| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| SPRING GROVE REHABILITATION AND HEALTHCARE CENTER | 144 GALES DRIVE NEW PROVIDENCE, NJ 07974 |

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| F 000 | INITIAL COMMENTS<br><br>COMPLAINT #: NJ00141821; NJ00144873;<br><br>CENSUS: 86<br><br>SAMPLE: 23 + 18<br><br>A Recertification Survey and a Complaint Visit Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. | F 000 | | |
| F 604 SS=D | Right to be Free from Physical Restraints<br>CFR(s): 483.10(e)(1), 483.12(a)(2)<br><br>§483.10(e) Respect and Dignity.<br>The resident has a right to be treated with respect and dignity, including:<br><br>§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).<br><br>§483.12<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(2) Ensure that the resident is free | F 604 | | 6/20/21 |

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

Electronically Signed | 06/25/2021

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| F 604 | Continued From page 1<br>from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure: a.) a resident in a broda chair was not positioned in a manner in which the broda chair acted as a physical restraint. This deficient practice was identified for 1 of 6 residents reviewed observed to be in broda chairs (Resident #34).<br><br>The evidence was as follows:<br><br>According to the facility's undated Use of Restraints policy included that, "Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls... 'Physical Restraints' are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that the resident's physical condition (i.e. side rails are put back down, rather than climbed over); and this restricts his/her typical ability to change position | F 604 | 1. Broda Chair for Resident #34 was discontinued on 5/26/21,<br><br>2. Resident using Broda Chairs have the potential to be affected<br><br>3.<br>A.Interdisciplinary team met on 5/28/21 and reviewed residents in Broda chairs for appropriateness..<br>B. Licensed Nurse were in-serviced on the policy and procedure for use of restraints by 6/20/21.<br>C. Interdisciplinary team will assess residents prior to implementing use of Broda chair.<br>D. Interdisciplinary team will meet monthly to review continued use of Broad chairs.<br><br>4. A. Director of Nursing or designee will conduct audits on resident using Broda weekly for 4 weeks and then monthly for 3 months to ensure continued use is warranted.<br>B. Results of the audits will be reported to the QA committee Monthly.<br>C. The QAPI Committee will make recommendations based upon the results | |

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| F 604 | Continued From page 2<br>or place, that device is considered a restraint...Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including: ...placing a resident in a chair that prevents the resident from rising; and placing a resident who uses a wheelchair so close to the wall that the wall prevents the resident from rising. ...Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints...to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve symptoms... Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor)."<br><br>On 5/24/21 between 11:53 AM to 12:04 PM, two surveyors observed Resident #34 sitting in a Broda wheelchair (a specialized low-sitting recliner that has the ability to tilt in space and is typically used for positioning and comfort tension) in the common dining/activity area in front of the nursing station. The Broda chair had wheels that were in the locked position, and the resident was sitting in front of a dining table that was positioned against an affixed half wall. The surveyor observed the resident swing his/her legs over the arm rests of the broda chair in an attempt to get out of the broda chair. Because of the locked broda chair that was positioned against the affixed half wall, it prevented the resident from standing. The surveyor then observed the resident swing his/her legs on the other side of the arm rest. During that time, a staff member repositioned the resident in the locked broda chair and kept the resident in front of the table. The resident continued attempting to move their | F 604 | of the audits.<br>D. The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. | |

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legs over the edge of the arms of the Broda chair and the resident was unable to stand.

The resident was not offered an opportunity to stand up with assistance or ambulate when he/she attempted to swing his/her legs on either side of the broda chair.

The surveyor observed the resident eat his/her lunch meal from at 12:12 PM when the meal trucks arrived to approximately 12:40 PM at the table in the locked broda chair. At that time, the surveyor attempted to interview Resident #34, but the resident did not respond in English.

The surveyor reviewed the medical record for Resident #34.

A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected the resident was not able to complete a brief interview for [redacted] (BIMS). The staff performed a [redacted]

In addition, the MDS reflected that the resident had functional abilities that required extensive assist with one person assisting to walk in the corridor and on the unit. In addition, the resident had no functional limitation in range of motion (ROM) and no impairment to the upper or lower extremities. According to the MDS, the resident had a walker as a mobility device. A review of the section to assess for the use of restraints, reflected that the resident utilized no physical restraints, including the use of a chair that

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prevents rising.

A review of the resident's Admission Record face sheet (an admission summary) revealed the resident had a diagnosi [redacted]

A review of the resident's interdisciplinary care plan (IDCP) revealed that the resident had a focus of being [redacted] In addition, the IDCP reflected that the resident kept trying to get out of bed and chair unassisted with a date initiated of [redacted]. The interventions that were initiated on [redacted] included to keep frequently used items within reach and anticipate and meet the resident's needs. The interventions initiated [redacted] were to allow the resident to sit by the nursing station and if restless ask the resident if toileting was needed. An intervention dated 5/3/21 was to remind the resident to use the rolling walker. The resident also had a focus of limited physical mobility related to weakness initiated 3/22/21 and a goal of increasing mobility by being able to ambulate 100 feet using the rolling walker with a target date of 6/15/21. The resident also had a focus of using [redacted] related to an [redacted] with a date [redacted] and an intervention of having someone sit with the resident when the resident was anxious and provide time for the resident to discuss feelings. The resident had an intervention initiated [redacted] to use a Broda chair when the resident was tired.

A review of the medical record revealed that there was no assessment or consent providing risks versus benefits for the use of a Broda chair.

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| F 604 | Continued From page 5<br>A review of the physician Order Listing revealed a physician's order (PO) dated [Executive Order 26] for an Occupational Evaluation and treatment: [Executive Order 26, 4.b] date. In addition, there was a PO dated [Executive Order 26] for discontinuation of PT. There was no PO for the use of a Broda chair.<br><br>On 5/27/21 at 9:22 AM, the surveyor observed Resident #34 sitting in a standard wheelchair. At that time a Certified Nursing Aide (CNA) stated to the surveyor that Resident #34 had asked her to use the bathroom in his/her primary language. She stated that the resident used to be in a broda chair but was re-evaluated and was now using a regular wheelchair. The CNA continued that the resident was a [Executive Order 26, 4.b] and kept trying to stand up throughout the day. At that time, the surveyor observed the CNA assist the resident to a standing position, and had the resident hold on to the handle bars of the standard wheelchair. The resident ambulated by pushing the wheelchair in front of him/her to the bathroom with the CNA providing contact guard supervision.<br><br>On 5/28/21 at 11:01 AM, the surveyor observed the resident sitting in the standard wheelchair in front of a table in the common area by the front of the nursing station. The surveyor attempted to interview the resident and the resident did not respond appropriately.<br><br>On 5/28/21 between 11:06 AM and 11:17 AM, the surveyor interviewed the resident's family representative (FR) who stated that the resident had [Executive Order 26, 4.] , spoke mostly [Executive Order 26, 4.] and [Executive Order 26, 4.] . The FR also stated that the resident had a [Executive Order 26, 4.b] when he/she stood up and went to use another resident's rolling walker. The | F 604 | | |

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FR added that the resident had been using a walker and Executive Order 26, 4.b. [redacted]

On 6/2/21 at 9:38 AM, the surveyor interviewed the Temporary Nursing Aide (TNA) who stated that he was familiar with Resident #34 when he had to monitor the common dining/activity area in front of the nursing station. The TNA stated that the resident frequently tried to stand up and walk on his/her own when it wasn't safe for him/her to do so. The TNA stated that he could speak some [redacted] and would try to engage the resident in an activity when that occurred.

On 6/2/21 between 9:40 AM to 9:46 AM, the surveyor observed a CNA propelling the resident in a wheelchair to the resident's room and asking in [redacted] if the resident had to go to the bathroom. The surveyor observed the resident shake his/her head no in response. The CNA then asked in [redacted] if the resident was cold and held up a sweater. The surveyor observed the resident shake his/her head in a yes response. The surveyor observed the CNA help the resident put on the sweater. The surveyor observed the CNA propel the resident in the wheelchair to the common dining/activity area by the nursing station and placed the resident in the wheelchair at a table with another resident sitting at the same table.

On 6/2/21 at 9:46 AM, the surveyor interviewed the CNA who stated that she was the usual CNA for Resident #34 and was familiar with the resident. The CNA stated that the resident tries to stand up and walk on his/her own. The CNA added that she would assist the resident walking and sometimes had the resident use a rolling

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| F 604 | Continued From page 7<br>walker or hold onto the back of the wheelchair. The CNA also stated that the resident had been receiving Executive Order 26, 4.b. and thought the resident was still receiving Executive. The CNA stated that the resident usually sat in a wheelchair. The CNA also stated that she had seen the resident in a Broda wheelchair a few times when she came on shift at approximately 7 AM. The CNA added that the resident sometimes had trouble sleeping and would get up at night so the night shift would put the resident in a Broda wheelchair when the resident had not wanted to go back to bed. The CNA added that she knew about the resident having trouble sleeping because the night shift would report the reason for the resident being in the Broda chair. The CNA stated that the Broda chair was a low-sitting recliner and was more comfortable. The CNA then stated that when the resident was in the Broda chair in the morning she would switch the resident to a standard wheelchair if agreeable or would walk the resident and then put the resident in a standard wheelchair. The CNA stated that the resident was usually in a standard wheelchair and several staff members would walk the resident.<br><br>On 6/2/21 at 10:01 AM, the surveyor observed the Registered Nurse (RN) assisting the resident to walk around the common dining/activity area.<br><br>On 6/2/21 at 11:17 AM, the surveyor observed the resident sitting in a standard wheelchair at a table with two other residents in the common dining/activity area.<br><br>At that time, the resident slowly stood up and an alarm sounded. The Activity Director responded to the alarm and went to the resident and helped the resident back to his/her standard wheelchair. | F 604 | | |

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| F 604 | Continued From page 8<br><br>On 6/2/21 at 11:29 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that she was familiar with the resident and that the resident liked to walk around a lot and needed assistance when walking. The LPN stated that she was unsure if the resident used a rolling walker. The LPN added that the resident had not been using a Broda wheelchair and usually sat in a standard wheelchair. The LPN also stated that she thought the physical therapy/occupational therapy (PT/OT) department decided which kind of chair was appropriate for a resident.<br><br>On 6/3/21 at 10:02 AM, the surveyor interviewed the Occupational Therapist (OT) who stated that she was familiar with the resident. The OT added that she was responsible for wheelchair management. The OT stated that the resident received PT/OT from Executive Order 26, 4.b.. The OT added that the resident was Executive Order 26, 4.b. Executive Order 26, 4.b. because the resident had reached maximum goals. The OT also stated that she thought the resident was sitting in a Broda wheelchair after the resident Executive Order 26, 4.b. The OT reviewed the PT/OT notes and was unable to define a date that the resident was assessed for the use of a Broda chair. The OT stated that there was a Executive Order 26, 4.b. done by OT on Executive Order and thought the resident was in a Broda chair because the notes indicated that the resident had balance and positioning difficulties. The OT acknowledged that the OT notes had not reflected whether a Broda wheelchair was being used or an assessment for its use. The OT added that on Executive Order 26, there was an assessment that the resident was evaluated for use of a standard wheelchair because the resident had improved sitting ability and positioning and balance had | F 604 | | |

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improved. The OT could not speak to the need for a PO from the physician.

A review of the resident's OT Executive Order 26, 4.b. Summary dated Executive Order 26, 4.b. reflected that the Executive Order 26, 4.b. recommendation was a restorative nursing program (RNP) and the resident can safely complete functional transfers with supervision and minimal verbal cues. In addition, the Executive Order 26, 4.b. Summary reflected that the CNA and nursing was educated. There was no assessment for the use of a Broda wheelchair.

A review of the PT Executive Order 26, 4.b. Summary dated Executive Order 26, 4.b. reflected that the Executive Order 26, 4.b. recommendation was that a restorative program was established and trained. The PT Executive Order 26, 4.b. Summary reflected that the resident was able to ambulate around the unit using a rolling walker with supervision. There was no assessment for the use of a Broda chair.

A review of the Executive Order 26, 4.b. reports for the last six months reflected that the resident had Executive Order 26, 4.b..

On 6/3/21 at 9:55 AM, the Regional Director of Operations informed the surveyor that Resident #34 began using the Broda chair when the care plan indicated that he/she was supposed to use it when it was initiated on Executive Order 26. She confirmed there was no formal assessment for the Broda chair, and no consent was provided to the surveyor.

At 12:18 PM, the Regional Director of Operations stated in the presence of the survey team that the broda chairs were not used as a restraint to keep anyone from standing up. The facility

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| F 604 | Continued From page 10<br>administration including the Licensed Nursing Home Administrator and the Director of Nursing (DON) acknowledged that if a broda chair was locked in front of a table positioned against a wall, and the resident had the capability of standing up, it could prevent the resident from standing and result in a physical restraint for the resident. On [redacted] when the resident was attempting to stand out of the broda chair, he/she was not offered an opportunity to ambulate, but instead repositioned in the chair. The Regional Director of Operations stated that it wasn't purpose to restrain the resident when the two surveyors observed the resident trying to get out of the locked broda chair when it was against the table on [redacted], and indicated that because it wasn't intended to be used as a restraint, it wasn't a restraint.<br><br>NJAC 8:39-27.1(c)(3) | F 604 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>NJ00141821<br><br>Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to: a.) toilet a resident who was dependent on staff upon their request in a timely manner, b.) ensure an appropriate care plan for the resident's activities of daily living (ADL) toileting status, and c.) apply | F 677 | 1. Resident [redacted] was discharged from the Facility.<br><br>Broda Chairs for residents [redacted] and [redacted] were discontinued on [redacted]<br><br>Adjustable Table was obtained on [redacted] | 6/27/21 |

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| F 677 | Continued From page 11<br>a barrier cream to prevent skin breakdown due to incontinence. This deficient practice was identified for 1 of 6 residents reviewed for ADL services (Resident #74). In addition, the facility failed to ensure table heights were of the appropriate level for residents eating in low-sitting broda chairs. This deficient practice was identified for 5 of 5 residents reviewed in Broda Chairs (Resident #9, #25, #34, #40 and #74) on 1 of 2 units [redacted] unit).<br><br>The evidence was as follows:<br><br>1. On 5/24/21 from 9:30 AM to approximately 1:15 PM during the initial pool/tour process, two surveyors interviewed two residents who requested to remain anonymous. One resident stated that staff are attentive to his/her needs, but residents that have dementia have to wait longer to get care. Another resident stated that sometimes during the night shift it takes up to two hours to get assistance. The resident denied an adverse outcome from having to wait two hours for assistance.<br><br>On 5/24/21 at 11:56 AM, the surveyor observed Resident #74 sitting in a broda chair at the nurses station. After finishing a four ounce cup of water that a Registered Nurse (RN) provided to the resident, the resident began reaching in the sky and began trying to maneuver the broda chair to turn.<br><br>At 12:07 PM, the surveyor observed that the resident was still in the dining room. At that time, the surveyor observed the resident attempt to stand up from the broda chair, and the Certified Nursing Aide (CNA) redirected the resident to sit back down. After the resident sat back down, the | F 677 | 2. All Residents have the potential to be affected.<br><br>3.<br>A. Interdisciplinary team met on [redacted] and reviewed residents in Broda chairs for appropriateness..<br>B. Nursing staff were in-serviced on responding to resident needs by 6/27/21.<br>C. Nursing staff were in-serviced on policy and procedure for restraints by 6/20/21.<br>D. Interdisciplinary was in-serviced on ensuring care plans are updated with changes timely 6/20/21.<br>E. MDS Coordinator will audit incontinent residents to ensure appropriate care pan is in place by 6/25/21.<br>F. Administrator or designee will make rounds weekly during meals to ensure table heights are appropriate for each resident.<br><br>4<br>A. Director of Nursing or designee will conduct audits on resident using Broda Chairs weekly for 4 weeks and then monthly for 3 months to ensure continued use is warranted.<br>B. Administrator will audit 10 dependent residents via resident interview weekly to ensure their requests are being met timely.<br>C. Results of the audits will be reported to the QA committee monthly<br>D. The QAPI Committee will make recommendations based upon the results of the audits. | |

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| F 677 | Continued From page 12<br>CNA propelled the resident in the broda chair to the center isle of the open dining room and two staff members moved a dining table in front of the resident.<br><br>At 12:13 PM, the surveyor continued to observe Resident #74 in the locked broda chair. The resident pushed forward on the table, causing the table to move forward slightly. Then, Resident #74 began slowly sliding down in the broda chair, and two staff repositioned the resident back up in a seated position in the broda chair. At that time, the Registered Nurse/Unit Manager (RN/UM) asked the resident's assigned CNA to toilet the resident.<br><br>At 12:16 PM, the surveyor observed Resident #74 still in the broda chair at the dining table. A Speech Language Pathologist (SLP) sat next to the resident at the table and began talking to him/her. At that time, the SLP called over the resident's assigned CNA to tell the CNA that Resident #74 was requesting to use the bathroom. The CNA replied to the SLP that she had just finished washing her hands and that she was about to pass out the lunch trays so she was not available to assist the resident to the bathroom. The CNA continued to pass out lunch trays to the other residents. (The CNA never told the SLP that she had just toileted the resident with the RN before the lunch trays came). The SLP then informed the resident's assigned Registered Nurse (RN) that Resident #74 had informed him that he/she had to use the bathroom. The RN addressed the SLP, and she proceeded to assist in the lunch service. The SLP observed that the resident was sliding out of the broda chair and two staff repositioned the resident to sit him/her into an upright position. | F 677 | E. The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. | |

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The resident was seated at a table without other residents.

At 12:25 PM, the surveyor observed an Activities Assistant place the resident's lunch tray in front of Resident #74 which included macaroni and cheese, chopped carrots, and mandarin oranges. The Activities Assistant opened a can of gingerale and placed it next to the resident's plate. The surveyor observed the resident eat some chopped carrots with his/her hand. The resident then reached for the gingerale and poured it all over his/her macaroni and cheese. The resident had not yet been taken to be toileted after his/her request.

At 12:31 PM, the surveyor observed the resident pick up a fork and throw it on the floor.

At 12:34 PM, the surveyor observed the Food Service Director (FSD) deliver another tray for the resident which included a hot dog on a bun.

At 12:39 PM, the SLP sat with the resident and attempted to encourage the resident to eat the cut up hot dog. The resident did not show interest in eating.

At 12:54 PM, the surveyor observed a staff member clean up the resident's lunch area. The resident had not yet been toileted by staff after he/she requested to use the bathroom at 12:16 PM, (This was a period of 38 minutes from the time the resident requested it, and 41 minutes since the RN/UM had asked the CNA to toilet the resident).

At 12:55 PM, the surveyor interviewed the RN. The RN stated that Resident #74 was alert and

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oriented to self only and had that the resident had "no sense of time" because they had changed the resident's incontinent brief a "little while ago." She stated that if any resident states that they have to go to the bathroom "we respond right away" but stated that they didn't do it this time because the resident "is incontinent all of the time." She stated that sometimes the resident will ask to use the bathroom, and when they take him/her to the toilet, the resident does not void anyway. She stated that the resident was [redacted] and toileting usually happened after lunch anyway. She stated that she also didn't do it when the SLP asked her to because she was passing out the lunch trays and because the resident required two staff members to assist in toileting because of the resident's behaviors. She stated that she would do it after lunch. At that time, she saw that the resident's lunch had been cleaned up and the RN stated that she would take the resident to the bathroom now.

At 1:00 PM, the surveyor observed the RN and the CNA propel the resident in the broda chair to toilet him/her.

According to an electronic Progress Note (ePN) dated [redacted] indicated that the resident was toileted at 1:05 PM and the resident's incontinent brief was dry and did not go when placed on the toilet. (This was a period of 49 minutes from the time the resident requested to be toileted at 12:16 PM, and and 52 minutes from the time the RN/UM asked the CNA to toilet the resident at 12:13 PM.)

The surveyor continued to review the medical record for Resident #74.

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A review of the Admission Record face sheet (an admission summary) reflected that the resident had been Executive Order 26 admitted to the facility Executive O [redacted].

A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Executive Orde 1 reflected that the resident had a BIMS of Executive Order 26, 4.b. indicating that on admission he/she had Executive Order 26, 4.b. [redacted] It included that the resident had Executive Order 26, 4.b. , nor had any physical or verbal behaviors in the last seven days. The MDS included that the resident wandered on the unit daily which intruded on the privacy/ activities of others, and that he/she was always continent of bladder and bowel.

A review of the resident's individualized comprehensive care plan reflected that the resident had an Executive Order 26, 4.b. [redacted] Interventions were to "Administer meds as ordered; Keep my routine consistent and try to provide consistent caregivers as much as possible in order to decrease confusion..." The care plan also had a focus that he/she had a communication problem related to the resident's voice being of low volume. Interventions included to: "Anticipate and meet my needs." Inventions if the resident began to wander included: "If I am wandering assess for unmet needs hunger, toileting, thirst, boredom." It further included that the resident had diabetes and to monitor/document/report to

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MD as needed signs and symptoms of high blood sugar including: "increased thirst, ...frequent urination..." It further included that the resident had an activity of daily living (ADL) deficit due to activity intolerance and dementia; For toileting it included that the resident was able to "complete toileting with [Minimal Assistance]". It did not address a toileting program or schedule, that the resident had incontinence and any means to protect the skin due to incontinence episodes, that he/she required two people to assist with toileting or fluctuations in staff assistance to meet toileting needs, or that the resident had a history of not producing any output when staff attempted to toilet him/her.

A review of the physician's Order Summary Report for [redacted] did not address a physician's order related to the resident's incontinence or evidence of a toileting schedule or program to promote continence.

A review of the electronic Medication Administration Record (eMAR) and the electronic Treatment Administration Record (eTAR) for April 2021 and May 2021 did not reflect documented evidence related to the resident's toileting or measures to address the resident's incontinence.

A review of the Activities of Daily Living (ADL) task record Documentation Survey Report v2 for April 2021 reflected that the resident was having [redacted] and [redacted] the resident was fully continent. It further reflected that the skin was checked by the CNA every shift and that the resident had no skin breakdown.

A review of the ADL task record Documentation

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| F 677 | Continued From page 17<br>Survey Report v2 for [redacted], reflected that the resident was [redacted] shifts, [redacted] and the remaining shifts the resident was incontinent.<br><br>on 5/26/21 at 10:59 AM, the surveyor observed a second RN (RN #2) take the resident to be toileted because he/she kept standing up from the broda chair. The RN #2 stated that sometimes when the resident gets restless, they try to toilet the resident. The surveyor observed the RN #2 wheel the resident in the broda chair to the bathroom. Resident #74 stated "I don't even know what to do." The RN #2 explained to the resident that she was taking him/her to the bathroom. The RN #2 placed the resident on the toilet and the resident had a dry incontinent brief. The resident stated that "I peed a lot before." The RN #2 asked the resident if he/she was "going to pee" again while on the toilet and the resident nodded his/her head no and replied "nuh uh."<br><br>Five minutes later at 11:04 AM, the RN #2 stood the resident back up, pulled up the incontinent brief, his/her pants, and sat the resident down in the broda chair. The resident did not have any skin barrier cream on his/her perineal area, nor did the RN #2 apply a skin protectant/barrier cream to protect the skin if the resident had an incontinent episode after her attempt to toilet the resident.<br><br>At 11:08 AM, the surveyor attempted to interview Resident #74 in the privacy of his/her room. The resident responded with his/her name, but did not respond appropriately to other questions. The resident stated, "I want to go home" and began pulling at his/her pants. The surveyor asked if | F 677 | | |

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he/she used the toilet and the resident stated, "I don't know."

The next day on 5/27/21 at 9:05 AM, the surveyor observed another CNA (CNA #2) in the bathroom with Resident #74. She stated that she was trying to collect a urine sample and that the resident was not voiding on the toilet.

On 5/27/21 at 9:08 AM, the surveyor interviewed the CNA #2 who stated that the resident was Executive Order 26, 4.b. " and would often not follow commands due to his/her Executive Order 26, 4.b.. She stated that the resident liked to drink a lot of fluids and that she would offer fluids to the resident every morning. The CNA #2 stated that the resident was "incontinent most of the time." She stated that sometimes the resident would be able to say if he/she had to be toileted. She stated that she performed incontinence care on the resident that morning and applied a skin barrier cream to the perineal area to protect the skin, and that the resident used a pull-up incontinent brief during the day that would get changed in the bathroom and not in the resident's bed. She further stated that after breakfast and after lunch she would usually ask the resident if he/she wanted to be toileted, adding that if she asked the resident, Resident #74 would usually answer. The CNA #2 stated that if the resident asked to be toileted she would not delay.

On 6/1/21 at 9:17 AM, the surveyor interviewed the Physical Therapy Assistant (PTA) who stated that she was familiar with Resident #74 and that the resident had Executive Order 26, 4.b. She stated that sometimes the

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resident would be more steady on his/her feet, and other days he/she would need closer supervision including more physical assistance for safety. She stated that the resident had a lack of safety awareness. The surveyor asked about toileting a resident. The PTA stated that if a resident asks to be toileted, she can assist in toileting the resident as well as the Physical Therapists and Occupational Therapists. She stated that if the resident already soiled themselves, they would bring them back to the nurses station to have the nurse assist in providing incontinence care. She stated that the SLP does not toilet residents. She stated that the toileting would happen "immediately" if a resident requested it, or as soon as possible in a reasonable time frame. She stated that if the CNA and RN was tied up doing something else, she would inform the Unit Manager. The surveyor asked what is a reasonable amount of time to toilet the resident if he/she makes the request and the PTA stated that while she didn't know the response time but that 15 minutes was reasonable. She stated that waiting over 45 minutes was just "too long."

