| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 18104 | A. BUILDING: _____ B. WING _____ | 11/07/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BRIDGEWAY CARE AND REHAB CENTER AT HILLSB( | 395 AMWELL ROAD HILLSBOROUGH, NJ 08844 |

| (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 |
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| S 000 | Initial Comments<br><br>The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations. | S 000 | | |
| S 560 | 8:39-5.1(a) Mandatory Access to Care<br><br>(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 11 out of 42 shifts reviewed.<br><br>Findings include:<br><br>Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in | S 560 | The facility works to staff on a daily basis based on at a minimum the standards as set forth by the state of New Jersey.<br>On the dates reviewed during the annual state survey, we appeared to not have sufficient staff for the days reviewed. Not from a lack of trying, as we attempted to utilize staffing agencies and paid additional incentives to our staff to pick up shifts. Our staffing system posts all our open positions allowing for staff and agency personnel to pick up those shifts. We post openings to be able to satisfy, at a minimum, the 1 C.N.A to 8 residents□ ratio on the day shift, 1 to 10 on the evening and 1 to 14 at night.<br>We contract with numerous agencies to fill | 11/23/22 |

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

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| S 560 | Continued From page 1<br>nursing homes. The following ratio(s) were effective on 02/01/2021:<br><br>One Certified Nurse Aide (CNA) to every eight residents for the day shift.<br><br>One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and<br><br>One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.<br><br>On 10/25/22 at 10:45 AM, the surveyor requested from the Director of Nursing (DON) to complete the "Nurse Staffing Report" for the past two weeks at the facility.<br><br>On 10/26/22 at 11:11 AM, the Licensed Nursing Home Administrator (LNHA) informed the surveyor that the facility used two Agency staffing companies to provide nursing staff as needed. At this time, the LNHA provided the requested "Nurse Staffing Report" completed by the facility for the weeks of 10/9/22 to 10/15/22 and 10/16/22 to 10/22/22, which revealed the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below:<br><br>10/9/22 had 12 CNAs for 120 residents on the day shift, required 15 CNAs.<br>10/11/22 had 13 CNAs for 120 residents on the day shift, required 15 CNAs. | S 560 | any remaining openings. We offer incentives to our staff and those in the agency to get those shifts filled. We have a staffing coordinator dedicated to obtaining the necessary staff. Aside from that person we have other nursing supervisors and managers that help in making any necessary phone calls and outreach to get the positions filled.<br>Our company is working tirelessly on recruiting qualified licensed personnel so that we can reduce agency usage and fill the open positions we have. We will continue to post on our schedule so that we can attempt to fulfill the need for a 1 to 8 ratio on the day shift as identified in the 2567.<br>Staffing Coordinator / designee will monitor staffing ratios daily and will report any days where staffing is lower than recommended. Data will be tracked and reported in the facilities monthly QAPI meeting. | |

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| S 560 | Continued From page 2<br>10/12/22 had 14 CNAs for 120 residents on the day shift, required 15 CNAs.<br>10/14/22 had 13 CNAs for 120 residents on the day shift, required 15 CNAs.<br>10/15/22 had 11.5 CNAs for 120 residents on the day shift, required 15 CNAs.<br>10/16/22 had 12 CNAs for 123 residents on the day shift, required 15 CNAs.<br>10/18/22 had 14 CNAs for 122 residents on the day shift, required 15 CNAs.<br>10/19/22 had 13 CNAs for 119 residents on the day shift, required 15 CNAs.<br>10/20/22 had 14 CNAs for 119 residents on the day shift, required 15 CNAs.<br>10/21/22 had 12 CNAs for 119 residents on the day shift, required 15 CNAs.<br>10/22/22 had 12.5 CNAs for 119 residents on the day shift, required 15 CNAs.<br><br>NJAC 8:39-5.1(a) | S 560 | | |

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| E 000 | Initial Comments<br><br>This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>Survey Date: 11/7/22<br><br>Census: 123<br><br>Sample: 24+3+7<br><br>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. | F 000 | | |
| F 550 SS=E | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal | F 550 | | 11/23/22 |

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| F 550 | Continued From page 1<br>access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to ensure residents were served their meals in a dignified manner during meal services. This deficient practice was identified in 1 of 3 nursing units during 4 of 4 meal observations and was evidenced by the following:<br><br>1. On 10/26/22 from 12:11 PM to 12:52 PM, the surveyor made the following meal observations in the dining room on the [redacted]:<br><br>There were 18 residents observed, who were all seated at dining tables. The Licensed Practical | F 550 | The corrective action put in place on 10/31/22 to rectify the deficient practice identified during the facilities annual survey was to:<br>1. Made a list of residents currently using the dining room (Residents 10, 20, 7, 115, 69, 72, 221). Combine all residents from the above list to the designated food service trucks being delivered to the unit. Serve all residents from this truck in table order.<br><br>2. To identify any new residents that would like to eat in the dining room, new | |

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| F 550 | Continued From page 2<br>Nurse/ Unit Manager (LPN/UM) stated that the first lunch truck usually arrived around 11:30 AM.<br><br>At 12:14 PM, the surveyor observed the first dining truck arrived in the [EX. Order 26.(4) B1] dining room. The staff began serving the trays immediately.<br><br>At 12:30 PM, the surveyor observed Resident #10 in the dining room, watching other residents eat lunch, and communicating to their tablemate that they were hungry.<br><br>At 12:30 PM, the surveyor observed Resident #20 watching other residents eat lunch, stated they were still waiting for their lunch tray. The Certified Nursing Aide (CNA) replied that the North food truck had not yet arrived and further stated that there were two other residents still waiting as well.<br><br>At 12:30 PM, the surveyor observed the second dining truck arrived in the [EX. Order 26.(4) B1] dining room. The staff began serving the trays immediately.<br><br>At 12:47 PM, the surveyor observed the third dining truck arrived in the [EX. Order 26.(4) B1] dining room and food was immediately served by the staff.<br><br>At 12:48 PM, the surveyor observed Resident #10 was served their lunch tray.<br><br>At 12:49 PM, the surveyor observed Resident #7 was served their lunch tray.<br><br>At 12:50 PM, the surveyor observed Resident #20 was served their lunch tray. | F 550 | admissions to a unit will be asked within 72 hours of admission by the Unit Manager/designee, existing residents will be asked during their care plan meetings, resident will be reminded to alert staff of their dining wishes during Resident Council and residents are always welcome to make their needs known to the staff at any time if they would like to eat their meals in the dining area. Any updates to list of residents who would like to eat their meals in their units dining room will be provided to the Dietary team verbally or in writing. This list will be maintained by the Dietary Manager/designee.<br><br>3. The facility will educate staff of the new policy and procedure. The Dietary Manager/designee will conduct audits to confirm compliance to the new practice, as follows: 2 x per week for 4 weeks, 1 x per week for 4 weeks and then monthly thereafter for 3 months.<br><br>4. Results of the audits will be reviewed in the facilities quarterly QAPI meeting. The revised policy will be reviewed by the Medical Director and facility leadership in the facilities quarterly QAPI meeting. | |

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| F 550 | Continued From page 3 | F 550 | | |

2. On 10/27/22 between 11:28 AM and 12:05 PM, the surveyor made the following meal observations in the dining room on the [EX. Order 26.(4) B1]:

At 11:28 AM, the surveyor observed the first dining truck arrived in the [EX. Order 26.(4) B1] dining room. The staff began serving the trays immediately. Eight of the nine residents were served.

