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	315479	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT LIVINGSTON	68 PASSAIC AVENUE LIVINGSTON, NJ 07039

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS STANDARD SURVEY: 1/30/2020 CENSUS: 68 SAMPLE SIZE: 22 +10 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 610 SS=D	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: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 documents, it was determined that the facility failed to investigate a [redacted]	F 610	1.An investigation for resident # 40, was completed with no negative outcome identified	2/13/20

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

Electronically Signed | 02/14/2020

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F 610	Continued From page 1 [redacted] after admission to the facility. This deficient practice was identified for 1 of 5 resident's reviewed with [redacted] (Resident #40), and the evidence was as follows: On 1/27/2020 at 10:42 AM, the surveyor observed Resident #40 in bed and lying on a low air-loss mattress with the head of the bed slightly elevated. The resident would not speak specifically to the surveyor's inquiry. The resident was unsure if he/she had any wounds that the nurse was treating. On 1/28/20 at 9:54 AM, the surveyor observed the Certified Nursing Aide (CNA) in the resident's room preparing to provide morning care to Resident #40. At that time in the presence of the CNA, the surveyor asked the resident's permission to observe morning care with the CNA, and the resident refused. The surveyor then exited the resident's room to allow the CNA to continue with the care. The surveyor reviewed the medical record for Resident #40. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility on [redacted] with diagnoses which included [redacted] A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a brief interview for mental status (BIMS) score of [redacted]	F 610	2.Residents newly admitted to the center have the potential to be affected. 3.Nurses were in-serviced regarding skin assessments upon admission and any discrepancies from the hospital record and center assessment will be investigated. 4. The administrator/DON/Designee will audit charts twice a week x 4 weeks, weekly x 2 weeks then monthly x 1 month to ensure that a wound that presents as center acquired is investigated to determine the origination of the [redacted] (hospital or center acquired). The results of the audits will be submitted quarterly and as needed to the Quality Assurance and Performance Improvement committee by the DON to determine if further action to the plan is needed.	

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F 610		F 610		

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[redacted] The assessment further included that the resident was admitted with [redacted].

A review of the Universal Transfer Form (UTF), a communication tool to summarize transfer information, dated [redacted] indicated that the resident had a [redacted]

A review of the electronic Progress Notes (ePN) dated upon admission on [redacted] at 11:38 PM included that the resident was admitted with [redacted]

A review of the Resident Evaluation/initial nursing admission assessment dated [redacted] included that the resident had an [redacted] for the contamination of a [redacted], and that the resident had a [redacted] that was [redacted] Under the Skin Evaluation section, the space to record additional observations/comments was blank. There was no documented evidence of additional [redacted] present upon admission.

A review of the physician's orders sheet with a start date of 12/25/19 included a physician order (PO) to cleanse the [redacted] with [redacted] There was no documented evidence of a physician order for any other [redacted].

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F 610	Continued From page 3 A review of the electronic Treatment Administration Record (eTAR) for December 2019 included the PO dated 12/25/19 for the [redacted], but there was no documented evidence upon admission for the accountability for a [redacted] dressing to any other [redacted] areas for the dates of 12/24/19, 12/25/19 or 12/26/19. A review of the subsequent ePN's dated 12/25/19 and 12/26/19 did not reflect documented evidence of an open [redacted] or treatment to an open [redacted] other than the [redacted]. A review of a ePN dated three days after admission on [redacted] at 4:30 PM, reflected that the Registered Nurse/Unit Manager documented that Resident #40 was "admitted on [redacted] with [redacted] care treatment orders as follows: [redacted] ..." The RN/UM then documented at 5:10 PM that day that the [redacted] was a [redacted]. She documented the [redacted] that measured [redacted] with [redacted] This did not correspond with the UTF, the Resident Evaluation nursing assessment upon admission on [redacted] or subsequent ePN's dated [redacted] that the resident had been admitted with the [redacted]	F 610		

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There was no documented evidence for the identification or a treatment order for the [redacted] on 12/24/19, 12/25/19 and 12/26/19.

A review of the [redacted] consultant initial Visit Report dated 12/31/19 reflected that the resident had a [redacted], in addition to a [redacted] The [redacted] measured [redacted] and had [redacted] and the [redacted] and also had [redacted]. The [redacted] consultant/Nurse Practitioner (NP) indicated that the [redacted] had [redacted] and recommended to apply [redacted]

On [redacted] at 11:20 AM, the surveyor interviewed the RN/UM who documented three days after admission that the resident was admitted with [redacted] The surveyor asked the RN/UM about the note she wrote on [redacted]9. The RN/UM stated that the resident was admitted on [redacted] and that usually she does a skin check on new admissions. She stated that she did a skin check on [redacted] and saw the [redacted], and she reviewed the hospital records and saw that the resident had [redacted] She was not sure where within the hospital documents it established that the resident had [redacted] or if the [redacted] had healed prior to discharge from the hospital. The RN/UM confirmed that the UTF reflected that the resident did not have a [redacted], and the admission Resident Evaluation assessment

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dated [redacted] did not address the [redacted] or behaviors that would have limited staff ability to inspect the skin. The RN/UM stated that upon admission, the LPN's are expected to perform a head to toe skin assessment and document the findings with in the resident's medical record. The RN/UM stated that she documented that the resident was admitted with the [redacted].

The surveyor asked if she spoke to the Licensed Practical Nurse (LPN) who performed the admission assessment, or if the CNA's who had performed incontinence care had observed the presence of the [redacted], and the RN/UM stated that she had not spoken to those staff prior to writing her note, and that she had just assumed that it had been there. She confirmed the hospital records were vague in the assessment of the skin/[redacted] and did not document evidence of what [redacted] the [redacted] were to the [redacted]. She acknowledged that the wound consultant/NP documented the [redacted] as [redacted]. The RN/UM stated that she had brought this situation up to the the Director of Nursing (DON) on 12/27/19. The RN/UM confirmed there was no physician order for the treatment to the [redacted] or [redacted] on [redacted] and [redacted] The RN/UM could not speak to if the [redacted] had healed and reopened. The RN/UM stated that she did not perform an investigation but that the surveyor could ask the DON.

On [redacted] at 11:46 AM, the surveyor interviewed the CNA who stated that she was always the CNA assigned to care for Resident #40 since admission, and that she worked full time during the day shift (7 AM to 3 PM). The CNA stated

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that the resident was always cooperative with care for [redacted] and that he/she was incontinent of bowel and had a bowel movement this morning. The CNA stated that the resident came in to the facility with [redacted], and that he/she always had a treatment over top of the [redacted] that she could recall, even on Christmas day when she worked. The CNA stated that she did not have to write a statement regarding the resident's skin and that no one had asked her about the condition of the resident's skin upon admission.

On 1/28/2020 at 1:16 PM in the presence of the survey team, the DON stated that there was no investigation conducted for the lack of documentation related to the [redacted] for the [redacted] after admission to the facility.