At 9:31 AM, the surveyor interviewed the SLP who stated that [redacted] was also the Director of Rehab. [redacted] stated that Resident #74 had been having a [redacted] at home due to [redacted] He stated that the resident's cognitive decline here at the facility was expected. He stated that he had been working with the resident for some [redacted] admission to the facility. The surveyor asked the SLP about the resident's request to be toileted prior to lunch on [redacted]. The SLP acknowledged that he had

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asked both the CNA and the RN to toilet the resident that day when the resident had informed him that he/she needed to go to the bathroom. He stated that "I thought it had been addressed and I didn't think it was urgent...I can't tell you how long ago they had toileted the resident" but that it had been "recent." The SLP acknowledged that he doesn't toilet the residents but that if the CNA and RN were unable to assist the resident to the toilet if the resident was asking to be toileted again, he should have let the Unit Manager know. The SLP acknowledged that even if the resident had been toileted recently, there could be other medical reasons that the resident could need to be toileted again.

On 6/1/21 at 1:00 PM, the Regional Director of Risk Management stated in the presence of the survey team and the Licensed Nursing Home Administrator, Director of Nursing (DON), and the Regional Director of Clinical Services and the Regional Director of Operations, acknowledged that on [redacted], a SLP, a CNA, and a RN all were aware that the resident had requested to be toileted before lunch and that it did not happen until surveyor inquiry, 49 minutes after the resident made the initial request to be toileted. The Regional Director of Risk Management stated that the resident had just been toileted by the CNA and the RN and that the resident had voided and had a bowel movement. The surveyor asked why the CNA didn't tell the SLP at that time that she had just toileted the resident when the SLP informed her that Resident #74 was requesting to go to the bathroom, and instead told him that she had just finished washing her hands and had to pass out lunch trays. The Director of Risk Management provided statements from the CNA and the RN,

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indicating that they had toileted the resident before lunch. The statements did not specify what time the resident had last been toileted. The RN statement indicated that they had just taken Resident #74 to the bathroom just before the trays came out. The RN statement included that "Sometimes [Resident #74] repeats things and says [he/she] needs to go to the bathroom even though [he/she] just went." The surveyor asked the facility administration if there were other reasons that could cause the resident to need to go to the bathroom again even if he/she had allegedly been recently taken; In addition the surveyor asked if it was appropriate to not address the resident's request regardless of the last time he/she had been toileted? The facility administration acknowledged the surveyors questions but stated they had investigated the incident and the Regional Director of Risk Management stated that the facility believed that resident's toileting needs were met because the resident had a dry incontinent brief after lunch that day. She continued to add that the resident had incontinence since admission to the facility and acknowledged that there was no care plan for incontinence/promote skin integrity related to incontinence, and that it was also not addressed in the care plan about fluctuations in staff assistance for toileting was necessary and that the resident sometimes doesn't void during toileting attempts. The Regional Director of Risk Management stated that the resident was hospitalized on Executive Order 26 for what she believed was a Executive Order 26, 4.b. Executive Order 26. The facility administration clarified that they had not received official confirmation of that yet.

A review of a Executive Order 26, 4.b. dated Executive Order 26 provided by the facility reflected that the resident

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| F 677 | Continued From page 22<br>had [redacted], and was subsequently sent out to the hospital for a medical evaluation and was admitted with a [redacted]<br><br>On 6/3/21 at 12:20 PM, the LNHA and the DON stated to the survey team that they had attempted to get the hospital records regarding the resident's admission, and that they still were waiting on the official hospital diagnosis.<br><br>According to the U.S. Centers for Disease Control and Prevention (CDC) guidelines for Urinary Tract Infection (UTI) updated 8/27/2019, included that signs and symptoms of UTI may include: "frequent urination; feeling the need to urinate despite having an empty bladder..."<br><br>According to the American Diabetes Association (ADA) copyright 2021, symptoms of high blood sugar can include symptoms such as urinating often and feeling thirsty.<br><br>A review of the facility's undated policy for Urinary Continence and Incontinence-Assessment and Management included, "The physician and staff will provide appropriate services and treatment to help restore or improve bladder function and prevent urinary tract infections to the extent possible." Relevant information related to urinary continence includes: ...Previous treatment/management attempts and response to interventions, pertinent diagnoses, including...diabetes mellitus; Functional and/or cognitive capabilities or limitations that could affect continence, including impaired cognitive function or dementia, impaired mobility... "<br><br>2. On [redacted] from Executive Order 26, 4.b. and on [redacted] from Executive Order 26, 4.b. during the | F 677 | | |

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lunch meal service, two surveyors observed five residents Resident #9, #25, #34, #40 and #74 in the dining room for lunch. The five residents were all sitting in broda chairs (a reclining chair that sits low to the ground) at various dining tables spread throughout the room. The surveyors observed that the dining tables were of standard height, and the table surface was at the level of the five residents' shoulders or chin. The surveyors observed the residents self-feeding their lunch meals and having to reach up above their shoulders to access their drinks and food positioned on the table.

On 6/1/21 at 9:31 AM, the surveyor interviewed the Speech Language Pathologist (SLP) who also introduced himself as the Director of Rehab. The SLP acknowledged that the broda chairs had seats that were lower to the ground than a standard chair or wheelchair. The surveyor asked if the heights of the dining tables were adjustable, and he stated that he thought they were. The surveyor asked about the height of tables for eating when the residents are sitting in the low sitting broda chairs, and he acknowledged that the standard table heights are not appropriate for positioning for residents that need to eat in the broda chairs. He stated that the therapy department had re-evaluated several of the residents who were previously in the broda chairs and that they were be trialed for use of standard wheelchairs anyway, but that they would look at the heights. He acknowledged that the appropriateness of the standard table heights for those sitting in broda chairs had not yet come to his attention.

On 6/3/21 at approximately 12:30 PM, the surveyor interviewed the Regional Director of

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| F 677 | Continued From page 24<br>Clinical Services, the Regional Director of Operations, the Director of Nursing (DON) and the Licensed Nursing Home Operations stated that she believed that the table heights in the dining room were adjustable, and acknowledged that if a resident was going to eat in a low-sitting broda chair, the table height would have to be adjusted to accommodate the resident's positioning with meals as well as activities to promote their highest practicable well-being.<br><br>A review of the facility's undated policy Assistance with Meals included that "Residents shall receive assistance with meals in a manner that meets the individual needs of each resident." It further included that assistance will be provided to ensure that "residents can use and benefit from special eating equipment and utencils....The nursing staff will prepare residents for eating." The policy did not address the appropriate positioning of the resident at the table.<br><br>NJAC 8:39-27.1(a), 27.2(g) | F 677 | | |
| F 679 SS=D | Activities Meet Interest/Needs Each Resident<br>CFR(s): 483.24(c)(1)<br><br>§483.24(c) Activities.<br>§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. | F 679 | | 6/30/21 |

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| F 679 | Continued From page 25<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, it was determined that the facility failed to consistently provide a program of meaningful activities in accordance with the resident's preferences as identified in the resident's assessment. This deficient practice was observed for 3 of 4 residents reviewed for activities (Resident #32, #51, and #74), and was evidenced by the following:<br><br>1. On 5/27/21 at 11:00 AM, the surveyor observed four residents seated in the day room of the [redacted] at separate tables with no activity except that Resident #32 was staring at a picture of dyed eggs in a magazine. The resident stated that there were [redacted] in the magazine in which he/she was provided. The surveyor and Resident #32 observed the front cover and noted that the magazine was from April 2021. The resident stopped reading the magazine, placed it on the table, and joined the other three residents at the table who had nothing in front of them to keep them occupied.<br><br>On 5/28/21 at 10:34 AM, the surveyor observed Resident #32 was conversing with another resident on the [redacted] Unit. Resident #32 had a crossword puzzle on the table, the other resident had a magazine. Resident #32 was not interested in the crossword puzzle. Resident #32 stated that the day before he/she was "working with a regular puzzle and really enjoying it and a nurse came along and swept up all the pieces and I don't know why."<br><br>On 5/28/21 at 10:39 AM, the Infection Preventionist (IP) offered to take the residents to | F 679 | 1. Residents #32, #51 were re-assessed for preferences and care plans were updated on 6/21/21.<br><br>Resident [redacted] was discharged from the facility on and is not anticipated to return.<br><br>2. All residents have the potential to be affected.<br><br>3.<br><br>A. Activities and nursing staff were in-serviced regarding accurate assessment and care plan integration of group and independent based on resident preferences for activities by 6/27/21.<br>B. Activity Director Conducted audit of residents by 6/25/21. to ensure each resident□s care plan is in place and in accordance with the resident□s preferences as identified in the resident□s assessment.<br>C. Activity Director will conduct Monthly Activity Council meeting with residents to develop Activity Calendar based on the residents□ requests.<br>D. Administrator or designee will round weekly during activities to ensure meaningful activities for each resident.<br><br>4.<br>A. Administrator or designee will conduct audits on 5 residents to include residents | |

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| F 679 | Continued From page 26<br>the [redacted] Unit for a sing-a-long and "Samba" activity. The IP brought the unsampled resident with the magazine. The surveyor observed that when the resident arrived to to the [redacted] Unit, he/she wasn't given any rhythm instrument for the "Samba" activity. In addition, the resident was not singing along, nor were the other residents in the activity area. The Activities Director used a tambourine type of instrument that she handed to one resident.<br><br>In the meantime, Resident #32 explained to the IP that a nurse took his/her puzzle away the day before. "They said they needed the table to eat, but there were plenty of tables."<br><br>On 5/28/21 at 10:42 AM, a nurse on the [redacted] Unit brought Resident #32 the 300 piece puzzle in a box that he/she was working on previously.<br><br>On 6/1/21 at 11:01 AM, the surveyor observed Resident #32 working on new jigsaw puzzle. The resident claimed, "I didn't finish the puzzle from last week. They pulled it away again. They said the people had to eat, but they had plenty of tables." The surveyor observed on all survey days that there were several empty tables on the [redacted] Unit, even when residents were eating in the day room.<br><br>The surveyor reviewed the medical record for Resident #32.<br><br>A review of the Face Sheet (an admission summary) reflected that the resident was recently admitted to the facility and had [redacted] | F 679 | #32 and #51 via interview and chart review weekly for 4 weeks and then monthly for 3 months to ensure activity programming is meaningful according to their preferences and assessment.<br>B. Administrator or designee will audit 5 resident care plans weekly for 4 weeks and then monthly for 3 months to ensure care plan reflect individualized activities.<br>C. Results of the audits will be reported to the QA committee Monthly.<br>D. The QAPI Committee will make recommendations based upon the results of the audits.<br>E. The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. | |

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Executive Order 26, 4.b. .

A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated Executive Order 26, 4.b., reflected that the resident had a Brief Interview for Mental Status (BIMS) score of Executive Order 26, 4.b. This score indicated a Executive Order 26, 4.b. . A review of the preferred activities listed in the admission MDS included books, newspapers, magazines, keeping up with news, group activities, going outside and religious services.

The resident's most recent updated Interdisciplinary Care Plan included the following Activity Interests: "I am independent in fulfilling my leisure time such as watching TV, socializing. My family is very supportive. I will be content with items provided for my leisure and invite me to group activities of interest through next review. Family visitations with my family. I enjoy group activities such as virtual spin class, samba fitness, food, socials. Provide me with independent leisure materials when needed/requested such as reading material."

While the facility staff did offer Resident #32 some of the activities on the care plan, he/she expressed no interest in them when observed during the survey including providing an outdated magazine. In fact, Resident #32 was most interested on 5/27, 5/28 and 6/1 in completing a jigsaw puzzle. The resident became verbally frustrated when the puzzles were disassembled before they could be completed on at least two occasions.

2. On 5/27/21 at 12:21 PM, the surveyor

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| F 679 | Continued From page 28<br>observed [redacted] residents in the [redacted] Unit day room with no activity, including Resident #51. All residents were seated at tables waiting for lunch. Music from The Beach Boys and later Elvis Presley was playing from a speaker on the wall. One resident was reading a magazine.<br><br>On 5/28/2021 at 9:24 AM, the surveyor observed that breakfast service was finished on the [redacted] Unit. There was 1950's and 1960's music playing on a Music Choice TV channel. There were two residents reading a newspaper or magazine. Ten other residents were just sitting at empty tables doing nothing, including Resident #51.<br><br>On 5/28/2021 at 10:45 AM, the surveyor observed the [redacted] Units Activity called "Samba". There were [redacted] residents in the room. Three were given wooden drumsticks to click together to the tune of "Run Around Sue" playing on the audio player. Three residents clicked the drum sticks together along with the Activity Director. One resident just left the drumsticks on the table. One resident was provided with a large beaded sculpture on the table and the resident was neither looking at it nor moving the beads along the wire. The other 14 residents were not provided with any rhythm instruments or supplies for tactile stimulation, including Resident #51.<br><br>"The Daily Chronicle", a newsletter, was available on several tables. None of the residents were observed reading the newsletter. The surveyor also did not observe any staff member reading aloud from The Daily Chronicle to engage the residents in the news of the day or reflections of the past.<br><br>On 5/28/2021 at 11:59 AM, the surveyor observed | F 679 | | |

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| F 679 | Continued From page 29<br>that a Certified Nursing Assistant (CNA) was singing Karaoke to the [Executive Order] Unit residents. The surveyor observed Resident #51 sleeping while seated at a table with no other activity in front of him/her.<br><br>On 5/28/21 at 11:15 AM, the surveyor interviewed the Recreation Director who stated that she was the only activities personnel working that day because her Activities Assistant was coming in late that day and she didn't know when he/she was going to make it in to work. She stated that she has been the Recreation Director of seven years, but the facility had previously had a Recreation Director specifically for Dementia but that they no longer work at the facility as of the end of April 2021. She stated that each resident had an activity attendance log in a software system that was not part of the resident's medical record nor was it accessible to the surveyors unless she printed it out for them. She stated that she has had no formal training on dementia and specific activities geared toward residents with dementia and that she was just filling in until the vacancy can be filled.<br><br>On 6/2/2021 at 9:34 AM, the surveyor observed Resident #51 seated in the [Executive Order] Unit day room in a wheelchair at a table alone. The surveyor observed that the resident was just playing with the clothing he/she was wearing. The surveyor observed that the Activities Director came to speak to Resident #51 momentarily. The surveyor then observed Resident #51 to smile and gaze off in the distance. However, nothing was provided to keep the resident occupied, only a cup of water with a straw on the table.<br><br>On 6/2/2021 at 9:57 AM, the surveyor observed | F 679 | | |

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Resident #51 trying to get out of his/her wheelchair. A nurse came by with the resident's medication and she assisted Resident #51 back into the wheelchair.

The surveyor reviewed the medical record for Resident #51.

A review of the Face Sheet (an admission summary) reflected that the resident was recently admitted to the facility with a Executive Order 26, 4.b. [redacted].

A review of the resident's admission MDS dated Executive Order 26, 4.b. the resident had a BIMS score that Executive Order 26, 4.b.. The assessment indicated that Resident #51 had short and long term memory problem with a severely impaired decision-making capacity. The Activity Section F of the MDS indicated that, according to the resident's family member or significant other, Resident #51 preferred to read books, newspapers, and magazines. Music was also important. The assessment also indicated that it was "very important to get fresh air when the weather is good. Somewhat important to go to religious services."

The surveyor reviewed the resident's current undated Interdisciplinary Care Plan which did not reference the resident's preferences for books, newspapers, music, fresh air, and religious services as referenced in the MDS. The care plan for activities only indicated a preference to schedule video calls with relatives.

On 6/2/21 at 1:35 PM, the surveyor reviewed the findings with the facility administration, including the Director of Nursing (DON) and the Licensed

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| F 679 | Continued From page 31<br>Nursing Home Administrator (LNHA).<br><br>On 6/3/21 at approximately 9:30 AM, the facility provided the surveyor a copy of an activity log for Resident #51. The activity log reflected that on 4/19/21 Samba Fitness was offered to the resident but was "not interested" in the activity. It did not specify what was offered as an alternative and his/her response to an alternative activity. There was no accountability for activity involvement on 4/20, 4/21, from 4/24-5/1, 5/3, 5/8, 5/10-5/19, 5/22-5/25, and 5/29-6/1. The activities that were documented as being provided from 4/19/21 to 5/21/21 only included "Watching TV" and family "Visitations." No other documentation was provided.<br><br>3. On 5/24/21 at 11:56 AM, the surveyor observed Resident #74 sitting in a broda chair at the nurses station. After finishing a cup of water that a Registered Nurse (RN) provided to the resident, the resident began reaching in the sky and began trying to maneuver the broda chair to turn. There was music being played in the day room of the | F 679 | | |

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Executive Orde[redacted] Unit, but there was no formal activity in progress. The resident had nothing in his/her arm, no activity mat or vest or other means of activity diversions.

At 12:07 PM, the surveyor observed Resident #74 attempting to stand up from the broda chair, and the CNA redirected the resident to sit back down. After the resident sat back down, the CNA propelled the resident in the broda chair to the center isle of the open dining room and the CNA locked the wheels on the broda chair which were unable to be accessed by the resident. The surveyor observed the resident attempt to scoot him/her-self while in the broda chair. At that time, the Licensed Nursing Home Administrator (LNHA) directed staff to move some tables in preparation for lunch service, and the surveyor observed two staff members pick up a dining table and place it in front of Resident #74 who was sitting in the broda chair.

At 12:13 PM, the surveyor observed Resident #74 in the locked broda chair push forward on the empty table, causing the table to move forward slightly. Then, Resident #74 began slowly sliding down in the broda chair, and two staff repositioned the resident back up in a seated position in the broda chair.

On 5/26/21 at 10:37 AM, the surveyor observed that on the Executive Orde[redacted] Unit there was a live musician singing and walking around the main dining room. The surveyor observed Resident #74 displaying signs of interest in the music and sitting at an empty dining table. The surveyor observed the resident stand up from the broda chair. A Certified Occupational Therapy Assistant (COTA) was in the room, and redirected the resident to sit

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back down into the broda chair.

At 10:45 AM, the surveyor observed Resident #74 try to stand up again from the broda chair by pushing down on the arm rests, the resident was able to slowly stand up, but he/she sat back down.

At 10:56 AM, the surveyor observed the resident slowly stand up from the broda chair again, and staff redirected the resident to sit back down. The resident was sitting alone and did not have any means of a diversion activity in front of him/her at the table. The resident was also not offered to ambulate when he/she kept attempting to stand up when he/she was not showing interest in the live music.

At 10:58 AM, the resident stood up a fourth time, and began to make small steps by holding onto the table in front of him/her. A Registered Nurse (RN) asked the resident to sit back down because he/she was only wearing one shoe. The surveyor observed the resident's other shoe on his/her broda chair seat where he/she was sitting. The RN assisted the resident in reapplying the shoe, then propelled the resident in the broda chair to his/her room to attempt to toilet. The RN stated that when the resident gets restless, sometimes that meant that he/she needed toileting.

At 11:08 AM, the surveyor attempted to interview Resident #74 in his/her room after the RN attempted to toilet the resident, but the resident did not respond back to the surveyor's questions appropriately. The resident stated that he/she wanted "to go home" and began pulling on his/her pants.

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| F 679 | Continued From page 34<br><br>On the same day on 5/26/21 at 12:12 PM, the surveyor observed the RN talking to Resident #74 while he/she was in a broda chair. The surveyor observed that the resident had not been offered a tactile activity or other means of recreational engagement when he/she was not showing interest in participating in the music activity.<br><br>The surveyor reviewed the medical record for Resident #74.<br><br>A review of the Admission Record face sheet reflected that the resident had been recently admitted to the facility with diagnoses [redacted]<br><br>A review of the admission MDS dated [redacted] reflected that the resident had a BIMS of [redacted] indicating that on admission [redacted] It included that the resident had [redacted], nor [redacted] The MDS included that the resident wandered on the unit daily which intruded on the privacy/activities of others. The MDS assessment reflected that the resident was interviewed for his/her preferences and that it was "Very Important" to keep up with the news, participate in favorite activities, to go outside to get fresh air when the weather was good, and participate in religious services or practices.<br><br>A review of the resident's individualized comprehensive care plan reflected that the | F 679 | | |

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resident had Executive Order 26, 4.b. [redacted] Interventions were to "Administer meds as ordered; Keep my routine consistent and try to provide consistent caregivers as much as possible in order to decrease confusion..." The care plan also had a focus that he/she had a communication problem related to the resident's voice being of low volume. Interventions included to: "Anticipate and meet my needs." Inventions if the resident began to wander included: "Distract me from wandering by offering pleasant diversions, structured activities, food, conversation, television, book." ..."If I am wandering assess for unmet needs hunger, toileting, thirst, boredom." Further interventions within the resident's care plan included to "Assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain, etc;"..."Give me as many choices as possible about care and activities." Interventions for the recreational care plan not initiated until 4/30/21 included that the resident enjoys "playing cards" and "place me next to a peer who is actively engaged." There was no other resident-specific preference for activities listed on the resident's recreational care plan

A review of an Activities Initial Assessment dated [redacted] reflected that the resident enjoyed, "watching TV, playing games on [his/her] tablet, Taking walks, Puzzles." It further reflected that the resident participated in "[redacted] Church" and it was unknown if the resident wished visits from a clergy member. It further reflected that the resident liked independent activities such as reading and puzzles.

A subsequent Activities Initial Assessment dated

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| F 679 | Continued From page 36<br>Executive Order reflected that the resident enjoyed Watching TV and taking walks and attended Executive Order church prior to admission. The assessment indicated that activities should be modified to accommodate a cognitive deficit. Accommodations to participate in activities included, "Provide assistance with independent activities when needed. Provide simple task activities." The assessment was not clear what the "impendent activities" or "simple task activities" were for the resident. It did not evaluate the resident's response to any activity that may have been provided to the resident thus far, or any activity that the resident may not prefer to participate in.<br><br>A review of the resident's attendance log for activities reflected from 4/21/21 to 4/25/21 reflected visitation from family and a daily chronicle provided on 4/22/21 but the resident declined it on 4/23/21. There was no evidence of alternate activities offered to the resident when he/she declined a daily chronicle or other means of the facility's involvement with recreational engagement. The log reflected that on 4/26/21 the resident participated in a craft at 11:30 AM, but no other activity for the day. Further the log reflected the following:<br>On 4/27/21 at 10 AM the resident had an outside visit, and at 11:30 AM listened to music. There was no other activity listed.<br>On 4/28/21 the resident participated in a crossword puzzle for 30 minutes and the Daily Chronicle at 10:30 AM, there were no other activities listed on the attendance log after 10:30 AM. On 4/29/21 the resident had a 2 PM outside visitation, but no other evidence of offering, involvement or response to an activity from 4/29/21 through 5/1/21, and on 5/2/21 the only | F 679 | | |

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activity offered to the resident was an "outdoor visitation" at 2 PM. From 5/6/21 to 5/9/21 there was no documented evidence of any involvement in a morning activity. Further from 5/16/21 to 5/24/21 the activity log listed a "visit" or "Visitations" and a vanilla pudding social.

The activities attendance log for April and May 2021 did not include any evidence of an opportunity to engage in spiritual/religious music or services, taking walks, offering the resident his/her tablet in accordance with the resident's Initial Activities Assessment.

A review of the Behavior Monitoring flow sheet for April and May 2021 and the electronic Progress Notes (ePN) for April and May 2021 reflected that nursing staff were not consistently providing diversional activities in accordance with the resident's recreational preferences.

On 5/28/21 at 11:15 AM, the surveyor interviewed the Recreation Director who stated that she was the only activities personnel working that day because her Activities Assistant was coming in late that day and she didn't know when he/she was going to make it in to work. She stated she was familiar with Resident #74. The surveyor asked about what she knew of the resident, and the Recreation Director stated that the resident was very supportive and have frequent visitations. She stated that they tried a beaded sculpture with the resident this week, coloring and a jigsaw puzzle and the resident did not seem interested in that. She stated that if her activity staff perform any activities with the resident, they would let her know and it would be added to the resident's attendance log in the activities software system. She stated that the resident used to volunteer in

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the community, enjoyed word puzzles, liked dogs but the pet therapy program had to be stopped due to the COVID-19 pandemic. The surveyor asked if they tried any of those items with the resident yet, and she stated that she had not tried any means of pet involvement or pet videos, religious activities through online services or gospel music, or word puzzles yet because she had just spoken to the resident's daughter yesterday to get more ideas. She stated that she didn't get any formal training on activities for dementia residents and acknowledged that there was no activity mat or other means of tactile stimulation offered to the resident. She acknowledged that the recreational care plan was not initiated until 4/30/21 and did address the resident's preferences listed on the MDS and the initial activities assessment.

On 5/28/21 at 12:01 PM, the Recreation Director informed the surveyor that the facility had just restarted recreational activities in group settings the end of April 2021.

