct. During an interview with the surveyor on 03/08/23 at 11:16 AM, ADON stated that the respiratory supply company came to the facility on [DATE] to train the nursing staff regarding trach care as nursing was primarily responsible for trach care. The ADON stated that the plan was to wean Resident #66 from the oxygen for now and later from the trach. During a phone interview with the surveyor in the presence of the survey team on 03/08/23 at 1:27 PM, the Respiratory Therapist (RT), who was employed by the respiratory supply company, stated that she was asked to come out to the facility on [DATE] to perform a whole assessment to assess patient care, what they needed and to take an inventory of supplies. The RT stated that she did not see a problem with Resident #66's concentrator and made a recommendation to maintain the resident on five liters of oxygen with 35% humidification. The RT explained that she was not part of the compressor delivery. She stated that the compressor was air to bleed in oxygen, it was called an air compressor by definition. The RT stated that the concentrator was required in order to delivery oxygen. The RT stated that no concerns were noted as the resident was verbal, cooperative and was in no distress. During an interview with the surveyor on 03/10/23 at 10:19 AM, the DON stated that LPN #4 was not fully educated on the use of Resident #66's compressor prior to surveyor inquiry and required additional in-service training. Review of the facility policy titled, Oxygen Administration (02/01/21) revealed the following: (continued on next page)

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	315279	A. Building B. Wing	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy Manor at Edison Nursing and Rehabilitation	10 Brunswick Avenue Edison, NJ 08817

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: It is the policy of this facility to provide comfort to residents by administering oxygen when insufficient oxygen is being carried by the blood to the tissues. Procedure: Check physician's order for liter flow and method of administration .A reserve oxygen concentrator/oxygen tank should be available to provide continuity of care . For PRN oxygen order the nurse will provide the oxygen concentrator or tank when needed .Oxygen Concentrators: Set the flow meter to the rate ordered by the physician. Properly affix mask or cannula to concentrator. Unused concentrators will be kept in Central Supply . NJAC 8:39-11.2(b);27.1(a)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 37547 Based on interviews, review of the medical record and review of other facility documentation, it was determined that the facility failed to ensure a resident's medication times were adjusted to accommodate their dialysis schedule for 1 of 2 residents (Resident #71) reviewed for dialysis. This deficient practice was evidenced by the following: During the initial tour of the facility on 02/21/23 at 11:22 AM, the Licensed Practical Nurse (LPN) #3 informed the surveyor that Resident #71 had begun dialysis (the process of removal of excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally) approximately one month ago and was presently out of the facility for dialysis treatment. According to the Admission Record (an admission summary), Resident #71 was admitted to the facility in January of 2023 with diagnoses which included but were not limited to: End stage renal (kidney) disease, dependence on renal dialysis, anemia (a deficiency of red blood cells or of hemoglobin in the blood that results in pallor (pale appearance) and weariness, essential hypertension (high blood pressure), artherosclerotic heart disease (buildup of fats, cholesterol and other substances in and on the artery walls), and a nondisplaced fracture of the greater trochanter (located at the top of thigh bone, the widest part of the hip) of the left femur. Review of Resident #71's Admission Minimum Data Set (MDS), an assessment tool dated 01/10/23, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 which indicated that the resident's cognition was severely impaired. Further review of the MDS revealed that Resident #71 received dialysis treatments while a resident at the facility. Review of the Order Summary Report revealed a physician's order dated 01/06/23 for Dialysis three times per week on Tuesdays, Thursdays, and Saturdays at 10:25 AM, transport at 9:25 AM. Review of a Consultant Pharmacist (CP) Evaluation contained within Resident #71's paper chart revealed an entry dated 02/17/23, in which the CP recommended that the facility adjust the resident's medications for dialysis. Review of Resident #71's Medication Administration Record (MAR) dated 01/01/23-01/31/23 revealed the following: 1. Gabapentin Capsule 100 mg. Give 1 (one) capsule by mouth one time a day for Neuropathy (dysfunction of peripheral nerves causing numbness or weakness) for 1 (one) month with a start date of 01/25/23 and D/C (discontinue) date of 02/08/23. The medication was plotted on the MAR for administration at 9:00 AM, and all doses were charted as administered. 