STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315419	A. BUILDING _____ B. WING _____	C 06/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N J EASTERN STAR HOME	**111 FINDERNE AVENUE BRIDGEWATER, NJ 08807**

(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 Complaint #: NJ144937 and NJ135858 Census: 89 Sample Size: 5 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609		7/13/21

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

Electronically Signed | 07/08/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 609	Continued From page 1 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint Intake NJ135858 Based on record review, interviews, and facility policy review, it was determined that the facility failed to report an injury of unknown source to the state agency for 1 (Resident #1) of 3 sampled residents reviewed for injuries of unknown source. Findings include: 1. Resident #1 was readmitted with diagnoses including NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted]. The annual Minimum Data Set (MDS), dated [redacted], revealed the resident was [redacted] with a Brief Interview for Mental Status (BIMS) score of [redacted]. The resident required one-person physical assistant for bed mobility, dressing, personal hygiene, locomotion and two-person physical assistant for transfer and [redacted]. A review of Resident #1's medical record revealed a nursing note dated 03/10/2020 at 6:00 AM. The note documented no unusual findings with Resident #1 during the shift, it further reported that no pain or acute distress was noted with Resident #1. At 10:00 AM of the same day, the nursing note indicated Resident #1 complained of [redacted]. On assessment, it was noted that the resident had a [redacted] to the [redacted]. The skin around the resident's [redacted] was reported as [redacted]. At 11:00 AM, it was documented that the medical director (MD) was	F 609	1.New administrator hired and started employment at NJ Eastern Star Home July 2020. Previous administrator who failed to report the injury of unknown origin to the state agency is no longer employed by the facility. Policy for injury of unknown origin implemented by new administrator upon employment and revised January 2021. An apparent cause analysis was performed and determined that the cause of the deficient practice was due to human error of the previous administrator. As per #3 and #4, below, in-service education, policy and process changes were made as part of the apparent cause analysis. Resident was transferred to acute care for evaluation and assessed by MD upon return to the facility. To ensure that the deficient practice does not reoccur for this resident, DON will ensure that all required assessments will be consistently completed at the required intervals accordance with professional standards of practice. 2. No other documentation or reports regarding other injuries of unknown origin were obtained or endorsed upon assuming the position of administrator at NJESH. As all residents have the potential to be	

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F 609	Continued From page 2 contacted with an order for an X-ray to Resident #1's [NJAC 8:43E-2.1 and E]. The nursing note reported that the said X-ray result was received at 6:00 PM and it was positive for an [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] [NJAC 8:43E-2.1 an], likely related to an [NJAC 8:43E-2.1 and Exec Order 2]. The note at 7:00 PM, read that Resident #1's family/responsible party was made aware of the injury and informed of the MD's directive to send Resident #1 to the emergency room (ER). On 03/10/2020 at 1:00 PM, it was reported that Resident #1 came back from the ER with a [NJAC 8:43E-2.1 and Exec Order 26, 4.] There was no documentation of a conclusive investigation to ascertain the cause/origin of the [NJAC 8:43E-2] to Resident #1's [NJAC 8:43E-2.1 and E] in the record. The record lacked information that revealed the facility reported a case of i[NJAC 8:43E] of unknown origin to the state survey agency (SSA). On 06/18/2021 at 10:12 AM, the Director of Nursing (DON) reviewed Resident #1's medical record and verified the cause of the [NJAC 8:43E] sustained by the resident to the [NJAC 8:43E-2.1 and E] was undetermined. He concluded that there was no record on file which showed that the SSA was notified. The DON said when a nursing assessment identified an injury on a resident that was not consistent with what the resident admitted with, he immediately started an investigation. The DON stated he would interview the resident and any witness to get a clear account of how, where, and when the injury occurred. The DON said the MD and the resident's family/responsible party were notified. The DON said the next course of action was to launch an investigation to ascertain the root cause of the injury. The DON clarified that, if the cause of the injury was undetermined, it was	F 609	affected by the deficient practice, current administrator and DON will conduct an audit of recent safety reports. This will ensure they are completed and any investigations and/or required reporting to the state agency are completed in accordance with regulation. 3. New Director of Nursing started August 2020. DON created and implemented new Safety Report and Injury of Unknown Origin Investigation Form. All staff re-educated on new forms, policy and reporting procedures by Staff Development Coordinator and DON. 4. Any safety reports including injuries of unknown origin are reported by the nursing supervisor at morning clinical meeting and by the DON at Safety Meeting and Quality Assurance Performance Improvement meetings which are held quarterly.	