On 6/1/21 at 12:48 PM in the presence of the survey team, the surveyor interviewed the Regional Director of Risk Management, the Regional Director of Operations, the Regional Director of Clinical Services, with the DON and LNHA present. The Regional Director of Risk Management stated that the resident had a progressive decline associated with his/her dementia diagnosis. She stated that the resident was evaluated and re-evaluated for activities twice on 4/23/21 and 5/7/21 and that they were trying the table top beaded sculpture and other kinds of activities but that the resident refused it. She stated that the resident was refusing the magazines and the electronic tablet was taken

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| F 679 | Continued From page 39<br>home by the family representative because the resident was not seeking it out or using it. The Regional Director of Risk Management acknowledged that the care plan wasn't comprehensive for the resident's preferences for activities and that the resident's request to participate in religious services wasn't done. She stated that there was documentation of the resident refusing activities dated 5/26/21, but not prior to surveyor inquiry. The surveyor also asked about the nursing involvement with providing diversion activities, and the facility administration all acknowledged that diversion activities were an interdisciplinary team effort and that it should be documented in the resident's medical record.<br><br>A review of the facility's undated policy for Activity Programs included that the programs are designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident. "Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident."..."All activities are documented in the resident's medical record." ..."Reflect the cultural and religious interests, hobbies, life experiences and personal preferences of the residents."..."Adequate space and equipment are provided to ensure that needed services identified in the resident's plan of care are met."<br><br>NJAC 8:39-7.3(a) | F 679 | | |
| F 688 SS=E | Increase/Prevent Decrease in ROM/Mobility<br>CFR(s): 483.25(c)(1)-(3)<br><br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a | F 688 | | 6/30/21 |

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| F 688 | Continued From page 40<br>resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to ensure: a.) residents who were observed to be in a broda chair were appropriately assessed for them and used in accordance with each resident's individualized plan of care, and b.) the restorative exercise programming was consistently implemented and documented to prevent deconditioning or decline. This deficient practice was identified for 6 of 10 residents reviewed for positioning and functional mobility (Resident #9, #32, #34, #35, #40, and #74).<br><br>The evidence was as follows:<br><br>1. On 5/24/21 at 11:56 AM, the surveyor observed Resident #74 sitting in a broda chair at the nurses station. After finishing a cup of water that a Registered Nurse (RN) provided to the resident, the resident began reaching in the sky and began | F 688 | 1. Residents #9, #34, and #74 were assessed by interdisciplinary team on [redacted].<br><br>Resident #35 was reassessed on [redacted] and Broda Chair was discontinued.<br><br>Broda Chairs for residents #9, #25, #34, and #74 were discontinued on [redacted].<br><br>Resident #40 was reassessed and was determined to require continued use of Broda Chair due to comfort and positioning.<br><br>Resident #32 was reassessed by therapy and placed on Therapy Program.<br><br>2. All residents have the potential to be affected. | |

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| F 688 | Continued From page 41<br>trying to maneuver the broda chair to turn. The broda chair was not in a locked position.<br><br>At 12:07 PM, the resident attempted to stand up from the broda chair, and the CNA redirected the resident to sit back down. After the resident sat back down, the CNA propelled the resident in the broda chair to the center isle of the open dining room and the CNA locked the wheels on the broda chair which were unable to be accessed by the resident. The surveyor observed the resident attempt to scoot him/her-self while in the broda chair. At that time, the Licensed Nursing Home Administrator (LNHA) directed staff to move some tables in preparation for lunch service, and the surveyor observed two staff members pick up a dining table and place it in front of Resident #74 who was sitting in the broda chair. The surveyor observed that the broda chair sat low to the ground and the table height was set at the level of the resident's shoulders.<br><br>At 12:13 PM, the surveyor observed Resident #74 in the locked broda chair push forward on the table, causing the table to move forward slightly. Then, Resident #74 began slowly sliding down in the broda chair, and two staff repositioned the resident back up in a seated position in the broda chair.<br><br>On 5/26/21 at 10:37 AM, the surveyor observed Resident #74 standing up from the the broda chair in the main dining room. A Certified Occupational Therapy Assistant (COTA) was in the room, and redirected the resident to sit back down into the broda chair. The broda chair was in the locked position.<br><br>At 11:08 AM, the surveyor attempted to interview | F 688 | 3.<br>A. Interdisciplinary team met on 5/28/21 and 6/9/21 and reviewed residents in Broda chairs for appropriateness.<br>B. Director of Nursing and Rehab Director audited residents on Restorative Program to ensure Orders were obtained, Care plan updated, and Tasks updated on 6/23/21.<br>C. Interdisciplinary team was in-serviced on New Process for Restorative referrals on 6/23/21.<br>D. Director of Nursing or designee will review residents on Restorative program weekly to ensure Goals is being met.<br><br>4.<br>A. Director of Nursing or designee will conduct audits on 5 residents receiving Restorative Therapy weekly for 4 weeks and then monthly for 3 months to ensure appropriate Documentation of progress and need for continuation of Program.<br>B. Director of Nursing or designee will conduct audits on resident using Broda Chairs weekly for 4 weeks and then monthly for 3 months to ensure continued use is warranted.<br>C. Results of the audits will be reported to the QA committee monthly.<br>D. The QAPI Committee will make recommendations based upon the results of the audits.<br>E. The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. | |

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Resident #74 in his/her room after the RN attempted to toilet the resident, but the resident did not respond back to the surveyor's questions appropriately. The resident stated that he/she wanted "to go home" and began pulling on his/her pants.

From 11:36 AM to 11:50 AM, the surveyor observed Resident #74 in the [redacted] gym receiving [redacted] services. The surveyor observed the resident slowly ambulate using a rolling walker with the Physical Therapist (PT) providing contact guard and using a gait belt. The resident ambulated one and a half laps around the rehab gym before he/she sat back down in the broda chair. After completing therapy, the resident was transported back to the main dining room in the broda chair.

On the same day on 5/26/21 at 12:00 PM, the surveyor interviewed the Physical Therapist (PT) assigned to Resident #74. The PT stated that she worked full time at the facility and had been working with Resident #74 for the last month since the resident's admission to the facility. The PT stated that the resident had a history of [redacted] She stated that th [redacted] She stated that the resident could ambulate with a rolling walker, adding that the resident has had some [redacted] but was "physically okay." She stated that the resident used the rolling walker in therapy sessions which she believed was newer to him/her, because he/she had previously ambulated independently at home. The surveyor asked what the purpose of the broda chair was if he/she could ambulate with a rolling walker? The

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| F 688 | Continued From page 43<br>PT responded that the resident Executive Order 26, 4.b. and a Executive Order 26, 4.b. and that it was "to keep [him/her] from getting up...the lower the seat the harder it is to get up. We want to minimize [Resident #74] getting up." The PT elaborated that when the resident was in a regular wheelchair he/she stood up and fell out of the wheelchair, so they opted for the broda chair. The surveyor asked if the resident was still able to stand up in the broda chair, and the PT stated that the resident was able to stand up in the broda chair but that it was much harder to stand up in one, and therefore the resident would attempt to stand up less frequently when positioned in a broda chair versus a standard chair or wheelchair. The surveyor asked if that was then considered a restrictive device if the intent was to keep the resident from standing up, and the PT replied that "we can't restrict or restrain them" adding that it was for safety and to Executive Order 26, 4.b. because if the resident was in a broda chair, staff could get to the resident quicker and Executive Order 26, 4.b. if it was more challenging for him/her to stand up in the broda chair. The PT stated that the resident had no injuries from any Executive Order 26, 4.b. .<br><br>The surveyor reviewed the medical record for Resident #74.<br><br>A review of the Admission Record face sheet (an admission summary) reflected that the resident had been recently Executive Order 26, 4.b. with diagnoses which Executive Order 26, 4.b. Executive Order 26, 4.b.<br><br>A review of the admission MDS dated Executive Order 26 | F 688 | | |

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reflected that the resident had a BIMS of [redacted] indicating that on Executive Order 26, 4.b. [redacted]. It included that the resident had [redacted] The MDS included that the resident wandered on the unit daily that intruded on the privacy of activities of others, the resident independently transferred from surface to surface and ambulated independently with a steady gait using a rolling walker, and to date that he/she had no [redacted] in the facility. The section to document if restraints were in use, included an option for "chair that prevents rising;" the facility marked "not used."

A review of the resident's individualized care plan initiated [redacted] included that the resident was at [redacted] and an intervention dated [redacted] indicated, "I may sit in a Broda chair if I am tired." (The broda chair was not addressed in any other areas of the resident's care plan).

A review of the [redacted] Order Summary Report for [redacted] did not include a physician's order for the use of the broda chair.

A review of the Occupational Therapy (OT) Evaluation and Plan of Treatment for Certification Period Executive Order 26, 4.b. did not address the use or an assessment of a broda chair. A review of the OT Therapy Progress Notes and Report for the certification period did not address an assessment for the use of a broda chair or its risks versus benefits. Further review of an In-Service Training Report dated [redacted] from occupational therapy indicated a training to a nurse and a Certified Nursing Aide (CNA) that the resident was "able to ambulate around [his/her]

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unit using R/W [rolling walker] requiring staff supervision for safety as [Resident #74] [redacted]

[redacted] nd Plan of Treatment for the Certification Period [redacted] did not address the use or an assessment of the broda chair. A review of the PT Progress Notes and Report for the certification period did not address an assessment for the use of a broda chair or its risk versus benefits.

A review of the [redacted] progress notes in the electronic Medical Record (eMR) for [redacted] did not include documented evidence for an assessment for the use of the broda chair or address the risks versus the benefits of using a broda chair.

A review of the Executive Order 26, 4.b. (ePN) for [redacted] and [redacted] did not address an assessment for the use of the broda chair, its intended use, under what circumstances the resident was placed in the broda chair, and the resident's response to being in the broda chair. In addition there was no documented evidence that the risks versus benefits were discussed with the resident's Power of Attorney (POA).

A review of the Activities of Daily Living (ADL) task record Documentation Survey Report v2 for [redacted] indicated that the CNA's were documenting every shift for the resident's "Mobility/Locomotion," the "Mobility/Locomotion in Resident's Room" and the "Mobility/Locomotion

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off Unit." The ADL task record did not reflect accountability for the use of the broda chair.

A review of the electronic Medication Administration Record (eMAR) for Executive Order 26, 4.b. and the electronic Treatment Administration Record (eTAR) for Executive Order 26, 4.b. also did not reflect accountability for the use of the broda chair.

The next day on 5/27/21 at 9:05 AM, the surveyor observed the Certified Nursing Aide (CNA) taking Resident #74 off the toilet. The CNA stated that the resident was unable to void. The CNA observed that the resident was now in a standard wheelchair and not in the broda chair.

At 9:08 AM, the surveyor interviewed the resident's assigned CNA who stated that the resident was "Executive Order 26, 4.b. ." She stated that the resident was Executive Order 26, 4.b. so staff rotate every 30 minutes who was in the dining room for resident supervision. The CNA stated that Resident #74 was in a broda chair for Executive Order 26, 4.b." adding that "it is harder for [Resident #74] to get up in the broda chair." The CNA continued that when the resident was in the wheelchair, he/she tried to get up even more, so the broda chair "might be more relaxing." The surveyor asked if the broda chair was being used as a restrictive device if it was being used to keep the resident from standing up, if he/she was capable of standing up? The CNA replied, "not exactly, because it is for Executive Order 26, 4.b." The CNA confirmed that the resident still would try to get up out of the broda chair, and that he/she could successfully do so independently, but that the broda chair made it harder for him/her. The CNA confirmed that the resident seemed to have

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| F 688 | Continued From page 47<br>less [redacted] when in the broda chair versus being in the wheelchair, and confirmed that the resident was now back in a standard wheelchair as of last night.<br><br>At 9:37 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that the resident [redacted] and the broda chair was used for his/her safety because he/she kept sliding out of the wheelchair even with a dycem (non-slip mat). She stated that the resident was very difficult to redirect and [redacted] with staff during redirection. She stated that the resident was [redacted] and the broda chair forced the resident to take longer to get stand up allowing the staff to try to get to her in time before he/she fell. She stated that the staff "can't stay beside" him/her all the time. She stated that it was not a restrictive device because it was used for his/her poor safety awareness and that he/she could still rise out of the chair. The surveyor asked if that assessment was documented anywhere. She stated that therapy evaluated the resident last night and that they re-assessed her for being in a wheelchair and not a broda chair. The surveyor asked the RN/UM about the care plan to use the broda chair if tired, and if the resident kept standing up out of the broda chair if that indicated he/she was "tired." The RN/UM acknowledged that the resident attempted to stand up no matter if he/she was in a wheelchair or a broda chair. The surveyor asked the RN/UM why they were using the broda chair then if the resident made efforts to stand just as much seated in both devices, and the RN/UM stated that she wasn't exactly sure. The surveyor asked where the documentation would be for the broda chair that was implemented [redacted], and she stated that it | F 688 | | |

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| F 688 | Continued From page 48<br>should be in the ePN.<br><br>On 5/28/21 at 10:30 AM, the surveyor interviewed the Registered Nurse (RN) assigned to care for Resident #74. The RN stated that the resident was Executive Order 26, 4.b., difficult to redirect and that he/she "kept standing" and "if you turn your back" the resident would [redacted] The RN confirmed that the resident was no longer in the broda chair to Executive Order 26, 4.b. and that any documentation should be in the ePN.<br><br>On 6/1/21 at 9:57 AM, the surveyor conducted a phone interview with the resident's Attending Physician (MD). The MD stated that the resident was admitted to the Executive Order 26, 4.b. [redacted] She continued that the resident was Executive Order 26, 4.b. [redacted] in which a consult for psychiatry was ordered. She stated that it seemed as though the resident was not easily re-directable. The surveyor asked about the broda chair, and the MD stated that she was not involved in the broda chair adding that "physical therapy recommends" and the Physiatrist (Rehabilitation Physician) would make the decision to order it. The surveyor asked what the purpose of the broda chair for the resident was, and she stated "possibly for set-up, maybe." The MD then had to abruptly end the call before the surveyor could ask for any further clarifying questions.<br><br>On 6/1/21 at 1:32 PM, the Regional Director of Risk Management stated in the presence of the survey team and the Licensed Nursing Home Administrator, Director of Nursing (DON), and the | F 688 | | |

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Regional Director of Clinical Services and the Regional Director of Operations, that Resident #74[Executive Order 26, 4.b]. She stated that the resident was sliding out of the wheelchair at times and that the broda chair would be more comfortable for the resident because of how it contours to the body. She stated that the intent of the broda chair was for the resident's comfort despite what staff may have told the surveyor. She stated that it was not a restrictive device. The Regional Director of Risk Management confirmed that there was no formal assessment done for the use of the broda chair. She acknowledged that the broda chairs have seats that are lower to the ground which can affect a resident's ability to easily stand. She stated that the resident was still attempting to stand up from the broda chair regardless of the intervention for comfort. The surveyor asked if a device (such as a broda chair) even if used for comfort could have risks associated with it, such as potentially decreased conditioning, and the Regional Director of Risk Management stated that it was not restricting the resident's movement. She stated that there should have been better documentation surrounding the assessment of the broda chair and its use.

The facility provided an undated statement from the OT on [Executive Order 26, 4.b]. The OT statement indicated that the resident demonstrated a [Executive Order 26, 4.b] therefore upon assessment patient was deemed appropriate for the broda chair at the time. The chair did not pose as a restraint for the patient as the patient was still able to get up from the chair independently." There was no documented evidence that the assessment for the broda chair had been done prior to surveyor inquiry, or documentation why

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the broda chair was no longer to be indicated on 5/27/21 after the surveyor had inquired to staff about its use. In addition, there was no documentation regarding the risk versus benefit of using the broda chair, when the broda chair was being used for reasons other than if the resident was tired.

2. On 6/1/2021 at 11:01 AM, the surveyor was speaking with Resident #32 on the [redacted] Unit. The resident, who was seated in a wheelchair in the day room, stated, "I'm supposed to be walking. I was doing good when I was on the other side. I moved here about a week ago. I was walking. But now, I don't walk at all."

On 6/1/2021 at 2:01 PM, the surveyors met with facility Administrators, including the Director of Nursing (DON) to discuss observations made during the survey. The surveyor inquired if there was a Restorative Nursing Program at the facility. The DON replied, "No" and that he didn't think so.

The surveyor interviewed Resident #32 again on 6/2/2021 at 10:28 AM. The resident stated, "I'm still not walking. What do I have to do, change doctors or something?"

On 6/2/2021, the surveyor interviewed the Registered Nurse/Supervisor (RN/Supervisor) on the [redacted] Unit. The RN/Supervisor stated that Resident #32 was new to the unit and explained that she had been off for a few days. She said that she would check after hearing that Resident #32 hadn't walked since he/she had come to the [redacted] Unit. The RN/Supervisor stated, "Maybe [his/her] time was up. I'll check to see."

On 6/2/2021 at 11:55 AM, the surveyor interviewed the Director of Therapy (DOT) who

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stated that Resident #32 had been discontinued from the Physical Therapy (PT) program. The surveyor asked the DOT what happened after a resident was [redacted] from PT. The DOT stated that residents are started on the [redacted] Nursing Program. The surveyor then stated that the surveyors were informed that there was no [redacted] Nursing Program. The DOT did not reply.

The surveyor reviewed the medical record for Resident #32.

A review of the Face Sheet (an admission summary) reflected that the resident was recently admitted to the facility and had diagnoses [redacted].

A review of the [redacted] MDS dated [redacted], reflected that the resident had a BIMS score of [redacted] This score indicated a moderately impaired mental status. The Activities of Daily Living Section of the MDS indicated that Resident #32 required extensive assistance of one staff member to walk between locations in his/her room and did not walk in the corridors at all.

A review of the resident's physician's Order Recap Report for Physician's orders from [redacted] revealed a Physician's order, dated [redacted] for a PT evaluation and [redacted]...patient/caregiver education and discharge planning. On 4/29/2021, the Physician

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wrote an order to continue the treatment for 4 weeks. The Order Recap Report also included an order, dated [redacted] with a start date of [redacted] to "Ambulate with assist of 1 and rolling walker 15-60 feet twice daily as tolerated and PRN (as needed), every day and evening shift Document how many feet."

On 6/10/2021 at 11:16 AM, during a follow-up telephone interview, the DOT explained to the surveyor that the second Physician order was necessary for Recertification of the PT services. The resident reached maximum potential on [redacted] and was [redacted] The PT [redacted] summary dated [redacted] indicated that Resident #32 could walk 100 feet with a rolling walker and minimal assistance.

On 6/3/2021, the surveyor reviewed the Documentation Survey Reports from May and June that indicated that Resident #23 was never walked by the nursing staff after [redacted] PT. The intervention/task for Nursing Rehab to ambulate Resident #32 did not appear on the report form until 6/2/2021 after surveyor inquiry.

On 6/3/2021 at 1:26 PM, the surveyor asked Resident #32 if he/she had been walked by the any staff on the North Unit. The resident stated that he/she had not been walked on either the [redacted] or the [redacted]

3. On 5/28/2021 at 10:45 AM, the surveyor observed Resident #40 seated in a Broda chair at a table in the day room. The resident was not touching the beaded sculpture placed as an activity on the table in front of him/her. Instead, Resident #40 began to stand up, out of the Broda

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chair. Resident #40 had risen from the chair completely. The surveyor alerted a nurse who was working on the medication cart in the day room. The nurse rushed to assist the resident back into the Broda chair. A male employee also came to assist and wheeled the Broda chair and resident out of the day room.

On 6/2/2021 at 9:38 AM, the surveyor interviewed a Temporary Nursing Aide (TNA) who stated that he had just finished assisting Resident #40. The TNA stated that the resident needed "help with everything...getting dressed, transferring..." He reported that the Certified Nursing Assistant (CNA) would check on his work and that he would report to the Registered Nurse (RN). He stated that he was not sure if Resident #40 could walk. The TNA stated that he knew to transfer the resident to a "geri" chair, meaning a Broda chair. He explained that he was familiar with Resident #40 and relayed that the resident had a tendency to stand up. He continued, "So, the geri chair is more difficult to get out of and also is more comfortable, causes a relaxed back state." The TNA explained that he could go to the other CNA's to ask if he wasn't sure which chair to use for the resident. He concluded, "Nursing decides which chair or walker, I guess."

On 6/2/2021, the surveyor observed Resident #40 from 10:10 AM until 11:30 AM. The resident was always in a Broda chair and only taken out of the day room between 10:24 AM and 10:39 AM. Although a variety of activity supplies were offered to provide tactile stimulation, Resident #40 only played with his/her surgical mask. The resident was never offered the opportunity to walk while the surveyor was observing on any occasion during the survey.

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| F 688 | Continued From page 54<br><br>The surveyor briefly reviewed the resident's electronic medical record. The Admission Record (an admission summary) revealed that Resident #40 was admitted to the facility in November of 2019 with diagnoses that included mild protein-calorie malnutrition, psychosis, major depressive disorder, anemia, dementia, and gastro-esophageal reflux disease.<br><br>A review of the most recent quarterly MDS dated 5/16/21 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] This score indicated that the resident had a severely impaired cognitive status. A review of the Activities of Daily Living Section in the MDS reflected that Resident #40 could walk in his/her room and in the corridor with limited assistance and required physical assistance of one person to ambulate.<br><br>On 6/2/2021 at 11:39 AM, the surveyor interviewed Registered Nurse (RN) on the unit. The RN stated that Resident #40 "used to walk a year or two years ago." During the pandemic, the RN continued, all the residents were in their rooms. Some of the residents had Covid. She stated that therapy had recently seen Resident #40 and that they had tried to walk the resident with a walker. The RN reported that Resident #40 could only walk one to two steps and that the Physical Therapist (PT) decided to reassess at a later date.<br><br>On 6/2/2021 at 11:44 AM, the surveyor interviewed the Director of Therapy (DOT). He stated that the department had assessed Resident #40 for the use of the Broda chair because the resident had curvature of the spine. | F 688 | | |

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The DOT explained that the Broda chair was the most appropriate chair for that condition. He also stated that Resident #40 was last seen by Occupational Therapy (OT) from 4/1/2021 to 4/20/2021.

On 6/3/2021 at 10:24 AM, the surveyor interviewed the MDS Coordinator regarding the resident's ambulation status on the most recent assessment. She explained that the CNA's would document the resident's status and that would be directly transmitted to the MDS assessment. She also stated that she had interviewed the CNA who cared for Resident #40, who explained that the resident could walk, while leaning on her, from the bed to the bathroom. The MDS Coordinator stated that she had validated the information with the Nurse who worked the 3-11 PM shift.

On 6/3/2021 at 10:51 AM, the surveyor interviewed the CNA who usually took care of Resident #40. She stated the resident walked but was very unsteady. The CNA stated that she would walk the resident from the bed to the bathroom in the morning and that was the time of day that the resident was up to the task. The CNA also stated that when she was assigned to day room duty, she would push the resident's chair from the day room to the resident's bedroom and walk Resident #40 from the bedroom door to the bathroom. She stated that when the resident stood up, that meant that he/she wanted to go to the bathroom. The CNA stated that having Resident #40 walk from the door to the toilet would limit the amount of time that the resident had to spend in the Broda chair. She explained how she would hold the resident on the weak side (the left side) and hold the resident's garment in the back with her other hand. When the resident

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got unsteady, she would stop, but eventually Resident #40 made it to the toilet.

On 6/3/2021 at 11:00 AM, the Therapy Department presented a screening form, dated 5/26/2021, which indicated that the resident was not a candidate for Physical Therapy because, "Patient ambulatory w/nursing. No change in ambulating [independently] noted. OT to eval for seating, positioning."

The Therapy Department also provided a copy of the OT Evaluation and Treatment Plan, dated 5/26/2021, which concluded that the Broda chair was appropriate for Resident #40 because of the resident's curvature of the spine.

A final review of the medical record revealed that the Physician's Order Listing Report with a date range from 1/1/2021 to 6/30/2021 included the following physician's order on 5/27/2021: "Broda chair when out of bed for positioning and to prevent pressure on spine from severe Kyphosis every shift Reposition every (sic) as needed."

The facility representatives provided a listing of dates that residents began using Broda chairs on 6/4/2021, which revealed that Resident #40 was initially placed in the chair on 2/21/20. The surveyor reviewed the resident's current Interdisciplinary Care Plan, which included the use of the Broda chair as an Intervention for [redacted] and was initiated on [redacted].

On 6/3/2021, the facility also provided an incident report which revealed that the resident had slid from the Broda chair on [redacted]. The conclusion of that report was that the nurse on the floor observed the resident sliding, but was

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too far away to catch him/her on time. The resident was then provided with a non-slip cushion for the Broda chair.

Therefore, there is evidence that the resident was in the Broda chair for more than a year. The facility could not provide a physician's order or assessment for the use of the chair prior to [redacted]. There was also no consent for the use of the restrictive chair for a resident who was ambulatory with assistance when the surveyor observed the broda chair to be used when the resident was not identified to be showing signs of tiredness.

4. On 5/26/21 at 10:40 AM during the initial tour of the facility, the surveyor observed Resident #35 lying in bed with a blanket. The surveyor also observed a broda chair next to the resident's bed. At that time the surveyor attempted to interview Resident #35, but he/she was unable to be interviewed.

The surveyor reviewed the medical record for Resident #35.

A review of an Admission Record face sheet for Resident #35 reflected that the resident was admitted to the facility with a diagnosis which included, but not limited to: muscle weakness, muscle atrophy (muscle wasting), difficulty in walking and cognitive communication deficit.

A review of the significant change MDS dated 4/8/21 reflected that the resident had a BIMS of 99 which indicated the facility was unable to complete the interview with the resident. The staff

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performed a cognitive assessment which resident that the resident had a short and long term memory problem with an impaired decision-making capacity. It further reflected that the resident required extensive assistance with activities of daily living (ADL), which included bed mobility, transferring, dressing and toileting.

A review of Resident #35 individualized, Interdisciplinary Plan of Care, dated [Executive Orde] reflected that the resident had an ADL self-care performance deficit related to [Executive Order 26, 4.b.] [redacted] In addition to a risk for falls [Executive Order 26, 4.b.] [redacted] The interventions included Physical Therapy (PT)/ Occupational Therapy (OT) evaluations and treat as ordered or as needed (PRN).

A review of the OT [Executive Order 26, 4.b.] Summary dated [Executive Order 26,] reflected the [ExExecutive Order 26, 4.] recommendation for Resident #35 was the [Executive Order 26, 4.b.] nursing program (RNP) which included the [Executive Order 26, 4.b.] ROM program and the [Executive Order 26, 4.b.] transfer program.

A review of the OT Treatment Encounter Notes, dated [Executive Order 26,] reflected that the therapist educated the Certified Nursing Assistant (CNA) and nursing staff on the RNP for passive range of motion (PROM - when movement is created by someone else) and transferring the resident into the geriatric chair for Resident #35. The RNP for PROM included to perform gentle PROM to the bilateral upper extremities (BUE) elbow and shoulder to decrease the risk of further joint contractures and stiffness. The resident was

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assessed for the geri-chair to "assist and aid with proper positioning of head, shoulder and spine as the resident demonstrated incorrect and inappropriate positioning in bed."

