STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315357		01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	110 GROVE AVE CEDAR GROVE, NJ 07009

(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	F 000		

Survey Date: 01/20/23

Census:120

Sample: 26+17 = 43

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.
During the Recertification survey conducted on 01/20/23, the Facility Adminisration was notified of the following Immediate Jeopardy (IJ) situations identified for 600J.
The facility's failure to ensure the abuse policy was followed to protect a resident from abuse, and ensure a process was in place to protect all residents from potential abuse resulted in an Immediate Jeopardy (IJ) situation that began on 01/17/23 when a family member of Resident #182 informed the facility that CNA #1 "was not nice" to Resident #182, and "had and attitude", and the facility failed to immediately initiate an investigation and CNA #1 proceeded to work on the same resident unit the following day, 01/18/23, and was assigned to nine residents.

The facility administration was notified of the IJ situation on 01/19/23 at 2:56 PM.

The facility submitted an acceptable removal plan on 01/20/23 at 9:00 AM.

On 01/20/23 at 9:00 AM, the removal plan was verified as implemented by the survey team during the survey.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/15/2023

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 000	Continued From page 1 The noncompliance remained on 01/20/22 for no actual harm that is not Immediate Jeopardy.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550		2/23/23

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F 550	Continued From page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records and review of other pertinent documentation, it was determined that the facility failed to treat all residents in a dignified manner by failing to provide: a.) oral and incontinence care to a resident assessed to be dependent on staff for activities of daily living (ADL's), and prior to serving the resident meal, b.) a timely clothing change to a resident whose clothing was visibly soiled, and c.) a resident with respect and dignity. This deficient practice was identified 2 of 26 residents reviewed (Resident #45 and #179), on 2 of 4 units, and was evidenced by the following: 1. On 01/04/23 at 9:30 AM, the surveyor observed Resident #45 in bed. The Certified Nursing Assistant (CNA) was at the bedside assisting the resident with care. On 01/04/23 at 10:37 AM, the surveyor conducted an interview with the CNA who revealed that Resident #45 required extensive assistance with care, could feed his/herself after set up, and was [redacted] and [redacted] On 01/06/23 at 7:45 AM, the surveyor completed a care tour with one of the CNAs assigned to the floor. The surveyor and the CNA observed that Resident #45's [redacted] was [redacted] and [redacted]. The CNA stated that Resident #45 was a [redacted] and would be	F 550	Resident #45 was checked by the RN. Resident is alert and dependent with personal hygiene and toilet use. RN informed assigned aide of the plan of care of resident #45 and resident was provided ADL care. Resident #179 was checked by the RN. RN provided [redacted] care and lubricated [redacted] swab. RN counseled CNA verbally about the use of cellphone in patient's area. All residents have the potential to be affected. The facility made a list of all residents on each unit who are totally dependent on staff for personal hygiene and toilet use. The CNA was in-serviced by the Director of Nursing and given disciplinary action by the Director of Nursing about use of cell phone in the patient's area. All nursing staff was in-serviced by the Director of Nursing and 3-11 and 11-7 Nursing Supervisors regarding plan of care of residents, respect and dignity, providing oral and incontinence care prior to serving the resident a meal and timely changing when clothes are soiled. All staff was in-serviced by the respective department head about the use of cell	

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F 550	Continued From page 3 left wearing [redacted] briefs when she had arrived in the morning. On 01/11/23 at 7:35 AM, the surveyor entered Resident #45's room and observed that the clothing was soiled with [redacted] like substances, and the resident was unshaven. A [redacted] permeated the room and became noticeably stronger while approaching the resident's bed. Resident #45 shared the room with two other residents. The resident answered to the surveyor's greetings and stated, "I need everything!", pointed at the soiled clothing and stated, "I need to be ready." The surveyor left the room to review the schedule and returned to the room at 8:20 AM only to observe that the resident was eating breakfast and had not been changed. On 01/11/23 at 8:30 AM, the surveyor interviewed the CNA assigned to Resident #45. The CNA stated that she did not deliver the breakfast tray to Resident #45. On 01/11/23 at 8:35 AM, the surveyor entered the room with the CNA, and the CNA stated that she provided morning care and dressed Resident #45 on 01/10/23 during the 7:00 AM- to 3:00 PM shift, and dressed him/her with the white T-shirt he/she still had on now. The CNA stated, two shifts went by (referring to the 3:00 PM - 11:00 PM and 11:00 PM - 7:00 AM) and the resident had still not been changed. The CNA checked the resident in the presence of the surveyor and the resident was soiled with [redacted] On 01/11/23 at 8:40 AM, the surveyor conducted an interview with the CNA who delivered the	F 550	phone in patient's area is not acceptable. The Administrator assigned managers, supervisors and department heads specific residents to check on rounds three times a week assuring that personal hygiene, assistance with toilet use, timely changing of soiled clothing and resident respect and dignity is maintained. Assigned staff will be monitoring that oral and incontinence care is provided prior to serving the resident a meal. These rounds include checking if any staff member is witnessed on cell phone. The managers, supervisors and department heads address any issues found during rounds immediately. Any variances from rounds at morning meeting. Any variances will be addressed immediately. Findings will be reported to the quarterly QA meeting by DON for review and follow up for the next 6 months.	