2. Auryxia Oral Tablet 1 (one) gm 210 mg (Fe) (Ferric Citrate, Iron) Give 1 (one) capsule by mouth three times a day for anemia. Start date 01/23/22 and D/C date 02/23/23. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The medication was plotted on the MAR for administration at 0900 (9 AM), 1300 (1 PM) and 1700 (5 PM). On Saturday 01/28/23 at 1300 the medication was charted as OO which indicated that the resident was Out on Pass. On Tuesday 01/31/23 at 1300, the status of the medication administration for this medication was not documented as evidenced by a blank space on the MAR. 3. Tylenol PM Extra Strength Tablet 500-25 mg (Diphenhydramine-Acetaminophen) (Sleep) Give 2 tablets by mouth four times a day for pain management Max-3 (three) grams acetaminophen/day from all sources. Start date 01/23/23 and D/C date 02/20/23. The medication was plotted on the MAR for administration at 0900 (9 AM), 1200 (12 PM), 1700 (5 PM) and 2100 (9 PM). On Saturday 01/28/23 at 1200 the medication was charted as OO which indicated that the resident was Out on Pass. On Tuesday 01/31/23 at 1200, the status of the medication administration for this medication was not documented as evidenced by a blank space on the MAR. 4. Heparin Sodium (Porcine, of a pig) Solution 5000 Units/ML Inject 5000 units subcutaneously every 8 (eight) hours for clotting prevention. The start date of the medication was on 01/25/23 and the D/C Date was on 02/20/23. The medication was plotted on the MAR for administration at 0600 (6 AM), 1400 (2 PM) and 2200 (10 PM). On Saturday 01/28/23 at 1400, the medication was charted as OO which indicated that the resident was Out on Pass. On Tuesday 01/31/23 at 1400, the status of the medication administration for this medication was not documented as evidenced by a blank space on the MAR. 5. Clonidine HCL Tablet 0.3 mg Give 1 (one) tablet by mouth every 8 (eight) hours for HTN (hypertension). Hold SBP (systolic blood pressure) less than 125. Start date 01/23/23 and D/C date 02/28/23. The medication was plotted on the MAR for administration at 0400 (4 AM), 1200 (12 PM) and 2000 (8 PM). On Saturday 01/28/23 at 1200, the medication was charted as OO which indicated that the resident was Out on Pass. On Tuesday 01/31/23 at 1200, the status of the medication administration for this medication was not documented as evidenced by a blank space on the MAR. Review of Resident #71's Medication Administration Record (MAR) dated 02/01/23-02/28/23 revealed the following: 1. Gabapentin Capsule 100 mg. Give 1 (one) capsule by mouth three times a day for Neuropathy for 1 (one) month until 03/08/23 at 07:43. Start date of 02/08/23 and D/C date of 03/06/23. The medication was plotted on the MAR for administration at 0900 (9 AM), 1300 (1 PM) and 1700 (5 PM). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On Thursday 02/09/23, Saturday 02/11/23, Thursday 02/16/23, Saturday 02/18/23 Tuesday 02/21/23, Thursday 02/23/23, and Saturday 02/25/23 at 1300, the medication was charted as OO which indicated that the resident was Out on Pass. 2. Auryxia Oral Tablet 1 (one) gm 210 mg (Fe) (Ferric Citrate, Iron) Give 1 (one) capsule by mouth three times a day for anemia. Start date 01/23/22 and D/C date 02/23/23. The medication was plotted on the MAR for administration at 0900 (9 AM), 1300 (1 PM) and 1700 (5 PM). On Thursday 02/02/23, Saturday 02/04/23, Tuesday 02/07/23, Thursday 02/09/23, Saturday 02/11/23, Thursday 02/16/23, Saturday 02/18/23, Tuesday 02/21/23, and Thursday 02/23/23 at 1300, the medication was charted as OO which indicated that the resident was Out on Pass. 3. Auryxia Oral Tablet 1 (one) gm 210 mg (Fe) (Ferric Citrate, Iron) Give 1 (one) capsule by mouth three times a day for anemia. Start date was 02/24/23 and the D/C date was 03/06/23. The medication was plotted on the MAR for administration at 0900 (9 AM), 1300 (1 PM), and 1700 (5 PM). On Saturday 02/25/23 at 1300, the medication was charted as OO which indicated that the resident was Out on Pass. 4. Heparin Sodium (Porcine, of a pig) Solution 5000 Units/ML Inject 5000 units subcutaneously every 8 (eight) hours for clotting prevention. Start date of the medication was on 01/25/23 and the D/C Date was on 02/20/23. The medication was plotted on the MAR for administration at 0600 (6 AM), 1400 (2 PM) and 2200 (10 PM). On Thursday 02/02/23, Saturday 02/04/23, Tuesday 02/07/23, Thursday 02/09/23, Saturday 02/11/23, and Saturday 02/18/23 at 1400, the medication was charted as OO which indicated that the resident was Out on Pass. 5. Heparin Sodium (Porcine) Solution 5000 Unit/ML Inject 1 ml subcutaneously every 8 (eight) hours for clotting prevention. The start date of the medication was on 02/20/23 and the D/C date was 03/06/23. The medication was plotted on the MAR for administration at 0600 (6 AM), 1400 (2 PM) and 2200 (10 PM). On Tuesday 02/21/23, Thursday 02/23/23 and Saturday 02/25/23 at 1400, the medication was charted as OO which indicated that the resident was Out on Pass. 6. Clonidine HCL Tablet 0.3 mg Give 1 (one) tablet by mouth every 8 (eight) hours for HTN. Hold SBP (systolic blood pressure) less than 125. Start date 01/23/23 and D/C date 02/28/23. