

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/28/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/09/2023
NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		
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E 000	Initial Comments	E 000			
F 000	<p>INITIAL COMMENTS</p> <p>SURVEY DATE: 03/09/23</p> <p>CENSUS: 115</p> <p>SAMPLE SIZE: 36 + 3 closed records</p> <p>A Recertification Survey was Conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.</p> <p>During a Standard Survey conducted on 03/09/23, it was determined that effective 02/04/23, the Facility was found to have been in Immediate Jeopardy for F600J and F609K. During a Standard Survey conducted on 03/09/23, it was determined that effective 03/01/23, the Facility was found to have been in Immediate Jeopardy for F689J and F835K</p> <p>The survey team identified the following:</p> <p>F600, s/s J On 02/04/23 the facility failed to implement appropriate interventions to <u>Ex Order 26. 4B1</u> Resident #15 from <u>Ex Order 26. 4B1</u> and follow their facility's Residents/Patient Rights -Abuse, Neglect, Mistreatment or Misappropriation of Resident/Patient's Property Policy and Procedure.</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/01/2023

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

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F 000	<p>Continued From page 1</p> <p>This resulted in an Immediate Jeopardy (IJ) situation which began on 02/04/23. The facility's Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) were notified of the IJ on 02/22/23 at 5:56 PM. On 02/23/23 at 5:30 PM, the facility provided an acceptable Removal Plan, and the immediacy was lifted. The surveyors confirmed/verified the implementation of the Removal Plan throughout the duration of the survey.</p> <p>F609, s/s K On 02/04/23, the facility failed to notify the New Jersey Department of Health (NJDOH) of actual <u>Ex Order 26. 4B1</u> between Resident #15 and Resident #99. Resident #99 <u>Ex Order 26. 4B1</u> Resident #15 <u>Ex Order 26. 4B1</u> in the <u>Ex Order 26. 4B1</u>. Resident #15 was sent to the <u>Ex Order 26. 4B1</u> for an evaluation and the police were called on <u>Ex Order 26. 4B1</u>.</p> <p>On 02/15/23, the facility failed to notify the NJDOH of actual <u>Ex Order 26. 4B1</u> between Resident #98 and Resident #72. Resident #98 <u>Ex Order 26. 4B1</u> Resident #72 <u>Ex Order 26. 4B1</u> with a <u>Ex Order 26. 4B1</u> on the <u>Ex Order 26. 4B1</u> and <u>Ex Order 26. 4B1</u>. The resident was sent to the <u>Ex Order 26. 4B1</u> for evaluation and the police were called on <u>Ex Order 26. 4B1</u>.</p> <p>Additionally, a review of the Audit Tool dated <u>Ex Order 26. 4B1</u> reflected the following: <u>Ex Order 26. 4B1</u> Resident #114 <u>Ex Order 26. 4B1</u> and Resident #320 <u>Ex Order 26. 4B1</u>; reported- no; comments - will report. <u>Ex Order 26. 4B1</u> Resident #13 <u>Ex Order 26. 4B1</u> and Resident #26 <u>Ex Order 26. 4B1</u>; reported - no; comments - will report.</p>	F 000			

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F 000	<p>Continued From page 2</p> <p>Ex Order 26. 4B1 Resident #82 Ex Order 26. 4B1 and Resident #115 Ex Order 26. 4B1 ; reported - no; comments - will report. Ex Order 26. 4B1 Resident #64 Ex Order 26. 4B1 ; reported - no; comments - will report. Resident #63 Ex Order 26. 4B1 was not listed on the facility's audit tool.</p> <p>This resulted in an Immediate Jeopardy (IJ) situation which began on 02/04/23. The facility's LNHA and Director of Nursing (DON) were notified of the revised IJ Template on 02/23/23 at 1:56 PM. An additional revised IJ Template was provided to the LNHA and DON on 02/28/23 at 4:04 PM. On 02/28/23 at 5:43 PM, the facility provided an acceptable removal plan, and the immediacy was lifted. The surveyors confirmed/verified the implementation of the Removal Plan throughout the duration of the survey.</p> <p>F689, s/s J On 3/1/23 at 12:16 PM, the surveyor observed Resident #94 in bed with two unopened and one opened twenty-four-ounce bottle of . The resident stated the liquids were ; he/she drank Ex Order 26. 4B1 .</p> <p>On 3/1/23 at 12:26 PM, the surveyor observed the resident's Certified Nursing Aide (CNA #1) deliver the resident's lunch meal tray which contained a Ex Order 26. 4B1 with that CNA #1 confirmed was Ex Order 26. 4B1 . Interview with both the resident's CNA #1 and Licensed Practical Nurse (LPN #1) revealed the resident was on a Ex Order 26. 4B1 . Review of the resident's medical record reflected a Progress Note (PN) dated , that the resident returned from an appointment with Ex Order 26. 4B1</p>	F 000			

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F 000	<p>Continued From page 3</p> <p><u>Ex Order 26. 4B1</u> or <u>Ex Order 26. 4B1</u> of the lungs.</p> <p>A review of the physician's orders (PO) revealed a PO dated <u>Ex Order 26. 4B1</u> for <u>Ex Order 26. 4B1</u>.</p> <p>The facility's failure to ensure a resident with a history of <u>Ex Order 26. 4B1</u> on <u>Ex Order 26. 4B1</u> and a physician order for <u>Ex Order 26. 4B1</u> was provided <u>Ex Order 26. 4B1</u> posed a serious and immediate threat for <u>Ex Order 26. 4B1</u>, including <u>Ex Order 26. 4B1</u>, which is likely to result in serious <u>Ex Order 26. 4B1</u>. This resulted in an Immediate Jeopardy (IJ) situation that began on 2/22/23 at 10:11 AM, when the physician ordered the <u>Ex Order 26. 4B1</u>.</p> <p>The facility's administration was notified of the IJ on 3/1/23 at 4:51 PM. The facility submitted an acceptable written Removal Plan on 3/3/23 at 9:35 AM. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 3/3/23.</p> <p>F835, s/s K The facility's Licensed Nursing Home Administrator (LNHA) failed to ensure that the facility's policies and procedures were implemented to ensure resident safety and well-being, by failing to: a.) ensure Resident #15 <u>Ex Order 26. 4B1</u> was <u>Ex Order 26. 4B1</u> from <u>Ex Order 26. 4B1</u> from Resident #99 <u>Ex Order 26. 4B1</u>, b.) report an actual <u>Ex Order 26. 4B1</u> between Resident #15 and Resident #99; Resident #72 and Resident #98; Resident #13 and Resident #26; Resident #63 and Resident #64; Resident #82 and Resident #115; Resident #114 and Resident #320 to the New Jersey Department of Health</p>	F 000			

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F 000	<p>Continued From page 4</p> <p>(NJDOH) and, c.) provide safe meal delivery for Resident #94, who was at risk for <u>Ex Order 26. 4B1</u> [REDACTED] according to the physician prescribed diet order to include <u>Ex Order 26. 4B1</u> [REDACTED].</p> <p>The IJ began on 02/04/23 when the facility's LNHA failed to <u>Ex Order 26. 4B1</u> Resident #15 <u>Ex Order</u> [REDACTED] from <u>Ex Order 26. 4B1</u> from Resident #99.</p> <p>The LNHA further failed to notify the NJDOH of the incident between Resident #15 and Resident #99 on <u>Ex Order 26. 4B1</u>. A further review of the facility's <u>Ex Order 26. 4B1</u> [REDACTED] indicated that the facility failed to report an additional five (5) reportable events involving 10 resident's.</p> <p>The LNHA's failure to ensure that the facility's policies and procedures were implemented to ensure resident safety and well-being posed a serious risk of adverse outcome to the resident's residing at the facility and resulted in an Immediate Jeopardy (IJ) situation. The facility's LNHA was made aware of the IJ situation on 03/01/23 at 4:51 PM and an acceptable Removal Plan was received on 03/03/23 at 9:35 AM. The surveyors confirmed/verified the implementation of the Removal Plan throughout the duration of the survey.</p>	F 000			
F 584 SS=D	<p>Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)</p> <p>§483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p>	F 584			3/31/23

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F 584	<p>Continued From page 5</p> <p>The facility must provide-</p> <p>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</p> <p>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, it was determined that the facility failed to maintain a clean and sanitary environment that</p>	F 584	<p>F584 SS D Element One - Corrective Action: The facility completed room repairs for</p>		

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F 584	<p>Continued From page 6</p> <p>was in good repair. This was identified in two (2) resident rooms and on one (1) of two (2) nursing units, the [REDACTED] floor. This deficient practice was evidenced by the following:</p> <p>On 02/22/23 the surveyor observed the following:</p> <p>1.) On 02/22/23 at 10:47 AM, in room [REDACTED] there was a cracked and missing piece of floor tile, loose wallpaper, and a large rectangular hole in the wall next to the heating/air conditioning unit.</p> <p>2.) On 02/22/23 at 11:03 AM, in room [REDACTED] there was loose wallpaper, and plastic wall paneling that was unattached from the wall which revealed a very large hole in the wall next to the heating/air conditioning unit. At that time, the surveyor interviewed Resident #102 who stated that the hole bothered him/her because cold air entered the room through the hole and that he/she had not told anyone.</p> <p>On 02/24/23 at 10:19 AM, in room [REDACTED], the surveyor interviewed the assigned Certified Nursing Assistant (CNA) who stated the resident had never complained to her about the hole in the wall and that it looked "raggedy". The CNA stated that if a resident had a concern with the room that they would tell maintenance to fix the issue or they would tell the nurse who would put it on the maintenance log. The CNA further stated that the wall should not have looked that way and that it was important that the wall was fixed so that no mold or debris could have entered room.</p> <p>On 02/24/23 at 10:44 AM, the surveyor observed a staff member walk into room [REDACTED] with a large rectangular piece of flat paper covered plaster paneling and started to repair the hole in the wall.</p>	F 584	<p>resident room [REDACTED] The cracked and missing floor tiles were replaced, the hole in the wall adjacent to the heating/air conditioning unit was repaired, and the loose wallpaper was re-glued to the wall.</p> <p>The facility completed room repairs for resident room [REDACTED]. The hole in the wall adjacent to the heating/air conditioning unit was repaired and the loose wallpaper was re-glued to the wall.</p> <p>Resident #102 was interviewed by the Administrator. The resident was satisfied with the repairs to the room. The Administrator advised Resident #102 to report any other concerns he/she may have with the room to the nurse, who would then report such concerns to the Maintenance staff.</p> <p>The facility inspected the remaining resident rooms on the [REDACTED] floor in order to identify other residents that may have been affected. The remaining rooms were found to be in compliance.</p> <p>Element Two - Identification of Other Residents: All residents have the potential to be affected by this practice.</p> <p>Element Three <input type="checkbox"/> Systemic Change The facility's Administrator and Lead Maintenance Director reviewed the facility's policies and procedures pertaining to preventative maintenance. According to the policies, all resident rooms are inspected at least quarterly for</p>		

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F 584	<p>Continued From page 7</p> <p>At that time, the surveyor interviewed the maintenance staff member who stated that the nurse had put a repair request through the computer that day and that the repair request information appeared on his phone which prompted him to repair the wall. The maintenance staff member stated that the wall should not have had a hole in it.</p> <p>On 02/24/23 at 11:43 AM, the surveyors met with administration and requested from the Regional Licensed Nursing Home Administrator the maintenance records for the last three months.</p> <p>On 03/06/23 at 10:23 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that if she had witnessed room damage or if a resident complained of room damage that she would have reported it to maintenance by entering the concern into the electronic medical record (EMR) or by calling maintenance. The LPN was unsure where to enter the concern in the EMR. The LPN stated that maintenance would have come and inspected the concern and that if the resident was in danger that they would have been moved out of the room. The surveyor showed the LPN pictures of the damage in rooms [REDACTED] and [REDACTED] and the LPN stated that the damage was "not aesthetically pleasing at all" and that it should not have been there and that the holes could have mice living in them.</p> <p>On 03/06/23 at 10:28 AM, the surveyor interviewed the [REDACTED] floor LPN Unit Manager (LPN/UM) who stated that if resident room damage was observed or that if a resident complained about room damage, it would have been addressed by the nurse. The LPN/UM</p>	F 584	<p>any needed repairs and safety issues. In addition, the staff are instructed to record any repair or safety issues in maintenance logs located at the nursing stations. Maintenance staff are responsible for reviewing the logs daily and scheduling repairs based on the severity of the necessary repair or safety issue. It was determined that the preventative maintenance policies and procedures were adequate and required no additional modifications or changes at this time.</p> <p>The facility will begin to utilize an electronic maintenance log system, which will enable all staff to record needed repairs and safety issues into an electronic data base. The data base will automatically forward the repair or safety issue to the facility's Maintenance Director and Administrator. The Maintenance Director will inspect the repair or safety issue and schedule a date for repair based on the severity of the needed repair or safety issue. Staff shall receive in-service training upon the commencement of the system.</p> <p>The Administrator and Lead Maintenance Director provided in-service training to the facility's recently hired Maintenance Director regarding the facility's preventative maintenance program. The in-service was completed. The new Maintenance Director was instructed to inspect all resident rooms quarterly using a resident room inspection checklist. Any repairs or safety issues are to be scheduled for repairs based on the</p>		

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F 584	<p>Continued From page 8</p> <p>explained that the information would have been recorded onto a maintenance log that contained what the issues were on the unit and that maintenance reviewed the log each morning. The surveyor showed the LPN/UM pictures of the damage in rooms [REDACTED] and [REDACTED] and the LPN/UM stated that the holes should not have been there and that it looked unkept and needed to be fixed. The LPN/UM further stated that it was important that resident rooms felt like home and were kept in a clean and orderly fashion for comfort and safety.</p> <p>On 03/06/23 at 11:20 AM, in the presence of administration, the surveyors interviewed the Consultant Licensed Nursing Home Administrator (CLNHA) who stated that the maintenance staff inspected each resident room once a quarter and documented a detailed list of issues which then created a priority list based on the inspections. The CLNHA stated that on each floor the staff filled out a maintenance log that the maintenance staff reviewed daily which would have indicated what repair work needed to be done. The CLNHA stated that the log had not been completed. The surveyor showed the CLNHA pictures of the damage in rooms [REDACTED] and [REDACTED] and the CLNHA stated that the damage was probably related to a leak in the heating unit, that it did not take one day to happen. The CLNHA added that it should not have been like that because it could have created a hazard. The CLNHA further stated that it was important to repair the damage for resident safety and to provide a comfortable, homelike environment.</p> <p>Review of the facility's policy, "Standard Operating Procedure Maintenance Reporting," reviewed 1/26/23, revealed 2.0 Scope 2.1</p>	F 584	<p>severity of the repair or safety issue. The Maintenance Director was instructed to report any safety issue to the Administrator for any necessary immediate corrective action. In addition, the Maintenance Director received training for the maintenance logs located at the nursing stations. The Maintenance Director was instructed to inspect the logs daily. Additional training will be provided upon activation of the aforementioned electronic maintenance system.</p> <p>The facility staff received re-education regarding the identification and reporting of safety issues and items that need repair. Staff were re-instructed to record items needing repair or safety issues in the maintenance logs. Staff were instructed to report any concerns of safety related issues to their supervisor or directly to the Administrator. Additional training will be provided upon activation of the aforementioned electronic maintenance system.</p> <p>Element Four - Quality Assurance: The facility's Administrator or designee shall on a randomly selected basis, inspect ten resident rooms weekly for a period of four weeks, and then monthly for a period of three months to ascertain the effectiveness of the preventive measures. In addition, monthly for a period of three months, the Administrator or designee shall review the resident room inspection logs completed by the Maintenance Director, to determine if rooms are inspected and any repairs are repaired</p>		

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F 584	Continued From page 9 Maintenance applies to all manufacturing, testing, repair, and ancillary equipment that requires routine maintenance, repair, inspection, or adjustment. 3.0 Definitions 3.3 Maintenance Procedure: A description of required actions to be performed on equipment. 4.0 Responsibilities/Authority 4.1 Originator: Responsible for reporting maintenance issues to Front Lobby Receptionist. 4.2 Recipient: Responsible for contacting Maintenance and reporting issues in a timely manner. The facility did not provide the survey team with maintenance logs.	F 584	promptly. Any need for additional corrective actions shall be completed when discovered. Thereafter the members of the Quality Assurance Performance Improvement (QAPI) committee shall review resident room safety as part of the QAPI process. Completion Date: 3/31/2023		
F 600 SS=J	NJAC 8:39-31.4(a, f) Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documents, it was	F 600			3/31/23
			F600 SS=J		

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F 600	<p>Continued From page 10</p> <p>determined that the facility failed to ensure: a.) Resident #15 <u>Ex Order 26. 4B1</u> was <u>Ex Order 26. 4B1</u> from <u>Ex Order 26. 4B1</u> from Resident #99 <u>Ex Order 26. 4B1</u> and b.) the facility's Residents/Patient Rights - Abuse, Neglect, Mistreatment or Misappropriation of Resident/Patient's Property was followed. This deficient practice was identified for one (1) of 12 resident's reviewed for <u>Ex Order 26. 4B1</u>, (Resident #15).</p> <p>On 02/22/23 at 12:09 PM, Resident #15 was observed lying in bed. The surveyor interviewed Resident #15 who stated that they were involved in a <u>Ex Order 26. 4B1</u> altercation with their roommate, Resident #99. Resident #15 stated that he/she was <u>Ex Order 26. 4B1</u> when Resident #99 came up to them, <u>Ex Order 26. 4B1</u> him/her in the <u>Ex Order 26. 4B1</u> and stated he/she <u>Ex Order 26. 4B1</u>. Resident #15 further stated the nurses, and the police were notified but felt that the altercation was not handled appropriately. Resident #15 stated upon returning from the <u>Ex Order 26. 4B1</u> he/she did not know why Resident #99 was still their <u>Ex Order 26. 4B1</u>. Resident #15 concluded he/she was very frustrated about the altercation and that they could <u>Ex Order 26. 4B1</u> <u>Ex Order 26. 4B1</u> in their <u>Ex Order 26. 4B1</u>. The resident further stated that he/she was <u>Ex Order 26. 4B1</u> with Resident #99.</p> <p>Resident #15 <u>Ex Order 26. 4B1</u> was never separated from Resident #99 <u>Ex Order 26. 4B1</u>. The residents remained in the <u>Ex Order 26. 4B1</u>.</p> <p>Upon interviews with facility staff and record review there were no prior physical <u>Ex Order 26. 4B1</u> between Resident #15 and Resident #99.</p> <p>A review of the electronic Progress Notes (PN)</p>	F 600	<p>ELEMENT ONE-CORRECTIVE ACTION Resident # 15 was moved to another <u>Ex Order 26. 4B1</u> with consent on <u>Ex Order 26. 4B1</u>.</p> <p>ELEMENT TWO IDENTIFICATION OF OTHER RESIDENTS All residents have the potential to be affected by this practice. Abuse Coordinator (LNHA) /designee conducted interviews with residents to ensure they are safeguarded from abuse.</p> <p>ELEMENT THREE-SYSTEMIC CHANGES Staff were educated following facilities policy Prohibition of Resident Abuse & Neglect which included: 1.The definition of abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, <u>Ex Order 26. 4B1</u> well-being. 2.Types of <u>Ex Order 26. 4B1</u> Physical, verbal, sexual, mental/emotional/psychological, involuntary seclusion, neglect, exploitation, and misappropriation of resident property. 3.Prevention which includes employee and volunteer screening, training, which is completed upon hire, and minimally quarterly to employees. Re-education is also completed when/if there is an <u>Ex Order 26. 4B1</u>. 4. Reporting <u>Ex Order 26. 4B1</u> must be reported to immediately to supervisor. The</p>		

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F 600	<p>Continued From page 11</p> <p>reflected on 02/04/23 at 7:00 AM, Resident #15 Ex Order 26. 4B1 was Ex Order 26. 4B1 by the roommate Resident #99 Ex Order 26. 4B1.</p> <p>A further review of the electronic PN revealed on 02/04/23 at 7:00AM, that Resident #15 requested to be sent out to the Ex Order 26. 4B1 to have his/her Ex Order 26. 4B1 evaluated because he/she was Ex Order 26. 4B1 and that the police were notified. Resident #15 returned from the Ex Order 26. 4B1 and the Ex Order 26. 4B1 Ex Order 26. 4B1 were normal.</p> <p>A review of Resident #15's medical record (MR) did not reflect interventions to Ex Order 26. 4B1 Resident #15 from Ex Order 26. 4B1.</p> <p>A review of Resident #15's individualized Care Plan (CP) initiated Ex Order 26. 4B1, two (2) days after the Ex Order 26. 4B1 occurred, reflected Fear related to recent NJ Exec. Order 26:4.b.1 which included the following interventions: A nurse will reassure safety, discuss the reality of the situation while acknowledging what can and cannot be changed to help the patient to feel in control, and reassure the patient that NJ Exec. Order 26:4.b.1 after a event are normal.</p> <p>On 2/23/23 at 12:41 PM, the surveyor interviewed Resident #99's primary care physician (PCP) who stated Ex Order 26. 4B1 Ex Order 26. 4B1 of Ex Order 26. 4B1 but was unable to specify. He further stated that after the physical altercation between the two residents, they should not have remained in the Ex Order 26. 4B1.</p> <p>A review of Resident #99's Ex Order 26. 4B1 MR</p>	F 600	<p>supervisor will then report to the Ex Order 26. 4B1 Coordinator. If the Ex Order 26. 4B1 coordinator is unavailable the next highest administrative position is made aware (DON).</p> <p>5. Protection-Immediately remove the resident(s) from the situation, assess and treat, accused employees (if applicable) will be suspended immediately pending further investigation.</p> <p>6. Investigation: a full investigation is completed with a comprehensive review of the situation, interviews with staff, residents, and any witnesses to the event and statements are recorded, statement review, environmental review, and medical record review.</p> <p>7. New hires are trained upon hire during facility orientation, quarterly and prn.</p> <p>ELEMENT FOUR QUALITY ASSURANCE Abuse Coordinator/designee to conduct random audits of residents ensure they feel safeguarded against abuse weekly x4, monthly x12.</p>		

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F 600	<p>Continued From page 12</p> <p>did not reflect behavioral interventions after the [redacted] altercation to prevent physical [redacted] Ex Order 26. 4B1.</p> <p>A review of Resident #99's CP initiated [redacted] Ex Order 26. 4B1, two (2) days after he/she [redacted] Ex Order 26. 4B1 Resident #15 in the [redacted] Ex Order 26. 4B1, reflected [redacted] Ex Order 26. 4B1 which included the following interventions: The nurse will identify what is not appropriate, such as [redacted] and [redacted] and also what is appropriate, the nurse will provide positive feedback to let the client know he/she is meeting expectations, the nurse will recognize behaviors before they become violent and, the nurse will set limits on unacceptable behavior.</p> <p>The facility's failure to implement appropriate interventions to [redacted] Ex Order 26. 4B1 Resident #15 from physical [redacted] Ex Order 26. 4B1 and follow their facility's Residents/Patient Rights -Abuse, Neglect, Mistreatment or Misappropriation of Resident/Patient's Property Policy and Procedure was likely to put Resident #15 at risk for future [redacted] Ex Order 26. 4B1. This resulted in an Immediate Jeopardy (IJ) situation which began on [redacted] Ex Order 26. 4B1. The facility's Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) were notified of the IJ on 02/22/23 at 5:56 PM. On 02/23/23 at 5:30 PM, the facility provided an acceptable removal plan, and the immediacy was lifted.</p> <p>The evidence was as follows:</p> <p>Refer to F609 and F610</p> <p>On 02/22/23 at 10:52 AM, during the initial tour, the surveyor observed Resident #99 sitting on the</p>	F 600			

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F 600	<p>Continued From page 13</p> <p>side of the bed watching TV and eating a bag of chips. Resident #99 stated everything was great and that he/she had no concerns.</p> <p>On 02/22/23 at 10:54 AM, during the initial tour, the surveyor observed Resident #99's roommate Resident #15 lying in bed watching TV. Resident #15 stated that he/she <u>Ex Order 26. 4B1</u>.</p> <p>A review of the electronic PN reflected the following: On 02/04/23 at 7:00 AM, Resident #15 <u>Ex Order 26. 4B1</u> was <u>Ex Order 26. 4B1</u> by the roommate Resident #99 <u>Ex Order 26. 4B1</u>. It further reflected Resident #15 requested to be sent out to the <u>Ex Order 26. 4B1</u> (ER) to have his/her <u>Ex Order 26. 4B1</u></p> <p><u>Ex Order 26. 4B1</u> evaluated because he/she was <u>Ex Order 26. 4B1</u> and the police were notified.</p> <p>On 02/22/23 at 12:09 PM, Resident #15 was observed lying in bed. The surveyor interviewed Resident #15 who stated they were involved in a <u>Ex Order 26. 4B1</u> altercation with their roommate Resident #99. Resident #15 stated that he/she was <u>Ex Order 26. 4B1</u> when Resident #99 came up to them, <u>Ex Order 26. 4B1</u> him/her in the <u>Ex Order 26. 4B1</u> and stated he/she <u>Ex Order 26. 4B1</u>. Resident #15 further stated the nurses, and the police were notified but felt that the altercation was not handled appropriately. Resident #15 stated upon returning from the <u>Ex Order 26. 4B1</u> that he/she did not know why Resident #99 was still their roommate. Resident #15 concluded he/she was very frustrated about the altercation and that they could <u>Ex Order 26. 4B1</u> in their <u>Ex Order 26. 4B1</u>. The resident further stated that he/she <u>Ex Order 26. 4B1</u>.</p>	F 600			

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F 600	<p>Continued From page 14</p> <p>On 02/22/23 at 12:21 PM, the surveyor interviewed the Licensed Practical Nurse/Unit manager (LPN/UM) for the [REDACTED]-floor nursing unit who confirmed Resident #15 and Resident #99 were roommates and were involved in a recent [REDACTED] altercation. The LPN/UM stated that both residents were confused at times and that Resident #99 ^{Ex Order 26. 4B1} Resident #15 in the ^{Ex Order 26. 4}. He further stated that Resident #15 did not [REDACTED] and that the resident was sent out to the [REDACTED]. The LPN/UM stated that he educated both residents on notifying the staff if they had any [REDACTED]. He further stated that Resident #99 (the ^{NJ Exec. Order 26:4.b.1} history of [REDACTED], and that the [REDACTED] altercation was "unexpected." The LPN/UM stated that he spoke with Resident #99 two (2) days later, on 02/06/23, when he arrived back to work and that the resident stated he ^{Ex Order 26. 4B1} Resident #15 because the ^{Ex Order 26. 4B1}. He further explained Resident #99 informed him that he/she ^{Ex Order 26. 4B1} Resident #15. The LPN/UM stated that the interventions they initiated were 30-minute safety checks to ensure that the residents were ^{Ex Order 26. 4B1}. He further stated Resident #99's family and staff explained to him/her that it was ^{Ex Order 26. 4B1} to ^{Ex Order 26. 4B1} another resident. The LPN/UM stated that Resident #15 and Resident #99 ^{Ex Order 26. 4B1} and that during their investigation they felt it was ^{Ex Order 26. 4B1} and the [REDACTED] altercation occurred ^{Ex Order 26. 4B1}. He then stated, ^{Ex Order 26. 4B1}. The LPN/UM stated Resident #15's family was made aware of the [REDACTED] altercation and that the family had wanted to make sure that he/she was monitored frequently and was safe. The LPN/UM concluded the ^{Ex Order 26. 4B1} came</p>	F 600			

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F 600	<p>Continued From page 15</p> <p>every Monday and that both residents were seen by them.</p> <p>A further review of the electronic PN revealed the following: On 02/04/23 at 7:43 AM, Resident #15 was noted with <u>Ex Order 26. 4B1</u> but was easily redirected.</p> <p>On 02/04/23 at 19:14 (7:14 PM), Resident #15 returned from the <u>Ex Order 26. 4B1</u> and the <u>Ex Order 26. 4B1</u> and the <u>Ex Order 26. 4B1</u> were normal. The Progress Notes further revealed that Resident #15 <u>Ex Order 26. 4B1</u> returned to the <u>Ex Order 26. 4B1</u> with the same roommate Resident #99 <u>Ex Order 26. 4B1</u>. There were no interventions initiated to <u>Ex Order 26. 4B1</u> Resident #15 from being <u>Ex Order 26. 4B1</u> again.</p> <p>A review of Resident #15's MR did not reflect interventions to <u>Ex Order 26. 4B1</u> Resident #15 from <u>Ex Order 26. 4B1</u>.</p> <p>The surveyor reviewed the electronic MR for Resident #15.</p> <p>A review of the resident's Admission Record (AR) reflected that the resident was admitted to the facility in <u>Ex Order 26. 4B1</u>, with diagnoses which included: <u>Ex Order 26. 4B1</u></p> <p><u>Ex Order 26. 4B1</u></p> <p>A review of the most recent quarterly Minimum Data Set (MDS-an assessment tool used to facilitate the management of care) dated</p>	F 600			

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F 600	<p>Continued From page 16</p> <p>██████████ reflected a Brief Interview for Mental Status (BIMS) score of ████^{Ex One} out of ████, which indicated the resident had a ████^{Ex Order 26. 4B1}.</p> <p>A review of Resident #15's individualized CP initiated ████^{Ex Order 26. 4B1}, two (2) days after the ████^{Ex Order 26. 4B1} occurred, reflected Fear related to recent ████^{NJ Exec. Order 26:4.b.1} which included the following interventions: A nurse will reassure safety, discuss the reality of the situation while acknowledging what can and cannot be changed to help the patient to feel in control, and reassure the patient that ████^{NJ Exec. Order 26:4.b.1} event are normal.</p> <p>The surveyor reviewed the electronic MR for Resident #99.</p> <p>A review of the resident's AR reflected that the resident was admitted to the facility in ████^{Ex Order 26. 4B1}, with diagnoses which included: ████^{Ex Order 26. 4B1}.</p> <p>A review of the most recent quarterly MDS dated ████ reflected a BIMS score of ████^{Ex One} out of ████ which indicated an ████^{Ex Order 26. 4B1}.</p> <p>A review of Resident #99's CP initiated ████^{Ex Order 26. 4B1}, two (2) days after he/she ████^{Ex Order 26. 4B1} Resident #15 in the ████^{Ex Order 26. 4B1}, reflected ████^{Ex Order 26. 4B1} which included the following interventions: The nurse will identify what is not appropriate, such as ████ and ████, and also what is appropriate, the nurse will provide positive feedback to let the</p>	F 600			

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F 600	<p>Continued From page 17</p> <p>client know he/she is meeting expectations, the nurse will recognize behaviors before they become violent and, the nurse will set limits on unacceptable behavior.</p> <p>A review of the [REDACTED] Order Summary Report revealed Resident #99 had an active order dated [REDACTED] for <i>Ex Order 26. 4B1</i> [REDACTED] tablet by mouth <i>Ex Order 26. 4B1</i> [REDACTED] a day for <i>Ex Order 26. 4B1</i>.</p> <p>A review of the 24-Hour Communication Sheet for the 2 [REDACTED] Wing revealed the following:</p> <p>On the sheet originally marked 02/04/23, with the date 02/04/23 crossed out and marked 02/03/23, and the Day of Week marked Saturday, the morning shift (7:00 AM to 3:00 PM) and the evening shift (3:00 PM to 11:00 PM) areas were left blank, and the night shift (11:00 PM to 7:00 AM) area indicated for both Resident #15 and Resident #99: Resident to resident with roommate, 911 called.</p> <p>On the sheet marked 02/04/23 and the Day of Week marked Saturday, for Resident #15, the morning shift area was left blank; the evening shift area was marked: Returned from <i>Ex Order 26. 4B1</i>, left note in <i>Ex Order 26</i>, no issues; and the night shift area was marked: Safety maintained, s/p [status post] resident to <i>Ex Order 26. 4B1</i>. On the same sheet for Resident #99, the morning shift area was left blank; the evening shift area was marked: No issues; and the night shift area was marked: s/p resident to resident incident.</p> <p>On the sheet marked <i>Ex Order 26. 4B1</i> and the Day of Week marked Sunday, for Resident #15, the</p>	F 600			

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F 600	<p>Continued From page 18</p> <p>morning shift and evening shift areas were left blank, and the night shift was marked: No issues, Safety maintained s/p incident. On the same sheet for Resident #99, the morning shift and evening shifts areas were left blank, and the night shift was marked: No issues.</p> <p>A further review of the February 2023 24-Hour Communication log did not reflect any documentation regarding the [REDACTED] altercation until <u>Ex Order 26.4B1</u> evening shift: Resident #15 <u>Ex Order 26.4B1</u> to a new room and okay.</p> <p>A review of Resident #15's electronic PN did not reflect documentation related to the 30-minutes safety checks or monitoring of the residents.</p> <p>A further review of electronic PN revealed on 02/19/23 at 13:25 (1:25 PM), PCP #1 evaluated Resident #15 and documented the following: "Problems: [REDACTED] altercation - unaware seen in [REDACTED], <u>NJ Exec. Order 26:4.b.1</u> noted."</p> <p>A review of Resident #99's electronic PN revealed on 02/07/23 at 21:26 (9:26 PM), PCP #2 evaluated Resident #99 and documented the following: "evaluated on monthly facility rounds. Patient is [REDACTED]...has [REDACTED]. Continue to monitor."</p> <p>A further review of the electronic PN for Resident #99 did not reflect any additional documentation related to monitoring the resident.</p> <p>On <u>Ex Order 26.4B1</u> at 1:22 PM and 1:23 PM, the surveyor attempted to call Resident #15's</p>	F 600			

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F 600	<p>Continued From page 19 representative.</p> <p>On 02/22/23 at 1:22 PM, the surveyor interviewed the Certified Nursing Aide (CNA)#1 who stated that he had worked at the facility for eight (8) years and was not aware of a [REDACTED] altercation between Resident #15 and Resident #99.</p> <p>On 02/22/23 at 1:23 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that Resident #15 was [REDACTED]. The LPN gave the example that the resident would sometimes forget [REDACTED] because the resident didn't recall if it was breakfast or dinner time, and that the resident could remember staff member's names. When the surveyor asked if the resident had [REDACTED] the LPN replied, [REDACTED] and stated that the resident would keep to himself/herself, would come out of their room for medications and "doesn't bother anybody."</p> <p>On 02/22/23 at 1:25 PM, the surveyor continued to interview the LPN who stated that Resident #99 had resided at the facility for approximately [REDACTED] and had a diagnosis of a [REDACTED]. The LPN further stated that the resident had [REDACTED], but not with staff. When the surveyor asked the LPN what kind of behaviors Resident #99 presented with, the LPN explained that one day when she came to work she received report that Resident #99 was not very nice to his/her roommate and [REDACTED] Resident #15 and Resident #15 was sent out to the [REDACTED] for an evaluation due to the [REDACTED] altercation. The LPN further stated that the evaluation at the [REDACTED] determined that</p>	F 600			

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F 600	<p>Continued From page 20</p> <p>Resident #15 did not [REDACTED] from being [REDACTED] and was put back into the [REDACTED] with Resident #99 after the [REDACTED] altercation. When asked what the facility did to protect Resident #15 from Resident #99 after the [REDACTED] altercation the LPN stated that she [REDACTED] Ex Order 26. 4B1 [REDACTED]. The LPN did not state how frequently she checked on the residents. The LPN stated that Resident #99 did not get [REDACTED] but had [REDACTED] Ex Order 26 [REDACTED] that were usually directed at Resident #99's [REDACTED]. The surveyor further inquired about what the behaviors Resident #99 had towards his/her family. The LPN told the surveyor that Resident #99 would have [REDACTED] Ex Order 26. 4B1 [REDACTED] and say mean things to the family if he/she did not get their way. The LPN further stated that Resident #99's family came to the facility every day and it was a family thing and nothing that we needed to be concerned about. The surveyor asked the LPN if the facility documented behavior monitoring for the residents in the facility after a behavior was identified. The LPN explained that sometimes the staff would document resident behaviors on the 24-hour report or in progress notes; however, behavior documentation never occurred after the [REDACTED] altercation between Resident #15 and Resident #99 because the staff [REDACTED] Ex Order 26. 4B1 [REDACTED] and would check to see if they were in a bad mood.</p> <p>On 02/22/23 at 1:26 PM, the surveyor interviewed CNA#2 who stated that she was employed at the facility for three (3) years. She stated that she was not made aware that Resident #15 was [REDACTED] by his/her roommate. CNA#2 stated that she had not personally provided care for the residents; however, she felt it would have been important for her to have known about the situation because</p>	F 600			

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F 600	<p>Continued From page 21</p> <p>she worked on that end of the hallway and could have been watching to make sure nothing else happened because they were still roommates. CNA#2 told the surveyor that the normal process after a [REDACTED] altercation was for the residents to be separated and stated, ^{Ex Order 26. 4B1} [REDACTED]</p> <p>On 02/22/2 at 1:32 PM, the surveyor interviewed CNA#3 who stated that she worked at the facility for approximately two (2) years and was the primary care giver for the two residents but was not working when the [REDACTED] altercation took place. CNA#3 further stated that when she arrived to work after the incident, another CNA told her that Resident #15 ^{Ex Order 26. 4B1} [REDACTED] Resident #99 in the ^{Ex Order 26. 4B1} [REDACTED]. When Resident #15 returned from the ^{Ex Order 26. 4B1} [REDACTED], it was the next day that she saw the resident and stated there was nothing special that she needed to do. CNA#3 stated that she was not told to document anything or perform "any special monitoring for the residents." CNA#3 further explained that Resident #99 did not have ^{Ex Order 26. 4B1} [REDACTED] and had no ^{Ex Order 26. 4B1} [REDACTED] another resident. She stated that she had asked Resident #99 why he/she had ^{Ex Order 26. 4B1} [REDACTED] Resident #15 and Resident #99 could not provide her with an answer. CNA#3 told the surveyor that facility management did not talk to her about the ^{Ex Order 26. 4B1} [REDACTED].</p> <p>On 02/22/23 at 1:40 PM, the surveyors interviewed the LPN/UM who stated that Resident #15 had resided at the facility for approximately four (4) years and had ^{Ex Order 26. 4B1} [REDACTED] and ^{Ex Order 26. 4B1} [REDACTED]. The LPN/UM explained that the resident resided at the facility for care related to activities of daily living and was unable to do for himself/herself. The LPN/UM further stated that</p>	F 600			

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F 600	<p>Continued From page 22</p> <p>there was an ^{Ex Order 26.4B1} not too long ago between Resident #15 and Resident #99 in which Resident #99 ^{Ex Order 26.4B1} Resident #15 in the ^{Ex Order 26.4}. The LPN/UM explained that after the ^{Ex Order 26.4B1} Resident #15 told the nurse to call the police on his/her behalf. The LPN/UM explained that the nurse working interviewed Resident #99 who told her that he/she ^{Ex Order 26.4B1} Resident #15 in the ^{Ex Order 26.4} because the ^{Ex Order 26.4B1}. The LPN/UM further stated that the nurse working notified the resident's families and Resident #15 was taken to the ^{Ex Order 26.4B1} for an evaluation after being ^{Ex Order 26.4B1} in the ^{Ex Order 26.4} and was then sent back to the facility from the ^{Ex Order 26.4B1} with no apparent ^{Ex Order 26.4B1}. The LPN/UM told the survey team that when Resident #15 returned from the ^{Ex Order 26.4B1} the resident was placed back into the ^{Ex Order 26.4B1} with Resident #99 because the resident "promised not to do anything and was educated." The LPN/UM stated that Resident #15 ^{Ex Order 26.4B1} in his/her ^{Ex Order 26.4B1} of residing at the facility had ^{Ex Order 26.4B1}. The LPN/UM explained that Resident #99 was ^{Ex Order 26.4B1} at times, had a ^{NJ Exec. Order 26:4.b.1} and was ^{NJ Exec. Order 26:4.b.1} to treat his/her ^{NJ Exec. Order 26:4.b.1}. The survey team asked the LPN/UM if he considered ^{Ex Order 26.4B1} someone ^{Ex Order 26.4B1} and he stated, ^{Ex Order 26.4B1}</p> <p>The survey team further interviewed the LPN/UM and asked what interventions were implemented after the ^{Ex Order 26.4B1} altercation between Resident #15 and Resident #99 took place? The LPN/UM stated that the facility did frequent 30-minute checks to make sure there were no issues going on and educated the resident to discuss their needs with staff. The survey team asked the LPN/UM how the staff evaluated Resident #99's</p>	F 600			

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F 600	<p>Continued From page 23</p> <p>understanding of the education and the LPN/UM explained that they asked Resident #99, [REDACTED] Ex Order 26. 4B1</p> <p>[REDACTED] The LPN/UM stated that Resident #99 told staff that he/she would ask the staff for help. The survey team inquired further if the facility documented on the implemented interventions. The LPN/UM stated that the facility did not document the interventions in the resident's medical records. The LPN/UM stated that Resident #99 was already being monitored for [REDACTED] NJ Exec. Order 26.4.b.1 because the resident was on Ex Order 26. 4B1</p> <p>[REDACTED] and because the resident was already on these medications, monitoring [REDACTED] NJ Exec. Order 26.4.b.1 was not a new intervention for Resident #99. The LPN/UM further stated that after the [REDACTED] altercation between Resident #15 and Resident #99 occurred, he and the facility's Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant Director of Nursing (ADON), and Social Worker (SW) all met together, discussed the [REDACTED] Ex Order 26. 4B1, and put the interventions in place on [REDACTED] Ex Order 26. 4B1. The LPN/UM was unable to produce documentation that 30-minute checks were conducted by staff and stated that the checks occurred by word of mouth from the CNAs and primary nurse on duty.</p> <p>On 02/22/23 at 1:44 PM, the surveyor interviewed CNA#4 who stated that he was employed at the facility for four (4) years and worked on the [REDACTED] floor. CNA#4 told the surveyor that the day of the [REDACTED] Ex Order 26. 4B1, Resident #15 was sitting at the nurse's station and was [REDACTED] so he asked the resident what was wrong. CNA#4 told the surveyor that the resident told him that he/she wasn't feeling good, but CNA#4 was not made aware that Resident #99 [REDACTED] Ex Order 26. 4B1. CNA#4</p>	F 600			