A review of the Documentation Survey Report for Executive Order 26, 4.b. reflected the CNA ADL task accountability for Resident #35, which included mobility/locomotion (how the resident moved for example in a geri-chair and/or broda chair), mobility (boosting in bed/wheelchair), turning and positioning (was the resident turned and repositioned during the shift). Upon further review it reflected there was no documentation or accountability for the PROM to the BUE exercises that was recommended in the OT Executive Order 26, 4.b. summary on Executive Order 26, .

Upon further review of the PT and OT therapy service notes from Executive Order 26, 4.b. reflected Resident #35 was assessed for a geri-chair but it did not address the use or assessment of the broda chair.

Upon further review of Resident #35 individualized, Interdisciplinary Plan of Care, dated Executive Order 2 reflected on Executive Order 26 Resident #35 was given a broda chair for positioning as a Executive Order 26, 4.b.

A review of the physician's Order Listing Report for January 2021 to June 2021, reflected the physician order (PO) dated not until 5/27/21 for a broda chair: Resident #35 may sit in the broda chair for positioning and comfort.

A review of the OT treatment Encounter Notes dated 5/28/21, reflected a wheelchair (w/c) management analysis of Resident #35 for body

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| F 688 | Continued From page 60<br>alignment and functional skills in a new or existing w/c did not address an assessment for the use of the broda chair.<br><br>On 5/26/21 at 12:18 PM, the surveyor interviewed the RN/UM. The RN/UM stated Resident #35 was a [redacted] and once he/she was awake they placed him/her into the broda chair. She further stated the resident was in a geri-chair prior, but after the resident fell out of the geri-chair on 5/19/21 the interdisciplinary team (IDT) which consisted of the Director of Nursing (DON), Unit Managers (UM), Therapy and the Administrator, they decided on a broda chair for Resident #35.<br><br>On the same day at 12:56 PM, the surveyor observed CNA #1 bring Resident #35 out to the dayroom in a broda chair.<br><br>On 5/27/21 at 12:04 PM, the surveyor observed Resident #35 sitting in a broda chair at a table in the dayroom.<br><br>On 05/28/21 at 10:37 AM, the surveyor observed the CNA #1 performing morning care on Resident #35 with the assistance of the Registered Nurse/Unit Manager (RN/UM). At that time the surveyor did not observe the CNA #1 and/or the RN/UM perform PROM exercises to the resident's extremities. The surveyor interviewed the CNA #1. The CNA #1 stated his daily routine was to perform morning care, get the resident dressed in his/her clothes and then place the resident into the broda chair.<br><br>On 6/1/21 at 9:59 AM, the surveyor observed the CNA #1 putting a shirt and pair of pants on Resident #35. At that time the surveyor did not observe the CNA #1 perform PROM exercises to | F 688 | | |

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| F 688 | Continued From page 61<br>the resident's extremities in accordance with the RNP.<br><br>On 6/2/21 at 9:49 AM, the surveyor interviewed the RN #1. The RN #1 stated, Resident #35 was in a broda chair because he/she had [redacted]. She further stated, the broda was soft and the resident was able to put his/her feet on the floor.<br><br>On 6/2/21 at 10:26 AM, the surveyor observed CNA #1 performing morning care for Resident #35. At that time, the surveyor did not observe the CNA #1 perform PROM exercises to the resident's BUE.<br><br>On 6/2/21 at 10:32 AM, the surveyor interviewed the RN/MDS Coordinator. The RN/MDS Coordinator stated, she was one of the staff members that updated the care plan. She stated Resident #35 had been in the broda chair since 5/19/21 and that it was the best for the resident because he/she would "fidget a lot" and now that the resident was in a broda chair he/she can relax in it "safely".<br><br>On the same day at 12:47 PM, the RN #1 stated to the surveyor that when a resident had a broda chair an assessment would be done by the IDT during their meetings.<br><br>At 12:48 PM, the RN/UM stated to the surveyor for residents in the broda chair during the IDT meetings, the DON, UM, therapists (PT/OT), Infection Preventionist (IP) and the Administrators recently discussed if the broda chairs are appropriate for the residents (after surveyor inquiry). The RN/UM further stated the facility used the broda chair as a "[redacted]" for | F 688 | | |

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residents. She concluded an assessment can be done by either the IDT or therapy.

On 6/3/21 at 11:18 AM, the surveyor interviewed CNA #2 regarding a restorative nursing program (RNP). She stated, "if there was any RNP for ROM, it would be documented in the computer system" specifically in the resident's electronic Medical Record, through the CNA's ADL task record.

On 6/3/21 at 12:08 PM, the surveyor interviewed the RN/UM. She stated she was "not sure" if Resident #35 was on a RNP and didn't think he/she was. She further stated, if Resident #35 was on a RNP for ROM then it would be performed when the staff was turning and washing the resident in the bed. The RN/UM emphasized those tasks were "considered ROM".

On 6/3/21 at 12:22 PM, in the presence of the survey team the DON stated during their IDT meetings they discussed that the broda chair was appropriate for Resident #35, but acknowledged there was no formal assessment for the use of the broda chair and no physician's order for its use prior to surveyor inquiry. The DON further stated therapy was also included in the IDT meeting.

On the same day at 12:35 PM, in the presence of the survey team the RN/Director of Clinical Services (RN/DCS) stated the RNP Executive Order 26, 4.b. recommendation was for proper Hoyer lift (a mechanical device designed to lift patients safely) transfer. The RN/DCS did not speak on the OT Executive Order 26, 4.b. recommendation for the PROM to the BUE.

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| F 688 | Continued From page 63<br><br>5. On 5/24/21 between 11:53 AM to 12:04 PM, the surveyor, in the presence of another surveyor, observed Resident #34 sitting in a Broda chair in the common dining/activity area in front of the nursing station. The Broda chair was locked in position in front of a table in an upright position. The resident was attempting to climb out of the chair by lifting their legs over the edge of the left side of the arms of the chair and then switched to the right side of the chair. During that time, a staff member repositioned the resident and the resident continued attempting to move their legs over the edge of the arms of the Broda chair and was unable to move freely.<br><br>The surveyor reviewed the medical record for Resident #34.<br><br>A review of the admission MDS dated [redacted], reflected the resident was not able to complete a BIMS score. The staff performed a cognitive assessment which reflected the resident had a short- and long-term memory problem with a severely impaired decision-making capacity.<br><br>In addition, the MDS reflected that the resident had functional abilities that required extensive assist with one-person assisting to walk in the corridor and on the unit. In addition, the resident had no functional limitation in range of motion (ROM) and no impairment to the upper or lower extremities. According to the MDS, the resident had a walker as a mobility device.<br><br>A review of the resident's Admission Record face sheet revealed a [redacted] | F 688 | | |

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A review of the resident's interdisciplinary care plan (IDCP) revealed that the resident had a focus of being at Executive Order 26, 4.b. related to Executive Order 26, 4.b. Executive Order 26, 4.b. In addition, the IDCP reflected that the resident kept trying to get out of bed and chair unassisted with a date initiated of 3/22/21. The interventions initiated 3/22/21 were to keep frequently used items within reach and anticipate and meet the resident's needs. The interventions initiated 3/23/21 were to allow the resident to sit by the nursing station and if restless ask the resident if toileting was needed. An intervention dated 5/3/21 was to remind the resident to use the rolling walker. The resident also had a focus of limited physical mobility related to weakness initiated 3/22/21 and a goal of increasing mobility by being able to ambulate 100 feet using the rolling walker with a target date of 6/15/21. The resident also had a focus of using Executive Order 26, 4.b. and an intervention of having someone sit with the resident when the resident was anxious and provide time for the resident to discuss feelings. The resident had an intervention initiated Executive Order 26, to use a Broda chair when the resident was tired.

The IDCP had no intervention for a RNP.

A review of the resident's OT Executive Order 26, 4.b. Summary dated Executive Order 26, 4.b. reflected that the Executive Order 26, 4.b. recommendation was a restorative nursing program (RNP) and the resident can safely complete functional transfers with minimal verbal cues and supervision. In addition, the Executive Order 26, 4.b. Summary reflected that the CNA and nursing were educated.

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A review of the PT [redacted] Summary dated [redacted] reflected that the discharge recommendation was that a [redacted] program was established and staff were trained. The PT [redacted] Summary reflected that the resident was able to ambulate around the unit using a rolling walker with supervision.

A review of the physician's Order Listing revealed a physician's order (PO) dated [redacted] for an Occupational Evaluation and treatment: [redacted] date. In addition, there was a PO dated [redacted] for discontinuation of PT. There was no PO for the use of a Broda chair. In addition, there was no PO for a restorative nursing program (RNP) or an exercise program.

A review of the resident's Documentation Survey Reports (an accountability task record of a resident's activities of daily living (ADL) tasks performed by the CNA's) for the months of [redacted] revealed that the resident's mobility choice for the day (7 AM to 3 PM) and evening (3 PM to 11 PM) shifts were either a wheelchair or a Geri chair (a geriatric chair designed to assist with limited mobility).

Further review of the resident's Documentation Survey Reports for [redacted] revealed two "Exercise Programs" dated as initiated [redacted]. The first Exercise Program specified that the resident would move bilateral upper extremities with one-pound free weights for two sets for 10 repetitions for 90 days. The first exercise program was initialed as the task completed on [redacted] The second Exercise Program specified

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that the resident would perform active assistive range of motion exercises with both lower extremities for 10 repetitions for two sets as needed daily. The second exercise program was initialed as the task completed o [redacted]

On 5/28/21 at 11:01 AM, the surveyor observed the resident sitting in a standard wheelchair in front of a table in the common area by the front of the nursing station. The surveyor attempted to interview the resident, but the resident did not respond appropriately.

On 5/28/21 between 11:06 AM and 11:17 AM, the surveyor interviewed the resident's family representative (FR) who stated that the resident had [redacted] spoke mostly [redacted] and was [redacted] The FR also stated that the resident had a [redacted] when he/she stood up and went to use another resident's rolling walker. The FR added that the resident had been using a walker and [redacted]

On 6/2/21 at 9:38 AM, the surveyor interviewed the Temporary Nursing Aide (TNA) who stated that he was familiar with Resident #34 when he had to monitor the common dining/activity area in front of the nursing station. The TNA stated that the resident frequently tried to stand and walk on his/her own. The TNA stated that he could speak some [redacted] and would try to engage the resident in an activity when that occurred.

On 6/2/21 between 9:40 AM to 9:46 AM, the surveyor observed a Certified Nursing Aide (CNA) propelling the resident in a wheelchair to the resident's room and asking in [redacted] if the

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resident had to go to the bathroom. The surveyor observed the resident shake his/her head in a no response. The CNA then asked if the resident was cold and held up a sweater. The surveyor observed the resident shake his/her head in a yes response. The surveyor observed the CNA help the resident put on the sweater. The surveyor observed the CNA propel the resident in the wheelchair to the common dining/activity area by the nursing station and placed the resident in the wheelchair at a table with another resident sitting at the same table.

On 6/2/21 at 9:46 AM, the surveyor interviewed the CNA who stated that she was the usual CNA for Resident #34 and was familiar with the resident. The CNA stated that the resident does try to stand up and walk on his/her own. The CNA added that she would assist the resident walking and sometimes had the resident use a rolling walker or hold onto the back of the wheelchair. The CNA also stated that the resident had been receiving physical therapy (PT) and thought the resident was still receiving PT. The CNA stated that the resident usually sat in a wheelchair. The CNA also stated that she had seen the resident in a Broda chair a few times when she came on shift at approximately 7 AM. The CNA added that the resident sometimes had trouble sleeping and would get up at night so the night shift would put the resident in a Broda chair when the resident had not wanted to go back to bed. The CNA added that she knew about the resident having trouble sleeping because the night shift would report the reason for the resident being in the Broda chair. The CNA stated that the Broda chair reclined and was more comfortable. The CNA then stated that when the resident was in the Broda chair in the morning she would switch the

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resident to a standard wheelchair if agreeable or would walk the resident and then put the resident in a standard wheelchair. The CNA stated that the resident was usually in a standard wheelchair and several staff members would walk the resident during the day shift (7 AM to 3 PM).

On 6/2/21 at 10:01 AM, the surveyor observed the Registered Nurse (RN) assisting the resident to walk around the common dining/activity area.

On 6/2/21 at 11:17 AM, the surveyor observed the resident sitting in a standard wheelchair at a table with two other residents in the common dining/activity area.

At that time, the resident slowly stood up and an alarm sounded. The Activity Director responded to the alarm and went to the resident and helped the resident back to his/her standard wheelchair.

On 6/2/21 at 11:29 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that she was familiar with the resident and that the resident liked to walk around a lot and needed assistance when walking. The LPN stated that she was unsure if the resident used a rolling walker. The LPN added that the resident had not been using a Broda chair and usually sat in a standard wheelchair. The LPN also stated that she thought the physical therapy/occupational therapy (PT/OT) department decided which kind of chair was appropriate for a resident.

On 6/2/21 at 11:34 AM, the surveyor observed the resident's room and there was no rolling walker inside the resident's room.

On 6/2/21 at approximately 1:45 PM, the survey

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team met with the facility's administrative team. The Director of Nursing (DON) stated that there was no RNP. The LNHA or the two Regional Directors present did not elaborate on the DON's response.

On 6/3/21 at approximately 9:00 AM, the Regional Director of Operations stated that the facility had a restorative program but that that it was not formalized as in one CNA was assigned to complete the tasks. She stated that all CNA's are responsible for the RNP for each resident that has a restorative program plan.

On 6/3/21 at 10:02 AM, the surveyor interviewed the Occupational Therapist (OT) who stated that she was familiar with the resident. The OT added that she was responsible for wheelchair management. The OT stated that the resident received PT/OT from Executive Order 26, 4.b.. The OT added that the resident was Executive Order 26, 4.b. from PT/OT services on Executive Order 26 because the resident had Executive Order 26, 4.b.. The OT also stated that she thought the resident was sitting in a Broda chair after the resident had a Executive Order 26 The OT reviewed the PT/OT notes and was unable to define a date that the resident was assessed for the use of a Broda wheelchair. The OT stated that there was a Executive Order 26, 4.b. done by OT on Executive Order 26 and thought the resident was in a Broda chair because the notes indicated that the resident had balance and positioning difficulties. The OT acknowledged that the OT notes dated Executive Order 26 had not reflected whether a Broda chair was being used. The OT added that on Executive Order 26 there was an assessment that the resident was evaluated for use of a standard wheelchair because the resident had improved sitting ability and positioning and balance had improved. The

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| F 688 | Continued From page 70<br>OT could not speak to the need for a PO from the physician for a Broda wheelchair. The OT stated that when the resident was Executive Order 26, 4.b. from PT/OT on Executive Order 26, 4.b. the recommendation was for an RNP and that the nursing staff was educated for the Executive Order 26, 4.b.. The OT could not speak to the RNP.<br><br>On 6/3/21 at 10:20 AM, the surveyor interviewed the Regional Director of Operations for Executive Order 26, 4.b. (RDOR) who stated that the Documentation Reports for Executive Order 26, 4.b. were completed by the nursing staff and PT/OT had no input to the reports. The RDOR could not speak to the Executive Order 26, 4.b. Program" reflected on the Documentation Survey Reports for April and May 2021. The RDOR stated that when a resident was Executive Order 26, 4.b. then PT/OT completed an In-Service Training Report with instructions for nursing.<br><br>On 6/3/21 at 10:35 AM, the surveyor, with the RDOR, reviewed the In-Service Training Report for Resident #34. The RDOR stated that the form was dated Executive Order 26, 4.b., two days prior to Executive Order 26, 4.b., in preparation for Executive Order 26, 4.b. from PT/OT. The RDOR stated that the In-Service Training Report was reviewed with nursing for the Restorative Nursing Program (RNP) and the nursing staff was educated.<br><br>A review of the resident's In-Service Training Report dated Executive Order 26, 4.b. reflected that the resident was able to ambulate around the unit using a rolling walker and required staff supervision for safety. The Report also reflected the goal was to prevent deconditioning.<br><br>On 6/3/21 at 12:57 PM, the surveyor, with the | F 688 | | |

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| F 688 | Continued From page 71 | F 688 | | |

RDOR, reviewed OT encounter notes dated [redacted] and [redacted]. The RDOR stated that the notes indicated that the resident had poor balance and needed comfort which could be a need for a Broda chair. The RDOR acknowledged that the initial evaluation had not specified whether the resident was assessed for use of a Broda chair. The RDOR also acknowledged that the In-Service Training Report dated [redacted] indicated use of a rolling walker. The RDOR acknowledged that there needed to be improved communication between PT/OT and nursing regarding the Restorative Nursing Programs.

6. On 5/26/21 at approximately 12:45 PM, the surveyor observed Resident [redacted] sitting in a broda chair at a dining table eating lunch. The surveyor observed the resident pick at the side of peas with his/her hands.

The surveyor reviewed the medical record for Resident #9.

A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility [redacted]

A review of the resident's admission MDS dated [redacted], reflected that the resident had a BIMS score of [redacted] indicating a severely impaired cognition. The assessment included that

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| F 688 | Continued From page 72 | F 688 | | |

the resident could walk in room with extensive assist (resident involved in activity, staff provide weight-bearing support) and one person physical assist. The assessment included that the resident normally used a walker and a wheelchair as mobility devices. The assessment included that the resident could walk [redacted] with partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort). The assessment included that the resident did not have any physical restraints or alarms in use.

A review of the resident's individualized, [redacted] care plan included a focus for at [redacted] which included the following intervention: "I may sit in a Broda wc [wheelchair] if I am tired" which was initiated on [redacted]. The intervention was resolved on [redacted] after surveyor inquiry. The intervention was then changed to the following: Allow me to sit by the nurse's station in a wc if I am restless, which was initiated on [redacted].

A review of the [redacted] Listing Report for [redacted] to [redacted] did not include a physician's order for a Broda wheelchair.

A review of the [redacted] Nurses Notes (eNN) revealed a care plan progress note dated [redacted] which included the following: Pt has tendency to stand up from Broda chair-however is able to be redirected. Pt is a [redacted] however has had no [redacted]. The review also revealed a mood/behavior note dated [redacted] which included the following: resident was ambulated with assistance in the hallway and was assisted back to the wheelchair but keeps on getting up and

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trying to walk. Resident is a [redacted] with very unsteady gait.

A review of the Physical Therapy [redacted] Summary dated [redacted] included the resident able to ambulate from the bed to toilet using rolling walker with minimal assist. A review of the Physical Therapy Recert, Progress Report and Updated Therapy Plan, for certification period of [redacted], included the short term goal that resident will safely ambulate on level surfaces 100 feet using two-wheeled walker. The functional skills assessment included ambulation on level surfaces equaled minimum assist.

On 6/3/21 at 12:18 PM, the facility administration were unable to provide any documentation that an assessment was performed for the use of the Broda chair, why it was being used for a resident during lunch when he/she was not exhibiting signs of tiredness in accordance with the plan of care for Resident #9 or any physician's order or accountability for the use of the Broda chair. The Regional Director of Operations stated that none of the residents had a functional decline as a result of the use of the broda chair. They stated that Resident #74 started the Broda chair on [redacted], Resident #9 started the Broda chair on [redacted], Resident #34 started the Broda chair on [redacted], Resident #35 started the Broda chair on [redacted], and Resident #40 started in the Broda chair on [redacted]. She stated that most of the residents only just started using the broda chairs this month according to the medical records.

A review of the facility's undated Assistive Devices and Equipment policy, included that "Certain devices and equipment that assist with resident mobility, safety, and independence are

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| F 688 | Continued From page 74<br>provided for residents. These may include (but are not limited to): ...Mobility devices (wheelchairs, walkers and canes)." ..."Recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the resident care plan." ..."Staff and volunteers will be trained on the use of devices and equipment prior to assisting or supervising residents." ... The policy further included that various factors would be addressed to the extent possible to decrease the risk of avoidable accidents associated with devices and equipment, including the "Appropriatness for resident condition...Personal fit...Device condition...Staff practices."<br><br>There was no policy provided on the implementation of an RNP.<br><br>NJAC 8:39 - 27.1(a) | F 688 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review and review of pertinent facility documents it was determined that the facility failed to ensure: a.) a resident with [redacted] in the facility was thoroughly evaluated for possible causative | F 689 | 1. Resident #74 was [redacted] from the Facility. Resident no longer resides in the Facility and is not anticipated to return.<br><br>Facility ensured Resident #38 is | 6/30/21 |

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| F 689 | Continued From page 75<br>factors for those and initiate appropriate interventions to [redacted], b.) [redacted] re-assessments were consistently done to evaluate [redacted], c.) the care plan was appropriately implemented to prevent further [redacted] and d.) a resident was transferred using a mechanical lift with a two person assistance in accordance with safety practices to prevent incidents/accidents. This deficient practice was identified for 2 of 4 residents reviewed for [redacted] (Resident #38 and #74).<br><br>The evidence was as follows:<br><br>1. On 5/24/21 at 11:56 AM, the surveyor observed Resident #74 sitting in a broda chair at the nurses station. After finishing a cup of water that a Registered Nurse (RN) provided to the resident, the resident began reaching in the sky and began trying to maneuver the broda chair to turn. The broda chair was not in a locked position.<br><br>At 12:07 PM, the resident attempted to stand up from the broda chair, and the CNA redirected the resident to sit back down. After the resident sat back down, the CNA propelled the resident in the broda chair to the center isle of the open dining room and the CNA locked the wheels on the broda chair which were unable to be accessed by the resident. The surveyor observed the resident attempt to scoot him/her-self while in the broda chair. At that time, the Licensed Nursing Home Administrator (LNHA) directed staff to move some tables in preparation for lunch service, and the surveyor observed two staff members pick up a dining table and place it in front of Resident #74 who was sitting in the broda chair. The surveyor observed that the broda chair sat low to the ground and the table height was set at the level of | F 689 | transferred via mechanical lift with 2 person assist.<br><br>The Certified Nursing Assistant #1 responsible for initiating transfer via Mechanical Lift without assistance was counseled on 5/30/21.<br><br>2. All Residents have the potential to be affected<br><br>3.<br>A. Director of Nursing or designee will reassess all residents fall risk by 6/23/21.<br>B. Director of Nursing or Designee audited residents triggering for high risk for falls to ensure interventions are appropriate to prevent falls by 6/28/21.<br>C. Director of Nursing or designee will conduct Mechanical lift Competencies on Nursing staff by 6/30/21 and annually.<br>D. IDT team was in-serviced on ensuring post [redacted] are appropriate and appropriately implemented to prevent [redacted]<br>E. IDT will meet weekly at the At Risk Meeting to discuss residents that are High Risk for falls and appropriateness of interventions, Fall Risk Assessments are completed timely, and causative factor discussed.<br><br>4.<br>A. MDS Coordinator will conduct audits on 5 residents with falls weekly to ensure they are thoroughly evaluated for possible causative factors for falls and appropriate interventions initiated to prevent further | |

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| F 689 | Continued From page 76<br>the resident's shoulders.<br><br>At 12:13 PM, the surveyor observed Resident #74 in the locked broda chair push forward on the table, causing the table to move forward slightly. Then, Resident #74 began slowly sliding down in the broda chair, and two staff repositioned the resident back up in a seated position in the broda chair.<br><br>On 5/26/21 at 10:37 AM, the surveyor observed Resident #74 standing up from the the broda chair in the main dining room. A Certified Occupational Therapy Assistant (COTA) was in the room, and redirected the resident to sit back down into the broda chair. The broda chair was in the locked position. The surveyor observed that there was no cushion or non-slip mat on the broda chair seat to prevent sliding.<br><br>At 10:45 AM, the surveyor observed Resident #74 try to stand up again from the broda chair by pushing down on the arm rests, the resident was able to slowly stand up, but he/she sat back down.<br><br>At 10:56 AM, the surveyor observed the resident slowly stand up from the broda chair again, and staff redirected the resident to sit back down.<br><br>At 10:58 AM, the resident stood up a fourth time, and began to make small steps by holding onto the table in front of him/her. A Registered Nurse (RN) asked the resident to sit back down because he/she was only wearing one shoe. The surveyor observed the resident's other shoe on his/her broda chair seat where he/she was sitting. The RN assisted the resident in reapplying the shoe, then propelled the resident in the broda | F 689 | falls, ~~fall~~ risk re-assessments were done post fall and the care plan was appropriately implemented to prevent further falls,<br>B. Administrator will audit 10 nursing staff members monthly to ensure completion of Mechanical lift competency.<br>C. Results of the audits will be reported to the QA committee Monthly.<br>D. The QAPI Committee will make recommendations based upon the results of the audits.<br>E. The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. | |

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chair to his/her room to attempt to toilet. The RN stated that when the resident gets restless, sometimes that meant that he/she needed toileting.

At 11:08 AM, the surveyor attempted to interview Resident #74 in his/her room after the RN attempted to toilet the resident, but the resident did not respond back to the surveyor's questions appropriately. The resident stated that he/she wanted "to go home" and began pulling on his/her pants.

From 11:36 AM to 11:50 AM, the surveyor observed Resident #74 in the rehab gym receiving rehab services. The surveyor observed the resident slowly ambulate using a rolling walker with the Physical Therapist (PT) providing contact guard and using a gait belt. The resident ambulated one and a half laps around the rehab gym with the rolling walker before he/she sat back down in the broda chair.

The surveyor reviewed the medical record for Resident #74.