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The medication was plotted on the MAR for administration at 0400 (4 AM), 1200 (12 PM) and 2000 (8 PM). On Thursday 02/02/23, Saturday 02/04/23, Tuesday 02/07/23, Thursday 02/09/23, Saturday 02/11/23, Thursday 02/16/23, Saturday 02/18/23, Tuesday 02/21/23, Thursday 02/23/23, and Saturday 02/25/23 at 1200, the medication was charted as OO which indicated the resident was Out on Pass. 7. Tobramycin Solution 0.3% Instill 2 (two) drop in left eye four times a day for Conjunctivitis (inflammation or infection of the conjunctiva of the eye) for 7 (seven) days. Start date 02/12/23. The medication was plotted on the MAR for administration at 0900 (9 AM), 1200 (12 PM), 1700 (5 PM) and 2100 (9 PM). On Thursday 02/16/23 and Saturday 02/18/23 at 1200, the medication was charted as OO which indicated that the resident was Out on Pass. 8. Tylenol PM Extra Strength Tablet 500-25 mg (Diphenhydramine-Acetaminophen) (Sleep) Give 2 tablets by mouth four times a day for pain management Max-3 (three) grams acetaminophen/day from all sources. Start date 01/23/23 and D/C date 02/20/23. The medication was plotted on the MAR for administration at 0900 (9 AM), 1200 (12 PM), 1700 (5 PM) and 2100 (9 PM). On Thursday 02/02/23, Saturday 02/04/23, Tuesday 02/07/23, Thursday 02/09/23, Saturday 02/11/23, Thursday 02/16/23, and Saturday 02/18/23 at 1200, the medication was charted as OO which indicated that the resident was Out on Pass. Review of Resident #71's Medication Administration Record (MAR) dated 03/01/23-03/31/23 revealed the following: 1. Gabapentin Capsule 100 mg. Give 1 (one) capsule by mouth three times a day for Neuropathy for 1 (one) month until 03/08/23 at 07:43. Start date of 02/08/23 and D/C date of 03/06/23. The medication was plotted on the MAR for administration at 0900 (9 AM), 1300 (1 PM) and 1700 (5 PM). On Thursday 03/02/23 at 1300, the medication was charted as OO which indicated the resident was Out on Pass. 2. Auryxia Oral Tablet 1 (one) gm 210 mg (Fe) (Ferric Citrate, Iron) Give 1 (one) capsule by mouth three times a day for anemia. The start date was 02/24/23 and the D/C date was 03/06/23. The medication was plotted on the MAR for administration at 0900 (9 AM), 1300 (1 PM), and 1700 (5 PM). On Thursday 03/02/23 at 1300, the medication was charted as OO which indicated the resident was Out on Pass. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Heparin Sodium (Porcine) Solution 5000 Unit/ML Inject 1 ml subcutaneously every 8 (eight) hours for clotting prevention. Start date of the medication was on 02/20/23 and the D/C date was 03/06/23. The medication was plotted on the MAR for administration at 0600 (6 AM), 1400 (2 PM) and 2200 (10 PM). On Thursday 03/02/23 at 1400, the medication was charted as OO which indicated that the resident was Out on Pass. Review of Resident #71's Order Summary Report provided by the Administrator on 03/07/23, which contained active orders as of 02/01/23, revealed the following Pharmacy Orders: 1. Gabapentin Capsule 100 mg Give 1 (one) capsule by mouth one time a day for Neuropathy. For 1 (one) month. 2. Auryxia Oral Tablet 1 (one) gm 210 mg (Fe) (Ferric Citrate) Give 1 (one) tablet by mouth three times a day for anemia. 3. Heparin Sodium (Porcine) Solution 5000 Unit/ML. Inject 5000 unit subcutaneously every 8 (eight) hours for clotting prevention. 4. Clonidine HCL Tablet 0.3 mg Give 1 (one) tablet by mouth every 8 (eight) hours for HTN (hypertension). Hold SBP <125 Monitor B/P per policy. 