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F 600	<p>Continued From page 24</p> <p>told the surveyor that no one reported the incident to him. CNA#4 stated that he then spoke with Resident #99 who <u>Ex Order 26. 4B1</u> CNA #4 further stated that management staff never told him of the <u>Ex Order 26. 4B1</u> altercation and there was no special monitoring that needed to be done.</p> <p>On 02/22/23 at 2:26 PM, the survey team interviewed the facility's SW who stated that Resident #15 had resided at the facility for a <u>Ex Order 26. 4B1</u> and a <u>Ex Order 26. 4B1</u>. The SW further explained the resident was quiet and that he/she needed another person to initiate a conversation with him/her, liked playing cards, doing puzzles, and watching television. The SW stated that Resident #15 liked to quietly walk around the hallways of the facility. The SW told the survey team that Resident #99 had recently moved to the facility, kept to himself/herself, did not leave his/her room, and would sometimes be observed <u>Ex Order 26. 4B1</u>. The SW further stated that the resident's family came to the facility every <u>Ex Order 26. 4B1</u> and the resident needed to be encouraged to participate in activities. The SW explained to the survey team that she never saw Resident #99 get out of line with staff or residents, but the resident did demonstrate <u>Ex Order 26. 4B1</u>. The SW stated that <u>Ex Order 26. 4B1</u>. The survey team asked the SW if she ever saw Resident #99 demonstrate this behavior. The SW stated that <u>Ex Order 26. 4B1</u>.</p>	F 600			

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F 600	<p>Continued From page 25</p> <p><u>Ex Order 26. 4B1</u> The SW recalled a scenario in which Resident #99's family had called her to notify her that the Resident was upset over a situation with <u>Ex Order 26.4B1</u> so she went to the resident's room and observed this <u>Ex Order 26.4B1</u> herself. The SW told the survey team that Resident #99's family had communicated to her <u>Ex Order 26. 4B1</u></p> <p><u>Ex Order 26. 4B1</u> However, the family had never reported that Resident #99 was <u>Ex Order 26. 4B1</u>, only <u>Ex Order 26. 4B1</u> and explained to her that the resident could get <u>Ex Order 26.4B1</u> very easily.</p> <p>The survey team continued the interview with the facility's SW who stated that she was not aware of the <u>Ex Order 26.4B1</u> altercation that took place during the 11:00 PM - 7:00 AM shift on <u>Ex Order 26.4B1</u> until 02/06/23, two (2) days after the event occurred. The SW stated that she was unsure who the Licensed Practical Nurse/Night Supervisor (LPN/NS) contacted to make them aware of the <u>Ex Order 26. 4B1</u>, but she would have expected the LPN/NS or whomever was on-call that evening to have notified the LNHA or ADON because a <u>Ex Order 26. 4B1</u> altercation had taken place and the police and Emergency Medical Technicians (EMTs) had to come to the facility to assess the residents. The SW further explained that on 02/06/23, she, the ADON, the LNHA, and the <u>Ex Order 26. 4B1</u> and <u>Ex Order 26. 4B1</u> floor Unit Managers discussed the incident. She told the survey team that Resident #15 decided not to <u>Ex Order 26. 4B1</u> against Resident #99 and the facility's <u>Ex Order 26. 4B1</u> was made aware of the <u>Ex Order 26. 4B1</u> on 02/06/23, because the <u>Ex Order 26. 4B1</u> made rounds at the facility early that morning. The SW further stated that she was unsure if anything was done to</p>	F 600			

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F 600	<p>Continued From page 26</p> <p>protect Resident #15 when he/she came back to the facility, but she would have done a room change right then and there because "we work and live in a hard climate and the residents that reside here have [REDACTED] and histories of [REDACTED]." The SW stated that if she was the Nursing Supervisor, she would have done a room change to keep the residents safe.</p> <p>On 02/22/23 at 3:03 PM, the survey team interviewed the ADON who stated that she started working at the facility on 01/25/23. The ADON stated that Resident #15 was <u>NJ Exec. Order 26:4.b.1</u> and <u>NJ Exec. Order 26:4.b.1</u> and that she did not know Resident #99 because she was new to her position. The ADON told the survey team that she learned about the residents <u>Ex Order 26. 4B1</u> [REDACTED]. The ADON explained that the 11:00 PM - 7:00 AM LPN/NS notified the DON that there was a [REDACTED] altercation between Resident #15 and Resident #99 and crisis was called. The ADON stated that Resident #15 was <u>Ex OR</u> by Resident #99, sent to the <u>Ex Order 26. 4B1</u>, and came back cleared. The ADON further stated that the roommates decided not to <u>Ex Order 26. 4B1</u> with the police department and that the <u>Ex Order 26. 4B1</u> occurred over an argument about the television. The surveyors asked the ADON how Resident #15 was protected upon return to the facility. The ADON stated that besides the resident's CP being updated she did not know of any intervention off hand. The ADON further stated <u>Ex Order 26. 4B1</u> <u>Ex Order 26. 4B1</u> and she guessed it was <u>Ex Order 26. 4B1</u> [REDACTED]. The ADON stated that the process for investigation should have been conducted by risk management in which statements were obtained by the residents and staff. The ADON explained that the purpose of the investigative</p>	F 600			

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F 600	<p>Continued From page 27</p> <p>process was to implement interventions and then, <u>Ex Order 26. 4B1</u> The ADON told the survey team that the facility's DON and LNHA were responsible for reporting <u>Ex Order 26. 4B1</u> and investigating.</p> <p>On 02/22/23 at 3:18 PM, the survey team interviewed the DON who stated that she started her position as DON for the facility on 02/01/23. The DON stated that Resident #15 was <u>Ex Order 26. 4B1</u>. The DON told the survey team that Resident #99 was more <u>Ex Order 26. 4B1</u> than Resident #15, <u>Ex Order 26. 4B1</u>, and could get a <u>Ex Order 26. 4B1</u> when he/she did not get their way. The DON stated that when Resident #99 looked <u>Ex Order 26. 4B1</u> that he/she would <u>Ex Order 26. 4B1</u> turn his/her head and dismiss the person that was speaking. The DON stated that she received a phone call on <u>Ex Order 26. 4B1</u> that Resident #99 <u>Ex Order 26. 4B1</u> Resident #15 because Resident #99 was <u>Ex Order 26. 4B1</u> and did not like what Resident #15 was <u>Ex Order 26. 4B1</u>. She further stated that she told the nurse that called her to call crisis and then call 911. The DON explained that 911 evaluated both residents and took Resident #15 to the <u>Ex Order 26. 4B1</u> and that he/she came back to the facility that same night with <u>Ex Order 26. 4B1</u>. The survey team asked the DON what interventions were put in place to <u>Ex Order 26. 4B1</u> Resident #15 and the DON stated that the LPN/UM called the <u>Ex Order 26. 4B1</u> for Resident #15 <u>Ex Order 26. 4B1</u>. The DON told the survey team that she was unsure when Resident #15 was seen by the <u>Ex Order 26. 4B1</u>. The DON explained to the survey team that she never spoke to either of the residents regarding a room change but was told by the LPN/UM that the residents were offered a <u>Ex Order 26. 4B1</u> and neither one of the residents wanted to move out of their room. The DON stated that the LPN/UM</p>	F 600			

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F 600	<p>Continued From page 28</p> <p>spoke with both residents, but to her knowledge it was not documented in the either of the resident's medical records.</p> <p>On 02/22/23 at 3:30 PM, the survey team conducted a follow up interview with the LPN/UM who stated that an <u>Ex Order 26. 4B1</u> report, not an investigation, was completed when Resident #99 <u>Ex Order 26. 4B1</u> Resident #15 in the <u>Ex Order 26. 4B1</u>. The LPN/UM told the survey team that the most important thing that should have happened was that Resident #15 was protected from future <u>Ex Order 26. 4B1</u>, and the residents should have been separated. The LPN/UM stated, <u>Ex Order 26. 4B1</u></p> <p><u>Ex Order 26. 4B1</u> The LPN/UM told the surveyors that he was not in the facility when the police came and he did not speak to the residents until 02/06/23, two days after the <u>Ex Order 26. 4B1</u> occurred, and that when he spoke to the residents on 02/06/23, they did not tell <u>Ex Order 26. 4B1</u> that they wanted to stay in the <u>Ex Order 26. 4B1</u> together. The LPN/UM stated that he wasn't exactly sure if Resident #15 or Resident #99's <u>Ex Order 26. 4B1</u> or primary care physicians were notified, but he was told they were notified. The LPN/UM further stated that everything that happened should have been documented in the resident's medical record when the <u>Ex Order 26. 4B1</u> altercation took place.</p> <p>On 02/22/23 at 3:48 PM, the survey team interviewed the facility's LNHA who stated that his first day working at the facility was 01/23/23. The LNHA stated that there were different types of <u>Ex Order 26. 4B1</u> and <u>Ex Order 26. 4B1</u> was one of them. The LNHA stated that the process when <u>Ex Order 26. 4B1</u> occurred was to isolate the situation and take away the <u>Ex Order 26. 4B1</u>. The LNHA stated <u>Ex Order 26. 4B1</u></p>	F 600			

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F 600	<p>Continued From page 29</p> <p><u>Ex Order 26. 4B1</u> The LNHA told the surveyors that according to the state and federal regulations the NJDOH should have been notified of the event between Resident #15 and Resident #99 within two (2) hours because <u>Ex Order 26. 4B1</u> had occurred. The LNHA further stated that he wasn't familiar with the investigative findings of the event because nursing handled the situation. The LNHA told the survey team that it was his understanding that there was a [REDACTED] altercation, the police were notified and both residents in question did not want to <u>Ex Order 26. 4B1</u>. The LNHA could not speak to why Resident #99 <u>Ex Order 26. 4B1</u> would legally be able to <u>Ex Order 26. 4B1</u> against Resident #15 <u>Ex Order 26. 4B1</u>. The LNHA stated that it was also his understanding that when Resident #15 returned from the <u>Ex Order 26. 4B1</u>, the nurse spoke with both residents and the residents wanted to stay in the room together. The LNHA stated that he was the person responsible for making sure that <u>Ex Order 26. 4B1</u> was thoroughly investigated in the facility.</p> <p>On 02/23/23 at 9:35 AM, in the presence of the survey team, the surveyor interviewed the LPN/NS via the telephone who stated that Resident #15 informed her that he/she was <u>Ex Order 26. 4B1</u> and wanted to be evaluated at the <u>Ex Order 26. 4B1</u>. The LPN/NS stated that Resident #99 admitted to <u>Ex Order 26. 4B1</u> Resident #15. She stated that she evaluated Resident #15 and there were <u>Ex Order 26. 4B1</u> and that the EMTs also evaluated Resident #15 prior to taking him/her to the <u>Ex Order 26. 4B1</u>. The LPN/NS stated that crisis evaluated Resident #99. She stated that both residents did not want to <u>Ex Order 26. 4B1</u> once the police arrived. The surveyor continued to interview the LPN/NS who stated that she wrote a progress note in the EMR but never completed a witness statement until the</p>	F 600			

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F 600	<p>Continued From page 30</p> <p><u>Ex Order 26. 4B1</u> [REDACTED]. She stated that the [REDACTED] altercation occurred over the weekend, and that she notified the DON, the ADON, the UM, the SW, the LNHA, as well as both residents' families and the doctors. The LPN/NS stated that the [REDACTED] altercation was considered <u>Ex Order 26. 4B1</u> because Resident #15 <u>Ex Order 26. 4B1</u>. She stated that she was in-serviced on abuse and that according to the facility's policy the first things after a [REDACTED] altercation would have been to ensure the residents were separated and evaluated and that the situation was assessed. She further stated that <u>Ex Order 26. 4B1</u> [REDACTED].</p> <p>[REDACTED]. The LPN/NS explained that since they were not in the <u>Ex Order 26. 4B1</u> after the <u>Ex Order 26. 4B1</u> that was how the residents were separated. She stated she was not at the facility when Resident #15 returned from the <u>NJ Exec. Order 26.4B.1</u> [REDACTED]. She further stated that she was told during report on 02/06/23, that Resident #15 and Resident #99 were asked if they wanted to remain in the shared room and they both agreed. The LPN/NS stated that the LPN/UM was responsible for the CP. She stated that Resident #15's CP was updated after he/she <u>EX Order 26.4B1</u> [REDACTED] but was not sure if Resident #99's CP was updated. The LPN/NS was unable to provide a response on if the CP should have been updated immediately. The LPN/NS concluded that to have been protected during a [REDACTED] altercation, the residents should have been separated and made sure that they were both individually in a safe space.</p> <p>On 2/23/23 at 12:41 PM, the surveyor interviewed</p>	F 600			

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F 600	<p>Continued From page 31</p> <p>Resident #99's Primary Care Physician (PCP #2) who stated he was informed that the resident had a history of "EX Order 26.4B1" but was unable to specify. PCP #2 further stated that after the altercation between the two residents they should not have remained in the same room.</p> <p>On 02/24/23 at 9:28 AM, the surveyor observed Resident #99 sitting on the side of their bed watching TV. The surveyor asked Resident #99 if he/she had been involved in a altercation and Resident #99 replied, "EX Order 26.4B1" Resident #99 stated that he/she never had any "EX Order 26.4B1" with anyone and denied ever "EX Order 26.4B1" another resident.</p> <p>On 02/24/23 at 9:29 AM, the surveyor observed Resident #15 lying in bed watching TV in his/her "EX Order 26.4B1". Resident #15 stated he/she was happy with the "EX Order 26.4B1" and thanked the surveyor for addressing his/her concerns. The surveyor asked the resident if staff had asked him/her after the altercation if he/she wanted to move their room? Resident #15 replied, "EX Order 26.4B1" The surveyor informed the resident that the staff stated he/she was asked, and that he/she declined to move. Resident #15 stated, "EX Order 26.4B1" Resident #15 further stated, "EX Order 26.4B1"</p> <p>On 02/24/23 at 9:57 AM, the surveyor interviewed PCP #3 for Resident #15 who stated he was covering for PCP #1 who was currently on vacation. PCP #3 stated that he was not made aware of the altercation until yesterday, "EX Order 26.4B1". PCP #3 emphasized that PCP #1 must have been informed a couple of days ago of the "EX Order 26.4B1"</p>	F 600			

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F 600	<p>Continued From page 32</p> <p>altercation because PCP #1 had documented on Resident #15 a few days ago. The surveyor continued to interview PCP #3 who stated that he was not a police officer but if a resident ^{Ex Order 26.4B1} another resident that would be ^{Ex Order 26.4B1} and a form of ^{Ex Order 26.4B1}. PCP #3 further stated that it was ^{Ex Order 26.4B1} to appropriately separate the residents and that they should not have remained in the ^{Ex Order 26.4B1}. PCP #3 stated that he had just assessed Resident #15 who had a history of ^{Ex Order 26.4B1} and appeared much better and calmer today ^{Ex Order 26.4B1}.</p> <p>On 03/01/23 at 3:04 PM, the survey team interviewed the ^{Ex Order 26.4B1} Nurse Practitioner (PNP) for the facility via the telephone. The PNP stated that she came to the facility every Monday and assessed residents regarding ^{NJ Exec. Order 26.4.b.1} and medication management. She stated that she was not aware of the ^{Ex Order 26.4B1} altercation until she reviewed Resident #15's electronic PN on 02/13/23. She further stated she was not made aware of the ^{Ex Order 26.4B1} altercation from the facility until Thursday, 02/23/23. She further stated that she had initially seen Resident #99 on 01/23/23 and that the resident had ^{NJ Exec. Order 26.4.b.1} at that time. The PNP stated that Resident #99 was not seen after the ^{Ex Order 26.4B1} altercation until 2/27/23, after the facility made her aware. She stated that if a ^{Ex Order 26.4B1} altercation occurred, she would be expected to be informed as soon as possible so the resident could have been evaluated. The PNP stated that after a ^{Ex Order 26.4B1} altercation the residents should not have been in the ^{Ex Order 26.4B1}. She further explained that if the residents were kept in the ^{Ex Order 26.4B1} that it would have put them at risk for another ^{Ex Order 26.4B1}. The PNP concluded that it was</p>	F 600			

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F 600	<p>Continued From page 33</p> <p>important that the residents were kept separated for their safety.</p> <p>On 03/06/23 at 11:00 AM, in the presence of the survey team, the DON and the Regional DON, the Consultant LNHA acknowledged that Resident #15 and Resident #99 should have been separated after the incident. The Consultant LNHA stated that there was a lack in the investigation and reporting process regarding [REDACTED] altercations.</p> <p>A review of the facility's Abuse Coordinator job description, signed by the LNHA on 01/23/23, included the following: "1. The Administrator has the overall responsibility for the coordination and implementation for our facility's abuse prevention program. 2. The Abuse Coordinator will oversee, and delegate education and in-services related to allegations of abuse, identifying abuse and reporting abuse."</p> <p>A review of the facility's Incident/Occurrence Investigation Policy, revised 05/22/22, included "1. All incidences of alleged abuse, mistreatment, or neglect of a resident by staff, other residents, visitors, etc. will be investigated. 4. The results of investigation that indicates that abuse, neglect, or mistreatment has occurred, or cannot be conclusively ruled out, will be reported to the DOH [Department of Health] utilizing standard reporting procedures."</p> <p>A Review of the facility's Resident/Patient Rights - Abuse, Neglect, Mistreatment or Misappropriation of Resident/Patient's Property, reviewed 05/22/22, included "IV. Identification. B1. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical</p>	F 600			

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F 600	Continued From page 34 harm, pain, or mental anguish4. Physical abuse is defined as hitting, slapping, pinching, kicking, etcVII. Protection A. While the investigation is being conducted, accused individuals not employed by the facility will be denied unsupervised access to the resident/patient."	F 600			
F 607 SS=E	N.J.A.C. 4.1(a),(3),(5),(12),(15) Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d) (3) of the Act.	F 607			3/31/23

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F 607	<p>Continued From page 35</p> <p>§483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to appropriately implement their <u>Ex Order 26. 4B</u> policy by ensuring a.) all residents were protected from <u>Ex Order 26. 4B</u> when an allegation of <u>Ex Order 26. 4B1</u> occurred, b.) all new employees were screened for potential <u>Ex Order 26. 4B</u> by conducting background checks prior to the employee's date of hire. This deficient practice was identified for one (1) of 12 resident's reviewed for <u>Ex Order 26. 4B</u>, (Resident #15) and two (2) of five (5) staff (Staff #1 and #4) reviewed for newly hired employees.</p> <p>This deficient practice was evidenced by the following:</p> <p>Refer to 600J</p> <p>1.) On 02/22/23 at 10:52 AM, during the initial tour, the surveyor observed Resident #99 sitting on the side of the bed watching TV and eating a bag of chips. Resident #99 stated everything was great and that he/she had no concerns.</p> <p>On 02/22/23 at 10:54 AM, during the initial tour, the surveyor observed Resident #99's roommate, Resident #15, lying in bed watching TV. Resident #15 stated that he/she <u>Ex Order 26. 4B1</u>.</p> <p>A review of the electronic PN reflected the following: On 02/04/23 at 7:00 AM, Resident #15 <u>Ex Order 26. 4B1</u> was <u>Ex Order 26. 4B1</u> by the roommate Resident #99 <u>Ex Order 26. 4B1</u>. It further</p>	F 607	<p>F607 SS E</p> <p>Element One - Corrective Action: Resident #15 was relocated to another room with his/her consent.</p> <p>Staff #1 was hired effective <u>Ex Order 26.4(b)(1)</u> Staff #1's background check was completed 02/01/2023. The report revealed no incidents of criminal activity.</p> <p>Staff #4 was rehired effective <u>Ex Order 26.4(b)(1)</u> Staff #4's background check was completed on 1/23/23. The report revealed no incidents of criminal activity.</p> <p>Element Two -Identification of at Risk Residents: All residents have the potential to be affected by this practice.</p> <p>Element Three <input type="checkbox"/> Systemic Change: The facility's Human Resource/Payroll Director (HR/PD) received re- education regarding the facility's policies and procedures for new and re-hired background checks. The HR/PD was instructed to obtain background checks for newly hired and re-hired employees within 2 days the facility's offer date of employment, the offer is contingent upon employee background check completion., and the prospective employee is made aware of contingent employment. The</p>		

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F 607	<p>Continued From page 36</p> <p>reflected Resident #15 requested to be sent out to the <u>Ex Order 26. 4B1</u> (ER) to have his/her <u>Ex Order 26. 4B1</u> evaluated because he/she was <u>Ex Order 26. 4B1</u>, and the police were notified.</p> <p>On 02/22/23 at 12:09 PM, Resident #15 was observed lying in bed. The surveyor interviewed Resident #15 who stated that they were involved in a <u>Ex Order 26. 4B1</u> altercation with their roommate, Resident #99. Resident #15 stated that he/she was <u>Ex Order 26. 4B1</u> when Resident #99 came up to them, him/her in the <u>Ex Order 26. 4B1</u> and stated he/she <u>Ex Order 26. 4B1</u>. Resident #15 further stated the nurses, and the police were notified but felt that the altercation was not handled appropriately. Resident #15 stated upon returning from the <u>Ex Order 26. 4B1</u> that he/she did not know why Resident #99 was still their roommate. Resident #15 concluded he/she was very frustrated about the altercation and that they could <u>Ex Order 26. 4B1</u> in their <u>Ex Order 26. 4B1</u>. The resident further stated that he/she was concerned about being in the <u>Ex Order 26. 4B1</u> with Resident #99.</p> <p>On 02/22/23 at 12:21 PM, the surveyor interviewed the Licensed Practical Nurse/Unit manager (LPN/UM) for the <u>Ex Order 26. 4B1</u>-floor nursing unit who confirmed Resident #15 and Resident #99 were roommates and were involved in a recent <u>Ex Order 26. 4B1</u> altercation. The LPN/UM stated that both residents were <u>Ex Order 26. 4B1</u> at times and that Resident #99 <u>Ex Order 26. 4B1</u> Resident #15 in the <u>Ex Order 26. 4B1</u>. He further stated that Resident #15 did <u>NJ Exec. Order 26:4.b.1</u> and that the resident was sent out to the <u>Ex Order 26. 4B1</u>. The LPN/UM stated that he educated both residents on <u>Ex Order 26. 4B1</u>.</p>	F 607	<p>HR/PD was instructed to report any delays in the receipt of background checks immediately to the new or re-hired employee's supervisor and the Administrator. The employee may not work until background check is cleared.</p> <p>The facility's Social Services Director has/will interview ten residents weekly x three weeks to determine if any other residents have expressed any safety concerns or have experienced any <u>Ex Order 26. 4B1</u>. The findings reveal that no other residents have reported any safety concerns or <u>Ex Order 26. 4B1</u>.</p> <p>The facility reviewed the personnel files of newly hired and re-hired employees for the last 6 months to identify other employees that may have been affected by this deficient practice. The review revealed that all new hires and re-hired employees within the last six months had completed background checks within two days of their employment date or an offer of employment date.</p> <p>The Administrator, DON, ADON, and Social Services Director reviewed the facility's Incident/Occurrence Investigation policy and the facility's Resident Rights policies related to <u>Ex Order 26. 4B1</u>, Neglect, and Mistreatment or Misappropriation of Resident Property. Based upon this review, it was determined that the policies were appropriate and required no additional modifications at this time.</p> <p>Staff including SW, LNHA, and DON were</p>		

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F 607	<p>Continued From page 37</p> <p>notifying the staff if they had any disagreements. He further stated that Resident #99 ^{Ex Order 26.4B1} had NJ Exec. Order 26:4.b.1 and that the ^{Ex Order 26.4B1} altercation was ^{Ex Order 26.4B1} The LPN/UM stated that he spoke with Resident #99 two (2) days later, on ^{Ex Order 26.4B1}, when he arrived back to work and that the resident stated he ^{Ex Order 26.4B1} Resident #15 because the ^{Ex Order 26.4B1} ^{Ex Order 26.4B1} further explained Resident #99 informed him that he/she ^{Ex Order 26.4B1} Resident #15. The LPN/UM stated that the interventions they initiated were 30-minute safety checks to ensure that the residents were ^{Ex Order 26.4B1} He further stated Resident #99's family and staff explained to him/her that it was ^{Ex Order 26.4B1} to ^{Ex Order 26.4B1} another resident. The LPN/UM stated that Resident #15 and Resident #99 ^{Ex Order 26.4B1} and that during their investigation they felt it was ^{Ex Order 26.4B1} and the ^{Ex Order 26.4B1} occurred ^{Ex Order 26.4B1} He then stated, ^{Ex Order 26.4B1} The LPN/UM stated Resident #15's family was made aware of the ^{Ex Order 26.4B1} and that the family had wanted to make sure that he/she was monitored frequently and was safe. The LPN/UM concluded the ^{Ex Order 26.4B1} came every Monday and that both residents were seen by them.</p> <p>On 02/22/23 at 1:40 PM, the surveyors interviewed the LPN/UM who stated that Resident #15 had resided at the facility for approximately NJ Exec. Order 26:4.b.1 and had ^{Ex Order 26.4B1} and ^{Ex Order 26.4B1}. The LPN/UM explained that the resident resided at the facility for care related to ^{Ex Order 26.4B1} and was unable to do for himself/herself. The LPN/UM further stated that there was an ^{Ex Order 26.4B1} not too long ago between</p>	F 607	<p>educated following facilities policy Prohibition of Resident Abuse & Neglect which included:</p> <ol style="list-style-type: none"> 1.The definition of ^{Ex Order 26.4B1} as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting ^{Ex Order 26.4B1} or pain or ^{Ex Order 26.4B1}, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and ^{Ex Order 26.4B1} well-being. 2.Types of ^{Ex Order 26.4B1}, verbal, sexual, ^{Ex Order 26.4B1} /emotional ^{Ex Order 26.4B1}, involuntary seclusion, neglect, exploitation, and misappropriation of resident property. 3.Prevention which includes employee and volunteer screening, training, which is completed upon hire, and minimally quarterly to employees. Re-education is also completed when/if there is an allegation of ^{Ex Order 26.4B1}. 4. Reporting ^{Ex Order 26.4B1} must be reported to immediately to supervisor. The supervisor will then report to the ^{Ex Order 26.4B1} Coordinator. If the ^{Ex Order 26.4B1} coordinator is unavailable the next highest administrative position is made aware(DON). 5. Protection-Immediately remove the resident(s) from the situation, assess and treat, accused employees (if applicable) will be suspended immediately pending further investigation. 6. Investigation: a full investigation is completed with a comprehensive review of the situation, interviews with staff, 		

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F 607	<p>Continued From page 38</p> <p>Resident #15 and Resident #99 in which Resident #99 ^{Ex Order 26. 4B1} Resident #15 in the ^{Ex Order 26. 4} ^{NO Exec. Order 26.4.b.1} The LPN/UM explained that after the ^{Ex Order 26. 4B1} Resident #15 told the nurse to call the police on his/her behalf. The LPN/UM explained that the nurse working interviewed Resident #99 who told her that he/she ^{Ex Order 26. 4B1} Resident #15 in the ^{Ex Order 26. 4} because the television in the room was too loud. The LPN/UM further stated that the nurse working notified the resident's families and Resident #15 was taken to the ^{Ex Order 26. 4B1} for an evaluation after being ^{Ex Order 26. 4B1} and was then sent back to the facility from the ^{Ex Order 26. 4B1} with ^{NJ Exec. Order 26:4.b.1} The LPN/UM told the survey team that when Resident #15 returned from the ^{Ex Order 26. 4B1} that the resident was placed back into the ^{Ex Order 26. 4B1} with Resident #99 because the resident ^{Ex Order 26. 4B1} The LPN/UM stated that Resident #15 had never in his/her four years of residing at the facility had ^{NJ Exec. Order 26:4.b.1} towards other residents or staff. The LPN/UM explained that Resident #99 was ^{Ex Order 26. 4B1} had a history of ^{Ex Order 26. 4B1} and was on medication to treat his/her ^{Ex Order 26. 4B1} diagnoses. The survey team asked the LPN/UM if he considered ^{Ex Order 26. 4B1} someone ^{NJ Exec. Order 26:4.b.1} ^{NJ Exec. Order 26:4.b.1} and he stated, ^{Ex Order 26. 4B1}</p> <p>The survey team further interviewed the LPN/UM and asked what interventions were implemented after the ^{Ex Order 26. 4B1} between Resident #15 and Resident #99 ^{Ex Order 26. 4B1} The LPN/UM stated that the facility did frequent 30-minute checks to make sure there were no issues going on and educated the resident to discuss their needs with staff. The survey team asked the LPN/UM how the staff evaluated Resident #99's understanding of the education and the LPN/UM</p>	F 607	<p>residents, and any witnesses to event and statements are recorded, statement review, environmental review, and medical record review.</p> <p>Element Four - Quality Assurance: The facility's Administrator or designee shall conduct random audits of residents weekly for four weeks, and then monthly for 3 months; as well as random audits of staff weekly for four weeks and monthly for three months, in order to ascertain the effectiveness of the preventive measures. In addition, the Regional Administrator or designee shall review incident reports weekly for four weeks, and then monthly for three months to ensure that any allegations of ^{Ex Order 26. 4B1} are properly identified, reported, investigated, and that interventions were taken to protect victims. Thereafter the members of the Quality Assurance Performance Improvement (QAPI) committee shall review reportable events and investigations and ^{Ex Order 26. 4B1} reports as part of the QAPI process.</p> <p>The facility's Administrator or designee shall inspect all personnel files for newly hired and re-hired employees for a period of three months to ascertain the effectiveness of the preventive measures, and to determine that employee background checks are completed in accordance with facility policy.</p> <p>Needed corrections will be addressed as they are discovered. Findings to be reported monthly to QAPI team for review</p>		

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F 607	<p>Continued From page 39</p> <p>explained that they asked Resident #99 ^{Ex Order 26. 4B1} [REDACTED]</p> <p>[REDACTED] The LPN/UM stated that Resident #99 told staff that he/she would ask the staff for help. The survey team inquired further if the facility documented on the implemented interventions. The LPN/UM stated that the facility did not document the interventions in the resident's medical records. The LPN/UM stated that Resident #99 was already being monitored for ^{NJ Exec. Order 26-4.b.1} [REDACTED] because the resident was on ^{Ex Order 26. 4B1} [REDACTED] and because the resident was already on these medications, monitoring ^{NJ Exec. Order 26-4.b.1} [REDACTED] was not a new intervention for Resident #99. The LPN/UM further stated that after the ^{Ex Order 26. 4B1} [REDACTED] between Resident #15 and Resident #99 occurred, he and the facility's Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant Director of Nursing (ADON), and Social Worker (SW) all met together, discussed the ^{Ex Order 26. 4B1} [REDACTED], and put the interventions in place on 02/06/23. The LPN/UM was unable to produce documentation that 30-minute checks were conducted by staff and stated that the checks occurred by word of mouth from the CNAs and primary nurse on duty.</p> <p>On 02/22/23 at 1:44 PM, the surveyor interviewed CNA#4 who stated that he was employed at the facility for four (4) years and worked on the [REDACTED] floor. CNA#4 told the surveyor that the day of the ^{Ex Order 26. 4B1} [REDACTED], Resident #15 was sitting at the nurse's station and was upset so he asked the resident what was wrong. CNA#4 told the surveyor that the resident told him that he/she ^{Ex Order 26. 4B1} [REDACTED], but CNA#4 was not made aware that Resident #99 ^{Ex Order 26. 4B1} [REDACTED] him. CNA#4 told the surveyor that no one reported the ^{Ex Order 26. 4B1} [REDACTED]</p>	F 607	<p>and action as necessary.</p> <p>Completion Date: 3/31/23</p>		

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F 607	<p>Continued From page 40</p> <p>to him. CNA#4 stated that he then spoke with Resident #99 who <u>Ex Order 26. 4B1</u> <u>Ex Order 26. 4B1</u> CNA #4 further stated that management staff never told him of the <u>Ex Order 26. 4B1</u> and there was no special monitoring that needed to be done.</p> <p>On 02/22/23 at 3:18 PM, the survey team interviewed the DON who stated that she started her position as DON for the facility on <u>Ex Order 26. 4B1</u>. The DON stated that Resident #15 was <u>Ex Order 26. 4B1</u> and cooperative with staff. The DON told the survey team that Resident #99 was more <u>Ex Order 26. 4B1</u> than Resident #15, also <u>Ex Order 26. 4B1</u>, and could get a little <u>Ex Order 26. 4B1</u> when he/she did not get their way. The DON stated that when Resident #99 looked frustrated that he/she would <u>Ex Order 26. 4B1</u> turn his/her head and dismiss the person that was speaking. The DON stated that she received a phone call on <u>Ex Order 26. 4B1</u>, that Resident #99 Resident #15 because Resident #99 was <u>Ex Order 26. 4B1</u> and did not like what Resident #15 was watching on television. She further stated that she told the nurse that called her to call crisis and then call 911. The DON explained that 911 evaluated both residents and took Resident #15 to the <u>Ex Order 26. 4B1</u> and that he/she came back to the facility that same night with <u>Ex Order 26. 4B1</u>. The survey team asked the DON what interventions were put in place to <u>Ex Order 26. 4B1</u> Resident #15 and the DON stated that the LPN/UM called the <u>Ex Order 26. 4B1</u> for Resident #15 <u>Ex Order 26. 4B1</u>. The DON told the survey team that she was unsure when Resident #15 was seen by the <u>Ex Order 26. 4B1</u>. The DON explained to the survey team that she never spoke to either of the residents regarding a room change but was told by the LPN/UM that the residents were offered a room change and neither one of the residents wanted to move out</p>	F 607			

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F 607	<p>Continued From page 41</p> <p>of their room. The DON stated that the LPN/UM spoke with both residents, but to her knowledge it was not documented in the either of the resident's medical records.</p> <p>On 02/22/23 at 3:30 PM, the survey team conducted a follow up interview with the LPN/UM who stated that an <u>Ex Order 26. 4B1</u> report, not an investigation, was completed when Resident #99 <u>Ex Order 26. 4B1</u> Resident #15 in the <u>Ex Order 26. 4B1</u>. The LPN/UM told the survey team that the most important thing that should have happened was that Resident #15 was protected from future <u>Ex Order 26. 4B1</u>, and the residents should have been separated. The LPN/UM stated, <u>Ex Order 26. 4B1</u></p> <p><u>Ex Order 26. 4B1</u> The LPN/UM told the surveyors that he was not in the facility when the police came and he did not speak to the residents until Monday, two days after the <u>Ex Order 26. 4B1</u> occurred. The LPN/UM told the surveyors that when he spoke to the residents on <u>Ex Order 26. 4B1</u>, they did not tell him that they wanted to stay in the <u>Ex Order 26. 4B1</u> together. The LPN/UM stated that he wasn't exactly sure if Resident #15 or Resident #99's <u>Ex Order 26. 4B1</u> or primary care physicians were notified, but he was told they were notified. The LPN/UM further stated that everything that happened should have been documented in the resident's medical record when the <u>Ex Order 26. 4B1</u> took place.</p> <p>On 02/22/23 at 3:48 PM, the survey team interviewed the facility's LNHA who stated that his first day working at the facility was <u>Ex Order 26. 4B1</u>. The LNHA stated that there were different types of <u>Ex Order 26. 4B1</u> and <u>Ex Order 26. 4B1</u> was one of them. The LNHA stated that the process when <u>Ex Order 26. 4B1</u> occurred was to isolate the situation and take</p>	F 607			

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F 607	<p>Continued From page 42</p> <p>away the alleged ^{Ex Order 26. 4B1} [REDACTED]. The LNHA stated ^{Ex Order 26. 4B1} [REDACTED]. The LNHA told the surveyors that according to the Federal Regulations the NJDOH should have been notified of the event between Resident #15 and Resident #99 within two (2) hours because ^{Ex Order 26. 4B1} [REDACTED] had occurred. The LNHA further stated that he wasn't familiar with the investigative findings of the event because nursing handled the situation. The LNHA told the survey team that it was his understanding that there was a ^{Ex Order 26. 4B1} [REDACTED], the police were notified and both residents in question did not want to ^{Ex Order 26. 4B1} [REDACTED]. The LNHA could not speak to why Resident #99 ^{Ex Order 26. 4B1} [REDACTED] would legally be able to ^{Ex Order 26. 4B1} [REDACTED] against Resident #15 ^{Ex Order 26. 4B1} [REDACTED]. The LNHA stated that it was also his understanding that when Resident #15 returned from the ^{Ex Order 26. 4B1} [REDACTED] the nurse spoke with both residents and the residents wanted to stay in the room together. The LNHA stated that he was the person responsible for making sure that ^{Ex Order 26. 4B1} [REDACTED] was thoroughly investigated in the facility.</p> <p>On 02/23/23 at 9:35 AM, in the presence of the survey team, the surveyor interviewed the LPN/NS via the telephone who stated that Resident #15 informed her that he/she was ^{Ex Order 26. 4B1} [REDACTED] and wanted to be evaluated at the ^{Ex Order 26. 4B1} [REDACTED]. The LPN/NS stated that Resident #99 admitted to ^{Ex Order 26. 4B1} [REDACTED] Resident #15. She stated that she evaluated Resident #15 and there were ^{Ex Order 26. 4B1} [REDACTED] and that the EMTs also evaluated Resident #15 prior to taking him/her to the ^{Ex Order 26. 4B1} [REDACTED]. The LPN/NS stated that crisis evaluated Resident #99. She stated that both residents did not want to ^{Ex Order 26. 4B1} [REDACTED] once the police arrived. The surveyor continued to interview the LPN/NS who</p>	F 607			

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F 607	Continued From page 43 stated that she wrote a progress note in the EMR but never completed a witness statement until the facility called last night on 02/22/23. She stated that the <u>Ex Order 26. 4B1</u> occurred over the weekend, and that she notified the DON, the ADON, the UM, the SW, the LNHA, as well as both residents' families and the doctors. The LPN/NS stated that the <u>Ex Order 26. 4B1</u> was considered <u>Ex Order 26. 4B1</u> because Resident #15 <u>Ex Order 26. 4B1</u> . She stated that she was in-serviced on <u>Ex Order 26. 4B1</u> and that according to the facility's policy the first thing after a <u>Ex Order 26. 4B1</u> would have been to ensure the residents were separated and evaluated and that the situation was assessed. She further stated that the residents were considered separated because Resident #15 <u>Ex Order 26. 4B1</u> was brought to the nurse's station while Resident #99 <u>Ex Order 26. 4B1</u> stayed in their <u>Ex Order 26. 4B1</u> . The LPN/NS explained that since they were not in the <u>Ex Order 26. 4B1</u> after the <u>Ex Order 26. 4B1</u> that was how the residents were separated. She stated she was not at the facility when Resident #15 returned from the <u>Ex Order 26. 4B1</u> . She further stated that she was told during report on 02/06/23, that Resident #15 and Resident #99 were asked if they wanted to remain in the <u>Ex Order 26. 4B1</u> and they both agreed. The LPN/NS stated that the LPN/UM was responsible for the CP. She stated that Resident #15's CP was updated after he/she returned from the <u>Ex Order 26. 4B1</u> but was not sure if Resident #99's CP was updated. The LPN/NS was unable to provide a response on if the CP should have been updated immediately. The LPN/NS concluded that in order to have been protected during a <u>Ex Order 26. 4B1</u> , the residents should have been separated and made sure that they were both individually in a safe space.	F 607			

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F 607	<p>Continued From page 44</p> <p>On 03/06/23 at 11:00 AM, in the presence of the survey team, the DON and the Regional DON, the Consultant LNHA stated that there was a lack in the investigation and reporting process regarding <u>Ex Order 26. 4B1</u>.</p> <p>A review of the facility's Abuse Coordinator job description, signed by the LNHA on 01/23/23, included the following: "1. The Administrator has the overall responsibility for the coordination and implementation for our facility's abuse prevention program. 2. The Abuse Coordinator will oversee, and delegate education and in-services related to allegations of abuse, identifying abuse and reporting abuse."</p> <p>A review of the facility's Incident/Occurrence Investigation Policy, revised 05/22/22, included "1. All incidences of alleged abuse, mistreatment, or neglect of a resident by staff, other residents, visitors, etc. will be investigated. 4. The results of investigation that indicates that abuse, neglect, or mistreatment has occurred, or cannot be conclusively ruled out, will be reported to the DOH [Department of Health] utilizing standard reporting procedures."</p> <p>A Review of the facility's Resident/Patient Rights - Abuse, Neglect, Mistreatment or Misappropriation of Resident/Patient's Property, reviewed 05/22/22, included "I. Screen Procedures. B. Resident/Patient Screening 1. Admitting Director, Medical Director, and the IDC [Interdisciplinary Care] Team will evaluate any resident/patient whole personal history renders them at risk for abusing other residents/patients..3. Interventions will be put into place by the IDC Team and noted on the care plan IV. Identification. B1</p>	F 607			

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F 607	<p>Continued From page 45</p> <p>.....Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish4. Physical abuse is defined as hitting, slapping, pinching, kicking, etcVI. Investigation Procedure B. The Nursing Supervisor or designee will contact the Abuse Coordinator and provide any supporting documentation relative to the investigation. C. The representative's investigation shall consist of 1. A comprehensive review of the event or incident; 2. An interview with the person(s) reporting the incident; 3. Interviews with any witness of the incident ...6 Interview with all staff members (on all shifts) having contact with the resident ...8 A review of all circumstances surrounding that incident....VII. Protection A. While the investigation is being conducted, accused individuals not employed by the facility will be denied unsupervised access to the resident/patient."</p> <p>2.) On 03/02/23 at approximately 09:00 AM, the Licensed Nursing Home Administrator (LNHA) provided the survey team with the personnel and health files for five (5) selected newly hired employees (Staff #1, #2, #3, #4, and #5) in the past four months.</p> <p>A review of the facility's Resident/Patient Rights - Abuse, Neglect, Mistreatment or Misappropriation of Resident/Patient's Property policy reviewed 05/22/22, included ...[facility name] "that procedures are in place to prevent any incidence of abuse; neglect, mistreatment or misappropriation1. Screening Procedures A. Screening of all employees; all employees are</p>	F 607			

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NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		
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F 607	<p>Continued From page 46</p> <p>screened prior to employment ...2. Facility will be thorough in the investigation of past histories of individuals hired."</p> <p>On 03/02/23 at 11:30 AM, the surveyor reviewed the five (5) employee health and personnel files requested and provided by the facility which included:</p> <p>Staff #1, LNHA hired [EX Order 26.4B]. The background check was done on [EX Order 26.4B], six (6) days after he started his LNHA position.</p> <p>A review of the New Hire Checklist for Staff #1 reflected, next to criminal background check was dated 1/23/23.</p> <p>A further review of the Staff #1 personnel file did not reflect a background check was completed prior to LNHA being hired.</p> <p>Staff #4, Licensed Practical Nurse/Nurse Supervisor (LPN/NS), rehired [EX Order 26.4B]. The background check was done on [EX Order 26.4B].</p> <p>A review of the New Hire Checklist for Staff #4 reflected, next to criminal background check was dated 12/24/22.</p> <p>A further review of the Staff #4 personnel file did not reflect a background check was completed prior to LPN/NS being rehired.</p> <p>On 03/02/23 at 12:05 PM, the surveyor interviewed the Human Resource/Payroll Director (HR/PD) who stated her role which included handling the employee personnel files. The HR/PD stated that she called all references to ensure they were valid. She stated that she was</p>	F 607			