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F 609	Continued From page 3 reported to the SSA as an injury of unknown origin. The Injury of Unknown Origin Policy, dated 01/18/2021, was provided by the nursing home administrator (NHA). It read in part, "If the cause of the injury remains unknown, the injury will be reported to the department of Health."	F 609		
F 610 SS=D	New Jersey Administrative Code § 8:39-5.1(a) 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: Complaint Intake: NJ135858 Based on record review, interviews, and facility policy review, it was determined that the facility failed to investigate an injury of unknown source	F 610	1.New administrator hired and started employment at NJ Eastern Star Home July 2020. Previous administrator and DON who failed to investigate the injury of unknown origin are no longer employed	7/13/21

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F 610	Continued From page 4 for 1 (Resident #1) of 3 sampled residents reviewed for injuries of unknown source. Findings include: 1. Resident #1 was readmitted with diagnoses including NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] The annual Minimum Data Set (MDS), dated [redacted], revealed the resident was [redacted] with a Brief Interview for Mental Status (BIMS) score of [redacted]. The resident required one-person physical assistant for bed mobility, dressing, personal hygiene, locomotion and two-person physical assistant for transfer and [redacted] A review of Resident #1's medical record revealed a nursing note dated 03/10/2020 at 6:00 AM. The note documented no unusual findings with Resident #1 during the shift, it further reported that [redacted] was noted with Resident #1. At 10:00 AM of the same day, the nursing note indicated Resident #1 complained of [redacted]. On assessment, it was noted that the resident had a [redacted] to the [redacted]. The skin around the resident's [redacted] was reported as [redacted]. At 11:00 AM, it was documented that the medical director (MD) was contacted with an order for an X-ray to Resident #1's [redacted]. The nursing note reported that the said X-ray result was received at 6:00 PM and it was positive for an [redacted] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1., likely related to an [redacted]. The note at 7:00 PM, read that Resident #1's family/responsible party was made aware of the injury and informed of the MD's	F 610	by the facility. Policy for injury of unknown origin implemented by new administrator upon employment and revised January 2021. An apparent cause analysis was performed and determined that the cause of the deficient practice was due to human error of the previous administrator. As per #3 and #4, below, in-service education, policy and process changes were made as part of the apparent cause analysis. Resident was transferred to acute care for evaluation and assessed by MD upon return to the facility. To ensure that the deficient practice does not reoccur for this resident, DON will ensure that all required assessments will be consistently completed at the required intervals accordance with professional standards of practice. 2. No other documentation or reports regarding failure to investigate injuries of unknown origin were obtained or endorsed upon assuming the position of administrator at NJESH. As all residents have the potential to be affected by the deficient practice, current administrator and DON will conduct an audit of recent safety reports. This will ensure they are completed and any investigations and/or required reporting to the state agency are completed in accordance with regulation.	

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F 610	Continued From page 5 directive to send Resident #1 to the emergency room (ER). On 03/10/2020 at 1:00 PM, it was reported that Resident #1 came back from the ER with a [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.]. There was no documentation of a conclusive investigation to ascertain the cause/origin of the injury to Resident #1's [NJAC 8:43E-2.1 and Ex] in the record. On 06/18/2021 at 02:30 PM, Licensed Practical Nurse (LPN) #1 said she would inform the nurse supervisor of any injury of unknown origin assessed on a resident. She said the nurse supervisor would tell the director of nursing who in turn started an investigation to ascertain the origin of the injury. On 06/18/2021 at 10:12 AM, the Director of Nursing (DON) reviewed Resident #1's medical record and verified the cause of the injury sustained by the resident to the [NJAC 8:43E-2.1 and E] was undetermined. He concluded that there was no record on file which showed an investigation was conducted. The DON said when a nursing assessment identified an injury on a resident that was not consistent with what the resident admitted with, he immediately started an investigation. The DON stated he would interview the resident and any witness to get a clear account of how, where, and when the injury occurred. The DON said the MD and the resident's family/responsible party were notified. The DON said the next course of action was to launch an investigation to ascertain the root cause of the injury. The facility policy, Injury of Unknown Origin, dated 01/18/2021, indicated "Injuries of unknown origin will be investigated. They will be reviewed	F 610	3. New Director of Nursing started August 2020. DON created and implemented new Safety Report and Injury of Unknown Origin Investigation Form. All staff re-educated on new forms, policy and reporting procedures by Staff Development Coordinator and DON. 4. Any safety reports including injuries of unknown origin are reported by the nursing supervisor at morning clinical meeting and by the DON at Safety Meeting and Quality Assurance Performance Improvement meetings which are held quarterly.	

