STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315129	A. BUILDING _____ B. WING _____	C 08/06/2020

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F 000	INITIAL COMMENTS COMPLAINT #: NJ 135787, NJ 137122, NJ 137804 CENSUS: 81 SAMPLE SIZE: 9 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 VISIT.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in	F 580		8/20/20

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed 08/19/2020

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F 580	Continued From page 1 §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Complaint #NJ 137122 Based on interview, review of medical records, and other facility documentation, it was determined that the facility failed to notify the resident's emergency contact of an incident for 1 of 6 residents (Resident #3) reviewed for notification. This deficient practice was evidenced by: According to the Admission Record, Resident #3	F 580	F580 D 1.Resident #3 was discharged to home. 2.Any resident who is involved in an incident/accident may have the potential to be affected. 3. Nursing Supervisors are responsible to verify that proper notifications have been completed for incidents/accidents that occur on their shift. DON re-educated licensed nurses regarding this verification process and documentation of same on 8/8/2020 DON will review incident/accident reports	

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F 580	Continued From page 2 was admitted on Exec Order 26 § 4b1 individual's health info [redacted] A review of the resident's Discharge Minimum Data Set (MDS), an assessment tool, dated Exec Order 26 § 4b1 individual's health info [redacted] Further review of the MDS revealed the resident had Exec Order 26 § 4b1 individual's health info since admission. A review of the resident's Care Plan (CP), revised on 5/7/20, reflected the resident had a Exec Order 26 § 4b1 individual's. A review of the incident report dated Exec Order 26 § 4 at 15:38 (3:38 PM) reflected that the resident Exec O [redacted]. Further review of the incident report revealed that the resident's emergency contact was not notified of the incident. A review of the nursing note dated Exec Order 26 § 4 at 15:48 (3:48 PM) did not include notification that the resident's emergency contact was notified of the Exec Order 26 § 4b1 indiv. During an interview with the surveyor on 8/5/20 at 10:06 AM, the Unit Manager (UM) stated that if a resident has a fall, the nurse will complete an incident report and notify the resident's family as soon as possible. During an interview with the surveyor on 8/5/20 at 10:27 AM, the Licensed Practical Nurse (LPN) stated that if a resident has a fall, the nurse will assess the resident, notify the doctor, and notify	F 580	at clinical meeting to verify that proper notifications have been made. Concerns identified will be addressed. The Interdisciplinary Team will review completed incident/accident reports, including a review to verify proper notification have been made and documented. These reviews will be completed during the weekly fall review meeting. Areas of concern will be addressed. 4.The DON will audit 3 incident/accident reports weekly for 4 weeks, then monthly for 2 months to verify proper notifications have been made and documented. Areas of concern will be addressed Results of these audits will be reviewed at the quarterly QAPI meeting for the next 2 quarters with follow up as needed.	

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F 580	Continued From page 3 the resident's family as soon as possible. During an interview with the surveyor on 8/6/20 at 2:00 PM, the Director of Nursing (DON) acknowledged that the incident report and nursing notes did not reflect that the resident's emergency contact was notified of the fall. The DON stated that the nurse should have documented the notification of the emergency contact on the incident report and in the nursing notes. Review of the facility's "Incident & Accident Protocol" policy dated 10/14 revealed, "Notify family and note time of family notification and name of family member notified." NJAC 8:39-13.1(c)	F 580		
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 # NJ 135787, NJ 137804 Based on observation, interview, and record review, it was determined that the facility failed to: a.) obtain a Physician's Order (PO) for bed and chair alarms and document the use of bed and chair alarms in the electronic Treatment Administration Record (eTAR) as a fall risk intervention; and, b.) appropriately document a	F 658	F658 D 1.Resident #4 was discharged from the facility. Resident #7 was discharged from the facility. 2.Residents receiving wound care have the potential to be affected. Residents utilizing bed and/or chair alarms have the potential to be affected. 3.DON completed an audit of residents receiving Exec Order 26 s treatments to verify	8/20/20