5. Tylenol PM Extra Strength Oral Tablet 500-25 mg Diphenhydramine-Acetaminophen (sleep) Give 2 tablets by mouth four times a day for pain management. Review of Resident #71's Care Plan revealed that the resident was ordered antibiotic therapy Tobramycin Solution 0.3% Instill 2 (two) drops in left eye four times a day for Conjunctivitis for 7 (seven) days on 02/13/23. Interventions included administer medications as ordered. During an interview with the surveyor on 03/02/23 at 1:01 PM, LPN #3 stated that Resident #71's medications were adjusted to correlate with the resident's dialysis schedule on Tuesday, Thursday, and Saturday as the resident was scheduled for transport at 9:25 AM and received dialysis treatment at 10:25 AM. LPN #3 further stated that the physician discontinued the resident's scheduled dose of Clonidine (medication used to treat high blood pressure) last week as the resident was out of the facility to dialysis when the medication was scheduled. LPN #3 further stated that the resident's blood pressure medications were administered at dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the surveyor on 03/06/23 at 10:58 AM, Registered Nurse Unit Manager (RNUM) #1 stated that the CP reviewed the resident's medications on a monthly basis and provided the Director of Nursing (DON) with the recommendations. RNUM #1 further stated that the DON then distributed the CP's recommendations to the unit managers. RNUM #1 stated that, A recommendation to adjust medications for dialysis indicated that the orders needed to be changed right away. RNUM #1 stated that oral medications scheduled for 9:00 AM were administered to Resident #71 at 8:00 AM before the resident left for dialysis. RNUM #1 stated that she spoke with the resident's primary physician during rounds regarding the resident's medication scheduling. RNUM #1 further stated that the DON had the documentation that directly related to the interventions that were implemented to the resident's medications in response to the CP recommendations. On 03/07/23 at 8:44 AM, the Administrator provided the surveyor with Resident #71's Consultant Pharmacist's Monthly Report which was dated 02/17/23 and revealed the following entry: A review of the Medication Administration Record indicated medication doses are being held due to the resident Out to dialysis. The times of administration should be modified to accommodate the needs of the resident. Please obtain a physicians order for changes in administration times. Review: Clonidine, Auryxia (medication that can lower the amount of phosphate in the blood for adults with chronic kidney disease who are on dialysis), gabapentin (nerve pain medication), heparin (anticoagulant used to prevent blood clotting), tobramycin (antibiotic), Tylenol PM (pain reliever, sleep aid). Further review of the Consultant Pharmacist's Monthly Report revealed a handwritten entry next to the recommendations which specified, Changed to accommodate dialysis days. During an interview with the surveyor on 03/07/23 at 11:01 AM, the CP stated that she visited the facility monthly and made recommendations based off review of the resident's Medication Administration Record (MAR). The CP stated that once the unit review was complete the office sent the report to the DON and Administrator to distribute to the unit managers. The CP stated that she reviewed the medical record on her next scheduled monthly visit to ensure the recommendations were addressed. The CP stated that she made recommendations for Resident #71 to ensure that the doses were given as ordered, rather than to reflect that they were going to be dialyzed out of the resident. During an interview with the surveyor on 03/08/23 at 11:25 AM, RNUM #1 stated that she first learned of the issue with Resident #71 who had not received his/her medications on dialysis days from the CP in February. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the surveyor on 03/09/23 at 11:33 AM, the DON stated that any resident who was on hemodialysis had to have their medications changed to match the dialysis days and times. The DON stated that if a medication was scheduled when the resident was out of the facility to dialysis, then the nurse had to call the doctor to obtain an order to change the time of administration to accommodate the resident's dialysis schedule. The DON stated that all nurses were trained to ensure that if a medication was missed, then they were required to call the doctor who would provide orders and instructions on how to proceed. The DON stated that the facility did not wait for the CP to review the resident's orders before they reviewed medications that were required to be administered on scheduled dialysis days. The DON stated the unit manager should have reviewed the medications when she initiated and prepared the resident's dialysis communication binder to ensure that the binder was complete and contained all related dialysis information. The DON stated that the nurses had a one-hour window of time to administer medications and if the medication was not administered within that time frame, then the nurse was required to notify the doctor. The DON further stated, If a medication was not administered, then you have to handle it immediately and ensure that the medications were given at alternate times when the residents are in the facility. Review of the facility policy titled, Dialysis-Care of the Patient Receiving (Reviewed 05/11/22) revealed the following: .Re-arrange medication and treatment times as needed to accommodate resident/patient being out of the building. NJAC 8:39-27.1(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46049 Based on observation, interview and policy review it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On [DATE] at 9:43 AM, the surveyor, in the presence of the Dietary Director (DD), observed the following during the kitchen tour: 1. In the food preparation area, Dietary Aide #1 and Dietary Aide #2 were observed wearing baseball caps with their hair at the back of the head exposed and were not wearing hairnets. The DD acknowledged the dietary aides should have been wearing hairnets. 