On 1/29/20 at 10:44 AM, the surveyor interviewed the DON and the Licensed Nursing Home Administrator (LNHA). The DON stated that she did not conduct an investigation at the time the [redacted] were first documented. She stated that she had since spoke to the admitting LPN who told her that the resident refused to turn and therefore the skin could not be adequately visualized. The DON stated that if a resident refuses to turn for the admission assessment, that the physician should be notified and it should get reported on the 24 hour report to check the skin at the next incontinence care change or at the next most convenient time when the resident was getting up, such as for physical therapy. The DON acknowledged that she did not get statements from the CNA's or nurses who cared for the resident on 12/24/19, 12/25/19 and 12/26/19 to see if [redacted] were identified during

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incontinence care, and if so, did they report the [redacted] to the nurse or the supervisor, because there had been no treatment order in place on those dates. The DON understood the surveyor's questions, and confirmed had she had obtained statements through an investigation, she would be able to demonstrate that the [redacted] to the [redacted] were actually there or not there upon admission. She provided the surveyor hospital records that reflected the resident had [redacted] during a hospital stay, but she could not speak to if the [redacted] had healed and subsequently reopened or if the resident was admitted with the [redacted]. The DON stated that as of yesterday [redacted] the [redacted] and [redacted]

On 1/29/2020 at 12:02 PM, the surveyor attempted to conduct a phone interview with the LPN who admitted the resident on [redacted]. The LPN did not answer the phone nor return the surveyor's request for a return call.

On 1/30/2020 at 12:36 PM, the surveyor conducted a phone interview with the Registered Nurse/Supervisor (RN/S) for the evening shift of 12/24/19. The RN/S stated that she was went into the resident's room with the LPN that evening to assess the resident's skin but the resident was refusing to be turned to fully check the skin. The RN/S stated that she believed there were [redacted] to the [redacted] due to the fact the resident had an [redacted] from the hospital, and that the hospital records reflected evidence of a [redacted]. She stated that she did not recall communicating with anyone (nurse or physician) that the resident's skin was not fully assessed

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due to his/her refusal to turn in bed in order for staff to adequately visualize the skin. The RN/S stated that she believed the resident was admitted on an air mattress due to the resident's condition and risk factors. The RN/S confirmed to the surveyor that there had been no investigation done prior to surveyor inquiry to evaluate if the [redacted] had been present upon admission and if they were determined to be not present on admission, to determine if they were avoidable or unavoidable.

A review of the facility's Investigating Injuries revised December 2016 included that the "Administrator will ensure that all injuries are investigated." It also included that if an incident/accident is suspected a nurse or nurse supervisor will complete a facility-approved accident/incident form. The form will be disseminated to the appropriate individuals, for example the Administrator and Director of Nursing Services.

A review of the facility's Abuse Investigation and Reporting policy revised July 2017 included that the individual conducting the investigation will, at a minimum include a review of the the resident's medical record to determine events leading up to the incident; interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; review all events leading up to the alleged incident. Upon conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms and provide the completed documentation to the Administrator.

NJAC 8:39-9.4(f)

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F 658 SS=D	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, record review and review of pertinent facility documents, it was determined that the facility failed to: a.) address a recommendation made by a wound consultant, b.) notify a physician in accordance with a physician order for a resident who had a [redacted] in two days, and c.) ensure the treatment administration record was signed in accordance with professional standards of nursing practice. This deficient practice was identified for 3 of 18 residents reviewed for standards of practice (Resident #3, #6, and #53). Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states:	F 658	1.Resident #6 had no decline in the [redacted] and an alternative bed surface was applied. Resident #53, MD was immediately notified and no additional orders were given, the resident remained stable. Resident # 3 medications and treatments were reviewed and the physician notified. A review of consults, weights, and treatment records was completed and no other residents were impacted. 2. Residents of the center that have consulting physicians, weight management, and have treatments administered had potential to be affected. A review of consults, weights, and treatment records was completed and no other residents were impacted. 3. Nurses were educated related to processing consultant recommendations, notification to physician in regards to weight changes, and signing treatment records timely.	2/13/20

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F 658	Continued From page 10 "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." The evidence was as follows: 1. On 1/28/2020 at 9:32 AM, the surveyor observed Resident #6 sitting upright on a seat cushion in a wheelchair in the activity room. There was a [redacted] sitting with the resident. The surveyor observed that the resident was [redacted] The [redacted] stated to the surveyor that the resident had a history of [redacted], and that she assisted in providing activities of daily living for the resident. The [redacted] told the surveyor that the resident's skin was intact. On 1/26/2020 at 11:54 AM, 1/27/2020 at 9:45 AM, and 1/29/2020 at 11:15 AM, the surveyor observed the resident's assigned room, which was vacant at the time. The surveyor observed that the resident had a pressure relieving mattress, that was not a low air-loss mattress. The surveyor reviewed the medical record for Resident #6. A review of the Admission Record face sheet (an admission summary) reflected that the resident was recently admitted to the facility and had diagnoses which included [redacted]	F 658	4. DON/Designee will audit wound consultant reports weekly x 4 weeks, then monthly for 1 to monitor recommendations (if any) have been completed. Unit Manager/designee will audit weights for four weeks, then monthly for one month to determine if variations in weights had physician notification. Unit Manager or Designee will review signatures on TAR weekly x 4 weeks, then monthly x 2 months to validate timely signature. The results of the above audits will be submitted to the Administrator/DON for review. These findings will be reported quarterly to the Quality Assurance and Performance Improvement committee by the DON to determine further action to the plan if needed.	

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The surveyor attempted to review the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, but the resident was admitted to the facility [redacted]

A review of the resident's individualized care plan dated [redacted], included that the resident had [redacted]. The care plan did not address the resident's mattress.

A review of [redacted] consultant initial Visit Report dated 1/14/2020 indicated that the resident had was admitted to the facility with a [redacted]. Recommendations included a new treatment order and a "low air loss mattress needed."

A review of a Skin Note written by the Registered Nurse/Unit Manager dated 1/14/2020 at 6:43 PM indicated that the resident was seen by the [redacted] consultant/ Nurse Practitioner (NP) and the resident had a [redacted]. The note included that a "new treatment order in place...Care plan and orders reviewed and updated accordingly. Will continue to monitor." The note did not address the recommendation regarding the low air loss mattress.

A review of the physician's orders sheet for

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January 2020 did not reflect evidence for a physician's order for a low air loss mattress.

A further review of the electronic Progress Notes (ePN) for January 2020 did not reflect documented evidence to address the [redacted] consultant's recommendation dated 1/14/2020 for a low air-loss mattress.

On 1/29/2020 at 11:22 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to Resident #6. The LPN stated that the resident was confused, dependent on staff for care, and was admitted to the facility with a [redacted]. The LPN further added that the resident was admitted to the facility for [redacted]

The LPN confirmed that the resident did not have a low air-loss mattress on the bed, and stated that the resident should have one, because a resident with a [redacted]. The LPN added that air mattresses are usually received within a day or two of when they are ordered.