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F 658	Continued From page 4 Exec Order 26 § treatment in the resident's medical record for 2 of 4 residents reviewed (Resident #4 and #7) for professional standards of nursing practice. This deficient practice was evidenced by: 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 case-finding, 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: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case-finding; 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." 1. According to the facility Admission Record, Resident #7 was admitted to the facility in Exec Order 26 § 4b1 individual's health info	F 658	orders are in place, have been correctly transcribed and are being documented on the ETAR. This audit was completed on 8/17/2020. Areas of concern were addressed. The DON will review new wound treatment orders in clinical meeting to verify that orders are in place, have been properly transcribed and are being documented on the ETAR. LPN was re-educated by DON on 8/18/20 regarding need to document Exec Order 26 § care provided to residents. ADON re-educated by DON on 8/18/202 regarding proper order transcription DON completed an audit of safety alarms in use on 8/17/20 to verify that Physician orders are in place and monitoring of the devices for placement and function is being documented on the ETAR each shift. DON will review new safety devices placed at the clinical meeting to verify Physician orders have been obtained, and that documentation of placement and function is being completed on the ETAR each shift. DON re-educated licensed nurses on 8/18/20 regarding need for Physician orders for safety alarms and documentation required on the ETAR each shift to verify placement and function. Safety device (bed/chair alarms) policy was modified to include verification of physician orders and documentation of placement and function each shift. 4.DON will audit charts of 4 residents receiving wound treatments weekly for 4 weeks, monthly for 2 months to verify	

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F 658	Continued From page 5 Exec Order 26 § 4b1 individual's health info A review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Exec Order 26 § 4b1 individual's health info . Further review of the MDS, indicated that the resident had no falls prior to admission to the facility. A review of the Incident/Accident Report dated Exec Order 26 § 4b1 individual's health info Interventions included implementing bed and chair alarms, as well as to, monitor Resident #7 every two hours. A review of the resident's individualized care plan initiated on 4/15/20 included that the resident was at Exec Order 26 § 4b1 individual's health info . Interventions included the use of bed and chair alarms dated 4/22/20 for seven days. A review of the electronic Progress Notes (ePN) dated 4/22/20 indicated that the resident had a bed and chair alarms for seven days. A review of the April 2020 electronic Order Summary Report indicated that the resident did not have a PO for bed and chair alarms. Review of the April 2020 Electronic Treatment Administration Record (eTAR) did not include monitoring of the bed and chair alarms.	F 658	treatment orders are in place, have been properly transcribed and are being documented as required on the ETAR. Areas of concern will be addressed. Results of the audit will be reviewed at the quarterly QAPI meeting for the next 2 quarters with follow up as needed. DON will audit 4 residents currently utilizing safety alarms weekly for 4 weeks, then monthly for 2 months to verify Physician orders are in place for the use of the alarms and that documentation is being completed on the ETAR each shift verifying placement and function of the safety alarms. Areas of concerns will be addressed. Results of the audit will be reviewed at the quarterly QAPI meeting for the next 2 quarters with follow up as needed	

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During an interview with the surveyor on 8/6/20 at 11:25 AM, the Unit Manager/Registered Nurse (UM/RN) stated the physician ordered the bed and chair alarms. The nurses monitor and check the function of the alarms each shift and sign-off/document that it was done on the eTAR.

During an interview with the surveyor on 8/6/20 at 11:33 AM, the Director of Nursing (DON) stated residents required a PO to have alarms. The nurses document the placement and function of the alarms in the eTAR or ePN. The DON said it was a standard of nursing practice to check the alarms every shift.

During a follow-up interview at 1:46 PM, the DON stated that she could not speak to why there was no PO or documentation on the eTAR for the use of the bed and chair alarm. The DON confirmed that the resident had both a bed and chair alarm at the time of the fall. The DON stated that the facility did not have a policy regarding bed and chair alarms.