2. In the food preparation area, Dietary Aide #2 was observed wearing a surgical mask above his chin area and his facial hair was exposed. The DD stated Dietary Aide #2 should have facial hair covered and provided a facial hair restraint to the dietary aide. 3. On a shelf in the walk-in refrigerator, the surveyor observed an 8-lb container of macaroni salad, which had a manufacturer's label that had a best used by date of [DATE]. The DD confirmed the date and stated the food item would be disposed. 4. On a shelf in the walk-in refrigerator, in a box containing cabbage, a half-cut head of cabbage wrapped in plastic, was observed undated and had an area that was grey in color to the cut side of the cabbage. The DD inspected the cabbage and stated it should be thrown away. On [DATE] at 10:25 AM, the Administrator provided the surveyor with the policy for expired foods and dietary personnel standards. The Administrator stated the macaroni salad was not being used as their menu had previously changed, and that the macaroni salad had not been thrown out at the time. The surveyor asked the Administrator how often and who was responsible for checking the refrigerated food items. The Administrator stated it was indicated in the policies provided. On [DATE] at 11:00 AM, the surveyor interviewed the DD about refrigerator storage being checked for expired items. The DD stated that himself or an assigned dietary staff would check for expired food items. The DD further stated they used a FIFO [First In, First Out] policy for food items stored. On [DATE] at 1:15 PM, the surveyor informed the Administrator, and the Director of Nursing of the above concerns. The surveyor reviewed the facility's policy titled, Personnel Standards with an effective date of February 2021. Under Procedure, it read All staff members will have their hair off the shoulders, confined in a hairnet or cap, and facial hair properly restrained. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor reviewed the facility's policy titled, Food Service with an effective date of [DATE]. The policy read Maintain a clean, safe, and sanitary storage for all items. Under Procedures, it read F-I-F-O (First In First Out) rule will be followed at all times and Put a date, label as necessary, all foods stored in walk-in refrigerators and freezers that are out of its original packaging from the time it was opened. The surveyor reviewed the facility's policy titled, Expired Foods with a revised date of [DATE]. The policy indicated The Dietary aide/designee will ensure proper dating for all food upon delivery and All expired food will be discarded immediately. The policy did not further address checking food item expiration dates. NJAC 8:,d+[DATE].2(g)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315279	A. Building B. Wing	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy Manor at Edison Nursing and Rehabilitation	10 Brunswick Avenue Edison, NJ 08817

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37217 Based on observation, interview, and record review, it was determined that the facility failed to a.) perform hand hygiene before and after podiatry care for 3 of 3 residents (Residents #180, #205 and #264). This deficient practice was evidenced by the following: 1.During the initial tour of the 2A unit on 2/21/23 at 11:13 AM, the surveyor observed the facility's podiatrist and his assistant enter Resident #205's room. Resident #205 was awake and seated in their wheelchair. The podiatrist sat on the floor in front of the resident, put on gloves and removed the resident's socks exposing the resident's toe nails. The Podiatrist opened a blue pad, chux (a disposable under pad) and placed it on the floor underneath the resident's feet. The door to the resident's room remained opened as the podiatrist performed toenail care to the resident which was visible to the surveyor in the hallway. After the podiatrist completed the resident's toenail care, the podiatrist folded the blue pad, stood up off the floor, removed his gloves and left the resident's room. There was no hand hygiene observed. The surveyor reviewed the medical records of Resident #205 which revealed the