At 11:35 AM, the surveyor interviewed the Activity Aide (AA) who stated that the residents should be served by tables, but that it was not possible because the trays do not arrive on the floor at the same time; they come up on different trucks.

At 11:45 AM, the surveyor observed Resident #115 watching other residents eat lunch, stated that they were hungry. The Licensed Practical Nurse (LPN) replied, where is your food?

At 12:01 PM, the surveyor observed Resident #115 was served their lunch tray.

3. On 10/28/22 from 11:15 AM to 12:19 PM, the surveyor made the following meal observations in the dining room on the [EX. Order 26.(4) B1]:

At 11:15 AM, the surveyor observed the first meal truck arrived in the [EX. Order 26.(4) B1] dining room. The staff began serving the trays immediately. The surveyor observed nine of the eleven residents in the dining room received their lunch trays.

At 11:37 AM, the surveyor observed the second dining truck arrived in the [EX. Order 26.(4) B1] dining room.

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| F 550 | Continued From page 4 | F 550 | | |

At 11:40 AM, the surveyor observed two residents (Resident# 69 and #72 ) still had not received their lunch tray.

At 11:45 AM, the surveyor observed Resident #69 was served their lunch tray.

At 12:02 PM, the surveyor observed Resident #72 was served their lunch tray.

4. On 10/31/22 from 11:23 AM to 11:48 AM, the surveyor made the following meal observations in the dining room on the EX. Order 26.(4) B1:

At 11:23 AM, the surveyor observed the first meal truck arrived in the EX. Order 26.(4) B1 dining room. The staff began serving the trays immediately. The surveyor observed eleven of the twelve residents in the dining room received their lunch trays.

At 11:32 AM, the surveyor observed the second dining truck arrived in the EX. Order 26.(4) B1 dining room.

At 11:38 AM, the surveyor observed the third dining truck arrived in the EX. Order 26.(4) B1 dining room.

At 11:46 AM, the surveyor observed Resident #221 watching another resident who was assisted to the dining room and be served immediately.

At 11:48 AM, the surveyor observed Resident #221 was served their lunch tray. Resident #221 stated he/she had chosen the chef's salad from the menu, not chicken. At that time, the Dietary Aide (DA) went to the kitchen to get the chef's salad.

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| F 550 | Continued From page 5 | F 550 | | |

At 11:53 AM, thirty minutes after the meal service began and several of the residents had finished their lunch, the surveyor observed Resident #221 received their chef salad.

On 10/31/22 at 11:55 AM, the surveyor interviewed the LPN/UM who acknowledged that Resident #221 should have been served at the same time as the other residents. The LPN/UM further stated that she had provided the kitchen with a list of residents who eat in the dining room so that all of those trays would be delivered at the same time and that they were still "working on it."

A review of the Meal Times List revised 2/1/2020, provided by the Licensed Nursing Home Administrator (LNHA) on 10/26/22 at 9:34 AM, reflected that residents on the EX. Order 26.(4) B1 who ate in their rooms were served lunch trays at 11:30 AM and residents who ate in the dining room were served lunch trays at 12:15 PM. The list further indicated that residents who ate in their rooms were served dinner at 4:30 PM, and residents who ate in the dining room were served at 5:00 PM.

On 10/27/22 at 9:30 AM, the surveyor interviewed the LNHA who stated that the facility had new mealtimes and provided the surveyor with another Meal Times List revised 8/15/22, which reflected that lunch meal service on the EX. Order 26.(4) B1 started at 11:00 AM; EX. Order 26.(4) B1 meal times were 11:20 AM/11:30 AM and EX. Order 26.(4) meal times were 11:40 AM/11:50 AM. The list further indicated that residents who resided on EX. Order 26.(4) B received dinner at 4:20 PM/4:30 PM and residents who resided on EX. Order 26.(4) received dinner trays at 4:40 PM/ 4:50 PM. The list did not include

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| F 550 | Continued From page 6<br>the meal service times for residents who ate in the dining rooms.<br><br>A review of the Resident Meal Service and Meal Times policy dated effective 1/1/19 included to ensure meals are served in a manner that provides quality service and enhances the meal experience for all residents; to ensure that meals are served I a timely and efficient manner while offering a sufficient span of time for residents to obtain their meals...<br><br>On 11/2/22 at 11:15 AM, the LNHA in the presence of the Director of Nursing (DON), and survey team acknowledged that residents who ate in the [redacted] dining room should have been served at the same time. | F 550 | | |
| F 576 SS=D | NJAC 8:39-27.1(a)<br>Right to Forms of Communication w/ Privacy<br>CFR(s): 483.10(g)(6)-(9)<br><br>§483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense.<br><br>§483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to:<br>(i) A telephone, including TTY and TDD services;<br>(ii) The internet, to the extent available to the facility; and | F 576 | | 11/23/22 |

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| F 576 | Continued From page 7<br>(iii) Stationery, postage, writing implements and the ability to send mail.<br><br>§483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:<br>(i) Privacy of such communications consistent with this section; and<br>(ii) Access to stationery, postage, and writing implements at the resident's own expense.<br><br>§483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research.<br>(i) If the access is available to the facility<br>(ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.<br>(iii) Such use must comply with State and Federal law.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to a.) provide privacy when receiving and delivering mail and b.) deliver mail within a reasonable timeframe. This deficient practice was identified for 2 of 31 residents reviewed for privacy and timeliness with their mail delivery (Resident #13 and #80) and was evidenced by the following:<br><br>On 11/1/22 at 10:13 AM, the surveyor interviewed Resident #13 who stated that he/she had ordered some items from their insurance company's catalog "about a month ago" and he/she still had not received the items. | F 576 | The corrective action that was put into place on 11/1/22 to rectify the deficient practice identified during the facilities annual survey was to:<br>1. Education completed with the DOP on 11/1/22in regard to opening packages that belong to the resident. If the DOP opens a package inadvertently that belongs to a resident, they are to take the package directly to the resident and apologize for the mistake made. Resident #13 and #80 received their packages once located in employee office on 11/1/22. | |

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| BRIDGEWAY CARE AND REHAB CENTER AT HILLSBOROUGH | 395 AMWELL ROAD HILLSBOROUGH, NJ 08844 |