The LPN further stated that she doesn't review the recommendations made by the [redacted] consultant but that the Registered Nurse/Unit Manager (RN/UM) reviews them, and she calls the physician for the orders.

On 1/29/2020 at 11:35 AM, the surveyor interviewed the RN/UM who confirmed that she does [redacted] rounds with the [redacted] consultant/NP. She added that she reviews all recommendations made by the NP and obtains a physician's order to implement them. The

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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
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RN/UM stated that residents that have a [redacted] should have a low air-loss mattress to aid in the healing of the [redacted]. The RN/UM confirmed the resident was admitted to the facility with a [redacted] The RN/UM was not sure if the resident had a low air loss mattress. The surveyor showed the RN/UM the recommendation by the [redacted] consultant/NP that a "low air loss mattress needed." The RN/UM stated that she didn't recall the recommendation and wasn't aware of it. The RN/UM indicated that the recommendation may have been missed, and she couldn't speak to it any further.

On 1/29/20 at 12:47 PM, the surveyor interviewed the [redacted] consultant/NP who stated that Resident #6 was admitted with a [redacted] and acknowledged that she usually recommends low air loss mattresses for a [redacted], especially if a resident was [redacted] and wouldn't have the [redacted] to remember to turn. The NP could not recall if she had seen one in place for the resident during the most recent subsequent visit. The NP stated that usually when she recommends the air mattresses, they are implemented very quickly. She could not speak to why there would be no air mattress for the resident at that time.

On 1/30/2020 at 11:36 AM, the surveyor interviewed the Director of Nursing (DON) in the presence of the survey team. The DON stated that the resident's low air loss mattress was reviewed for appropriateness, but due to the fact the resident was status-post [redacted], an air mattress was

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contraindicated. The DON stated that this contraindication should have been documented within the electronic Progress Notes in accordance with professional standards of nursing practice. The DON acknowledged that the LPN, RN/UM, and the [redacted] consultant/NP were not aware of the contraindication for the resident's recommended low air loss mattress.

2. On 1/27/2020 at 11:24 AM, the surveyor observed Resident #53 sitting upright in a wheel chair in his/her room. The resident appeared well nourished. The resident told the surveyor that he/she was a [redacted] and needed to follow a specific diet and could not eat foods that had a lot of sugar. The surveyor observed that the resident had snacks on his/her over bed table. The snacks included were a one ounce (oz) package of baked goldfish crackers, a peanut butter and jelly round snack pie in its original sealed packaging, four oz of cranberry juice, and a package of whole grain graham crackers. The resident stated that he/she liked the graham crackers the best and they were the healthiest food option to eat.

The surveyor reviewed the medical record for Resident #53.

A review of the resident's Admission Record face sheet reflected that the resident had diagnoses which included, but were not limited to [redacted]

A review of the resident's most recent quarterly MDS dated [redacted] reflected that the resident had a BIMS score of [redacted] which indicated

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A review of the resident's January 2020 electronic Order Summary Report (OSR) reflected a physician's order (PO) dated 10/21/2020 for daily weights. The PO further specified to call for a weight gain greater than three pounds (lbs.) for two consecutive nights related to fluid retention.

A review of the resident's January 2020 Weights and Vitals Summary reflected the following weights:
On 1/6/2020 the resident's weight was [redacted] lbs
On 1/7/2020 the resident's weight was [redacted] lbs
On 1/8/2020 the resident's weight was [redacted] lbs.
(This reflected a [redacted] non-significant weight gain for two consecutive days.)

A review of the resident's January 2020 ePN did not reflect that the physician was made aware of the residents [redacted] weight gain.

A review of the resident's undated comprehensive care plan reflected a focus area for nutrition related to the fact the resident was noted with a trending weight gain. The goal specified that the resident would not experience a significant change in weight through the next review date and to consume appropriate foods and fluids to maintain nutritional status. The interventions included daily weights as ordered and to notify the physician and responsible party of significant weight changes.

On 1/29/2020 at 11:39 AM, the surveyor interviewed the resident's Registered Dietician (RD) who stated that the resident had a PO for daily weights related to swelling and fluid

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retention of the resident's [redacted]. The RD further stated that the resident had a PO, and if there was a weight gain of three or more pounds, the nurse was to notify the resident's primary physician. The RD stated that she was aware that the resident had more than a three pound weight gain, so she made recommendations to notify the physician. The RD told the surveyor that she or the nursing staff would be responsible for notifying the physician of the resident's weight gain. The RD was unsure if the physician was notified when the resident had a weight gain. She stated that she would have to follow-up.

On 1/29/2020 at 11:56 AM, the surveyor interviewed the resident's LPN who stated that the resident was weighed daily related to a history of [redacted]. The LPN stated that if there was a weight discrepancy of five lbs or more the physician should be notified. The LPN did not know if the physician was notified of the resident's [redacted] weight gain.

On 1/29/2020 at 12:41 PM, the surveyor interviewed the RN/UM who stated that if the staff noticed a discrepancy in a resident's weight, the resident would be re-weighed to determine the accuracy of the weight. The RN/UM stated that the physician would also be notified.

On 1/30/2020 at 11:15 AM, the RD/Licensed Nursing Home Administrator (RD/LNHA) stated that there was no documentation that the resident's physician was notified of the resident's weight gain. The RD/LNHA stated that the staff failed to notify the physician, and that they should have in accordance with the physician's order.

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A review of the facility's Change in a Resident's Condition or Status Policy dated 5/2017 included, "1. The nurse will notify the resident's Attending Physician or physician on call when there has been a (an) i. specific instruction to notify the Physician of changes in the resident's condition."

3. On 1/26/2020 at 9:41 AM, the surveyor interviewed the RN/Supervisor who stated that he was not sure of residents on the unit with [redacted] and would have to check with the DON.

At that time, the DON stated that Resident #3 had a facility-acquired [redacted].

On 1/27/2020 at 9:57 AM, the surveyor observed Resident #3 lying in bed in an upright position on a low air loss mattress. The surveyor interviewed the resident who stated that the nursing staff came into his/her room all the time and provided the care needed. The resident could not elaborate further concerning his/her skin condition or treatments.

On 1/28/2020 at 10:32 AM, the surveyor interviewed the CNA who stated that she had provided care to Resident #3 and the resident had a [redacted] on the [redacted]. The CNA added that the nurses took care of the [redacted] area.

On 1/29/2020 at 9:20 AM, the surveyor interviewed the LPN who stated that Resident #3 had a [redacted]) area

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and had provided treatments to the [redacted] according to the physician's orders signed on the electronic treatment administration record (eTAR). The LPN could not speak to the [redacted] of the [redacted] but knew that the [redacted] consultant had seen the resident on 1/28/20. The LPN added that the RN/UM had a [redacted] book which outlined the [redacted] and treatment of each resident who had a [redacted].

