STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315497	A. BUILDING _____ B. WING _____	C 04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLENDALE REHABILITATION AND HEALTHCARE CENTER	85 HARRETON ROAD ALLENDALE, NJ 07401

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F 000	INITIAL COMMENTS COMPLAINT#: NJ151343, #NJ153512 CENSUS: 95 SAMPLE SIZE: 4 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	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: C#: NJ153512	F 610	1) Resident #3 was interviewed by social worker and verbalized [redacted] was fine and did not recall any instances of mistreatment.	4/22/22

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

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F 610	Continued From page 1 Based on interviews, medical record review, and review of other pertinent facility documents on 4/4/2022, 4/5/2022, and 4/6/2022, it was determined that the facility failed to investigate an Injury of Unknown Origin, a [redacted]; an allegation of rough handling by staff, and failed to follow the facility's policies titled "Change in a Resident's Condition or Status," "Abuse, Neglect, Exploitation, and Misappropriation Prevention Program" and "Abuse, Neglect, Exploitation and Misappropriation Prevention Program-Reporting, and Investigating." This deficient practice was identified for 1 of 4 residents (Resident #3) and was evidenced by the following: Review of the Electronic Medical Record (EMR) were as follows: According to the Admission Record (AR)," Resident #3 was admitted to the facility on [redacted] with diagnoses which included but were not limited to: EX. Order 26.(4) B1 [redacted] and [redacted] According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #3 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the Resident had EX. Order 26.(4) B1 . The MDS also showed Resident #3 required extensive assistance with Activities of Daily Living (ADLs) and was EX. Order 26.(4) B1 [redacted]	F 610	The Nurse that cared for resident #3 on [redacted] was counseled for not completing incident report or reporting [redacted] to supervisor. The Unit manager for resident #3 was counseled for not investigating the [redacted] she observed on [redacted] 2) Residents of the facility have the potential to be affected. Residents with injuries within last 30 days reviewed to ensure Injuries of unknown origin were investigated and reported. 3) A. All staff were in-serviced on the policy and procedure for Abuse, Policy including reporting and investigating injuries of unknown origin, reporting and allegations of Abuse or mistreatment on 4/4/22. B. Licensed Nurses were in-serviced on completion of Incident report with any injury of unknown origin on 4/5/22. C. Licensed nurses were in-serviced on Change in condition Policy on 4/5/22. D. Regional Risk team will scrub progress notes daily for key words to monitor for injuries of unknown origin and completion of incident report. E. DON or designee will review progress notes for previous 24 hours daily to monitor for documentation of injuries and ensure incident report completed and injury investigated. F. Administrator will review Resident Council meeting minutes Monthly to	

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F 610	Continued From page 2 Review of Resident #3's Progress Notes (PNs) dated EX. Order 26.(4) B1 at 11:30 a.m., written by the Registered Nurse (RN) and documented as a late entry, revealed under EX. Order 26.(4) B1 ," the Resident had a "New change in EX. Order 26.(4) B1 , EX. Order 26.(4) below (the) EX. Order 26.(4) B1 A review of the PNs dated 3/14/2022 at 4:01 p.m., written by the Unit Manager (UM), for Resident #3 showed that the resident "(family) calls every day in regards to (a) EX. Order 26. to (the Resident's) EX. Order 26 The PNs also revealed Resident #3 "had a EX. Order 26. EX. Order 26.(4) B1 " The UM also wrote that she "Explained (to the family) that (the Resident) could have EX. Order 26.(4) B1 against the bed, (Resident #3) stated its nothing. Today it is barely there." A review of the "(Facility) Incident List" dated EX. Order 26.(4) B1 - EX. Order 26.(4) B1 , received from the facility on EX. Order 26.(4) B1 revealed no entries related to Resident #3. At the time of the survey, the RN who wrote the PNs dated EX. Order 26.(4) B1 was unavailable for an interview. During an interview on 4/4/2022 at 3:20 p.m., the UM stated the protocol for EX. Order 26.(4) is to measure it, do an incident report, investigation, and put it into the computer / PCC (Point Click Care), which would be visible to the Director of Nursing (DON). The UM also stated the EX. Order 26. would also be in the PNs and the 24 hours report. She further stated that she would also inform the Resident's family, the DON, and the Administrator. During the same interview on 4/4/2022 at 3:20	F 610	ensure residents are being treated appropriately 4)A. Administrator or designee will conduct interviews with 5 residents weekly regarding care and treatment four weeks and then Monthly for three months to ensure residents are being treated appropriately. B. Director of Nursing will audit 5 Incident reports weekly for four weeks and then monthly for three months to ensure injuries were investigated and reported timely. C. Results of the audits will be reported to the QA committee monthly. D. The QAPI Committee will make recommendations based upon the results of the audits. E. The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved	