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F 550	Continued From page 4 breakfast tray. The CNA stated she was not aware that Resident #45 needed to be changed. She added that the room had the "same smell every day". The surveyor escorted the CNA to the room and when asked about the [redacted] still present in the room, she replied that the resident was not on her assignment. On 01/11/23 at 8:45 AM, the surveyor shared the above concerns with the Unit Manager (UM). The UM told the surveyor that any staff regardless if assigned to a resident or not, should change a resident if the resident needed to be changed. On 01/11/23 at 8:50 AM, the surveyor interviewed the resident who stated, "I told you I needed everything. I needed to be changed and get ready." When asked how did he/she feel regarding not being changed prior to breakfast, Resident #45 stated, "the girls (referring to the CNAs) they are overworked, I just stay put". A review of Resident #45's medical record revealed the resident was admitted to the facility with diagnoses which included but were not limited to: [redacted] The most recent Quarterly Minimum Data Set (MDS), a resident assessment tool used by the facility to prioritize care dated [redacted], revealed that Resident #45 had some [redacted]. Resident #45 scored [redacted] on the Brief Interview for Mental Status (BIMS). The MDS reflected that Resident #45 was always [redacted] and [redacted] and was not on a toileting program. Resident #45 was totally dependent on staff for personal hygiene and toilet use.	F 550		

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F 550	Continued From page 5 The administrative staff was made aware of the above concerns on 01/11/23 at 9:30 AM and again on 01/19/23 at 12:30 PM. On 01/20/23 at 11:30 AM and no additional information was provided. 2. On 01/03/23 at 11:14 AM, the surveyor observed Resident #179 lying in bed, awake, and was on an [redacted]. The television was on and the resident did not appear to be engaged. The resident appeared [redacted], an [redacted], and the resident did not respond to the surveyors greeting. The resident's [redacted] appeared very [redacted] with a [redacted] on the [redacted]. On 01/03/23 at 12:37 PM, the surveyor observed through the doorway that Resident #179 was in bed, with the resident meal tray covered on the overbed table next to the resident. The surveyor entered the room, and heard a noise in the resident's bathroom. There were no other residents assigned to the room. At that time, the door to the bathroom opened and a staff member exited the bathroom holding her cell phone. The staff identified herself as a Certified Nurse Aide (CNA #1) assigned to care for Resident #179. CNA #1 proceeded to explain to the surveyor that she was having some filmily issues and that was why she was on the phone. CNA #1 did not engage the resident, or interact with the resident at all, including with the meal tray and proceeded to exit the resident's room. On 01/04/23 at 8:35 AM, the surveyor observed Resident #179 with eyes closed, lying in bed and the breakfast meal had not yet arrived on the unit. The surveyor observed a brownish tan flaky food	F 550		

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F 550	Continued From page 6 like substance on Resident #179's top [redacted]. The surveyor engaged the resident who opened his/her eyes, looked at surveyor and did not verbally respond. On 01/04/23 at 1:48 PM, the surveyor, in the presence of the survey team, informed the Licensed Nursing Home Administrator (LNHA) and Corporate Nurse of the observation with CNA #1 talking on the phone in Resident #179's bathroom. The LNHA stated that was "not tolerated", and they [staff] were not supposed to be talking on cell phones in a resident's room. A review of the facility provided policy titled, "Quality of life: Dignity", initiated 03/24/12 and revised 12/04/17, revealed, "Each resident of the [facility name] shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Treated with dignity means the resident will be assisted in maintaining his or her self esteem and self-worth.", Procedure: 1. Residents shall be treated with dignity and respect at all times, 2. Residents shall be groomed as they wish to be groomed (hair styles, nails, facial hair, etc.), 4. Residents' private space and property shall be respected at all times, a. Staff will knock and request permission before entering residents' rooms. N.J.A.C.8:39-4.1(a)(12)	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and	F 584		2/23/23

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F 584	Continued From page 7 supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, it was determined that the facility failed to	F 584	Resident # 180's [redacted] was immediately replaced by the housekeeper.	

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F 584	Continued From page 8 have a process in place to identify a bed that was broken for 1 of 26 residents reviewed who had a visibly broken bed (Resident #180). The deficient practice was evidenced by the following: On 01/03/23 at 12:09 PM, the surveyor interviewed Resident #180 while the resident was sitting in bed. The resident stated the only issue was that he/she could feel the screws from the bed frame and it was hard to sleep. Resident #180 stated he/she had to sleep a certain way, and kept telling them (the facility staff) and "nothing is done". Resident #180 was sitting in the bed and the surveyor was unable to observe the [redacted] at that time. On 01/04/23 at 11:53 AM, the surveyor observed that Resident #180 was not in the room and observed that the [redacted]s was not covered by a blanket and was visibly sunken in, in a circular pattern about a foot long. The surveyor brought the Unit Manager (UM) into Resident #180's room and asked him to look at the [redacted] The UM looked at the [redacted] felt the indent, and stated the [redacted] "needs to be changed". At that time, the surveyor interviewed the Licensed Practical Nurse (LPN) who was assigned to Resident #180 regarding the resident's [redacted]. The LPN stated "to be honest, [he/she] did not tell me about the [redacted]" On 01/04/23 at 11:59 AM, the surveyor brought Resident #180's Certified Nurse Aide (CNA) into the resident's room for an interview at the same time Resident #180 was self propelling in a wheelchair into the room. At that time the surveyor asked the CNA if she ever changes Resident #180's bed and she stated "I always change the bed", "[he/she] didn't tell me".	F 584	All residents have the potential to be affected. The housekeeping director checked all [redacted] in all units to make sure they are all in good condition. All housekeeping and nursing staff were in-serviced by the Director of Housekeeping and Director of Nursing on reporting any issues with resident's mattresses to housekeeping. The housekeeping and nursing staff were inserviced by Director of Nursing and Director of Housekeeping to record any issues with resident's [redacted] in the Maintenance Log located on each unit. The Director of Housekeeping and/or designee will monitor the log book on a daily basis for any issues reported with resident [redacted] and take prompt action to correct the issue. The Director of Housekeeping will do monthly check of all [redacted] in the building to identify any issues and will replace as needed. The Director of Housekeeping will report results of monthly check at morning meeting. Findings will be reported to the quarterly QA meeting by the Director of Housekeeping for review and follow up for the next 6 months.	