A review of the Admission Record face sheet (an admission summary) reflected that the resident had been recently admitted to the facility with diagnoses Executive Order 26, 4.b. [redacted]

A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 4/27/21 reflected that the resident had a BIMS of Executive Order 26, 4.b. indicating that on admission he/she had an intact cognition

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with moderate forgetfulness. It included that the resident had no signs or symptoms of delirium, nor had any physical or verbal behaviors in the last seven days. The MDS included that the resident wandered on the unit daily which intruded on the privacy/ activities of others, and that he/she had a Executive Order 26, 4.b. the last six months prior to admission, but to date, had no Executive Order 26, 4.b..

A review of a Executive Order 26, 4 Assessment dated Executive Order 26 reflected that the resident was at low risk for Executive.

A review of the resident's individualized comprehensive care plan initiated on Executive Order 26 reflected that the resident wa Executive Order 26, 4.b. [redacted]. The care plan indicated that the resident was supposed to have Executive Order 26, 4 surgery prior to the COVID-19 pandemic, but that it was canceled due to the COVID-19 restrictions. Interventions on Executive Order 26 included that the resident was supervised with "bed mobility, transfers, and ambulation on the unit." Physical Therapy/Occupational Therapy evaluation and treatment as ordered or as needed and "Anticipate and meet my needs."

A review of the Physical Therapy (PT) Evaluation and Plan of Treatment for the Certification Period Executive Order 26, 4.b. reflected that the resident was receiving Physical Therapy upon admission to the facility.

The surveyor reviewed within the resident's medical record which reflected that he/she had Executive Order 26, 4.b.

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Executive Order 26,

Executive Order 26

According to the Executive Order 26, 4.b. (ePN) dated Executive Order 26, 4.b. reflected that the resident had a witnessed Executiv while walking out of his/her room with the rolling walker. The resident stated that he/she was okay but was Executive Order 26, 4.b. ."

A review of the Executive Order 26, 4.b. /QA Report for the Executive Order 2 dated Executive Order 26 indicated that at Executive Order 26, , the resident had a witnessed Executiv without an injury while using the rolling walker. The resident's footwear indicated "socks." Actions taken included that assessments were completed, the resident was assisted to a standing position and into a chair, the supervisor was notified. The LPN provided a statement, but there was no CNA statement in the investigation. The conclusion indicated that the resident had lost his/her balance while using the rolling walker while ambulating in the hallway, and the Interdisciplinary Team (IDT) recommended that as a Executive Order 26, 4.b. to be referred to Physical Therapy (PT) for an evaluation Executive Order 26 (The investigative report did not identify or address the use of regular socks to be a possible causative factor, any use of specific psychoactive medications, specific behaviors leading up to the incident, or interventions to address mitigate the use of regular socks when in bed. In addition, the resident was Executive Order 26, 4.b.

A review of the ePN dated Executive Order 26 reflected that Occupational Therapy (OT) performed the evaluation following the Executive Order 26, 4.b. . The OT

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| F 689 | Continued From page 80<br>created a [redacted] nursing program for supervision for the resident to be reminded to use the rolling walker, and the therapist went over safety precautions when completing functional mobility.<br><br>A review of the care plan for [redacted] reflected that it was updated on [redacted] to include a PT evaluation for the [redacted] that occurred on [redacted]. There were no additional interventions for [redacted] updated for that date, or the OT recommendation to have staff remind the resident to use the rolling walker for functional mobility.<br><br>A review of the [redacted] dated the next day on [redacted] reflected that the resident had a [redacted] in the facility in which he/she [redacted] The resident claimed that he/she was having a dream of riding a roller coaster and that caused [redacted].<br><br>A review of the investigative [redacted]/QA Report for the [redacted] dated [redacted] reflected that the resident had a witnessed [redacted] at [redacted] in which he/she was sitting in a chair in the dining room and the resident was lowered him/her-self to the floor. The resident was wearing "shoes." The investigation only included the resident statement and a statement by the Registered Nurse (RN). There was no CNA statement. Actions taken included assessments and notification of parties. The conclusion indicated that the resident had dementia with poor safety awareness and impaired judgment. Intervention included a second time, "referred to PT evaluation. Care plan was reviewed and revised to reflect this post intervention." | F 689 | | |

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| F 689 | Continued From page 81<br>A review of the updated care plan for the [redacted] and inform MD [Medical Doctor].<br><br>A review of the ePN for subsequent dates in [redacted] did not reflect documented evidence of attempts to obtain Executive Order 26, 4.b. [redacted] The ePN dated [redacted] reflected a Executive Order 26, 4.b. was taken while the resident was lying down which read [redacted], but there was Executive Order 26, 4.b. taken while sitting, or while standing to determine if there were fluctuations possibly contributing to [redacted]<br><br>A review of the At Risk IDT Meeting Note dated [redacted] inaccurately reflected that the resident only had Executive Order 26, 4.b. and was at risk for wandering, elopement and had use of Executive Order 26, 4.b.. The note included that the resident often forgets to use the rolling walker while ambulating and staff continue to remind the resident to use the rolling walker.<br><br>[redacted]<br>A review of the [redacted] dated [redacted] reflected that the resident had a [redacted] in the facility at [redacted] The resident was found Executive Order 26, 4.b. and unable to explain what happened. The resident was Executive Order 26, 4.b. [redacted] The ePN reflected that at [redacted] when the physician was notified, it was recommended to get an order for a Executive Order 26, 4.b.. The resident returned at [redacted] from the [redacted] the [redacted] were of normal findings. | F 689 | | |

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A review of the Executive Order 26, 4.b. /QA Report for the [redacted] on [redacted]1 at 10:30 AM, indicated that the resident was previously sitting in a chair in the dining area and that the walker was in use at the time of the [redacted]. The witness statement indicated that the Licensed Practical Nurse (LPN) was performing a medication pass and observed the resident walking with the rolling walker and when the resident made a turn, it caused the resident to trip over the walker. The resident [redacted] Executive Order 26, 4.b. . The conclusion indicated that the resident was using the rolling walker and wearing the appropriate footwear and [redacted] Executive Order 26, 4.b. [redacted] Interventions included to obtain [redacted] to rule out an Executive Order 26, 4.b. which may be causing the [redacted] The investigation did not address the [redacted], or the results of the [redacted].

The care plan was updated to reflect that the resident had a Executive Order 26, 4.b. which was [redacted] and labs were ordered to Executive Order 26, 4.b. [redacted] as a cause for the [redacted]. The care plan indicated that "I refused the Executive Order 26, 4.b. )" and [redacted] were unable to be done because [Resident #74] was so Executive Order 26, 4.b. " There were no new interventions incorporated into the residents care plan to address any increased level of supervision, diversion activities, appropriate footwear, or other methods to Executive Order 26, 4.b. from Executive Order 26, 4.b.

[redacted]

A review of an ePN dated [redacted] reflected that the resident had a [redacted] at [redacted] The ePN reflected that the resident was ambulating in the hallway and suddenly Executive Order 26, 4.b. [redacted] The note indicated that the resident did not sustain any Executive Order 26, 4.b. The

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resident was walked to the day room and all parties were notified.

A review of the Executive Order 26, 4.b. report/QA Report for the Executive Order 26, 4.b. reflected that the resident was previously seen at Executive Order 26, 4.b. but did not specify what the resident was doing at that time, such as when he/she had last been toileted, potential boredom or thirst, or other reasons that resident may have been ambulating without a device. It indicated that he/she was only wearing regular socks and not shoes and was not using the rolling walker. The investigation only included a nurse interview but did not include an interview from the resident's assigned CNA. The conclusion for the Execut indicated that the resident was walking without an assistive device (walker) and lost his/her balance and fell. The resident was resistive to redirection and encouragement to use the rolling walker and became Executive Order 26, 4.b. with staff when redirected. As a Executive Order 26, 4.b., the IDT recommended that the resident be referred for a psych consult for behavior evaluation and medication review. The investigation addressed that the resident was already Executive Order 26, 4.b.. It did not address why the resident was only wearing socks instead of shoes, nor did it evaluate the lack of footwear as Executive Order 26, 4.b.

A review of the At Risk IDT Meeting Note dated Executive Orde and signed by the Director of Nursing (DON) reflected that the resident has had Executive Orde since admission and that "interventions are not effective at this time...continues to wander and was aggressive towards staff when redirected...seen by Executive Orde today for behavioral review." (There were no additional interventions incorporated into the resident's plan of care at

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| F 689 | Continued From page 84<br>that time when the current interventions were evaluated to be ineffective.)<br><br>Executive Order 26, 4.b. A review of the Executive Order 26, 4.b. at Executive Order 26, 4.b. reflected that the resident had a Executive Order 26, 4.b. on Executive Order 26, 4.b. at Executive Order 26, 4.b. in which the CNA reported that while he was behind the nurses station he saw the resident Executive Order 26, 4.b. to his/her buttocks from a standing position. The resident was unable to explain what had happened but there was no injury. The resident was aggressive during care that evening at 9 PM.<br><br>A review of the Executive Order 26, 4.b./QA Report for the Executive Order 26, 4.b. dated Executive Order 26, 4.b. reflected that the resident was last seen at Executive Order 26, 4.b. visiting with family. The resident was wearing shoes and socks and a wheelchair was in use at the time of the Executive Order 26, 4.b.. The conclusion from the call indicated that the resident Executive Order 26, 4.b. for an "unknown reason." ..."The main reason for the Executive Order 26, 4.b. the resident forgets to use the rolling walker, unsteady gait, impulsive behavior and poor safety awareness. As Executive Order 26, 4.b., the IDT recommended that the resident be placed on around the clock pain medication for arthritic pain.<br><br>A review of the care plan reflected it was updated on 5/6/21 to obtain an "Eye MD consultation when Eye Doctor comes into the facility" and that the resident was placed on around the clock pain medication for arthritic pain. The care plan was also updated on 5/13/21 included: "I may sit in a broda chair if I am tired."<br><br>A review of the physician's Order Summary | F 689 | | |

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| F 689 | Continued From page 85<br>Report for May 2021 reflected a physician's order (PO) dated 5/7/21 to start Tylenol 650 milligrams three times a day around the clock for arthritic pain.<br><br>[redacted]<br>A review of an ePN dated [redacted] reflected that the resident had a [redacted] when he/she was observed to be [redacted], when he/she had been previously sleeping in bed. The resident showed no sign on injury and all parties were notified.<br><br>A review of the [redacted]/QA Report for the [redacted] reflected that the resident was found on the floor without injury at [redacted] and was [redacted] toward the nurses station barefoot. The call light had been within reach but was not turned on. The bed was in a low position and no ambulation devices were in use at the time of the [redacted] The conclusion indicated that a bed alarm wound be used so as to alert staff if the resident tries to get up from bed at night. The investigation did not include a statement from the CNA to determine what the resident had been assisted to wear in bed, if the resident had removed the clothes, or when the resident had last been toileted to determine other possible causes of the [redacted] It also did not address the resident's bare feet or implement interventions to [redacted] related to the resident's lack of non-skid footwear.<br><br>A review of the care plan indicated that a bed alarm was placed on the resident's bed on 5/19/21 and to check it for proper placement and function. | F 689 | | |

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Executive Order 26

A review of the ePN dated Executive Order 26, 4.b. reflected that the resident had a [redacted] on Executive Order 26, 4.b. . The ePN reflected that at [redacted] the resident was toileted and snacks were offered and was under staff supervision, and at [redacted] the resident remained in the day room under staff supervision, and at [redacted] during the medication pass, the nurse saw the resident stand up and couldn't get to him/her in time and was Executive Order 26, 4.b. . The resident was assessed and parties were notified and the resident ate dinner with a poor appetite, and the resident was given an Executive Order 26, 4.b. which was [redacted] .

A review of the investigative [redacted] /QA Report for the [redacted] dated [redacted] . The investigation revealed that fluids were given to the resident at [redacted] , and Executive Order 26, 4.b. The report reflected that te resident was wearing shoes and fell while standing up from the broda chair. The conclusion indicated to perform an "activity assessment for diversion activities that the resident may enjoy...to keep resident busy and engaged during the day."

A review of the updated care plan reflected that on Executive Order 26, 4.b. included to conduct an "Activities assessment for diversional activities that the resident may enjoy for [redacted] 5/21/21." A review of the Recreational activity care plan for Resident #74 initiated and last updated on 4/30/21 did not address any updates to the resident's recreational programming interests and preferences following [redacted]

A review of the Executive Order 26, 4.b. for Resident

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| F 689 | Continued From page 87<br>#74 reflected that the resident already had an Activities-Initial Review assessment completed on 4/23/21, and an Activities Initial Review was completed again on 5/7/21. A review of the ePN did not reflect updated recreational preferences until 5/26/21 when the Social Worker called the family representative for further information on the resident's social history and past interests. There was no documented assessment in the resident's medical record to evaluate the resident's involvement in activities or diversional activities until 5/26/21 at 13:41 PM (two days after the survey team entered to conduct a survey). The Activity Note indicated that the resident was refusing a beaded sculpture, magazines, and that the resident did not participate in a jigsaw puzzle.<br><br>Executive Order 26<br>A review of the ePN dated Executive Order 26, 4.b. reflected that Resident #74 had an Executive Order 26, 4.b. in the facility on Executive Order 26. The note reflected that the resident was refusing to sit on the wheelchair and the resident was assisted to the floor. The resident refused to be assessed and stated that staff were not helping. After a few minutes on the floor the resident agreed to be transported to the wheelcahir without injury. The note included that all parties were notified, vital signs were obtained and the resident had an Executive Order 26, 4.b.<br><br>A review of the Executive Order 26, 4.b. QA Report for the Executive Order 26, 4.b. dated Executive Order 26, 4.b. reflected that the resident was with staff and was holding onto the exit door and the resident was lowered to the ground by staff without injury. Actions taken included that the resident was kept under continuous supervision and placed in a chair located closer to the nurses station, Executive Order 26 | F 689 | | |

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Executive Order 26, 4.b., and activities were provided, but it did not specify what specific activities were provided and the resident's response to those activities. Statements revealed that the resident was sitting on a wheelchair forcing the door to open and when standing up refused to be assisted back to the wheelchair. As the resident was walking away from the wheelchair, the resident began to slide on his/her right side while pulling on the door, and staff assisted in lowering the resident to the floor. The conclusion indicated that the [redacted] happened as the resident stood up while being resistive and aggressive toward staff, and not receptive to re-direction. A Executive Order 26, 4.b. included that the resident was "referred again to the Executive Order 26, 4.b. Executive Order 26, 4.b.] for continued display of behaviors." The report indicated that adjustments to medications were made including increasing the Executive Order 26, 4.b. medication of Executive Order 26, 4.b. [redacted]

A review of the care plan reflected that it was updated on 5/25/21 with the medication changes from the Executive Order 26, 4.b. [redacted]

Executive Order 26 [redacted]

A review of the ePN dated the next day on Executive Order 26, 4.b. reflected that the resident had a Executive Order 26, [redacted] when he/she slid out of the broda chair in the dining room and Executive Order 26 [redacted] without injury and all parties were notified.

A review of the Executive Order 26, 4.b. /QA Report for the Executive Order 26, [redacted] dated Executive Order 26, [redacted] reflected that the resident was in the broda chair at 2:30 AM and staff saw the resident Executive Order 26, 4.b.

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| F 689 | Continued From page 89<br>Actions taken included that assessments were done, activities were provided and monitoring of further behaviors was being implemented. The Investigation did not include a CNA statement as to when the resident was last assisted, what he/she was doing at the time of the [redacted] why he/she was in a broda chair at a dining table at 2:30 AM or evaluating other possible contributing factors. The conclusion indicated that the resident would be changed from a broda chair to a standard wheelchair with a sensor alarm, in addition to an ambulation program. Staff to ambulate resident 150 feet with rolling walker twice a shift on days and evenings and as needed.<br><br>A review of the resident's individualized care plan was updated on [redacted] with the ambulation program and the utilization of a standard wheelchair with a sensor alarm instead of the broda chair.<br><br>[redacted]<br>A review of the ePN dated Executive Order 26, 4.b. [redacted], reflected that the resident had a [redacted] The resident was assessed and able to Executive Order 26, 4.b. [redacted]. The resident was transferred back to the wheelchair with a two person assist, and all parties were notified of the [redacted]<br><br>A review of the Executive Order 26, 4.b. report/QA Report for the Executive Order 26, 4.b. reflected that the resident was last visualized one minute before [redacted] and that staff was sitting with the resident in the dining room when the resident was seen sliding down from the wheelchair at 1:00 | F 689 | | |

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PM. The chair alarm sounded and the wheelchair was in the locked position at the [redacted]. The report indicated [redacted] was caused by the residents behaviors or intent, but neither the ePN nor the investigative report indicated what behaviors the resident was exhibiting at [redacted]. The CNA statement indicated that she was sitting with the resident in the dining room and when she stood up to return a lunch tray back on the cart, the chair alarm sounded and the resident w as sliding down from the wheelchair and she couldn't get to the resident in time. The conclusion indicated that since [redacted] the resident was sent to the Emergency Room for an evaluation to evaluate underlying medical conditions. The report indicated that the resident was "admitted with [redacted]"

The [redacted] for each [redacted] were not consistently and thoroughly being evaluated for causative factors including what the resident was last doing, when any form of activity of daily living (ADL) care had last been provided, if the resident had been incontinent at the [redacted], a review of recent [redacted] medication administered to determine if it contributed to the resident's [redacted] assessing [redacted], incorporating and determining the resident's response to [redacted], and address the use of appropriate footwear and include interventions to mitigate the recurrence of [redacted] from the use of improper footwear. In addition, there was no intervention for an enhanced level of supervision when possible medical causes were unable to be ruled out due to the resident's refusal for blood

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draws and a Executive Order 26, 4.b. [redacted]

Subsequent Executive Assessments dated Executive Order 26, 4.b. and Executive Order 26, 4.b. reflected that the resident was now at "Moderate Risk" for Executive Order 26, 4.b. [redacted] reflected that the resident was at Executive Order 26, 4.b. with the risk scores increasing with Executive Order 26, 4.b. Executive Order 26, 4.b. .

There was no documented re-assessments to evaluate for Executive Order 26, 4.b. potential after the Executive Order 26, 4.b. that Executive Order 26, 4.b. [redacted]

The surveyor conducted the following interviews with facility staff regarding the resident's Executive Order 26, 4.b. [redacted]

On 5/26/21 at 12:00 PM, the surveyor interviewed the Physical Therapist (PT) assigned to Resident #74. The PT stated that she worked full time at the facility and had been working with Resident #74 for the last month since the resident's admission to the facility. The PT stated that the resident had a Executive Order 26, 4.b. [redacted]. She stated that the confusion had been getting worse and at times the resident was difficult to redirect. She stated that the resident could ambulate with a rolling walker, adding that the resident has had some cognitive decline but was "physically okay." She stated that the resident used the rolling walker in therapy sessions which she believed was newer to him/her, because he/she had previously ambulated independently at home. The surveyor asked what the purpose of the broda chair was if he/she could ambulate with a rolling walker? The PT responded that the resident has Executive Order 26, 4.b. and a lack of safety

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awareness and that it was "to keep [him/her] from getting up...the lower the seat the harder it is to get up. We want to minimize [Resident #74] getting up." The PT elaborated that when the resident was in a regular wheelchair he/she stood up and fell out of the wheelchair, so they opted for the broda chair. The surveyor asked if the resident was still able to stand up in the broda chair, and the PT stated that the resident was able to stand up in the broda chair but that it was much harder to stand up in one, and therefore the resident would attempt to stand up less frequently when positioned in a broda chair versus a standard chair or wheelchair. The PT stated that the broda chair was for safety and to Executive Order 26, 4.b. Executive Order 26, 4.b. because if the resident was in a broda chair, staff could get to the resident quicker and prevent a Execut if it was more challenging for him/her to stand up in the broda chair. The PT stated that the resident had no injuries from any Executive Order 26, 4.b.. (The use of the broda chair for this stated purpose was not what was reflected in the resident's individualized care plan Executive Order 2 which indicated to use the broda chair if the resident became tired).

Over a period of 22 minutes from Executive Order 26, 4.b. , the surveyor observed Resident #74 stand up from the broda chair four times and staff redirected the resident to sit back down. Resident #74 was not exhibiting tiredness, but staff continued to utilize the broda chair.

The next day on 5/27/21 at 9:08 AM, the surveyor interviewed the resident's assigned CNA who stated that the resident was "Executive Order 26, 4.b. ." She stated that the resident was at high risk for Executive and so staff rotate every 30 minutes who was in the dining room for resident

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supervision. The CNA stated that Resident #74 was in a broda chair for "[redacted] prevention" adding that "it is harder for [Resident #74] to get up in the broda chair." The CNA continued that when the resident was in the wheelchair, he/she tried to get up even more, so the broda chair "might be more relaxing." The CNA confirmed that the resident still would try to get up out of the broda chair, and that he/she could successfully do so independently, but that the broda chair made it harder for him/her. The CNA confirmed that the resident seemed to have less falls when in the broda chair versus being in the standard wheelchair, and confirmed that the resident was now back in a standard wheelchair as of last night.

At 9:37 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that the resident was very confused and the broda chair was used for his/her safety because he/she kept sliding out of the wheelchair "even with a dycem" (non-slip mat). (There was no documented evidence that a dycem was trialed for the resident and its effectiveness evaluated within the resident's medical record to prevent [redacted]. The RN/UM stated that the resident was very difficult to redirect and was [redacted] with staff during redirection. She stated that the resident was unsteady on his/her feet and the broda chair forced the resident to take longer to get stand up allowing the staff to try [redacted]. She stated that the staff "can't stay beside" him/her all the time. She stated that the resident had poor safety awareness and that he/she could still rise out of the broda chair. She stated that therapy evaluated the resident last night and that they re-assessed her for being in a standard

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wheelchair and not a broda chair. The surveyor asked the RN/UM about the care plan to use the broda chair if tired, and if the resident kept standing up out of the broda chair if that indicated he/she was "tired." The RN/UM acknowledged that the resident attempted to stand up no matter if he/she was in a wheelchair or a broda chair. She acknowledged that the broda chair was not being used only if the resident was "tired" in accordance with the care plan. The surveyor asked the RN/UM why they were using the broda chair then if the resident made efforts to stand just as much seated in both devices, and the RN/UM stated that she wasn't exactly sure. The RN/UM stated that the facility tried redirection, toileting, and snacks and ongoing supervision to Executive Order 26, 4.b. but the resident would often not be redirectable. She confirmed that the resident refused lab work at the facility in the past, but that it wasn't re-attempted. The surveyor asked what interventions were tried to Executive Order 26, 4.b. and the RN/UM stated, "I can't recall all the interventions we used..." but that it was all addressed in the care plan. She stated that the resident was very Executive Order 26, 4.b. here he/she was being watched. She acknowledged that "watching" the resident was not adequate unless staff was right there, because if staff turned their back for just a minute to handle another issue, the resident would often Execut. She stated that the resident had no injuries from any of the Executive Order 26, 4.b. in the facility.

On 5/28/21 at 10:30 AM, the surveyor interviewed the Registered Nurse (RN) assigned to care for Resident #74. The RN stated that the resident Executive Order 26, 4.b., difficult to redirect and that he/she "kept standing" and "if you turn your back" the resident would Executiv. The RN

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confirmed that the resident was no longer in the broda chair to [redacted], and that any documentation should be in the ePN. She stated that sometimes she would call the family to have the resident speak to them so as to provide diversion, or offer toileting or fluids since the resident liked to drink fluids.

On 6/1/21 at 11:21 AM, the surveyor conducted a phone interview with the [redacted] who stated that the resident had [redacted] She stated that the resident thought he/she was on a roller coaster at one point. She stated that the resident also had a [redacted] She stated that the reason for the [redacted] was that the resident had episodes that he/she "had to get something" even if it wasn't there, and the resident would get very upset, causing him/her distress. The [redacted] stated that she wasn't aware that the resident was having any [redacted] She stated that no one addressed with her that the resident had [redacted], but that she would have to look further into that.

On 6/3/21 at 12:21 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) in the presence of the survey team. The DON stated that he was responsible for the conducting the [redacted] The DON stated that Resident #74 [redacted] He stated that "we haven't explored the labs" again after the resident's initial refusal but that the facility believed the [redacted]

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Executive Order 26, 4.b. He stated that prior to the resident's admission to the facility, he/she had Executive Order 26, 4.b. Executive Order 26, 4.b., but he confirmed that the resident was not in a skilled nursing facility when thoseExecutive Order 26, 4.b. . He stated that they had discussed the with the family representative and that they facility had attempted to engage in diversions, but he acknowledged the attempts were not always documented or reflected directly into the investigations. The surveyor requested a copy of the second activities assessment that was conducted as a result of the Executive Order 26, 4.b. but none was provided. A that the facility provided included that between Executive Order 26, 4.b. activities trialed several types of activities (beaded sculpture, jigsaw puzzle, and magazines) but the resident had "refused them all." There was no evidence that the resident was offered an opportunity to engage in diversional activities that the resident had been assessed to previously enjoy (TV, the news, attending religious services). The surveyor asked about the broda chair during the survey and if the resident kept standing up in it on , if staff should have offered the resident a different chair, since the resident was not exhibiting tiredness. The Regional Director of Clinical Operations responded that the resident was re-assessed for the use of a regular wheelchair that evening, and they had stopped using the broda chair at that time.

A review of the facility's undated policy for Falls and Fall Risk, Managing, included that "Environmental factors that contribute to the risk of falls include: ...footwear that is unsafe or

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absent." Resident conditions that may contribute to the risk of falls include: ...infection, delirium and other cognitive impairment, pain, lower extremity weakness...medication side effects, orthostatic hypotension [blood pressure that drops upon rising], functional impairments; visual deficits; and incontinence." The policy included that "Examples of initial approaches might include...improving footwear." ..."If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant....If underlying causes cannot be readily identified or corrected, staff will try various interventions based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable; In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g. hip padding...,as applicable) to try to minimize serious consequences of falling..." (The policy did not address performing fall risk assessments or re-assessments to determine fall risk potential.)

A review of the facility's undated policy, Care Plans, Comprehensive Person-Centered, included that "Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change."