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F 607	<p>Continued From page 47</p> <p>also responsible for completing the background checks. She further stated that the facility utilized their own system that she ran the background checks through. The HR/PD confirmed that the background checks all should be done prior to the employee's start date. The surveyor continued to interview the HR/PD who stated that the facility had hired the LNHA prior to her knowledge and as soon as she got his paperwork, she ran the background check on 02/01/23. The HR/PD stated that was <u>Ex Order 26. 4B1</u> and that the LNHA's background check should have been done prior. She explained that if she was not available to perform the background check prior to the start date, that the corporate office could also run the background checks. She then stated she was not sure what the delay in the process was because <u>Ex Order 26. 4B1</u></p> <p>On 03/02/23 at 12:10 PM, the surveyor interviewed the HR/PD regarding Staff #4 who stated that the LPN/NS was rehired, and she believed she did not have to re-run the background check. The HR/PD stated she believed the facility's practice was that if they employee was rehired less than a year then the background check did not have to be completed again. The surveyor asked if a background check was completed in 2020 and Staff #4 was rehired in 2022, should there be another background check done? The HR/PD stated that she should have done another background check prior to the rehire. She further stated the importance of performing background checks was to ensure that the employee did not have any new inquires such as <u>Ex Order 26. 4B1</u> that may have occurred since the last time it was run. The HR/PD stated she had not seen any policy regarding background checks</p>	F 607			

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F 607	<p>Continued From page 48</p> <p>but knew based off her previous trainings that if staff were rehired after more than a year then a background check should have been done. The HR/PD acknowledged that the background checks for Staff #1 (LNHA) and Staff #4 (LPN/NS) should have been completed prior to their date of hire.</p> <p>On 03/03/23 at 09:56 AM, in the presence of the survey team and DON, the Regional Director of Nursing (RDON) stated the human resource (HR) department was responsible for completing the background check on employees. The RDON further stated that the importance of background checks was for the safety of the residents and staff. She confirmed that completing a background check was a part of the facility's <small>Ex Order 26, 48</small> policy. The surveyor continued to interview the RDON who stated she was not sure when a background check should be performed for an employee who was rehired. The RDON then stated she "was not a HR director" and could not speak on when the background check should be completed.</p> <p>On 03/06/23 at 10:57 AM, in the presence of the survey team, RDON and DON, the Consultant LNHA stated that everyone knew why we were doing a criminal background check. He explained there were guidelines that they had to follow and that it was for the safety of all residents. The Consultant LNHA acknowledged that all background checks should have been completed prior to the employee start date and that it was part of the screening process that prevented residents from potential <small>Ex Order 26, 48</small>.</p> <p>A review of the facility's Standard Operating Procedure Background Verification policy revised</p>	F 607			

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F 607	Continued From page 49 1/26/23, included "1. The Personnel/Human Resources Director, or other designee, will conduct employee background checks, reference checks and criminal conviction checks on persons making application for employmentSuch investigation will be initiated within two [2] days of employment or offer of employment."	F 607			
F 609 SS=K	NJAC 4.1(a)(5) Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving ^{(a) Under 26.40} [REDACTED] , neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve ^{(a) Under 26.40} [REDACTED] or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve ^{(a) Under 26.40} [REDACTED] and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609			3/31/23

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F 609	<p>Continued From page 50</p> <p><u>Ex Order 26. 4B1</u>, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interviews, record review, and review of other pertinent facility documentation, it was determined that the facility failed to: a.) report actual <u>Ex Order 26. 4B1</u> to the New Jersey Department of Health (NJDOH) in accordance with state and federal guidelines, b.) report <u>Ex Order 26. 4B1</u> to the NJDOH in accordance with state and federal guidelines, and c.) follow their Resident/Patient - Abuse, Neglect, Mistreatment or Misappropriation of Resident/Patient's Property Policy and Procedure. This deficient practice was identified for 12 of 12 residents, (Resident #13, #15, #26, #63, #64, #72, #82, #98, #99, #114, #115, and #320) reviewed for <u>Ex Order 26. 4B1</u>.</p> <p>The facility failed to report actual <u>Ex Order 26. 4B1</u> of abuse for Resident #15 <u>Ex Order 26. 4B1</u>, Resident #26 <u>Ex Order 26. 4B1</u>, Resident #63 <u>Ex Order 26. 4B1</u>, Resident #72 <u>Ex Order 26. 4B1</u>, Resident #82 <u>Ex Order 26. 4B1</u>, and Resident #114 <u>Ex Order 26. 4B1</u> to the NJDOH.</p> <p>On 02/04/23 on the 11 PM to 7 AM shift, Resident #99 <u>Ex Order 26. 4B1</u> <u>Ex Order 26. 4B1</u> Resident #15 <u>Ex Order 26. 4B1</u> in the <u>Ex Order 26. 4B1</u>. Resident #15 was sent to the <u>Ex Order 26. 4B1</u> for an evaluation and the police were called on <u>Ex Order 26. 4B1</u>.</p> <p>On 02/22/22, Resident #15 told the surveyor that Resident #99 <u>Ex Order 26. 4B1</u> him/her in the <u>Ex Order 26. 4B1</u>.</p> <p>Resident #15 stated that he/she did not understand why Resident #99 was still their roommate and stated that he/she still felt the <u>Ex Order 26. 4B1</u> and was concerned about</p>	F 609	<p>F609 SS=K ELEMENT ONE-CORRECTIVE ACTION Reportable (AAS45) were completed and reported to NJDOH and Ombudsman office for the following residents:</p> <p>" #15 and #98 " #72 and #99 " #114 and #320 " #13 and #26 " #82 and #115 " #64 and #63</p> <p>ELEMENT TWO-IDENTIFICATION OF OTHER RESIDENTS All residents have the potential to be affected . " Resident #15 was relocated to another room that was available and moved to another " Resident #72 and resident #99 rooms were <u>Ex Order 26. 4B1</u> that were available on 2 " Resident # 13 and resident #26 rooms were <u>Ex Order 26. 4B1</u> to rooms that were available on " Resident #82 and #115 have since been <u>Ex Order 26. 4B1</u>. " Resident #64 and resident # 63 were <u>Ex Order 26. 4B1</u> within the facility on " Resident #114 and #320 have since been <u>Ex Order 26. 4B1</u> An audit was completed by the Administrator and DON of the last 30 days of <u>Ex Order 26. 4B1</u> to ensure that all <u>Ex Order 26. 4B1</u></p>		

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F 609	<p>Continued From page 51</p> <p>being in the <u>Ex Order 26. 4B1</u> with Resident #99.</p> <p>Upon interviews with facility staff, it was identified that the facility staff did not report the <u>Ex Order 26. 4B1</u> to the NJDOH but should have.</p> <p>On 02/15/23, Resident #98 <u>Ex Order 26. 4B1</u> Resident #72 <u>Ex Order 26. 4B1</u> with a <u>Ex Order 26. 4B1</u> on the <u>Ex Order 26. 4B1</u>. The resident was sent to the <u>Ex Order 26. 4B1</u> for evaluation and the police were called on <u>Ex Order 26. 4B1</u>.</p> <p>On 02/22/23 at 10:57 AM, the surveyor interviewed Resident #72 who stated that Resident #98 <u>Ex Order 26. 4B1</u> him/her with a <u>Ex Order 26. 4B1</u> three (3) times on the <u>Ex Order 26. 4B1</u>. Resident #72 showed the surveyor <u>Ex Order 26. 4B1</u> that were sustained on the <u>Ex Order 26. 4B1</u> which consisted of <u>Ex Order 26. 4B1</u> and <u>NJ Exec. Order 26:4.b.1</u> of the <u>Ex Order 26. 4B1</u>. Resident #72 stated that he/she did not have a <u>Ex Order 26. 4B1</u> of the <u>Ex Order 26. 4B1</u> where the <u>Ex Order 26. 4B1</u> were but stated that he/she was so angry about the resident <u>Ex Order 26. 4B1</u> him/her with the <u>Ex Order 26. 4B1</u>, that he/she went into the dayroom and punched the wall with his/her <u>Ex Order 26. 4B1</u> which resulted in a <u>Ex Order 26. 4B1</u> of the <u>Ex Order 26. 4B1</u>. He/she admitted that the <u>Ex Order 26. 4B1</u> to the <u>Ex Order 26. 4B1</u> was self-inflicted.</p> <p>Review of Resident #72's Brief Interview for Mental Status (BIMS) revealed a score of <u>Ex Order 26. 4B1</u> out of <u>Ex Order 26. 4B1</u> which meant the resident was <u>Ex Order 26. 4B1</u>. Review of Resident #98's BIMS revealed a score of <u>Ex Order 26. 4B1</u> out of <u>Ex Order 26. 4B1</u>, which meant this resident was also <u>Ex Order 26. 4B1</u>.</p> <p>Upon interviews with facility staff, it was identified that the facility staff did not report the <u>Ex Order 26. 4B1</u> to the NJDOH but</p>	F 609	<p>regarding <u>Ex Order 26. 4B1</u> were investigated and reported to the NJDOH and the Ombudsman office.</p> <p>ELEMENT THREE SYSTEMIC CHANGES</p> <p>Staff were educated following facilities policy Prohibition of Resident Abuse & Neglect which included:</p> <ol style="list-style-type: none"> 1.The definition of <u>Ex Order 26. 4B1</u> as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting <u>Ex Order 26. 4B1</u> or pain or <u>Ex Order 26. 4B1</u>, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and <u>Ex Order 26. 4B1</u> well-being. 2.Types of <u>Ex Order 26. 4B1</u>, verbal, sexual, mental/emotional <u>Ex Order 26. 4B1</u>, involuntary seclusion, neglect, exploitation, and misappropriation of resident property. 3.Prevention which includes employee and volunteer screening, training, which is completed upon hire, and minimally quarterly to employees. Re-education is also completed when/if there is an allegation of <u>Ex Order 26. 4B1</u>. 4. Reporting <u>Ex Order 26. 4B1</u> must be reported to immediately to supervisor. The supervisor will then report to the Abuse Coordinator. If the <u>Ex Order 26. 4B1</u> coordinator is unavailable the next highest administrative position is made aware(DON). Administrative team will then run the investigation. 5. Protection-Immediately remove the resident(s) from the situation, assess and treat, accused employees (if applicable) 		

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F 609	<p>Continued From page 52 should have.</p> <p>A review of the Audit Tool dated 02/23/23, reflected the following: -02/03/23 Resident #114 <u>Ex Order 26. 4B1</u> and Resident #320 <u>Ex Order 26. 4B1</u>. Verbal aggression; <u>Ex Order 26. 4B1</u>; reported- no; comments - will report. -02/04/23 Resident #13 <u>Ex Order 26. 4B1</u> and Resident #26 <u>Ex Order 26. 4B1</u>. Physical aggression; <u>Ex Order 26. 4B1</u>; reported - no; comments - will report. -02/05/23 Resident #82 <u>Ex Order 26. 4B1</u> and Resident #115 <u>Ex Order 26. 4B1</u>. Physical aggression; <u>Ex Order 26. 4B1</u> ; reported - no; comments - will report. -02/07/23 Resident #64 <u>Ex Order 26. 4B1</u>. Physical aggression <u>Ex Order 26. 4B1</u>; reported - no; comments - will report. Resident #63 <u>Ex Order 26. 4B1</u> was not listed on the facility's audit tool.</p> <p>On 02/03/23 at 8:22 PM, Resident #114 stated that he/she had a prior <u>Ex Order 26. 4B1</u> with Resident #320 and that Resident #320 came into their room. Resident #114 stated he/she felt <u>Ex Order 26. 4B1</u> and 911 was called.</p> <p>On 02/04/23 at approximately 3:30 PM, Resident #26 stated that they were <u>Ex Order 26. 4B1</u> by their roommate, Resident #13. Resident #26 stated he/she was <u>Ex Order 26. 4B1</u>. An <u>Ex Order 26. 4B1</u> was done, and <u>NJ Exec. Order 26.4.b.1</u> were identified.</p> <p>On 02/05/23 at 10:14 PM, Resident #82 was <u>Ex Order 26. 4B1</u>, Resident #115. Police were called and Resident #115 was taken to <u>Ex Order 26. 4B1</u>. <u>NJ Exec. Order 26.4.b.1</u> were noted.</p> <p>On 02/07/23 at approximately 11:40 AM, Resident #64 <u>Ex Order 26. 4B1</u> Resident #63 with a <u>Ex Order 26. 4B1</u>. <u>NJ Exec. Order 26.4.b.1</u> were noted.</p>	F 609	<p>will be suspended immediately pending further investigation.</p> <p>6. Investigation: a full investigation is completed with a comprehensive review of the situation, interviews with staff, residents, and any witnesses to event and statements are recorded, statement review, environmental review, and medical record review.</p> <p>Education was also completed with the Licensed Nursing Home Administrator and the Director of Nursing on <u>Ex Order 26. 4B1</u> including facility policy, reporting <u>Ex Order 26. 4B1</u> to the appropriate agencies in a timely manner as per policy, and protection of resident post <u>Ex Order 26. 4B1</u>.</p> <p>ELEMENT FOUR-QUALITY ASSURANCE</p> <p>To maintain and monitor ongoing compliance, LNHA/designee will audit completed investigations daily x 14 days, twice weekly x4weeks and then monthly x2.</p> <p>In addition, DON/designee will monitor all incidents /accidents and 24 hour report including progress notes, daily at clinical morning meeting for any indication of <u>Ex Order 26. 4B1</u> and investigate and report accordingly.</p> <p>Needed corrections will be addressed as they are discovered.</p> <p>Findings to be reported monthly to QAPI team for review and action as necessary.</p> <p>Completion Date: 3/31/23</p>		

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F 609	<p>Continued From page 53</p> <p>On 02/28/23 at 10:52 AM, the Licensed Nursing Home Administrator (LNHA) stated he reported the above listed <u>Ex Order 26. 4B1</u> on <u>Ex Order 26. 4B1</u>.</p> <p>Upon interviews with facility staff, it was identified that the facility staff did not report the <u>Ex Order 26. 4B1</u> to the NJDOH but should have.</p> <p>A review of the facility's Resident/Patient - Abuse, Neglect, Mistreatment or Misappropriation of Resident/Patient's Property Policy and Procedure, reviewed 05/22/22, indicated that staff should report abuse to their supervisor immediately and appropriate agencies will be contacted by telephone to report incidences of abuse.</p> <p>The facility's failure to immediately report to the NJDOH and follow their facility's Residents/Patient Rights -Abuse, Neglect, Mistreatment or Misappropriation of Resident/Patient's Property Policy and Procedure resulted in an Immediate Jeopardy (IJ) situation which began on 02/04/23. The facility's LNHA and Director of Nursing (DON) were notified of the revised IJ Template on 02/23/23 at 1:56 PM. An additional revised IJ Template was provided to the LNHA and DON on 02/28/23 at 4:04 PM. On 02/28/23 at 5:43 PM, the facility provided an acceptable removal plan, and the immediacy was lifted.</p> <p>The evidence was as follows:</p> <p>Refer to F600 and F610</p> <p>1.) On 02/22/23 at 12:09 PM, Resident #15 was observed lying in bed. The surveyor interviewed</p>	F 609			

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F 609	<p>Continued From page 54</p> <p>Resident #15 who stated they were involved in a <u>Ex Order 26. 4B1</u> with their roommate, Resident #99. Resident #15 stated that he/she was <u>Ex Order 26. 4B1</u> when Resident #99 came up to them, <u>Ex Order 26. 4B1</u> him/her in the <u>Ex Order 26. 4B1</u> and stated he/she <u>Ex Order 26. 4B1</u>. Resident #15 further stated that the nurse and the police were notified but felt that the <u>Ex Order 26. 4B1</u> was not handled appropriately. Resident #15 stated upon returning from the <u>Ex Order 26. 4B1</u> (ER) that he/she did not know why Resident #99 was still their roommate. Resident #15 concluded he/she was very frustrated about the altercation and that they could <u>Ex Order 26. 4B1</u> in their <u>Ex Order 26. 4B1</u>. The resident further stated that he/she was concerned about being in the <u>Ex Order 26. 4B1</u> with Resident #99.</p> <p>The surveyor reviewed the electronic medical record (EMR) for Resident #15.</p> <p>A review of the resident's Admission Record (AR) reflected that the resident was admitted to the facility in <u>Ex Order 26. 4B1</u>, with diagnoses which included: <u>Ex Order 26. 4B1</u></p> <p><u>Ex Order 26. 4B1</u></p> <p>A review of the most recent quarterly Minimum Data Set (MDS-an assessment tool used to facilitate the management of care) dated <u>Ex Order 26. 4B1</u>, reflected a BIMS score of <u>Ex Order 26. 4B1</u> out of <u>Ex Order 26. 4B1</u>, which indicated that the resident had a <u>Ex Order 26. 4B1</u>.</p>	F 609			

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F 609	<p>Continued From page 55</p> <p>A review of Resident #15's individualized Care Plan (CP) initiated on ^{Ex Order 26. 4B1}, two (2) days after the ^{Ex Order 26. 4B1} occurred, reflected ^{Ex Order 26. 4B1} related to recent ^{NJ Exec. Order 26:4.b.1} which included the following interventions: A nurse will reassure safety, discuss the reality of the situation while acknowledging what can and cannot be changed to help the patient to feel in control, and reassure the patient that ^{NJ Exec. Order 26:4.b.1} after a traumatic event are normal.</p> <p>The surveyor reviewed the ^{Ex Order 26. 4B1} for Resident #99.</p> <p>A review of the resident's AR reflected that the resident was admitted to the facility in ^{Ex Order 26. 4B1}, with diagnoses which included: ^{Ex Order 26. 4B1}</p> <p>A review of the most recent quarterly MDS dated 12/12/22, reflected a BIMS score of ^{Ex One} out of ^{Ex One}, which indicated an ^{Ex Order 26. 4B1}.</p> <p>A review of Resident #99's individualized CP initiated ^{Ex Order 26. 4B1}, two (2) days after he/she ^{Ex Order 26. 4B1} Resident #15 in the ^{Ex Order 26. 4B1}, reflected ^{NJ Exec. Order 26:4.b.1} related to ^{NJ Exec. Order 26:4.b.1} disturbances which included the following interventions: The nurse will identify what is not appropriate, such as ^{Ex Order 26. 4B1} and ^{Ex Order 26. 4B1}, and also what is appropriate, the nurse will provide positive feedback to let client know he/she is meeting expectations, the nurse will recognize behaviors before they become violent and the nurse will set limits on unacceptable behavior.</p>	F 609			

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F 609	<p>Continued From page 56</p> <p>On 02/22/23 at 2:26 PM, the survey team interviewed the facility's Social Worker (SW) who stated that she was not aware of the [Ex Order 26. 4B1] that took place on [Ex Order 26. 4B1] between Resident #15 and Resident #99 until [Ex Order 26. 4B1], two days after the event occurred. The SW stated that she was unsure who the Nursing Supervisor (NS) contacted to make them aware of the [Ex Order 26. 4B1], but she would have expected the NS or whomever was on-call that evening to have notified the LNHA or Assistant Director of Nursing (ADON) because a [Ex Order 26. 4B1] had taken place and the police and Emergency Medical Technicians (EMTs) had to come to the facility to assess the residents. The SW further explained that on 02/06/23, she, the ADON, the LNHA, the [Ex Order 26. 4B1] and [Ex Order 26. 4B1] floor Unit Managers, and the Minimum Data Set Coordinator discussed the incident. She told the survey team that Resident #15 decided not to [Ex Order 26. 4B1] against Resident #99 and that the facility's [Ex Order 26. 4B1] was made aware of the [Ex Order 26. 4B1] on [Ex Order 26. 4B1] because the [Ex Order 26. 4B1] made rounds at the facility early that morning. The SW further stated that she was unsure if anything was done to protect Resident #15 when he/she came back to the facility, but she would have done a room change right then and there because, "we work and live in a hard climate and the residents that reside here have [Ex Order 26. 4B1] and histories of [Ex Order 26. 4B1]." The SW stated that if she was the NS, she would have done a room change to keep the residents safe. The SW did not speak to time frames for reporting or investigating a [Ex Order 26. 4B1].</p> <p>On 02/22/23 at 3:09 PM, the survey team asked the ADON if the incident of [Ex Order 26. 4B1] between Resident #99 and Resident #15 was</p>	F 609			

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F 609	<p>Continued From page 57</p> <p>investigated and reported to the NJDOH. The ADON stated that the [Ex Order 26. 4B1] should have been reported to the NJDOH within a two-hour time frame and thoroughly investigated. The ADON stated that anytime there was a [Ex Order 26. 4B1] between two residents that it was a reportable event. The ADON told the survey team that after the facility reported the incident to the NJDOH, the facility had 72 hours to thoroughly investigate the [Ex Order 26. 4B1]. The ADON stated that the process for investigation should have been conducted by risk management in which statements were obtained by the residents and staff. The ADON explained that the purpose of the investigative process was to implement interventions and then "safeguard the residents." The ADON told the survey team that the facility's DON and LNHA were responsible for reporting and investigating [Ex Order 26. 4B1].</p> <p>On 02/22/23 at 3:18 PM, the survey team interviewed the DON who stated that she started her position as DON for the facility on [Ex Order 26. 4B1]. The DON stated that Resident #15 was [Ex Order 26. 4B1] at times and cooperative with staff. The DON told the survey team that Resident #99 was [Ex Order 26. 4B1] than Resident #15, also [Ex Order 26. 4B1], and could get a [Ex Order 26. 4B1] when he/she did not get their way. The DON stated that when Resident #99 looked frustrated, he/she would, [Ex Order 26. 4B1] turn his/her head and dismiss the person that was speaking. The DON stated that she received a phone call on [Ex Order 26. 4B1] that Resident #99 [Ex Order 26. 4B1] Resident #15 because Resident #99 was [Ex Order 26. 4B1] and did not like what Resident #15 was watching on television. She further stated that she told the nurse that called her to call crisis and then call 911. The DON explained that 911 evaluated both residents and took Resident #15</p>	F 609			

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F 609	<p>Continued From page 58</p> <p>to the <u>Ex Order 26.4B1</u>, and that the resident came back that same night to the facility with <u>Ex Order 26.4B1</u>. The survey team asked the DON what interventions were put in place to <u>Ex Order 26.4B1</u> Resident #15 and the DON stated that the Licensed Practical Nurse Unit Manager (LPN/UM) called the <u>Ex Order 26.4B1</u> for Resident #15 who was the <u>Ex Order 26.4B1</u>. The DON told the survey team that she was unsure when Resident #15 was seen by the <u>Ex Order 26.4B1</u>. The DON further explained to the survey team that she never spoke to either of the residents regarding a room change but was told by the LPN/UM that the residents were offered a room change and neither one of the residents wanted to move out of their room. The DON stated that the LPN/UM spoke with both residents, but to her knowledge it was not documented in the either of the resident's medical records. The DON told the survey team that an <u>Ex Order 26.4B1</u> report was completed, and statements were obtained. The DON further stated that the <u>Ex Order 26.4B1</u> should have been reported to the NJDOH immediately and then the facility would have had time to investigate <u>Ex Order 26.4B1</u> When the survey team asked the DON if she could provide documentation related to the <u>Ex Order 26.4B1</u> the DON shook her head from side to side, indicating no.</p> <p>On 02/22/23 at 3:30 PM, the survey team conducted a follow up interview with the LPN/UM who stated that an <u>Ex Order 26.4B1</u> report, not an investigation, was completed when Resident #99 hit Resident #15 in the <u>Ex Order 26.4B1</u>. The LPN/UM further stated that there was no documentation that he could provide to reflect the <u>Ex Order 26.4B1</u>. The LPN/UM told the surveyors that he was not in the facility when the police came and he did not speak to the residents until <u>Ex Order 26.4B1</u>, two days after the</p>	F 609			

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F 609	<p>Continued From page 59</p> <p><u>Ex Order 26. 4B1</u> occurred. The LPN/UM told the surveyors that when he spoke to the residents on 02/06/23 they did not tell him that they wanted to stay in the <u>Ex Order 26. 4B1</u> together. The LPN/UM stated that he wasn't exactly sure if Resident #15's or Resident #99's <u>Ex Order 26. 4B1</u> or Primary Care Physicians were notified, but he was told they were notified. The LPN/UM further stated that everything that happened should have been documented in the resident's medical record. The LPN/UM told the surveyors that the facility should have reported the <u>Ex Order 26. 4B1</u> to the NJDOH immediately and an investigation should have been completed and that <u>Ex Order 26. 4B1</u></p> <p>On 02/22/23 at 3:48 PM, the survey team interviewed the facility's LNHA who stated that his first day working at the facility was <u>Ex Order 26. 4B1</u>. The LNHA stated that there were different types of abuse and <u>Ex Order 26. 4B1</u> was one of them. The LNHA stated that the process when <u>Ex Order 26. 4B1</u> occurred was to isolate the situation and take away the alleged <u>Ex Order 26. 4B1</u>. The LNHA stated, <u>Ex Order 26. 4B1</u>. The LNHA told the surveyors that according to the Federal Regulations the NJDOH should have been notified of the event between Resident #15 and Resident #99 within two (2) hours because <u>Ex Order 26. 4B1</u> had occurred.</p> <p>On 02/23/23 at 09:35 AM, in the presence of the survey team, the surveyor interviewed the LPN/Night Supervisor (LPN/NS) via the telephone who stated that Resident #15 informed her that he/she was <u>Ex Order 26. 4B1</u> and wanted to be evaluated at the <u>Ex Order 26. 4B1</u>. The LPN/NS stated that Resident #99 admitted to <u>Ex Order 26. 4B1</u> Resident #15.</p>	F 609			

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F 609	Continued From page 60 She stated that she evaluated Resident #15 and there were ^{Ex Order 26.4 b.1} and that the EMTs also evaluated Resident #15 prior to taking him/her to the ^{Ex Order 26.4 b.1} . The LPN/NS stated that crisis evaluated Resident #99. She further stated that both residents did not want to ^{Ex Order 26.4B1} once the police arrived. The surveyor continued to interview the LPN/NS who stated she wrote a progress note in the EMR but never completed a witness statement until the facility called her last night on 02/22/23. She stated that the ^{Ex Order 26.4B1} occurred over the weekend, and that she notified the DON, the ADON, the LPN/UM, the SW, the LNHA, as well as both residents' families and the doctors. The LPN/NS stated that the ^{Ex Order 26.4B1} was considered ^{Ex Order 26.4B1} because Resident #15 ^{Ex Order 26.4B1} . She stated that she was in-serviced on ^{Ex Order 26.4B1} and that according to the facility's policy the first things after a ^{Ex Order 26.4B1} would have been to ensure the residents were separated and evaluated, and that the situation was assessed. She further stated that the residents were considered separated because Resident #15 ^{Ex Order 26.4B1} was brought to the nurse's station while Resident #99 ^{Ex Order 26.4B1} stayed in their shared room. The LPN/NS explained since they were not in the ^{Ex Order 26.4B1} after the ^{Ex Order 26.4B1} that was how the residents were separated. She stated she was not at the facility when Resident #15 returned from the ^{Ex Order 26.4B1} . She further stated that she was told during report on ^{Ex Order 26.4B1} that Resident #15 and Resident #99 were asked if they wanted to remain in the shared room and they both agreed. The LPN/NS stated that the LPN/UM was responsible for the CP. She stated that Resident #15's CP was updated after he/she returned from the ^{Ex Order 26.4B1} but was not sure if Resident #99's CP	F 609			

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F 609	<p>Continued From page 61</p> <p>was updated. The LPN/NS was unable to provide a response on if the CP should be updated immediately. The LPN/NS concluded that to have been protected during a Ex Order 26. 4B1, the residents should have been separated and made sure that they were both individually in a safe space.</p> <p>On 02/24/23 at 09:45 AM, the surveyor interviewed LPN#1, who stated the process for reporting an Ex Order 26. 4B1 was that the risk management form was completed in the EMR and that the nurse would have assessed the resident. She further stated that if it was an unwitnessed Ex Order 26. 4B1 then the nurse would have done a Ex Order 26. 4B1, called the medical doctor and determined if the resident needed to be taken to the Ex Order 26. 4B1.</p> <p>On 02/24/23 at 09:52 AM, the surveyor interviewed the LPN/UM, who stated that all Ex Order 26. 4B1 were reported to the immediate supervisor, the DON and the LNHA. He further stated that they needed to be made aware immediately because they would have determined if the Ex Order 26. 4B1 needed to be reported. The LPM/UM stated that if Ex Order 26. 4B1 was suspected then they were required to investigate the situation.</p> <p>On 02/24/23 at 12:12 PM, the LNHA provided three (3) Reportable Event Record/Reports which included the Ex Order 26. 4B1 between Resident #15 and Resident #99. The LNHA stated those were the only three (3) Ex Order 26. 4B1 in the last three (3) months.</p> <p>A further review of the Reportable Event Record/Report form reflected that the Ex Order 26. 4B1</p>	F 609			

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F 609	<p>Continued From page 62</p> <p><u>Ex Order 26.4B1</u> between Resident #15 and Resident #99 was not reported until <u>Ex Order 26.4B1</u>.</p> <p>The surveyor reviewed the incident Audit Tool dated [REDACTED], which reflected the following:</p> <p>02/03/23 Resident #114 and Resident #320 [REDACTED]; [REDACTED] - yes; reported- no; comments - will report.</p> <p>02/04/23 Resident #13 and Resident #26 [REDACTED]; [REDACTED] - yes; reported - no; comments - will report.</p> <p>02/05/23 Resident #82 and Resident #115 [REDACTED]; [REDACTED] yes; reported - no; comments - will report.</p> <p>02/07/23 Resident #64 [REDACTED]; [REDACTED] yes; reported - no; comments - will report.</p> <p>Resident #63 was not listed</p> <p>A review of the electronic PN revealed the following:</p> <p>On 02/03/23 at 8:22 PM, Resident #114 stated that he/she had a prior <u>Ex Order 26.4B1</u> with Resident #320 and that Resident #320 came into their room. Resident #114 stated he/she felt <u>Ex Order 26.4B1</u> [REDACTED] and 911 was called.</p> <p>On 02/04/23 at approximately 3:30 PM, Resident #26 stated that they were <u>Ex Order 26.4B1</u> by their roommate, Resident #13. Resident #26 stated he/she was <u>Ex Order 26.4B1</u> [REDACTED]. An <u>Ex Order 26.4B1</u> was done, and <u>NJ Exec. Order 26.4.b.1</u> were noted.</p> <p>On 02/05/23 at 10:14 PM, Resident #82 was <u>Ex Order 26.4B1</u> by their roommate, Resident #115. Police were called and Resident #115 was taken to <u>Ex Order 26.4B1</u> [REDACTED] were noted.</p>	F 609			

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F 609	<p>Continued From page 63</p> <p>On 02/07/23 at approximately 11:40 AM, Resident #64 hit Resident #63 with a [REDACTED] [REDACTED] were noted.</p> <p>2.) The surveyor reviewed the [REDACTED] for Resident #114.</p> <p>A review of the resident's AR reflected that the resident was admitted to the facility in [REDACTED] [REDACTED], with diagnoses which included: [REDACTED].</p> <p>A review of the most recent Admission MDS dated 01/24/23, reflected a BIMS score of [REDACTED] out of 15, which indicated an [REDACTED].</p> <p>A review of Resident #114's individualized CP, initiated 01/20/23 and revised 02/17/23, did not reflect the residents [REDACTED] after the [REDACTED] with Resident #320. A further review revealed, Focus: the resident has a [REDACTED].</p> <p>[REDACTED]</p> <p>The surveyor reviewed the [REDACTED] for Resident #320.</p> <p>A review of the resident's AR reflected that the resident was admitted to the facility in [REDACTED] [REDACTED], with diagnoses which included: [REDACTED].</p> <p>A review of the most recent Admission MDS dated [REDACTED], reflected a BIMS score of [REDACTED] out</p>	F 609			

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F 609	<p>Continued From page 64 of [REDACTED], which indicated an <u>Ex Order 26. 4B1</u>.</p> <p>A review of Resident #320's individualized CP, revised 02/06/23, does not reflect the resident's previous history of <u>NJ Exec. Order 26:4.b.1</u> with other residents and staff. A further review revealed, Focus: the resident has a [REDACTED] well-being problem potential related to [REDACTED], and [REDACTED]. The interventions included: Allow the resident time to answer questions and to [REDACTED] perceptions, and fears as needed.</p> <p>3.) The surveyor reviewed the <u>Ex Order 26</u> for Resident #13.</p> <p>A review of the resident's AR reflected that the resident was admitted to the facility in <u>Ex Order 26. 4B1</u>, with diagnoses which included: <u>Ex Order 26. 4B1</u>.</p> <p>A review of the most recent Admission MDS dated 07/13/22, reflected a BIMS score of <u>Ex Order 26</u> out of [REDACTED], which indicated a <u>Ex Order 26. 4B1</u>.</p> <p>A review of Resident #13's individualized CP initiated <u>Ex Order 26. 4B1</u>, two (2) days after he/she [REDACTED] Resident #26, reflected <u>Ex Order 26. 4B1</u> which included the following interventions: The nurse will identify what is not appropriate, such as [REDACTED] and [REDACTED] and also what is appropriate, the nurse will provide positive feedback to let client know he/she is meeting expectations, the nurse will set limits on [REDACTED] behavior.</p> <p>The surveyor reviewed the <u>Ex Order 26</u> for Resident #26.</p>	F 609			

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F 609	<p>Continued From page 65</p> <p>A review of the resident's AR reflected that the resident was admitted to the facility in <u>Ex Order 26. 4B1</u>, with diagnoses which included: <u>Ex Order 26. 4B1</u>.</p> <p>A review of the most recent Significant Change MDS dated <u>Ex Ord</u>, reflected a BIMS score of <u>Ex Order 26. 4B1</u> out of <u>Ex Order 26. 4B1</u> which indicated a <u>Ex Order 26. 4B1</u>.</p> <p>A review of Resident #26's individualized CP initiated <u>Ex Order 26. 4B1</u>, two (2) days after the <u>Ex Order 26. 4B1</u> occurred, reflected <u>Ex Order 26. 4B1</u> related to recent <u>Ex Order 26. 4B1</u> which included the following interventions: A nurse will reassure safety, discuss the reality of the situation while acknowledging what can and cannot be changed to help the patient <u>NJ Exec. Order 26:4.b.1</u> feel in control, and reassure the patient that <u>Ex Order 26. 4B1</u> after a traumatic event are normal.</p> <p>4.) The surveyor reviewed the EMR for Resident #82.</p> <p>A review of the resident's AR reflected that the resident was admitted to the facility in <u>Ex Order 26. 4B1</u> and readmitted in <u>Ex Order 26. 4B1</u>, with diagnoses which included: <u>Ex Order 26. 4B1</u>.</p> <p>A review of Resident #82's CP, initiated <u>Ex Order 26. 4B1</u>, does not reflect any interventions related to the <u>Ex Order 26. 4B1</u> the resident had with Resident #115.</p> <p>The surveyor reviewed the <u>Ex Order 26</u> for Resident #115.</p>	F 609			

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F 609	<p>Continued From page 66</p> <p>A review of the resident's AR reflected that the resident was admitted to the facility in <u>Ex Order 26. 4B1</u>, with diagnoses which included: <u>Ex Order 26. 4B1</u>.</p> <p>A review of the most recent Admission MDS dated <u>Ex One</u>, reflected a BIMS score of <u>Ex One</u> out of <u>Ex One</u> which indicated an <u>Ex Order 26. 4B1</u>.</p> <p>A review of Resident #115's individualized CP, initiated <u>Ex Order 26. 4B1</u> and revised <u>Ex Order 26. 4B1</u>, does not reflect the resident's previous history of <u>Ex Order 26. 4B1</u>. A further review revealed, Focus: the resident has a <u>Ex Order 26. 4B1</u> problem potential related to <u>Ex Order 26. 4B1</u> and <u>Ex Order 26. 4B1</u> which included the following interventions: Allow the resident time to answer questions and to <u>Ex Order 26. 4B1</u>, and <u>Ex Order 26. 4B1</u> as needed.</p> <p>5.) The surveyor reviewed the <u>Ex Order 26. 4B1</u> for Resident #63.</p> <p>A review of the resident's AR reflected that the resident was admitted to the facility in <u>Ex Order 26. 4B1</u>, with diagnoses which included: <u>Ex Order 26. 4B1</u>.</p> <p>A review of the most recent Annual MDS dated 12/01/22, reflected a BIMS score of <u>Ex One</u> out of <u>Ex One</u> which indicated a <u>Ex Order 26. 4B1</u>.</p> <p>A review of Resident #63's individualized CP, initiated <u>Ex Order 26. 4B1</u>, reflected <u>Ex One</u> related to recent <u>Ex One</u> which included the following interventions: A nurse will reassure safety, discuss the reality of the situation while acknowledging what can and cannot be changed</p>	F 609			

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F 609	<p>Continued From page 67</p> <p>to help the patient to feel in control, and reassure the patient that [REDACTED] after a traumatic event are normal.</p> <p>The surveyor reviewed the EMR for Resident #64.</p> <p>A review of the resident's AR reflected that the resident was admitted to the facility in [REDACTED] Ex Order 26. 4B1, with diagnoses which included: [REDACTED] Ex Order 26. 4B1</p> <p>A review of the most recent Significant Change MDS dated [REDACTED] reflected a BIMS score of [REDACTED] out of [REDACTED], which indicated a [REDACTED] Ex Order 26. 4B1.</p> <p>A review of Resident #63's individualized CP initiated [REDACTED] Ex Order 26. 4B1, reflected [REDACTED] NJ Exec. Order 26:4.b.1 related to [REDACTED] NJ Exec. Order 26:4.b.1 which included the following interventions: The nurse will identify what is not appropriate, such as [REDACTED] and [REDACTED] and also what is appropriate, the nurse will provide positive feedback to let client know he/she is meeting expectations, the nurse will recognize [REDACTED] NJ Exec. Order 26:4.b.1 before they become violent, the nurse will set limits on unacceptable [REDACTED] NJ Exec. Order 26:4.b.1</p> <p>On 02/28/23 at 10:52 AM, the survey team interviewed the DON in the presence of the Regional DON (RDON) and the LNHA who stated that she was still learning the progress but that she was responsible for filling out the audit tool for abuse. The DON further stated that the Regional Nurse/Infection Preventionist (RN/IP), had filled</p>	F 609			

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F 609	<p>Continued From page 68</p> <p>out the audit tool that was provided to the survey team. At that time, the LNHA stated for the <u>Ex Order 26. 4B1</u> listed on the audit tool that he did not report them at the time of the <u>Ex Order 26. 4B1</u>. He further stated that he did not report them until yesterday, <u>Ex Order 26. 4B1</u>.</p> <p>On 02/28/23 at 10:58 AM, the survey team continued to interview the DON who stated that <u>Ex Order 26. 4B1</u> included <u>Ex Order 26. 4B1</u>. The DON stated that suspected <u>Ex Order 26. 4B1</u> should have been reported immediately to the supervisors and then the LNHA would have reported it to the NJDOH.</p> <p>On 02/28/23 at 11:09 AM, the survey team interviewed the RN/IP in the presence of the RDON who stated she completed the <u>Ex Order 26. 4B1</u> audit tool on 02/23/23. The RN/IP stated that the administrative team was not sure if the <u>Ex Order 26. 4B1</u> on the audit tool were considered reportable but that they <u>Ex Order 26. 4B1</u> and reported them yesterday, <u>Ex Order 26. 4B1</u>. The RN/IP acknowledged any <u>Ex Order 26. 4B1</u> was considered a reportable event. The RN/IP stated that there was no other <u>Ex Order 26. 4B1</u> audit done prior to the survey team inquiry. She further stated that all <u>Ex Order 26. 4B1</u> should have been reported immediately but that the administrative team investigated all the incidents and concluded they were unsubstantiated and were not considered <u>Ex Order 26. 4B1</u>.</p> <p>On 03/06/23 at 11:00 AM, in the presence of the survey team, the DON and the Regional DON, the Consultant LNHA stated that there was a lack in the investigation and reporting process regarding <u>Ex Order 26. 4B1</u>.</p> <p>A review of the facility's <u>Ex Order 26. 4B1</u> Coordinator job</p>	F 609			

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F 609	<p>Continued From page 69</p> <p>description signed by the LNHA on 1/23/23 included the following: "1. The Administrator has the overall responsibility for the coordination and implementation for our facility's abuse prevention program. 2. The Abuse Coordinator will oversee, and delegate education and in-services related to allegations of abuse, identifying abuse and reporting abuse."</p> <p>A review of the facility's Incident/Occurrence Investigation Policy revised 05/22/22, included "1. All incidences of alleged abuse, mistreatment, or neglect of a resident by staff, other residents, visitors, etc. will be investigated. 4. The results of investigation that indicates that abuse, neglect, or mistreatment has occurred, or cannot be conclusively ruled out, will be reported to the DOH [Department of Health] utilizing standard reporting procedures."</p> <p>A Review of the facility's Resident/Patient Rights - Abuse, Neglect, Mistreatment or Misappropriation of Resident/Patient's Property reviewed 05/22/22, included "IV. Identification. B1. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish4. Physical abuse is defined as hitting, slapping, pinching, kicking, etcVII. Protection A. While the investigation is being conducted, accused individuals not employed by the facility will be denied unsupervised access to the resident/patientA review of the facility's Incident/Occurrence Investigation Policy revised 05/22/22, included "1. All incidences of alleged abuse, mistreatment, or neglect of a resident by staff, other residents, visitors, etc. will be investigated. 4. The results of investigation that indicates that abuse, neglect, or mistreatment has occurred, or cannot be conclusively ruled out,</p>	F 609			

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F 609	<p>Continued From page 70</p> <p>will be reported to the DOH [Department of Health] utilizing standard reporting procedures."</p> <p>A Review of the facility's Resident/Patient Rights - Abuse, Neglect, Mistreatment or Misappropriation of Resident/Patient's Property, reviewed 05/22/22, included "IV. Identification. B1. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish4. Physical abuse is defined as hitting, slapping, pinching, kicking, etcVI. Investigation Procedure B. The Nursing Supervisor or designee will contact the Abuse Coordinator and provide any supporting documentation relative to the investigation. C. The representative's investigation shall consist of 1. A comprehensive review of the event or incident; 2. An interview with the person(s) reporting the incident; 3. Interviews with any witness of the incident ...6 Interview with all staff members (on all shifts) having contact with the resident ...8 A review or all circumstances surrounding that incident....VII. Protection A. While the investigation is being conducted, accused individuals not employed by the facility will be denied unsupervised access to the resident/patient."</p> <p>6.) According to the AR, Resident #72 was admitted to the facility with diagnoses which included but were not limited to, <u>Ex Order 26. 4B1</u> [REDACTED]. The MDS dated [REDACTED], indicated that the resident scored a [REDACTED] out of [REDACTED] on the BIMS which indicated that the resident was <u>Ex Order 26. 4B1</u>. The MDS also reflected that Resident #72 had [REDACTED] and required <u>NJ Exec. Order 26:4.b.1</u> with activities of daily living</p>	F 609			