following: Resident #205 was admitted in 12/2022 with diagnoses which included but were not limited to; Type 2 diabetes mellitus and cognitive communication deficit. Review of Resident #205's Admission Minimum Data Set (MDS), an assessment tool, dated 12/6/22 revealed that the resident had a brief interview for mental status (BIMS) of 3 which indicated that the resident's cognition was severely impaired. On 02/21/23 at 11:27 AM, the surveyor observed the podiatrist enter Resident #264's room. Resident #264 was awake and in bed. The podiatrist put gloves on and introduced himself to the resident as the foot doctor. The podiatrist removed a blue pad from his bag and placed it under the resident's feet on the bed. The door to the resident's room remained opened as the podiatrist performed toenail care to the resident which was visible to the surveyor in the hallway. After the podiatrist completed the resident's toenail care, the podiatrist folded the blue pad and placed it back into his bag, removed his gloves and left the resident's room. There was no hand hygiene observed. The surveyor reviewed the medical records of Resident #264 which revealed the following: Resident #264 was admitted in 6/2022 with diagnoses which included but were not limited to, Type 2 diabetes mellitus and Alzheimer's disease. Review of Resident #264's Quarterly MDS, dated [DATE], revealed that Resident #264 had short- and long-term memory impairments. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315279	A. Building B. Wing	03/10/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/21/23 at 11:31 AM, the surveyor observed the podiatrist enter Resident #180's room. Resident #180 was awake and seated in a wheelchair. The Podiatrist touched resident's hand to greet the resident and explained to the resident that he would look at their feet. The podiatrist sat on floor, put gloves on, unfolded a blue pad from his bag and put it down onto the floor under the resident's feet. The door to the resident's room remained opened as the podiatrist performed toenail care to the resident which was visible to the surveyor in the hallway. After the podiatrist completed the resident's toenail care, the podiatrist folded the blue pad, discarded it, removed his gloves and left the resident's room. There was no hand hygiene observed. The surveyor reviewed the medical records of Resident #180 which revealed the following: Resident #180 was admitted in 7/2022 with diagnoses which included but were not limited to Type 2 diabetes mellitus, and dementia. Review of Resident #180's Quarterly MDS dated , 1/4/23, revealed that Resident #180 had a BIMS of 3 which indicated that the resident's cognition was severely impaired. During an interview with the surveyor on 2/21/23 at 11:36 AM, the podiatrist stated he kept hand sanitizer in his bag and would do hand hygiene after care. The podiatrist acknowledged that he did not perform hand hygiene in between the three residents. During an interview with the surveyor 3/2/23 at 9:40 AM, Licensed Practical Nurse Unit Manager (LPNUM) #1 stated that hand hygiene should be performed before and after resident care for infection control. During an interview with the surveyor on 03/06/23 at 11:38 AM the Director of Nursing (DON) stated the podiatrist should perform hand hygiene because of infection control. She stated that the Assistant Director of Nursing (ADON) and the Infection Preventionist (IP) had previously spoke to the podiatrist about hand hygiene. During an interview with the surveyor on 03/08/23 at 01:19 PM, the IP stated that she and the ADON had previously went over hand hygiene, use of the blue pad (chux), with the podiatrist. She stated between each resident the podiatrist should perform hand hygiene for infection control because he touched toes, and the blue pad (chux) should be individualized for infection control. Review of a facility policy titled, Handwashing and hand hygiene purposes, dated 2/2021, revised on 2/2022, included but was not limited to; It is the policy of Embassy Manor that hand washing and hand hygiene will be performed in accordance with the Center of Disease Control (CDC) Guidelines. Definitions: Hand hygiene cleansing the hands with facility-approved alcohol- based antimicrobial hand cleanser. Procedure: Hand washing and hand hygiene indications. 1. The use of gloves does not eliminate the use of hand hygiene. 2. Indications for hand washing and hand hygiene include, but are not limited to the following: After situations during which microbial contamination of hands is likely to occur, especially those involving contact with mucous membranes blood or body fluid secretions or excretions .Before and after performing invasive procedures .After removing gloves. Handwashing Method: Scrub the hands for at least 20 seconds. NJAC 8:39-19.4(a)