A review of the facility's undated policy for Abuse Investigation and Reporting, included that the role of the investigator will at a "minimum: Review the resident's medical record to determine events leading up to the incident...Interview staff members...who have had contact with the

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| F 689 | Continued From page 98<br>resident during the period of the alleged incident; ...Review all events leading up to the alleged incident."<br><br>2. On 5/27/21 at 10:57 AM, the surveyor entered through the double doors on the [redacted] unit, and observed one CNA (CNA #1) transport a mechanical lift into the room of Resident #38. The surveyor observed that there were no other staff visibly present in the resident's room when she pushed open the door to move the mechanical lift into the resident's room. The surveyor continued down the hallway and entered the [redacted] unit Nurses station.<br><br>Three minutes later at 11:00 AM, the surveyor returned to the room of Resident #38, and knocked, and CNA #1 stated that she was inside the resident's room. The surveyor requested to enter the resident's room, and the surveyor observed at the CNA #1 was holding the handles of the mechanical lift independently and Resident #38 was suspended about six inches off the mattress of the bed in a mechanical lift sling. There were no other staff present in the room assisting in the mechanical lift transfer. The surveyor asked what she was doing and the CNA #1 stated that she was transferring the resident into the chair. The surveyor asked if someone was assisting her in the transfer and she stated that RN #1 was helping, but that she had stepped out. The surveyor asked if the RN #1 was going to return, and she stated that she didn't know. The surveyor asked why the RN #1 would leave the room while the resident was in mid-transfer, and the CNA #1 could not answer. The surveyor asked if she was going to wait for the RN #1 to return and she stated that she was not going to | F 689 | | |

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do that and that she would get someone else. While leaving the resident suspended over the bed in the mechanical lift, she then opened the door and called for assistance. CNA #2 entered the resident room and stated that she would help.

At 11:06 AM, the surveyor observed CNA #1 and #2 finish the transfer using the mechanical lift and positioned the resident in a wheelchair. At that time, in the presence of the CNA's the surveyor attempted to interview the resident by asking him/her their name, and the resident was awake and alert but did not verbally respond. The surveyor interviewed CNA #2 who stated that a mechanical lift transfer requires two staff members to safely transport the resident. The surveyor asked the CNA #1 how many staff members were assisting in the transfer of Resident #38 before she got the assistance of CNA #2, and she stated that while she was in the room by herself when the surveyor entered, she insisted that she was using two people, and that the RN #1 had left during the transfer.

At 11:09 AM, the surveyor noted that RN #1 still never returned to the room to assist in allegedly finishing the resident transfer using the mechanical lift as CNA #1 had stated to the surveyor. At this time, while the two CNA's were repositioning the resident in the wheelchair, the surveyor stepped out of the room and interviewed the RN #1 who was standing at the nurses station in the main dining room behind her locked medication cart. The RN #1 stated that she was currently assigned to supervise the dining room. She stated that she was aware that CNA #1 was going to transfer the resident, but that she couldn't be there for it because it was her time to supervise the main dining room area. The

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surveyor asked if she was in the resident's room at any point during the transfer using the mechanical lift and she indicated that she was not because she had been assigned to supervision duties, but that she knew the resident was about to to be transferred using the lift. The surveyor asked if the resident should have been suspended in the room while in the mechanical lift if only one staff member was present in the room, and the RN #1 replied that CNA #1 should have waited and that two staff members were required to transfer the resident using the lift.

The surveyor reviewed the medical record for Resident #38.

A review of the [redacted] Record reflected that the resident was admitted to the facility in [redacted]

A review of the resident's quarterly MDS dated [redacted]1, reflected that a brief interview for [redacted] could not be obtained, so staff conducted a cognitive assessment which indicated that the resident had a [redacted]. It further included that the resident was totally dependent on staff and required a two-person physical assist with all transfers. The MDS reflected that the resident had Executive Order 26, 4.b. quarter.

A review of the resident's Executive Order 26, 4.b. (a communication tool that provides instruction to

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| F 689 | Continued From page 101<br>CNA staff regarding the individualized needs of each resident) printed on 5/28/21 included that the resident was a "Total assist of two with all transfers from bed to wc [wheelchair] with the mechanical lift..."<br><br>A review of the resident's undated individualized comprehensive care plan included that the resident was at Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. included, "Total assist of two with all transfers from bed to wc [wheelchair] with the mechanical lift..."<br><br>On 6/1/21 at 1:16 PM, the Regional Director of Risk Management stated in the presence of the survey team and the Licensed Nursing Home Administrator, Director of Nursing (DON), the Regional Director of Clinical Services and the Regional Director of Operations, that Resident #38 required a two-person physical assist for transfers while using the mechanical lift. The Regional Director of Risk Management stated that they did a mechanical lift competency for all staff and that the CNA #1 did not intend to transfer Resident #38 independently and that there was some miscommunication with the CNA #1 and the RN #1. She stated that the CNA #1 thought that the RN #1 was going to come back to assist in the transfer. The surveyor asked why the RN #1 would have told the surveyor that she did not assist in the mechanical lift transfer at that time, when the surveyor had observed the resident suspended in the lift with only CNA #1 present in the room. The surveyor asked if it was not the RN #1 that assisted in suspending the resident using the mechanical lift, than who was it, because their individual statements to the surveyor did not corroborate. The Director of Risk | F 689 | | |

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| F 689 | Continued From page 102<br>Management stated that it was the RN's responsibility to monitor the CNA #1 to ensure that two staff members were transporting the resident, but that it "slipped her mind." The resident had no known incidents or accidents associated with the use of the mechanical lift.<br><br>A review of the facility's undated policy, Using a Mechanical Lifting Machine, included that: the purpose of the procedure was to "establish the general principles of safe lifting using a mechanical lift device."...and "At least two (2) nursing assistant (sic) are needed to safely move a resident with a mechanical lift."<br><br>NJAC 8:39-27.1 (a) | F 689 | | |
| F 698 SS=D | Dialysis<br>CFR(s): 483.25(l)<br><br>§483.25(l) Dialysis.<br>The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, it was determined that the facility failed to provide care and services in accordance with professional standards by adjusting medication times of administration to accommodate for Executive Order 26, 4.b. This deficient practice was identified for 1 of 1 residents reviewed receiving Executive Order 26, services (Resident #75), and was evidenced by the following: | F 698 | 1. The medication times for resident #75 were adjusted to accommodate for Executive Order 26, Executive Order 26, 4.b.<br><br>Resident #75 Executive Order 26, 4.b.<br><br>2. Dialysis residents have the potential to be affected | 6/30/21 |

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| F 698 | Continued From page 103<br>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 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."<br><br>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."<br><br>On 5/24/21 at 10:24 AM, the surveyor interviewed Resident #75 who stated that he/she went to the [redacted], and believed that the days the resident went were[redacted]<br><br>On 5/28/21 at 9:14 AM, the surveyor observed Resident #75 in bed with their eyes closed. The surveyor attempted but was unable to interview the resident. | F 698 | 3.<br><br>A. Director of Nursing or designee conducted audit on current Dialysis residents to ensure medication times are scheduled to accommodate for [redacted].<br>B. Director of Nursing or designee will review dialysis residents newly admitted to facility daily to ensure medication times are scheduled to accommodate for dialysis scheduled times.<br>C. Director of Nursing or designee will review dialysis residents daily for new orders to ensure medication times are scheduled to accommodate for dialysis scheduled times.<br>D. Licensed Nurses were educated on ensuring medication times are scheduled to accommodate for dialysis scheduled times on [redacted]<br><br>4.<br><br>A. Director of Nursing or designee will conduct audits on dialysis residents weekly for four weeks and then monthly to ensure medication times are scheduled to accommodate for dialysis scheduled times.<br>B. Results of the audits will be reported to the QA committee monthly.<br>C. The QAPI Committee will make recommendations based upon the results of the audits.<br>D. The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. | |

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| F 698 | Continued From page 104<br>On 5/28/21 at 9:17 AM, the surveyor interviewed the Registered Nurse Supervisor (RNS) who stated that she was familiar with Resident #75. The RNS stated that the resident was picked up at approximately Executive Order 26, 4.b. Executive Order 26, 4.b. and taken to the Executive Order 26, 4.b.<br><br>The surveyor reviewed the medical record for Resident #75.<br><br>A review of a significant change Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Executive Order 26, 4.b., reflected the resident had a brief interview for mental status (BIMS) Executive Order 26, 4.b., indicating that the resident had a moderately impaired cognition.<br><br>A review of the resident's Executive Order 26, 4.b. Record face sheet revealed a diagnosis of a Executive Order 26, 4.b.<br><br>A review of the resident's undated interdisciplinary care plan (IDCP) revealed that the resident received Executive Order 26, 4.b. In addition, the IDCP reflected that the resident had Executive Order 26, 4.b. | F 698 | | |

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Continued From page 105

A review of the [redacted] Communication Forms dated [redacted] that were completed by the facility and the [redacted] center indicated that the resident had received [redacted]

A review of the resident's progress notes dated 5/15/21 indicated that the resident returned from [redacted] and the progress notes dated 5/20/21 indicated that the resident returned from [redacted] In addition, the progress notes dated [redacted] indicated that the resident [redacted]

A review of the Order Listing Report reflected a physician's orders (PO) dated [redacted] for "[redacted] treatment received at a [redacted] ."

Further review of the Order Listing Report reflected the following PO with the date the PO started:

-[redacted]) [redacted]

.

[redacted]

[redacted]

[redacted]

.

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| F 698 | Continued From page 106<br>Executive Order 26, 4.b. [redacted]<br><br>In addition, the Order Listing Report reflected a discontinued PO dated 5/7/21 for "May revise medication schedules (times) as per Executive Order 26, 4.b. [redacted]<br><br>A review of the Executive Order 26, 4.b. [redacted]<br><br>Further review of the Executive Order 26, 4.b. [redacted]<br><br>In addition, the Executive Order 26, 4.b. [redacted]<br><br>Executive Order 26, 4.b. [redacted] | F 698 | | |

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Executive Order 26, 4.b. [redacted]

On 6/1/21 at 10:19 AM, the surveyor interviewed the Registered Nurse (RN) who stated that she was able to administer the resident's medications during her shift because the resident does not leave Executive Order 26, 4.b. The RN stated that the resident was not Executive Or [redacted] The RN also stated that the resident had a history of Executive Order 26, [redacted] in the past but has been more compliant since being Executive Order 26, 4.b. [redacted]. The RN stated that if the resident refused going to Executive Order 26, 4.b. then there would be a progress note indicating that the resident did not go to Executive Order 26, or the resident refused medications. The RN added that if medications were not able to be administered because the resident was at Executive Order 26, then the physician would have to be called and the times of administration changed. The RN was unsure of when the resident returned from Executive Order 26, The RN added that Executive Order 2 does take a while so the return time would be at least 3 to 4 hours after leaving the facility. The RN could not speak to the medications that were due on the evening shift of 3 PM to 11 PM.

On 6/1/21 at 10:45 AM, the surveyor interviewed

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| F 698 | Continued From page 108<br>the Unit Manager/RN (UM/RN) who stated that she was unsure of what time the resident returned from [Executive Order 26] and thought the time would be noted on the [Executive Order 26] Communication Form or in the progress notes. The UM/RN stated that [Executive Order 26] can take at least 3 to 4 hours before returning and that medication times should be adjusted to accommodate the resident being out of the facility.<br><br>On 6/2/2021 at 10:22 AM, the surveyor interviewed the Consultant Pharmacist (CP) who stated that she does make recommendations to adjust medication times of administration to accommodate [Executive Order 26] times. The CP added that she had not reviewed the resident's medications because the resident had returned to the facility after she had completed her monthly review. The CP added that she had reviewed the resident's medications as requested by the administration after surveyor inquiry and acknowledged that the medication times of administration had not accommodated [Executive Order 26] times. The CP also stated that she could not speak to why the nurses were documenting on the EMAR for medication administration for times when the resident was out to [Executive Order 26]<br><br>On 6/2/2021 at 1:35 PM, the survey team met with the facility administrative team. The Regional Director of Operations stated that the resident returned from [Executive Order 26] at varying times usually between 8 PM and 8:30 PM, unless there was a problem at the [Executive Order 26] center. She acknowledged that the medication administration times needed to be adjusted to accommodate the resident being out to [Executive Order 26]. She was unable to speak to the documented administration of medications on the EMAR during the time the resident was at the | F 698 | | |

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| F 698 | Continued From page 109<br>Executive Order 26 center.<br><br>A review of the facility undated policy for "Care of a Resident with End Stage Renal Disease" provided by the Regional Director of Operations reflected that residents will be cared for according to currently recognized standards of care. In addition, the education and training of the staff included the timing and administration of medications, in particular the medications before and after Executive Order 26<br><br>A review of the facility policy dated as revised 9/2020 for "Administering Medications" reflected that medications are to be administered in a timely manner as prescribed. Further review reflected that medications are to be administered within 1 hour of the prescribed time or at a specified prescribed time which included before a meal or after a meal.<br><br>A review of the Manufacturer specifications for Executive Order 26 reflected that the medication be administered with a meal.<br><br>A review of the Manufacturer specifications for Executive Order 26 reflected that the medication be administered 30 minutes after a meal. | F 698 | | |
| F 755 SS=E | NJAC: 8:39-11.2(b), 27.1(a), 29.2(a)(d)<br>Pharmacy Srvcs/Procedures/Pharmacist/Records<br>CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in | F 755 | | 6/30/21 |

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| F 755 | Continued From page 110<br>§483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to maintain accurate accountability and reconciliation for two (2) controlled drugs, an [redacted] Executive Order 26, 4.b. [redacted].<br>This deficient practice was identified for 2 of 5 residents reviewed for medication management, (Resident #74 and #75), and was evidenced by the following: | F 755 | 1. Resident [redacted] Executive Order 26, 4.b. [redacted]<br><br>Resident [redacted] Executive Order 26, 4.b. [redacted]<br><br>The Nurses responsible for not signing EMAR for [redacted] given to resident [redacted] | |

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| F 755 | Continued From page 111<br><br>1. On 5/24/21 at 10:24 AM, the surveyor interviewed Resident #75. The resident stated that Executive Order 26, 4.b. and would tell the nurse and would get a pain medication which helped.<br><br>On 5/28/21 at 9:17 AM, the surveyor interviewed the Registered Nurse Supervisor (RNS) who stated that she was familiar with Resident #75. The RNS stated that the resident had just finished having care rendered and was probably tired and that the resident had received a medication for pain earlier.<br><br>At that time, the surveyor with the RN reviewed the resident's Individual Patient's Controlled Drug Record (IPCDR) dated as received Executive Order 26, 4.b. The surveyor and the RNS verified the count for Executive Order 26, 4.b. remaining in inventory. There was no documentation of any wastage.<br><br>The surveyor reviewed the medical record for Resident #75.<br><br>A review of the resident's Executive Order 26, 4.b. Record revealed a Executive Order 26, 4.b.<br><br>A review of a significant change Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Executive Order 26, reflected the resident had a brief interview for mental status (BIMS) Executive Order 26, 4.b. indicating that the resident had a Executive Order 26, 4.b..<br><br>A review of the Order Listing Report reflected a | F 755 | were counseled on Executive Order 26,<br><br>The Nurses responsible for not signing EMAR for Executive Order 26, 4.b. given to resident Executive were counseled on Executive Order 2<br><br>2. Resident receiving PRN medication have the potential to be affected.<br><br>3.<br><br>A. Nurses were in-serviced on ensuring they maintain accurate accountability and reconciliation when administering PRN controlled drugs by 6/20/21<br>B. Director of Nursing audited resident receiving PRN medication to ensure accurate accountability of administration on 6/28/21. Discrepancies will be addressed with each nurse.<br>C. Unit Manager will review Individual Patient controlled drug Record Daily for previous days administration and compare to EMAR for accountability.<br>D. Pharmacy Consultant will audit residents receiving PRN controlled drugs monthly to ensure accountability<br><br>4.<br><br>A. Director of Nursing or designee will audit 5 residents receiving PRN controlled drugs weekly for 4 weeks and then monthly for three months to ensure accountability and reconciliation.<br>B. Results of the audits will be reported to the QA committee monthly.<br>C. The QAPI Committee will make recommendations based upon the results | |

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| F 755 | Continued From page 112<br>physician's order dated Executive Order 26, 4.b. [redacted]<br><br>A review of the electronic Executive Order 26, 4.b. [redacted] Record (eMAR) for Executive Order 26, 4.b. [redacted] reflected the same physician's order dated Executive Order [redacted] Executive Order 26, 4.b. Executive Order 26, 4.b. [redacted]."<br><br>Further review of the IPCDR revealed entries of removal from inventory of the resident's Executive Order 26, 4.b. on the following dates, times and number of tablets removed:<br><br>Executive Order 26, 4.b. [redacted]<br><br>Further review of the eMAR for Executive Order 26, 4.b. [redacted] reflected that there were no corresponding administration dates, times and number of tablets administered for the above entries on the IPCDR.<br><br>On 6/2/2021 at 10:22 AM, the surveyor interviewed the Consultant Pharmacist (CP) who stated that entries for removal on the IPCDR should correspond with the eMAR for the same dates, times, and number of tablets. The CP added that if there was wastage of any controlled drug then that would be documented on the IPCDR. In addition, the CP stated that a refusal of a medication by the resident would be reflected in the eMAR. The CP also stated that she had | F 755 | of the audits.<br>D. The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. | |

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| F 755 | Continued From page 113<br>reviewed the IPCDR for the [Executive Order 26, 4.b.] for Resident #75 after surveyor inquiry and acknowledged that the IPCDR had removal entries that did not correspond with the eMAR. The CP added that she does a spot check of IPCDR and the resident had not been [Executive Order 26, 4.b.] The CP added that the nurses who removed the [Executive Order 26, 4.b.] tablets from inventory had not documented on the EMAR for the administration. The CP also stated that she would be checking the IPCDR and corresponding eMAR moving forward.<br><br>On 6/2/2021 at 1:35 PM, the survey team met with the facility administrative team. The Regional Director of Operations stated that a review of the resident's IDCP and eMAR was done after surveyor inquiry and acknowledged that the IDCP and eMAR did not correspond. She stated that she had spoken with the nurses who had signed for removing the [Executive Order 26, 4.b.] from inventory and the nurses had said that the [Executive Order 26, 4.b.] tablets were administered to the resident. She added that the nurses stated that they had been distracted and forgot to document the medication administration. She also stated that the nurses were written up, educated and completed a Statement of Witness.<br><br>2. On 5/24/21 at 11:56 AM, the surveyor observed Resident #74 sitting in a broda chair at the nurses station. After finishing a four ounce cup of water that a Registered Nurse (RN) provided to the resident, the resident began | F 755 | | |

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reaching in the sky and began trying to maneuver the broda chair to turn.

On 5/26/21 at 11:08 AM, the surveyor attempted to interview Resident #74 in the privacy of his/her room. The resident responded to his/her name, but did not respond appropriately to other questions. The resident stated, "I want to go home" and began pulling at his/her pants.

The surveyor reviewed the medical record for Resident #74.

A review of the Admission Record face sheet (an admission summary) reflected that the resident had been recently admitted to the facility with diagnoses which included Dementia without behavioral disturbances, a cognitive communication deficit, insomnia, and psychophysical visual disturbances.

A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [Executive Order 26,] reflected that the resident had a BIMS of [Executive Order 26, 4.b.] indicating that on admission he/she had an intact cognition with moderate forgetfulness. It included that the resident had Executive Order 26, 4.b. , nor had any physical or verbal behaviors in the last seven days. The MDS included that the resident wandered on the unit daily which intruded on the privacy/activities of others.

A review of the resident's individualized comprehensive care plan reflected that the resident had an impaired cognitive function or impaired thought processes related to dementia initiated on 4/30/21. Interventions included to, "Administer meds as ordered..."

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| F 755 | Continued From page 115<br><br>A review of the physician's cumulative Order Review Report for Executive Order 26, 4.b. reflected a physician's order (PO) dated Executive Order 26, for the Executive Order 26, 4.b. ( . The order specified to Executive Order 26, 4.b.<br><br>The PO for the Executive Order 26, 4.b.<br><br>A review of the Individual Patient's Controlled Drug Record (IPCDR, a declining inventory sheet used for the Executive Order 26, 4.b. The surveyor reviewed the IPCDR with a comparative review of the electronic Medication Administration Record (eMAR) for May 2021. The review revealed that the Executive Order 26, 4.b. rom the resident's active inventory but not signed as administered in the eMAR on the following dates and times:<br><br>Executive Order 26, 4.b.<br><br>Further review of the documents revealed in the IPCDR that Executive Order 26, 4.b. | F 755 | | |

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Executive Order 26, 4.b. but the eMAR was signed that the dose was administered at 2:30 AM.

A review of the Executive Order 26, 4.b., reflected Executive Order 26, 4.b. was administered due to inability to be Executive Order 26, 4.b.. It was not signed in the eMAR as administered.

There was no corresponding ePN for the doses of Executive Orde signed out from active inventory on the IPCDR for the removal date and time of: Executive Order 26, 4

A review of the ePN dated Executive Order 26, 4.b., reflected that the resident had refused Executive Order 26, 4.b. and stating that he/she would not take any of the medications but "about a half hour later [Resident #74] took the Executive Order ." This dose signed out on the Executive Order 26, 4.b. was not signed as administered in the Executive Orde.

In addition, there was a dose removed from active inventory on 5/21/21 at 11:30 AM, and another dose removed at 9 PM, but the eMAR was signed to reflect that only Executive Order 26, 4.b. which does not correspond with the times it was documented as removed from active inventory. Further, the Executive Order 26, 4.b. Notes (ePN) dated Executive Order 26 at Executive Order 26, , reflected that the resident returned from a physician appointment at 11 AM that morning with episodes of Executive Order 26, 4 and that the Executive Order was given. (There was no documented evidence that a dose of Executive Orde was administered before Executive E Executive Order 26, 4.b.

A review of the ePN dated 5/24/21 at 7:20 AM

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reflected that the nurse administered [Executive Order] because the resident "attempted to get out of bed x2. [Executive Order] Administered." (This dose was not signed as administered in the eMAR).

On 5/28/21 at 10:30 AM, the surveyor interviewed the resident's assigned Registered Nurse (RN) who stated that the resident was confused, and had behaviors of, "keeps standing" and if staff tried to touch him/her to provide redirection the resident would sometimes become [Executive Order 26, 4.b.] [redacted]. She added that the resident also had a history of wandering into other resident rooms and she stated that the resident could also be [Executive Order 26, 4.b.] for no reason. The RN stated that after a dose of [Executive Order] was removed from active inventory, the nurse would sign in the IPCDR that a tablet was removed and how many tablets were remaining. She stated that "after" administering the tablet to the resident, the nurse was then responsible to sign the eMAR. The surveyor showed the RN the IPCDR for the [Executive Order 26, 4.b.] and the discrepancies with the eMAR for May 2021. The RN acknowledged that the eMAR wasn't always signed when a tablet was removed from the active inventory. She stated that sometimes the resident would spit out the [Executive Order] with his/her other medications and that was probably why it wasn't signed as administered in the eMAR. The surveyor asked about the process if a resident refuses to take a controlled drug that was prepared for administration, and she replied that nurses are supposed to sign that the dose was wasted on the IPCDR form. The RN confirmed that there was no documented evidence on the IPCDR form that any tablets of the [Executive Order] had been wasted by two nurses. She stated that there should be documentation in the ePN to

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clarify why it was removed, but she stated that she could not show the surveyor right now because she had to pass out medications to other residents.

On 5/28/21 at 10:44 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who confirmed that the resident had a [redacted] he RN/UM stated that the resident had behaviors of refusing lab work, trying to stand up unassisted and ambulate with an unsteady gait. She stated that when trying to re-direct the resident, he/she would kick and fight making it more dangerous for the resident because it would affect his/her balance. The surveyor reviewed the discrepancies within the IPCDR for the [redacted] and the eMAR for [redacted] with the RN/UM. The RN/UM acknowledged that surveyor's findings. She acknowledged that nurses should be documenting in the ePN, if its not documented in the eMAR. She further stated that the resident would sometimes refuse his/her medications when given and spit them out, but the [redacted] was very small and that often the resident would swallow the smaller tablets and spit out the larger ones. She stated that if the resident had spit out any tablets of [redacted] that dose should be documented on the IPCDR as "wasted" with two nurses. She acknowledged there were no tablets documented as wasted in the IPCDR for the [redacted] She stated that if a resident spit out a dose of [redacted] it should be recorded in the ePN. She stated that sometimes the nurses may not know what tablets the resident swallowed or not because it gets mixed in applesauce, stating that could be another reason of the eMAR not being signed as administered when it was removed from active

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inventory. She stated that she would look into it.

On 6/1/21 at 1:18 AM, the surveyor interviewed the Director of Nursing (DON) in the presence of the survey team and the Regional Director of Risk Management, the Regional Director of Operations, the Regional Director of Clinical Services. The DON stated that they reviewed the discrepancies with the IPCDR for the Executive Order 26, 4.b. and the eMAR for Executive Order 26, 4.b. He stated that in their investigation they saw that there were four nurses who weren't signing for the doses administered in the eMAR. He stated that the nurses reported that they stayed with the resident after giving the medication and had "forgot to sign" for the administration of the Executive Order 26, 4.b. thereafter. He stated that the four nurses reported through means of a statement that the resident always swallowed the tablets of the Executive Order 26, 4.b. that was given, and that failing to sign that a dose of the Executive Order 26, 4.b. was wasted in the IPCDR was therefore not a possibility.