On 1/29/20 at 9:42 AM, the surveyor with the RN/UM reviewed the [redacted] records regarding Resident #3. The RN/UM stated that the resident had several hospitalizations and the [redacted] was improving. The RN/UM added that the [redacted] consultant had seen the resident on [redacted] and the treatment that was ordered by the physician on [redacted] was going to continue.

The surveyor reviewed the medical record for Resident #3.

A review of the Admission Record face sheet reflected that the resident was recently admitted to the facility with diagnoses which included a [redacted]

A review of the quarterly MDS dated [redacted] reflected the resident had a BIMS score of [redacted], indicating that the resident had a [redacted]. In addition, the section M for Skin Conditions reflected that the resident's skin condition had an [redacted]

A review of the current Order Summary Report

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F 658	Continued From page 19 reflected a physician's order (PO) dated 1/7/20 to [redacted] A review of the current electronic medication treatment record (eTAR) reflected the administration of the PO [redacted] treatment to the resident from [redacted]. According to the eTAR, there was no documentation that the treatment was administered on 1/8/20, 1/9/20, 1/14/20 and 1/22/20. On 1/29/2020 at 10:23 AM, the surveyor with the LPN reviewed the eTAR for January 2020 for the resident. The LPN stated that when she does the treatment she then signs the eTAR after completing the treatment. The LPN added that there were days that an extra nurse worked and that nurse would complete the [redacted] treatments for the floor. The LPN also stated that whoever does the treatment should sign the eTAR when the treatment was completed. The LPN could not speak to the blanks for the administration of the [redacted] treatment on 1/8, 1/9, 1/14 and 1/22. On 1/30/2020 at 10:34 AM, the survey team met with the LNHA and the DON. The DON stated that she had checked with the nurses responsible for administering the [redacted] treatment to Resident #3 and the [redacted] treatment was completed but the nurses had not signed the eTAR for 1/8, 1/9, 1/14 and 1/22. The DON stated that the nurse who administers the treatment must sign the eTAR after the treatment was	F 658		

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F 658	Continued From page 20 completed in accordance with professional standards of nursing practice. NJAC 8:39- 11.2(b), 35.2(g)(1)	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that a resident who was dependent on staff for activities of daily living was provided nail care consistent with his/her needs and preferences. This deficient practice was identified for 1 of 5 residents reviewed for activities of daily living (Resident #51), and was evidenced by the following: On 1/26/2020 at 10:04 AM, the surveyor observed Resident #51 in an upright position in bed. The resident's breakfast tray was located on the tray table to the right of the resident's bed. The resident pointed at the surveyor and stated that he/she had spilled his/her coffee and needed a new cup. The surveyor observed a white thick food-like substance on the resident's thumb. The surveyor observed that all 10 of the resident's fingernails were long with a black colored substance underneath the nails. On 1/28/2020 at 9:38 AM, the surveyor observed	F 677	1. For resident #5, who□s preference is to eat with their hands, had their nails cleaned and trimmed immediately. 2. An audit was completed to ensure that all residents□ nails were cleaned and trimmed and no other residents were affected. 3. In-services were conducted for nursing staff on care of Fingernails/Toenails as part of daily routine care. 4. Unit Manager/designee will conduct biweekly audits x 4 weeks, then weekly x 4 weeks to ensure that nail care is provided. Results of the audits will be submitted to DON for review. The results of the audits will be submitted to the Quality assurance and Performance improvement committee quarterly by the	2/13/20

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F 677	Continued From page 21 the resident in bed. The resident's fingernails were long with a blackish substance underneath the nails. The surveyor asked the resident about the length of his/her nails. The resident stated that his/her fingernails were cut. The surveyor asked how often his/her nails got cut and the resident stated his/her age incorrectly, and that his/her fingernails no longer grew. The surveyor reviewed the medical record for Resident #51. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included [redacted]. A review of the resident's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a brief interview for mental status (BIMS) score of [redacted] A further review of the MDS, Section G for Functional Status reflected that the resident required a one-person extensive physical assist for personal hygiene. A review of the resident's individualized care plan dated 10/15/18 included that the resident had an activities of daily living (ADL) self-care performance deficit related to physical limitations. Interventions included for one person assist with ADL's and to assist with daily hygiene, grooming, dressing, oral care, and eating as needed. The care plan did not specifically address nail care.	F 677	DON/designee to determine further action to the plan if needed	

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A review of the resident's electronic Certified Nursing Aide (CNA) kardex, a communication tool used by CNA's with specific resident care needs and preferences, included under eating/nutrition to check hands/nails and offer to wash if visibly soiled. There was no evidence of when that intervention was initiated.

On 1/29/2020 at 9:20 AM, the surveyor interviewed the resident's CNA who stated that nail care was done when she "had time" or the resident's fingernails were too long. The CNA continued that if the fingernail was passed the nail bed, then the fingernail would be cut or filed down. The CNA stated that she soaked the resident's hands in water and cleaned under the fingernails usually one to two times a week, only if she had time to do it. The CNA stated that there was no tracking or accountability for nail care. The CNA stated that the resident had not refused nail care in the past.

At 10:19 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that the CNA performed care on the resident. The LPN stated that she was not aware that the resident refused showers or personal hygiene care. The LPN stated at times, the resident became angry and would demand staff get out of his/her room. When the resident calmed down, staff would be able to return to the room and continue with that task.

At 11:39 AM, the surveyor observed the CNA and the resident in the resident's room. The CNA assisted the resident with the lunch meal setup. The surveyor observed the resident pick up a piece of bread and observed the resident's fingernails were long and beyond the nail bed,

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F 677	Continued From page 23 with a blackish substance underneath. At this time, the surveyor stepped out of the room with the CNA. The CNA confirmed that the resident's fingernails were long and had a blackish substance underneath the nails. The CNA stated that the fingernails should be cut and cleaned and she would do that today. The CNA was unable to recall the last time she performed nail care on the resident. On 1/30/2020, the Director of Nursing (DON) stated, in the presence of the Licensed Nursing Home Administrator (LNHA) and the survey team, that cleaning underneath the fingernails should be performed daily with care. The LNHA stated that staff were in-serviced yesterday on nail care. The DON acknowledged that there was no accountability system for nail care. A review of the facility's Fingernails/Toenails, Care of policy dated revised February 2018, included that nail care includes daily cleaning and regular trimming. NJ 8:39-27.1(a)	F 677		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		2/13/20

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F 686	Continued From page 24 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to: a.) accurately assess the skin and obtain a physician order for [redacted] treatments for a newly admitted resident with [redacted] for two days, b.) appropriately apply a moisture barrier cream to prevent skin breakdown during an incontinence care observation, c.) apply a [redacted] treatment in accordance with a physician's order, and d.) maintain the proper functioning of two low-air loss mattresses used for skin protection. This deficient practice was identified for 3 of 5 residents reviewed with [redacted] (Resident #40, #53, and #166). The evidence was as followed: 1. On 1/27/2020 at 10:42 AM, the surveyor observed Resident #40 in bed and lying on a low air-loss mattress with the head of the bed slightly elevated. There was an [redacted] secured to the resident's bed frame with the [redacted] in a blue privacy cover. The [redacted] was draining [redacted]. At that time, the resident wouldn't speak specifically to the surveyor's inquiry. The resident was unsure if he/she had any [redacted] that the nurse was treating. On 1/28/20 at 9:54 AM, the surveyor observed the Certified Nursing Aide (CNA) in the resident's	F 686	1. a)Resident # 40 reassessment was completed on [redacted] and appropriate orders were obtained which supported [redacted] healing and the [redacted] healed on [redacted] b)Resident #166 continued with same treatment and skin alteration improved and is resolving. c)For resident # 53, the dressing was changed and dated. d)O-rings were immediately replaced. 2. Residents with an alteration in skin have the potential to be affected. 3. In-services were conducted for nursing staff on documentation of complete skin assessment upon admission, proper [redacted] care to include applying moisture barrier, and performing wound treatment as per MD order/policy. Maintenance and nursing staff were educated bed surface systems and proper function/application.	