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F 609	<p>Continued From page 71 (ADL's).</p> <p>According to the AR, Resident #98 was admitted to the facility with the diagnoses which included but were not limited to <u>Ex Order 26. 4B1</u> [REDACTED]. The admission MDS dated <u>Ex Order 26. 4B1</u>, indicated that the resident scored a <u>Ex Order 26. 4B1</u> out of [REDACTED] on the BIMS which indicated <u>Ex Order 26. 4B1</u> [REDACTED]. The MDS also reflected that Resident #98 had [REDACTED] and required <u>NJ Exec. Order 26.4.b.1</u> with activities of daily living (ADL's).</p> <p>On 02/22/23 at 10:57 AM, during tour, the surveyor interviewed Resident #72 who stated that a resident named [Resident #98] him/her with a <u>Ex Order 26. 4B1</u> on the <u>Ex Order 26. 4B1</u>. The resident held up his/her [REDACTED] and showed the surveyor the <u>Ex Order 26. 4B1</u> [REDACTED] on the [REDACTED] of the [REDACTED] and stated that these were <u>Ex Order 26. 4B1</u>. He/she stated that he/she did not have a [REDACTED] of the <u>Ex Order 26. 4B1</u> and that the <u>NJ Exec. Order 26.4.b.1</u> were injuries. Resident #72 stated that he/she was so [REDACTED] about the resident [REDACTED] him/her with the <u>Ex Order 26. 4B1</u>, that he/she went into the dayroom and [REDACTED] which resulted in a [REDACTED]. He/she did admit that this was a [REDACTED]. Resident #72 then added that when he/she went to the <u>Ex Order 26. 4B1</u> he/she did not show the <u>Ex Order 26. 4B1</u> staff the <u>NJ Exec. Order 26.4.b.1</u> on the <u>Ex Order 26. 4B1</u> and kept the <u>Ex Order 26. 4B1</u> in his/her [REDACTED] of his/her [REDACTED].</p> <p>The surveyor reviewed Resident #72's medical record which revealed a Progress Note (PN) dated [REDACTED] and titled, "Incident Note". The PN indicated that at</p>	F 609			

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F 609	<p>Continued From page 72</p> <p>approximately 05:45 PM, Resident #72 got into a [REDACTED] with a resident. Resident #72 insisted the other resident was constantly [REDACTED] him/her and tonight he/she just [REDACTED]. <i>Ex Order 26. 4B1</i> The PN indicated that Resident #72 [REDACTED] and [REDACTED] his/her [REDACTED]. <i>Ex Order 26. 4B1</i></p> <p>On 02/22/23 at 11:47 AM, during tour, the surveyor interviewed Resident #98 who stated that he/she got into an <i>Ex Order 26. 4B1</i> with another resident but did not give specifics to the <i>Ex Order 26. 4B1</i>.</p> <p>Review of Resident #98's PN reflected that following documentation:</p> <p>On <i>Ex Order 26. 4B1</i> at 21:57 (09:57 PM) titled: Incident Note: At approximately 08:30 PM, Resident #98 was involved in a <i>Ex Order 26. 4B1</i> with another resident. The PN indicated that the resident stated <i>Ex Order 26. 4B1</i></p> <p>[REDACTED] The PN indicated that Resident #98 stated that the other resident <i>Ex Order 26. 4B1</i> him/her, and he/she took a <i>Ex Order 26. 4B1</i> at the other resident. The PN also revealed that that Resident #98 stated that he/she used his/her <i>Ex Order 26. 4B1</i> to <i>Ex Order 26. 4B1</i> back, the <i>Ex Order 26. 4B1</i> was broken up by the nurse and aides, the police were called, and that Resident #98 was sent to the <i>Ex Order 26. 4B1</i> with [REDACTED] of <i>Ex Order 26. 4B1</i>.</p> <p>On 02/24/23 08:18 AM, the surveyor requested all incident and accident investigations as well as facility reportable event (FRE) regarding the <i>Ex Order 26. 4B1</i> between Resident #98 and Resident #72 from the LNHA.</p> <p>The surveyor reviewed the typed Investigation and Summary (IS) dated 02/16/23 and signed by</p>	F 609			

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F 609	<p>Continued From page 73</p> <p>the DON. According to the IS, the nurse (un-named in the report) heard a [REDACTED] between Resident #72 and Resident #98. The IS indicated that the nurse heard Resident #98 tell Resident #72 to get back to his/her room. The nurse went to intervene to find out what the [REDACTED] was about, when she observed Resident #72 moving toward Resident #98. According to the IS, Resident #98 then raised his/her [REDACTED] to place distance between himself/herself and Resident #72 and that Resident #72 was sent back to his/her room and Resident #98 was sent to the [REDACTED] with [REDACTED] in the [REDACTED] after [REDACTED] his/her [REDACTED].</p> <p>The investigative findings indicated that an assessment was completed on both residents and no injury was noted and no physical contact was made between the two residents.</p> <p>On 02/24/23 at 10:52 AM, the surveyor interviewed the DON who stated that she was made aware of the [REDACTED] between Resident #72 and Resident #98, and she investigated the incident. She stated that it was not reported to her that Resident #98 had [REDACTED] Resident #72 with a [REDACTED], and she was not aware that this was a [REDACTED]. She stated that she thought that the [REDACTED] between the two residents was just a [REDACTED]. She stated that she investigated the [REDACTED] but could not speak to why she did not know that Resident #72 was [REDACTED] with a [REDACTED] by Resident #98 and had [REDACTED] to his/her [REDACTED]. The DON further stated that the LNHA and the DON were responsible to ensure that the investigations were completed and thorough. She stated that when both the residents returned from the [REDACTED] that</p>	F 609			

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F 609	<p>Continued From page 74</p> <p>Resident #98 <u>Ex Order 26.4B1</u> was moved to a different hallway and away from Resident #72 <u>Ex Order 26.4B1</u>. She stated that both residents were seen by the <u>Ex Order 26.4B1</u>. The DON did not have an answer as to why the CP was not updated after the <u>Ex Order 26.4B1</u> to include these <u>NJ Exec. Order 26.4.b.1</u> or why interventions were not implemented on the CPs for both Resident #98 and Resident #72. The DON also revealed that she did not know if the <u>Ex Order 26.4B1</u> between the two residents was reported to the NJDOH. She stated that she did not interview Resident #98 because the resident had <u>Ex Order 26.4B1</u> and <u>Ex Order 26.4B1</u> and she did not think that this resident would have been <u>NJ Exec. Order 26.4.b.1</u>. The DON further revealed that she did not interview Resident #72 regarding the <u>Ex Order 26.4B1</u> because the resident was <u>Ex Order 26.4B1</u> and explained that the resident did not lose <u>Ex Order 26.4B1</u>; however, she did not think if she interviewed him/her that he/she would be <u>NJ Exec. Order 26.4.b.1</u>. The DON also did not have a response as to why there were no skin assessments done on either resident after the <u>Ex Order 26.4B1</u> and did not know that Resident #72 suffered <u>NJ Exec. Order 26.4.b.1</u> on his/her <u>Ex Order 26.4B1</u> after being <u>Ex Order 26.4B1</u> by Resident #98's <u>Ex Order 26.4B1</u>.</p> <p>On 02/24/23 at 11:07 AM, the surveyor interviewed the LNHA who stated he was aware that there was <u>Ex Order 26.4B1</u> of <u>Ex Order 26.4B1</u> between Resident # 72 and Resident #98 however was not aware there was an actual <u>Ex Order 26.4B1</u> with a <u>Ex Order 26.4B1</u> to Resident #72's <u>Ex Order 26.4B1</u>. The LNHA stated that it was the nursing administration's responsibility to have investigated and conducted a thorough and complete investigation. The LNHA confirmed that the <u>Ex Order 26.4B1</u> was not reported to the NJDOH. The LNHA did not have an answer as to why the DON did not interview Resident #72 or Resident #98 during her investigation and the</p>	F 609			

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F 609	<p>Continued From page 75</p> <p>LNHA was not aware that Resident #72 suffered <small>NJ Exec. Order 26.4.b.1</small> to his/her <small>Ex Order 20.4B1</small> during the <small>Ex Order 26.4B1</small> with Resident #98.</p> <p>On 03/06/23 at 10:45 AM, the LNHA, DON and RDON provided no additional information.</p> <p>The facility policy titled, "Resident /Patient Rights-Abuse, Neglect, Mistreatment or Misappropriation of Resident/Patient's Property dated 5/22/22, indicated that it was the policy of the facility that procedures were in place to prevent any incidence of abuse; neglect; mistreatment or misappropriation of resident/patient's property. If any actual or suspected incidents occur there was a process in place for reporting and investigation abuse; neglect; mistreatment or misappropriation of resident/patient's property, including injuries of unknown source and resident to resident abuse. The policy indicated in section 5 (five) that: --The appropriate agencies will be contacted by telephone to report instances of abuse and a written report will follow as requested by the reporting agency.</p> <p>-Failure to report abuse of the elder or dependent adult is punishable by law. Any caretaker, social worker, physician, registered nurse, or licensed practical nurse or other professional, who as a result of that any information obtained in the course of his employment has reasonable cause to suspect or believe that an institutionalized elderly person is being abused or exploited, shall report such information in a timely manner to the Ombudsman, or to the person designated by him to receive such report.</p> <p>-All phases of the reporting process would be kept confidential.</p>	F 609			

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F 609	Continued From page 76 The surveyor reviewed the facility policy titled, "Incident/Occurrence Investigation Policy" dated 05/22/22, which indicated that all incidences of alleged abuse, mistreatment, or neglect of a resident by staff, other residents, visitors, etc. will be investigated. The procedures were as follows according to the facility policy: -Following the occurrence or notification or complaint the Registered Nurse Manager or Registered Nurse Supervisor will submit to the DON, a copy of the accident/report with staff members statements. -The DON-nursing/designee will promptly notify the Administrator that the investigation has occurred. -Nursing Administration or Social Services will conduct their initial investigation and review all pertinent documentation related to the event within 24 hours. -A summary of the investigation will be documented and the Administrator, DON-nursing designee will meet to review the summary of the investigation to decide if an event is reportable to the NJDOH. The medical director and social services may be asked to participate in the decision-making process depending on the type of event that has occurred. -The Administrator, DON-Nursing designee will notify the DOH when applicable.	F 609			
F 610 SS=H	NJAC 8:39-9.4 (f) Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610			3/31/23

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F 610	<p>Continued From page 77</p> <p>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to complete thorough investigations for allegations of [REDACTED] This deficient practice was identified for four (4) of 12 resident's, (Resident #15, #72, #98 and #99) reviewed for [REDACTED] Two (2) of the four (4) residents, (Resident #15 and Resident #72) whose investigations were not thoroughly completed, were harmed as a result of the [REDACTED] Ex Order 26. 4B1</p> <p>The deficient practice was evidenced by the following:</p> <p>Refer to F600 and F609</p> <p>According to the Admission Record (AR), Resident #72 was admitted to the facility with the diagnoses which included but were not limited to: [REDACTED] Ex Order 26. 4B1</p>	F 610	<p>F610 SS-H</p> <p>Element One Corrective Actions On 2/22/2023, Resident (#72), [REDACTED] Ex Order 26. 4B1 with resident (#98) was immediately investigated, reported to the New Jersey Department of Health, and care plan updated.</p> <p>On 2/24/2023, Resident (#15), [REDACTED] Ex Order 26. 4B1 with resident (#99) was immediately investigated, reported to the New Jersey Department of Health, and care plan updated.</p> <p>On 3/1/2023, The Licensed Nursing Home Administrator (LNHA) was re-educated immediately to identify [REDACTED] Ex Order 26. 4B1 and report all allegations timely to regulatory authorities. Element Two <input type="checkbox"/> Identification of at Risk Residents</p>		

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F 610	<p>Continued From page 78</p> <p>The Minimum Data Set (MDS- an assessment tool utilized to facilitate the management of care) dated 02/05/23, indicated that the resident scored a Ex Order 26. 4B1 out of Ex Order 26. 4B1 on the Brief Interview for Mental Status (BIMS) which indicated that the resident was Ex Order 26. 4B1. The MDS also reflected that Resident #72 had NJ Exec. Order 26:4.b.1 and required NJ Exec. Order 26:4.b.1 with Ex Order 26. 4B1.</p> <p>According to the AR, Resident #98 was admitted to the facility with the diagnoses which included but were not limited to: Ex Order 26. 4B1.</p> <p>Ex Order 26. 4B1. The admission MDS dated Ex Order 26. 4B1 indicated that the resident scored a Ex Order 26. 4B1 on the BIMS which indicated Ex Order 26. 4B1. The MDS also reflected that Resident #98 had NJ Exec. Order 26:4.b.1 and required NJ Exec. Order 26:4.b.1 with Ex Order 26. 4B1.</p> <p>On 02/22/23 at 10:57 AM, during tour, the surveyor interviewed Resident #72 Ex Order 26. 4B1 who stated that a resident named [Resident #98] Ex Order 26. 4B1 him/her with a Ex Order 26. 4B1 three (3) times on the Ex Order 26. 4B1. The resident held up his/her Ex Order 26. 4B1 and showed the surveyor the NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 on the Ex Order 26. 4B1 of the Ex Order 26. 4B1. He/she further stated that these were defensive wounds. He/she stated that he/she did not have a NJ Exec. Order 26:4.b.1 of the Ex Order 26. 4B1 and that the NJ Exec. Order 26:4.b.1 were NJ Exec. Order 26:4.b.1. Resident #72 stated that he/she was so angry about the resident Ex Order 26. 4B1 him/her with the Ex Order 26. 4B1, that he/she went into the EX Order 26.4B1 which resulted in a NJ Exec. Order 26:4.b.1 of the Ex Order 26. 4B1. He/she did admit that this was a self-inflicted injury. Resident #72 then added that when he/she went to the Ex Order 26. 4B1 that he/she did not show the Ex Order 26. 4B1.</p>	F 610	<p>All Residents have the potential to be affected by this practice.</p> <p>Element Three <input type="checkbox"/> Systemic Change Staff were educated following facilities policy Prohibition of Resident Abuse & Neglect which included:</p> <ol style="list-style-type: none"> 1.The definition of abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. 2.Types of abuse-Physical, verbal, sexual, mental/emotional/psychological, involuntary seclusion, neglect, exploitation, and misappropriation of resident property. 3.Prevention which includes employee and volunteer screening, training, which is completed upon hire, and minimally quarterly to employees. Re-education is also completed when/if there is an allegation of abuse. 4. Reporting abuse- Abuse must be reported to immediately to supervisor. The supervisor will then report to the Abuse Coordinator. If the abuse coordinator is unavailable the next highest administrative position is made aware(DON). DON/Admin 5. Protection-Immediately remove the resident(s) from the situation, assess and treat, accused employees (if applicable) will be suspended immediately pending further investigation. 		

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F 610	<p>Continued From page 79</p> <p>staff the [redacted] on the [redacted] and kept the [redacted] in his/her pocket of his/her pants.</p> <p>The surveyor reviewed Resident #72's medical record which revealed a Progress Note (PN) dated 02/15/2023 at 22:23 (10:23 PM), and titled, <u>Ex Order 26. 4B1</u>. The PN indicated that at approximately 5:45 PM, Resident #72 got into a verbal [redacted] with a resident. Resident #72 insisted the other resident was constantly antagonizing him/her and tonight he/she just [redacted]. The PN indicated that Resident #72 punched the wall and possibly [redacted].</p> <p>On 02/22/23 at 11:47 AM, during tour, the surveyor interviewed Resident #98 who stated that he/she got into an [redacted] with another resident but did not give specifics to the incident.</p> <p>Review of Resident #98's PN reflected the following documentation:</p> <p>On 02/15/2023 at 21:57 (9:57 PM) titled: <u>Ex Order 26. 4B1</u> Note: At approximately 8:30 PM, Resident #98 was involved in a [redacted] with another resident. The PN indicated that the resident stated, <u>Ex Order 26. 4B1</u>. The PN indicated that Resident #98 stated that the other resident [redacted] him/her, and he/she took a [redacted] at the other resident. The PN also revealed that that Resident #98 stated that he/she used his/her [redacted] to [redacted] back. The [redacted] was broken up by the nurse and aides, the police were called, and that Resident #98 was sent to the [redacted] with complaints of severe [redacted].</p> <p>On 02/24/23 08:18 AM, the surveyor requested all</p>	F 610	<p>6. Investigation: a full investigation is completed with a comprehensive review of the situation, interviews with staff, residents, and any witnesses to event and statements are recorded, statement review, environmental review, and medical record review.</p> <p>Newly hired staff will receive education during orientation.</p> <p>Element Four <input type="checkbox"/> Quality Assurance The facility Director of Nursing/designee will conduct an audit on all incidents/accidents daily x 14 days, weekly x 4 weeks, and then monthly x 2 months (with potential for an extension) to ensure any allegations of abuse are investigated and reported per policy and in compliance with regulations.</p> <p>Needed correction will be made immediately and the the findings of these audits will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met and recommends moving to quarterly monitoring by the Administrator when completing their quality systems review.</p> <p>Date of compliance: 3/31/23</p>		

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F 610	<p>Continued From page 80</p> <p>Ex Order 26. 4B1 investigations as well as facility reportable event (FRE) regarding the Ex Order 26. 4B1 between Resident #98 and Resident #72 from the Licensed Nursing Home Administrator (LNHA).</p> <p>The surveyor reviewed the typed Investigation and Summary (IS) dated 02/16/23 and signed by the Director of Nursing (DON). According to the IS, the nurse (un-named in the report) heard a verbal disagreement between Resident #72 and Resident #98. The IS indicated that the nurse heard Resident #98 tell Resident #72 to get back to his/her room. The nurse went to intervene to find out what the verbal disagreement was about, when she observed Resident #72 moving toward Resident #98.</p> <p>According to the IS, Resident #98 then raised his/her Ex Order 26. 4B1 to place distance between himself/herself and Resident #72 and was sent back to his/her room. Resident #98 was sent to the Ex Order 26. 4B1 with complaints of pain in the Ex Order 26. 4B1 after raising his/her Ex Order 26. 4B1.</p> <p>The investigative findings indicated that an assessment was completed on both residents and Ex Order 26. 4B1 was noted and no physical contact was made between the two residents. The investigative findings contradict Resident #72's statement to the surveyor and the PN documented on 02/15/23 at 9:57 PM.</p> <p>The DON could not provide any documentation that the nurse performed a body check or assessment for injury for either resident after the Ex Order 26. 4B1. The DON could also not provide any documentation that she interviewed either resident during her investigation.</p>	F 610			

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F 610	<p>Continued From page 81</p> <p>The surveyor continued to review the IS which included a handwritten statement dated 02/16/23 and signed by the Social Worker (SW). The SW interviewed Resident #72 on 02/15/23, after the <u>Ex Order 26.4B1</u>, and Resident #72 told the SW that he/she could not remember the altercation because he/she <u>Ex Order 26.4B1</u> and could not remember punching the wall or talking with the police. During this interview, Resident #72 showed the SW a <u>Ex.Order 26.4(b)(1)</u> <u>Ex Order 26.4B1</u> and stated, <u>Ex Order 26.4B1</u></p> <p>The surveyor reviewed another statement included in the IS dated 02/16/23, from the SW that she interviewed Resident #98. The statement revealed that Resident #98 told the SW that he/she heard Resident #72 being loud in the hallway and because he/she had <u>Ex Order 26.4B1</u>, it was giving him/her <u>Ex Order 26.4B1</u>. The statement indicated that Resident #98 admitted that he <u>Ex Order 26.4B1</u> at Resident #72 however was unsure if he/she <u>Ex Order 26.4B1</u> him/her.</p> <p>The surveyor reviewed a typed statement included in the IS dated 02/23/23 (after surveyor inquiry) from the Licensed Practical Nurse (LPN)#1 that was working on 02/15/23 on the 3:00 PM - 11:00 PM shift when the <u>Ex Order 26.4B1</u> between Resident #72 and Resident #98 took place. LPN#1 indicated in the statement that she did not visually see the initial <u>Ex Order 26.4B1</u> between Resident #72 and Resident #98, but that she did see Resident #98 raising his/her <u>Ex Order 26.4B1</u> in the air. LPN#1 documented on the IS that there was no actual contact between the two residents. LPN#1 documented on the statement that she stepped in</p>	F 610			

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F 610	<p>Continued From page 82</p> <p>between the two residents and that she asked Resident #72 to go back to his/her room. The statement indicated that LPN#1 interviewed Resident #98 and the resident stated that Resident #72 charged him/her and that he/she raised his/her ^{Ex Order 26. 4B1} in defense. The IS also indicated that Resident #98 was sent to the ^{Ex Order 26. 4B1} for evaluation due to complaints of ^{Ex Order 26. 4B1} in the ^{Ex Order 26. 4B1} which occurred when the resident raised the ^{Ex Order 26. 4B1} causing more pressure on the ^{Ex Order 26. 4B1}. There was no documentation on LPN#1's statement that Resident #72 was assessed for injury or interviewed after the ^{Ex Order 26. 4B1} with Resident #98.</p> <p>The surveyor reviewed a typed statement dated 02/15/23 from a Certified Nursing Assistant (CNA)#1 that was working on 02/15/23 on the 3:00 PM - 11:00 PM shift, when the ^{Ex Order 26. 4B1} took place between Resident #72 and Resident #98. CNA#1 indicated in the statement that he was passing out snacks and heard his name being called. He then saw the nurse rushing down the other hallway and by the time he got to the ^{Ex Order 26. 4B1} between Resident #72 and Resident #98, he saw the nurse standing between two resident's and he did not see any physical contact between Resident #72 and Resident #98.</p> <p>The surveyor reviewed Resident #72's and Resident 98's comprehensive Care Plans (CP) and there was no documentation regarding this ^{Ex Order 26. 4B1} on either resident's CP nor were there interventions implemented on either residents CP regarding Resident #72's and Resident #98's behaviors.</p> <p>On 02/24/23 at 09:27 AM, the surveyor</p>	F 610			

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F 610	<p>Continued From page 83</p> <p>interviewed the temporary nursing assistant (TNA) who stated that Resident #98 ^{Ex.Order 26.4(b)(1)} take care of himself/herself ^{Ex.Order 26.4(b)(1)} stays to himself/herself and enjoyed smoking. The TNA stated that he had not seen Resident #98 become ^{Ex.Order 26.4(b)(1)} with any other residents. The TNA added that Resident #98 would sometimes go ^{Ex.Order 26.4(b)(1)} to himself/herself but did not ^{Ex.Order 26.4(b)(1)} to staff or any other resident. The TNA stated that the resident's nurse was usually able to redirect the resident easily with conversation.</p> <p>On 02/24/23 09:35 AM, the surveyor interviewed LPN#2 who stated that Resident # 98 had been in the facility for three (3) to four (4) weeks. She stated that the resident had a history of ^{Ex Order 26.4B1} and was ^{Ex Order 26.4B1}. She stated that Resident #98 would ^{Ex Order 26.4B1} and that his/her thought processes were ^{Ex Order 26.4B1} and it was difficult for him/her to ^{Ex Order 26.4B1} himself/herself. She added that the resident had difficulty ^{Ex Order 26.4B1}. LPN#2 further added that the resident had ^{Ex Order 26.4B1} toward staff or other residents that she was aware of. She stated that Resident #98 was ^{Ex.Order 26.4(b)(1)} himself/herself with ^{Ex.Order 26.4(b)(1)}.</p> <p>On 02/24/23 at 9:56 AM, the surveyor interviewed Licensed Practical Nurse Unit Manager (LPN/UM)#1 for the ^{Ex Order 26.4B1} floor nursing unit who stated that Resident # 98 was usually ^{Ex Order 26.4B1} and did not exhibit any ^{Ex Order 26.4B1} toward staff or other residents. She stated that she spoke with the SW and Resident # 98 regarding the incident with Resident #72, and Resident #98 stated that Resident #72 ^{Ex Order 26.4B1}.</p>	F 610			

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F 610	<p>Continued From page 84</p> <p>him/her. She further stated that Resident #98 did not admit to ^{Ex Order 26. 4B1} Resident #72 with a ^{Ex Order 26. 4B1}. LPN/UM#1 further added that both residents were sent to the ^{Ex Order 26. 4B1}. She explained to the surveyor that after Resident #98 returned from the ^{Ex Order 26. 4B1} he/she was ^{Ex Order 26. 4B1} away from Resident #72. She stated that no other interventions were put in place. She stated that she was aware that Resident #98 had suffered a ^{Ex Order 26. 4B1} during the incident but was not aware of any other injuries. She stated that she did not personally interview either resident after she found out about the ^{Ex Order 26. 4B1} between the two. She further revealed that there was a CNA that witnessed the ^{Ex Order 26. 4B1}. She added that there was an ^{Ex Order 26. 4B1} report written and investigation was done by the DON.</p> <p>On 02/24/23 at 10:21 AM, the surveyor interviewed the SW. The DSW stated that Resident #98 told her that Resident # 72 was arguing with the other resident in the hallway. The SW explained that Resident #98 had ^{Ex Order 26. 4B1} and got upset with ^{Ex Order 26. 4B1} and that Resident #98 was upset with the ^{Ex Order 26. 4B1} of Resident #72 and ^{Ex Order 26. 4B1} him/her with a ^{Ex Order 26. 4B1}. She further added that Resident # 72 blocked the ^{Ex Order 26. 4B1} of the ^{Ex Order 26. 4B1} with ^{Ex Order 26. 4B1}. She stated that Resident #72 suffered ^{Ex Order 26. 4B1} to the ^{Ex Order 26. 4B1}. She added that both residents were separated, and the police were notified. She stated that Resident #72 was sent to ER and ^{Ex Order 26. 4B1} were done of the ^{Ex Order 26. 4B1} and there was not a ^{Ex Order 26. 4B1}, just ^{Ex Order 26. 4B1}. The SW stated that she had never known of Resident #72 to get into ^{Ex Order 26. 4B1} with any other resident. She stated that the interventions that were put into place after the resident returned</p>	F 610			

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F 610	<p>Continued From page 85</p> <p>from the ^{Ex Order 26. 4B1} were that both residents were seen by ^{Ex Order 26. 4B1}. She also stated that they had an aide sit in the hallway on each side of the unit to monitor the residents on the 3:00 PM - 11:00 PM and 11:00 PM - 7:00 AM shifts. The SW further stated that the ^{Ex Order 26. 4B1} was notified, physician was notified, and responsible party was notified. She added that the following day after the ^{Ex Order 26. 4B1} that the administration team met and discussed the ^{Ex Order 26. 4B1} between Resident #72 and Resident #98. She stated that the Administration team included the Administrator, Assistant Director of Nursing (ADON), DON, UM/LPN, Admissions Director, and ^{Ex Order 26. 4B1} attended the meeting.</p> <p>On 02/24/23 at 10:52 AM, the surveyor interviewed the Director of Nursing (DON) who stated that she was made aware of the ^{Ex Order 26. 4B1} between Resident #72 and Resident #98, and she investigated the incident. She stated that it was not reported to her that Resident #98 had ^{Ex Order 26. 4B1} Resident #72 with a ^{Ex Order 26. 4B1}, and she was not aware that this was a ^{Ex Order 26. 4B1}. She stated that she thought that the ^{Ex Order 26. 4B1} between the two residents was just a ^{Ex Order 26. 4B1}. She stated that she investigated the incident but could not speak to why she did not know that Resident #72 was ^{Ex Order 26. 4B1} with a ^{Ex Order 26. 4B1} by Resident #98 and had injuries to his/her ^{Ex Order 26. 4B1}. The DON further revealed that the Licensed Nursing Home Administrator (LNHA) and herself were responsible to make sure that the investigation was complete and through. She stated that when both the residents returned from the ^{Ex Order 26. 4B1} that Resident #98 ^{Ex Order 26. 4B1} was moved to a different hallway and away from Resident #72 ^{Ex Order 26. 4B1}. She stated that both residents were seen by the ^{Ex Order 26. 4B1}. The</p>	F 610			

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F 610	<p>Continued From page 86</p> <p>DON did not have an answer to as why the Care plan (CP) was not updated after the <u>Ex Order 26. 4B1</u> to include these behaviors or why interventions were not implement on the CP for Resident #98's or Resident #72's. The DON also revealed that she did not know if the <u>Ex Order 26. 4B1</u> between the two residents was reported to the NJDOH. She stated that she did not interview Resident #98 because the resident had <u>Ex Order 26. 4B1</u> and heard voices and she did not think that this resident would be reliable. The DON further revealed that she did not interview Resident #72 regarding the <u>Ex Order 26. 4B1</u> because the resident was <u>Ex Order 26. 4B1</u>. She explained that the resident did <u>Ex Order 26.4(b)(1)</u> however Resident #72 was <u>Ex Order 26. 4B1</u> and she did not think if she interviewed him/her that he/she would be reliable. The DON also did not have a response as to why there were no skin assessment done on either resident after the <u>Ex Order 26. 4B1</u> and did not know that Resident #72 suffered <u>Ex Order 26.4(b)(1)</u> on his/her <u>Ex Order 26. 4B1</u> after being <u>Ex Order 26. 4B1</u> by Resident #98's <u>Ex Order 26. 4B1</u>.</p> <p>On 02/24/23 at 11:07 AM, the surveyor interviewed the LNHA who stated he was aware that there was <u>Ex Order 26. 4B1</u> of <u>Ex Order 26. 4B1</u> between Resident # 72 and Resident #98 however was not aware there was an actual <u>Ex Order 26. 4B1</u> with a <u>Ex Order 26. 4B1</u> to Resident #72 <u>Ex Order 26. 4B1</u>. The LNHA stated that the nursing administration was responsible to investigate and conduct a thorough and complete investigation. The LNHA confirmed that the <u>Ex Order 26. 4B1</u> was not reported to the New Jersey Department of Health (NJDOH). The LNHA did not have a answer as to why the DON did not interview Resident #72 or Resident #98 during her investigation and the LNHA was not aware that Resident #72 suffered injuries to his/her <u>Ex Order 26. 4B1</u> during the <u>Ex Order 26. 4B1</u> with Resident #98.</p>	F 610			

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F 610	<p>Continued From page 87</p> <p>On 02/28/23 at 10:44 AM, the surveyor conducted an interview over the telephone with LPN#1 who stated that she usually worked 3:00 PM - 11:00 PM shift full time on the [REDACTED] floor. LPN#1 stated that she worked for agency and had been working at the facility full time at the facility since September. LPN#1 stated that Resident #98 was [REDACTED] and did not have a history of having [REDACTED] Ex Order 26.4B1 with other residents. She stated that Resident #72 was also a [REDACTED] and did not have a history of [REDACTED] Ex Order 26.4B1 with any other resident. She stated that on [REDACTED] Ex Order 26.4B1, at around 5:00 PM or 6:00 PM at night, Resident #72 was in the hallway and was [REDACTED] Ex Order 26.4B1. She stated that Resident #98 was also in the hallway, and she heard Resident #98 tell Resident #72 to [REDACTED] Ex Order 26.4B1. She stated that she did not actually witness this verbal [REDACTED] Ex Order 26.4B1 but could hear the [REDACTED] Ex Order 26.4B1.</p> <p>She stated that by the time she looked to see what was going on, Resident #98 had his/her [REDACTED] Ex Order 26 up in the air. [REDACTED] Ex Order 26.4B1</p> <p>[REDACTED] She stated that she spoke with Resident #72 after the [REDACTED] Ex Order 26.4B1, however she did not ask him/her if he/she was [REDACTED] Ex Order 26.4B1 by the other resident's [REDACTED] Ex Order 26 or if he/she was [REDACTED] Ex Order 26.4B1(1). LPN#1 did not have a response as to why she did not ask Resident #72 if he/she was [REDACTED] Ex Order 26 by the other resident's [REDACTED] Ex Order 26 or suffered any injuries during the [REDACTED] Ex Order 26.4B1. She then stated that she was more concerned about Resident #98 because he/she said he/she hurt his/her [REDACTED] Ex Order 26. She elaborated to explain that Resident #98 did not hurt his/her [REDACTED] Ex Order 26.4B1 but that when Resident #98 lifted the [REDACTED] Ex Order 26 to [REDACTED] Ex Order 26 Resident #72, he/she [REDACTED] Ex Order 26 the</p>	F 610			

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F 610	<p>Continued From page 88</p> <p>support from [REDACTED] and had to bear all his/her weight on [REDACTED] causing him/her to have [REDACTED] the [REDACTED] Ex Order 26.4B1.</p> <p>The surveyor asked LPN#1 if she completed a skin/body assessment on the two residents and she stated that she did not perform complete body checks on the two residents because they were sent to the [REDACTED] Ex Order 26.4B1. She stated that she just [REDACTED] Ex Order 26.4B1 at the body areas that she could readily see. She added that she did not observe any injuries. She then stated that she called the police. She stated that both residents returned from the [REDACTED] Ex Order 26.4B1 but that it was after her shift ended and she was not sure what interventions were put in place after the resident returned from the [REDACTED] Ex Order 26.4B1. She stated that there was not a supervisor in house during the 3:00 PM - 11:00 PM shift, but that she text messaged the ADON, DON, and LPN/UM to inform them about the incident. She stated that she called the physician and responsible party about the [REDACTED] Ex Order 26.4B1.</p> <p>On 02/24/23 at 12:23 PM, the surveyor observed Resident #72 lying in bed with [REDACTED] on [REDACTED] Ex Order 26.4B1. The surveyor observed a [REDACTED] Ex Order 26.4B1 on the [REDACTED] Ex Order 26.4B1. The surveyor asked the resident where he/she got that [REDACTED] Ex Order 26.4B1. The resident felt the [REDACTED] Ex Order 26.4B1 area and stated, [REDACTED] Ex Order 26.4B1. He/she then stated that it could have been caused when he/she was [REDACTED] Ex Order 26.4B1 by the [REDACTED] Ex Order 26.4B1 on the [REDACTED] Ex Order 26.4B1 during the [REDACTED] Ex Order 26.4B1 with Resident #98. The resident then stated that he/she told the SW and the LPN#1 about the injuries that happened when he got [REDACTED] Ex Order 26.4B1 by the other resident's [REDACTED] Ex Order 26.4B1. The resident then stated that no one from Administration came to talk with him/her regarding the [REDACTED] Ex Order 26.4B1.</p>	F 610			

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F 610	<p>Continued From page 89</p> <p>On 02/28/23 at 10:55 AM, the surveyor attempted to telephone interview CNA#1 and the telephone number provided was not a working number.</p> <p>On 03/01/23 at 8:30 AM, the surveyor interviewed the SW and Regional Director of Nursing (RDON). The SW stated that when she wrote the statement on <u>Ex Order 26.4B1</u>, regarding the <u>Ex Order 26.4B1</u> between Resident #72 and Resident #98 that she should have written that Resident #98 had told her that he had <u>Ex Ord</u> Resident #72 on the <u>Ex Order 26.4B1</u> with the <u>Ex Order 26.4B1</u>. She stated that this should have been included in her statement. She stated that she was never questioned by the Administration regarding the statement that she wrote regarding the <u>Ex Order 26.4B1</u> between Resident #98 and Resident #72.</p> <p>On 03/06/23 at 10:45 AM, the LNHA, DON and RDON provided no additional information</p> <p>2.) On 02/22/23 at 12:09 PM, Resident #15 was observed lying in bed. The surveyor interviewed Resident #15 who stated they were involved in a <u>Ex Order 26.4B1</u> with their roommate Resident #99. Resident #15 stated that he/she was <u>Ex Order 26.4B1</u> when Resident #99 came up to them, <u>Ex Ord</u> him/her in the <u>Ex Order 26.4B1</u> and stated he/she <u>Ex Order 26.4B1</u> Resident #15 further stated the nurses, and the police was notified but felt that the <u>Ex Order 26.4B1</u> was not handled appropriately. Resident #15 stated upon returning from the <u>Ex Order 26.4B1</u> he/she did not know why Resident #99 was still their roommate. Resident #15 concluded he/she was very frustrated about the <u>Ex Order 26.4B1</u> and that they could <u>Ex Order 26.4B1</u> in their <u>Ex Order 26.4B1</u>. The resident further stated that he/she was concerned about being in the <u>Ex Order 26.4B1</u> with Resident #99.</p>	F 610			

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F 610	<p>Continued From page 90</p> <p>The surveyor reviewed the electronic medical record (EMR) for Resident #15.</p> <p>A review of the resident's Admission Record reflected that the resident was admitted to the facility <u>Ex Order 26. 4B1</u>, with diagnoses which included: <u>Ex Order 26. 4B1</u></p> <p>[REDACTED]</p> <p>A review of the most recent quarterly MDS, dated [REDACTED], reflected a BIMS score of <u>Ex One</u> out of [REDACTED] which indicated the resident had a <u>Ex Order 26. 4B1</u></p> <p>[REDACTED]</p> <p>A review of Resident #15's individualized Care Plan (CP) initiated <u>Ex Order 26. 4B1</u> two (2) days after the <u>Ex Order 26. 4B1</u> occurred, reflected Fear related to recent <u>Ex.Order 26.4(b)(1)</u> which included the following interventions: A nurse will reassure safety, discuss the reality of the situation while acknowledging what can and cannot be changed to help the patient to feel in control, and reassure the patient that <u>Ex.Order 26.4(b)(1)</u> after a traumatic event are normal.</p> <p>The surveyor reviewed the electronic medical record (EMR) for Resident #99.</p> <p>A review of the resident's Admission Record reflected that the resident was admitted to the facility <u>Ex Order 26. 4B1</u>, with diagnoses which included: <u>Ex Order 26. 4B1</u> and</p>	F 610			

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F 610	<p>Continued From page 91</p> <p><i>Ex Order 26. 4B1</i> [REDACTED]</p> <p>A review of the most recent quarterly MDS dated 12/12/22, reflected a BIMS score of <i>Ex Order 26. 4B1</i> out of [REDACTED] which indicated an <i>Ex Order 26. 4B1</i>.</p> <p>A review of Resident #99's Care plan initiated <i>Ex Order 26. 4B1</i> two (2) days after he/she <i>Ex Order 26. 4B1</i> Resident #15 in the <i>Ex Order 26. 4B1</i>, reflected <i>Ex Order 26. 4B1</i> related to <i>Ex Order 26. 4B1</i> disturbances which included the following interventions: The nurse will identify what is not appropriate, such as [REDACTED] and [REDACTED], and also what is appropriate, the nurse will provide positive feedback to let client know he/she is meeting expectations, the nurse will recognize <i>Ex Order 26. 4B1</i> before they become <i>Ex Order 26. 4B1</i> and, the nurse will set limits on <i>Ex Order 26. 4B1</i> Ex Order 26.4(b)(1) [REDACTED]</p> <p>On 02/22/23 at 01:32 PM, the surveyor interviewed CNA#2 who stated she was the primary CNA for both Resident #15 and Resident #99. She stated she was not working that day of the event but was informed of the incident when she came to work the next day from another CNA. She stated that the nurses did not inform her of anything extra that she needed to do. She explained she was not asked to document anything and was not asked to perform any special monitoring.</p> <p>On 02/22/23 at 2:26 PM, the survey team interviewed the facility's SW who stated that she was not aware of the <i>Ex Order 26. 4B1</i> that took place on <i>Ex Order 26. 4B1</i>, between Resident #15 and Resident #99 until Monday <i>Ex Order 26. 4B1</i>, two days after the event occurred. The SW stated that she was unsure who the Nursing Supervisor (NS)</p>	F 610			

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F 610	<p>Continued From page 92</p> <p>contacted to make them aware of the <u>Ex Order 26. 4B1</u>, but <u>Ex Order 26. 4B1</u> would have expected the NS or whoever was on-call that evening to have notified the LNHA or ADON because a <u>Ex Order 26. 4B1</u> had taken place and the police and Emergency Medical Technician's (EMT)'s had to come to the facility to assess the residents. The SW further explained that on Monday, 02/06/23 <u>Ex Order 26. 4B1</u>, the ADON, LNHA, <u>Ex Order 26. 4B1</u> Unit Managers, and Minimum Data Set (MDS) Coordinator discussed the <u>Ex Order 26. 4B1</u>. She told the survey team that Resident #15 decided not to <u>Ex Order 26. 4B1</u> against Resident #99 and the facility's <u>Ex Order 26. 4B1</u> was made aware of the <u>Ex Order 26. 4B1</u> on Monday <u>Ex Order 26. 4B1</u> because the <u>Ex Order 26. 4B1</u> made rounds at the facility early that morning. The SW further stated that she was unsure if anything was done to protect Resident #15 when he/she came back to the facility, but she would have done a <u>Ex Order 26. 4B1</u> right then and there because, <u>Ex Order 26. 4B1</u></p> <p><u>Ex Order 26. 4B1</u>. The SW stated that if she was the NS, she would have done a room change to keep the resident's safe. The SW did not speak to time frames for reporting or investigating a <u>Ex Order 26. 4B1</u>.</p> <p>On 02/22/23 at 3:09 PM, the survey team asked the ADON if the <u>Ex Order 26. 4B1</u> of <u>Ex Order 26. 4B1</u> between Resident #99 and Resident #15 was investigated and reported to the New Jersey Department of Health (NJDOH). The ADON stated that the <u>Ex Order 26. 4B1</u> should have been reported to the NJDOH within a two-hour time frame and thoroughly investigated. The ADON stated that anytime there was a <u>Ex Order 26. 4B1</u> between two residents it was a</p>	F 610			

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F 610	<p>Continued From page 93</p> <p>reportable event. The ADON told the survey team that after the facility reported the incident to the NJDOH, the facility had 72 hours to thoroughly investigate the [Ex Order 26. 4B1]. The ADON stated that the process for investigation should have been conducted by risk management in which statements were obtained by the residents and staff. The ADON explained that the purpose of the investigative process was to implement interventions and then, [Ex Order 26. 4B1]. The ADON told the survey team that the facility's DON and LNHA were responsible for reporting and investigating [Ex Order 26. 4B1].</p> <p>On 02/22/23 at 3:18 PM, the survey team interviewed the DON who stated that she started her position as DON for the facility on [Ex Order 26. 4B1]. The DON stated that Resident #15 was [Ex Order 26. 4B1] at times and cooperative with staff. The DON told the survey team that Resident #99 was more alert than Resident #15, also [Ex Order 26. 4B1], and could get a little [Ex Order 26.4(b)(1)] when he/she did not get their way. The DON stated that when Resident #99 looked frustrated, he/she would, [Ex Order 26. 4B1] turn his/her head and dismiss the person that was speaking. The DON stated that she received a phone call on 02/04/23, that Resident #99 [Ex Order 26. 4B1] Resident #15 because Resident #99 was [Ex Order 26. 4B1] and did not like what Resident #15 was watching on television. She further stated that she told the nurse that called her to call crisis and then call 911. The DON explained that 911 evaluated both residents and took Resident #15 to the [Ex Order 26. 4B1] the resident came back that same night to the facility with no injuries. The survey team asked the DON what interventions were put in place to [Ex Order 26. 4B1] Resident #15? The DON stated that the LPN/UM called the [Ex Order 26. 4B1] for Resident #15 who was the [Ex Order 26. 4B1]. The DON told</p>	F 610			