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F 610	Continued From page 3	F 610		

p.m., the UM further stated she was familiar with the [EX. Order 26] she wrote about in the PNs on [EX. Order 26.(4) B1]. She explained when Resident #3's family member called, she placed the family member on hold and checked the Resident. The UM stated she told the family member the [EX. Order 26.(4)] was now [EX. Order 26.(4)] and [EX. Order 26.(4) B1]. When asked by the Surveyor when the [EX. Order 26] was first identified and by whom, the UM stated she did not recall when the [EX. Order 26] was first seen or who saw the [EX. Order 26] initially. She further stated that when the Resident's family called her about the [EX. Order 26], she checked in PCC and did not see any investigation about the [EX. Order 26.(4)].

During an interview on 4/5/2022 at 1:35 p.m., the Assistant Director of Nursing (ADON) stated he did Resident #3's admission assessment. The ADON further stated that he would have documented it if the [EX. Order 26] had been present on admission. The ADON explained that "if a resident has a [EX. Order 26], we investigate to see if it was abuse ...."

During an interview on 4/5/2022 at 2:46 p.m., in the presence of the Regional Nurse and the Director of Nursing (DON), the Administrator stated I know for Resident #3, there was a question of [EX. Order 26.(4) B1] but when the nurse assessed, there was no [EX. Order 26.(4) B1]. He believed the UM told him around the same time it was documented in the PNs. When asked by the Surveyor what should have been done when the [EX. Order 26.(4)] was identified, he stated, "no one told me, or I would have investigated." The Administrator further stated that Resident #3 can speak for himself/ herself and tell us if he/she is unhappy.

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The Regional Nurse stated during the same interview on 4/5/2022 at 2:46 p.m., the Administrator is the Abuse Coordinator and that the RN should have reported the [redacted] and did an incident report.

During the same interview on 4/5/2022 at 2:46 p.m., the Director of Nursing (DON) stated all allegations of abuse and [redacted] of unknown origin were investigated. The DON explained that when a new [redacted] is identified, they first interview the Resident if he/she is alert. If the Resident is confused, they interview the nurses and staff.

During an interview on 4/6/2022 at 10:05 a.m., the Regional Nurse stated that the facility could not locate the assignment sheets for the staff assigned to Resident #3 on 3/3/2022.

During an interview on 4/6/2022 at 10:33 a.m., the Social Worker (SW) stated she knew Resident #3. The SW said Resident #3's family member "felt aides were too rough with him/her." The SW explained the family member did not talk directly to her but spoke with the "nurse (and the) Administrator." She further explained, "we interviewed other residents in that hallway. I am not sure of the date." The SW was unable to identify the rough handling allegation date as [redacted] but stated she believed the allegation was in [redacted] or the beginning of [redacted]. The SW stated the allegations of rough handling were discussed in the morning meetings. The SW said she keeps personal files and will look to see if she has the statements. The survey team requested the statements and documentation from the SW for the allegations involving Resident #3.