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| F 576 | Continued From page 8<br><br>At this time, the surveyor interviewed Resident #80 who stated that he/she had also ordered some items from his/ her insurance company's catalog about a month ago and he/she still had not received the items.<br><br>The surveyor reviewed Resident #13's most recent quarterly Minimal Data Set (MDS), an assessment tool, dated [redacted] which reflected that the resident had a brief interview for mental status (BIMS) score of [redacted] out of [redacted], which indicated a EX. Order 26.(4) B1.<br><br>The surveyor reviewed Resident #80's most recent quarterly MDS dated [redacted], which reflected the resident had a BIMS score of [redacted] out of [redacted] which indicated a EX. Order 26.(4) B1.<br><br>On 11/1/22 at 10:18 AM, the surveyor interviewed the License Nursing Home Administrator (LNHA) who stated that the facility's mail delivery procedure included that the mail was delivered to the Receptionist. It was the Receptionist's responsibility to notify the Activities Department when the mail was available and ready to be delivered. The mail was to be delivered within 24 to 48 hours of receipt.<br><br>On 11/1/22 at 10:22 AM, the surveyor interviewed the Social Worker (SW) who stated that Resident #13 and Resident #80 brought this concern to her attention "a few minutes ago". The SW further stated that she had placed the order for both of these residents on 10/3/22 just prior to her vacation. The SW stated she had called the company a few minutes ago and they confirmed that the packages were delivered to the facility on 10/19/22. | F 576 | 2. The facility will identify other residents having the potential to be affected by the same deficient practice by interviewing residents during resident council meetings. The Activities Director/designee will ask the residents during Resident Council meetings monthly for 3 quarters if they have packages that are outstanding. The Activities Director/designee will then follow up with the Receptionist if anything is reported and then report back to the resident.<br>3. The facility has created a tracking tool for resident packages that the Receptionist/designee will maintain as the measure to ensure that the deficient practice does not occur. The Activities Department/designee will ensure to collect the packages, sign-off on the log, and deliver it to the resident within 24/48 hours of being delivered to the facility. The Receptionist, Activities Department, and DOP have been in-serviced on this updated practice.<br>4. The facility will monitor the corrective actions to ensure that the deficient practice is being corrected and will not recur during our quarterly QAPI meeting. The Activities Director/designee will report data on any occurrences and what was done to rectify the situation. | |

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On 11/1/22 at 10:35 AM, the surveyor interviewed the Director of Activities (DOA) who stated that the SW just notified her about the missing packages. She stated that her staff were responsible for the mail delivery, and she would begin an investigation.

On 11/1/22 at 10:45 AM, the DOA stated that on 10/19/22 the boxes were not delivered to the Receptionist, but instead were mistakenly delivered to the Purchasing Director where the facility's medical treatment supplies were delivered. The DOA stated that the Purchasing Director delivered the boxes to the EX. Order 26.(4) B1 Unit Manager's (UM) office. The surveyor asked the DOA if the packages were addressed to Resident #13 and Resident #80. The DOA replied that she was not sure, but that they may have been addressed to the facility.

On 11/1/22 at 12:00 PM, the DOA located the empty box with the label which confirmed that the package was in fact addressed to Resident #13, not the facility. The DOA was unable to locate the box with the label for Resident #80.

On 11/1/22 at 12:40 PM, the surveyor interviewed the Director of Purchasing (DOP) who stated that she received the packages for Resident #13 and Resident #80 on EX. Order 26.(4) B1. The DOP stated that she saw the [name redacted] company logo on each of the boxes, which was the same company that delivered the medical supplies so she "didn't even look at the labels" and opened the boxes. She further stated that as soon as she saw the packing slips were addressed to Resident # 13 and #80, she realized she had made a mistake in opening them. The DOP stated that she put the

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slips back into the boxes and delivered the packages to the EX. Order 26.(4) B1. Licensed Practical Nurse/Unit Manager's (LPN/UM) office. The surveyor asked the DOP when she had put the boxes in the office, if she had informed the LPN/UM the packages were there and mistakenly opened? The DOP replied, "I can't remember when I brought the boxes up or when I told the nurse that they were there. I didn't inform the residents; I don't even know them."

On 11/1/22 at 1:00 PM, the DOP provided the surveyors with copies of the Packing Lists which indicated that the packages were shipped and addressed to Resident #13 and Resident #80.

On 11/1/22 at 2:42 PM, the LNHA in the presence of the Director of Nursing and survey team, stated that the DOP should have gone directly to each of the residents, explained what happened and apologized for the mistake.

On 11/2/22 at 10:55 AM, the surveyor conducted a phone interview with the EX. Order 26.(4) B1. LPN/UM who stated that the DOP informed her that she had left the packages in her office for Resident #13 and #80. The LPN/UM stated, "I can't recall when the Central Supply lady told me, either this week or last week." The surveyor asked the LPN/UM why she did not deliver the packages to the residents. The LPN/UM replied, "I just forgot about them." The LPN/UM further stated that she should have delivered them as soon as she was made aware they were there.

A review of the Mail Delivery policy dated effective 11/28/19 included the facility would deliver mail to residents within 24-48 hours of receipt...the mail is to remain sealed until it has been delivered to

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| F 576 | Continued From page 11<br>the intended recipient...<br><br>A review of the Resident Rights policy dated effective 8/1/21 included... the residents have the right to communications, including mail and telephones to receive and send your mail in unopened envelopes; request and receive assistance in reading and writing correspondence, communicate in person and by mail, email, and telephone with privacy...<br><br>On 11/2/22 at 11:15 AM, the LNHA acknowledged that the DOP and LPN/UM should have followed facility policy and delivered the mail unopened within 24-48 hours of receipt.<br><br>NJAC 8:39-4.1(a)(19) | F 576 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review it was determined that the facility failed to | F 686 | The corrective action that was put into place on 11/1/22 to rectify the deficient | 11/23/22 |