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F 610	<p>Continued From page 94</p> <p>the survey team that she was unsure when Resident #15 was seen by the <u>Ex Order 26.4B1</u>. The DON further explained to the survey team that she never spoke to either of the residents regarding a <u>Ex Order 26.4B1</u> but was told by the LPN/UM that the residents were offered a <u>Ex Order 26.4B1</u> and neither one of the residents wanted to move out of their room. The DON stated that the LPN/UM spoke with both residents, but to her knowledge it was not documented in the either of the resident's medical records. The DON told the survey team that an incident report was completed, and statements were obtained. The DON further stated that the incident should have been reported to the NJDOH immediately and then the facility had time to investigate, <u>Ex Order 26.4B1</u>. When the survey team asked the DON if she could provide documentation related to the incident the DON shook her head from side to side, indicating no.</p> <p>On 02/22/23 at 3:30 PM, the survey team conducted a follow up interview with LPN/UM#2 who stated that an incident report, not an investigation was completed when Resident #99 <u>Ex Order 26.4B1</u> Resident #15 in the <u>Ex Order 26.4B1</u>. LPN/UM#2 further stated that there was no documentation that he could provide to reflect the <u>Ex Order 26.4B1</u> altercation. LPN/UM#2 told the surveyors that he was not in the facility when the police came and he did not speak to the residents until Monday, two days after the incident occurred. LPN/UM#2 told the surveyors that when he spoke the residents on Monday <u>Ex Order 26.4B1</u>, they did not tell him that they wanted to stay in the same room together. LPN/UM#2 stated that he wasn't exactly sure Resident #15 or Resident #99's <u>Ex Order 26.4B1</u> or Primary Care Physicians were notified, but he was told they were notified. LPN/UM#2 further</p>	F 610			

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F 610	<p>Continued From page 95</p> <p>stated that everything that happened should have been documented in the resident's medical record. LPN/UM#2 told the surveyors that the facility should have reported the <u>Ex Order 26. 4B1</u> to the NJDOH immediately and an investigation should have been completed. LPN/UM#2 stated that, <u>Ex Order 26. 4B1</u></p> <p>On 02/22/23 at 3:48 PM, the survey team interviewed the facility's LNHA who stated that his first day working at the facility was 01/23/23. The LNHA stated that there were different types of <u>Ex Order 26. 4B1</u> and <u>Ex Order 26. 4B1</u> was one of them. The LNHA stated that the process when <u>Ex Order 26. 4B1</u> occurred was to isolate the situation and take away the <u>Ex Order 26. 4B1</u>. The LNHA stated, <u>Ex Order 26. 4B1</u>. The LNHA told the surveyors that according to the Federal Regulations the NJDOH should have been notified of the event between Resident #15 and Resident #99 within two (2) hours because <u>Ex Order 26. 4B1</u> had occurred. The LNHA further stated that he wasn't familiar with the investigative findings of the event because nursing handled the situation. The LNHA further stated that it was his understanding that there was a <u>Ex Order 26. 4B1</u> altercation, the police were notified and both residents in question did not want to <u>Ex Order 26. 4B1</u>. The LNHA told the survey team that it was also his understanding that when Resident #15 returned from the <u>Ex Order 26. 4B1</u>, the nurse spoke with both residents and the residents wanted to stay in the room together. The LNHA explained that the process of an <u>Ex Order 26. 4B1</u> investigation included gathering witness statements and documenting the <u>Ex Order 26. 4B1</u> in the resident's medical record. The LNHA was unaware if nursing had documented on the</p>	F 610			

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F 610	<p>Continued From page 96</p> <p>_____ altercation because he had never seen statements and they were not in his possession. The LNHA told the survey team that _____ needed to be thoroughly investigated and he was the person in the facility responsible for making sure that it was.</p> <p>On 02/24/23 at 9:52 AM, the surveyor interviewed LPN/UM#2, who stated that all _____ were reported to the immediate supervisor, the DON and the LNHA. He further stated that they needed to be made aware immediately because the LNHA would determine if it needed to be reported. LPM/UM#2 stated that if _____ was suspected then they were required to investigate the situation.</p> <p>A review of the _____ report between Resident #15 and Resident #99 reflected the following: -Incident Description: Resident #99 stated that he/she _____ Resident #15 _____ in the _____. -Immediate Action Taken: Family and MD [medical doctor] were made aware. _____ taken. Care plan updated. The _____ report indicated that an assessment was completed on both residents and no injury was noted.</p> <p>A further review of the _____ report revealed there were no additional witness statements or signatures.</p> <p>On 02/28/23 at 02:00 PM, the surveyor interviewed LPN#3 who stated that all nurses every shift were required to document on the 24-hour communication log sheet. #3 stated that the nurses were informed of _____ during report but that they were also responsible for checking the 24-hour communication sheet. She</p>	F 610			

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F 610	<p>Continued From page 97</p> <p>stated that if a [REDACTED] altercation occurred then they used "standard precautions". She explained standard precautions included to reassure the resident by separating and talking to them. LPN#3 stated that she would talk to the aggressor to assure they were mentally okay. She stated that they monitored the aggressor the first three (3) days by writing a progress note every shift. She further stated, <u>Ex Order 26. 4B1</u>, educate the resident that their behavior was <u>Ex Order 26. 4B1</u> and called <u>Ex Order 26. 4B1</u> as needed. LPN#2 did not explain further on the set limits. LPN#2 stated, <u>Ex Order 26. 4B1</u> [REDACTED]</p> <p>On 02/28/23 at 02:18 PM, the surveyor conducted a follow up interview LPN/UM#2 who stated the process for investigating a [REDACTED] altercation was to interview both residents, assess them from head to toe and ensure they were safe. He stated that the DON and LNHA were notified, and they would obtain written statements to complete the investigation. LPN/UM#2 stated that the care plans should be updated the same day the <u>Ex Order 26. 4B1</u> occurred and not two (2) days after. He stated that they also conducted 30-minute checks. The surveyor asked could he provide the documentation of the 30-minute checks? LPN/UM#2 stated it should be a sheet but believed it was just a verbal report and that he could not provide any documentation. He stated if the resident stayed safe, they would just continue to monitor, but if they felt the resident was <u>Ex Order 26. 4B1</u> then they would investigate it. LPN/UM#2 did not speak on how they would investigate it further.</p> <p>On 03/06/23 at 11:00 AM, the Consultant LNHA in the presence of the survey team, DON and</p>	F 610			

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F 610	<p>Continued From page 98</p> <p>Regional/DON stated that there was a lack in the investigation and reporting process regarding <u>Ex Order 26. 4B1</u>.</p> <p>A review of the facility's Abuse Coordinator job description signed by the LNHA on 1/23/23 included the following: "1. The Administrator has the overall responsibility for the coordination and implementation for our facility's abuse prevention program. 2. The Abuse Coordinator will oversee, and delegate education and in-services related to allegations of abuse, identifying abuse and reporting abuse."</p> <p>The facility policy titled, "Resident /Patient Rights-Abuse, Neglect, Mistreatment or Misappropriation of Resident/Patient's Property dated 5/22/22, indicated that it was the policy of the facility that procedures were in place to prevent any incidence of abuse; neglect; mistreatment or misappropriation of resident/patient's property. If any actual or suspected incidents occur there was a process in place for reporting and investigation u abuse; neglect; mistreatment or misappropriation of resident/patient's property, including injuries of unknown source and resident to resident abuse. According to this policy the investigation procedure included the following:</p> <ul style="list-style-type: none"> -When an incident of abuse, neglect, mistreatment, or misappropriation of resident/patient's property is reported the nursing supervisor or designee will appoint a representative to investigate the incident. -The nursing supervisor or designee will contact the abuse coordinator and provide any supporting documents relative to the investigation. -The investigation will consist of: A comprehensive review of the event and incident, 	F 610			

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F 610	<p>Continued From page 99</p> <p>interview with persons reporting the incident, interviews with any witness of the incident, an interview with the resident, a review of the residents medical record, interviews with staff members (on all shifts) having contact with the resident during the period of the alleged incident, interviews with the resident's roommate having contact with the resident during the alleged incident, family members and visitors and review all circumstances surrounding the incident.</p> <p>The surveyor reviewed the facility policy titled, "Incident/Occurrence Investigation Policy" dated 05/22/22, which indicated that all incidences of alleged abuse, mistreatment, or neglect of a resident by staff, other residents, visitors, etc. will be investigated. The procedures were as follows according to the facility policy:</p> <ul style="list-style-type: none"> -Following the occurrence or notification or complaint the Registered Nurse Manager or Registered Nurse Supervisor will submit to the DON, a copy of the accident/report with staff members statements. -The DON-nursing/designee will promptly notify the Administrator that the investigation has occurred. -Nursing Administration or Social Services will conduct their initial investigation and review all pertinent documentation related to the event within 24 hours. -A summary will of the investigation will be documented and the Administrator, DON-nursing designee will meet to review the summary of the investigation to decide if an event is reportable to the NJDOH. The medical director and social services may be asked to participate in the decision-making process depending on the type of event that has occurred. 	F 610			

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F 642	NJAC 8:39-9.4(f);27.1(a)	F 642			
SS=D	Coordination/Certification of Assessment CFR(s): 483.20(h)-(j)				3/31/23
	<p>§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>§483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.</p> <p>§483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>§483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-</p> <p>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or</p> <p>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the required Minimum Data Set (MDS-an assessment tool used to facilitate the management of care), for entry tracking</p>		<p>F642 SS D</p> <p>Element One <input type="checkbox"/> Corrective Actions The Entry MDS assessment and discharge MDS assessment for resident</p>		

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F 642	<p>Continued From page 101</p> <p>assessment and discharge tracking assessment was completed. This deficient practice was identified for one (1) of 26 residents (Resident #119) and was evidenced by the following:</p> <p>The Admission Record dated <u>Ex Order 26. 4B1</u> at 10:37 AM, indicated that Resident #119 was admitted to the facility on <u>Ex Order 26. 4B1</u>, with the diagnoses which included but was not limited to, <u>Ex Order 26. 4B1</u>.</p> <p>The surveyor reviewed the resident census history (RCH) section of the facility's electronic medical record (EMR) which indicated that Resident #119's billing cycle ended on <u>Ex Order 26. 4B1</u>, and then restarted on <u>Ex Order 26. 4B1</u>.</p> <p>The surveyor reviewed Resident #119's nursing progress notes (PN) and there was no documentation on <u>Ex Order 26. 4B1</u> that the resident was admitted to the facility, nor was there any documentation on <u>Ex Order 26. 4B1</u>, in the PN, that the resident was discharged from the facility.</p> <p>On 03/03/23 at 10:16 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that when she reviewed Resident #119's RCH in the EMR it indicated that Resident #119 was admitted to the facility on <u>Ex Order 26. 4B1</u> and discharged on <u>Ex Order 26. 4B1</u>. The ADON stated that she did not know why there was no nursing documentation in the resident's medical record regarding the resident's admission to the facility on <u>Ex Order 26. 4B1</u>, or why there was no nursing documentation regarding the resident's discharge on <u>Ex Order 26. 4B1</u>. She stated that it was the nurse's responsibility to write an admission note when the</p>	F 642	<p>#119 was completed to reflect accurate dates.</p> <p>The Regional MDS Coordinator conducted an audit of all residents in facility to ensure entry and discharge MDS submissions were accurate and dated appropriately.</p> <p>Element Two <input type="checkbox"/> Identification of at Risk Residents All Residents have the potential to be affected by this practice.</p> <p>Element Three <input type="checkbox"/> Systemic Change The MDS Coordinator was re-educated by the Regional MDS Coordinator on accurately assessing and dating MDS submissions timely. In addition, the MDS coordinator was re-educated on how to run a report on MDS assessments to ensure correct documentation is in place and reflects the daily census.</p> <p>Element Four <input type="checkbox"/> Quality Assurance Regional MDS Coordinator will audit all residents daily x7, weekly x2 and monthly x2 to ensure MDS submissions are correct and reflect accurate assessments with date. Needed corrections will be addressed as they are discovered. Findings will be reported monthly to QAPI team for review and action as necessary.</p> <p>Completion Date: <u>Ex Order 26. 4B1</u></p>		

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F 642	<p>Continued From page 102</p> <p>resident entered the facility and a discharge note when the resident was discharged.</p> <p>The surveyor reviewed the MDS section of Resident #119's EMR. There was no documentation that an entry tracking assessment MDS was completed, which would have indicated that the resident was admitted to the facility, or that a discharge tracking assessment MDS was completed, which would have indicated that the resident was discharged from the facility.</p> <p>On 03/03/23 at 10:26 AM, the surveyor interviewed the Admissions Director (AD) who stated that according to the census and billing section of the EMR, Resident # 119 entered the facility on [Ex Order 26. 4B1], and then discharged [Ex Order 26. 4B1] on [Ex Order 26. 4B1].</p> <p>On 03/03/23 at 10:28 AM, the surveyor interviewed the Registered Nurse MDS Coordinator (RN/MDSC) who stated that she was not aware that Resident #119 was admitted to the facility on [Ex Order 26. 4B1], and was not aware that the resident discharged from the facility on [Ex Order 26. 4B1], because there was no documentation in the resident's medical record. The RN/MDSC stated that the process for admission and discharges was that she would usually check the [Ex Order 26. 4B1] of the EMR which would provide information regarding admissions and discharges. She stated that she would complete the required entry tracking assessment and discharge tracking assessment MDS according to this process. She stated that she thought that there was a communication error and thought that maybe she missed the fact that the resident was admitted on [Ex Order 26. 4B1], and discharged on [Ex Order 26. 4B1]. The RN/MDSC did confirm that the</p>	F 642			

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F 642	Continued From page 103 entry tracking assessment MDS and discharge tracking assessment MDS was not completed as required. On 03/03/23 at 01:30 PM, the Licensed Nursing Home Administrator and Regional Director of Nursing both confirmed that an entry tracking assessment and a discharge tracking assessment should have been completed by the MDSC. The surveyor reviewed the facility unsigned MDS Coordinator job description which indicated that the MDS Coordinator was repsonsible for preparing discharge and entry tracking assessments.	F 642			
F 656 SS=D	NJAC 8:39-11.1 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656			3/31/23

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F 656	<p>Continued From page 104</p> <p>provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to implement a comprehensive care plan (CP) to address the <u>Ex Order 26.4(b)(1)</u> of a resident with <u>Ex Order 26.4(b)(1)</u>. This deficient practice was identified for one (1) of one (1) resident (Resident #98) reviewed for <u>Ex Order 26.4(b)(1)</u> and was evidenced by the following:</p> <p>According to the <u>Ex Order 26.4B1</u> (AR),</p>	F 656	<p>F656 SS-D</p> <p>Element one-CORRECTIVE ACTION Resident #98 was discharged home <u>Ex Order 26.4B1</u>, a care plan was placed <u>Ex Order 26.4B1</u> in residents' chart in the event resident returns to facility.</p> <p>ELEMENT TWO-IDENTIFICATION OF OTHER RESIDENTS</p>		

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F 656	<p>Continued From page 105</p> <p>Resident #98 was admitted to the facility with the diagnoses which included but was not limited to <u>Ex Order 26. 4B1</u> [REDACTED]. The admission Minimum Data Set (MDS-an assessment tool utilized to facilitate the management of care) dated 01/31/23, indicated that the resident scored a [REDACTED] out of 15 on the Brief Interview for Mental Status (BIMS) which indicated <u>Ex Order 26. 4B1</u> [REDACTED]. The MDS also reflected that Resident #98 had <u>Ex Order 26.4(b)(1)</u> and required supervision with <u>Ex Order 26. 4B1</u> [REDACTED].</p> <p>On 02/22/23 at 11:47 AM, the surveyor interviewed Resident #98 who was observed in his/her room and stated that he/she had gotten into an altercation with another resident, but did not give specifics to the incident.</p> <p>On 02/24/23 at 09:27 AM, the surveyor interviewed the temporary nursing assistant (TNA) who stated that Resident #98 was <u>Ex Order 26.4(b)(1)</u> take care of himself/herself with <u>Ex Order 26.4(b)(1)</u> and indicated that the resident stays to himself/herself and enjoyed smoking. The TNA stated that he had not seen Resident #98 become aggressive with any other residents. The TNA added that the resident would sometimes get upset and talk loudly to himself/herself but did not direct the anger to staff or any other resident. The TNA stated that the resident's nurse was usually able to redirect the resident easily with conversation.</p> <p>On 02/24/23 at 09:35 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that Resident # 98 had been in the facility for three (3) to four (4) weeks. She stated that the resident had a <u>Ex Order 26. 4B1</u> [REDACTED] and</p>	F 656	<p>Social Worker/designee completed a diagnosis audit on all residents to ascertain any with a <u>Ex Order 26.4(b)(1)</u> and placed care plan as appropriate.</p> <p>ELEMENT THREE- SYSTEMIC CHANGES Procedure Initiated: admissions /sw/administrative staff and members of IDCP team educated on procedure including : Admission coordinator to review all admission referrals for a <u>Ex Order 26. 4B1</u> [REDACTED] and refer to IDCP team on impending admissions with said diagnoses. All new admissions are reviewed by the clinical team in morning meeting where the baseline care plan will be initiated to include <u>Ex Order 26. 4B1</u> [REDACTED], if applicable.</p> <p>QUALITY ASSURANCE Social Worker/designee to audit all new admissions for diagnosis of <u>Ex Order 26.4(b)(1)</u> daily x7, weekly x4 and monthly x 4, in addition to above process. Needed corrections will be addressed as they are discovered. Findings to be reported monthly to QAPI team for review and action as necessary.</p> <p>Completion Date: 3/31/23</p>		

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F 656	<p>Continued From page 106</p> <p>was ^{Ex Order 26.4B1} with a ^{Ex Order 26.4B1} diagnosis of ^{Ex Order 26.4B1}. She stated that the resident would ^{Ex Order 26.4(b)(1)} at times and that his/her thought processes were ^{Ex Order 26.4B1} and it was ^{Ex Order 26.4(b)(1)} him/her to express himself/herself. She added that the resident had difficulty making decisions. The LPN further added that she was not aware if the resident had ever ^{Ex Order 26.4B1} towards staff or other residents and that Resident #98 was able to take care of himself/herself with supervision and set up.</p> <p>The surveyor reviewed Resident #98's progress note dated 02/15/2023 at 21:57 (09:57 PM) titled: Incident Note Note Text: At approx. 08:30 PM, [Resident #98] was involved in a ^{Ex Order 26.4B1} altercation with another resident.</p> <p>On 02/24/23 at 10:21 AM, the surveyor interviewed the Social Worker (SW). The SW stated that Resident #98 told her that a resident was arguing with another resident in the hallway. The SW explained that Resident #98 had ^{Ex Order 26.4B1} and got upset with loud noises and that he/she was upset with the loud tone of the other resident in the hallway and ^{Ex Order 26.4B1} him/her with a ^{Ex Order 26.4B1}. She stated that both residents were separated, and the police were notified. She stated that there were interventions that were put into place after the resident returned from the ^{Ex Order 26.4B1} and that the ^{Ex Order 26.4B1} were consulted to address the ^{Ex Order 26.4B1} with Resident #98. The SW could not explain to the surveyor why there was not a CP implemented for Resident #98, if he had ^{Ex Order 26.4B1}.</p> <p>The surveyor reviewed a typed Investigative Summary (IS) dated 02/16/23, that was conducted by the Director of Nursing (DON) after</p>	F 656			

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F 656	<p>Continued From page 107</p> <p>Resident #98 had an altercation with another resident. There was a handwritten statement included in the IS dated 02/16/23, from the Director of Social Work (DSW), that after Resident #98 had an altercation with another resident, Resident #98 told the DSW that the other resident was being loud in the hallway and that because Resident #98 had [Ex Order 26.4B] it was giving him/her [Ex Order 26.4B] so he/she swung at the other resident. The CP was not updated after this altercation to include behaviors and triggers associated with Resident #98's [Ex Order 26.4B].</p> <p>The surveyor reviewed the physician progress note (PPN) dated 02/23/23 at 15:51 (03:51 PM) that indicated that Resident #98 had a [Ex Order 26.4B] and that the resident had very [Ex Order 26.4B] and that, per nursing, the resident had [Ex Order 26.4B]. The PPN also reflected that the resident was very [Ex Order 26.4B], [Ex Order 26.4B] and had a [Ex Order 26.4B] of [Ex Order 26.4B].</p> <p>On 02/24/23 at 10:52 AM, the surveyor interviewed the Director of Nursing (DON) who stated that Resident #98 had [Ex Order 26.4B] another resident with a [Ex Order 26.4B]. The DON did not have a response as to why the CP was not updated after the altercation to include this [Ex Order 26.4B] or why interventions weren't implemented on the resident's CP to address the resident's behaviors and triggers associated with [Ex Order 26.4B]. The DON further stated that she did not interview Resident #98 after the [Ex Order 26.4B] because the resident had [Ex Order 26.4B] and [Ex Order 26.4B] and she did not think that this resident would be a reliable interview. The DON did not have a response as to why a CP was not developed for Resident #98 for the diagnoses of [Ex Order 26.4B].</p>	F 656			

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F 656	<p>Continued From page 108</p> <p>On 03/01/23 at 02:52 PM, the surveyor interviewed the resident's father who stated that Resident #98 had <u>Ex Order 26. 4B1</u> due to a severe <u>Ex Order 26. 4B1</u> and would have episodes of <u>Ex Order 26. 4B1</u>. He also stated that Resident #98 would go <u>Ex Order 26. 4B1</u> with loud noises and had trouble concentrating. He stated that the facility should have known what to do for him/her because the facility were the ones that were caring for him/her. He stated that he knew about a couple incidents that Resident #98 had since he/she was at the facility, but wasn't sure how the facility handled it.</p> <p>On 03/01/23 at 03:04 PM, the surveyor interviewed the psychiatric Nurse Practitioner (NP) who stated that she was consulted to see residents in the facility for <u>Ex Order 26. 4B1</u> care and for <u>Ex Order 26. 4B1</u> management and that she came to the facility every Monday. She stated that if it was reported to her that one of the residents had a <u>Ex Order 26. 4B1</u> altercation, she would expect that the facility would notify her so that she could evaluate the residents. She stated that a nurse asked her to speak to Resident #98 regarding the resident having an <u>Ex Order 26. 4B1</u> with a <u>Ex Order 26. 4B1</u>. She stated that while she was reviewing Resident #98's medical records, she saw that the resident had an altercation with another resident. The NP stated that she reviewed her consultations since the resident was admitted to the facility and stated that she got the resident <u>Ex Order 26. 4B1</u> from the <u>Ex Order 26. 4B1</u> records. She stated that the resident's <u>Ex Order 26. 4B1</u> records reflected that Resident #98 had <u>Ex Order 26. 4B1</u> and that she did not know why the resident had <u>Ex Order 26. 4B1</u> and that the resident had never relayed to her as to why he/she had <u>Ex Order 26. 4B1</u>. She stated that in her medical opinion it would</p>	F 656			

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F 656	<p>Continued From page 109</p> <p>have been important for the resident to have been care planned for <u>Ex Order 26. 4B</u> so that the staff would know how to care for him/her and what would trigger him/her to have behaviors. She stated that a CP for <u>Ex Order 26. 4B</u> would be beneficial to prevent the resident from having triggers that could exacerbate the resident's <u>Ex Order 26. 4B</u> and behaviors.</p> <p>The surveyor reviewed the NP's <u>Ex Order 26. 4B1</u> consult for Resident #98 dated 02/20/23, which indicated that Resident #98 <u>Ex Order</u> at a <u>Ex Order 26. 4B1</u> and had an altercation with another resident. The consult reflected that Resident #98 was tearful when the NP questioned him/her regarding the above-mentioned incidents and that the resident stated, <u>Ex Order 26. 4B1</u>. The consult reflected a diagnosis of <u>Ex Order 26. 4B</u>. The consult also indicated that the NP discussed this consultation with the resident and the staff.</p> <p>On 03/02/23 at 10:35 AM, the surveyor interviewed the resident's primary care physician (PCP) who was also the facility's medical director. The PCP explained to the surveyor that the <u>Ex Order 26. 4B1</u> wrote the progress note on <u>Ex Order 26. 4B1</u> at 15:51 (03:51 PM) indicating that the resident had a history of <u>Ex Order 26. 4B</u>. The PCP stated that <u>Ex Order 26. 4B</u> should have been care planned to include interventions for triggers for <u>Ex Order 26. 4B</u>, however he did not know if the resident told someone he/she had the diagnoses, or if the resident actually had the diagnoses for <u>Ex Order 26. 4B</u>.</p> <p>On 03/06/23 at 11:00 AM, the surveyor interviewed the Regional Director of Nursing (RDON) who confirmed that a CP was not implement for <u>Ex Order 26. 4B</u> for Resident #98. She added that the facility implemented a CP on the</p>	F 656			

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F 656	Continued From page 110 resident's closed medical record in case the resident returned to the facility. On 03/01/23 at 10:50 AM, the RDON provided the surveyor with a facility policy titled, "Care Plans-Comprehensive" and dated 11/22/22, which indicated that the facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. The policy also indicated that the Care Planning/Interdisciplinary Team was responsible for the review and updating of care plans. The policy further indicated that the comprehensive care plan was designed to reflect treatment goals, timetables, and objectives in measurable outcomes and to incorporate identified problem areas.	F 656			
F 658 SS=D	NJAC 8:39-11.2 (e) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to follow professional standards of practice by ensuring that staff consistently changed and dated the irrigation water bottle set for a [redacted] [redacted] every 24 hours. This deficient	F 658	F658 SS-D CORRECTIVE ACTION Resident # 37 water bottle with [redacted] [redacted] was replaced and dated accordingly.		3/31/23

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F 658	<p>Continued From page 111</p> <p>practice was identified for one (1) of two (2) residents reviewed for Ex Order 26.4B1 (Resident #37).</p> <p>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."</p> <p>The deficient practice was evidenced by the following:</p> <p>On 02/22/23 at 10:12 AM, during the initial tour, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) for the Ex Order 26.4B1 nursing unit who stated that Resident #37 received a Ex Order 26.4B1 Ex Order 26.4B1.</p> <p>On 02/22/23 at 10:46 AM, the surveyor observed Resident #37 lying in bed sleeping with the bed in the lowest position. At that time, the surveyor did not see any supplies for the Ex Order 26.4B1.</p> <p>The surveyor reviewed the Ex Order 26.4B1 (EMR) for Resident #37.</p> <p>A review of the resident's Admission Record</p>	F 658	<p>IDENTIFICATION OF OTHER RESIDENTS</p> <p>Resident MDS assessments were reviewed to identify all residents on each unit who have Ex.Order 26.4(b)(1) and have the potential to be affected by this practice.</p> <p>SYSTEMIC CHANGES</p> <p>Nursing staff were in-serviced on changing and dating water bottle with piston syringe daily.</p> <p>QUALITY ASSURANCE</p> <p>DON/designee to audit all new admission charts daily to ascertain any new admissions that have a Ex.Order 26.4(b)(1) to ensure appropriate dated equipment is in place. Furthermore DON/designee will conduct daily rounds of all residents with a Ex.Order 26.4(b)(1) to ensure dated equipment in place, daily x14days, then weekly x4 them monthly x4. Needed corrections will be addressed as they are discovered. Findings to be reported monthly to QAPI team for review and action as necessary.</p> <p>Completion Date: 3/31/23</p>		

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NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		
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F 658	<p>Continued From page 112</p> <p>reflected that the resident was admitted to the facility in <u>Ex Order 26. 4B1</u>, with diagnoses which included: <u>Ex Order 26. 4B1</u></p> <p>[REDACTED]</p> <p>A review of the most recent Admission Minimum Data Set (MDS-an assessment tool used to facilitate the management of care) dated <u>Ex Order 26.4(b)(1)</u> reflected a Brief Interview for Mental Status (BIMS) score of <u>Ex Order 26. 4B1</u> out of 15, which indicated a <u>Ex Order 26. 4B1</u>.</p> <p>A review of the February 2023 Medication Administration Record (MAR) reflected the following physician's order: - <u>Ex Order 26. 4B1</u> every shift start date 01/24/23 order status discontinued 02/03/23. - <u>Ex Order 26. 4B1</u> (3) times a day start date 02/04/23.</p> <p>A review of the March 2023 MAR reflected the following: <u>Ex Order 26. 4B1</u> three (3) times a day start date 02/22/23.</p> <p>On 03/02/23 at 12:22 PM, the surveyor observed the water bottle, dated 02/28/23, with a <u>Ex Order 26. 4B1</u> and a clear liquid inside on Resident #37's overbed table. Resident #37 stated that he/she received <u>Ex Order 26. 4B1</u> but not all the time. Resident #37 further stated that they also ate food.</p> <p>On 03/02/23 at 12:24 PM, the surveyor interviewed the LPN/UM who stated that Resident #37 received <u>Ex Order 26. 4B1</u> but was having</p>	F 658			

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F 658	<p>Continued From page 113</p> <p>an upcoming procedure to possibly remove the <i>Ex Order 26. 4B1</i></p> <p>The LPN/UM stated that the supplies that the nurses used for <i>Ex Order 26. 4B1</i> included the water bottle and <i>Ex Order 26. 4B1</i> for <i>Ex Order 26. 4B1</i> and to administer the <i>Ex Order 26. 4B1</i>. He stated that the supplies should be dated daily and discarded after 24 hours. He further stated that the night shift (11 PM to 7 AM) nurses should have been changing the supplies daily. The LPN/UM stated that it was important to change the <i>Ex Order 26. 4B1</i> supplies daily because they were following the physician's order. He further stated that the supplies should have been changed daily for <i>Ex Order 26. 4B1</i> and so that the resident was kept safe from <i>Ex Order 26.4(b)(1)</i>. The LPN/UM acknowledged that the water bottle should have been changed every 24 hours and did not speak to how the physician's order should have been documented.</p> <p>On 03/02/23 at 12:27 PM, the surveyor interviewed the LPN who stated that she was the nurse for Resident #37. The LPN stated that the resident received <i>Ex Order 26. 4B1</i> but generally refused. She stated that the resident did not like the <i>Ex Order 26. 4B1</i> and was going out tomorrow, 03/03/23, to have it removed. The LPN stated that the supplies included the water bottle and <i>Ex Order 26. 4B1</i>, and that it should have been changed every day for <i>Ex Order 26. 4B1</i> and for <i>Ex Order 26. 4B1</i>. At that time, the surveyor and the LPN went into Resident #37's room. The water bottle dated 02/28/23 was now on top of the resident's dresser. The LPN confirmed that the clear liquid inside the water bottle, that was dated 2/28/23, was <i>Ex Order 26. 4B1</i>. The LPN stated that yesterday, 03/01/23, there were two (2) water</p>	F 658			

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F 658	<p>Continued From page 114</p> <p>bottles in the resident's room. She stated that if she would have given the resident their ^(s Order 26. 4B1) and flushed the ^(s Order 26. 4B1) today, 03/02/23, then she would have ^{Ex Order 26. 4B1}. The LPN stated that the 11 PM to 7 AM nurses were responsible to make sure that the water bottles were changed and dated. At that time, Resident #37 pointed to his/her drawer. The LPN opened the top drawer and pulled out an undated water bottle that had a ^{Ex Order 26. 4B1} inside which the LPN identified as ^{Ex Order 26. 4B1}. The LPN then stated that the undated water bottle must have been the bottle from yesterday, 03/01/23. The surveyor asked the LPN what was today's date? She replied today was 03/02/23 and that yesterday was 03/01/23. The LPN acknowledged it was still two (2) days later. The surveyor asked if a bottle was undated, how would she know it was changed? She replied that if it was not dated that she ^{Ex Order 26. 4B1}. The LPN acknowledged the water bottle should have been discarded and changed every 24 hours.</p> <p>On 03/02/23 at 12:42 PM, the surveyor observed that the LPN had removed the water bottle dated 02/28/23 and the undated water bottle and placed a new empty water bottle dated 03/02/23 in the resident's room.</p> <p>A further review of the March 2023 MAR reflected the following: ^{Ex Order 26. 4B1} by ^(s Order 26. 4B1) three (3) times a day was administered on 03/01/23 at 1000 (10:00 AM); at 1400 (2:00 PM); and at 2000 (8:00 PM) and on 03/02/23 at 1000.</p> <p>On 03/03/23 at 11:23 AM, the surveyor interviewed the Director of Nursing (DON) in the presence of the Assistant Director of Nursing</p>	F 658			

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F 658	Continued From page 115 (ADON) who stated that the ^{Ex Order 26, 4B1} supplies included the water bottle, the ^{Ex Order 26, 4B1} and ^{Ex Order 26, 4B1} if needed. The DON stated that the supplies were changed during the 11 PM to 7 AM shift by the nurses and that the supplies should have been labeled and changed daily. At that time, the surveyor showed the DON and the ADON the picture of the water bottle dated 02/28/23. The DON acknowledged that it was not best practice and that the water bottle should have been discarded and changed every 24 hours. On 03/03/23 at 11:25 AM, the surveyor interviewed the ADON in the presence of the DON who stated that the water bottle should have been changed daily so that it prevented bacterial growth and for infection control. On 03/03/23 at 11:28 AM, both the DON and the ADON stated that the facility's practice was to change the water bottle daily. Both the DON and ADON acknowledged that the water bottle should have been changed and dated every 24 hours. A review of the facility's undated policy, Enteral Tube Feeding, included "Establishment and Monitoring of Tube Feedings 1. The Physician will provide orders for enteral feedings ...5. Enteral feeding orders will be written to ensure consistent volume infusion ...Administration of Tube Feedings 4. Change administration sets for open-system [gravity] enteral feedings at least 24 hours."	F 658			
F 689 SS=J	NJAC 8:39-27.1(a) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689			3/31/23

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F 689	<p>Continued From page 116</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Part A</p> <p>Based on observation, interviews, and review of other pertinent documentation, it was determined that the facility failed to a.) ensure a physician's order for a diet change to nectar thick liquids was followed and communicated to dietary staff for a resident with a history of aspiration on thin liquids; b.) ensure staff who were caring for a resident were aware of their modified diet order; and c.) develop a policy to ensure staff were aware of the process to communicate physician's orders, diet changes, and therapeutic diets. This deficient practice was identified for 1 of 2 residents (Resident #94) reviewed for tube feeding.</p> <p>On 3/1/23 at 12:16 PM, the surveyor observed Resident #94 in bed with two unopened apple juices and one opened twenty-four-ounce bottle of soda. The resident stated the liquids were [redacted]; he/she drank [redacted] Ex Order 26. 4B1.</p> <p>On 3/1/23 at 12:26 PM, the surveyor observed the resident's Certified Nursing Aide (CNA #1) deliver the resident's lunch meal tray which contained a mechanically altered diet with apple juice that CNA #1 confirmed was [redacted] Ex Order 26. 4B1. Interview with both the resident's CNA #1 and Licensed Practical Nurse (LPN #1) revealed the</p>	F 689	<p>F689 SS J</p> <p>Element One <input type="checkbox"/> Corrective Actions Part A On 3/1/2023, all [redacted] Ex Order 26. 4B1 were immediately removed from the room of Resident #94. Staff that care for Resident #94 were immediately re-educated. (LPN#1 ,C.N.A. #1)</p> <p>On 3/1/2023, Resident #94 communication was sent to dietary department to ensure order was updated to reflect the physicians order of [redacted] Ex Order 26. 4B1.</p> <p>The Licensed Practical Nurse (LPN#1) was re-educated immediately ensuring that physicians diet orders should be reflected on diet tickets. The Certified Nursing aide (C.N.A.#1) was re-educated immediately on confirming the accuracy of the dietary tickets versus items on meal trays to ensure accuracy and safe meal delivery, and to ensure tray is checked by nurse prior to giving resident tray.</p> <p>Part B</p>		

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F 689	<p>Continued From page 117</p> <p>resident was on a thin liquid diet. Review of the resident's medical record reflected a Progress Note (PN) dated 2/14/23, that the resident returned from an appointment with <u>Ex Order 26. 4B1</u> on <u>Ex Order 26. 4B1</u> of the lungs on <u>Ex Order 26. 4B1</u>.</p> <p>A review of the physician's orders (PO) revealed a PO dated 2/22/23 for <u>Ex Order 26. 4B1</u>.</p> <p>Interview with the Speech Language Pathologist (SLP) indicated that the resident had a <u>Ex Order 26.4(b)(1)</u> performed on 2/14/23, with the results of <u>Ex Order 26. 4B1</u> on <u>Ex Order 26. 4B1</u> of the lungs on <u>Ex Order 26. 4B1</u>. The SLP stated the resident was picked up by <u>Ex Order 26. 4B1</u> on 2/17/23 to <u>Ex Order 26.4(b)(1)</u> of <u>Ex Order 26. 4B1</u> and should have been started on <u>Ex Order 26. 4B1</u> on <u>Ex Order 26. 4B1</u>.</p> <p>Interview with the dietary staff revealed there was no communication with them for the resident's diet change.</p> <p>Follow-up observation with LPN #1 confirmed the resident had <u>Ex Order 26. 4B1</u> present in their room. LPN #1 verified the PO and confirmed the resident had a PO dated 2/22/23 for <u>Ex Order 26. 4B1</u>.</p> <p>The facility's failure to ensure a resident with a history of <u>Ex Order 26. 4B1</u> on <u>Ex Order 26. 4B1</u> and a physician order for <u>Ex Order 26. 4B1</u> was provided <u>Ex Order 26. 4B1</u> posed a serious and immediate threat for adverse effects, including <u>Ex Order 26. 4B1</u>, which is likely to result in serious</p>	F 689	<p>On 3/2/2023, all <u>Ex Order 26. 4B1</u> were removed from Resident #17 Staff that care for Resident #19 were immediately re-educated.(LPN#2 C.N.A. #2)</p> <p>On 3/2/2023, Resident #17 communication was sent to dietary department to ensure order was updated to reflect the physicians order of <u>Ex Order 26. 4B1</u>.</p> <p>The Licensed Practical Nurse (LPN#1) was re-educated immediately ensuring that physicians diet orders should be reflected on tray and meal ticket.</p> <p>The Certified Nursing aide (C.N.A.#1) was re-educated immediately on confirming the accuracy of the dietary tickets versus items on meal trays to ensure accuracy and safe meal delivery, and to ensure tray is checked by nurse prior to giving resident tray. Including red ticket to identify Mechanically altered meals.</p> <p>The LNHA/designee conducted an audit of residents receiving mechanically altered diets to ensure foods were provided and prepared in a manner consistent with physician prescribed mechanically altered diets.</p> <p>Kitchen staff responsible for meal preparation were evaluated through competency including return demonstration related to mechanically altered diets by the Food Services Director (FSD) /Registered Dietician to</p>		

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F 689	<p>Continued From page 118</p> <p>harm, impairment, or even death. This resulted in an Immediate Jeopardy (IJ) situation that began on 2/22/23 at 10:11 AM, when the physician ordered the <u>Ex Order 26. 4B1</u>.</p> <p>The facility's administration was notified of the IJ on 3/1/23 at 4:51 PM. The facility submitted an acceptable written Removal Plan on 3/3/23 at 9:35 AM. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 3/3/23.</p> <p>The evidence was as follows:</p> <p>On 3/1/23 at 12:16 PM, the surveyor observed Resident #94 lying in bed awake with a overbed table located to his/her side. The overbed table contained an opened twenty-four-ounce bottle of soda with approximately <u>Ex Order 26. 4B1</u> of the liquid removed and two unopened apple juices. The resident informed the surveyor that the soda was purchased by herself a few months ago and he/she now and then would <u>Ex Order 26. 4B1</u> on it, and the two apple juices were from that morning's breakfast tray. The surveyor asked if the resident's liquids were <u>Ex Order 26. 4B1</u>, and the resident responded that the nurses sometimes put something in his/her drinks to <u>Ex Order 26. 4B1</u> it he/she thought. The surveyor asked if the soda contained <u>Ex Order 26. 4B1</u>, and the resident stated, <u>Ex Order 26. 4B1</u> and that he/she just <u>Ex Order 26. 4B1</u> on it. The surveyor asked the resident if he/she was on speech therapy, and they responded, <u>Ex Order 26. 4B1</u>. The surveyor asked the resident if he/she had a <u>Ex Order 26. 4B1</u> <u>Ex Order 26. 4B1</u>, which the resident stated he/she had a <u>Ex Order 26. 4B1</u>, but they did not receive their nutrition from the <u>Ex Order 26. 4B1</u>, they only received water flushes for <u>Ex Order 26. 4B1</u>.</p>	F 689	<p>ensure foods are provided and prepared in a manner consistent with physician prescribed mechanically altered diets. An audit was completed to ensure physicians orders for diet types were reflective of orders received in the dietary department.</p> <p>Element Two <input type="checkbox"/> Identification of at Risk Residents All residents have the potential to be affected by this practice.</p> <p>Element Three <input type="checkbox"/> Systemic Change The Facility adopted Med-Pass Therapeutic Diet Policy and the staff was re-educated utilizing policy which includes:</p> <ol style="list-style-type: none"> 1. Mechanically altered diets, as well as diets modified for medical or nutritional needs, will be considered therapeutic diets. 2. A <u>Ex Order 26. 4B1</u> must be prescribed by the resident's Attending Physician. The physician's diet order should match the terminology used by Food Services. 3. The Clinical Dietitian, nursing staff, and Attending Physician will review, along with other orders, the need for, and resident acceptance of, prescribed therapeutic diets. 4. Routine menus (without therapeutic purpose) are planned by the Food Services Manager and approved by a Registered Dietitian for nutritional adequacy. The regular menu will be modified by the Registered Dietitian for therapeutic diets, with input from the Dietary Manager for feasibility of kitchen 		