A review of the Fall Prevention Program dated revised 10/14 did not include the use of bed and chair alarms.

A review of the Assessing Falls and Their Causes form, revised March 2018, did not include the use of bed and chair alarms.

2. According to the facility Admission Record, Resident #4 was admitted to the facility in Exec Order 26 s [redacted]

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F 658	Continued From page 7 A review of the Admission MDS, dated Exec Order 26 § 4b1 in [redacted] Further review of the MDS, identified that the resident had a Exec Order 26 § 4b1 individual's hea th info, a formal assessment tool was completed, and the Exec Order 26 § 4b1 individual's health info was clinically assessed. The current number of Exec Order 26 § 4b1 individual's health inf [redacted] on admission was documented as Exec Order 26 § 4b1 individual's health info [redacted] A review of the resident's individualized care plan initiated on 5/12/20 included that the resident was at risk for impairment of skin integrity due to Exec Order 26 § 4b1 individual's health info [redacted] Interventions included administer treatments as ordered, and to monitor for effectiveness. A review of the ePN dated 6/10/20 indicated that the resident had been seen by a Exec Order 26 care Nurse Practitioner (NP). Further examination of ePN revealed the NP assessed Resident #4's Exec O [redacted] and recommended to Exec Order 26 § 4b1 individual's h [redacted] A review of the June monthly wound record report indicated that Resident #4's weekly assessment dated 6/10/20 for the Exec Order 26 § 4b1 individual's he	F 658		

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treatment order had been changed to skin prep daily.

A review of the June 2020 electronic Order Summary Report indicated that the resident did not have a physician's order for Exec Order 26 § 4b1 individual's h treatment from 6/11/20-6/17/20.

Review of the June 2020 eTAR did not include an order for Exec Order 26 § 4b1 individual's h care for the above-referenced dates.

During a telephone interview with the surveyor on 8/11/20 at 11:59 AM, the DON acknowledged Resident #4 had a Exec Order 26 § 4b1 individual's he treatment order from the NP dated 6/10/20 and stated she would expect the order to be on the eTAR.

During a telephone interview with the surveyor on 8/11/20 at 12:21 PM, the Assistant Director of Nursing (ADON) stated she entered the order incorrectly and that the order was directed to the eMAR (electronic Medication Administration Record) instead of the eTAR. Together the surveyor and the ADON reviewed the June eMAR, which included the order from 6/10/20 for the Exec Order 26 § 4b1 individual's health info. The ADON acknowledged there was no record to confirm the Exec Order 26 § 4 treatments had been documented as completed during the referenced timeframe.

During a telephone interview with the surveyor on 8/11/20 at 2:37 PM, Resident #4's primary Licensed Practical Nurse (LPN) who was assigned to the resident during the above-referenced timeframe, stated he had treated the resident's Exec Order 26 § 4b1 individual's h. The LPN further indicated that he was unable to document in the eMAR. He acknowledged he should have

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recorded the treatment in the ePN if he was unable to document in the eMAR.

During a telephone interview with the surveyor on 8/12/20 at 8:14 AM, the wound care Nurse Practioner stated she could not recall Resident #4 specifically, and could not recall any resident during that time that had dirty or unkempt Exec Order 26 coverings.

A review of the Pressure Ulcers/Skin Breakdown-Clinical Protocol policy dated and revised 4/18, "Treatment and Management 1. The physician will order pertinent Exec Order 26 treatments, including Exec Order 26 § 4b1 individual's health info , dressings (occlusive, absorptive, etc.), and application of Exec Order 26 § 4b1 individual's he

A review of Administering Medications policy dated and revised 4/19, "Policy Interpretation and Implementation 4. Medications are administered in accordance with prescriber orders, including any required time frame. 24. Exec Order 26 § 4b1 individual's health info used in treatments are recorded on the resident's treatment record (TAR)."

NJAC 8:39-11.2(b)