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F 584	Continued From page 9 Resident #180 stated to the CNA and Surveyor "I have told everybody about the bed", "I may be able to sleep better". The CNA felt the middle of the [redacted] and stated, "oh yes, that needs to be changed". The UM entered the room and the CNA then stated that she never took care of Resident #180 until that day. Resident #180 told the CNA and UM, in front of the surveyor, "I have told so many people about my [redacted] and if you lay on it you can feel the screws". The CNA and UM both denied, to the resident, that he/she told either one of them about the [redacted]. The UM stated to Resident #180 that "if you told me, I would have changed it". On 01/04/23 at 12:17 PM, the surveyor reviewed the 12/29/22 nursing assignment sheet, provided by the UM, which revealed the CNA was also assigned to Resident #180 on that day. The UM stated if the resident has a complaint we can call or put in the maintenance book. At that time, the surveyor reviewed the maintenance book, along with the surveyor, from the time Resident #180 was admitted. The maintenance book did not have any documented evidence of Resident #180's broken bed. On 01/04/23 at 12:21 PM, the UM informed the surveyor that a new [redacted] was provided to Resident #180. On 01/06/23 at 8:30 AM, the surveyor observed Resident #180 sleeping in bed. On 01/06/23 at 9:01 AM, the surveyor observed Resident #180 sitting at the side of the bed, eating breakfast. The surveyor interviewed the resident how the bed was, and the resident stated "much improved", the surveyor asked the resident	F 584		

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F 584	Continued From page 10 if he/she was more comfortable. Resident #180 stated, "yes", "my body is not in one position and I don't have to contort my body to sleep", "the [redacted] improved". Resident #180 stated he/she was looking forward to going home. On 01/06/23 at 9:28 AM, the surveyor interviewed the Regional Maintenance Director, along with the facility Maintenance Director (MD) regarding mattress repair. The MD stated he was not responsible for [redacted] and that housekeeping was responsible. On 01/06/23 at 9:38 AM, the surveyor interviewed the Housekeeping Director (HD), in the presence of two surveyors, regarding any responsibility that his department had regarding [redacted] The HD stated he was primarily responsible for changing the [redacted] and he did not recently change Resident #180's [redacted]. The HD stated he was not made aware that the resident needed a new one. The surveyor inquired to the HD about what kind of [redacted] was the dark matter, and he stated a standard mattress. The surveyor asked if the [redacted] could sink in. The HD stated he didn't see that often, but "it does happen", and stated that maybe the housekeeper changed it, and he would look into it. When asked who was responsible for checking if the [redacted] was in good condition. The HD stated the housekeepers do not determine the integrity of the [redacted], and they were responsible for keeping it clean. On 01/20/23 at 10:24 AM, the survey team met with the administrative team which included the Director of Nursing, Administrator, Corporate Director of Operations, and Quality Assurance Nurse. The surveyor informed the administrative	F 584		

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F 584	Continued From page 11 team about Resident #180's sunken in bed, confirmed by the UM and CNA and was not documented in the maintenance log. On 01/20/23 at 12:44 PM, the administrative team did not provide additional information regarding the broken bed. The facility provided Maintenance Service Policy, undated, revealed a policy Statement: It is the policy of this facility that maintenance service be provided to all aeas of the building, grounds, and equipment. Procedure: 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. The following functions are performed by maintenance, but are not limeited to: a. Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines, b. Maintaining the building in good repair and free from hazards, f. Establishing priorities in providing repair service, h. Providing routinely scheduled maintenance service to all areas, i. Others that may become necessary or appropriate.	F 584		
F 600 SS=J	NJAC 8:39-27.1(a) Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to	F 600		2/23/23

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F 600	Continued From page 12 treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of pertinent documents, it was determined that the facility failed to protect a resident (Resident #182) from abuse by a Certified Nurse Aide (CNA #1) by failing to ensure: a.) the facility policy was followed to identify an allegation of abuse, b.) that upon receiving an allegation of abuse on [redacted] during the 7:00 AM to 3:00 PM shift, the facility immediately protected Resident #182, and other residents from potential abuse, and c.) a thorough investigation was immediately initiated. This deficient practice occurred for 1 of 2 residents reviewed for abuse, and on 1 of 4 resident units. The facility's failure to ensure the abuse policy was followed to protect a resident from abuse, and ensure a process was in place to protect all residents from potential abuse resulted in an Immediate Jeopardy (IJ) situation that began on [redacted] when a family member of Resident #182 informed the facility that CNA #1 "was not nice" to Resident #182, and "had and attitude", and the facility failed to immediately initiate an investigation and CNA #1 proceeded to work on the same resident unit the following day, [redacted] and was assigned to nine residents. The facility administration was notified of the IJ situation on 01/19/23 at 2:56 PM.	F 600	Investigation for resident was implemented and CNA was suspended pending investigation. All alert and oriented residents on CNA assignment were interviewed by Unit Manager and body assessment was completed on all residents on assignment who were not alert and oriented. Nothing unusual noted. A team meeting was held with Resident #182 to reassure her safety and security in the facility. Resident reported that she felt safe and comfortable. The Administrator and/or Manager on duty will visit resident daily to inquire about her stay and address any concerns she may have. All residents have the potential to be affected. The Administrator and Director of Nursing were inserviced on the procedures for abuse allegation investigation, including immediate removal of any accused staff member pending investigation and how to identify other residents who may have been affected by the Director of Education and Quality and the Director of Compliance. The Social Service Director, Social	