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F 689	<p>Continued From page 119</p> <p>On 3/1/23 at 12:20 PM, the surveyor observed the lunch trays arrive on the Ex Order 26. 4B1 nursing unit West wing.</p> <p>On 3/1/23 at 12:26 PM, the surveyor observed CNA #1 deliver Resident #94's meal tray to their room. The meal tray contained thin apple juice Ex Order 26. 4B1 served in a plastic cup, Ex Order 26. 4B1 ice cream, vanilla pudding, a pulled pork sandwich, vegetables, and an oatmeal sandwich cookie. The surveyor observed the resident put the apple juice to their lips and place the cup back down. There was no significant amount of apple juice removed from the cup, the cup still appeared untouched.</p> <p>A review of the resident's meal ticket located on their tray, revealed the resident received a Ex Order 26. 4B1, but it did not specify the liquids.</p> <p>On 3/1/23 at 12:28 PM, the surveyor interviewed CNA #1 who stated that the resident had a Ex Order 26. 4B1 but received all their food and beverages Ex Order 26.4(b)(1). CNA #1 confirmed the apple juice was a Ex Order 26. 4B1 with no added Ex Order 26. 4B1 and she stated the resident's diet ordered was a mechanical altered diet and regular Ex Order 26. 4B1. CNA #1 stated the resident had something wrong with their Ex Order 26. 4B1, but that was years ago and did not require Ex Order 26. 4B1.</p> <p>On 3/1/23 at 12:30 PM, the surveyor interviewed LPN #1 who confirmed she was the resident's nurse for the day and familiar with the resident. LPN #1 stated the resident had a Ex Order 26. 4B1, but only received medication through the Ex Order 26. 4B1. LPN #1</p>	F 689	<p>production.</p> <p>5. The Food Services Manager will establish and use a tray identification system to ensure that each resident receives his or her diet as ordered., Ex Order 26. 4B1 tray ticket color is red.</p> <p>6. Prior to passing out trays the nurse will check all trays for correct diet and c.n.a. will re-check when passing out the meal tray.</p> <p>7. The Clinical Dietitian and nursing staff will document significant information relating to the resident's response to his/her therapeutic diet in the resident's medical record.</p> <p>8. Residents on Ex Order 26.4B1 diets will not receive extra or reduced portions or modifications that are not part of the diet, unless approved by the Attending Physician in conjunction with the Clinical Dietitian.</p> <p>9. Any snacks provided must be compatible with the therapeutic diet.</p> <p>10. As appropriate, the Attending Physician may temporarily suspend a Ex Order 26.4B1 diet for special occasions.</p> <p>11. The interdisciplinary team along with MD, may choose to temporarily liberalize the diet if the resident is losing weight or not eating well.</p> <p>12. If the resident or the resident's representative declines the recommended Ex Order 26.4B1 diet, the interdisciplinary team will collaborate with the resident or representative to identify possible alternatives. Family and resident will be educated on the need and reason for Ex Order 26.4B1 diets.</p>		

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F 689	<p>Continued From page 120</p> <p>stated the resident was on a regular textured diet and received <u>Ex Order 26. 4B1</u>.</p> <p>The surveyor reviewed the medical record for Resident #94.</p> <p>A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in <u>Ex Order 26. 4B1</u> with diagnoses which included <u>Ex Order 26. 4B1</u></p> <p>[REDACTED]</p> <p>A review of the most recent quarterly Minimum Data Set (MDS-an assessment tool utilized to facilitate the management of care) dated 2/10/23, reflected a Brief Interview for Mental Status (BIMS) score of <u>Ex One</u> out of <u>Ex One</u>, which indicated a <u>Ex Order 26. 4B1</u>. A further review indicated for <u>Ex Order 26. 4B1</u>, the resident required supervision of setup help only for <u>Ex Order 26.4B1</u>. A review of <u>Ex Order 26. 4B1</u> reflected the resident had a mechanically altered diet which required change in texture of food or liquids.</p> <p>A review of the Order Summary Report included a physician's order (PO) dated 2/22/23, for a regular diet mechanical <u>Ex Order 26. 4B1</u>. A review of the Progress Notes for 2/22/23, did not include any documentation why the resident's diet was changed that day.</p> <p>A review of the individualized person-centered care plan included a focus area initiated <u>Ex Order 26. 4B1</u> and last revised <u>Ex Order 26. 4B1</u>, that the resident had</p>	F 689	<p>By 03/31/23, kitchen staff were reeducated by the Food Services Director (FSD) or Registered Dietician on the importance of preparing and serving therapeutic diets, to include mechanically altered diets, including red ticket for Mechanically Altered Diets per adopted policy.</p> <p>to residents in a manner consistent with physician prescribed mechanically altered diets.</p> <p>DON/dietician will review all new admissions for mechanically altered diet and assess resident and communicate findings to FSD/designee to ensure diet in place.</p> <p>DON/Dietician to review 24hour report daily for any new physician orders related to diet and communicate to FSD during daily morning meeting of residents diet to ensure proper diet is in place.</p> <p>RN/LPN will complete 24 hour chart check with the purpose being to reconcile orders and ensure new orders are in place.</p> <p>Newly hired licensed nurses will receive education during orientation.</p> <p>Element Four <input type="checkbox"/> Quality Assurance</p> <p>The LNHA/designee will conduct a daily audit x 14 days, weekly audit x4 weeks and then monthly x4 months of residents receiving mechanically altered diets to ensure foods were provided and prepared in a manner consistent with physician prescribed mechanically altered diets.</p> <p>DON/dietician will review all new admissions for mechanically altered diet</p>		

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F 689	<p>Continued From page 121</p> <p>nutritional problems with regards to <u>Ex Order 26. 4B1</u> need for mechanical soft diet and refusal of <u>Ex Order 26. 4B1</u> and noncompliance with recommended diet, with planned weight gain trend. Interventions included to provide diet as ordered - mechanically altered; to explain and reinforce to the resident the importance of maintaining the diet ordered, encourage the resident to comply, explain consequences of refusal; provide food preferences - yogurt at meals; Registered Dietitian (RD) to evaluate and make diet change recommendations as needed; <u>Ex Order 26. 4B1</u> to keep <u>Ex Order 26. 4B1</u>; and weight as ordered. The care plan did not include the resident's <u>Ex Order 26. 4B1</u>.</p> <p>On 3/1/23 at 1:39 PM, the surveyor interviewed the Rehabilitation Director (Rehab Director) who stated the resident was followed by <u>Ex Order 26. 4B1</u>. The surveyor requested a copy of the resident's <u>Ex Order 26. 4B1</u> and to speak with the <u>Ex Order 26. 4B1</u>.</p> <p>On 3/1/23 at 1:47 PM, the SLP provided the surveyor with the resident's <u>Ex Order 26. 4B1</u>. The SLP stated that she had only been at the facility for three weeks now but did evaluate Resident #94 who was referred to her after a <u>Ex Order 26. 4B1</u>. The SLP stated on <u>Ex Order 26. 4B1</u>, the resident received a <u>Ex Order 26. 4B1</u> which was a camera attached to a <u>Ex Order 26. 4B1</u> that went down the resident's throat and the evaluator was able to see that the resident <u>Ex Order 26. 4B1</u> on <u>Ex Order 26. 4B1</u>, which meant liquids went into the windpipe. The SLP stated that there was also penetration of the lungs with <u>Ex Order 26. 4B1</u>, which meant liquid</p>	F 689	<p>daily and ensure communication to FSD. DON/designee to check 24 hour report daily.</p> <p>The above audit completed by don/designee will be audited daily by regional DON /designee followed by a pcc audit to ensure diet in place.</p> <p>Needed corrections will be addressed as they are discovered. Findings to be reported monthly to QAPI team for review and action as necessary.</p> <p>Date of compliance: 3/31/23</p>		

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F 689	<p>Continued From page 122</p> <p>went into the lungs when the resident had <u>Ex Order 26. 4B1</u>. The surveyor asked if penetration of the lungs was bad, and the SLP stated yes, because it could cause <u>Ex Order 26. 4B1</u> if the resident continued with <u>Ex Order 26. 4B1</u>. The SLP stated the purpose of <u>Ex Order 26. 4B1</u> was to teach the resident techniques to block the airway to tolerate the <u>Ex Order 26. 4B1</u> so that was why <u>Ex Order 26. 4B1</u> were recommended. The SLP stated she thought the resident was already on <u>Ex Order 26. 4B1</u> when she started at the facility on <u>Ex Order 26. 4B1</u>, and the resident was evaluated on <u>Ex Order 26. 4B1</u> by her. The SLP stated the resident at this time would not be a candidate for <u>Ex Order 26. 4B1</u> because of the <u>Ex Order 26. 4B1</u>.</p> <p>On 3/1/23 at 2:09 PM, the surveyor interviewed the Dietary Aide (DA) who stated the kitchen had a list of diet orders for all residents that was updated and printed daily. The nursing staff, RD, or SLP sent the kitchen a Diet Order & Communication form with any changes to the residents' diets. The DA provided the surveyor with a copy of the List of Residents and Diet for Crosscheck which revealed Resident #94 was to receive <u>Ex Order 26. 4B1</u>. At this time, the Food Service Director (FSD) joined the surveyor and the DA who confirmed the document provided by the DA contained all the residents' diet orders. The FSD stated the diet order was printed on the residents' meal tickets. The surveyor asked how staff <u>Ex Order 26. 4B1</u> resident's beverages, and the FSD stated the kitchen ordered <u>Ex Order 26. 4B1</u>, juices, and coffee. The FSD showed the surveyor an unopened case of <u>Ex Order 26. 4B1</u> apple juice that was stored in the dry storage area. The FSD stated that the kitchen had powder <u>Ex Order 26. 4B1</u> that could be added to liquids in the event the kitchen ran out of</p>	F 689			

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F 689	<p>Continued From page 123</p> <p><u>Ex Order 26. 4B1</u>, but the FSD stated that the kitchen always had <u>Ex Order 26. 4B1</u>.</p> <p>On 3/1/23 at 2:23 PM, the surveyor accompanied by LPN #1 went into Resident #94's room, and she confirmed the resident had an opened twenty-four-ounce soda and two unopened apple juices. LPN #1 confirmed all the liquids were thin. At this time, the surveyor asked LPN #1 to confirm the resident's diet order, and LPN #1 confirmed the resident had a PO for <u>Ex Order 26. 4B1</u> that was changed on 2/22/23. LPN #1 stated the CNAs checked the meal trays when they arrived at the nursing floor prior to be delivered to the resident to ensure accuracy of the meal. LPN #1 confirmed she did not check the lunch meal trays today when they arrived from the kitchen. LPN #1 stated giving a resident <u>Ex Order</u> when <u>Ex Order 26. 4B1</u> was ordered, could cause <u>Ex Order 26. 4B1</u>. LPN #1 stated a copy of all diet orders was located in the resident's paper medical record.</p> <p>A review of the resident's paper medical record included two Diet Order & Communication forms; one completed <u>Ex Order 26. 4B1</u> for a regular mechanical soft diet and <u>Ex Order 26. 4B1</u> were not indicated, and the last form was dated <u>Ex Order 26. 4B1</u> for <u>Ex Order 26. 4B1</u> only.</p> <p>On 3/1/23 at 2:32 PM, the surveyor asked the SLP who communicated diet changes with the kitchen, and she responded the RD informed the kitchen.</p> <p>On 3/1/23 at 2:41 PM, the surveyor asked the FSD if they kept a record for the residents' Diet Order & Communication forms, and she responded yes. The surveyor asked if she</p>	F 689			

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F 689	<p>Continued From page 124</p> <p>received a diet change for Resident #94 in February, and the FSD looked through <u>Ex Order</u> forms and confirmed no. The FSD stated the resident had been at the facility for a while and did not recall having any diet changes recently. At this time, the DA stated the last change for Resident #94 was for a <u>Ex Order 26. 4B1</u> and not diet change. The surveyor continued to review the medical record.</p> <p>A review of the Progress Notes included a Nurses Note dated 2/14/23 at 6:58 PM, that the resident returned from appointment with findings of <u>Ex Order 26. 4B1</u> on <u>Ex Order 26. 4B1</u> and penetration <u>Ex Order</u> with <u>Ex Order 26. 4B1</u>. There was a diagnosis of <u>Ex Order 26. 4B1</u>.</p> <p>The note did not indicate if the diet was changed, or the physician was notified.</p> <p>A review of the Progress Notes included a Plan of Care Note dated 2/15/23 at 7:03 PM, signed by Physician #1 which did not include the results of the resident's <u>Ex Order 26. 4B1</u> test with <u>Ex Order 26. 4B1</u> on <u>Ex Order</u> and penetration on <u>Ex Order 26. 4B1</u>. The note included nutrition - <u>Ex Order 26. 4B1</u>. A further review of the notes from 2/14/23 until 2/22/23, did not include the resident's results from their <u>Ex Order 26. 4B1</u> test on 2/14/22 or the diet recommendation of <u>Ex Order 26. 4B1</u>.</p> <p>On 3/1/23 at 3:05 PM, the surveyor asked the SLP when Resident #24 should have started on <u>Ex Order 26. 4B1</u>, and she responded on 2/14/23 when the resident was seen by the <u>Ex Order 26. 4B1</u> SLP. At this time, the Rehab Director stated that <u>Ex Order 26. 4B1</u> picked the resident up at that time and gave the RD the referral as well.</p>	F 689			

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F 689	<p>Continued From page 125</p> <p>On 3/1/23 at 3:17 PM, the surveyor attempted to interview the RD via telephone with no response. The surveyor left a message for the RD to return the call, but never received a call back for the rest of the survey.</p> <p>On 3/1/23 at 3:20 PM, the surveyor interviewed the Medical Director (MD), via telephone, who was the resident's primary care physician. The MD stated he did not have the resident's notes present, but stated he heard the resident's eating had Ex Order 26.4(b)(1) and Ex Order 26.4(b)(1). The MD stated he was unsure why the resident's diet was not changed until 2/22/23, and not after the Ex Order 26.4(b) test on 2/14/23, but stated to call back in thirty minutes.</p> <p>On 3/1/23 at 3:33 PM, the surveyor interviewed the Director of Nursing (DON) who stated that nursing staff, the SLP, or the RD could inform the kitchen of diet changes. The DON stated the nurse called the physician to obtain an order; the nurse completed the Diet Order & Communication form and sent to the kitchen and placed a copy in the resident's paper medical record; put the PO into the computer; and the kitchen changed their diet order to send the appropriate diet. The DON stated the RD was currently out of the building on medical leave that started today, and she was unsure when she would return. The DON stated if the resident had an issue with chewing or swallowing, they would be referred to the SLP. The DON acknowledged it was important to follow a diet; a resident with a history of Ex Order 26.4B1 on Ex Order 26.4B1 and a PO for Ex Order 26.4B1 should receive Ex Order 26.4B1 because Ex Order 26.4B1 could cause Ex Order 26.4B1 or Ex Order 26.4B1 which could cause</p>	F 689			

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F 689	<p>Continued From page 126</p> <p><u>Ex Order 26.4B1</u> or <u>Ex Order 26.4B1</u>. The surveyor asked how the nurse knew a PO was changed, and the DON stated it should be on the twenty-four-hour report and the diet was on the computer in the PO section as well as when administering medications. The DON stated she thought the CNAs had a <u>Ex Order 26.4B1</u> system which provided all the information for the care of the resident, as well as it was indicated on their meal ticket. The surveyor asked who checked the meal trays when they arrived on the nursing floor prior to be delivered to the residents, and the DON stated the CNAs checked the trays with the meal ticket to ensure meal accuracy. At this time, the surveyor requested a copy of the resident's <u>Ex Order 26.4B1</u>, and a copy of the following policies which included the process for physician's orders, <u>Ex Order 26.4B1</u>, and meal ticket changes.</p> <p>On 3/1/23 at 3:52 PM, the surveyor interviewed the MD via telephone who stated he was unsure if the facility had only received the preliminary report on 2/14/23 or the official report, and he was waiting to hear back from the <u>Ex Order 26.4B1</u>. The MD stated he would look into the surveyor's concern and would be in touch the next day.</p> <p>On 3/1/23 at 4:43 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, and Regional DON. The Regional DON stated the facility had no policy for physician's orders; the facility followed standards of practice. The surveyor asked the LNHA if he was aware the facility had no policy for physician's order, and he stated no. The surveyor asked what the standard of practice for physician's orders was, and the Regional DON stated they would need to look it up. The LNHA confirmed the facility had nothing in writing, would</p>	F 689			

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F 689	<p>Continued From page 127</p> <p>be standards of practice. The LNHA confirmed the expectation would be to follow a physician's order. The DON then confirmed there was no policy for obtaining diet orders. The DON confirmed the expectation was the nurse gave kitchen staff a diet order slip and a copy went in the resident's paper medical record. The Administration team confirmed there was no policy for <u>Ex Order 26. 4B1</u> or giving residents food. The DON stated if a diet changed, the same procedure as diet order. The LNHA confirmed the expectation would be to provide the resident with the appropriate consistency of the <u>Ex Order 26. 4B1</u> as ordered.</p> <p>The facility's failure to ensure a resident with a history of <u>Ex Order 26. 4B1</u> on <u>Ex Order 26. 4B1</u> and a physician order for <u>Ex Order 26. 4B1</u> was provided <u>Ex Order 26. 4B1</u> posed a serious and immediate threat for adverse effects, including <u>Ex Order 26. 4B1</u>, which is likely to result in serious harm, impairment, or even death. This resulted in an immediate jeopardy situation. The IJ was identified on 2/22/23, when the resident received a PO for <u>Ex Order 26. 4B1</u>, and the LNHA, DON, and Regional DON was notified of the IJ on 3/1/23 at 4:51 PM.</p> <p>The facility submitted an acceptable written Removal Plan on 3/3/23. The Removal Plan included communication was sent to dietary staff to change Resident #94's to <u>Ex Order 26. 4B1</u>; LPN #1 and CNA #1 were educated on the resident's diet and the importance of meal accuracy; education was provided to staff on <u>Ex Order 26. 4B1</u> and modified diets; a procedure was put into place to ensure residents on modified diets that staff were aware and following physician's orders; and staff were</p>	F 689			

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F 689	<p>Continued From page 128 educated on new procedure.</p> <p>On 3/2/23 at 10:17 AM, the surveyor interviewed the MD who stated after surveyor inquiry, he completed a thorough review of the resident's medical record and spoke with the SLP and Rehab Director. The MD confirmed that the resident had an evaluation <u>Ex Order 26. 4B1</u> on 2/24/23 and returned to the facility that day with a recommendation for <u>Ex Order 26. 4B1</u>. The MD stated since he did not have the actual report just the preliminary report, so he did not want to change the resident's diet until he received the final report. The MD continued that the resident received an evaluation with the SLP on 2/17/23, and on 2/22/23 there was still no final report and the MD felt he could not wait any longer, so he then changed the resident's liquids to <u>Ex Order 26. 4B1</u>. The MD stated since the resident did not want <u>Ex Order 26. 4B1</u>, he delayed the order as well. The MD confirmed he did not document any of this in the resident's medical record. The MD stated the SLP thought it was a good idea for the resident to be on <u>Ex Order 26. 4B1</u>, but <u>Ex Order 26. 4B1</u> but then I did not want to wait any longer. The MD stated the Social Worker (SW) also documented a note in the Progress Notes on 2/22/23, that the resident did not want <u>Ex Order 26. 4B1</u>. The surveyor asked the MD if the expectation was to follow the PO, which the MD confirmed. The MD stated the resident should be on <u>Ex Order 26. 4B1</u> as a precautionary matter. The MD was also unaware that the facility did not have policies for physician's orders, dietary orders, or <u>Ex Order 26. 4B1</u>. The MD stated the facility should have these policies and maybe they were unaware; he also confirmed he did not</p>	F 689			

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F 689	<p>Continued From page 129</p> <p>review facility policies annually, just when the policy was updated.</p> <p>On 3/2/23 at 11:07 AM, the surveyor reviewed the Progress Notes which now included a Late Entry Social Services note created on 3/1/23 at 6:53 PM <u>Ex Order 26. 4B1</u>, and back dated to 2/22/23 at 6:37 PM, to reflect the SW spoke to the resident regarding the PO to change their diet, and the resident stated he/she wanted regular food, coffee, and soda. A review of the facility's "Care Plans - Comprehensive" policy dated revised 11/22/22, included our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative <u>Ex Order 26. 4B1</u>, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident maybe expected to attain...each resident's care plan is designed to: incorporate identified problems; incorporate risk factors associated with identified problems...reflect the resident's expressed wishes regarding care and treatment goals...identify professional services that are responsible for each element of care; aid in preventing and reducing declines in the resident's functional status and/or functional levels...reflect currently recognized standards of practice for problem areas and conditions...assessments of residents are ongoing and care plans are to be revised as information about the resident and resident's condition change...</p> <p>NJAC 8:39-17.4(a)(1)(2); 27.1(a)</p> <p>F689 remains a deficiency at a scope and severity level of a D based on the following:</p>	F 689			

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PRINTED: 09/28/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/09/2023
NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		
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F 689	<p>Continued From page 130 Part B</p> <p>Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to provide the diet ordered of <u>Ex Order 26. 4B1</u> for an observed lunch meal for a resident with a history of <u>Ex Order 26. 4B1</u> on <u>Ex Order</u>. This deficient practice was identified for 1 of 6 residents (Resident #17) reviewed for accidents and was evidenced by the following:</p> <p>On 3/2/23 at 12:44 PM, the surveyor reviewed the facility's List of Residents and Diets for Crosscheck which revealed Resident #17 received a diet of double portions <u>Ex Order 26. 4B1</u> and <u>Ex Order 26. 4B1</u>.</p> <p>On 3/2/23 at 12:45 PM, the surveyor observed the lunch meal trays arrive for the <u>Ex Order 26. 4B1</u> nursing unit North side. The surveyor observed Certified Nursing Aide (CNA #2) perform hand hygiene using alcohol-based hand rub (ABHR) and started to deliver residents' meal trays. CNA #2 informed the surveyor that the nurse needed to check the meal trays to ensure accuracy of the meal tray with the meal ticket prior to delivering them to the residents, but the surveyor did not observe the nurse check the trays. The surveyor observed CNA #2 continue to deliver meal trays to the residents without checking the trays to ensure accuracy.</p> <p>On 3/2/23 at 12:48 PM, the surveyor observed Resident #17 in bed with their lunch meal tray on their overbed table. The resident informed the surveyor that he/she received a diet of <u>Ex Order 26. 4B1</u> and <u>Ex Order 26. 4B1</u>. The resident then informed the surveyor that he/she</p>	F 689			

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F 689	<p>Continued From page 131</p> <p>could not drink the apple juice they received because the juice was a <u>Ex Order 26.4B1</u> and not <u>Ex Order 26.4B1</u> like he/she was supposed to receive. The resident stated this <u>Ex Order 26.4B1</u>. The surveyor asked the resident what he/she did when they received the inappropriate liquids, and the resident stated they <u>Ex Order 26.4B1</u>. At this time, the resident stood up and placed their lunch meal tray on their <u>Ex Order 26.4B1</u> and ambulated to the hallway pushing their <u>Ex Order 26.4B1</u>. In the hallway, the surveyor observed the Director of Nursing (DON) checking meal trays, and the surveyor asked the DON to speak. The resident informed the DON that he/she cannot have this tray. The surveyor asked the DON the consistency of the apple juice on the meal tray, and she responded thin. The surveyor then asked the DON what consistency the resident was on, but the DON was unsure. The surveyor then asked the resident what consistency liquids they were supposed to receive, and he/she stated <u>Ex Order 26.4B1</u>. The surveyor showed the DON the resident's meal ticket, and she confirmed the resident was supposed to receive <u>Ex Order 26.4B1</u> and not the <u>Ex Order 26.4B1</u> on the tray.</p> <p>On 3/2/23 at 12:56 PM, the surveyor observed Licensed Practical Nurse (LPN #2) now checking the residents' lunch meal trays. The surveyor asked if she checked Resident #17's meal tray, and she stated no, she had just started checking trays now.</p> <p>On 3/2/23 at 12:58 PM, the surveyor interviewed CNA #2 who stated she was not the resident's aide, but she delivered their lunch meal tray today. The surveyor asked CNA #2 if she checked the meal tray with the meal ticket prior to</p>	F 689			

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F 689	<p>Continued From page 132</p> <p>delivering the resident's tray, and CNA #2 stated no, LPN #2 checked it. The surveyor asked if she knew what diet the resident was on, and CNA #2 stated <u>Ex Order 26. 4B1</u> with <u>Ex Order 26. 4B1</u>. CNA #2 stated if she was unsure of the resident's diet, she could always look at the resident's meal ticket.</p> <p>On 3/2/23 at 1:00 PM, the surveyor interviewed LPN #2 who stated the resident was on <u>Ex Order 26. 4B1</u> which he/she disliked as well as <u>Ex Order 26. 4B1</u>. The surveyor asked LPN #2 what the process was when meal trays arrived at the floor? LPN #2 responded that whoever the nurse was on the floor checked the meal trays with the meal tickets to ensure accuracy, meaning the diet matched the ticket as well as preferences and dislikes. LPN #2 stated Resident #17's tray came on the first cart, and she was not present when the cart arrived, so she did not check the trays. The surveyor asked what the process was if the nurse was not present, and LPN #2 stated the CNAs or Unit Manager would then check the trays.</p> <p>On 3/2/23 at 1:05 PM, surveyor interviewed the DON who confirmed Resident #17 received the wrong diet. The surveyor asked what the process was when the meal trays arrived on the floor, and the DON responded either the nurse or the CNA checked the trays for accuracy. The DON continued it was okay for the CNAs to check the meal trays because the aides fed the residents, so they were aware of the appropriate consistencies of diets. The surveyor asked the DON if it was okay for a meal tray to be delivered to a resident without being checked, and the DON stated no. The DON stated if the resident's meal tray was incorrect, staff were expected to put the</p>	F 689			

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F 689	<p>Continued From page 133</p> <p>tray aside and call the kitchen to deliver the appropriate meal tray. The surveyor reviewed the medical record for Resident #17.</p> <p>A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in <u>Ex Order 26. 4B1</u> with diagnoses which included <u>Ex Order 26. 4B1</u>.</p> <p>A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated <u>Ex Order 26. 4B1</u>, reflected the resident had a brief interview for mental status (BIMS) score of a <u>Ex Order 26. 4B1</u> out of <u>Ex Order 26. 4B1</u>, which indicated a <u>Ex Order 26. 4B1</u>.</p> <p>A review of <u>Ex Order 26. 4B1</u> revealed the resident had a significant <u>Ex Order 26. 4B1</u> on a prescribed diet and received a mechanically altered diet which required change in texture of food or liquids.</p> <p>A review of the Order Summary Report included a physician's order dated <u>Ex Order 26. 4B1</u>, for a regular diet <u>Ex Order 26. 4B1</u> with <u>Ex Order 26. 4B1</u>.</p> <p>A review of the individualized person-centered care plan included a focus area initiated on <u>Ex Order 26. 4B1</u> and last revised on <u>Ex Order 26. 4B1</u>, that the resident was at <u>Ex Order 26. 4B1</u> related to <u>Ex Order 26. 4B1</u> with diagnoses of <u>Ex Order 26. 4B1</u>.</p> <p>Interventions include to obtain and monitor laboratory/diagnostic work as ordered, report results to physician's and follow up as indicated; provide and serve diet as ordered; provide</p>	F 689			

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F 689	<p>Continued From page 134</p> <p>protein-calorie dense foods with meals - pudding with meals, requests double portions; provide resident food preferences; <u>Ex Order 26.4(b)(1)</u> as ordered; and weight as ordered.</p> <p>On 3/2/23 at 1:36 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, and Regional DON, and the surveyor informed them of the observation with Resident #17 who received <u>Ex Order 26. 4B1</u> and not <u>Ex Order 26. 4B1</u> at lunch today. The DON confirmed this observation. The Regional DON confirmed the facility had no policy regarding <u>Ex Order 26. 4B1</u> or ensuring residents received their diets as ordered. The surveyor asked if there was no policy and procedure, how were staff expected to know what to do? The surveyor received no answer.</p> <p>On 3/3/23 at 9:20 AM, the Regional DON in the presence of the Vice President of Operations (VP of Operations) informed the survey team that the facility as of 3/3/23, will now be adapting and implementing the <u>Ex Order 26. 4B1</u> policy.</p> <p>On 3/3/23 at 10:29 AM, the surveyor interviewed the Rehabilitation Director (Rehab Director) who stated Resident #17 was currently not on <u>Ex Order 26. 4B1</u>. The Rehab Director stated the resident was evaluated by <u>Ex Order 26. 4B1</u> on 12/8/22 after a <u>Ex Order 26. 4B1</u> on 12/6/22. There was a recommendation on 12/8/22, for <u>Ex Order 26. 4B1</u> with <u>Ex Order 26. 4B1</u> for <u>Ex Order 26. 4B1</u> in risk, but the resident refused the diet change. The <u>Ex Order 26. 4B1</u> stated the current <u>Ex Order 26. 4B1</u> (SLP) was not at the facility during</p>	F 689			

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F 689	<p>Continued From page 135</p> <p>this time. The surveyor requested additional information on why the diet was then changed on 1/12/23. A review of the <u>Ex Order 26. 4B1</u> and Plan of Treatment document dated _____, with a recommendation for <u>Ex Order 26. 4B1</u> and <u>Ex Order 26. 4B1</u> with small single sips. The resident currently refusing <u>Ex Order 26. 4B1</u> let with <u>Ex Order 26. 4B1</u>. Nursing, dietary, Physician, Social Worker, and SLP (former) educated resident on health and <u>Ex Order 26. 4B1</u> risk however resident adamantly refusing. Resident will remain on <u>Ex Order 26. 4B1</u> with <u>Ex Order 26.4(b)(1)</u> per physician's orders.</p> <p>The surveyor continued to review the resident's medical record.</p> <p>A review of the Progress Notes did not include documentation as to why the resident's diet was changed on 1/12/23 to <u>Ex Order 26. 4B1</u> with <u>Ex Order 26. 4B1</u>. On 3/3/23 at 10:53 AM, the surveyor interviewed the Food Service Director (FSD) who stated that all diet orders were put into a computer system that printed the resident's diet as well as their likes and dislikes on the meal ticket. The FSD continued that during meal service, there were three dietary aides on the tray line whose job was to check the accuracy of the meal on the tray with the meal ticket. The FSD stated as of yesterday, she was checking all meal trays with their meal tickets to ensure accuracy. The surveyor asked if the FSD checked all the lunch trays yesterday, and the FSD stated yes, she could not explain how Resident #17 received <u>Ex Order 26. 4B1</u>. The FSD stated the facility only had three residents on <u>Ex Order 26. 4B1</u>.</p> <p>On 3/3/23 at 1:28 PM, the surveyor in the presence of the LNHA, Consultant LNHA (Consult</p>	F 689			

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F 689	<p>Continued From page 136</p> <p>LNHA), DON, Regional DON, VP of Operations, and survey team requested additional information on why Resident #17's diet was downgraded on 1/12/23.</p> <p>On 3/6/23 at 11:19 AM, the Regional DON in the presence of the Consult LNHA, DON, and survey team stated she could not provide additional information as to why the resident's diet was downgraded on 1/12/23.</p> <p>On 3/6/23 at 11:28 AM, the surveyor asked the Rehab Director for the additional information requested for Resident #17 as to why the resident's diet was downgraded on 1/12/23, since the resident was adamant on 12/8/22 that the diet was not to change. The Rehab Director stated she could not speak to why it was changed since she did not write the order.</p> <p>On 3/6/23 at 11:58 AM, the Regional DON stated the resident's diet was downgraded on 1/12/23, as the result of <u>Ex Order 26. 4B1</u>. The surveyor asked if the <u>Ex Order 26. 4B1</u> study was the study performed on 12/6/22, or the resident had another study. The Regional DON could not speak to it. The facility provided no additional information.</p> <p>A review of the facility's newly implemented <u>Ex Order 26. 4B1</u> policy implemented 3/3/23, included <u>Ex Order 26. 4B1</u> will be prescribed by the Attending Physician...mechanically altered diets, as well as diets modified for medical or nutritional needs, will be considered <u>Ex Order 26. 4B1</u>. A <u>Ex Order 26. 4B1</u> must be prescribed by the resident's Attending Physician. The physician's diet order should match the terminology used by Food Services...the Food</p>	F 689			

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F 689	Continued From page 137 Service Manager will establish and use a tray identification system to ensure each resident received his or her diet as ordered...	F 689			
F 690 SS=E	NJAC 8:39-17.1(a); 17.4(a)(1)(2); 27.1(a) Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must	F 690			3/31/23

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F 690	<p>Continued From page 138</p> <p>ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, review of medical records and other pertinent facility documentation, it was determined that that facility failed to obtain physician's orders for a resident admitted to the facility with an <u>Ex Order 26. 4B1</u> as well as implement a person-centered Care Plan (CP) for <u>Ex Order</u>. This deficient practice was identified for one (1) of two (2) residents (Resident # 74) reviewed for <u>Ex Order 26. 4B1</u> and was evidenced by the following:</p> <p>According to the Admission Record, Resident #74 was admitted to the facility with the diagnoses which included but was not limited to <u>Ex Order 26. 4B1</u>.</p> <p>The admission Minimum Data Set (MDS-an assessment tool utilized to facilitate the management of care) dated 01/23/2023, indicated that the resident was <u>Ex Order 26. 4B1</u>, required <u>Ex Order 26.4(b)(1)</u> with <u>Ex Order 26. 4B1</u> and had an <u>Ex Order</u>. The resident's CP did not address that the resident had an <u>Ex Order</u>.</p> <p>On 02/22/23 at 10:46 AM, during tour, the surveyor observed Resident # 74 lying in bed with the head of bed up. The resident agreed to be interviewed and was pleasant and cooperative. The surveyor observed that the resident had an <u>Ex Order</u> hanging at the bottom of the bed. The surveyor asked the resident about the <u>Ex Order 26. 4B1</u> and the resident stated that he/she</p>	F 690	<p>F690 SS D</p> <p>Element 1 -Corrective action A physician order for an <u>Ex Order 26. 4B1</u> was obtained for resident (#74); the order included <u>Ex Order 26. 4B1</u> care, size and diagnosis.</p> <p>An <u>Ex Order 26. 4B1</u> was added to the care plan for resident (#74).</p> <p>Element 2 Identification of at Risk Residents</p> <p>All Residents have the potential to be affected by this practice.</p> <p>Element 3 Systemic Changes</p> <p>The Director of Nursing/designee conducted an audit the charts of residents with <u>Ex Order 26. 4B1</u> to ensure care and services are documented with an emphasis on:</p> <ul style="list-style-type: none"> " Physicians <input type="checkbox"/> orders " <u>Ex Order 26. 4B1</u> care plan initiated and updated as appropriate. " Documentation related to urinary output for amount, color, clarity, and presence of sediment is present within the medical record if applicable. <p>Any concerns identified were immediately addressed.</p>		

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F 690	<p>Continued From page 139</p> <p>wanted to know when it could be removed.</p> <p>On 02/23/23 at 09:55 AM, the surveyor observed Resident # 74 sitting up in the wheelchair in his/her room. The surveyor observed the [Ex Order 26.4B1] hanging at the bottom of the [Ex Order 26.4B1] r intact and in a privacy bag. The [Ex Order 26.4B1] that was observed in the [Ex Order 26.4B1] was [Ex Order 26.4B1](1).</p> <p>On 02/23/23 at 10:10 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding the size of the resident's [Ex Order 26.4B1]. In the presence of the surveyor, the LPN looked at the resident's physician's orders in the [Ex Order 26.4B1] (EMR) and stated that there was not a physician's order for the [Ex Order 26.4B1]. The LPN stated that she usually worked at the facility through the agency however, it was a standard of practice to have a physician's order for an [Ex Order 26.4B1] to include [Ex Order 26.4B1] size and type of care required for the [Ex Order 26.4B1].</p> <p>On 02/23/23 at 10:13 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) who stated that she had been employed in the facility for approximately three (3) years. She stated that the process for an IUC was that there should have been a physician's order for the [Ex Order 26.4B1] that included size, [Ex Order 26.4B1] care, and diagnoses. She stated that [Ex Order 26.4B1] care was usually done every shift and that a physician's order was required for [Ex Order 26.4B1] care. The LPN/UM reviewed Resident #74's physician's orders with the surveyor and confirmed that the resident did not have a physician's order for the [Ex Order 26.4B1] or an order for [Ex Order 26.4B1] care. The LPN/UM stated that the resident had an [Ex Order 26.4B1] since his/her admission in [Ex Order 26.4B1]. The LPN/UM stated that it would have been</p>	F 690	<p>The Director of Nursing/designee re-educated licensed nurses with review of facility policy/procedure on foley catheter care and on the components of this regulation with emphasis on ensuring:</p> <ul style="list-style-type: none"> " Physician orders " [Ex Order 26.4B1] care plan initiated and updated as appropriate " Documentation related to urinary output for amount, color, clarity, and presence of sediment is present within the medical record if applicable <p>Newly hired licensed nurses will receive education during orientation, annually and prn.</p> <p>Newly admitted residents will be reviewed in the daily clinical meeting to ensure orders related to [Ex Order 26.4B1] are completed as ordered.</p> <p>Element 4 Quality Assurance</p> <p>The Director of Nursing/designee will conduct a weekly audit x4 weeks and then monthly x 2 months of residents with indwelling catheters to ensure documentation standards surrounding indwelling catheter care is being carried and plan of care is initiated and updated as appropriate.</p> <p>Needed corrections will be addressed as they are discovered. Findings to be reported monthly to QAPI team for review and action as necessary.</p>		

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F 690	<p>Continued From page 140</p> <p>important to include the <u>Ex Order 3</u> on the CP because the plan of care assures that all staff know what type of care was to be provided to the resident.</p> <p>On 02/23/23 at 10:42 AM, the surveyor interviewed the Minimum Data Set Coordinator Registered Nurse (MDSC/RN) who stated that she was an RN however had no responsibility to update the CP. She stated that when she completed the comprehensive admission MDS assessment for Resident #74 on 01/23/23, that specified that the resident had an <u>Ex Order 2</u>, she informed the clinical team to include the LPN/UM and informed them that there was not a physician's order for the <u>Ex Order</u> or <u>Ex Order 26. 4B1</u> care. She stated that she was not aware that a CP was not developed for the <u>Ex Order 26. 4B1</u>. The MDSC/RN stated that the LPN/UM should have updated the CP during care conference. She added that the facility was in the process of educating the nurses about the importance of updating and implementing CPs and there was a Quality Assurance Performance Improvement (QAPI-a data driven and proactive approach to quality improvement) regarding CP.</p> <p>On 02/23/23 at 12:32 PM, the surveyor interviewed the resident's Primary Care Physician and Medical Director (MD) who stated Resident #74 had a diagnoses of <u>Ex Order 26. 4B1</u> and was followed by the <u>Ex Order 26. 4B1</u>. The MD stated that the <u>Ex Order 3</u> should have been changed since the resident had been in the facility but he would have to investigate that. He did confirm that there should have been a physician's order for the <u>Ex Order 26. 4B1</u> and <u>Ex Order 26. 4B1</u> care but that he would have to investigate why there was not.</p> <p>On 02/24/23 at 10:44 AM, the surveyor</p>	F 690	Date of compliance: 3/31/23		

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F 690	<p>Continued From page 141</p> <p>interviewed the Director of Nursing (DON) who stated that Resident #74 was admitted in [REDACTED], with an [REDACTED] and should have had a valid diagnosis documented. She stated that if a resident was admitted with an [REDACTED] and did not have a valid diagnosis that they would have had to begun a [REDACTED] in the facility and obtained a [REDACTED] consult. She then added that if a resident had a valid diagnosis for the [REDACTED] that the facility was required to get a physician's order for the size of the [REDACTED], size of the balloon, and also an order for [REDACTED] care. She also confirmed that the CP should include the [REDACTED] with size and instructions for care of the [REDACTED]. The DON stated that it would be important to have developed a CP so that the staff knew that the resident had a [REDACTED] and what care was required for that resident.</p> <p>On 03/01/23 at 10:50 AM, the Regional Director of Nursing (RDON) stated that the facility did not have a policy on [REDACTED]</p> <p>On 03/01/23 at 10:50 AM, the RDON provided the surveyor with a facility policy titled, "Foley Catheter Management" and dated 01/15/23, which indicated that [REDACTED] changes must be ordered by a physician and irrigations must be ordered by a physician.</p> <p>On 03/01/23 at 10:50 AM, the RDON provided the surveyor with a facility policy titled, "Care Plans-Comprehensive" and dated 11/22/22 which indicated that the facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected</p>	F 690			

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F 690	Continued From page 142 to attain. The policy also indicated that the Care Planning/Interdisciplinary Team was responsible for the review and updating of care plans. The policy further indicated that the comprehensive care plan was designed to reflect treatment goals, timetables and objectives in measurable outcomes and to incorporate identified problem areas.	F 690			
F 755 SS=E	NJAC-8:39-33.2 (c) 5 Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §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. §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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F 755			3/31/23

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F 755	<p>Continued From page 143</p> <p>sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to accurately document for the removal of Ex.Order 26.4(b)(1) inventory. This deficient practice was identified on two of two medication carts for four unsampled residents, (Resident #32, #72, #85, and #116).</p> <p>This deficient practice was evidenced by the following:</p> <p>1.) On 02/22/23 at 12:36 PM, the surveyor reconciled the Ex.Order 26.4(b)(1) inventory on the two (2) North medication cart with Licensed Practical Nurse (LPN)#1. The surveyor observed LPN#1 count three (3) Ex Order 26.4B1 films in individual packages for Resident #32 in the surveyor's presence.</p> <p>A review of Resident #32's Individual Patient Ex.Order 26.4(b)(1) Record revealed that there were four (4) Ex Order 26.4B1 films in inventory. The surveyor observed LPN#1 sign the resident's Individual Patient Ex.Order 26.4(b)(1) Record at that time in front of the surveyor. LPN#1 stated that the medication was administered that morning and should have been signed after she removed the Ex.Order 26.4(b)(1) from inventory.</p> <p>A review of the Resident #32's Ex Order 26.4B1</p>	F 755	<p>F755 SS E</p> <p>Element One - Corrective Action: LPN #1 and LPN #2 signed the declining inventory sheet. LPN #1 and LPN#2 received in-service training related to the proper recording of controlled substances from the narcotic inventory. Although the nurses recorded the drug administration properly on the residents' Medication Administration Record (MAR), both LPNs failed to record the administration of controlled substances to residents on the residents' Individual Controlled Drug Records at the time the controlled substances were administered to the residents. This resulted in discrepancies between the actual on hand inventory of the controlled substance and the inventory amount indicated on the resident's Individual Controlled Drug record. LPN #1 and LPN #2 were instructed by the facility's Director of Nurses (DON) to record all administration of controlled substances at the time the drug was administered in the resident's MAR and the resident's Individual Controlled Drug Record. The in-service was conducted 03/11/2023.</p> <p>The facility's DON and Assistant Director</p>		