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During a second interview on 4/6/2022 at 11:05 a.m., the SW stated, "I did not document the conversations with the residents. The SW stated that Resident #3 did not admit to being treated unkindly to her directly. She further stated, "He/She was [redacted]; he/she said everything was okay. The whole team has been in touch with the situation. I discussed it with the Administrator in the morning meeting. "The SW continued to explain, "I talked to the patient (Resident), the Administrator, the DON, and other residents in that hallway... They were quick conversations; I didn't document it." When asked by the Survey team if she followed the facility's policy when she became aware of the rough handling allegation, the SW stated, "Yes, I did; they already knew; (Resident #3) was okay (he/she) was not upset or scared when I spoke to him/her."

Review of the facility's policy titled "Change in a Resident's Condition or Status" undated included Under "Policy Statement": "Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status ..." Under "Policy Interpretation and Implementation": 1. "The nurse will notify the resident's attending physician or physician on call when there has been a(an): ... b. discovery of injuries of an unknown source."

Review of the facility's undated policy titled "Abuse, Neglect, Exploitation and Misappropriation Prevention Program" indicated the following: Under "Policy Statement": "Policy Interpretation and Implementation" "The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment

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F 610	Continued From page 6	F 610		

and resource allocation to support the following objective: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: a. facility staff; ...7. Implement measures to address factors that may lead to abusive situations, for example: ...d. help staff understand how cultural, religious and ethnic differences can lead to misunderstanding and conflicts. 8. Identify and investigate all possible incidents of abuse, neglect, mistreatment ...9. Investigate and report any allegations within timeframes required by federal requirements. 10. Protect residents from any further harm during investigations. 11. Establish and implement a QAPI (Quality Assurance Performance and Improvement) review and analysis of reports, allegations or findings of abuse, neglect mistreatment or misappropriation of property. 12. Involve the resident council in monitoring and evaluating the facility's abuse prevention program."

Review of the facility's undated policy titled "Abuse, Neglect, Exploitation and Misappropriation -Reporting and Investigating" indicated the following: Under "Policy Statement": "All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported." Under "Policy Interpretation and Implementation": "Reporting Allegations to the Administrator and Authorities" included: "1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of

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F 610	Continued From page 7 unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law." Under "Investigating Allegations" included: "1. All allegations are thoroughly investigated. The administrator initiates investigations ....4. The administrator is responsible for keeping the resident and his/her representative (sponsor) informed of the progress of the investigation ..." Under "Reporting Results of Investigation" included: "1. The administrator, or his/her designee, provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident. 2. The resident and/or representative are notified of the outcome immediately upon conclusion of the investigation ..." Under "Corrective Actions": included " ...6. Corrective actions may include a full review of the incident(s) by the QAPI committee." N.J.A.C. 8:39- 4.1 (a) (5)	F 610		

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H5790	8:43E-13.4(d) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer Form sent with a patient when a patient is transferred as part of the patient's medical record. This REQUIREMENT is not met as evidenced by: C#: NJ151343 Based on interviews, review of the Medical Record (MR), and review of other pertinent facility documentation on 4/4/2022, 4/5/2022, and 4/6/2022, it was determined that the facility failed to maintain a copy of the Universal Transfer Form (UTF) as part of the medical record for 1 of 4 sampled residents (Resident #2). This deficient practice was evidenced by the following: Reference: New Jersey Hospital Association "Provider Resources" Section 6: The NJ Universal Transfer Form (UTF) must be used by all licensed healthcare facilities and programs when a patient is transferred from one care setting to another. According to the "Admission Record (A/R)," Resident #2 was admitted to the facility on [redacted] and readmitted on [redacted] with diagnoses including, but not limited to: [redacted]	H5790	1) Resident #2 was discharged from facility on [redacted] 2) Residents being transferred out of facility have the potential to be affected. 3) A. Licensed Nurses were in-serviced on completing universal transfer form and maintaining a copy when residents are being transferred to another facility on 4/6/22. B. Medical records coordinator will audit resident's charts after discharge to ensure a copy of the universal transfer form is in the closed record. 4) A. Administrator or designee will audit 5 charts for residents transferred to another facility monthly for three ensure the Universal Transfer form is in the closed medical record. B. Results of the audits will be reported to	4/22/22

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H5790	Continued From page 1 for EX. Order 26.(4) B1 [redacted].	H5790		

According to the Minimum Data Set (MDS), an assessment tool dated EX. Order 26.(4) B1, Resident #2 had a Brief Interview of Mental Status (BIMS) score of EX. Order 26.(4) B1 indicating the resident was EX. Order 26.(4) B1. The MDS also showed that Resident #2 needed extensive assistance with Activities of Daily Living (ADLs).