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F 686	Continued From page 25 room preparing to provide morning care to Resident #40. At that time in the presence of the CNA, the surveyor asked the resident's permission to observe morning care with the CNA, and the resident refused. The surveyor then exited the resident's room to allow the CNA to continue with the care. The surveyor reviewed the medical record for Resident #40. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility on [redacted] with diagnoses which included [redacted] A review of the hospital records printed on [redacted] reflected that the resident had an extended hospitalization for [redacted] The hospital records reflected that the resident had a [redacted] which was [redacted] The hospital records reflected that the resident had multiple [redacted] to the [redacted], and that the resident had an [redacted] to promote [redacted] healing due to the multiple [redacted]. The hospital records did not include documented evidence of [redacted]	F 686	4. DON/Designee will conduct weekly chart audits x 4 weeks, then monthly x 1 month to validate appropriate skin evaluation upon admission. In addition, care will be observed on two residents per week for four weeks to evaluate the application of moisture barrier. Unit Manager/Designee will check weekly for four weeks up to five patients for application of wound treatments, including the date. Maintenance Director or designee will conduct monthly audit of air mattress and O-Ring operation for 2 months. Results of the above audits will be submitted quarterly to the Quality Assurance and Performance Improvement committee by the DON/Designee to determine further action to the plan if needed.	

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A review of the Universal Transfer Form (UTF) (a communication tool to summarize transfer information) dated [redacted] indicated that the resident had a [redacted] but no other [redacted] or [redacted]

A review of the electronic Progress Notes (ePN) dated upon admission on [redacted] at 11:38 PM included that the resident was admitted with "current skin breakdown/skin conditions: refer to the completed evaluation and physician orders for type and location."

A review of the Resident Evaluation/initial nursing admission assessment dated [redacted] included that the resident had an [redacted] for the contamination of a [redacted] Under the Skin Evaluation section, the space to record additional observations/comments was blank. There was no documented evidence of additional [redacted] present upon admission.

A review of the physician's orders sheet with a start date of 12/25/19 included a physician order (PO) to cleanse the [redacted] with [redacted] every shift. There was no documented evidence of a physician order for a treatment to [redacted] to the [redacted].

A review of the electronic Treatment Administration Record (eTAR) for December 2019 included the PO dated 12/25/19 for the [redacted]

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F 686	Continued From page 27 [redacted], but there was no documented evidence upon admission for the accountability for a [redacted] dressing or treatment to [redacted] for the dates of 12/24/19, 12/25/19 or 12/26/19. A review of the subsequent ePN's dated 12/25/19 and 12/26/19 did not reflect documented evidence to address the [redacted] or a treatment to those areas. A review of a ePN dated three days after admission on 12/27/19 at 4:30 PM, reflected that the Registered Nurse/Unit Manager documented that Resident #40 was "admitted on [redacted] with [redacted] care treatment orders as follows: [redacted] ..." The RN/UM then documented at 5:10 PM that day that the [redacted]. She documented the [redacted] (This was the first time the [redacted] were addressed). There was no documented evidence for the identification or a treatment order for the [redacted] on [redacted] upon admission to the facility. A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected	F 686		

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that the resident had a brief interview for mental status (BIMS) score of [redacted], indicating a [redacted]. The assessment further included that the resident was admitted with [redacted].

A review of the [redacted] consultant initial Visit Report dated 12/31/19 reflected that the resident had a [redacted], in addition to a [redacted] The [redacted] measured [redacted] and also had [redacted] The [redacted] consultant/Nurse Practitioner (NP) indicated that the [redacted] and recommended to appl [redacted].

On 1/28/20 at 11:20 AM, the surveyor interviewed the RN/UM who had documented three days after admission that the resident was admitted with [redacted] The surveyor asked the RN/UM about the note she wrote on 12/27/19, and the RN/UM stated that the resident was admitted on [redacted] and that usually she does a skin check on new admissions. She stated that she did a skin check on [redacted] and saw the [redacted], and she reviewed the hospital records and saw that the resident had skin breakdown while at the hospital. She confirmed the hospital records did not include what [redacted] were, so she could not speak to if the [redacted] had improved, stayed the same, or worsened

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since admission. The RN/UM confirmed that the UTF reflected that the resident did not have a [redacted], and she suggested maybe it was an error by the transferring hospital.

The RN/UM acknowledged that the admission Resident Evaluation assessment dated [redacted] did not address the [redacted] or that Resident #40 had any behaviors that would have limited staff's ability to inspect the resident's skin. The RN/UM stated that upon admission, the LPN's are expected to perform a head-to-toe skin assessment and document the findings within the resident's medical record. The RN/UM stated that she documented that the resident came to the facility with the [redacted]. The surveyor asked if she spoke to the Licensed Practical Nurse (LPN) who performed the admission assessment, or if the CNA's who had performed incontinence care had observed the presence of the [redacted] and the RN/UM stated that she had not spoken to those staff prior to writing her note, and that she had just assumed that it had been there based solely on the hospital record. She confirmed the hospital records were vague in the assessment stage of the [redacted]. She acknowledged that the [redacted] consultant/NP documented the [redacted]

The RN/UM stated that she had brought this situation up to the the Director of Nursing (DON) on 12/27/19. The RN/UM confirmed there was no physician order for the treatment to the [redacted] on 1[redacted] and [redacted]. The RN/UM could not speak to if the [redacted] had reopened. The RN/UM stated that she did not perform an investigation but that the surveyor could ask the DON.