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F 600	Continued From page 13 The facility submitted an acceptable removal plan on 01/20/23 at 9:00 AM. On 01/20/23 at 9:00 AM, the removal plan was verified as implemented by the survey team during the survey. The non-compliance remained on 01/20/23 for no actual harm with the potential for more than minimal harm, that is not Immediate Jeopardy, based on the following: The evidence was as follows: On 01/19/23 at 8:27 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with a written memo that she had received regarding a request to speak with a family member. On 01/19/23 at 8:46 AM, the surveyor contacted the family member (FM) of Resident #182 and conducted a telephone interview. The FM stated Resident #182 had an issue with CNA #1 who had walked into Resident #182's room and was "nasty" to Resident #182 on [redacted] The FM stated CNA #1 told the resident that she was not going to have to change (provide incontinence care) the resident again, since Resident #182 was not her only resident. CNA #1 told Resident #182 that she was on her break at the time, and CNA #1 refused to change Resident #182. CNA #1 then proceeded to throw down the food plate lid with force on Resident#182's over bed table. The FM stated that he/she had made the Director of Social Services (DSS) aware of what happened on the same day.[redacted] On 01/19/23 at 8:50 AM, the surveyor interviewed	F 600	Worker, and Unit Manager were on inserviced on the procedures for abuse allegation investigation, including immediate removal of any accused staff member pending investigation and how to identify other residents who may have been affected by the Director of Education and Quality and the Director of Compliance. Inservicing began on all staff from all departments on 1/19/23 on the procedures for abuse allegation investigation, including immediate removal of any accused staff member pending investigation, by Administrator and/or designee. If an employee is not on duty, the Administrator, Director of Nursing, or Regional staff member will call employee and maintain a record of verbal education and then obtain signature on next scheduled workday. Any staff member who we are unable to reach by phone, will be inserviced on next scheduled workday prior to start of shift. The Administrator, Director of Nursing, Infection Preventionist, Director of Social Service, Director of Recreation will each interview 3 alert and oriented residents per week as quality assurance check for any potential abuse allegations. Results will be reported to the Administrator. Regional Director of Compliance, Regional Director of Education and Quality, Regional QA RN, Regional RD, Regional Rehab Director, and Regional Recreation Director will each conduct interviews on 3 alert and oriented residents monthly as a quality assurance check for any potential abuse allegations.	

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F 600	Continued From page 14 Resident #182 while the resident was in bed. Resident #182 stated that he/she had a problem with a female Certified Nurse Aide (CNA #1) on [redacted] Resident #182 stated that CNA #1 told him/her that he/she was not her only resident, and CNA #1 also threw the meal tray down. Resident #182 stated that CNA #1 had seemed mad at the time because CNA #1 stated she was on her break. Resident #182 stated he/she had informed the DSS what happened on the same day, [redacted] On 01/19/23 at 8:54 AM, the surveyor reviewed the CNA assignment sheet for [redacted], with the Unit Manager (UM). The assignment sheet for [redacted], revealed that there were two CNAs listed to care for the residents on the unit. The surveyor inquired to the UM what the current resident census was for the unit. The UM stated [redacted] residents were on the unit, and the surveyor asked what the staffing typically was, and if any of the CNAs that had worked on 01/17/23 were removed from the schedule for any reason. The UM stated that there was usually five or six CNAs staffed on the unit, and he was not sure who had called out sick. The UM then stated "no", CNAs had been removed from the schedule for any reason and stated there were three CNAs that had scheduled days off (which included CNA #1). On 01/19/23 at 9:23 AM, the surveyor conducted an interview with the DSS and inquired if there were currently any investigations in progress. The DSS stated that he had received a grievance from Resident #182 on [redacted] At that time the DSS provided the surveyor with the copy of the "[Facility Name], Grievance/Missing Item Report", which revealed: "Date: [redacted] (untimed),	F 600	Results will be reported to the Administrator. Any unusual occurrence, which may potentially constitute abuse, neglect, or involuntary seclusion will be identified as a potential abuse incident and will be investigated as indicated at the facility Abuse Prevention Program #VI. Monthly QAPI meetings will analyze all abuse investigations. Analysis will include timelines of investigation, timelines of suspending staff pending investigation, if necessary, and review if facility identified and protected other residents who may have been affected. Result of resident interviews will be reported to the Administrator. Any concerns will be investigated immediately. Monthly QAPI meetings will analyze all abuse investigations. Analysis will include timelines of investigation, timelines of suspending staff pending investigation, if necessary, and review if facility identified and protected other residents who may have been affected. Monthly QAPI meetings will occur for the next 6 months and then be re-evaluated	