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| F 686 | Continued From page 12<br>consistently provide EX. Order 26.(4) care in a manner to reduce the spread of infection and promote healing for 1 of 1 resident (Resident #19) observed during EX. Order 26.(4) treatments.<br><br>The deficient practice was evidenced by the following:<br><br>On 10/27/22 at 10:05 AM, the surveyor observed Resident #19 in bed with his/her eyes closed.<br><br>The surveyor reviewed the medical record for Resident #19.<br><br>The Admission Record face sheet (admission summary) reflected that the resident was admitted to the facility in EX. Order 26.(4) B1 with diagnoses that included EX. Order 26.(4) B1 .<br><br>A review of the admission Minimum Data Set (MDS), an assessment tool dated EX. Order 26.(4) B reflected the resident had a brief interview for mental status (BIMS) score of EX out of EX. Or which indicated a EX. Order 26.(4) B1 . The MDS further indicated that Resident #19 required extensive assistance with activities of daily living, had a range of motion impairment on one side of the upper extremities, was admitted with EX. Order 26.(4) B1 EX. Order 26.(4) B1 , and the treatments included applications of ointments/medications.<br><br>A review of the EX. Order 26.(4) B1 Physician Order Summary which was transcribed onto the Treatment Administration Record (TAR) included a physician's order dated EX. Order 26.(4) B1 to cleanse EX. Order 26.(4) B1 ); apply EX. Order 26.(4) B ointment (a EX. Order 26.(4) B1 agent) and EX. Order 26.(4) B1 | F 686 | practice identified during the facilities annual survey was to:<br>1. Educate the nurse who performed the treatment to Resident #19 on hand hygiene requirements when doffing and donning gloves during the removal and replacement of dressings. The nurse was also educated on 11/1/22 the need to date and initial the dressing before application to the resident. Resident #19 was monitored for signs and symptoms of a EX. Order 26.(4 infection daily and during EX. Order 26.(4 rounds with the EX. Order 26.(4 doctor. EX. Order 26.(4 was reported healed and without any signed of infection as of 11/16/22.<br>2. The facility will identify other residents having the potential to be affected by the same deficient practice by reviewing all residents with physician orders for a dressing change for EX. Order 26.(4) B1 , EX. Order 26.(4 , and/or EX. Order 26.(4) B1 where treatment involves the donning and doffing of gloves.<br>3. The following measures will be implemented to ensure that this practice does not recur:<br>a. In-Service education by the Infection Preventionist, Staff Development Coordinator and/or designee for all licensed nursing staff on glove use and hand hygiene requirements during dressing changes and need for dating/initialing the dressing.<br>b. Review of dressing change policy to determine if additional guidance is needed regarding dressing change procedure and policy revision if appropriate<br>c. Inclusion of treatment competency in orientation of licensed nursing staff and | |

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| F 686 | Continued From page 13<br>(EX. Order 26.(4) B1 ) and cover with a EX. Order dressing two times a day for EX. Order 26.(4 care.<br><br>On 11/1/22 at 11:00 AM, the surveyor observed the Licensed Practical Nurse (LPN) perform a wound treatment to Resident #19's EX. Order 26.(, while the Certified Nursing Assistant (CNA) assisted with the positioning of Resident #19. The LPN disinfected the over-bed table (OBT) with bleach wipes and then applied a clean barrier.<br><br>The LPN assembled the needed supplies from the treatment cart and placed them on the EX. Order in the resident's room. Among the supplies was a tube of EX. Order 26.(4) B1 ointment, EX. Order 26.(4) B1 dressing, EX. Order 26 dressing, gauze sponges, two single-use plastic bullets of EX. Order 26.(4) B1 solution, and a plastic trash bag.<br><br>The LPN provided the treatment to Resident #19's sacrum per the physician's orders. During the treatment, the LPN removed Resident #19's soiled dressing; doffed (removed) her soiled gloves and donned (applied) a new pair of gloves without performing hand hygiene. The LPN cleansed the wound with EX. Order 26.(4) B1, doffed the soiled gloves and without performing hand hygiene donned a new pair of gloves. The LPN then patted the wound dry using a 4x4 gauze pad. The LPN doffed her gloves and without performing hand hygiene, donned a new pair. The LPN changed her gloves three times without performing hand hygiene. The LPN did not date or initial the foam dressing.<br><br>At that time, the surveyor discussed the breaks in technique with the LPN. The LPN acknowledged she should have performed hand hygiene each time she removed her gloves and before she | F 686 | annual staff education programs.<br>4. The Infection Preventionist, Staff Development Coordinator, and/or designee will conduct a treatment pass weekly for 4 weeks and then monthly for 3 months. using a competency check list Results will be used to evaluate education effectiveness and need for any changes. Results will be presented quarterly to the QAPI committee and will continue until it is determined that the deficient practice has been corrected. | |

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| F 686 | Continued From page 14<br>donned new gloves. The LPN further stated that she should have initialed and dated the foam dressing.<br><br>A review of the undated Skills Performance Evaluation: Treatment Competency included the following instructions:...remove soiled dressing and discard...remove soiled gloves and perform hand hygiene; apply new clean gloves...provide treatment to wound as ordered by physician; apply dressing; label and date dressing prior to its application; remove gloves and perform hand hygiene...<br><br>On 11/1/22 at 2:42 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) and discussed the concerns observed during the [redacted] treatment.<br><br>On 11/2/22 at 11:15 AM, the DON acknowledged that the LPN should have performed hand hygiene each time she removed her soiled gloves, before putting on new gloves, and should have initialed and dated the [redacted] dressing before its application.<br><br>NJAC 8:39-27.1(a) | F 686 | | |
| F 692 SS=D | Nutrition/Hydration Status Maintenance<br>CFR(s): 483.25(g)(1)-(3)<br><br>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- | F 692 | | 11/23/22 |

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| F 692 | Continued From page 15<br>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to ensure the accuracy of a resident's weight who had a history of EX. Order 26.(4) B1. This deficient practice was identified for 1 of 6 residents reviewed for nutrition (Resident #42) and was evidenced by the following:<br><br>On 10/25/22 at 11:37 AM, the surveyor entered Resident #42's room and observed the resident sitting in a wheelchair, wearing a shirt that appeared loose at the neckline. The resident expressed to the surveyor that he/she ate very little, was not hungry, and had meal choices.<br><br>The surveyor reviewed the medical record for Resident #42.<br><br>A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility in EX. Order 26.(4) B1 with diagnoses which included EX. Order 26.(4) B1 | F 692 | The corrective action that was put into place to rectify the deficient practice identified during the facilities annual survey was to:<br>1. Conduct a reweight of the Resident #42 which determined that the resident was at EX. Order 26 pounds, showing a EX -pound decrease from the previous month. A reweight would not be required since this was a EX -pound loss and per our policy, a reweight would be required if there was a 5-pound variance. Resident #42 is stable and not showing signs of EX. Order 26.(4) B1 exacerbation at this time. Resident MD did not make any changes to the residents orders.<br>2. The facility will identify other residents having the potential to be affected by the same deficient practice by reviewing residents with orders for daily, weekly, and monthly weights.<br>3. The following measures will be implemented to ensure that this practice does not recur: | |

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| F 692 | Continued From page 16<br>([redacted], and [redacted].<br><br>A review of the most recent annual Minimum Data Set (MDS), an assessment tool dated [redacted], reflected a brief interview for mental status (BIMS) score of [redacted] out [redacted], which indicated a [redacted].<br><br>A review of Weight and Vital Summary report located in electronic Health Record (eHR), revealed the following:<br><br>On 6/22/22, the resident weighed [redacted] pounds (lbs).<br>On 7/7/22, the resident weighed [redacted] lbs.<br>On 8/9/22, the resident weighed [redacted] lbs.<br>On 9/9/22, the resident weighed [redacted] lbs.<br>On 10/12/22, the resident weighed [redacted] (lbs).<br><br>A review of the electronic Progress Note (ePN) included a Nutrition/Dietary Note (NDN) dated [redacted] which reflected the resident's monthly weight was [redacted] which indicated a 5% weight gain over 30 days. The NDN further indicated that the weight gain was a regain of the weight he/she recently lost and continue to monitor resident's weight.<br><br>A review of the ePN included a NDN dated 10/19/22, which indicated the resident's monthly weight was [redacted] lbs which indicated a 5% weight loss in over 30 days. The NDN further indicated that the Resident #42's [redacted]) was increased on [redacted] which may account for weight loss, continued monitor of resident's weight. | F 692 | a. In-service education by the Staff Development Coordinator and Registered Dietician for nursing staff on the facility weight/reweight policy and how to document both numbers.<br>b. The Registered Dietician/designee will select 10 random residents once a week for 4 weeks, then monthly thereafter for 3 months.<br>4. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected by having Monthly Weight meetings and the results will be discussed during this meeting and data will be shared at the quarterly QAPI meetings. | |