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F 686	Continued From page 30 On 1/28/20 at 11:46 AM, the surveyor interviewed the CNA who stated that she was always the CNA assigned to care for Resident #40 since admission, and that she worked full time during the day shift (7 AM to 3 PM). The CNA stated that the resident was always cooperative with care for her, and that he/she was incontinent of bowel and had a bowel movement this morning. The CNA stated that the resident came in to the facility with [redacted], and that he/she always had a treatment over top of the [redacted] that she could recall, even on Christmas day when she worked. On 1/28/20 at 12:04 PM, the surveyor interviewed the MDS Coordinator/Registered Nurse who stated her primary full time role was to complete the MDS assessments for each resident in the building. The MDS Coordinator stated that she does not directly observe skin during her assessments, but that she relies on the initial nursing Resident Evaluation assessment done on admission and the [redacted] flow sheets which reflect if the [redacted] were present upon admission. At that time, the MDS Coordinator/RN provided the surveyor a copy of the [redacted] for the [redacted] with dates of origin identified as 12/24/19. The boxes were checked that the resident was admitted with these [redacted]. The MDS Coordinator stated that she relies on the accuracy of the [redacted] flow sheets when completing the MDS assessments, to determine if the resident was admitted with the [redacted] or if a [redacted] was facility-acquired. She stated that since the flow sheet indicated that the resident was admitted with the [redacted], then she documented in the MDS dated [redacted]	F 686		

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F 686	Continued From page 31 that the resident came with the [redacted] On 1/28/2020 at 2:27 PM, the surveyor interviewed the full time Registered Dietician (RD), who stated that Resident #40 had some [redacted], keeps snacks in the room, and that the resident gets added protein with medication pass due to [redacted]. The RD stated that she completed an initial assessment on [redacted] and when a resident is forgetful or an unreliable historian, she relies on the admission nursing assessment/Resident Evaluation to be accurate when reviewing skin conditions to determine if she should make recommendations for vitamins or supplements to aid in [redacted] healing. She acknowledged that her initial evaluation on [redacted] did not reflect the [redacted] because it was not in the Resident Evaluation dated 12/24/19. She stated that she knew the resident had a [redacted] and had made recommendations based on that [redacted] to promote [redacted] healing through nutritional means. She added that she also recommended labs to determine nutritional status which were done. The RD stated she adjusted the resident's nutritional plan after the [redacted] collected on [redacted]. On 1/28/2020 at 1:16 PM in the presence of the survey team, the DON stated that there was no investigation conducted for the [redacted] On 1/29/20 at 10:44 AM, the surveyor interviewed the DON and the Licensed Nursing Home Administrator (LNHA). The DON stated that she spoke to the admitting LPN who told her that the	F 686		

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resident refused to turn on the side to do a full skin inspection, and therefore the skin could not be adequately visualized. The DON stated that if a resident refuses to turn for the admission assessment, that the physician should be notified when obtaining orders, and it should get reported on the 24 hour report to check the skin at the next incontinence care change or at the next most convenient time when the resident was getting up, such as for physical therapy. The DON acknowledged that she did not get statements from the CNA's or nurses who cared for the resident on 12/24/19, 12/25/19 and 12/26/19 to see if [redacted] were identified during incontinence care, and if so, did they report the [redacted] to the nurse or the supervisor, because there had been no treatment order in place one those dates. The DON acknowledged that there was no treatment order in place on 12/25/19 and 12/26/19 to the [redacted]. The DON stated that the resident was admitted with the [redacted] and that as of yesterday [redacted], the [redacted] had both healed. The DON and LNHA were unable to provide documented evidence from the hospital as to what [redacted] were upon admission to the facility.

On 1/29/2020 at 12:32 PM, the surveyor conducted a phone interview with the [redacted] consultant/Nurse Practitioner (NP) who stated that she started consulting with the facility in April or May of 2019. The NP stated that she makes [redacted] rounds every Tuesday. The NP added that Resident #40 had a [redacted] with [redacted] and [redacted] to the [redacted] that she believed were present on admission. The NP stated that the resident had been on an air mattress every since

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she started seeing the resident [redacted]), otherwise she would have recommended one. The NP stated that she doesn't document where the [redacted] are acquired but that the RN/UM tells her, and that she makes recommendations based on that information provided. The NP stated that when she made rounds yesterday on [redacted], both [redacted] were healed, and that she just recommended a barrier cream to the [redacted] for skin protection.

On 1/29/2020 at 12:02 PM, the surveyor attempted to conduct a phone interview with the LPN who admitted the resident on [redacted]. The LPN did not answer the phone nor return the surveyor's request for a return call.

On 1/30/2020 at 12:36 PM, the surveyor conducted a phone interview with the Registered Nurse/Supervisor (RN/S) for the evening shift of 12/24/19. The RN/S stated that she went into the resident's room with the LPN that evening to assess the resident's skin but the resident was refusing to be turned to fully check the skin, even with family attempting to encourage the resident to turn. The RN/S stated that she believed there were open areas to the [redacted] due to the fact the resident had an [redacted] from the hospital, and that the hospital records reflected evidence of a history of [redacted] to the [redacted]. She stated that she did not recall communicating with anyone (nurse or physician) that the resident's skin was not fully assessed due to his/her refusal to turn in bed to adequately visualize the skin. The RN/S stated that she believed the resident was admitted on an air mattress due to the resident's condition and risk factors. The RN/S confirmed to the surveyor that there had been no investigation done prior to

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surveyor inquiry to evaluate why there had been no treatment in place to the [redacted] for two full days when the resident allegedly was admitted with [redacted].

2. On 1/27/20 at 10:58 AM, the surveyor observed Resident #166 in bed with the resident's family representative at the bedside. A CNA (CNA #1) and Occupational Therapist (OT) were in the resident's room, and CNA #1 was preparing to turn the resident to the left side to perform incontinence care. At that time, the surveyor observed CNA #1 and OT turn the resident and remove an incontinent brief soiled with a moderately sized loose bowel movement (BM). CNA #1 removed the BM from the resident's skin using a terry cloth towel and with each long motion of the cloth against the [redacted], the resident flinched forward, saying "It hurts."

The surveyor and CNA #1 observed the resident's [redacted] area which was [redacted] in appearance, but the skin was intact. The [redacted] area had a [redacted] about the size of a softball. There was no evidence of residual barrier cream or [redacted] ointment observed on the skin. At that time, CNA #1 stated to the surveyor that this was the first time that she has worked with Resident #166. The resident was not assigned to her, she was just covering for the resident's assigned CNA #2 who was assisting with another resident at that time. CNA #1 stated that the resident's skin was "very reddened" and didn't know what the redness was from. At that time, the CNA #1 removed personal protective equipment (PPE), washed her hands and told the surveyor that she

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wanted to get a nurse to assess the resident's [redacted] skin.

At 11:09 AM, the surveyor observed the resident's assigned CNA #2 apply PPE and enter the resident's room with LPN #1. LPN #1 introduced herself stating that she was not the resident's assigned LPN today, but that she would assess the resident's skin. At that time CNA #2 stated to the surveyor that she performed morning care for Resident #166 before 8:00 AM. She stated that the resident had a formed bowel movement this morning and that she hadn't yet been back until now. CNA #2 confirmed it had been three hours since she was last checked for an incontinence episode. At that time, the CNA #2 secured the new incontinent brief and pulled up the resident's pants without applying a barrier cream, and before the LPN #1 could inspect the skin.