Record review of the "Discharge Summary," dated EX. Order 26.(4) B1 revealed Resident #2 was discharged to another facility.

There was no documentation in the medical record of a Universal Transfer Form (UTF) done for Resident #2.

During an interview on EX. Order 26.(4) B1 at 10:42 a.m., the Regional Nurse stated no UTF was done for Resident #2.

During an interview on 4/6/2022 at 12:40 p.m., when the surveyor asked the Director of Nursing (DON) if Resident #2 should have a UTF, the DON replied, "Yes, the resident should have had one; done by the nurse."

Review of an undated facility policy titled "Transfer Form" revealed Under "Policy Statement" included: "This facility provides a completed and accurate transfer form to a resident transferred or discharged from our facility." Under "Policy Interpretation and Implementation" indicated: " ...2. The transfer form will be completed by nursing service and will include: a. current medical findings; ...c.

the QA committee monthly.
C. The QAPI Committee will make recommendations based upon the results of the audits.
D. The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved

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H5790	Continued From page 2 medications at time of discharge; ...3. A copy of the transfer form will be filed in the resident's medical record ..." C#: NJ151343, NJ153512	H5790		
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: C#: NJ151343, NJ153512 Based on facility document review on 4/4/2022, 4/5/2022 and 4/6/2022, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for	S 560	1) No residents were identified 2) Residents of the facility have the potential to be affected 3) A. Director of Nursing, Administrator and Staffing coordinator were in-serviced on minimum staffing requirements. B. Director of Nursing, Staffing	4/22/22

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S 560	Continued From page 3 2 of 21-day shifts reviewed. This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the week of 01/09/2022 to 01/15/2022, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: On 01/15/22 had 12 CNAs for 101 residents on the day shift, required 13 CNAs. For the 2 weeks from 02/13/2022 to 02/26/2022, the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows: On 02/26/22 had 12 CNAs for 100 residents on	S 560	Coordinator and Administrator will meet daily during the week to review recruitment efforts, staffing for next day, and staffing for upcoming week. C. The facility has developed a Culture Committee focused on recruitment. D. and retention of staff along with customer service and the employee experience. E. The facility has implemented a Charge to Service Program to support newly admitted residents. F. The facility has implemented the Care Champion Program to mentor new employees which has been proven to raise retention rates. G. The facility participates in an interdisciplinary Quality Care Resource call to review open positions, recruitment tactics, and changes to improve outcomes. H. Contract staff utilization is reviewed bi-weekly to identify trends and opportunities. I. The facility has implemented a multifaceted approach for recruitment and retention of employees, Job fairs, Flexible scheduling, Increased utilization of PRN staff, Implementation of OnShift, Multimedia advertisements, Partnership with schools, Sign on bonuses, Referral bonuses, Pick-up shift bonuses, Boomerang campaign to rehire staff that have resigned , Rate adjustments, Benefit adjustments, Contract staff utilization, Implementation of Temporary Nurse Aide program, Text message campaigns. J. The facility has implemented processes to increase communication with employees through Townhall meetings	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060201	A. BUILDING: _____ B. WING _____	C 04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 4 the day shift, required 13 CNAs.	S 560	and Digital Suggestion Box. 4) A. The administrator/designee will review the minutes from resident council to determine whether any concerns regarding care and services are identified monthly for three months and then quarterly. B. The administrator/designee will review the minutes from daily staffing meeting to determine whether all efforts are resulting in meeting staffing requirements. C. The administrator/designee will interview five residents weekly for 4 weeks and then monthly to determine if needs are being met. D. Results of the audits will be reported to the QA committee monthly. E. The QAPI Committee will make recommendations based upon the results of the audits. F. The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved.	