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F 755	<p>Continued From page 144</p> <p>Medication Administration Record (MAR) reflected that on 02/22/23 at 0900 (9:00 AM), the resident was administered the medication, [REDACTED].</p> <p>On 02/22/23 at 12:30 PM, the surveyor interviewed the second floor Licensed Practical Nurse/Unit Manager (LPN/UM) who stated the declining inventory sheet (Individual Patient <u>Ex. Order 26.4(b)(1)</u> Drug Record) should reflect the amount of <u>Ex. Order 26.4(b)(1)</u> medication in inventory because the medications were <u>Ex. Order 26.4(b)(1)</u> and needed to be accounted for.</p> <p>2.) On 02/22/23 at 12:53 PM, the surveyor reconciled the <u>Ex. Order 26.4(b)(1)</u> inventory on the three (3) North medication cart with LPN#2. The surveyor observed LPN#2 count 34 [REDACTED] in individual packages for Resident #85 in the surveyor's presence.</p> <p>A review of Resident #85's Individual Patient <u>Ex. Order 26.4(b)(1)</u> Record reflected that there were 35 [REDACTED] in inventory. At that time LPN#2 stated, <u>Ex. Order 26. 4B1</u> [REDACTED].</p> <p>A review of Resident #85's <u>Ex. Order 26. 4B1</u> MAR revealed that on 02/22/23 at 0900, the resident was administered the medication, <u>Ex. Order 26. 4B1</u> [REDACTED].</p> <p>3.) LPN#2 and the surveyor continued the <u>Ex. Order 26.4(b)(1)</u> count. The surveyor observed LPN#2 count 21 <u>Ex. Order 26. 4B1</u> in the medication bingo card for Resident #72.</p> <p>A review of Resident #72's Individual Patient <u>Ex. Order 26.4(b)(1)</u> record revealed the resident had</p>	F 755	<p>of Nurses (ADON) conducted controlled substance reconciliation audits on all medication carts on to identify other medication carts and nurses and potential residents that may be affected by this practice. The audits revealed no other discrepancies in the control substance reconciliations.</p> <p>Element Two - Identification of at Risk Residents: All residents have the potential to be affected by this practice.</p> <p>Element Three <input type="checkbox"/> Systemic Changes The facility's Administrator, DON and ADON reviewed the facility's policies and procedures pertaining to the recording and reconciliation of controlled substances. The policy "Medication Dispensing System Policy and Procedure" was amended to include that "controlled substances shall be documented as given at the time of administration. The administering nurse shall document the time of administration on the resident's MAR and the resident's Individual Patient Controlled Drug Record. An Individual Patient Controlled Drug record shall be used for each controlled substance administered to each resident."</p> <p>The facility's DON and ADON initiated re-education to licensed nurses referencing amended facility policy Medication Dispensing System regarding the proper recording and reconciliation of controlled substance medications to the residents. Nurses will be instructed to</p>		

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F 755	<p>Continued From page 145</p> <p>22 Ex Order 26. 4B1 in inventory. LPN#2 told the surveyor that she, Ex Order 26. 4B1 just popped out the medication from the bingo card for the resident.</p> <p>A review of Resident #72's February 2023 MAR revealed that on 02/22/23 at 0600 (6:00 AM) and on 02/22/23 at 1400 (2:00 PM), the resident was administered the medication, Ex Order 26. 4B1.</p> <p>4.) LPN#2 and the surveyor further continued the Ex Order 26.4(b)(1) count on the 3 North medication cart. The surveyor observed LPN#2 count seven (7) Ex Order 26. 4B1 for Resident #116 in the presence of the surveyor.</p> <p>A review of Resident #116's Individual Patient Ex Order 26.4(b)(1) Drug Record indicated that there were eight (8) Ex Order 26. 4B1 in the Ex Order 26.4(b)(1) inventory.</p> <p>A review of Resident #116's Ex Order 26. 4B1 MAR revealed that on 02/22/23 at 1200 (12:00 PM), the resident was administered the medication, Ex Order 26. 4B1.</p> <p>On 02/22/23 at 1:00 PM, LPN#2 stated that the Ex Order 26.4(b)(1) were supposed to be signed out immediately after dispensing the medication from the Ex Order 26.4(b)(1) inventory for the resident.</p> <p>On 03/06/23 at 11:18 AM, the surveyor made the facility's administrative staff aware of the above concerns. At that time the Director of Nursing (DON) stated that the nursing staff were responsible for signing out the Ex Order 26.4(b)(1) declining inventory sheets when the Ex Order 26.4(b)(1) was removed from inventory.</p>	F 755	<p>record all administration of controlled substances on the residents' MAR and the residents' Individual Patient Controlled Drug record at the actual time the medication was administered. New hires(RN,LPN) are educated on "Medication Dispensing System Policy and Procedure" during facility new/rehire orientation.</p> <p>Element Four - Quality Assurance: To ascertain the effectiveness of the above preventive measures, the facility's DON or designee shall review the MAR and Individual Patient Controlled Drug records for ten randomly selected residents weekly for four weeks and then monthly for three months and reconcile the records to physical counts of the residents' controlled substance medications found in the medication carts. Errors shall be reported to the Administrator for any additional corrective measures. Results will be reported to QAPI team for review and revision as necessary x4 months with potential for extension as determined by QAPI team.</p> <p>Completion Date: 3/31/23</p>		

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F 755	Continued From page 146 A review of the facility's Medication Dispensing System Policy and Procedure, revised September 2020, indicated that, "As specified by federal and state regulations, controlled substances are documented as given at the time of administration." The facility's Medication Dispensing Policy and Procedure did not indicate the process of controlled substances being signed out on the facility's Individual Patient Controlled Drug Record.	F 755			
F 761 SS=D	NJAC 8:39-29.7(c) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761			3/31/23

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F 761	<p>Continued From page 147</p> <p>quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview and review of other pertinent facility documentation, it was determined that the facility failed to secure a medication administration cart during the medication pass that was conducted on 03/02/23. This deficient practice occurred with one (1) of two (2) nurses observed during the medication pass and was evidenced by the following:</p> <p>On 03/02/23 at 08:45 AM, the surveyor walked onto the <u>Ex Order 26.4B1</u> floor and observed an unattended medication cart in the hallway. The surveyor observed that the medication cart was unlocked. The nurse was not visualized by the surveyor anywhere in the hallway. The surveyor stood by the medication cart until the nurse came out of a resident's room. The nurse identified herself as a Licensed Practical Nurse (LPN). The nurse admitted that she should not have left the medication cart unattended/unsecured and out of her sight and that she should have locked the medication cart when she was leaving the medication cart unattended.</p> <p>On 03/03/23 at 1:20 PM, the Licensed Nursing Home Administrator (LNHA) and Regional Director of Nursing (RDON) confirmed that medication carts were to be locked and secured when the medication cart was unattended by the nurse.</p> <p>The surveyor reviewed the facility policy titled, "6.0 Medication Storage" and dated 01/26/23, which indicated that medications will be stored in a manner that maintains the integrity of the</p>	F 761	<p>F761 SS D</p> <p>Element 1 - Corrective Actions On 3/2/2023, LPN (#1) immediately locked the medication cart. LPN #1 was immediately re-educated to keep the medication cart locked at all times when not in use.</p> <p>Element 2 - Identification of at-risk Residents All Residents have the potential to be affected by this practice.</p> <p>Element 3 - Systemic Changes The Director of Nursing/designee conducted an observational audit of medication carts to ensure: " Medication carts are locked when not in use. " Medication carts are locked during med pass.</p> <p>Any concerns identified were immediately addressed.</p> <p>The Director of Nursing/designee re-educated licensed nurses on the components of this regulation with an emphasis on: " Securing a medication administration cart during med pass. " Securing a medication cart when not in use.</p>		

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F 761	Continued From page 148 product, ensures the safety of the customers in accordance with the Department of Health guidelines and are accessible only to licensed nursing and pharmacy personnel. The policy also indicated that with the exception of emergency drug kits and medications requiring refrigeration, all medications will be stored in a locked cabinet, cart, or medication room that is accessible only to authorized personnel, defined by facility policy. NJAC 8:39-29.2(d)	F 761	<p>Newly hired licensed nurses will receive education during orientation.</p> <p>Element 4 - Quality Assurance</p> <p>The Director of Nursing /designee will conduct a weekly audit x4 weeks and then every monthx2 months to ensure: " Medication carts are secure when not in use " Medication carts are secure during med pass</p> <p>Needed Corrections will be addressed as they are discovered.</p> <p>The findings of these audits will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met and recommends moving to quarterly monitoring by the Administrator when completing their quality systems review.</p> <p>Date of compliance:3/31/23</p>		
F 835 SS=K	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 835			3/31/23

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 835	<p>Continued From page 149</p> <p>by: Based on observation, interview, record review, and review of pertinent facility documentation it was determined, that the facility's Licensed Nursing Home Administrator (LNHA) failed to ensure that the facility's policies and procedures were implemented to ensure resident safety and well-being, by failing to: a.) ensure Resident #15 <u>Ex Order 26.4B1</u> was <u>Ex Order 26.4B1</u> from <u>Ex Order 26.4B1</u> from Resident #99 <u>Ex Order 26.4B1</u>, b.) report an actual <u>Ex Order 26.4B1</u> of <u>Ex Order 26.4B1</u> between Resident #15 and Resident #99; Resident #72 and Resident #98; Resident #13 and Resident #26; Resident #63 and Resident #64; Resident #82 and Resident #115; Resident #114 and Resident #320 to the New Jersey Department of Health (NJDOH), and c.) provide safe meal delivery for Resident #94, who was at risk for <u>Ex Order 26.4B1</u> <u>Ex Order 26.4B1</u>, according to the physician prescribed diet order to include <u>Ex Order 26.4B1</u> <u>Ex Order 26.4B1</u>.</p> <p>The LNHA's failure to ensure that the facility's policies and procedures were implemented to ensure resident safety and well-being posed a serious risk of adverse outcome to the resident's residing at the facility and resulted in an Immediate Jeopardy (IJ) situation. The facility's LNHA was made aware of the IJ situation on 03/01/23 at 4:51 PM and an acceptable Removal Plan was received on 03/03/23 at 9:35 AM.</p> <p>The IJ began on 02/04/23 when the facility's LNHA failed to <u>Ex Order 26.4B1</u> Resident #15 <u>Ex Order 26.4B1</u> from <u>Ex Order 26.4B1</u> from Resident #99.</p> <p>The LNHA further failed to notify the NJDOH of the incident between Resident #15 and Resident</p>	F 835	<p>F835 SS K</p> <p>Element One <input type="checkbox"/> Corrective Actions</p> <p>Resident #15 room was <u>Ex Order 26.4B1</u> with his consent.</p> <p>Reportable (AAS45) were completed and reported to NJDOH and Ombudsman office for the following residents:</p> <ul style="list-style-type: none"> " #15 and #98 " #72 and #99 " #114 and #320 " #13 and #26 " #82 and #115 " #64 and #63 <p>" Resident #15 was relocated to another room .</p> <p>" Resident #72 and resident #99 rooms were <u>Ex Order 26.4B1</u> that were available.</p> <p>" Resident # 13 and resident #26 rooms were <u>Ex Order 26.4B1</u> to rooms that were available.</p> <p>" Residents #82 and #115 have since been discharged <u>Ex Order 26.4B1</u></p> <p>" Resident #64 and resident # 63 were <u>Ex Order 26.4B1</u> within the facility on</p> <p>" Residents #114 and #320 have since been discharged <u>Ex Order 26.4B1</u></p> <p>All <u>Ex Order 26.4B1</u> were immediately removed from the room of Resident #94.</p> <p>Resident #94 communication was sent to</p>		

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F 835	<p>Continued From page 150</p> <p>#99 on 02/04/23. A further review of the facility's <u>Ex Order 26. 4B1</u> indicated that the facility failed to report an additional five (5) reportable events involving 10 resident's.</p> <p>The facility's failure to ensure a resident with a history of <u>Ex Order 26. 4B1</u> on <u>Ex Order 26. 4B1</u> and a physician order for <u>Ex Order 26. 4B1</u> was provided <u>Ex Order 26. 4B1</u> posed a serious and immediate threat for adverse effects, including <u>Ex Order 26. 4B1</u>, which was likely to result in serious harm, impairment, or even death.</p> <p>The deficient practice was evidenced by the following:</p> <p>Refer to F600J, F609K, and F689J</p> <p>1.) On 02/22/23 at 12:09 PM, Resident #15 was observed lying in bed. The surveyor interviewed Resident #15 who stated that they were involved in a <u>Ex Order 26. 4B1</u> altercation with their roommate, Resident #99. Resident #15 stated that he/she was <u>Ex Order 26. 4B1</u> when Resident #99 came up to them, <u>Ex Order 26. 4B1</u> him/her in the <u>Ex Order 26. 4B1</u> and stated he/she <u>Ex Order 26. 4B1</u>. Resident #15 further stated the nurses, and the police were notified but felt that the altercation was not handled appropriately. Resident #15 stated upon returning from the <u>Ex Order 26. 4B1</u> he/she did not know why Resident #99 was still their roommate. Resident #15 concluded he/she was very frustrated about the altercation and that they could <u>Ex Order 26. 4B1</u> in their <u>Ex Order 26. 4B1</u>. The resident further stated that he/she was concerned about being in the <u>Ex Order 26. 4B1</u> with Resident #99.</p> <p>Resident #15 <u>Ex Order 26. 4B1</u> was never separated</p>	F 835	<p>dietary department to ensure order was updated to reflect the physicians order of <u>Ex Order 26. 4B1</u>.</p> <p>Element Two <input type="checkbox"/> Identification of at Risk Residents All residents have the potential to be affected by this practice.</p> <p>Element Three <input type="checkbox"/> Systemic Change: The LNHA Consultant, VP of Operations and Regional DON immediately re-in serviced the Administrator and Director of nursing on abuse following the facilities policy:</p> <p>Prohibition of Resident Abuse & Neglect which included:</p> <p>1.The definition of abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and <u>Ex Order 26. 4B1</u>.</p> <p>2.Types of <u>Ex Order 26. 4B1</u>-Physical, verbal, sexual, mental/emotional/<u>Ex Order 26. 4B1</u>, involuntary seclusion, neglect, exploitation, and misappropriation of resident property.</p> <p>3.Prevention which includes employee and volunteer screening, training, which is completed upon hire, and minimally quarterly to employees. Re-education is also completed when/if there is an allegation of <u>Ex Order 26. 4B1</u>.</p> <p>4. Reporting <u>Ex Order 26. 4B1</u> must be</p>		

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F 835	<p>Continued From page 151</p> <p>from Resident #99 <u>Ex Order 26. 4B1</u>. The residents remained in the <u>Ex Order 26. 4B1</u> together.</p> <p>Upon interviews with facility staff and record review there were no prior physical <u>Ex Order 26. 4B1</u> between Resident #15 and Resident #99.</p> <p>A review of the electronic Progress Notes reflected on 02/04/23 at 7:00 AM, Resident #15 <u>Ex Order 26. 4B1</u> was <u>Ex Order 26. 4B1</u> by the roommate Resident #99 <u>Ex Order 26. 4B1</u></p> <p>A review of Resident #15's individualized Care Plan (CP) initiated <u>Ex Order 26. 4B1</u> two (2) days after the <u>Ex Order 26. 4B1</u> occurred, reflected Fear related to recent physical aggression which included the following interventions: A nurse will reassure safety, discuss the reality of the situation while acknowledging what can and cannot be changed to help the patient to feel in control, and reassure the patient that <u>Ex Order 26.4(b)(1)</u> after a traumatic event are normal.</p> <p>On 2/23/23 at 12:41 PM, the surveyor interviewed Resident #99's primary care physician who stated he was informed that the resident had a history of <u>Ex Order 26. 4B1</u> but was unable to specify. He further stated that after the physical altercation between the two residents, they should not have remained in the <u>Ex Order 26. 4B1</u>.</p> <p>A review of Resident #99's <u>Ex Order 26. 4B1</u> medical record did not reflect behavioral interventions after the <u>Ex Order 26. 4B1</u> altercation to prevent <u>Ex Order 26. 4B1</u>.</p> <p>A review of Resident #99's Care plan initiated <u>Ex Order 26. 4B1</u> two (2) days after he/she <u>Ex Order 26. 4B1</u></p>	F 835	<p>reported to immediately to supervisor. The supervisor will then report to the Abuse Coordinator. If the abuse coordinator is unavailable the next highest administrative position is made aware (DON).</p> <p>5. Protection-Immediately remove the resident(s) from the situation, assess and treat, accused employees (if applicable) will be suspended immediately pending further investigation.</p> <p>6. Investigation: a full investigation is completed with a comprehensive review of the situation, interviews with staff, residents, and any witnesses to the event and statements are recorded, statement review, environmental review, and medical record review.</p> <p>7. New hires are trained upon hire during facility orientation, quarterly and prn.</p> <p>The facility adopted Policy Therapeutic Diets and educated staff on policy which includes utilizing a red ticket to alert staff of mechanically altered diet.</p> <p>The Licensed Practical Nurse was re-educated immediately ensuring that physicians' diet orders should be reflected on diet tickets, including red ticket for Mechanically Altered Diets per adopted policy.</p> <p>The Certified Nursing aide was re-educated on confirming the accuracy of the dietary tickets versus items on meal trays to ensure accuracy and safe meal delivery including red ticket for</p>		

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F 835	<p>Continued From page 152</p> <p>Resident #15 in the <u>Ex Order 26. 4B1</u>, reflected Aggression related to behavior disturbances which included the following interventions: The nurse will identify what is not appropriate, such as <u>Ex Order 26. 4B1</u> and <u>Ex Order 26. 4B1</u>, and also what is appropriate, the nurse will provide positive feedback to let client know he/she is meeting expectations, the nurse will recognize behaviors before they become violent and, the nurse will set limits on unacceptable behavior.</p> <p>On 02/22/23 at 3:48 PM, the survey team interviewed the facility's LNHA who stated that his first day working at the facility was 01/23/23. The LNHA stated that there were different types of <u>Ex Order 26. 4B1</u> and <u>Ex Order 26. 4B1</u> was one of them. The LNHA stated that the process when <u>Ex Order 26. 4B1</u> occurred was to isolate the situation and take away the <u>Ex Order 26. 4B1</u>. The LNHA stated "the first thing we do is separate." The LNHA told the surveyors that according to the Federal Regulations the NJDOH should have been notified of the event between Resident #15 and Resident #99 within two (2) hours because <u>Ex Order 26. 4B1</u> had occurred. The LNHA further stated that he wasn't familiar with the investigative findings of the event because nursing handled the situation. The LNHA told the survey team that it was his understanding that there was a <u>Ex Order 26. 4B1</u> altercation, the police were notified and both residents in question did not want to <u>Ex Order 26. 4B1</u>. The LNHA could not speak to why Resident #99 <u>Ex Order 26. 4B1</u> would legally be able to <u>Ex Order 26. 4B1</u> against Resident #15 <u>Ex Order 26. 4B1</u>. The LNHA stated that it was also his understanding that when Resident #15 returned from the <u>Ex Order 26. 4B1</u>, the nurse spoke with both residents and the residents wanted to stay in the room together.</p>	F 835	<p>Mechanically Altered Diets per adopted policy.</p> <p>Kitchen staff were reeducated by the Food Services Director (FSD) and Registered Dietician on the importance of preparing and serving <u>Ex Order 26. 4B1</u>, to include <u>Ex Order 26. 4B1</u>, to residents in a manner consistent with physician prescribed <u>Ex Order 26. 4B1</u>, including red ticket for Mechanically Altered Diets per adopted policy.</p> <p>Newly hired licensed applicable employees will receive education during orientation including, but not limited to <u>Ex Order 26. 4B1</u> and <u>Ex Order 26. 4B1</u>.</p> <p>An audit was completed to ensure physicians orders for diet types were reflective of orders received in the dietary department, by the Regional DON. The LNHA/designee conducted an audit of residents receiving <u>Ex Order 26. 4B1</u> to ensure foods were provided and prepared in a manner consistent with physician prescribed <u>Ex Order 26. 4B1</u>. This audit was reviewed by VP of Operations and all future audits will be reviewed by VP of Operations.</p> <p>Element Four <input type="checkbox"/> Quality Assurance</p> <p>Abuse Coordinator/designee to conduct random audits of residents ensure they</p>		

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F 835	<p>Continued From page 153</p> <p>The LNHA stated that he was the person responsible for making sure that abuse was thoroughly investigated in the facility.</p> <p>On 03/06/23 at 11:00 AM, the Consultant LNHA in the presence of the survey team, DON and Regional DON acknowledged that Resident #15 and Resident #99 should have been separated after the [Ex Order 26. 4B1]. The Consultant LNHA stated that there was a lack in the investigation and reporting process regarding [Ex Order 26. 4B1].</p> <p>A review of the facility's Abuse Coordinator job description, signed by the LNHA on 01/23/23, included the following: "1. The Administrator has the overall responsibility for the coordination and implementation for our facility's abuse prevention program. 2. The Abuse Coordinator will oversee, and delegate education and in-services related to allegations of abuse, identifying abuse and reporting abuse."</p> <p>2.) The facility failed to report actual [Ex Order 26. 4B1] of [Ex Order 26. 4B1] for Resident #15 [Ex Order 26. 4B1], Resident #26 [Ex Order 26. 4B1], Resident #63 [Ex Order 26. 4B1], Resident #72 [Ex Order 26. 4B1], Resident #82 [Ex Order 26. 4B1], and Resident #114 [Ex Order 26. 4B1] NJDOH.</p> <p>On 2/4/23, Resident #99 [Ex Order 26. 4B1] [Ex Order 26. 4B1] Resident #15 [Ex Order 26. 4B1] in the [Ex Order 26. 4B1]. Resident #15 was sent to the [Ex Order 26. 4B1] for an evaluation and the police were called on 2/4/23.</p> <p>On Wednesday 2/22/22, Resident #15 told the surveyor that Resident #99 [Ex Order 26. 4B1] him/her in the [Ex Order 26. 4B1]. Resident #15 stated that he/she did not understand why Resident #99 was still their roommate and stated that he/she still felt the</p>	F 835	<p>feel [Ex Order 26. 4B1] against [Ex Order 26. 4B1] weekly x4, monthly x2.</p> <p>Abuse Coordinator/designee to conduct random audits of staff to ensure staff aware of how to recognize and respond to abuse.</p> <p>Regional Administrator/Regional Nurse to review incident reports weekly x 4, then monthly x 2 to ensure any allegations of abuse are being properly identified and reported.</p> <p>Regional Administrator/Regional DON will have oversight on these audits.</p> <p>Administrator/designee will conduct a daily audit of residents receiving mechanically altered diets to ensure foods were provided and prepared in a manner consistent with physician prescribed mechanically altered diets, daily x 14 days, followed by weekly x 4 and monthly x 3.</p> <p>Regional Administrator/Regional DON will have oversight on these audits.</p> <p>Needed corrections will be addressed as they are discovered. Findings to be reported monthly to QAPI team for review and action as necessary x3 months with potential for extension based on QAPI team recommendations.</p> <p>Date of compliance: 3/31/23</p>		

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F 835	<p>Continued From page 154</p> <p><u>Ex Order 26. 4B1</u> and was concerned about being in the <u>Ex Order 26. 4B1</u> with Resident #99.</p> <p>Upon interviews with facility staff, it was identified that the facility staff did not report the <u>Ex Order 26. 4B1</u> to the NJDOH but should have.</p> <p>On Wednesday 2/15/23, Resident #98 <u>Ex Order 26. 4B1</u> Resident #72 <u>Ex Order 26. 4B1</u> with a <u>Ex Order 26. 4B1</u> on the <u>Ex Order 26. 4B1</u>. The resident was sent to the <u>Ex Order 26. 4B1</u> for evaluation and the police were called on 02/15/23.</p> <p>On 02/22/23 at 10:57 AM, the surveyor interviewed Resident #72 who stated that Resident #98 <u>Ex Order 26. 4B1</u> him/her with a <u>Ex Order 26. 4B1</u> three (3) times on the <u>Ex Order 26. 4B1</u>. Resident #72 showed the surveyor <u>Ex Order 26. 4B1</u> that were sustained on the <u>Ex Order 26. 4B1</u> which consisted of <u>Ex Order 26. 4B1</u> and <u>Ex Order 26. 4B1</u> on the top of the <u>Ex Order 26. 4B1</u>. Resident #72 stated that he/she did not have a <u>Ex Order 26. 4B1</u> of the <u>Ex Order 26. 4B1</u> where the <u>Ex Order 26. 4B1</u> were but stated that he/she was so angry about the other resident <u>Ex Order 26. 4B1</u> him/her with the <u>Ex Order 26. 4B1</u>, that he/she went into the dayroom and punched the wall with his/her <u>Ex Order 26. 4B1</u> resulting in a <u>Ex Order 26. 4B1</u> of the <u>Ex Order 26. 4B1</u>. He/she did admit that this <u>Ex Order 26. 4B1</u> to the <u>Ex Order 26. 4B1</u> was <u>Ex Order 26. 4B1</u>.</p> <p>Upon review of the Resident #72's Brief interview for Mental Status (BIMS) score of <u>Ex Order 26. 4B1</u>, the resident was <u>Ex Order 26. 4B1</u>. Upon review of Resident #98's BIMS score of <u>Ex Order 26. 4B1</u>, this resident was also <u>Ex Order 26. 4B1</u>.</p> <p>Upon interviews with facility staff, it was identified that the facility staff did not report the <u>Ex Order 26. 4B1</u> to the NJDOH but</p>	F 835			

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F 835	<p>Continued From page 155 should have.</p> <p>On 02/24/23 at 12:12 PM, the LNHA provided three (3) Reportable Event Record/Reports which included the <u>Ex Order 26. 4B1</u> between Resident #15 and Resident #99. The LNHA stated those were the only three (3) incidents in the last three (3) months.</p> <p>A further review of the Reportable Event Record/Report form reflected that the 02/04/23 <u>Ex Order 26. 4B1</u> between Resident #15 and Resident #99 was not reported until 02/23/23.</p> <p>The surveyor reviewed the incident Audit Tool dated 2/23/23, which reflected the following:</p> <p>A review of the Audit Tool dated 2/23/23, reflected the following:</p> <p>-2/3/23 Resident #114 <u>Ex Order 26. 4B1</u> and Resident #320 <u>Ex Order 26. 4B1</u>. Verbal aggression; <u>Ex Order 26. 4B1</u>; reported- no; comments - will report.</p> <p>-2/4/23 Resident #13 <u>Ex Order 26. 4B1</u> and Resident #26 <u>Ex Order 26. 4B1</u>. Physical aggression; <u>Ex Order 26. 4B1</u>; reported - no; comments - will report.</p> <p>-2/5/23 Resident #82 <u>Ex Order 26. 4B1</u> and Resident #115 <u>Ex Order 26. 4B1</u>. Physical aggression; <u>Ex Order 26. 4B1</u>; reported - no; comments - will report.</p> <p>-2/7/23 Resident #64 <u>Ex Order 26. 4B1</u>. Physical aggression; <u>Ex Order 26. 4B1</u>; reported - no; comments - will report. Resident #63 <u>Ex Order 26. 4B1</u> was not listed on the facility's audit tool.</p> <p>On 02/28/23 at 10:52 AM, the survey team interviewed the DON in the presence of the Regional DON (RDON) and the LNHA who stated that she was still learning the progress but that she was responsible for filling out the audit tool for <u>Ex Order 26. 4B1</u>. The DON further stated that the</p>	F 835			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 835	<p>Continued From page 156</p> <p>Regional Nurse/Infection Preventionist (RN/IP), had filled out the audit tool that was provided to the survey team. At that time, the LNHA stated for the incidents listed on the audit tool he did not report at the time of the incidents. He further stated that he did not report them until yesterday 2/27/23.</p> <p>On 2/3/23 at 8:22 PM, Resident #114 stated that he/she had a prior incident with Resident #320 and that Resident #320 came into their room. Resident #114 stated he/she felt <u>Ex Order 26. 4B1</u> 911 was called.</p> <p>On 2/4/23 at approximately 3:30 PM, Resident #26 stated that they were <u>Ex Order 26. 4B1</u> by their roommate Resident #13. Resident #26 stated he/she was <u>Ex Order 26. 4B1</u> in the <u>Ex Order 26. 4B1</u>. An <u>Ex Order 26. 4B1</u> was done, and no injuries were identified.</p> <p>On 2/5/23 at 10:14 PM, Resident #82 was <u>Ex Order 26. 4B1</u> by their roommate Resident #115. Police were called and Resident #115 was taken to <u>Ex Order 26. 4B1</u>. <u>Ex Order 26. 4B1</u> were noted.</p> <p>On 2/7/23 at approximately 11:40 AM, Resident #64 <u>Ex Order 26. 4B1</u> Resident #63 with a <u>Ex Order 26. 4B1</u> <u>Ex Order 26. 4B1</u> were noted.</p> <p>On 2/28/23 at 10:52 AM, the Licensed Nursing Home Administrator (LNHA) stated he reported the above listed <u>Ex Order 26. 4B1</u> on 2/27/23.</p> <p>Upon interviews with facility staff, it was identified that the facility staff did not report the <u>Ex Order 26. 4B1</u> to the NJDOH but should have.</p> <p>On 02/24/23 at 10:52 AM, the surveyor</p>	F 835			

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F 835	Continued From page 157 interviewed the DON who stated that she was made aware of the altercation between Resident #72 and Resident #98, and she investigated the incident. She stated that it was not reported to her that Resident #98 had ^{Ex Order 26.4B1} Resident #72 with a ^{Ex Order 26.4B1} , and she was not aware that this was a ^{Ex Order 26.4B1} altercation. She stated that she thought that the altercation between the two residents was just a ^{Ex Order 26.4B1} altercation. She stated that she investigated the ^{Ex Order 26.4B1} but could not speak to why she did not know that Resident #72 was struck with a ^{Ex Order 26.4B1} by Resident #98 and had ^{Ex Order 26.4B1} his/her ^{Ex Order 26.4B1} . The DON further stated that the LNHA and the DON were responsible to make sure that the investigation was complete and thorough. She stated that when both the residents returned from the ^{Ex Order 26.4B1} that Resident #98 ^{Ex Order 26.4B1} was moved to a different hallway and away from Resident #72 ^{Ex Order 26.4B1} . She stated that both residents were seen by the ^{Ex Order 26.4B1} . The DON did not have an answer to as why the Care plan (CP) was not updated after the altercation to include these behaviors or why interventions were not implemented on the CP for Resident #98's or Resident #72's. The DON also revealed that she did not know if the altercation between the two residents was reported to the NJDOH. She stated that she did not interview Resident #98 because the resident had ^{Ex Order 26.4B1} and ^{Ex Order 26.4B1} and she did not think that this resident would be reliable. The DON further revealed that she did not interview Resident #72 regarding the altercation because the resident was ^{Ex Order 26.4B1} . She explained that the resident did not ^{Ex Order 26.4B1} ^{Ex Order 26.4B1} however Resident #72 was ^{Ex Order 26.4B1} and she did not think if she interviewed him/her that he/she would be reliable. The DON also did not have a response as to why	F 835			

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F 835	<p>Continued From page 158</p> <p>there were no skin assessment done on either resident after the altercation and did not know that Resident #72 suffered ^{Ex Order 26.4(B)(1)} on his/her ^{Ex Order 26} after being ^{Ex Order 26} by Resident #98's ^{Ex Order 26}.</p> <p>On 02/24/23 at 11:07 AM, the surveyor interviewed the LNHA who stated he was aware that there was "some sort" of altercation between Resident # 72 and Resident #98 however was not aware there was an actual ^{Ex Order 26.4B1} with a ^{Ex Order 26} to Resident #72 ^{Ex Order 26.4B1}. The LNHA stated that the nursing administration was responsible to investigate and conduct a thorough and complete investigation. The LNHA confirmed that the incident was not reported to the NJDOH. The LNHA did not have an answer as to why the DON did not interview Resident #72 or Resident #98 during her investigation and the LNHA was not aware that Resident #72 suffered ^{Ex Order 26.4(B)(1)} to his/her ^{Ex Order 26.4B1} during the altercation with Resident #98.</p> <p>The surveyor reviewed the facility policy titled, "Incident/Occurrence Investigation Policy" dated 05/22/22, which indicated that all ^{Ex Order 26.4B1} of ^{Ex Order 26.4B1}, mistreatment, or neglect of a resident by staff, other residents, visitors, etc. will be investigated. The procedures were as follows according to the facility policy:</p> <ul style="list-style-type: none"> -Following the occurrence or notification or complaint the Registered Nurse Manager or Registered Nurse Supervisor will submit to the DON, a copy of the accident/report with staff members statements. -The DON-nursing/designee will promptly notify the Administrator that the investigation has occurred. -Nursing Administration or Social Services will conduct their initial investigation and review all 	F 835			

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F 835	<p>Continued From page 159</p> <p>pertinent documentation related to the event within 24 hours.</p> <p>-A summary will of the investigation will be documented and the Administrator, DON-nursing designee will meet to review the summary of the investigation to decide if an event is reportable to the NJDOH. The medical director and social services may be asked to participate in the decision-making process depending on the type of event that has occurred.</p> <p>-The Administrator, DON-Nursing designee will notify the DOH when applicable.</p> <p>3.) On 03/01/23 at 12:16 PM, the surveyor observed Resident #94 in bed with two unopened apple juices and one opened twenty-four-ounce bottle of soda. The resident stated the liquids were thin; he/she drank <u>Ex Order 26. 4B1</u>.</p> <p>On 03/01/23 at 12:26 PM, the surveyor observed the resident's Certified Nursing Aide (CNA) deliver the resident's lunch meal tray which contained a <u>Ex Order 26. 4B1</u> with apple juice that CNA confirmed was <u>Ex Order 26. 4B1</u>.</p> <p>Interview with both the resident's CNA and Licensed Practical Nurse (LPN) revealed the resident was on a <u>Ex Order 26. 4B1</u>. Review of resident's medical record reflected a Progress Note dated 02/14/23, that the resident returned from an appointment with <u>Ex Order 26. 4B1</u> on <u>Ex Order 26. 4B1</u> and penetration <u>Ex Order 26. 4B1</u> of the lungs on <u>Ex Order 26. 4B1</u>.</p> <p>A review of the physician's orders (PO) revealed a PO dated 02/22/23 for <u>Ex Order 26. 4B1</u>.</p> <p>Interview with the <u>Ex Order 26. 4B1</u></p>	F 835			

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F 835	<p>Continued From page 160</p> <p>(SLP) indicated the resident had a <u>Ex Order 26. 4B1</u> performed on <u>Ex Order 26. 4B1</u>, with the results of <u>Ex Order 26. 4B1</u> on <u>Ex Order 26. 4B1</u> and penetration of the lungs on <u>Ex Order 26. 4B1</u>. The SLP stated the resident was picked up by <u>Ex Order 26. 4B1</u> on <u>Ex Order 26. 4B1</u> to improve <u>Ex Order 26.4(b)(1)</u> <u>Ex Order 26. 4B1</u> and should have been started on <u>Ex Order 26. 4B1</u> on <u>Ex Order 26. 4B1</u>.</p> <p>Interview with the dietary staff revealed there was no communication with them for the resident's diet change.</p> <p>Follow-up observation with LPN confirmed the resident had <u>Ex Order 26. 4B1</u> present in their room. LPN verified the PO and confirmed the resident had a PO dated 02/22/23 for <u>Ex Order 26. 4B1</u>.</p> <p>On 3/1/23 at 1:47 PM, the SLP provided the surveyor with the resident's <u>Ex Order 26. 4B1</u> notes. The SLP stated that she had only been at the facility for three weeks now but did evaluate Resident #94 who was referred to her after a <u>Ex Order 26. 4B1</u>. The SLP stated on <u>Ex Order 26.4B1</u>, the resident received a <u>Ex Order 26. 4B1</u> which was a <u>Ex Order 26. 4B1</u> on <u>Ex Order 26. 4B1</u>, which meant liquids went into the windpipe. The SLP stated that there was also penetration of the <u>Ex Order 26.4(b)(1)</u> with <u>Ex Order 26. 4B1</u>, which meant liquid went into the <u>Ex Order 26.4(b)(1)</u> when the resident had <u>Ex Order 26. 4B1</u>. The surveyor asked if penetration of the <u>Ex Order 26.4(b)(1)</u> was bad, and the SLP stated <u>Ex Order 26. 4B1</u> because it could cause <u>Ex Order 26. 4B1</u> continuing with <u>Ex Order 26. 4B1</u>. The SLP stated the purpose of <u>Ex Order 26. 4B1</u> was to teach the resident techniques to block the airway to tolerate</p>	F 835			

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F 835	<p>Continued From page 161</p> <p>the <u>Ex Order 26. 4B1</u> so that was why <u>Ex Order 26. 4B1</u> were recommended. The SLP stated she thought the resident was already on <u>Ex Order 26. 4B1</u> when she started at the facility on 2/14/23, and the resident was evaluated on 2/17/23 by her. The SLP stated the resident at this time would not be a candidate for <u>Ex Order 26. 4B1</u> because of the <u>Ex Order 26. 4B1</u> risk.</p> <p>On 3/1/23 at 3:05 PM, the surveyor conducted a follow up interview with the SLP and asked the SLP when Resident #24 should have started on <u>Ex Order 26. 4B1</u>. She responded on 2/14/23 when the resident was seen by the <u>Ex Order 26. 4B1</u> SLP. At this time, the Rehab Director stated that <u>Ex Order 26. 4B1</u> picked the resident up at that time and gave the Registered Dietician the referral as well.</p> <p>On 3/1/23 at 4:43 PM, the survey team met with the LNHA, Director of Nursing (DON), and Regional DON. The Regional DON stated the facility had no policy for physician's orders; the facility followed standards of practice. The surveyor asked the LNHA if he was aware the facility had no policy for physician's order, and he stated no. The surveyor asked what the standard of practice for physician's orders was, and the Regional DON stated they would need to look it up. The LNHA confirmed the facility had nothing in writing, would be standards of practice. The LNHA confirmed the expectation would be to follow a physician's order. The DON then confirmed there was no policy for obtaining diet orders. The DON confirmed the expectation was the nurse gave kitchen staff a diet order slip and a copy went in the resident's paper medical record. The Administration team confirmed there was no policy for therapeutic diets or giving residents food. The DON stated if a diet</p>	F 835			

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F 835	<p>Continued From page 162</p> <p>changed, the same procedure as diet order. The LNHA confirmed the expectation would be to provide the resident with the appropriate consistency of the therapeutic diet as ordered.</p> <p>A review of the facility's newly implemented "Therapeutic Diets" policy implemented 3/3/23, included therapeutic diets will be prescribed by the Attending Physician...mechanically altered diets, as well as diets modified for medical or nutritional needs, will be considered "therapeutic diets." A therapeutic diet must be prescribed by the resident's Attending Physician. The physician's diet order should match the terminology used by Food Services...the Food Service Manager will establish and use a tray identification system to ensure each resident received his or her diet as ordered...</p> <p>A review of the Administrator Job Description, signed by the LNHA on 01/23/23, included the following: "The Administrator establishes, directs and is responsible for the overall operation of the Facility's internal and external activities and works to ensure regulatory and corporate compliance, quality assurance, and the fiscal viability of the facilityResponsible for the overall organization and management of the facilityMaintains a fundamental knowledge and awareness of the status of all residents.....Develops, revises, and implements policies and procedures to enhance service provision and operations.....Protects residents' rights and develops mechanisms for protection....Ensures accurate documentation, implementation, and compliance of all issues."</p> <p>N.J.A.C. 8:39-9.2(a)</p>	F 835			

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F 842 F 842 SS=E	Continued From page 163 Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners,	F 842 F 842			3/31/23

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F 842	<p>Continued From page 164</p> <p>medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <ul style="list-style-type: none"> (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. <p>§483.70(i)(5) The medical record must contain-</p> <ul style="list-style-type: none"> (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and review of the medical record and other facility documentation, it was determined that the facility failed to maintain medical records accurately and completely in accordance with acceptable standards and practices for one (1) of 26 residents reviewed (Resident #119). This deficient practice was evidenced by the following:</p>	F 842	<p>F842 SS-E</p> <p>Element One - Corrective Action:</p> <p>Resident #119 was admitted to the facility on <u>Ex Order 26. 4B1</u> from a local <u>Ex Order 26. 4B1</u>. The resident was discharged against medical advice (<u>Ex Order 26. 4B1</u>) on <u>Ex Order 26. 4B1</u>. The resident was re-admitted <u>Ex Order 26. 4B1</u>, and discharged <u>Ex Order 26. 4B1</u> on <u>Ex Order 26. 4B1</u>.</p>		