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A review of the Order Summary Report (OSR) dated as of EX. Order 26.(4), included a physician's order (PO) dated EX. Order 26.(4) for EX. Order 26.(4) B1 milligram; give EX. tablets equal to EX. mg by mouth one time a day related to EX. Order 26.(4) B1 EX. Order 26.(4) B1. The OSR did not include a PO for weight monitoring.

On 10/31/22 at 10:37 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) who stated that residents' weights were obtained for each resident by their assigned CNA on the floor at beginning of the month and completed by the end of that week. CNA #1 continued the assigned CNA on the 7:00 AM to 3:00 PM shift weighed their resident and when unable, the 3:00 PM to 11:00 PM shift weighed their resident instead. CNA #1 stated afterward at the nurse's station, the assigned CNA wrote the weight next to the resident's name on a paper titled Weight Entry and the nurses entered the weight obtained into the eHR.

At that time, CNA #1 informed the surveyor that reweighs were conducted when the weight did not match the previous month or when the resident lost a lot of weight. CNA #1 was unable to define the value of a lot of weight lost and stated that the Unit Manager (UM) or the Registered Dietician (RD) instructed the CNA which resident needed to be re-weighed.

On 10/31/22 at 10:00 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who explained the process for residents' weight measurement that began the first week of the month. The LPN stated that the CNAs were assigned when to measure the weight of a

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resident. The collected weight was then written on a paper and the UM entered the information into the eHR. The LPN stated that reweighs were conducted for a discrepancy of five pounds. The LPN clarified that the UM would see the discrepancy for the resident then order the reweigh.

On 10/31/22 at 10:47 AM, the surveyor interviewed the LPN/Unit Manager (LPN/UM) who stated she has been the LPN/UM since EX. Order 26.(4) B1 and explained the process for residents' weight measurement. She confirmed the CNAs were assigned to take the weight measurement and the LPN/UM entered the data into the eHR. She also stated that when the weight was off, the resident was re-weighed. The LPN/UM was unable to specify the amount of weight loss or weight gain to trigger a reweigh. The LPN/UM stated that a weight loss of 20 lbs in a month would cause the RD to step in. The LPN/UM further explained that she would see the weight and the RD would sit with her but she [LPN/UM] had not done this process yet. The LPN/UM stated she was unsure of the actual number but thought 10 to 20 lbs would be a weight loss to address. She also stated she recently completed orientation on EX. Order 26.( and the previous UM just left.

On 11/1/22 at 11:46 AM, in the presence of the survey team, the surveyor interviewed the Primary Medical Physician (PMD) via telephone who explained to the surveyors that for residents with EX. Order 4 their weights were monitored based on the stability of their condition. The PMD further explained that management of a EX. Order2 resident with a symptom of EX. Order 26.(4) B1 ) would include monitored weights, the EX. Order 26.(4) B1

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| BRIDGEWAY CARE AND REHAB CENTER AT HILLSBOROUGH | 395 AMWELL ROAD HILLSBOROUGH, NJ 08844 |

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| F 692 | Continued From page 19 | F 692 | | |

informed, and labs ordered. The PMD clarified that the addition of EX. Order 26.(4) B1 for the management of Resident #42's EX. Order 26.(4 was a clinical change in status. The PMD acknowledged the interconnection between an unmanaged thyroid level and its contribution to the worsening of weight changes and EX. Order.

On 11/2/22 at 9:43 AM, the surveyor interviewed the RD who explained the weight assessment process. The RD stated she worked in the facility three times a week and on those days she used the electronic Medical Record (eMR) to obtain the Weights and Vitals exception report as a tool and investigated weights variances such as:
greater or equal to 5.0% over 30 days
greater or equal to 7.5% over 30 days
greater or equal to 10 % over 30 days

At that time, the surveyor and RD reviewed the Weights and Vitals exception report. The RD stated Resident #42 had a weight exception (flagged) in EX. Order 26.(4) B1 and EX. Order 26.(4) B1. The RD acknowledged that after Resident #42 was flagged for weight exception she did not check the recorded weights for re-weighs.

On 11/2/22 at 12:26 PM, the surveyors and the DON reviewed the paper document reweigh sheet titled Weight Entry for the EX. Order 26.(4) B1 and the DON confirmed reweighs were not conducted for Resident #42 in EX. Order 26.(4) B1 and EX. Order 26.(4 EX. Order2. No additional information was provided for October 2022.

A review of the facility's Weight and Height policy dated 4/20/12, include it is the policy of this facility to monitor residents' weights from the time of admission and to provide interdisciplinary

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| F 692 | Continued From page 20<br>assessment and intervention as needed. Nursing is responsible for obtaining weights on admission, readmission with a significant change and monthly. More frequently weights may be ordered by the physician, nurse, or registered dietician. The registered dietician collaborated with the interdisciplinary team, resident, and family in regard to identifying problems with weight and nutrition, developing a plan of care, and identifying appropriate interventions...The registered dietician will review all weights and identify any weight which is plus or minus 5 pounds if greater than 100 lbs and 3 pounds if less than 100 pounds. These residents will be reweighed and the second weight evaluated for accuracy by the unit manager. All re-weights [reweighs] will occur within one business day of the first weight. Only the weight determined to be accurate by the unit manager will be recorded on the resident' [resident's] weight flow record...<br><br>Refer F710<br><br>NJAC 8:39-27(a) | F 692 | | |
| F 710 SS=D | Resident's Care Supervised by a Physician<br>CFR(s): 483.30(a)(1)(2)<br><br>§483.30 Physician Services<br>A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs.<br><br>§483.30(a) Physician Supervision.<br>The facility must ensure that- | F 710 | | 11/23/22 |