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F 610	Continued From page 6 at the safety committee meetings." New Jersey Administrative Code § 8:39-5.1(a)	F 610		
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: Complaint Intake: NJ135858 Based on interviews and record review, it was determined that the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice for 1 (Resident #1) of 3 sampled residents reviewed for emergency care services. Specifically, the facility failed to ensure nursing staff requested emergency medical service timely when Resident #1 was exhibiting symptoms of a [redacted] Findings include: 1. Resident #1 was admitted with diagnoses including [redacted] The annual Minimum Data Set (MDS), dated [redacted], revealed the resident was [redacted] with a Brief Interview for Mental Status (BIMS) score of [redacted] The resident required one-person physical assistant for bed mobility, dressing, personal hygiene, and locomotion; and	F 658	1.An apparent cause analysis was performed in relation to this deficiency. It was determined that the cause of the deficient practice cited was due to human error of the nurse assigned to resident #1. The nurse who was assigned to resident #1 was terminated as of [redacted]. With the start of the new administrator and DON during July 2020 and August 2020, prudent clinical practice has been established and nursing staff re-inserviced on ensuring that emergency medical services are requested in a timely manner. Resident was transferred to acute care for evaluation and assessed by MD upon return to the facility. To ensure that the deficient practice does not reoccur for this resident, DON will ensure that all required assessments will be consistently completed at the required intervals in accordance with professional standards of practice.	7/13/21

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F 658	Continued From page 7 two-person physical assistant for transfer and [redacted]. A review of Resident #1's medical record revealed a nursing note dated 03/15/2020 at 5:45 PM which reported that Resident #1 readmitted after hospitalization for a [redacted]. The note at 8:45 PM indicated Resident #1 remained alert with [redacted] The note further revealed the resident's [redacted] on the resident's [redacted]. The resident's vital signs were obtained and recorded as follows: blood pressure (BP) [redacted]; pulse (P) [redacted] temperature (T) [redacted] degrees Fahrenheit (F), oxygen saturation (SPO2) [redacted] [record did not indicate whether on room air or with portable oxygen]; blood sugar [redacted] [unit of measurement omitted in original]. The record indicated the resident's attending physician gave order to send Resident #1 to the hospital. A review of the Bridgewater Police Department Incident Report, [redacted], revealed a 911 call to request for emergency service was placed at 9:38 PM. Although, the nursing note reviewed above did not explicitly document the time stamp for when the physician's order was received to send Resident #1 to the hospital, a comparison of the documented time stamp for when the nurse assessed Resident #1, identified Resident #1 had [redacted] detailed above approximately more than 50 minutes before the nurse called 911. The details about the timeline which spoke to the initial observation made of Resident #1 exhibiting [redacted] by the resident's family member was not documented in the resident's medical record.	F 658	2. No other instances or reports regarding similar issues were obtained or endorsed upon assuming the position of administrator or DON at NJESH. As all residents have the potential to be affected by the deficient practice, current DON will conduct an audit of recent resident transfers to acute care to ensure that residents receive treatment and care in accordance with professional standards of practice. 3. As per #1 above, nursing staff have been re-inserviced on ensuring that emergency medical services are requested in a timely manner. 4. To ensure that the deficient practice will not reoccur, current DON or designee will perform random chart audits of transferred patients to acute care. These random audits will be performed monthly for a period of 6 months starting in July 2021. The results of these audits will be reported at the Quarterly Quality Assurance Performance Improvement Committee meetings.	

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F 658	Continued From page 8	F 658		

A review of Resident #1 hospital admission record dated [NJAC 8:43E-2.1 and Exec O] revealed the resident's admission diagnosis was [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. NJAC 8:43E-2.].

A review of the personnel file of Registered Nurse (RN) #2 [nursing staff implicated in the allegation] revealed she was terminated on ground of an apparent error in nursing judgement about timing and urgency regarding the lag with calling 911.

On 06/18/2021 at 3:15 PM, the Director of Nursing (DON) and the Nursing Home Administrator (NHA) said they both were not employed with the facility at the time of the incident. The DON reviewed the record of file for the 03/15/2020 incident with Resident #1 and reiterated the information on the file. Specially, the DON said the primary issue regarding the situation with Resident #1 was whether the nurse who took care of the resident called 911 in a timely manner, given that it had been identified by a relative who was on a video call with the resident when the resident started exhibiting symptoms and the nurse who assessed and verified the resident was exhibiting symptoms of a [NJAC 8:43E-2.]. He clarified that the record lacked any rationale that led to more than 50 minutes delay before the nurse called 911. He said, with [NJAC 8:43E-2.], time was of essence in determining whether one lived, suffered irreversible brain damage, or died from a [NJAC 8:43E-2.]. The DON said, "Without any documented rationale in the record, it took too long for the nurse to call the emergency response." He said the facility had since adopted a standing order for nursing staff to send residents to the hospital on firsthand assessment which indicated a deviation from the resident's

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F 658	Continued From page 9 baseline and not having to wait on hearing back from the doctor. He expressed that the facility had continued to reinforce its emergency response training amongst staff, so they were efficiently reactive. New Jersey Administrative Code § 8:39-5.1(a)	F 658		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315419	A. Building B. Wing	7/13/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
N J EASTERN STAR HOME	111 FINDERNE AVENUE BRIDGEWATER, NJ 08807

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0609 Reg. # 483.12(c)(1)(4) LSC	Correction Completed 07/13/2021	ID Prefix F0610 Reg. # 483.12(c)(2)-(4) LSC	Correction Completed 07/13/2021	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 07/13/2021
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/18/2021

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**