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F 842	<p>Continued From page 165</p> <p>The Admission Record dated 03/03/23 at 10:37 AM, indicated that Resident #119 was admitted to the facility on <u>Ex Order 26. 4B1</u> with the diagnoses which included but was not limited to, <u>Ex Order 26. 4B1</u> <u>Ex Order 26. 4B1</u>.</p> <p>The surveyor reviewed the resident census history (RCH) section of the facility's electronic medical record (EMR) which indicated that Resident #119's billing cycle ended on <u>Ex Order 26. 4B1</u> and then restarted on <u>Ex Order 26. 4B1</u>.</p> <p>The surveyor reviewed Resident #119's nursing progress notes (PN) and there was no documentation on <u>Ex Order 26. 4B1</u> that the resident was admitted to the facility, nor was there any documentation on <u>Ex Order 26. 4B1</u> in the PN that the resident was discharged from the facility.</p> <p>On 03/03/23 at 10:16 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that when she reviewed Resident #119's RCH in the EMR it indicated that Resident #119 was admitted to the facility on <u>Ex Order 26. 4B1</u> and discharged on <u>Ex Order 26. 4B1</u>. The ADON stated that she didn't know why there was no nursing documentation in the resident's medical record regarding the resident's admission to the facility on <u>Ex Order 26. 4B1</u> or why there was no nursing documentation regarding the resident's discharge on <u>Ex Order 26. 4B1</u>. She stated that it was the nurse's responsibility to write an admission note when the resident entered the facility and a discharge note when the resident discharged.</p> <p>The surveyor reviewed the Minimum Data Set (MDS-an assessment tool utilized to facilitate the</p>	F 842	<p>The facility's DON and Assistant Director of Nurses (ADON) conducted an audit on those residents who had multiple admission and discharges during a short length of stay and those residents who were discharged <u>Ex Order 26. 4B1</u> to determine the adequacy of the documentation of the residents' medical records. No other residents were identified to be affected by this deficient practice.</p> <p>Element Two- Identification of at Risk Residents: All residents have the potential to be affected by this practice.</p> <p>Element Three <input type="checkbox"/> Systemic Change The facility's Administrator, DON and ADON reviewed the facility's policies and procedures pertaining to the clinical charting and documentation for nurses and social workers. The policy provides guidance to nurses and social workers for charting and documentation purposes for new admissions, re-admissions, residents with changes in conditions, MDS documentation, and required discharge documentation including documentation for residents who were discharged <u>Ex Order 26. 4B1</u>.</p> <p>The facility's DON and ADON shall provide in-service training to all nurses, social workers, therapists, and dieticians regarding the facility's clinical charting and documentation policies. Specifically, the in-service shall focus on the need for proper documentation for re-admitted residents and those residents that were discharged against medical advice.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/28/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/09/2023
NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 842	<p>Continued From page 166</p> <p>management of care) section of Resident #119's EMR and there was no documentation that an ^{Ex Order 26.4B1} MDS was completed that would have indicated that the resident was admitted to the facility. There was also no "discharge" MDS completed that would have indicated that the resident was discharged from the facility.</p> <p>On 03/03/23 at 10:26 AM, the surveyor interviewed the Admissions Director (AD) who stated that according to the census and billing section of the EMR, Resident # 119 re-entered the facility on ^{Ex Order 26.4B1} and then discharged ^{Ex Order 26.4B1} on ^{Ex Order 26.4B1}.</p> <p>On 03/03/23 at 10:28 AM, the surveyor interviewed the Registered Nurse MDS Coordinator (RN/MDSC) who stated that she was not aware that the resident was admitted to the facility on ^{Ex Order 26.4B1} and was not aware that the resident discharged from the facility on ^{Ex Order 26.4B1} because there was no documentation in the resident's medical record. The RN/MDSC explained that the process for MDS completion for admissions and discharges was that she would usually check the "dashboard section" of the EMR which would provide information regarding admissions and discharges. She stated that she thought that there was a communication error and thought that maybe she missed the fact that the resident was admitted on ^{Ex Order 26.4B1} and discharged on ^{Ex Order 26.4B1}. The RN/MDSC did confirm the entry MDS and discharge MDS was not completed as required. The RN/MDSC explained that when a resident was admitted to the facility that the nurses were to perform a nursing admission assessment and write an admission note which would include the resident's medical conditions, vital signs (VS),</p>	F 842	<p>Element Four - Quality Assurance: To ascertain the effectiveness of the above preventive measures, the facility's DON or designee shall review the clinical records for all new admissions and re-admitted residents as well as discharged residents weekly for a period of four weeks and then monthly for a period of three months. Needed corrections will be addressed as they are discovered. Thereafter the review of clinical records for new and re-admitted residents and discharge residents shall be part of the QAPI process.</p> <p>Completion Date: 3/31/23</p>		

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F 842	<p>Continued From page 167</p> <p>cognitive status and perform a body system check. She further revealed that the nurses were also responsible to complete a discharge summary and obtain a physician's order for discharge. She added that the Social Worker was required to write a discharge summary.</p> <p>On 03/03/23 at 11:29 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) for the [REDACTED] floor who stated that he only remembered Res #119's ethnicity and no other details. The LPN/UM explained when a resident was admitted to the facility that the nurses' responsibilities included that a resident assessment was completed, a head-to-toe body assessment was documented, an admission assessment was performed, and that the nursing admission was documented in the PN. He stated that if a resident discharged [REDACTED] the nurse had to notify the MD. He explained that if the resident was alert and oriented to person, place, and time and wanted to leave the facility [REDACTED], then they could leave at their will and if the resident was confused that the police and family would have been notified because it would not have been safe for the resident. He stated that it would have been the nurse's responsibility to have documented in the PN what occurred when the resident discharged [REDACTED].</p> <p>On 03/03/23 at 12:38 PM, the surveyor interviewed the Director of Social Work (DSW) who stated that when a resident wanted to discharge from the facility [REDACTED] and was alert and oriented, the discharge [REDACTED] would be explained to the resident that no durable medical equipment would be ordered, no referrals for extra services would be ordered and no prescriptions would be</p>	F 842			

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NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		
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F 842	<p>Continued From page 168</p> <p>provided to the resident discharging [REDACTED]. The facility would also have the resident sign an [REDACTED] form which would have gone into the resident's medical record. She explained that the [REDACTED] form indicated that the resident understood the risk and consequences that could occur when leaving the facility against medical advice. The DSW also explained that it depended on the time of day and what staff was available, but all nurses in the facility were aware of the [REDACTED] procedure and were aware that the resident had to sign an [REDACTED] form before leaving the facility. The nurse would have notified the Assistant Director of Nursing (ADON) or Director of Nursing (DON) that the resident was leaving the facility [REDACTED]. She stated that if a resident discharged from the facility [REDACTED] that the SW was not required to do a discharge summary. She then added that the nurse should have written a note regarding Resident #119 being discharged [REDACTED] in the progress notes. The SW stated that she would have obtained the signed [REDACTED] forms for Resident #119 in the closed medical records.</p> <p>On 03/06/23 at 10:45 AM, the Licensed Nursing Home Administrator (LNHA) confirmed that there was no documentation on [REDACTED] in the PN regarding Resident #119's admission to the facility. The LNHA provided the surveyor a PN dated [REDACTED] at 12:44 PM that addressed that Resident #119 was a re-admit day [REDACTED] to the facility. The LNHA stated that there was no admission assessment done because it was unclear if the resident was discharged on [REDACTED]. He also added that he was unsure if the resident was a re-admission and wasn't sure what should have been done. The LNHA provided the surveyor with a late discharge SW note dated [REDACTED] at 17:42 (05:42 PM). The LNHA</p>	F 842			

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F 842	<p>Continued From page 169</p> <p>explained that the process for residents wanting to leave [REDACTED] was that the nurse had to have the resident sign the [REDACTED] form and document a note as to why the resident left the facility [REDACTED]. He stated that when the administration reviewed Resident #119's medical record that the "only thing we saw was the nurse documented a readmission note on [REDACTED]."</p> <p>The surveyor reviewed the [REDACTED] form dated [REDACTED] at 05:52 PM which indicated that the resident refused to sign. There is also no signature in the "witness" section of this form.</p> <p>The surveyor reviewed the undated facility policy titled, "Admissions to the facility" which did not include the responsibilities of the nursing staff or SW on documentation expectations upon resident's admission to the facility.</p> <p>The surveyor reviewed the undated facility policy titled, "Discharging a resident without physician approval/against Medical Advice" which indicated that a physician's order should be obtained for all resident discharges.</p> <p>-The order for discharge must be signed and dated by the physician and recorded in the resident's medical record no later than 72 hours after discharge.</p> <p>-Should the resident or legal representative (sponsor) insist upon discharge without the approval of the attending physician, the resident and/or representative (sponsor) must sign a release of responsibility/against medical advice form. Should either party refuse to sign the release, such refusal must be documented in the resident's medical record and witnessed by a staff member.</p>	F 842			

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F 842	Continued From page 170 NJAC 8:39- 11.1, 35.2 (d)(5)	F 842			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/09/2023
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MAJESTIC CENTER FOR REHAB & SUB-ACUT

**TWO COOPER PLAZA
CAMDEN, NJ 08103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments THE FACILITY WAS IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/01/23

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315205	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 4/27/2023	Y3
NAME OF FACILITY MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584	Correction	ID Prefix F0600	Correction	ID Prefix F0607	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.12(a)(1)	Completed	Reg. # 483.12(b)(1)-(5)(ii)(iii)	Completed
LSC	03/31/2023	LSC	03/31/2023	LSC	03/31/2023
ID Prefix F0609	Correction	ID Prefix F0610	Correction	ID Prefix F0642	Correction
Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.20(h)-(j)	Completed
LSC	03/31/2023	LSC	03/31/2023	LSC	03/31/2023
ID Prefix F0656	Correction	ID Prefix F0658	Correction	ID Prefix F0689	Correction
Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	03/31/2023	LSC	03/31/2023	LSC	03/31/2023
ID Prefix F0690	Correction	ID Prefix F0755	Correction	ID Prefix F0761	Correction
Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	03/31/2023	LSC	03/31/2023	LSC	03/31/2023
ID Prefix F0835	Correction	ID Prefix F0842	Correction	ID Prefix	Correction
Reg. # 483.70	Completed	Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. #	Completed
LSC	03/31/2023	LSC	03/31/2023	LSC	
REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 3/9/2023		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/27/2023
NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUT			STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		
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{S 000}	Initial Comments	{S 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		
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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 03/08/2023 and 03/09/2023 and Majestic Center Rehab. and Sub-Acute Care was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies.	K 000			
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 03/08/2023 in the presence of facility management, it was determined that the facility failed to: 1.) Provide a battery backup emergency light above one (1) of one (1) emergency generator transfer switch, independent of the building's electrical system and emergency generator and 2.) provide a functioning battery back up emergency light above the emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1.	K 291	K291 Element One - Corrective Action: The facility installed a battery backup emergency light above the emergency generator transfer switch. The light is independent of the building's electrical system and emergency generator. The facility repaired the battery backup emergency light located above the emergency generator. The installation of the new light and the repair of the existing		3/31/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/02/2023

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

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K 291	<p>Continued From page 1</p> <p>This deficient practice was evidenced by the following:</p> <p>On 03/08/2023 (day one of life safety code survey), during the survey entrance at approximately 9:10 AM, a request was made to the Lead Maintenance Director of Support (LMDS) and Maintenance Director (MD). The surveyor asked if the facility had an Emergency Generator. The LMDS told the surveyor, "yes we a Diesel Generator".</p> <p>Starting at approximately 10:05 AM on 03/08/2023, in the presence of the facility's LMDS and MD a tour of the facility was conducted.</p> <p>On 03/08/2023:</p> <p>1.) At approximately 11:07 AM, an inspection in the basement, where the emergency generator was located was performed.</p> <p>The surveyor observed one battery back up emergency light mounted on the wall above the emergency generator. A request was made to the LMDS to press the test button on the emergency light. When the LMDS pressed the test button, the light did not function properly.</p> <p>2.) At approximately 11:09 AM, an inspection inside the main electrical room where the emergency generator's transfer switch was located was performed. The surveyor observed no evidence of a battery back up emergency light for the generator's transfer switch.</p> <p>At this time the surveyor made a request to the LMDS and asked, do you have a battery back up emergency light in here for the generator transfer</p>	K 291	<p>light were completed.</p> <p>Element Two - Identification of Other Residents: The facility inspected and tested all of the battery backup emergency lights located in the facility in order to identify other lights that may have been affected by the deficient practice. All the lights were found to be operational.</p> <p>Element Three - Systemic Change: The facility's Administrator and Lead Maintenance Director reviewed the facility's policies and procedures pertaining to preventative maintenance. The emergency lighting system is to be inspected monthly as part of the facility's preventative maintenance program.</p> <p>The Administrator and Lead Maintenance Director provided in-service training to the facility's recently hired Maintenance Director regarding the facility's preventative maintenance program. The new Maintenance Director was instructed to inspect the emergency lights monthly, document all inspections, and make timely repairs when necessary.</p> <p>Element Four - Quality Assurance: The facility's Administrator or designee shall inspect the facility's emergency lights weekly for a period of four weeks, and then monthly for a period of three months to ascertain the effectiveness of the preventive measures. In addition, for a period of three months, the Administrator or designee shall review the monthly</p>		

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K 291	Continued From page 2 switch? The LMDS told the surveyor, [REDACTED] .	K 291	preventative maintenance inspection logs completed by the Maintenance Director. Any required repairs will be completed immediately. Thereafter the members of the Quality Assurance Performance Improvement (QAPI) committee shall review the facility's emergency lighting as part of the QAPI process.		
K 311 SS=D	NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9 Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility documentation on 03/08/2023 and 03/09/2023, in the presence of facility Management it was determined that the facility failed to ensure that one (1) of 11 exit access stairwell doors tested were capable of maintaining the 1-1/2 hour fire rated construction. This is evidenced by the following,	K 311	Completion Date: 3/31/2023 K311 Element One - Corrective Actions: The facility repaired the third floor stairway #2 corridor exit access door. The door now latches properly into its frame. The facility inspected and tested all of the corridor exit access doors leading into exit stairways in order to identify other doorways that may be affected by the	3/31/23	

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K 311	<p>Continued From page 3</p> <p>On 03/08/2023 (day one of the life safety code survey), during the survey entrance at approximately 9:10 AM, a request was made to the Lead Maintenance Director of Support (LMDS) and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility.</p> <p>A review of the facility provided lay-out identified the facility was a three-story building with a basement. There are three (3) exit stairways with two (2) stairways going to the basement.</p> <p>Starting at approximately 10:05 AM on 03/08/2023 and continued on 03/09/2023, in the presence of the facility's LMDS and MD a tour of the facility was conducted.</p> <p>Along the two (2) day tour the surveyor performed a closure test of eleven (11) corridor exit access doors leading into exit stairways with the following results,</p> <p>1.) On 03/08/2023 at approximately 12:15 PM, during a closure test of the Ex Order 26. 4B1 stairway #2 corridor exit access door, the door did not positive latch into its frame. This test was repeated two additional times with the same results.</p> <p>The surveyor observed that door had no means to positive latch.</p> <p>The stairwell doors would need to positive latch into its frame to maintain the fire rated construction to prevent fire, smoke and poisonous gases to enter the exit stairwell in the event of a fire.</p> <p>The LMDS and MD confirmed the finding at the</p>	K 311	<p>same deficient practice. All doors were found to be working properly, latching into their door frames.</p> <p>Element Two - Identification of at Risk Residents: All residents have the potential to be affected by this practice.</p> <p>Element Three <input type="checkbox"/> Systemic Change: The facility's Administrator and Lead Maintenance Director reviewed the facility's policies and procedures pertaining to preventative maintenance. Emergency exits and corridor exit access doors are to be inspected monthly as part of the facility's preventative maintenance program.</p> <p>The Administrator and Lead Maintenance Director provided in-service training to the facility's recently hired Maintenance Director regarding the facility's preventative maintenance program. The new Maintenance Director was instructed to inspect all emergency exits and corridor exit access doors monthly. Specifically, the Maintenance Director was instructed to test all such doors to ensure that the doors latch properly into their door frames. The inspections and any required repairs are to be documented and retained for further review.</p> <p>Element Four - Quality Assurance: The facility's Administrator or designee shall inspect the facility's emergency exits and corridor exit access doors weekly for a period of four weeks, and then monthly</p>		

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K 311	Continued From page 4 time. The surveyor informed the Covering Corporate Administrator and LMDS of the deficiency at the Life Safety Code exit conference on 03/09/2023 at approximately 12:50 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 311	for a period of three months to ascertain the effectiveness of the preventive measures. In addition, for a period of three months, the Administrator or designee shall review the monthly preventative maintenance inspection logs completed by the Maintenance Director to determine that the emergency exits and corridor exit access doors were inspected and any required repairs were completed timely. Any required repairs will be completed immediately. Thereafter the members of the Quality Assurance Performance Improvement (QAPI) committee shall review the facility's emergency exits and corridor access doors as part of the QAPI process. Completion Date: 3/31/23		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.	K 321			3/31/23

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K 321	<p>Continued From page 5 19.3.2.1, 19.3.5.9</p> <p>Area Automatic Sprinkler Separation N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation on 03/08/2023 and 03/09/2023 in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7.</p> <p>This deficient practiced was evidenced by the following:</p> <p>On 03/08/2023 (day one of life safety code survey) during the survey entrance at approximately 9:10 AM, a request was made to the Lead Maintenance Director of Support (LMDS) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms in the facility.</p> <p>A review of the facility provided lay-out identified the facility is a three-story building with a</p>	K 321	<p>K321 Element One - Corrective Actions: The facility reconnected the automatic door closure found on the Dietician's room corridor door. The facility installed an automatic door closure on the corridor door of the Environmental Services room. Both repairs were completed. The two rooms now have self closing corridor doors.</p> <p>The Dietician and Environmental Service Director received in-service training from the Administrator regarding their respective areas, and were instructed that the doors must remain self-closing and at no time should the doorways be left opened to the corridor.</p> <p>The facility inspected and tested all of the corridor exit access doors located in hazardous areas including the basement, boiler rooms, laundry and soiled linen</p>		

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K 321	<p>Continued From page 6 basement.</p> <p>Starting at approximately 10:05 AM on 03/08/2023 and continued on 03/09/2023, in the presence of the facility's LMDS and MD a tour of the facility was conducted. Along the tour of the facility, in the presence of the LMDS and MD the surveyor observed the following hazardous areas that failed to have smoke resisting doors:</p> <p>1.) On 03/08/2023 at approximately 10:15 AM, an inspection in the basement level Dieticians room was performed. The surveyor observed that this room connected to the Environmental Services room. The surveyor observed that the Dieticians corridor doors automatic door closure had been disconnected. The corridor door for the Environmental Services room had no automatic door closure. The surveyor observed in both rooms multiple combustible cardboard boxes and multiple diaper boxes. The surveyor observed both corridor doors had no means to self-close and the both connected rooms were larger than 50 square feet each.</p> <p>With these corridor doors not self-closing this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire.</p> <p>The LMDS and MD confirmed the finding at the time of observation.</p> <p>The surveyor informed the Covering Corporate Administrator and LMDS of the deficiency at the Life Safety Code exit conference on 03/09/2023.</p>	K 321	<p>rooms, maintenance and repair areas, paint storage areas, trash collection rooms, and combustible storage areas, in order to identify other doorways that may be affected. All doors were found to be working properly, with automatic self-closing door closures.</p> <p>Element Two - Identification of at Risk Residents: All residents have the potential to be affected by this practice.</p> <p>Element Three <input type="checkbox"/> Systemic Change The facility's Administrator and Lead Maintenance Director reviewed the facility's policies and procedures pertaining to preventative maintenance. Doorways in hazardous areas are to be inspected monthly as part of the facility's preventative maintenance program.</p> <p>The Administrator and Lead Maintenance Director provided in-service training to the facility's recently hired Maintenance Director regarding the facility's preventative maintenance program. The new Maintenance Director was instructed to inspect all corridor access doors located in hazardous areas monthly. Specifically, the Maintenance Director was instructed to inspect and test all such doors to ensure that the doors are self closing and latch properly into their door frames. The inspections and any required repairs are to be documented and retained for further review.</p> <p>Element Four - Quality Assurance:</p>		

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K 321	Continued From page 7 NJAC 8:39-31.2 (e) Life Safety Code 101	K 321	The facility's Administrator or designee shall inspect the facility's corridor access doors located in hazardous areas weekly for a period of four weeks, and then monthly for a period of three months to ascertain the effectiveness of the preventive measures. In addition, for a period of three months, the Administrator or designee shall review the monthly preventative maintenance inspection logs completed by the Maintenance Director to determine that the doors were inspected and any required repairs were completed timely. Any items needing repair will be completed immediately. Thereafter the members of the Quality Assurance Performance Improvement (QAPI) committee shall review the facility's corridor access doors located in hazardous areas as part of the QAPI process. Completion Date: 3/31/23		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.	K 351		3/31/23	

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K 351	<p>Continued From page 8</p> <p>In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.</p> <p>19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and review of facility provided documentation on 03/08/2023 and 03/09/2023, in the presence of facility management it was determined that: 1.) the Facility failed to properly install sprinklers, 2.) the Facility failed to ensure sidewall spray sprinklers were installed at the bottom of the elevator hoist-way not more than two (2) ft (0.61m) above the floor of the pit that contained combustible hydraulic fluids, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition, and as required by the New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy.</p> <p>The deficient practice is evidenced by the following,</p> <p>On 03/08/2023 (day one of life safety code survey) during the survey entrance at approximately 9:10 AM, a request was made to the Lead Maintenance Director of Support (LMDS) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke</p>	K 351	<p>K351</p> <p>Element One - Corrective Action:</p> <p>The facility contracted with its fire sprinkler provider to install the required fire sprinkler escheon caps in the following rooms/areas:</p> <ul style="list-style-type: none"> " Basement level Maintenance Shop bathroom " Resident Ex Order 26. 4B1 bathroom " Ex Order 26. 4B1 Classroom " EX Order 26.4B1 Soiled Utility room " Ex Order 26. 4B1 Housekeeping closet " Ex Order 26. 4B1 suite <p>The facility contracted with its fire sprinkler provider for the installation of fire sprinkler protection in the Emergency Generator room and in Elevator #1 hoist-way.</p> <p>Element Two - Identification of Other Residents:</p> <p>The facility inspected all rooms and areas in order to identify other rooms and areas that may have missing fire sprinkler escheon caps. All rooms and areas were found to have the escheon caps with no gaps in the ceiling tiles.</p>		

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K 351	<p>Continued From page 9</p> <p>compartments in the facility. A review of the facility provided lay-out identified there are three (3) floors and a basement in the facility.</p> <p>Starting at approximately 10:05 AM on 03/08/2023 and continued on 03/09/2023, in the presence of the facility's LMDS and MD a tour of the facility was conducted. Along the two day tour of the facility the surveyor observed the following locations that failed to provide proper fire sprinkler coverage:</p> <p>On 03/08/2023:</p> <p>1.) At approximately 10:18 AM, the surveyor observed inside the basement level Maintenance shop bathroom one fire sprinkler had no escheon cap. This left an approximately 3/8 of an inch gap in the ceiling tile. With the opening in the ceilings, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system.</p> <p>2.) At approximately 11:02 AM, an inspection inside the basement level Emergency Generator room was performed. The surveyor observed no evidence of fire sprinkler protection inside the 18' by 20'-6" generator room. At this time the surveyor made a request to the LMDS, "Do you see any fire sprinkler coverage in this room?" The LMDS looked up and around the room and said, "No".</p> <p>3.) At approximately 11:54 AM, the surveyor observed inside Resident room # [REDACTED] bathroom one fire sprinkler had no escheon cap. This left an approximately 1/4 of an inch gap in the ceiling tile. With the opening in the ceilings, in the event of a fire the heat would by pass the fire sprinkler</p>	K 351	<p>The facility inspected all rooms and areas to identify other rooms and areas that may not have fire sprinklers. All rooms were and were found to have fire sprinklers.</p> <p>Element Three - Systemic Changes: The facility's Administrator and Lead Maintenance Director reviewed the facility's policies and procedures pertaining to preventative maintenance. Rooms and areas are inspected at least quarterly in order to identify needed repairs. Sprinkler heads are observed during the room inspections to determine that the sprinkler heads are free from dust and dirt and that escheon caps are in place to eliminate gaps in ceiling tiles.</p> <p>The Administrator and Lead Maintenance Director provided in-service training to the facility's recently hired Maintenance Director regarding the facility's preventative maintenance program. The new Maintenance Director was instructed to inspect all rooms and areas quarterly. As part of the inspection process, the Maintenance Director is to observe sprinkler heads and escheon caps to ensure that the sprinkler heads are free from dust and dirt and the escheon caps are in place to eliminate any gaps between the sprinkler head and ceiling tiles. The inspections and any required repairs are to be documented and retained for further review.</p> <p>Element Four - Quality Assurance: The facility's Administrator or designee shall on a randomly selected basis,</p>		

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K 351	<p>Continued From page 10</p> <p>in the area and not activate the fire sprinkler system.</p> <p>4.) At approximately 12:17 PM, the surveyor observed inside the [REDACTED] floor Classroom closet one fire sprinkler had no escheon cap. This left an approximately 3/8 of an inch gap in the ceiling tile. With the opening in the ceilings, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system.</p> <p>On 03/09/2023:</p> <p>5.) At approximately 10:54 AM, during a tour of the building the surveyor observed an elevator contracted mechanic had the outer elevator doors on the basement level in the open position while he was working inside elevator #1 hoist-way. The surveyor observed that there were not fire sprinklers at the bottom of the hoist-way. At this time the surveyor asked the elevator mechanic, "Are there fire sprinklers at the top or bottom of the elevator hoist-way?" The elevator mechanic told the surveyor, "no there is only smoke detection".</p> <p>6.) At approximately 11:10 AM, the surveyor observed inside the [REDACTED] floor Soiled Utility room one fire sprinkler that had no escheon cap. This left an approximately 3/8 of an inch gap in the ceiling tile. With the opening in the ceilings, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system.</p> <p>7.) At approximately 11:55 AM, the surveyor observed inside the [REDACTED] floor Housekeeping closet one fire sprinkler had no escheon cap. This left an approximately 3/8 of an inch gap in the ceiling</p>	K 351	<p>inspect ten rooms or areas in the facility weekly for a period of four weeks, and then monthly for a period of three months to ascertain the effectiveness of the preventive measures. In addition, monthly for a period of three months, the Administrator or designee shall review the monthly preventative maintenance inspection logs completed by the Maintenance Director pertaining to fire safety. Any required repairs will be completed immediately. Thereafter the members of the Quality Assurance Performance Improvement (QAPI) committee shall review sprinkler heads and escheon caps throughout the facility as part of the QAPI process.</p> <p>Completion Date: 3/31/2023</p>		

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K 351	Continued From page 11 tile. With the opening in the ceilings, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system. 8.) At approximately 12:35 PM, the surveyor observed inside the Physical Therapy ADL suite bathroom one fire sprinkler had no escheon cap. This left an approximately 1/4 of an inch gap in the ceiling tile. With the opening in the ceilings, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system. The LMDS confirmed the finding at the time. The surveyor informed the Covering Corporate Administrator and LMDS of the deficiency at the Life Safety Code exit conference on 03/09/2023 at approximately 12:50 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351			
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 03/08/2023 and 03/09/2023 in the presence of facility management, it was determined that the facility failed to: 1.) perform a	K 355	K355 Element One - Corrective Action: The facility contracted with its fire safety provider to perform an annual inspection		3/31/23

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NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		
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K 355	<p>Continued From page 12</p> <p>monthly examination for 18 of 25 portable fire extinguishers, 2.) maintain one (1) of 25 portable fire extinguisher in proper working condition, 3.) perform Hydrostatic testing for one (1) of 25 fire extinguishers, as required by National Fire Protection Association NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3. and N.J.A.C. 5:70.</p> <p>Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads,</p> <ul style="list-style-type: none"> - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. <p>The findings include the following:</p> <p>On 03/08/2023 (day one of life safety code survey) during the survey entrance at approximately 9:10 AM, a request was made to</p>	K 355	<p>and maintenance of its portable fire extinguishers. Inspection was completed.</p> <p>The facility inspected all portable fire extinguishers and recorded the inspection on a label attached to the fire extinguishers. All extinguishers were found to be properly charged and ready for use with the following exceptions:</p> <p>" The ABC type extinguisher in the corridor that was last inspected in April 2018 was removed from service and replaced with a new ABC type extinguisher.</p> <p>" The ABC type extinguisher near the corridor smoke doors and last Hydrostatic tested April 2014 was removed and replaced with a new ABC type extinguisher.</p> <p>" The ABC type extinguisher FI, E-18 was removed during the life safety inspection and replaced with a charged ABC type extinguisher.</p> <p>All portable fire extinguishers were inspected during the Life Safety Inspection by the surveyor together with facility maintenance staff. No other portable fire extinguishers were identified to be effected.</p> <p>Element Two - Identification of Other Residents: All residents have the potential to be affected by this practice.</p> <p>Element Three <input type="checkbox"/> Systemic Change The facility's Administrator and Lead Maintenance Director reviewed the</p>		

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K 355	<p>Continued From page 13</p> <p>the Lead Maintenance Director of Support (LMDS) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility.</p> <p>Starting at approximately 10:05 AM on 03/08/2023 and continued on 03/09/2023, in the presence of the facility's LMDS and MD a tour of the facility was conducted. Along the two day tour of the facility the surveyor observed and inspected twenty five (25) portable fire extinguishers with twenty-four (24) extinguishers that were last annually inspected April 2022 in various locations with the following issues identified:</p> <p>On 03/08/2023: On the Basement level,</p> <p>1.) One ABC Type fire extinguisher, facility identification number (FI), E-4 in the elevator mechanical room was missing monthly visual examination performed and documented for May, June, July, August, September, October, November, December 2022 and January 2023.</p> <p>2.) One ABC Type fire extinguisher in the corridor was last annually inspected April 2018.</p> <p>3.) One ABC Type fire extinguisher near stairwell two (2) was missing a monthly examination for October 2022.</p> <p>4.) One ABC Type fire extinguisher in the Boiler room was missing a monthly examination for October 2022.</p> <p>5.) One ABC Type fire extinguisher FI, E-7 was missing a monthly examination for October 2022.</p>	K 355	<p>facility's policies and procedures pertaining to preventative maintenance. Portable fire extinguishers are inspected monthly in order to identify any extinguishers that need to be replaced.</p> <p>The Administrator and Lead Maintenance Director provided in-service training to the facility's recently hired Maintenance Director regarding the facility's preventative maintenance program. The new Maintenance Director was instructed to inspect all portable fire extinguishers monthly at approximately 30 day intervals, and to record such inspections by recording the date and the initials of the person performing the inspection on a label attached to the fire extinguishers. The Maintenance Director was instructed to replace fire extinguishers found with insufficient charge and return such to the facility's fire safety provider. The Maintenance Director is responsible to arrange annual inspections of the fire extinguishers with the fire safety provider.</p> <p>Element Four - Quality Assurance: The facility's Administrator or designee shall on a randomly selected basis, inspect ten portable fire extinguishers weekly for a period of four weeks, and then monthly for a period of three months to ascertain the effectiveness of the preventive measures. In addition, for a period of three months, the Administrator or designee shall review the monthly preventative maintenance inspection logs completed by the Maintenance Director, specifically the monthly inspection logs for</p>		

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K 355	<p>Continued From page 14</p> <p>On the Third floor,</p> <p>6.) One ABC Type fire extinguisher near the corridor smoke doors was last Hydrostatic tested April 2014 and missing a monthly examination for October 2022.</p> <p>7.) One ABC Type fire extinguisher FI, E-23 was missing a monthly examination for October 2022.</p> <p>8.) One ABC Type fire extinguisher FI, E-25 was missing a monthly examination for October 2022.</p> <p>9.) One ABC Type fire extinguisher in the corridor near stairwell one (1) was missing a monthly examination for October 2022.</p> <p>10.) One ABC Type fire extinguisher at the Nursing Station was missing a monthly examination for October 2022.</p> <p>On 03/09/2023:</p> <p>On the Second floor,</p> <p>11.) One ABC Type fire extinguisher FI, E-20 was missing a monthly examination for October 2022.</p> <p>12.) One ABC Type fire extinguisher FI, E-18 pressure indicating needle was in the "RED" discharge zone on the pressure gauge and was missing a monthly examination for October 2022.</p> <p>This fire extinguisher would not function properly in the event of a fire. At this time the surveyor requested that the MD replace the fire extinguisher with an available facility spare fire extinguisher.</p> <p>On the [REDACTED] floor,</p> <p>13.) One ABC Type fire extinguisher FI, E-13 was</p>	K 355	<p>the fire extinguishers. Any required findings shall be corrected immediately. Thereafter the members of the Quality Assurance Performance Improvement (QAPI) committee shall review fire extinguishers throughout the facility as part of the QAPI process.</p> <p>Completion Date: 3/31/23</p>		

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K 355	Continued From page 15 missing a monthly examination for May 2022 and June 2022. 14.) One ABC Type fire extinguisher FI, E-12 was missing a monthly examination for June 2022. 15.) One ABC Type fire extinguisher FI, E-14 was missing a monthly examination for October 2022. 16.) One Class "K" Wet Chemical" extinguisher in the kitchen was missing a monthly examination for November and December 2022. 17.) One ABC Type fire extinguisher FI, E-16 was missing a monthly examination for May and June 2022. 18.) One ABC Type fire extinguisher FI, E-11 was missing a monthly examination for October 2022. 19.) One ABC Type fire extinguisher FI, E-9 was missing a monthly examination for October 2022. The LMDS confirmed the finding at the time. The surveyor informed the Covering Corporate Administrator and LMDS of the deficiency at the Life Safety Code exit conference on 03/09/2023.	K 355			
K 521 SS=D	NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e). HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's	K 521			3/31/23

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K 521	<p>Continued From page 16 specifications. 18.5.2.1, 19.5.2.1, 9.2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations on 03/08/2023 and 03/09/2023 in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were: 1.) being properly maintained for three (3) of seven (7) Resident bathroom exhaust systems and 2.) provide a bathroom exhaust system for one (1) of seven (7) Resident bathrooms, as per the National Fire Protection Association (NFPA) 90A.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 03/08/2023 (day one of life safety code survey) during the survey entrance at approximately 9:10 AM, a request was made to the Lead Maintenance Director of Support (LMDS) and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. The surveyor also requested how many Resident sleeping rooms were in the facility. The MD told the surveyor that there are sixty-four (64) Resident sleeping rooms.</p> <p>A review of the facility provided lay-out identified that the facility was a three-story building with sixty-four (64) Resident sleeping rooms.</p>	K 521	<p>K521 Element One - Corrective Action: The facility repaired the bathroom exhaust system for resident rooms <u>Ex Order 26. 4B1</u> [REDACTED].</p> <p>Element Two - Identification of at Risk Residents: All Residents have the potential to be affected by this practice.</p> <p>Element Three - Systemic Changes: The facility's Administrator and Lead Maintenance Director reviewed the facility's policies and procedures pertaining to preventative maintenance. The bathroom exhaust systems are inspected at least quarterly as part of the resident room quarterly inspections.</p> <p>The Administrator and Lead Maintenance Director provided in-service training to the facility's recently hired Maintenance Director regarding the facility's preventative maintenance program. The new Maintenance Director was instructed to inspect the exhaust systems located in the resident rooms during the quarterly resident room inspections to verify that the exhaust systems are operating properly. Any exhaust system not working</p>		

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K 521	<p>Continued From page 17</p> <p>Starting at approximately 10:05 AM on 03/08/2023 and continued on 03/09/2023, in the presence of the facility's LMDS and MD a tour of the facility was conducted. Along the two (2) day building tour the surveyor inspected seven (7) Resident sleeping rooms.</p> <p>This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation was present), the exhaust did not function properly in 3 of 7 resident bathrooms in the following locations:</p> <p>On 03/08/2023,</p> <p>1.) At approximately 11:35 AM, inside Resident room [REDACTED] bathroom, when tested the exhaust system did not function properly. At this time, the surveyor informed the LMDS and MD that the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation.</p> <p>2.) At approximately 11:38 AM, inside Resident room [REDACTED] bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation.</p> <p>3.) At approximately 11:54 AM, inside Resident room [REDACTED], the surveyor observed no evidence of an exhaust system in the bathroom. At this time the surveyor asked the LMDS, "Do you see an exhaust system in the bathroom?" The LMDS looked up and around the bathroom and said, "No". The surveyor observed that the bathroom had no window with an area that would open.</p>	K 521	<p>properly should be reported to the Administrator so that appropriate repairs can be arranged.</p> <p>Element Four - Quality Assurance: The facility's Administrator or designee shall on a randomly selected basis, inspect ten exhaust systems in resident rooms weekly for a period of four weeks, and then monthly for a period of three months to ascertain the effectiveness of the preventive measures. In addition, monthly for a period of three months, the Administrator or designee shall review the monthly preventative maintenance inspection logs completed by the Maintenance Director, specifically the resident room inspection logs to determine if the bathroom exhaust systems are inspected and working properly. Any required repairs shall be completed immediately. Thereafter the members of the Quality Assurance Performance Improvement (QAPI) committee shall review the bathroom exhaust systems throughout the facility as part of the QAPI process.</p> <p>Completion Date: 3/31/23</p>		

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K 521	Continued From page 18 This bathroom would rely on mechanical ventilation. 4.) At approximately 12:01 PM, inside Resident room [REDACTED] bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. The LMDS and MD confirmed the finding at the time of observation. The surveyor informed the Covering Corporate Administrator and LMDS of the deficiency at the Life Safety Code exit conference on 03/09/2023. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521			
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 03/08/2023 and 03/09/2023, in the presence of facility management, it was determined that the facility failed to ensure that two (2) of 11 electrical outlets located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection.	K 911	K911 Element One - Corrective Action: The facility replaced the Ground-Fault Circuit Interrupter (GFCI) electrical outlets located to the right of the sink in the Maintenance Shop bathroom and located to the right of the sink in the [REDACTED] Floor Day/Dining Room.		3/31/23

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K 911	<p>Continued From page 19</p> <p>This deficient practice was evidenced by the following:</p> <p>Starting at approximately 10:05 AM on 03/08/2023 and continued on 03/09/2023, in the presence of the facility's Lead Maintenance Director of Support (LMDS) and Maintenance Director (MD) a tour of the facility was conducted.</p> <p>During tour, the surveyor observed and tested eleven (11) electrical outlets (with-in 6 feet of a sink) in wet locations with a GFCI tester to de-energize the outlets. The surveyor observed the following,</p> <p>1.) On 03/08/2023 at approximately 10:18 AM, the surveyor observed inside the basement level Maintenance shop bathroom, one (1) GFCI electrical outlet to the right of a sink in the room. When the surveyor tested the GFCI electrical outlet with a GFCI tester to de-energize, the GFCI electrical outlet did not de-energize as required by code.</p> <p>2.) On 03/08/2023 at approximately 11:48 AM, the surveyor observed inside the [REDACTED] floor Day/ Dining room a Duplex electrical outlet sixteen (16") inches to the right of a sink. When the surveyor tested the Duplex electrical outlet with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code.</p> <p>The LMDS and MD confirmed the finding at the time of observation.</p> <p>The surveyor informed the Covering Corporate Administrator and LMDS of the deficiency at the Life Safety Code exit conference on 03/09/2023.</p>	K 911	<p>The facility inspected all GFCI electrical outlets to identify other GFCI outlets that may have been affected. All GFCI outlets were found to be operating properly.</p> <p>Element Two - Identification of Other Residents: All residents have the potential to be affected by this practice.</p> <p>Element Three <input type="checkbox"/> Systemic Change The facility's Administrator and Lead Maintenance Director reviewed the facility's policies and procedures pertaining to preventative maintenance. GFCI electrical outlets are inspected at least quarterly as part of the facility's resident rooms and other areas quarterly inspections.</p> <p>The Administrator and Lead Maintenance Director provided in-service training to the facility's recently hired Maintenance Director regarding the facility's preventative maintenance program. The new Maintenance Director was instructed to inspect the GFCI electrical outlets located in the residents' rooms and other areas throughout the facility during the quarterly room inspections. The Maintenance Director was instructed to use a GFCI tester to de-energize the outlet during testing and replace any non-operating GFCI outlets.</p> <p>Element Four - Quality Assurance The facility's Administrator or designee shall on a randomly selected basis,</p>		

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K 911	Continued From page 20 NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911	inspect ten GFCI electrical outlets weekly for a period of four weeks, and then monthly for a period of three months to ascertain the effectiveness of the preventive measures. In addition, monthly for a period of three months, the Administrator or designee shall review the preventative maintenance inspection logs completed by the Maintenance Director, specifically the resident room inspection logs to determine if the GFCI outlets were inspected and working properly. Any needed repairs shall be completed immediately. Thereafter the members of the Quality Assurance Performance Improvement (QAPI) committee shall review GFCI electrical outlets throughout the facility as part of the QAPI process.		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36	K 918	Completion Date: 3/31/23		3/31/23

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K 918	<p>Continued From page 21</p> <p>months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview on 03/08/2023 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for one (1) of 1 emergency generator was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.</p> <p>The deficient practice was evidenced by the following:</p> <p>On 03/08/2023 (day one of life safety code survey) during the survey entrance at approximately 9:10 AM, a request was made to the Lead Maintenance Director of Support (LMDS) and Maintenance Director (MD) to provide a copy of the facility lay-out which</p>	K 918	<p>K918</p> <p>Element One - Corrective Action: The facility installed a remote Emergency Stop button for the emergency generator.</p> <p>Element Two - Identification of Other Residents: All residents have the potential to be affected by this issue. The facility has one emergency generator. No other emergency generators are on-site. Therefore all emergency generators are affected by this deficient practice.</p> <p>Element Three - Preventive Measures: The facility's Administrator and Lead Maintenance Director reviewed the</p>		

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NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 918	<p>Continued From page 22</p> <p>identifies the various rooms and smoke compartments in the facility. The surveyor also asked if the facility had an Emergency Generator. The LMDS told the surveyor, yes we a Diesel Generator.</p> <p>Starting at approximately 10:05 AM on 03/08/2023 and continued on 03/09/2023, in the presence of the facility's LMDS and MD a tour of the facility was conducted.</p> <p>On 03/08/2023 at approximately 11:07 AM, an inspection in the basement, where the emergency generator was located was performed. The surveyor observed no evidence of a remote Emergency Stop button for the Emergency Generator.</p> <p>At this time a request was made to the LMDS, do you have a remote Emergency Stop button for the generator. The LMDS told the surveyor, "There is no E-stop."</p> <p>The LMDS and MD confirmed the finding at the time of observation.</p> <p>The surveyor informed the Covering Corporate Administrator and LMDS of the deficiency at the Life Safety Code exit conference on 03/09/2023.</p> <p>NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.</p>	K 918	<p>facility's policies and procedures pertaining to operation of the emergency generator. The policies and procedures were amended to include the recently installed Emergency Stop button. The Emergency Stop button will be tested during the semi-annual independent inspection of the emergency generator by the facility's emergency generator provider.</p> <p>The Administrator, Lead Maintenance Director, and recently hired Maintenance Director received in-service training regarding the installation and proper use of the emergency generator's remote Emergency Stop button by the facility's contracted emergency generator provider. Testing of the remote Emergency Stop button shall be completed during the semi-annual generator inspections conducted by the contracted provider.</p> <p>Element Four - Quality Assurance: The facility's Administrator or designee shall review the semi-annual emergency generator inspection reports to verify that the remote Emergency Stop button was tested and worked properly, as well as to identify other aspects of the emergency generator that may require repair or service. In addition, the Administrator or designee shall inspected monthly for six months, the facility's monthly emergency generator records to determine the facility's compliance with its policies and procedures and required regulations. Any repairs will be completed immediately. Thereafter the members of the Quality</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/28/2023
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315205	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/09/2023
NAME OF PROVIDER OR SUPPLIER MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103		
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K 918	Continued From page 23	K 918	<p>Assurance Performance Improvement (QAPI) committee shall review the emergency generator logs and records as part of the QAPI process.</p> <p>Completion Date: 03/31/2023</p>		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315205	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	DATE OF REVISIT 4/27/2023
NAME OF FACILITY MAJESTIC CENTER FOR REHAB & SUB-ACUTE CARE	STREET ADDRESS, CITY, STATE, ZIP CODE TWO COOPER PLAZA CAMDEN, NJ 08103	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0291	03/31/2023	LSC K0311	03/31/2023	LSC K0321	03/31/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	03/31/2023	LSC K0355	03/31/2023	LSC K0521	03/31/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0911	03/31/2023	LSC K0918	03/31/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 3/9/2023		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			