He acknowledged there wasn't consistent documentation in the ePN regarding the discrepancies. He stated that on Executive Order 26, 4.b. when two doses of Executive Order 26, 4.b. were removed from active inventory at Executive Order 26, 4.b. but only one dose was signed as administered at Executive Order 26, 4.b. the DON stated that this occurred because during a shift-to shift count, the nurse had realized she forgot to sign the eMAR for the administration of the medication earlier in the day at Executive Order 26, 4.b. when the resident came back from an appointment. The DON acknowledged that surveyors findings.

A review of the facility's undated policy for Behavioral Assessment, Intervention and Monitoring included that "The facility will comply

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| F 755 | Continued From page 120<br>with regulatory requirements related to the use of medications to manage behavioral changes."<br><br>A review of the facility policy dated as revised September 2020 for "Administering Medications" reflected that medications were to be administered in accordance with the prescribers' orders. In addition, the medication label was to be checked three times to verify the right dosage and the individual administering medications was to initial the medication administration record after giving a medication.<br><br>NJAC: 8:39-29.2(a)(d), 29.4(k), 29.7(c) | F 755 | | |
| F 758 SS=E | Free from Unnec Psychotropic Meds/PRN Use<br>CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic | F 758 | | 6/30/21 |

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| F 758 | Continued From page 121<br>drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to ensure: a.) an [redacted] prescribed to be given as needed for agitation had a documented rationale for why it was being administered, and any non-pharmacological interventions trialed before administering the medication, b.) a clinical rationale was documented for why the as needed [redacted] This deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications | F 758 | 1. Resident [redacted]<br><br>2. Resident receiving [redacted] have the potential to be affected.<br><br>3.<br>A. Nurses were in-serviced on ensuring non-pharmacological interventions trialed before administering the medication | |

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| F 758 | Continued From page 122<br>(Resident #74), and was evidenced by the following:<br><br>On 5/24/21 at 11:56 AM, the surveyor observed Resident #74 sitting in a broda chair at the nurses station. After finishing a four ounce cup of water that a Registered Nurse (RN) provided to the resident, the resident began reaching in the sky and began trying to maneuver the broda chair to turn.<br><br>On 5/26/21 at 11:08 AM, the surveyor attempted to interview Resident #74 in the privacy of his/her room. The resident responded to his/her name, but did not respond appropriately to other questions. The resident stated, "I want to go home" and began pulling at his/her pants.<br><br>The surveyor reviewed the medical record for Resident #74.<br><br>A review of the Admission Record face sheet (an admission summary) reflected that the resident had been recently admitted to the facility with Executive Order 26, 4.b. [redacted]<br><br>A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a BIMS of [redacted] indicating that on admission he/she had an [redacted] It included that the resident had no Executive Order 26, 4.b. [redacted] The MDS included that the resident wandered on the unit daily which | F 758 | based on Resident plan of care. Nurses were in-serviced on ensuring they are documenting rationale for why a [redacted].<br><br>B. Unit Manager will review residents receiving PRN Antianxiety medication Daily to ensure Nurses are documenting rationale for why a PRN Antianxiety is being administered and the non-pharmacological interventions trialed before administering the medication.<br>C. Pharmacy Consultant will audit resident receiving PRN Antianxiety medication Monthly to ensure nurses are documenting rationale for why a PRN Antianxiety is being administered and the non-pharmacological interventions trialed before administering the medication.<br><br>4.<br>A. DON or designee will audit 5 residents receiving PRN Antianxiety medication weekly for 4 weeks and then monthly for three months to ensure nurses rationale for why a PRN Antianxiety is being administered and the non-pharmacological interventions trialed before administering the medication..<br>B. Results of the audits will be reported to the QA committee monthly.<br>C. The QAPI Committee will make recommendations based upon the results of the audits.<br>D. The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. | |

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intruded on the privacy/activities of others.

A review of the resident's individualized comprehensive care plan reflected that the resident had an Executive Order 26, 4.b. [redacted] Interventions were to "Administer meds as ordered; Keep my routine consistent and try to provide consistent caregivers as much as possible in order to decrease confusion..." The care plan also had a focus that he/she had a Executive Order 26, 4.b. [redacted] Interventions included to: "Anticipate and meet my needs." Inventions if the resident began to wander included: "Distract me from wandering by offering pleasant diversions, structured activities, food, conversation, television, book." ..."If I am wandering assess for unmet needs hunger, toileting, thirst, boredom." The care plan was also updated on Executive Order [redacted] and included that the resident had the potential to demonstrate physical behaviors "directed at me by other residents related to Executive Order 26, 4.b. [redacted] It indicated that the resident was Executive Order 26, 4.b. when redirected, Executive Order 26, 4.b. [redacted], a Executive Order 26, 4.b. [redacted]. The goal for the behaviors was that the resident would not harm him/her-self or others through the next review date of 7/14/21. Interventions included to "Assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain, etc;"..."Give me as many choices as possible about care and activities." The Executive Order 26, 4.b. reflected that the resident Executive Order 26, 4.b. cutive Order 26, 4.b. related to an "Executive Order 26, 4.b." Interventions

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included, "Give Executive Order 26, 4.b. Executive Order 26 . Monitor/document side effects and effectiveness." The side effects were listed on the care plan. Another intervention indicated that "I am taking Executive Order 26, 4.b. meds which are associated with an Executive Order 26, 4.b. Interventions for the recreational care plan initiated on Executive Order 26 included that the resident enjoys "playing cards" and "place me next to a peer who is actively engaged."

A review of the physician's cumulative Order Review Report for April and Executive Order 26, 4.b. reflected a physician's order (PO) dated Executive Order 26, for the Executive Order 26, 4.b. , Executive Order 26, 4.b. The order specified to Executive Order 26, 4.b. A PO dated Executive Order 26 included to monitor for Executive Order 26 with interventions "that may include but are not limited to: 1. Redirection, 2. (1:1), 3. Activity, 4. Toilet, 5. Food/Fluid offered, 6. Position Change, 7. Other intervention (specify in progress notes), 8. Medication." The order specified to monitor for the Executive Order 2 every shift (day, evening and night shift) for 14 days. There was also an order dated Executive Order 26 to Executive Order 26 for Executive Order 26, 4.b. of the Executive Order 26, 4.b. every shift. The PO to monitor for the resident's Executive Order 2 behaviors and the Executive Order 26, 4.b. Executive Order 26, 4.b. and Executive Order 26, 4.b. .

Further there was a PO dated Executive Order 26, included to monitor for Executive Order 26, 4.b. behaviors with interventions "that may include but are not limited to: 1. Redirection, 2. (1:1), 3. Activity, 4. Toilet, 5.

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Food/Fluid offered, 6. Position Change, 7. Other intervention (specify in progress notes), 8. Medication." The order specified to monitor for the [redacted]. There was no stop date on this order. A PO dated [redacted] also included to monitor for side effects of any [redacted]

The PO for the [redacted]

A review of the [redacted] Evaluation dated [redacted] reflected that Resident #74 was observed to be [redacted] The history of present illness indicated that the resident had [redacted] The consultation indicated that the resident had a [redacted] The [redacted] Practitioner (NP) adjusted the resident's [redacted], and recommended to "Continue [redacted]." The clinical rationale for exceeding a [redacted] order for [redacted] was not documented in the [redacted] Evaluation.

A review of the Individual Patient's Controlled Drug Record [redacted] for the resident's [redacted]

A review of the [redacted] Administration Record (eMAR) for [redacted] reflected the PO dated [redacted] to administer the

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Executive Order 26, 4.b. Executive Order 26, 4.b. The eMAR was signed to reflect the resident received doses on the following dates and time without consistent documented evidence as to why, including:

Executive Order 26, 4.b.

A review of the Behavior Monitoring flow sheets for Executive Order 26, 4.b. indicated the PO dated Executive Order 26, 4.b. to monitor for Executive Order 26, 4.b. every Day shift (7 AM to 3 PM), Evening shift (3 PM - 11 PM) and Night shift (11 PM - 7 AM) and to document interventions "that may include but are not limited to: 1. Redirection, 2. (1:1), 3. Activity, 4. Toilet, 5. Food/Fluid offered, 6. Position Change, 7. Other intervention (specify in progress notes), 8. Medication." The order specified to monitor for the Executive Order 26, 4.b. Executive Order 26, 4.b. . The Behavior Monitoring flow sheet reflected that Behavior monitoring for "Executive Order 26, 4.b." was Executive Order 26, 4.b. , and therefore there was Executive Order 26, 4.b. Executive Order 26, 4.b.

The surveyor reviewed the Executive Order 26, 4.b. Progress Notes (ePN) for Executive Order 26, 4.b. in comparison with the Behavior Monitoring flow sheets for Executive Order 26, 4.b. to determine what the resident's target behavior was specific to

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[redacted]" for each dose of [redacted] signed as administered in the eMAR and any interventions trialed and failed prior to administering the [redacted] medication, [redacted] The following was revealed:

For the [redacted] dose signed in the eMAR as administered on [redacted], the Behavior Monitoring flow sheet reflected that the resident had "NO" behaviors that shift, and there was no ePN that corresponded with resident's behaviors that warranted the use of the [redacted]

For the [redacted] dose given on [redacted], the Behavior Monitoring flow sheet reflected that the resident had [redacted] and was offered redirection, toileting, and food/fluids. It did not specify that a medication was given. There was no corresponding ePN that specified what specific behavior the resident was exhibiting that presented as [redacted]

For the [redacted] dose given on [redacted] the nurses did not document in the behavior monitoring section for [redacted] as it had been [redacted] Instead the nurses began documenting resident behaviors under the behavior monitoring for [redacted] as the resident was also on an [redacted] The Behavior Monitoring flow sheet revealed that the resident had six episodes of [redacted] and was offered redirection, toileting and food/fluids. There was no corresponding ePN for the dose given that specified what specific target behavior the resident was exhibiting and if that differed from the "[redacted]" to warrant the use of the [redacted], [redacted]

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| F 758 | Continued From page 128<br>For the [redacted] dose given on Executive Order 26, 4.b., the Behavior Monitoring flow sheet revealed that the resident had four episodes of [redacted] and was offered redirection, toileting and food/fluids. There was no corresponding ePN for the dose given that specified what specific target behavior the resident was exhibiting and if that differed from the "[redacted] to warrant the use of the Executive Order 26, 4.b..<br><br>For the [redacted] dose given on Executive Order 26, 4.b. the Behavior Monitoring flow sheet revealed that the resident had Executive Order 26, 4.b. and was offered redirection, toileting and food/fluids. There was no corresponding ePN for the dose given that specified what specific target behavior the resident was exhibiting and if that differed from the [redacted] " to warrant the use of the [redacted] medication [redacted]<br><br>For the [redacted] given on Executive Order 26, 4.b. the Behavior Monitoring flow sheet revealed that the resident had "NO" episodes [redacted]. There was no corresponding ePN for the dose given at 2:30 AM that specified what specific target behavior the resident was exhibiting, what Executive Order 26, 4.b. [redacted]<br><br>For the Executive Order 26, 4.b. [redacted] reflected an ePN dated [redacted] which indicated that [redacted] was given on [redacted] during the evening shift when the resident was seen to be sitting on the floor. The note specified that all the resident's medications were given and tolerated well, but the [redacted] Executive Order 26, 4.b. [redacted] There was no documented evidence of the resident's specific target behavior, if any | F 758 | | |

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[redacted] were trialed prior to administering the dose of [redacted] and what target behaviors the resident continued to exhibit for the [redacted] to not be effective. The ePN also did not reflect if the resident being found to be sitting on the floor was a possible side effect of the [redacted]. The Behavior Monitoring flow sheet was signed to reflect during that evening shift (3 PM to 11 PM) on 5/21/21 the resident exhibited "NO" [redacted] No trialed interventions were listed.

For the [redacted], the Behavior Monitoring flow sheet revealed that the resident had [redacted] of [redacted] and was offered redirection, toileting and food/fluids. There was no corresponding [redacted] for the dose given that specified what specific target behavior the resident was exhibiting and if that differed from the [redacted]" to warrant the use of the [redacted], [redacted]

For the [redacted], the Behavior Monitoring flow sheet revealed that the resident had [redacted] of [redacted] and was offered redirection, toileting and food/fluids. There was no corresponding ePN for the dose given that specified what specific target behavior the resident was exhibiting and if that differed from the "[redacted]" to warrant the use of the [redacted], [redacted]

A review of the ePN dated 5/24/21 at 7:20 AM reflected that the nurse administered [redacted] because the resident "attempted to get out of bed x2. [redacted]." There was no documented evidence of [redacted] trialed prior to administering [redacted], and if administering [redacted] due to trying to get out

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of bed without further documentation was an appropriate use for the [redacted].

Further review of an ePN on [redacted] at [redacted], reflected that the resident returned from a physician appointment at 11 AM that morning with [redacted] and that the [redacted] was given. There was no documented evidence of what was potentially causing the resident's agitation, what specific specific target behaviors the resident was exhibiting that presented as "agitation," and any non-pharmacological interventions trialed and failed prior to administering the [redacted]. (This dose was also not signed as administered in the eMAR for May 2021). In addition, a review of the Behavior Monitoring flow for May 2021 revealed that the resident exhibited '[redacted]' behaviors of [redacted] that shift on [redacted] during the day shift or any shift that day. No interventions were listed as trialed.

A comparative review of the eMAR for [redacted] the Behavior Monitoring flow sheets for [redacted] and [redacted] and the ePN for [redacted] revealed that Resident #74 was not trialed with an activity of interest as a means to evaluate if any behaviors that may have been exhibited were associated with "boredom" in accordance with the resident's plan of care.

A review of the [redacted] Order Summary Report for [redacted] reflected a PO dated [redacted] for [redacted] related to [redacted] visual disturbances."

A review of the eMAR for [redacted] reflected that

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| F 758 | Continued From page 131<br>the nurses were signing twice a day (during the day shift and evening shift) routinely for the administration of the Executive Order 26, 4.b. [redacted]<br><br>A review of a follow-up Psychiatric Evaluation performed by the Psychiatric NP and dated 5/25/21 reflected that the resident presented calm with confusion, and "as per staff, [Resident #74] Executive Order 26, 4.b. with care, hits staff." The recommendations included to discontinue the Executive Order 26, 4.b. and start the Executive Order 26, 4.b. [redacted]<br><br>A review of the physician's Order Summary Report for Executive Order 26, 4.b. reflected the physician's orders for the recommendations made by the Executive Order 26, 4.b. [redacted]<br><br>On 5/27/21 at 9:08 AM, the surveyor interviewed the resident's assigned Certified Nursing Aide (CNA). The CNA stated that Resident #74 was Executive Order 26, 4.b. and that he/she had behaviors of standing up repeatedly from the chair and would be difficult to redirect. She stated that the facility "watched" him/her and rotated who was responsible for supervising the dining room every 30 minutes. She stated that the majority of the time, she assists with feeding the resident but the family brought in snacks like muffins and oranges that she would give to the resident. She stated that the resident also always asked for fluids to drink so she would give the residents fluids also. She stated that she can tell if the resident wants to walk and she would try to walk the resident if his/her gait was steady. She stated that the facility had also implemented a | F 758 | | |

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broda chair (a reclining chair that sits low to the ground) to assist in "relaxing" the resident and to keep him/her from standing up so much. She stated that it had implementing the broda chair helped reduce the number of falls, even though the resident was still able to stand up from the broda chair.

On 5/28/21 at 10:30 AM, the surveyor interviewed the resident's assigned Registered Nurse (RN) who stated that the resident was confused, and had behaviors of, "keeps standing" and if staff tried to touch him/her to provide redirection the resident would sometimes become [redacted] or not follow commands. She added that the resident also had a [redacted] for no reason. She stated that sometimes she would call the resident's family representative a non-pharmacological intervention, stating that it would help initially, but then would exhibit the behaviors again one hour later. She stated that they would offer the resident food but he/she would spit it out, including the medicine sometimes. She added that they try to toilet the resident at times too, but he/she would be "dry." The surveyor showed the RN the IPCDR for the [redacted], the eMAR for [redacted] and the Behavior Monitoring flow sheet for April and May 2021. The RN acknowledged that there was not consistent documentation for the use of the [redacted] stating that ideally all specific target behaviors should be addressed in the ePN. She could not speak if there was always documentation of [redacted], but she stated that there should be documentation associated with each dose given. The surveyor asked what the

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resident enjoyed doing and the RN could not speak to what he/she enjoyed or used to enjoy other than having visits with family representatives, to offer as a means to distract or prevent boredom in accordance with the resident's plan of care.

On 5/28/21 at 10:44 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who confirmed that the resident had a Executive Order 26, 4.b. Executive Order 26, 4.b. . The RN/UM stated that the resident had Executive Order 26, 4.b. trying to stand up Executive Order 26, 4.b. . She stated that when trying to re-direct the resident, he/she would kick and fight making it more dangerous for the resident because it would affect his/her balance. She stated that when the resident exhibited these behaviors of Executive Order 2, the resident would be offered snacks and toileting but most of the time they "weren't effective." The surveyor asked what she knew about the resident and his/her past regarding what preference for activities the resident enjoyed, and the RN/UM stated that the resident loved to shop, cook, and he/she enjoyed "leisure activities." She elaborated and stated that she was aware that the resident was very social and "liked church." The RN/UM was not sure what religion the resident was, and further stated that she didn't offer the activities to the resident, but stated that the activities department handled that. She added that the resident had only been at the facility for a month and initially when he/she was admitted, the resident was calm. The surveyor asked if the nurses don't offer diversional activities that he/she had been previously known to enjoy, what Executive Order 26, 4.b. The

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RN/UM replied they would offer fluids, snacks, redirection, toileting, reassurance and acknowledging feelings, and "do whatever [Resident #74] wanted to do." The RN/UM was not sure what triggered the resident's Executive Order 26.

The surveyor reviewed the IPCDR, the eMAR for May 2021, and the Behavior Monitoring flow sheets with the RN/UM who acknowledged that nurses were not consistently documenting what non-pharmacological interventions were trialed prior to administering the Executive Order. She acknowledged that nurses should be documenting in the ePN what specific target behavior the resident was exhibiting and what Executive Order 26, 4.b.

On 6/1/21 at 11:21 AM, the surveyor conducted a phone interview with the Psychiatric NP who stated that the resident had Executive Order 26, 4.b. Executive Order 26, 4.b. which caused him/her to Executive Order 26. She stated that the resident thought he/she was on a roller coaster at one point. The surveyor asked the Executive Order 26, 4.b. NP if the Executive Order and the Executive Order 26, 4.b. NP stated that from what she understood, the resident was Executive Order 26, 4.b. and that it would cause him/her to reach out and grab at staff. She stated that the resident's target Executive Order 26, 4.b. She stated that the resident also had a Executive Order 26, 4.b., Executive Order 26, 4.b. She stated that the reason for the Executive Order 26, 4.b. was that the resident had episodes that he/she "had to get something" even if it wasn't there, and the resident would get very upset, causing him/her distress. She stated that in addition, the resident

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was unable to consistently articulate what it was he/she wanted or needed. The surveyor asked the [redacted] NP if she was involved in recommending any diversional activities or non-pharmacological interventions, and she stated that she was "not aware" of any activity preferences that the resident enjoyed, and indicated that she always encourages non-pharmacological interventions such as speaking with a calm approach and trying to minimize external stimulation/noises. The Psychiatric NP stated that nursing staff may be able to speak better on the resident's diversional non-pharmacological preferences.

On 6/1/21 at 1:18 AM, the surveyor interviewed the Director of Nursing (DON) in the presence of the survey team and the Regional Director of Risk Management, the Regional Director of Operations, the Regional Director of Clinical Services. The DON stated that they reviewed the surveyor's findings regarding the [redacted] being given without evidence of a documented behavior and non-pharmacological interventions being trialed first. He stated that when he interviewed the nurses that mostly worked in the evening shifts, "most weren't saying [redacted] is a last resort" if non-pharmacological interventions had failed. He stated that all documentation should be charted in the ePN. He stated that the had a [redacted] and when the resident was brought to the Emergency Room by their family, the resident had been [redacted] with the [redacted]. The DON stated that the resident had stated that he/sh [redacted] surveyor asked where this would be

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| F 758 | Continued From page 136<br>documented and he stated that it should be in the ePN. He stated that the RN/UM does the monthly psychotropic drug summary but that it was just up for review. He acknowledged there wasn't consistent documentation to warrant the use of the [redacted] on the dates in question. The DON provided the surveyor statements from four nurses, but no additional documentation was provided from the resident's medical record.<br><br>A review of the facility's undated policy for Behavioral Assessment, Intervention and Monitoring included that "The facility will comply with regulatory requirements related to the use of medications to manage behavioral changes." ... "The interdisciplinary team will evaluate new or changing behavioral symptoms in order to identify underlying causes and address any modifiable factors that may have been contributed to the resident's change in condition, including: ...Emotional, psychiatric and/or psychological stressors (for example): Depression; Boredom; Loneliness; Anxiety; and/or Fear." ..."Non-pharmacologic approaches will be utilized to the extent possible to avoid or reduce the use of antipsychotic medications to manage behavioral symptoms....documentation will include: other approaches and interventions tried prior to the use of the antipsychotic medication"<br><br>NJAC 8:39-11.2 (b); 27.1 (a) | F 758 | | |
| F 807 SS=D | Drinks Avail to Meet Needs/Prefs/Hydration<br>CFR(s): 483.60(d)(6)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(6) Drinks, including water and other | F 807 | | 6/30/21 |

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| F 807 | Continued From page 137<br>liquids consistent with resident needs and preferences and sufficient to maintain resident hydration.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, it was determined that the facility failed to ensure a resident's preferences for nutritional health shakes were honored when the resident was experiencing weight loss. This deficient practice was identified for 1 of 5 residents reviewed for dietary preferences (Resident #74). The evidence was as follows:<br><br>On 5/26/21 at 11:08 AM, the surveyor attempted to interview Resident #74 in his/her room . The resident was sitting in a broda chair and mumbling to him/her-self. The resident responded to his/her name but did not respond back to the surveyor's questions appropriately. The resident stated that he/she wanted "to go home" and began pulling on his/her pants. The surveyor was unable to complete the interview.<br><br>The surveyor reviewed the medical record for Resident #74.<br><br>A review of the hospital records dated for the Executive Order 26, 4.b. encounter of Executive Order 26 indicated that during his/her hospitalization the Physician wrote a progress note that staff had requested to "stop the Executive Order 26, 4.b shakes" because [Resident #74] was refusing them and several Executive Order 26, 4.b shakes were seen at the "bedside untouched." The hospital Registered Dietician (RD) also indicated in nutrition assessment that the resident had a poor/varying oral intake and was refusing "all meal supplements. Many untouched on bed table." | F 807 | 1. Resident Executive was discharged from Facility. Resident no longer resides in the Facility and is not anticipated to return.<br><br>2. All residents receiving health shakes have the potential to be affected<br><br>3.<br>A. The Dietician was educated to ensure resident preferences for health shakes are honored when recommending on 6/23/21.<br>B. Dietician audited resident receiving Health sakes to ensure they are receiving health shakes based on their preferences by6/28/21<br><br>4.<br>A. Administrator or designee will audit 5 residents receiving health shakes to ensure resident preferences for health shakes are honored.<br>B. Results of the audits will be reported to the QA committee monthly.<br>C. The QAPI Committee will make recommendations based upon the results of the audits.<br>D. The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. | |

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A review of the Admission Record face sheet (an admission summary) reflected that the resident had been recently admitted Executive Order 26, 4.b. [redacted]

A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, Executive Order 26, 4.b. reflected that the resident had a BIMS of Executive Order 26, 4.b. [redacted] The assessment indicated that the resident was able to eat independently with meal set-up by staff and that he/she had no known weight loss.

A review of the facility's initial Nutrition [redacted] included that the resident had a Executive Order 26, 4.b.. The assessment revealed that labs were not available from the hospital records but the Registered Dietician (RD) was able to interview the resident. The Evaluation indicated "per hospital documentation, resident received Executive Order 26, 4.b. Rt [Resident] reports disliking Executive Order 26, 4.b., is agreeable to try Executive Order 26, 4.b.] Executive Order 26, 4.b. " Executive Order 26, 4.b. [redacted].

A review of the resident's individualized comprehensive care plan initiated on [redacted]

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reflected that the resident had an impaired cognitive function or impaired thought processes related to dementia and a communication problem related to the resident's voice being of low volume. Interventions included to: "Anticipate and meet my needs." The care plan indicated to provide and serve a nutritional supplement as ordered: "Executive Order 26, 4.b. " Executive Order 26, 4.b. initiated on 4/21/21 due to a potential nutritional problem due to resident's Executive Order 26, 4.b. (This intervention for Executive Order 26, 4.b. did not correspond with the RD recommendation on 4/1/21 for the Executive Order 26, 4.b. Executive Order 26, 4.b. ). The care plan did not address a Executive Order 26, 4.b. . In addition the care plan did not address the resident's dislike for Executive Order 26, 4.b. in accordance with the hospital records and the initial Nutritional Assessment.

A review of the electronic Progress Notes (ePN) for Executive Order 26, 4.b. did not reflect documented evidence that a rationale or a risk versus benefit with using Executive Order 26, 4.b. was the appropriate supplement of choice for a resident with diabetes and on an oral hypoglycemic medication (a medication that lowers the blood sugar).

A review of the physician Order Review Report for all physician orders (PO) from admission to the facility through 5/27/21, reflected that the Ensure supplement was changed to a Executive Order 26, 4.b. supplement three times a day with meals on 5/21/21. (This did not correspond with the known resident preferences as referenced in the hospital records and the initial Nutrition Evaluation assessment dated 4/21/21 in which the resident informed the RD that he/she disliked Executive Order 26, 4.b.