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| F 710 | Continued From page 21<br><br>§483.30(a)(1) The medical care of each resident is supervised by a physician;<br><br>§483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to ensure the physician provided an order for routine laboratory [redacted] tests for [redacted] for a resident diagnosed with [redacted]. This deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications (Resident #42) and was evidenced by the following:<br><br>A review of the manufacturer's specifications for [redacted] under section 2.4 titled, Monitoring [redacted] and/or [redacted] 4) levels included:<br>In adult patients with primary [redacted], monitor [redacted] levels after an interval of 6 to 8 weeks after any change in dose. In patients on a stable and appropriate replacement dose, evaluate clinical and biochemical response every 6 to 12 months and whenever there is a change in the patient's clinical status.<br><br>On 10/25/22 at 11:37 AM, the surveyor entered Resident #42's room and observed the resident sitting on a wheelchair, wearing a shirt that appeared loose at the neckline. The resident expressed to the surveyor that he/she ate very little, was not hungry but has meal choices.<br><br>The surveyor reviewed the medical record for Resident #42. | F 710 | The corrective action that was put into place to rectify the deficient practice identified during the facilities annual survey was to:<br>1. Resident #42 has a diagnosis of [redacted] and is receiving [redacted] micrograms (mcg) by mouth one time a day. To address the practice identified in the facility's 2567 report, the attending physician for Resident #42 was contacted and laboratory orders related to [redacted] levels were obtained for this resident. Lab results received on [redacted] include: TSH3 = [redacted] and Free T4 = 1[redacted] - both [redacted]. The need for routine and change of condition laboratory monitoring for patients with [redacted] and receiving [redacted] was reinforced with attending physician.<br>2. Residents with physician orders for medications which require routine laboratory monitoring were identified as having the potential to be affected by the same practice identified in the 2567. Residents on [redacted] medications and other medications identified as having monitoring requirements will be reviewed for required laboratory orders by the Unit | |

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| F 710 | Continued From page 22<br><br>A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility in EX. Order 26.(4) B1 with diagnoses which included EX. Order 26.(4) B1 [redacted], and EX. Order 26.(4) B1.<br><br>A review of the most recent annual Minimum Data Set (MDS), an assessment tool dated EX. Order 26.(4), reflected a brief interview for mental status (BIMS) score of [redacted] out of EX. Ord which indicated a EX. Order 26.(4) B1.<br><br>A review of the Order Summary Report (OSR) from admission in EX. Order 26.(4) B1, reflected the following physician orders (PO):<br><br>An active PO dated EX. Order 26.(4) B1, for EX. Order 26.(4) B1 EX. O micrograms (mcg); 1 tablet by mouth one time a day for low EX. Order 26.(4) B1<br>A discontinued PO dated EX. Order 26.(4), for laboratory blood work which included EX. Order 26.(4) B1 test; measurement of the amount of EX. Order 26.(4) B1) and EX. Order 26.(4) B1; measurement of EX. Order 26.(4) B1).<br>An active PO dated EX. Orc Order 26.(, for EX. Order 26.(4) B1 milligram (mg); [redacted] tablets to equal EX. O mg one time a day related to EX. Order 26.(4) B1.<br><br>A review of the Physician Progress note dated EX. Order 26.(4) B1, revealed laboratory values that included EX. O and EX. Order were normal on EX. Order 26.(4) B<br><br>On 11/1/22 at 10:22 AM, the surveyor interviewed the Director of Nursing (DON) who stated that | F 710 | Manager/designee on a monthly basis.<br>3. The following measures will be implemented to ensure that this practice does not recur:<br>• In collaboration with our Medical Director and Consultant Pharmacist, development of a list of medications which require routine laboratory monitoring and its frequency<br>• Development of a policy which outlines individual responsibilities related to placement of orders and review of orders and results for residents on medications which require this type of monitoring<br>• Education of medical, nursing, and other staff identified in policy related to its content and individual responsibilities to be conducted by the Staff Nurse Educator/designee<br>4. On a weekly basis for 8 weeks, new admission pharmacy orders and pharmacy orders on existing residents will be reviewed by Unit Managers/designee to determine if laboratory orders are entered for medications which require routine laboratory monitoring. On a monthly basis, the pharmacy consultant/designee will monitor residents on these medications for inclusion of laboratory orders. Weekly and monthly results will be reported to the Medical Director, DON, and Administrator. All results and trends will be presented quarterly QAPI. | |

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EX. Order 26.(4) B1 should have been monitored at least every six months. The DON informed the surveyor that the resident's EX. Order 26.(4) B1 were last checked on EX. Order 26.(4). The DON acknowledged that monitoring the resident's EX. Order 26.(4) B1 therapeutic levels through EX. Order and or EX. O was important to avoid worsening of Resident #42's existing diseases.

On 11/1/22 at 11:46 AM, in the presence of the survey team, the surveyor interviewed the Primary Medical Physician (PMD) via telephone who explained that residents with EX. Order weights were monitored based on the stability of the resident's condition. The PMD further explained that management of a resident with EX. Order experiencing a symptom of EX. Order 26.(4) B1 would include monitored weights, the EX. Order 26.(4) B1t informed, and laboratory tests ordered. The PMD clarified that the addition of EX. Order 26.(4) B1 for the management of Resident #42's EX. Order 26.(4) was a clinical change in status. The PMD acknowledged the interconnection between an unmanaged EX. Order 26.(4 level and its contribution to the worsening of weight changes and EX. Order.

At that time, the PMD stated that the EX. Order and or EX. O should have been checked every six months or at least once a year for stable residents. The PMD acknowledged that the order for EX. Order was unintentionally omitted/neglected for Resident #42. The PMD stated a follow up would be made with the DON.

On 11/2/22 at 11:20 AM, in the presence of the survey team, the DON stated the PMD placed a new order for EX. Order lab draw on EX. Order 26.(4) and a repeated order every EX. Or months. The DON confirmed the PMD acknowledged it was

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| F 710 | Continued From page 24<br>inadvertently left out. No additional information was provided, and the facility was unable to provide a policy. | F 710 | | |
| F 755 SS=D | NJAC 8:39-11.2 (a)<br>Pharmacy Srvcs/Procedures/Pharmacist/Records<br>CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in | F 755 | | 11/23/22 |

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| F 755 | Continued From page 25<br>order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to ensure medications were administered to a resident in accordance with professional standards of practice. This deficient practice was identified for 1 of 31 residents reviewed for medication management (Resident #57) and was evidenced by the following:<br><br>On 10/25/22 at 11:30 AM, the surveyor observed Resident #57 lying in bed. Resident #57 informed the surveyor that he/she was having a bad day and requested the surveyor to remove the EX. Order 26.(4) B1 on their tray table in front of them. The surveyor observed a medication cup which contained one EX. O capsule. The resident informed the surveyor that the nurse (Registered Nurse (RN)) administered the EX. Order 26.(4 to them thirty minutes ago and he/she informed the RN they did not need to take the EX. Order 26.(4.<br><br>On 10/25/22 at 11:49 AM, the surveyor interviewed the RN who confirmed she administered medications to Resident #57 that morning, but stated the resident refused to take the EX. Order 26.(4) so she discarded the EX. Order 26.(4) At this time, the surveyor asked the RN if they documented on the Medication Administration Record (MAR) that Resident #57 refused their Colace. The RN responded she had documented the resident received the EX. Order 26.(4 prior to administering the medication and she had to go back into the MAR to document the resident refused. The RN acknowledged she should not document the administration of medication until | F 755 | The corrective action put into place on 10/25/22 to rectify the deficient practice identified during the facilities annual survey was to:<br>1. Immediately educate the nurse who performed the medication administration of Resident #57 on the correct method of Medication Administration per facility policy and professional standards of practice. The medication was taken from the resident and the resident was informed the right to refuse medications should they not wish to take them. Note: Nurse identified in the Medication error was an agency nurse and is no longer working in this building.<br>2. The facility will identify other residents having the potential to be affected by the same deficient practice by interviewing the residents during resident council meetings and asking them if they are given the ability to refuse medications and if the nurse stays with them throughout the entire medication administration process. The Activities Director/Designee will note the answer in the minutes.<br>3. The following measures will be implemented to ensure that this practice does not recur:<br>a. Administration along with guidance from the Medical Director will review the medication administration policy to determine if any additional guidance is needed and a policy revision will be made if necessary. | |