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F 600	Continued From page 15 Resident: [#182], Room: [Resident #182's room number]. Complaint Made By: Patient, Complaint Made to: DSS, Statement of Complaint:", "On [redacted], at about lunch time, the patient stated a CNA threw the lid cover on the food/tray table". A handwritten "Addendum" documented directly below the [redacted]3 "Statement of Complaint" revealed "On [redacted], on the date above, the Patient stated that the same CNA, while on the total lift machine, wanted to be placed in bed ...The statement continued on a blank page which revealed ... and in need of a change of [his/her] disposable brief, the CNA stated, "Your [sic.] not my only patient, there's no way I'm doing this tomorrow." While in bed, [he/she] was not changed by that CNA. After a while, [he/she] was changed by someone else." The DSS stated that he completed his portion on [redacted], when the FM of Resident #182 brought him into the resident's room to speak with Resident #182, and he confirmed that he took the statement from Resident #182 and stated, "the complaint was made to me". The DSS stated he brought the initial complaint, on [redacted], to the Director of Nursing (DON), because when the complaint involved nursing the DON was responsible for getting statements. The DSS stated that the DON was responsible for the investigation, along with the LNHA, who was the facility abuse coordinator. The DSS stated "I would imagine the Director of Nursing has followed up on it [the complaint made by Resident #182]". The DSS stated that he conducted a follow-up interview with Resident #182 on [redacted], and at that time, the resident provided an additional statement that he also documented on the form. At that time, the surveyor requested and the DSS provide the surveyor with a copy of the facility abuse policy. The surveyor inquired to the DSS if what	F 600		

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F 600	Continued From page 16 Resident #182 stated to the DSS would fall under the abuse category. The DSS stated, "yes", that "it is verbal abuse, neglect, and it touches many bases". The DSS stated again, he immediately informed the DON of the allegation made by Resident #182 on [redacted]. The surveyor inquired to the DSS what the process was when an allegation of abuse occurred, and what his involvement was. The DSS stated he was not involved with the abuse investigation, he assisted with grievances, and missing items, and because the allegation received from the FM and Resident #182 was related to abuse. The DSS stated "I immediately told the DON" and stated, "I would imagine that the DON has followed up on it". The surveyor asked the DSS if this allegation would be a priority, and he stated, "yes", and the first thing that would be done would be "[CNA #1] would be removed from providing care", and stated "if it is alleged abuse, then she cannot come to the facility until the investigation is completed, because you would not want someone who was alleged to have performed an abusive act working because it could happen again." The DSS stated when he took the initial complaint from Resident #182, he had initially thought it was an allegation of abuse and neglect because CNA #1 failed to perform care for the resident, and then slammed the lid down which was aggressive and possibly violent. The DSS stated he was instructed by the DON to provide the UM with blank statement forms on [redacted], which he had done, and he instructed the UM to get the statements per the DON's instructions. The DSS stated he provided the copy of the grievance form to the UM on [redacted]. The surveyor asked the DSS what further involvement he had in the abuse investigation process, and had he received any further communication	F 600		

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F 600	Continued From page 17 regarding the allegation provided by the DON/ LNHA, and he stated, "no, not to me". An initial review of the Facility "Policy/ Procedure, Abuse Prevention Program", Original Issue Date: 2/2014, Revised: 10/21/22, in the presence of the DSS revealed under Part V, Investigation, Procedure: The administrator who is the Abuse Prevention Program Coordinator, and the DON will initiate investigations of any allegations of abuse, determine necessary response, and report to the office of the Ombudsman and the Department of Health and Senior Services, as necessary. The scope of the investigation shall be determined by the Administrator and/or the DON. The Protection Procedure revealed, "When a potential abuse incident is reported to a supervisor, the immediate priority is the safety of the resident, who is to be removed from potential danger. After the supervisor, notifies the administrator and the DON after ensuring the temporary safety of the resident, the administrator and the DON will make permanent arrangements for the resident's safety. Staff members being investigated for possible involvement in abuse will be removed from contact with the resident, such as suspended pending results of the investigation, as necessary." On 01/19/23 at 9:50 AM, the surveyor conducted an interview with the UM for the unit that Resident #182 resided on. The surveyor inquired to the UM if he had received any complaints or was currently involved in any investigations regarding any residents. The UM stated that the FM of Resident #182, came to him on [redacted] and informed him that CNA #1 had an attitude, and "she was not nice" to the resident. The UM stated that he informed the DON and the DSS the same day of the FM's complaints. The surveyor inquired	F 600		

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F 600	Continued From page 18 if the UM had been instructed to do anything because of the complaint. The UM stated, "I was told to take statements", but because the UM found out late in the afternoon on [redacted]3, CNA #1 had already left for the day and he was unable to obtain a statement. The UM confirmed to the surveyor that CNA #1 was the CNA assigned to Resident #182, and then stated he obtained a statement from CNA #1 on [redacted], which was the following day after the allegation The UM stated that CNA #1 worked her full resident assignment on [redacted] and again on [redacted] At that time, the surveyor reviewed the [redacted], 7:00 AM-3:30 PM assignment sheet for the CNAs, and CNA #1's assignment included nine residents. Resident #182's room had both beds crossed off, and it was replaced with two other beds in another room. The UM stated that when CNA #1 arrived to work on 01/18/23, that she had started her assignment first, and then he had spoken to her (time not provided by UM) regarding the reason for being removed from providing care to Resident #182. However, the UM confirmed that CNA #1 continued to work and was assigned to a resident care assignment which included nine residents. The assignment was located on the same unit where Resident #182 still resided and had access to Resident #182, and all other residents. The surveyor asked the UM if he had been provided a copy of the grievance from the DSS, and he stated, "yes". The surveyor asked the UM if what was written on the form represented abuse and neglect, and the UM stated, "yes", and stated CNA #1 told him, "it never happened", and that Resident #182 was happy with the care she had provided. The surveyor asked the UM if he had interviewed anyone else regarding the allegation. The UM	F 600		