At 11:14 AM, LPN #1 stated she needed to assess the resident's skin. At that time, LPN #1 and CNA #2 removed the incontinence brief to inspect the skin. LPN #1 just looked at the area without touching and stated, "it's reddened so [Resident #166] needs to get barrier cream to the area." LPN #1 stated that the resident was not assigned to her but that she believed the resident had an order for a barrier cream to protect the skin. At that time, the LPN #1 removed the PPE and washed her hands and exited the room to get barrier cream. LPN #1 stated there was no barrier cream in the room and that barrier cream was not kept in individual resident rooms, only the treatment cart.

The LPN #1 returned to the resident's room with LPN #2 who was assigned to care for the

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resident. Wearing a gown and gloves, LPN #2 came into the room with a medicine cup filled with "barrier cream" and handed it to LPN #1 to apply. LPN #2 stood by the doorway while LPN #1 and CNA #2 went over to the resident to apply the barrier cream. LPN #1 then applied a thick layer of barrier cream to the [redacted] area on the [redacted] using a tongue blade. She did not apply barrier cream to any other areas of the resident's [redacted] or [redacted] areas of the [redacted]. She then secured the resident's incontinent brief and CNA #2 assisted in adjusting the resident's pants and repositioning the resident. The facility staff then obtained a mechanical lift to transfer the resident into a chair.

At 11:30 AM, the surveyor interviewed LPN #1 who stated that she just applied the barrier cream only to the reddened area. The surveyor asked what the reddened area was, and she stated stated it is a "non-blanchable redness" and thinks it might be from pressure. The surveyor asked LPN #1 how she knew it was non-blanchable (a condition of the skin that remains red when pressed, typically indicative of a stage I pressure ulcer) and LPN #1 could not speak to it, as the surveyor did not observe LPN #1 press or palpate the area. LPN #1 stated that the [redacted] team came every Tuesday (tomorrow) to evaluate [redacted], and that they would be able to better evaluate what the redness was. She stated that in the mean time, the barrier cream would protect the area. She didn't speak about protecting the rest of the [redacted] from incontinence episodes when asked.

At approximately 11:32 AM, the surveyor interviewed LPN #2 who stated that Resident

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#166 was on transmission based precautions for [redacted] and was currently only on an [redacted] to treat it since admission to the facility. LPN #2 stated the resident had a bowel movement this morning when the CNA #2 changed her. LPN #2 acknowledged that she had not done an incontinence check between when CNA #2 had last been in the room at the beginning of the shift until now at 11:00 AM. LPN #2 confirmed it was approximately three hours since the resident had last been checked. She couldn't speak to how often a resident with [redacted] should be checked for incontinence episodes for the purpose of protection of the skin.

At approximately 11:35 AM, the surveyor interviewed CNA #2 who stated that she keeps the residents skin protected by applying a moisturizing lotions to her body when she does care, including the [redacted] area. She stated she applied lotion to the resident this morning. The surveyor asked where the lotion was kept, the CNA #2 stated that it was kept at the bedside. The CNA #2 acknowledged that barrier cream that the nurse applied today was not kept at the bedside, and that nurses apply the barrier cream.

The surveyor reviewed the medical record for Resident #166.

A review of the Admission Record reflected that the resident was recently admitted to the facility with diagnoses which included [redacted]

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The surveyor attempted to review the admission MDS, but the resident was admitted [redacted]

A review of the resident's individualized care plan initiated on [redacted] included that the resident was admitted with a [redacted] The goal specified, "will decrease/minimize skin breakdown risks." Interventions included, to apply "Barrier cream to p[redacted] as needed." Provide preventative skin care routinely and as needed. (The care plan did not address the resident's bowel incontinence or how often incontinent checks should be performed with a [redacted]).

A review of the CNA kardex (communication tool for CNA's addressing resident-specific needs and preferences) with a print date of 1/23/2020 included toileting and elimination needs. The kardex indicated, "Apply barrier cream after incontinence/peri care and as needed (FYI) [For Your Information]."

A review of the nursing admission assessment/Resident Evaluation dated [redacted] included that the resident was admitted with [redacted]"

A review of a physician's order dated [redacted] included to apply a barrier cream to the [redacted] after routine cleansing every shift "for [redacted]."

A review of the electronic Treatment Administration Record (eTAR) for January 2020 revealed that nurses were signing every shift for applying barrier cream to the [redacted] every shift (day, evening and night shift)

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A review of the [redacted] consultant/NP initial Visit Report dated [redacted] included that the resident had a [redacted] to the [redacted]. The NP recommended [redacted] barrier cream to continue to the region with each shift change and maintain a turning and repositioning program as per facility protocol.

On 1/29/20 at 10:22 AM, the surveyor interviewed a third LPN (LPN #3) who stated that "We apply barrier cream every shift and with each incontinence care." LPN #3 stated it should be applied to the [redacted] and the entire [redacted] area, and not just the reddened area.

At approximately 10:30 AM, the surveyor interviewed the RN/UM who stated that barrier cream was to be applied to the [redacted] a with each incontinent episode and not just on reddened areas. The RN/UM added that the residents are checked every 2-3 hours for incontinence.

On 01/29/2020 at 10:34 AM, the surveyor interviewed the DON who stated that incontinence care checks should be done every every 2-3 hours routinely. The surveyor asked if incontinence checks get performed any more frequently for a resident with a CDI, and the DON stated it was dependent on how often the resident was having a bowel movement. The DON could not speak to how often the resident was having BM or if they were loose. The DON stated that the barrier cream was kept in the treatment cart of the nurse and not in individual resident rooms. CNA's can carry the individual barrier ointment cream packs in their pockets. She could not

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speak to if they do that, but confirmed that that the packs are kept in the locked treatment cart. The DON stated resident's are not assigned bottles of barrier cream but that it is dispensed into a medicine cup from a stock supply or they had individual packets. She was not exactly sure why barrier cream was not kept at the resident bedside, but thought it might be for safety reasons. The DON stated that with each incontinence care, CNA's should apply the barrier cream over the entire [redacted] to protect the skin, and not just on the reddened area. She confirmed if the barrier cream was only applied to the reddened areas, it would not protect the non-reddened areas.

On 1/29/2020 at 12:38 PM, the surveyor conducted a phone interview with the [redacted] consultant/NP who stated that Resident #166 had a [redacted]. The NP stated that the expectation was that direct care staff apply barrier cream over the entire surface of the [redacted] to protect the skin from moisture and incontinent/moisture associated dermatitis (moisture rash). She stated that the expectation to prevent skin breakdown or prevent recurrence of skin breakdown would be to prophylactically apply the barrier cream after each incontinence episode. The NP could not speak to the accessibility of the barrier cream for CNA's.