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| F 807 | Continued From page 140<br>supplements.<br><br>A review of the electronic Medication Administration Record (eMAR) for [redacted] reflected that physician's order dated [redacted] for the [redacted]. The [redacted] was plotted to be administered at [redacted], [redacted]. The eMAR reflected that the resident consumed between 2 ounces to 8 ounces of [redacted] from [redacted], and the resident refused it on [redacted] and [redacted]. The order for the [redacted] was clarified on 5/25/21 to give [redacted]. The eMAR reflected that the resident consumed all 8 ounces of the [redacted]<br><br>On 5/26/21 at 12:35 PM, the surveyor observed a Certified Nursing Aide (CNA) deliver the lunch meal to Resident #74 at the table. The resident received a [redacted]. The CNA set up the resident's lunch tray but left the [redacted] supplement in its container closed. The resident began to eat meat loaf with a spoon.<br><br>At 12:41 PM, the surveyor observed the RD sit with the resident briefly, and the RD encouraged the resident to try some more of the food. The RD then stated to the resident that she would give the resident privacy to eat.<br><br>At 12:50 PM, the resident's [redacted] had not yet been opened and there was no cup on the tray to drink it from. At that time, the CNA approached the medication cart to obtain a straw and returned to open the resident's [redacted] and placed the straw in it. She then put the straw in the | F 807 | | |

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resident's mouth to drink the [redacted], but the resident did not even take a sip. The CNA stated to the resident as she was attempting to give the [redacted]: "You aren't going to drink it? Let me try the ginger ale." The resident took a sip of the ginger ale.

At 1:05 PM, the surveyor observed the CNA clear the resident's lunch setting. The CNA left the resident's [redacted] on the table with the straw in it. The resident was sitting quietly in the broda chair with his/her eyes closed and had not yet taken any sips from the [redacted] carton.

A review of the resident's lunch meal ticket dated for the lunch meal on [redacted] indicated that supplements on the tray included: "[redacted]." The section on the meal ticket to record the resident's dislikes, read: "None."

On 6/1/21 at 10:44 AM, the surveyor interviewed the RD who stated that she started working at the facility in April 2021. The RD stated that she was familiar with Resident #74 and that on admission the resident was able to express preferences, likes and dislikes and seemed to answer questions appropriately. She stated that the resident had had a decline in weight since admission and that she was aware that the resident had been previously supplemented with [redacted] However at that time, the resident had reported to her that he/she did not like the [redacted] health shake which was why the Sugar Free health shake was recommended to him/her and the resident seemed agreeable. The RD stated that the Medical Doctor (MD) changed supplement order to [redacted]

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[redacted] The RD stated that she wasn't aware that the MD had ordered the [redacted] and stated that she was not sure if [redacted] was appropriate for diabetics or if it came in a formulary appropriate for diabetics. She stated that although the resident has lost weight, he/she had remained within a normal BMI (Body Mass Index). The surveyor asked about the order for the [redacted] when the resident had told her that he/she didn't like it, and the RD acknowledged that it was in the hospital records as well as in her [redacted], but stated that she was not aware that the MD changed the order to [redacted]. She stated that she didn't make the recommendation to change it to [redacted] She stated that she knew the resident didn't like it. She stated that it was documented in the eMAR that the resident was consuming it at times. The surveyor discussed what was observed with the resident not drinking the [redacted] during lunch on 5/26/21 and that the RD was there with the resident at the time. The RD was unable to provide documented evidence of the documented justification for the use of the Executive Order 26, 4.b. when the resident had diabetes and was on an oral hypoglycemic medication with a varying oral intake. She acknowledged that without documented blood sugar readings, it was difficult to justify the use of the [redacted] In addition the RD acknowledged that the resident' should not have received the [redacted] if he/she had reported not liking it. She stated that when it was identified on 5/27/21, it was switched to a Executive Order 26, 4.b.

On 6/1/21 at approximately 12:50 PM, the surveyor interviewed the Regional Director of Risk Management in the presence of the survey team and the Director of Nursing and Licensed

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| F 807 | Continued From page 143<br>Nursing Home Administrator (LNHA). The Regional Director of Risk Management confirmed that the resident's nutrition preferences should have been more clear on the resident's plan of care.<br><br>No additional documents were provided regarding the justification for the nutritional supplements when the resident had a diagnosis of diabetes as well as preferences of not liking [redacted], but it was still being served to the resident.<br><br>A review of the facility's undated Care Plans, Comprehensive Person-Centered policy included that the "resident's personal ...preferences in developing the goals of care" would be incorporated. In addition it included that the resident's expressed wishes would be reflected regarding care and treatment goals.<br><br>NJAC 8:39-17.4 (c), (e) | F 807 | | |
| F 810 SS=D | Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g)<br><br>§483.60(g) Assistive devices<br>The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to ensure a.) a resident who repeatedly spilled liquids during their meals was assessed and provided an adaptive drinking cup to prevent spills. This deficient practice was identified for 1 | F 810 | 1. Resident [redacted] was discharged from Facility. Resident no longer resides in the Facility and is not anticipated to return.<br><br>2. Resident needing assistive devices have the potential to be affected. | 6/30/21 |

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| F 810 | Continued From page 144<br>of 17 residents reviewed for dining services (Resident #74). The evidence was as follows:<br><br>On 5/24/21 at 12:25 PM, the surveyor observed Resident #74 sitting in a broda chair at a dining room table. The surveyor observed an Activities Assistant place the resident's lunch tray in front of Resident #74 which included macaroni and cheese. The Activities Assistant opened a can of ginger ale and placed it next to the resident's plate. It was not poured into an alternate cup. After the Activities Assistant walked away, the resident, while sitting alone, then reached for the can of ginger ale and poured it all over his/her macaroni and cheese and placed the emptied can on top of the food.<br><br>At 12:34 PM, the surveyor observed the Food Service Director (FSD) deliver another tray for the resident which included a hot dog on a bun.<br><br>At 12:39 PM, the surveyor observed a Speech Language Pathologist (SLP) sitting with the resident and attempted to encourage the resident to eat the cut up hot dog. The resident did not show interest in eating.<br><br>On 5/26/21 at 11:08 AM, the surveyor attempted to interview Resident #74 in the privacy of his/her room. The resident responded to his/her name, but did not respond appropriately to other questions. The resident stated, "I want to go home" and began pulling at his/her pants.<br><br>On 5/26/21 at 12:35 PM, the surveyor observed a second meal for Resident #74. The resident was sitting in a broda chair by him/her-self at a dining table positioned at the height of the resident's chin. The surveyor observed a Certified Nursing | F 810 | 3.<br>A. Rehabilitation and Nursing staff were in-serviced on use of Nursing Therapy Communication Change of Status Form to notify Rehabilitation of a residents need for assistive device on 6/30/21.<br>B. Rehabilitation staff will conduct rounds in dining room during meals to assess for residents needing assistive devices during meals weekly.<br><br>4.<br>A. Director of rehab will audit 5 residents weekly for four weeks and then monthly residents during dining to assess for need for assistive devices.<br>B. Results of the audits will be reported to the QA committee monthly.<br>C. The QAPI Committee will make recommendations based upon the results of the audits.<br>D. The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. | |

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Aide (CNA) cut up the resident's meat loaf, and prepare hot tea in a regular mug.

At 12:50 PM, after the resident ate almost all of the meatloaf, the surveyor observed the resident reach for the hot tea and the resident spilled it all over the rest of his/her lunch.

At 12:54 PM, the surveyor observed the CNA return to check on the resident and saw that the resident's lunch plate was covered in the hot tea. The CNA then attempted to feed the resident a spoonful of some mashed potatoes that were not moistened from the hot tea. She stated to the resident "I have to make sure you eat something." She then saw that a nutritional health shake carton had not been opened, so she walked over to the medication cart in the room, and accessed a straw and placed a straw in the health shake. The resident did not drink the health shake from the straw. She then offered the resident some ginger ale and with the CNA holding the ginger ale the resident took a small sip of it. There were no adaptive cups provided to the resident or any adaptive equipment listed on his/her lunch meal ticket.

At 1:05 PM, the surveyor observed the CNA clean up the resident's lunch meal and plate with the hot tea that was spilled in the food. The CNA left the nutritional health shake in front of him/her with a straw in it. The surveyor observed the resident with his/her eyes closed, sitting in the broda chair at the table.

On 5/27/21 at 9:23 AM, the surveyor observed a third meal service for Resident #74. The surveyor observed the resident sitting in a standard wheelchair and cutting up his/her egg

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breakfast with a fork and knife appropriately. The resident was served hot tea from a regular mug, orange juice from a reusable plastic cup and four ounces of water in a disposable plastic cup. There were no lids on the cups or adaptive cups on the tray. After the resident completed eating 50% of the breakfast, he/she spilled the hot tea all over the floor in front of him/her. After the tea was spilled, the mug of hot tea was observed to have only a small amount of remaining in the mug.

On the same day on 5/27/21 at 9:44 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who was present in the dining room during the breakfast meal service. The RN/UM acknowledged that Resident #74 had spilled the hot tea all over the floor and that she would have to get housekeeping to assist in the clean up. She stated that the resident utilized regular cups for meal service. She stated that she knew that the resident also improperly "pours milk" on the food as well at times. She stated that the resident "is always spilling." The surveyor asked what the plan was if the resident was "always spilling." The RN/UM stated that the facility believed that it may be the resident's behaviors, and that they were focused on managing those behaviors. The surveyor asked if the resident had always been spilling, if he/she had been assessed for an adaptive cup with a lid or other adaptive cup to prevent spilling, and the RN/UM stated that it was a "good idea" and that no-one had thought of that. The surveyor discussed with the RN/UM that the surveyor had observed three (3) of three (3) meals in which the resident had spilled his/her liquids either on the food or on the floor. She acknowledged that if a resident was having difficulty using regular eating

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utensils during meal service, the nurses could request a referral for Occupational Therapy to evaluate for any adaptive eating/drinking equipment. She stated that it had not been done prior to surveyor inquiry.

The surveyor reviewed the medical record for Resident #74.

A review of the Admission Record face sheet (an admission summary) reflected that the resident had been recently Executive Order 26, 4.b. [redacted]

A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 4/27/21 reflected that the resident had a BIMS of Executive Order 26, 4.b. indicating that on admission he/she had an intact cognition with moderate forgetfulness. It included that the resident had Executive Order 26, 4.b. [redacted], Executive Order 26, 4.b. [redacted]. The MDS included that the resident was able to eat independently with set-up by staff at the time of the assessment.

A review of the resident's individualized comprehensive care plan reflected that the resident had an Executive Order 26, 4.b. [redacted] initiated on [redacted]. Interventions were to "Administer meds as ordered; Keep my routine consistent and try to provide consistent caregivers as much as possible in order to decrease confusion..." The care plan did not address the resident as "always spilling" or the

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| F 810 | Continued From page 148<br>means to prevent further spilling of liquids, including an assessment for the use of an adaptive drinking cup.<br><br>A review of the electronic Progress Notes (ePN) for [redacted] did not address the resident spilling liquids on their food for the lunch meal on [redacted] and it wasn't until the surveyor inquired on [redacted] that the spilling of liquids was addressed.<br><br>A review of the Occupational Therapy (OT) Evaluation and Plan of Treatment for Certification Period [redacted] did not address a referral for an adaptive cup due to spilling of liquids.<br><br>On 6/1/21 at 9:31 AM, the surveyor interviewed the SLP who had sat with the resident during the lunch meal on 5/24/21, and had observed that the resident had spilled the ginger ale on the macaroni and cheese. The SLP introduced himself and stated that he was also the Director of Rehab Services. He stated that Resident #74 was confused and difficult to redirect with a decline in cognition. He stated that he had been seeing the resident for some [redacted] He stated that the resident was being seen by OT to also assist in promoting self-feeding strategies. She stated that the resident did not like to be fed and can become resistant if he/she felt that staff were "leaning over [him/her] to eat." She stated that the resident had no hand tremors when eating. The surveyor asked the SLP about the resident spilling liquids on the macaroni and cheese on 5/24/21. He acknowledged that the resident had spilled liquids onto the food and that was the first time he had seen that from the resident. He stated that it was | F 810 | | |

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| F 810 | Continued From page 149<br>possible that the resident was "misunderstanding what the object was" stating that with the resident's dementia, he/she may be thinking that the drinks may be a condiment and mistakenly the resident may pour it onto their food for that purpose. He stated that they were trying to figure that out. He acknowledged that staff had not brought up that the resident had been spilling liquids on their tray until the surveyor inquired about it on [redacted] The surveyor asked if the facility had adaptive cups available, and he stated that they did not have a stock of adaptive cups and that one had to get specially ordered for the resident. He stated that the facility maintained a stock of adaptive plates and utensils, but not cups. He stated that if the facility needed it, the nurses would request a referral and it would get ordered right away.<br><br>On 6/1/21 at 1:46 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the survey team. The DON stated that the facility had adaptive utensils but no adaptive cups on hand, but added that their sister-facilities had adaptive cups that they could use until any purchased item arrived. He stated that the residents wouldn't have to wait for an adaptive cup if he/she needed it right away. The Regional Director of Risk Management stated that there was no documentation of the resident spilling in the ePN, and that this was new for the resident with regard to spilling during the meal service. The surveyor asked why the RN/UM would tell the surveyor that the resident was "always spilling" if he/she was not always spilling? The surveyor also asked if it wasn't documented in the ePN that the resident spilled his/her liquids for the lunch meal on [redacted] when the surveyor observed it happen, could it be also be | F 810 | | |

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| F 810 | Continued From page 150<br>possible that the resident spilled during other meals as the RN/UM stated to the surveyor, and it just not be documented in the ePN? The facility's Regional administration including the DON and the Licensed Nursing Home Administrator (LNHA) were unable to speak to those questions. They acknowledged the spilling wasn't addressed in the care plan either. They stated that out of respect to the surveyor's findings of the resident spilling the liquids for 3 of 3 meals, the resident was subsequently assessed for an adaptive cup and one was ordered and provided to the resident.<br><br>On 6/3/21, the Regional Director of Clinical Operations provided the surveyor a copy of the facility's undated Assistive Devices and Equipment policy which included, that "Certain devices and equipment that assist with resident...independence are provided for residents. These may include (but are not limited to): Specialized eating utensils and equipment." ..."Recommendations for the use of devices and equipment are based on the comprehensive assessment and documentation in the resident's care plan." ..."Requests or the need for special equipment should be referred to the Nursing, Rehabilitation, or Social Services Departments."<br><br>NJAC 8:39-27.5(b); 46.5 | F 810 | | |
| F 836 SS=E | License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c)<br><br>§483.70(a) Licensure.<br>A facility must be licensed under applicable State and local law.<br><br>§483.70(b) Compliance with Federal, State, and | F 836 | | 6/30/21 |

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| F 836 | Continued From page 151<br>Local Laws and Professional Standards.<br>The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.<br><br>§483.70(c) Relationship to Other HHS Regulations.<br>In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews and facility document review, the facility failed to ensure staffing ratios were met for 55 of 66 shifts reviewed. There was no increase in the resident census for a period of nine consecutive shifts. This deficient practice had the potential to affect all residents.<br><br>Findings include:<br><br>Reference: New Jersey Department of Health | F 836 | 1. No residents were identified.<br><br>2. All residents have the potential to be affected.<br><br>3.<br><br>A. Director of Nursing, Administrator and Staffing coordinator were in-serviced on new minimum staffing requirements on | |

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| F 836 | Continued From page 152<br>(NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:<br><br>One Certified Nurse Aide (CNA) to every eight residents for the day shift.<br><br>One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and<br><br>One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.<br><br>On 5/24/21 between 9:30 AM and 1:00 PM, during initial pool tour, surveyors interviewed residents and 7 residents complained that the facility did not have a sufficient number of staff and that impacted their perception of care. One of the residents stated that he/she knew that the New Jersey staffing laws required to have one CNA for every eight residents during the day shift but that the facility never followed it. All 7 residents stated that the short staffing ratios had them wait longer than necessary if they needed something.<br><br>On 6/3/21, the surveyor reviewed the facility | F 836 | 6/3/21<br>B. Director of Nursing, Staffing Coordinator and Administrator will meet daily during the week to review recruitment efforts, staffing for next day, and staffing for upcoming week. Facility has contracted with 4 agency to fill gaps. Trends identified from these meeting will be presented during monthly QAPI meeting.<br>C. The facility has developed a Culture Committee focused on recruitment and retention of staff along with customer service and the employee experience.<br>D. The facility has implemented Charge to Service Program to support newly admitted residents.<br>E. The facility has implemented the Care Champion Program to mentor new employees.<br>F. The facility participates in an interdisciplinary Quality Care Resource call to review open positions, recruitment tactics, and changes to improve outcomes.<br>G. Contract staff utilization is reviewed bi-weekly to identify trends and opportunities.<br>H. The facility has implemented a multifaceted approach for recruitment and retention of employees, Job fairs, Flexible scheduling, Increased utilization of PRN staff, Implementation of OnShift, Multimedia advertisements, Partnership with schools, Sign on bonuses, Referral bonuses, Pick-up shift bonuses, Boomerang campaign to rehire staff that have resigned , Rate adjustments, Benefit adjustments., Contract staff utilization, | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SPRING GROVE REHABILITATION AND HEALTHCARE CENTER | 144 GALES DRIVE NEW PROVIDENCE, NJ 07974 |

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| F 836 | Continued From page 153<br>provided Nursing Home Resident Care Staffing Reports from 5/13/21 to 6/3/21 which included the following staff to resident ratio for each shift:<br><br>5/13/21-(Census-86) Day shift 1 CNA:12.3 residents<br>5/14/21-(Census-84) Day shift 1 CNA:14 residents<br>5/15/21-(Census-84) Day shift 1 CNA:12 residents<br>5/16/21-(Census-83) Day shift 1 CNA:11.9 residents<br>5/17/21-(Census-83) Day shift 1 CNA:11.9 residents<br>5/18/21-(Census-82) Day shift 1 CNA:13.7 residents<br>5/19/21-(Census-84) Day shift 1 CNA:10.5 residents<br>5/20/21-(Census-85) Day shift 1 CNA:12.1 residents<br>5/21/21-(Census-86) Day shift 1 CNA:12.3 residents<br>5/22/21-(Census-86) Day shift 1 CNA:17.2 residents<br>5/23/21-(Census-86) Day shift 1 CNA:14.3 residents<br>5/24/21-(Census-86) Day shift 1 CNA:10.8 residents<br>5/25/21-(Census-87) Day shift 1 CNA:10.9 residents<br>5/26/21-(Census-87) Day shift 1 CNA:10.9 residents<br>5/27/21-(Census-87) Day shift 1 CNA:10.9 residents<br>5/28/21-(Census-84) Day shift 1 CNA:10.5 residents<br>5/29/21-(Census-87) Day shift 1 CNA:12.4 residents<br>5/30/21-(Census-87) Day shift 1 CNA:14.5 | F 836 | Implementation of Temporary Nurse Aide program, Text message campaigns.<br>I. The facility has implemented processes to increase communication with employees through Townhall meetings and Digital Suggestion Box<br><br>4.<br>A. The administrator/designee will review the minutes from resident council to determine whether any concerns regarding care and services are identified monthly for three months and the quarterly.<br>B. The administrator/designee will review the minutes from daily staffing meeting to determine whether all efforts are resulting in meeting staffing requirements.<br>C. The administrator/designee will interview five residents weekly for 4 weeks and then monthly to determine if needs are being met.<br>D. Results of the audits will be reported to the QA committee monthly.<br>E. The QAPI Committee will make recommendations based upon the results of the audits.<br>F. The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. | |

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| F 836 | Continued From page 154<br>residents<br>5/31/21-(Census-85) Day shift 1 CNA:12.1 residents<br>6/1/21-(Census-86) Day shift 1 CNA:12.3 residents<br>6/2/21-(Census-86) Day shift 1 CNA:10.8 residents<br>6/3/21-(Census-85) Day shift 1 CNA:12.1 residents<br>22 of 22 day shifts did not meet the minimum required ratio of 1 CNA to 8 residents.<br><br>5/13/21-Evening shift 1 CNA:12.3 residents<br>5/14/21-Evening shift 1 CNA:12 residents<br>5/15/21-Evening shift 1 CNA:14 residents<br>5/16/21-Evening shift 1 CNA:11.9 residents<br>5/17/21-Evening shift 1 CNA:13.8 residents<br>5/18/21-Evening shift 1 CNA:13.7 residents<br>5/19/21-Evening shift 1 CNA:12 residents<br>5/20/21-Evening shift 1 CNA:12.1 residents<br>5/21/21-Evening shift 1 CNA:14.3 residents<br>5/22/21-Evening shift 1 CNA:17.2 residents<br>5/23/21-Evening shift 1 CNA:17.2 residents<br>5/24/21-Evening shift 1 CNA:12.3 residents<br>5/25/21-Evening shift 1 CNA:10.9 residents<br>5/26/21-Evening shift 1 CNA:12.4 residents<br>5/27/21-Evening shift 1 CNA:10.9 residents<br>5/28/21-Evening shift 1 CNA:12 residents<br>5/29/21-Evening shift 1 CNA:17.4 residents<br>5/30/21-Evening shift 1 CNA:17.4 residents<br>5/31/21-Evening shift 1 CNA:14.2 residents<br>6/1/21-Evening shift 1 CNA:12.3 residents<br>6/2/21-Evening shift 1 CNA:12.3 residents<br>6/3/21-Evening shift 1 CNA:12.1 residents<br>22 of 22 evening shifts did not meet the minimum required ratio of 1 CNA to 10 residents.<br><br>5/13/21-Night shift 1 CNA:17.2 residents<br>5/15/21-Night shift 1 CNA:16.8 residents | F 836 | | |

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| F 836 | Continued From page 155<br>5/16/21-Night shift 1 CNA:20.8 residents<br>5/22/21-Night shift 1 CNA:17.2 residents<br>5/23/21-Night shift 1 CNA:17.2 residents<br>5/25/21-Night shift 1 CNA:17.4 residents<br>5/26/21-Night shift 1 CNA:14.5 residents<br>5/27/21-Night shift 1 CNA:17.4 residents<br>5/29/21-Night shift 1 CNA:14.5 residents<br>5/30/21-Night shift 1 CNA:21.8 residents<br>6/3/21-Night shift 1 CNA:17 residents<br>11 of 22 night shifts did not meet the minimum required ratio of 1 CNA to 14 residents.<br><br>On 6/3/21 at 9:46 AM, the surveyor interviewed the Staffing/Ancillary Clerk, who stated she also had a CNA background, about the staffing of CNAs. She stated that she would staff each shift by the census of the facility. She would try to utilize 8 CNAs on the day and evening shift but would try to get 9 if she could, and try to get 5 or 6 aides for the night shift. She further stated that normally that 1 CNA to 10 or 11 residents were the final results. The surveyor then asked the Staffing/Ancillary Clerk if the facility had sufficient staff in which she replied that they need more staff and have been trying to hire more people. The surveyor then asked her if the facility used agency staff or had implemented their emergency staffing strategies, in which she replied that the facility did not use agency staff and that it was not her call to use agency staff if needed. The surveyor then asked if she was aware of the minimum direct care staff to resident ratio which became effective 2/1/21 in which she stated that she was aware of the mandate and the facility had been talking to see how they could hire more staff.<br><br>At 10:21 AM, the surveyor interviewed the Director of Nursing (DON) regarding the staffing | F 836 | | |

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of the facility. The DON stated that the facility had staffing meetings and that there was a formula that the Staffing/Ancillary Clerk used. The surveyor then asked the DON if he was aware of the minimum direct care staff to resident ratio (which had became effective 2/1/21) in which he stated that he had read about it in the news but was not sure if it had been implemented yet. The surveyor then asked the DON if the facility used agency staff, and the DON replied that the facility did not use agency staff. The surveyor then asked the DON if the facility had sufficient staff in which he stated that the facility had good staffing until COVID-19 started. He then added that right now the facility had good staffing unless there were call outs.

At 10:26 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding the staffing of the facility. The surveyor asked if the facility had sufficient staff in which he stated that the facility had enough staff and that they use a formula which was based off the assessed needs of the residents and the ability of staff. The surveyor then asked if he was aware of the minimum direct care staff to resident ratio which became effective 2/1/21 in which he stated that he was aware of the ratio but that he did not know what the ratio was off hand. The surveyor then asked the LNHA if the facility used agency staff in which he stated that the facility did not use agency staff and that the reason was when they used them in the past there was not a continuity of care for the residents and it impacted resident care. He further stated that the facility was actively seeking full-time, part-time and per diem (as needed) staff. After review of the requirements, the LNHA acknowledged that the facility was not meeting the New Jersey minimum

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staffing ratios that went into effect on 2/1/21. He stated that they had hired and implemented the Concierge employee about three weeks ago who goes around to check on the residents and answer call bells as needed, because the facility had noticed that many times when the resident's needed assistance, it was an non-nursing issue that could be addressed but non-direct care staff. He acknowledged that the Concierge would not fulfill the direct care staff ratio requirements for New Jersey. He stated that the also utilized Temporary Nurse Aides and will be assisting them as they transition to get certified as a CNA.

At 10:29 AM, during surveyor interview of the LNHA in the presence of the survey team, the Regional Director of Operations added that the reason the facility did not use agency staff to provide direct was that they were not dependable. She further added that the agency staff in the past would commit to a shift and then they would call out or not show up.

A review of the facility provided policy titled, "Staffing", with a revised date of October 2017 included the following:
Policy Statement
Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment.
Policy Interpretation and Implementations
1. Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services.
2. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of

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| F 836 | Continued From page 158<br>care.<br>3. Other support services (e.g., dietary, activities/recreational, social, therapy, environmental, etc.) are also staffed to ensure that resident needs are met.<br>4. Direct care staffing information per day (including agency and contract staff) is submitted to the CMS payroll-based journal system on the schedule specified by CMS, but no less than once a quarter.<br>5. Inquiries or concerns relative to our facility's staffing should be directed to the Administrator or his/her designee.<br>The facility policy did not include information regarding the state mandated minimum direct care staff (CNA) to resident ratio.<br><br>N.J.A.C. 8:39-5.1(a) | F 836 | | |