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F 600	Continued From page 19 stated he had interviewed the four CNAs (including CNA #1) that worked on the unit on [redacted], the date when the allegation was received, and the surveyor asked if the UM had interviewed anyone else in addition to the CNAs. The UM stated, "no", and the surveyor then asked if the UM had interviewed any residents. The UM stated, "no", and that he provided the statements he collected to the DON. The surveyor inquired to the UM if it was still an ongoing investigation, and the UM stated "yes". On 01/19/23 at 10:46 AM, the surveyor, in the presence of the survey team, interviewed the DON and LNHA. The surveyor asked what the process was if there was an allegation of abuse. The DON stated the process was, if there was an allegation of abuse, an investigation would be started immediately, and stated "right away" after she received the complaint. The surveyor inquired if there had been any recent complaints, or allegations of abuse. The LNHA stated there was a grievance provided by the DSS, and the DON and LNHA confirmed it was provided to both on [redacted], and the LNHA stated she had been made aware by the UM on [redacted] at 4:00 PM. The surveyor asked what the process was when a grievance was received. The DON stated as soon as she received it, that she would identify the caregiver and nurse assigned to the patient, and then she would obtain a statement from the staff that were involved with the resident, including the family, doctor, nurses, and other residents assigned to the staff. The DON stated that the assigned aide to the person who had the complaint would be suspended while the investigation was ongoing, because "we don't want any incident to happen", "we want to protect the resident and any other resident assigned".	F 600		

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F 600	Continued From page 20 The surveyor informed the DON and LNHA that CNA #1 worked on [redacted], despite the DON stating the staff would be suspended during the investigation, and the surveyor informed the DON and LNHA that the UM had confirmed he was made aware of the allegation on [redacted] and CNA #1 was allowed to work and provide resident care the following day. The surveyor asked about Resident #182's allegation that CNA #1 threw the lid cover, and the DON stated, "I would say that was an attitude", and the DON stated based on that assumption she took CNA #1 off Resident #182's assignment. The surveyor asked where "attitude" would fall in the abuse policy and the LNHA stated it was "just sensitivity", and the DON stated the employee could have "burnout" but may not have intended to be insensitive to the resident. The DON stated we would have to investigate to see if there was an intention of abuse. The DON was asked if there had to be intention for abuse and the DON responded to the survey team, "no". The DON then stated that we spoke with the aide on [redacted] (no time provided), after the complaint was made. When the surveyor inquired to the DON when she was informed about the incident from the UM, the DON stated, "I could not even remember what he told me" on [redacted], because "it was late in the afternoon". The surveyor inquired to what time the DON received the statement from CNA #1, and the LNHA stated we found out at 4:00 PM about the allegation, and that was when the statement was written. At that time, the surveyor inquired to the LNHA who had the facility received statements from, and the LNHA confirmed she had a statement from CNA #1, and three other CNAs who worked that day. The DON stated "we didn't" get statements from the nurses that worked that day and then stated that they	F 600		

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F 600	Continued From page 21 received statements from the four CNAs that worked on [redacted], and the UM. The surveyor inquired to the DON if she had interviewed the resident when she had found out about the allegation on [redacted] the DON stated "yes", at 3:00 PM, but that was late in the afternoon. The surveyor asked what the DON had asked the resident, and the DON stated, "how are you today" and no other specific questions per the DON. The DON stated the UM also spoke with the resident on [redacted] and confirmed there was no documented evidence when inquired by the surveyor. The DON stated that other alert and oriented residents would still need to be interviewed to obtain statements, and confirmed the investigation was "not complete yet", that they "cannot just let it go", and "we don't tolerate that". The surveyor asked was anything done for residents who were not alert and oriented and the DON stated we would do a body assessment. The surveyor inquired if that was done and the DON stated "no", and the LNHA stated "we could ask the family members about any concerns with the caretaker." The LNHA stated "yesterday was really when the investigation began, and the other day was just a comment". The surveyor inquired if the investigation was completed on [redacted], and the DON stated, "no". The surveyor then asked if it the investigation was not completed, was CNA #1 supposed to work and have a resident assignment on [redacted] The DON stated, "this was given to us late", and the DON and LNHA did not offer an explanation as to why CNA #1 worked on [redacted] and provided resident care. The surveyor asked why it was important to interview other staff, and the LNHA stated "to make sure other residents are safe". The surveyor asked what kind of an allegation the statements made by Resident #182 represent,	F 600		

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F 600	Continued From page 22 the DON stated, "a complaint". The surveyor asked if the allegation was an allegation of abuse, and the LNHA stated, "yes". The surveyor asked is there anything else that should be done when an allegation of abuse was made. The LNHA stated "I have to report it to the State and Ombudsman within two hours", and confirmed it was reported to the State Department of Health on [redacted], [redacted] days later, and not within two hours. On 01/19/23 at 12:00 PM, the surveyor reviewed the medical record for Resident #182 which revealed the following: An Admission Record revealed the resident had diagnoses which included, but were not limited to; [redacted]. The Admission Minimum Data Set, an assessment tool, dated [redacted], revealed the resident was totally dependent on one person for toileting, and had no behavioral symptoms. The Care Plan included a Focus: date initiated [redacted] for an ADL (Activity of Daily Living) deficit r/t (resulted to) [redacted], Goal: Resident will improve current level of function in (bed mobility, transfers, eating, dressing, toilet use and personal hygiene, ADL score) through the review date, a Focus: date initiated [redacted] for Resident is at risk for [redacted] r/t [redacted], Goal: Resident will not sustain serious injury through review date, Interventions: Anticipate and meet needs, Anticipate toileting needs, Be sure call light is within reach and encourage to use it for assistance as needed. Provide prompt response to all requests for assistance, Monitor effects of medications, a Focus: date initiated [redacted], Resident has a potential for skin breakdown secondary to limited mobility in bed, Goal:	F 600		