On 1/30/2020 at 10:45 AM, the surveyor interviewed the DON and the LNHA in the presence of the survey team. The DON acknowledged that the barrier cream must be applied to the entire [redacted], "everywhere" and not just the reddened area. The DON provided the surveyor copies of in-service education from 5 CNAs regarding incontinence care, titled [redacted]

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F 686	Continued From page 41 Management. The education included, "understanding the proper procedure for [redacted] and [redacted] is important to prevent odors, infections, and skin breakdown." A review of the facility's [redacted] policy revised 3/4/19 included that barrier creams and lotions (as indicated) was a supply necessary when performing care. After providing incontinence care, rinse well and pat dry. The next step specified to "Apply barrier creams or lotions as indicated." (The policy did not specify where the barrier cream would be applied) A review of the facility's [redacted] Care policy revised February 2018, did not include use of a barrier cream. 3. On 1/27/2020 at 11:24 AM, the surveyor observed Resident #53 sitting upright in a wheelchair in his/her room. The surveyor observed that the resident had a low-air loss mattress. The resident told the surveyor that he/she had a '[redacted] on his/her [redacted] that occurred at the facility and the nurses performed a treatment to it every day. On 1/29/2020 at 10:50 AM to 11:35 AM, the surveyor observed a LPN with the assistance of the RN/UM, perform a [redacted] treatment to Resident #53's [redacted]. Prior to performing the wound dressing change to the resident's [redacted] area, the LPN reviewed the Physician's Order (PO) with the surveyor. The LPN told the surveyor that she was going to cleanse the Moisture Associated Skin	F 686		

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Damage (MASD) (moisture rash) with [redacted] dressing that does not stick to the area and is comfortable and soothing to the skin), and then cover with a [redacted] dressing.

The surveyor observed the resident positioned on his/her right side. The surveyor observed a white border dressing attached to the resident's [redacted]. The dressing was observed to be smaller than the affected area on the resident's [redacted] and did not completely cover the MASD on the resident's [redacted]. The surveyor further observed that the dressing was not dated, timed, and there were no initials on it.

At 11:20 AM, the LPN removed the dressing attached to the resident's [redacted]. The surveyor observed that when the LPN removed the [redacted]. The surveyor asked the LPN to describe what the [redacted] looked like to the surveyor. The LPN stated that the [redacted] was MASD, had [redacted] The surveyor asked the LPN to look at the dressing she had just removed from the resident's [redacted] and describe what the [redacted] looked like. The LPN stated that there was a [redacted]

The surveyor reviewed the medical records for Resident #53.

A review of the resident's Admission Record record face sheet reflected that the resident had

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F 686	Continued From page 43 diagnoses which included, but were not limited to [redacted]. A review of the resident's most recent quarterly MDS dated [redacted] reflected that the resident had a BIMS score of [redacted]. A review of the resident's January 2020 Order Summary Report (OSR) reflected a PO dated [redacted] to [redacted]. A review of the resident's undated comprehensive care plan reflected a focus area that the resident had actual skin breakdown on the [redacted] related to MASD. The goal reflected that that resident's [redacted] would heal without complications. The interventions included to administer a treatment in accordance with physician's orders and provide follow-up care with the physician as ordered. On 1/29/2020 at 11:56 AM, the surveyor interviewed the resident's LPN who stated that the resident was alert and oriented and could make their needs known. The LPN stated that the resident was [redacted] at times and needed assistance with repositioning in bed. The surveyor explained to the LPN the observations made during the [redacted] care treatment. The surveyor asked about the dressing she removed	F 686		

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from the resident's [redacted] which was small, didn't cover the affected area, was undated/timed, and there was no [redacted] when removed. The LPN responded, "You're right. I noticed that too when I took off the dressing." The LPN stated that the [redacted] care nurse came to the facility on 1/28/2020 so she wasn't sure who performed the treatment to the resident's [redacted] the day before because she did not. She could not speak to if the dressing was changed during an incontinence episode either.

On 1/29/2020 at 12:41 PM, the surveyor interviewed the RN/UM who stated that she noticed when the LPN removed the dressing to the resident's [redacted] it was the incorrect [redacted] treatment and did not correspond with the physician's order. The RN/UM further stated that she was the nurse who performed the correct [redacted] treatment to the resident's [redacted] with the [redacted] care physician the day before at approximately 5:00 PM. The RN/UM further stated that a nurse working the 3:00 PM to 11:00 PM or the 11:00 PM to 7:00 AM nurse must have incorrectly applied the treatment to the resident during incontinence care and she would have to conduct an investigation as to what exactly happened.

On 1/30/20 at 11:39 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the resident was provided incontinence care during the 11:00 PM to 7:00 AM shift at which time the resident's dressing became soiled and the nurse applied an incorrect treatment to the resident's [redacted]. This was not reflected in the eTAR or the progress notes.

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F 686	Continued From page 45 A review of the facility's policy for [redacted] in the skin revised September 2013 included to "Review the resident's care plan, current orders, and diagnoses to determine resident needs. Check the treatment record...assemble the equipment and supplies as needed." 4. On 1/27/2020 between 10:30 AM and 12:00 PM during tour of the building in the presence of the Maintenance Director, the surveyor observed 2 of 5 resident rooms (Room [redacted] and Room [redacted] with air mattresses. The residents were observed to be in bed on top of their respective air mattresses. The surveyor observed that the air mattresses were making a slight hissing sound. Upon closer inspection, the PSI gaskets in the respective rooms had an air leak producing a continuous air flow in an attempt to keep the mattress inflated to their settings. The surveyor could palpate the air. The Maintenance Director confirmed to the surveyor that the air mattresses needed a new "O-ring" to prevent leaking and hissing of the air. The surveyor observed that despite the air leaking from the site of the O-ring, the resident's air mattresses were not currently deflated.	F 686		
F 732 SS=B	NJAC 8:39-27.1(a) Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily	F 732		2/13/20

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F 732	Continued From page 46 basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to post the nurse staffing report daily. This deficient practice was identified	F 732	1.The nurse staffing data was correctly posted on 1/26/20 after survey entrance. 2.No residents were impacted.	

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F 732	Continued From page 47 on 1/26/2020, and was evidenced by the following: On Sunday 1/26/2020 at 8:57 AM, the surveyor observed a nursing staffing report posted on the front reception desk. The receptionist was present. The nursing staffing report was dated for Friday 1/24/2020 evening shift and reflected a census of 70. On 1/30/2020 at 11:06 AM, the Director of Nursing (DON) stated that the staffing coordinator had printed out the nurse staffing report for the weekend, and it was the receptionist's job responsibility to post the accurate daily staffing report when she arrived at the facility. The DON acknowledged that the receptionist did not update the posting on 1/25/2020 and 1/26/2020 upon the start of her shift. The DON further stated that when the corporate nurse came to the facility the morning of 1/26/2020, the corporate nurse also noticed that the nurse staffing report was not posted accurately in accordance with the correct day and census. NJAC 8:39-41.2	F 732	3.Staff was re-educated to ensure that data is pulled forward at the beginning of their shift. 4.The administrator/designee will check/audit weekly x 4 weeks that both days are posted appropriately. The results of the audits will be submitted quarterly to the Quality Assurance and Performance committee by the administrator/designee to determine further action to the plan if needed.	