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| F 755 | Continued From page 26<br>after she watched the resident take the medication. The RN acknowledged there was one [redacted] capsule in a medication cup in the resident's room, but stated she administered two [redacted] tablets to the resident, and she discarded both [redacted] so the [redacted] on the resident's tray table could not have been from her. The RN confirmed medication should not be left at residents' bedside; the nurse needed to watch the resident take the medication.<br><br>The surveyor reviewed the medical record for Resident #57.<br><br>A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in EX. Order 26.(4) B1 with diagnoses which included EX. Order 26.(4) B1 [redacted] and [redacted] in EX. Order 26.(4) B1.<br><br>A review of the most recent annual Minimum Data Set (MDS), an assessment tool dated [redacted], reflected the resident had a brief interview for mental status score of a [redacted] out of [redacted], which indicated a EX. Order 26.(4) B1.<br><br>A review of the active Order Listing Report included a physician's order (PO) dated [redacted] for EX. Order 26.(4) B1 milligram (mg) capsule; give one capsule by mouth two times a day for [redacted]. This contradicted the RN's verbal statement that the resident was administered two [redacted] capsules that she disposed of.<br><br>A review of the corresponding MAR reflected the resident refused [redacted] on [redacted] | F 755 | b. The medication administration policy will be reviewed with current nursing personnel and reviewed in the nursing orientation onboarding for new hires and reviewed yearly thereafter by the Staff Development Coordinator/designee.<br>c. The Staff Development Coordinator/designee will conduct In-service to nurses on medication administration and any changes made to the policy. Agency nurses will have the information in the agency orientation packet.<br>4. After education is given to nurses, the Staff Development Coordinator/designee will conduct medication pass audits to 4 residents on each floor once a week for four weeks and then monthly thereafter for three months. The results of the audit will be reviewed during our quarterly QAPI meeting. | |

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A review of the corresponding Medication Admin Audit Report indicated that the EX. Order 26.(4 was signed as administered (refused) on EX. Order 26.(4) B1 at 11:53 AM.

A review of the Progress Notes included a Orders - Administration Note dated EX. Order 26.(4) B1 at 11:53 AM, for EX. Order 26.(4 capsule EX. Orde mg; give one capsule by mouth two times a day for EX. Order 26.(4) B1 patient took out medication from the rest of the medication.

On 10/28/22 at 11:27 PM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated the resident was EX. Order and EX. Order 26.(4) B1 who could make all their needs known. The LPN stated Resident #57 sometimes required assistance when administering medications because of their EX. Order 26.(4) B so she had to at times place the medication in the resident's mouth. The LPN stated you have to watch residents take their medication to ensure the medication was taken; you cannot leave medication with residents.

On 10/28/22 at 12:47 PM, the surveyor interviewed the LPN/Unit Manager (LPN/UM) who stated when the nurse administered medication, the nurse was responsible to watch the resident swallow the medication prior to leaving the room. The LPN/UM stated nurses cannot leave medication with residents, and they signed for the administration of medications after the resident took the medication to ensure they swallowed it. The LPN/UM stated the nurse signed for the administration of the medication after the resident took the medication and not before because certain medications might have parameters so it needed to be held or the resident could refuse.

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| F 755 | Continued From page 28<br>The UM/LPN acknowledged EX. Order 26.(4) was left at Resident #57's bedside, but stated the RN informed her that they medication was not left by her. The UM/LPN confirmed Resident #57 was alert and oriented who was able to make all needs known.<br><br>On 10/28/22 at 12:27 PM, the surveyor interviewed the Director of Nursing (DON) who stated nurses signed for the administration of medication after it was administered and not before to ensure the resident swallowed the medication. The DON confirmed medications could not be left with the resident and she was aware the EX. Order 26.(4) was left with Resident #57. The DON confirmed Resident #57 was EX. Order and EX. Order 26.(4)E and could make all needs known.<br><br>A review of the facility's "Medication Administration" policy dated effective 10/26/22, included administration of a "by mouth" medication is not complete until the patient takes the medication and shows evidence of safely swallowing the medication. Medication must be documented following administration by the person administering the drugs...self-administration of drugs is permitted when approved by the interdisciplinary team, and all components of the facility are met. | F 755 | | |
| F 836 SS=E | NJAC 8:39-27.1(a)<br>License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c)<br><br>§483.70(a) Licensure.<br>A facility must be licensed under applicable State and local law. | F 836 | | 11/23/22 |

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| BRIDGEWAY CARE AND REHAB CENTER AT HILLSBOROUGH | 395 AMWELL ROAD HILLSBOROUGH, NJ 08844 |

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| F 836 | Continued From page 29<br>§483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards.<br>The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.<br><br>§483.70(c) Relationship to Other HHS Regulations.<br>In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and review of pertinent facility documents, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for 11 out of 14 day shifts reviewed during a two-week period prior to survey and for 3 of 5 day shifts observed on the [redacted] nursing unit. | F 836 | The facility works to staff on a daily basis based on at a minimum the standards as set forth by the state of New Jersey.<br>On the dates reviewed during the annual state survey, we appeared to not have sufficient staff for the days reviewed. Not from a lack of trying, as we attempted to utilize staffing agencies and paid additional incentives to our staff to pick up | |