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F 600	Continued From page 23 Resident will have care needs met as evidenced by no skin breakdown, Interventions included: keep skin clean and dry, sheets as wrinkle free as possible, observe skin during bathing, turning, and incontinence care for early signs of breakdown, turn and reposition resident every 2 hours and as needed, use proper positioning, transferring, and turning techniques to minimize skin injury due to friction and shear force (all interventions date initiated [redacted] On 01/19/23 at 12:21 PM, the surveyor requested a copy of the investigation file from the LNHA and the LNHA stated the DSS was still in the process of collecting interviews. On 01/19/23 at 12:23 PM, the LNHA provided the surveyors with an incomplete copy which included page one and three of the Reportable Event Record that was submitted to the Department of Health, Dated [redacted] and Timed, 9:55 AM, along with a copy of a statement from CNA #1, dated [redacted] (untimed), a statement, dated [redacted] (untimed) from CNA#2, a statement from CNA #3, dated [redacted] (untimed), and a statement from CNA #4, dated [redacted] (untimed). The statements also included the Grievance/Missing Item Report from the DSS with additional information added in the Department Responsible for Resolution section statement, dated [redacted] and a statement dated, [redacted] from the DON (untimed), and a statement from the UM, dated [redacted] (untimed). The handwritten statement dated [redacted] and signed by the UM revealed...8:00 AM During rounds, pt [patient] was in bed eating breakfast and watching TV [television], 10:20 AM pt was helped with his/her am [morning] care and went to rehabilitation gym for pt/ot [therapy],	F 600		

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F 600	Continued From page 24 12:00 PM pt in bed having lunch, 2:00 PM CNA's helped with diaper change spouse at the side, 3:00 PM "Pt [patient] was in bed resting. Pt did not voiced [sic.] any complaint to me". The statement written by the UM failed to include the allegations confirmed by the UM that he had received from the FM of Resident #182 on [redacted] who had informed him that CNA #1 had an attitude, and "she was not nice" to the resident, and the statement failed to document any follow-up from the allegations the UM received from the DSS which the UM confirmed had confirmed receiving, and failed to document any follow-up regarding the allegations that the UM confirmed he received from the DSS. The statement provided from CNA #1 on [redacted] contradicted what the UM stated regarding not being able to obtain a statement from CNA #1 because she had already left for the day, and he stated he informed her of the allegations on [redacted] On 01/19/23 at 1:02 PM, the surveyor, in the presence of another surveyor, interviewed Resident #182 with the FM present. The surveyor asked Resident #182 about the incident that occurred with CNA #1, and how it made the resident feel. Resident #182 stated it made him/her feel "[redacted], and he/she was "[redacted]", and the resident was concerned for how he/she would receive care the following day after the incident. Resident #182 stated CNA #1 "was mad" and left the room and then stated there was no one present when the CNA was not nice to the resident. The FM stated they now had to hire private care to ensure Resident #182 would receive care. On 01/19/23 at 1:30 PM, the DON provided the	F 600		

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F 600	Continued From page 25 "Time Card Report", for CNA #1 which revealed CNA #1 worked [redacted] from 6:55 [AM] to 15:30 [3:30 PM], and on [redacted] from 6:53 [AM] to 15:47 [3:47 PM]. On 01/19/23 at 1:36 PM, Surveyor #2 conducted an interview with the UM. Surveyor #2 asked the UM when he was first made aware of the allegations made by Resident #182. The UM stated the FM of Resident #182 told the UM on [redacted], and the UM immediately informed the LNHA and DON. Surveyor #2 asked the UM if he had interviewed Resident #182, and he stated "I just asked how [he/she] was and [he/she] stated fine. The UM failed to document the allegation received from the FM, failed to document any interviews with Resident #182 regarding the allegations made by Resident #182, nor with the resident's [redacted] or FM. A further review of the Policy/Procedure: Abuse Prevention Program, Original Issue Date: 2/2014 revealed Policy: This facility prohibits abuse, neglect, involuntary seclusion, and misappropriation of property from residents and will utilize the abuse prevention program to effectively prevent occurrences, screen and train staff, identify, investigate, report, and respond to any occurrences ...Definitions: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish ...Willful, as used in this definition	F 600		