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| F 836 | Continued From page 30<br>This deficient practice was evidenced by the following:<br><br>Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:<br><br>One Certified Nurse Aide (CNA) to every eight residents for the day shift.<br><br>One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and<br><br>One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.<br><br>On 10/25/22 at 10:45 AM, the surveyor requested from the Director of Nursing (DON) to complete the "Nurse Staffing Report" for the past two weeks at the facility.<br><br>On 10/25/22 at 11:41 AM, the surveyor asked CNA #1 on the [redacted] Floor nursing unit what her assignment was for the day. CNA #1 stated she was on light duty, so she did not have an assignment, but provided the surveyor with a | F 836 | shifts. Our staffing system posts all our open positions allowing for staff and agency personnel to pick up those shifts. We post openings to be able to satisfy, at a minimum, the 1 C.N.A to 8 residents ratio on the day shift, 1 to 10 on the evening and 1 to 14 at night.<br>We contract with numerous agencies to fill any remaining openings. We offer incentives to our staff and those in the agency to get those shifts filled. We have a staffing coordinator dedicated to obtaining the necessary staff. Aside from that person we have other nursing supervisors and managers that help in making any necessary phone calls and outreach to get the positions filled.<br>Our company is working tirelessly on recruiting qualified licensed personnel so that we can reduce agency usage and fill the open positions we have. We will continue to post on our schedule so that we can attempt to fulfill the need for a 1 to 8 ratio on the day shift as identified in the 2567.<br>Staffing Coordinator / designee will monitor staffing ratios daily and will report any days where staffing is lower than recommended. Data will be tracked and reported in the facilities monthly QAPI meeting. | |

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copy of the [redacted]-Floor CNA Assignment sheet for 10/25/22. The sheet revealed there were three CNAs assigned to fifty-two residents.

On 10/25/22 at 11:43 AM, the surveyor interviewed CNA #2 who stated the facility was short staffed today, so he was assigned to residents on both sides of the [redacted]-Floor nursing unit. When asked how many residents he was assigned for the day, he replied "eighteen".

At this time, the surveyor reviewed the CNA Assignment sheet for 10/25/22, which confirmed CNA #2 was assigned eighteen residents for that shift.

On 10/26/22 at 11:11 AM, the Licensed Nursing Home Administrator (LNHA) informed the surveyor that the facility used two Agency staffing companies to provide nursing staff as needed. At this time, the LNHA provided the requested "Nurse Staffing Report" completed by the facility for the weeks of 10/9/22 to 10/15/22 and 10/16/22 to 10/22/22, which revealed the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below:

10/9/22 had 12 CNAs for 120 residents on the day shift, required 15 CNAs.
10/11/22 had 13 CNAs for 120 residents on the day shift, required 15 CNAs.
10/12/22 had 14 CNAs for 120 residents on the day shift, required 15 CNAs.
10/14/22 had 13 CNAs for 120 residents on the day shift, required 15 CNAs.
10/15/22 had 11.5 CNAs for 120 residents on the day shift, required 15 CNAs.
10/16/22 had 12 CNAs for 123 residents on the

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day shift, required 15 CNAs.
10/18/22 had 14 CNAs for 122 residents on the day shift, required 15 CNAs.
10/19/22 had 13 CNAs for 119 residents on the day shift, required 15 CNAs.
10/20/22 had 14 CNAs for 119 residents on the day shift, required 15 CNAs.
10/21/22 had 12 CNAs for 119 residents on the day shift, required 15 CNAs.
10/22/22 had 12.5 CNAs for 119 residents on the day shift, required 15 CNAs.

On 10/28/22 at 11:07 AM, the surveyor interviewed CNA #3 on the Third-Floor nursing unit who stated she was behind on providing morning care for residents. When asked how many residents were on her assignment for the day, she responded "eleven". CNA #3 stated when there were six CNAs scheduled for the day, each CNA was assigned eight residents, but when there were five CNAs, they were assigned eleven residents. When asked if the nursing unit scheduled less than five CNAs ever, CNA #3 confirmed there had been times when there were less than five CNAs.

The surveyor reviewed the CNA Assignment Sheet for 10/28/22, which revealed there were five CNAs assigned to 52 residents. The sheet also confirmed CNA #3 was assigned eleven residents.

On 10/31/22 at 11:26 AM, the surveyor interviewed CNA #2 who stated his usual resident assignment was ten residents, but today he had thirteen residents assigned to him. CNA #2 stated the facility usually had five CNAs assigned for the [redacted]-Floor nursing unit.

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The surveyor reviewed the CNA Assignment Sheet for 10/31/22, which revealed there were four CNAs assigned to fifty-two residents. The sheet also revealed CNA #2 was assigned to thirteen residents.

On 10/31/22 at 11:30 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated there was usually six CNAs assigned to the [redacted]-Floor nursing unit with three CNAs assigned to either side. The LPN stated if a CNA called out, the facility usually tried to have another aide come in to help.

On 10/31/22 at 11:31 AM, the surveyor interviewed the LPN/Unit Manager (LPN/UM) who stated there were usually five or six CNAs assigned to the [redacted]-Floor nursing unit for the day shift. The LPN/UM stated the number of CNAs needed was determined by the resident census for that day. The LPN/UM confirmed today there were four CNAs with resident assignments plus CNA #1 who was on light-duty and had no residents assigned to her. When asked how many CNAs should be scheduled during the day shift, the LPN/UM stated there should be one CNA for every eight residents. At this time, the surveyor reviewed the CNA Assignment Sheet for 10/31/22, and the LPN/UM confirmed CNA #2 had thirteen residents assigned, CNA #4 had fourteen residents assigned to her; CNA #5 had twelve residents assigned to her; and CNA #6 had thirteen residents assigned to her. The LPN/UM stated when the floor was short, CNAs were assigned more residents.

On 10/31/22 at 11:36 AM, the surveyor observed CNA #7 arrive at the [redacted]-Floor Nurse's Station

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and he informed the LPN/UM he was an Agency CNA scheduled to help.

On 10/31/22 at 11:51 AM, the surveyor interviewed the Acting Staff Coordinator who stated she came to the facility from another facility to help. The Acting Staff Coordinator stated she made the nursing schedules, but she was unsure how the number of CNAs needed was determined. The Acting Staff Coordinator stated for the day shift, she usually scheduled five to six CNAs for the [redacted]-Floor nursing unit. The Acting Staff Coordinator stated if the facility staff could not cover the shift, then she called for Agency staff. The Acting Staff Coordinator confirmed there were four CNAs assigned to the [redacted]-Floor nursing unit today and that an Agency CNA (CNA #7) had just arrived.

On 10/31/22 at 12:02 PM, the surveyor interviewed the DON who stated CNAs were scheduled based on resident census. The DON continued for the day shift, there should be one CNA for every eight residents. The DON stated the [redacted]-Floor nursing unit which was a long-term care unit usually had fifty-two residents and required six CNAs for the day shift. The DON stated on the weekends and holidays, staffing was challenging because of callouts. The DON stated CNA #1 should be coming off [redacted] and confirmed [redacted] five CNAs assigned to the [redacted]-Floor nursing unit residents because [redacted] was a "weekend" so it would be lower.

On 10/31/22 at 12:19 PM, the surveyor reviewed the CNA Assignment Sheet for 10/25/22 which indicated there were three assigned CNAs for the [redacted]-Floor nursing unit. The DON

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| F 836 | Continued From page 35<br>acknowledged the three CNAs and stated there was a callout and this was "not usually how operate".<br><br>NJAC 8:39-5.1(a) | F 836 | | |