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F 600	Continued From page 26 of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Forms of resident abuse: Active Forms of Abuse: ...2. Verbal Abuse: Talking to residents in a demanding manner, shouting, cursing, and name-calling..., Passive Forms of Abuse: 1. Emotional Abuse: Deliberately ignoring a resident's request, denying a resident water, food, a bedpan, a call bell, etc. for a period of time., 2. Neglect: The failure of the facility, it's employees, or service provides to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress (ex: [example] allowing a resident to lie in urine or feces, ignoring a resident, not providing daily cleanliness, personal hygiene, proper mouth care, shaving, hair washed and combed, dressing a resident inappropriately and or in dirty clothing. Leaving resident exposed during bathing, dressing, changing etc...). Neglect of goods or services may occur when staff are aware of residents' care needs, based on assessment and care planning, but are unable to meet the identified needs due to other circumstances, such as lack of training to perform an intervention (Example-suctioning, transfers, use of equipment". Lack of sufficient staffing to be able to provide the services, lack of supplies, or lack of knowledge of the needs of the resident. Abuse Prevention Program-Part VII- Protection, Procedure: When a potential abuse incident is reported to a supervisor, the immediate priority is the safety of the resident, who is to be removed from potential danger. After the supervisor notifies the administrator and the DON after ensuring the temporary safety of the resident, the administrator and the DON will make permanent arrangements for the resident's safety. Staff	F 600		

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F 600	Continued From page 27 members being investigated for possible involvement in abuse will be removed from contact with the resident, such as suspended pending results of the investigation, as necessary. Abuse Prevention Program-Part V1-Identification, Procedure: ...Any unusual occurrence, which may potentially constitute abuse, neglect, or involuntary seclusion, will be identified as a potential abuse incident and investigated as such...Abuse Prevention Program-Part V11 Reporting/Response...When an incident is reported to the supervisor, the supervisor is responsible for ensuring that the resident is safe and will notify the administrator as well as the DON, or their designees..The administrate and DON will initiate the investigation of the potential abuse incident, determine the necessary response and report to the Department of Health and Senior Services and/or the office of the Ombudsman (if applicable) as per regulations including Peggy's Law. Alleged violates 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 that 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury...The scope of the investigation shall be determined by the administrator and/or the DON... N.J.A.C. 8:39-4.1 (a)5,12; 27.1(a)	F 600		
F 607 SS=F	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii)	F 607		2/23/23

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F 607	Continued From page 28 §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview, and review of pertinent documents it was determined that the facility failed to have written procedures in place to ensure: a.) all residents were protected from abuse when an allegation of staff to resident abuse occurred, b.) a process was in place for identifying other potential victims of abuse, and c.) a process to ensure all potential	F 607	Investigation for resident was implemented and CNA was suspended pending investigation. All alert and oriented resident on CNA assignment were interviewed by Unit Manager and body assessment was completed on all residents on assignment who were not alert and oriented. Nothing unusual noted.	

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F 607	Continued From page 29 witnesses/persons aware of the allegation were interviewed. This deficient practice was evidenced for 4 of 4 resident units, and for 1 of 2 residents reviewed for abuse, and occurred when an allegation of abuse by a Certified Nurse Aide (CNA #1) against a resident (Resident #182) was received on [redacted] and CNA #1 proceeded to work a resident care shift the following day, [redacted], and had access to Resident #182 and other residents who resided at the facility, and was prior to an abuse investigation being completed. The deficient practice was evidenced by the following: Refer to 600J On 01/19/23 at 8:27 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with a request to speak with a family member. On 01/19/23 at 8:46 AM, the surveyor contacted the family member (FM) of Resident #182 and conducted a telephone interview. The FM stated Resident #182 had an issue with CNA #1 who had walked into Resident #182's room and was "nasty" to Resident #182 on [redacted]. The FM stated CNA #1 told the resident that she was not going to have to change (provide incontinence care) the resident again, since Resident #182 was not her only resident. CNA #1 told Resident #182 that she was on her break at the time, and CNA #1 refused to change Resident #182. CNA #1 then proceeded to throw down the food lid with force on Resident#182's over bed table. The FM stated that he/she had verbally informed the Director of Social Services (DSS) of what happened on the same day, [redacted] and the FM did not complete a written statement.	F 607	A team meeting was held with Resident #182 to reassure [redacted] safety and security in the facility. Resident reported that she felt safe and comfortable. The Administrator and/or Manager on Duty will visit resident daily to inquire about her stay and address any concerns she may have. All residents have the potential to be affected. The facility's immediate priorty is the safety of the resident who is to be removed from potential danger. The facility revised the Facility Abuse Prevention Program to ensure all residents were protected from abuse when allegation of staff to resident abuse occurs, identify other potential victims and process to assure all pontential witnessess aware of allegation are interviewed. All staff were inserviced by their respected department heads on the revised Facility Abuse Prevention Program Policy. Facility Abuse Prevention Program Policy will be reviewed at the QA Committee meeting quarterly for the next 6 months and annually thereafter. The Facility Abuse Prevention Program Policy will be reviewed at the QA Committee. Any indentified issued will be corrected immediately. QA Committee will review policy quarterly for the next 6 months and annually thereafter.	

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F 607	Continued From page 30 On 01/19/23 at 8:50 AM, the surveyor reviewed the CNA assignment sheet for [redacted], with the Unit Manager (UM). The assignment sheet for [redacted] revealed that there were two CNAs listed to care for the residents on the unit. The surveyor inquired to the UM what the current resident census was for the unit. The UM stated thirty-eight residents were on the unit, and the surveyor asked what the staffing typically was, and if any of the CNAs that had worked on [redacted] were removed from the schedule for any reason. The UM stated that there was usually five or six CNAs staffed on the unit, and he was not sure who had called out sick. The UM then stated "no", CNAs had not been removed from the schedule for any reason and stated there were three CNAs that had scheduled days off (which included CNA #1). On 01/19/23 at 9:23 AM, the surveyor conducted an interview with the DSS and inquired if there were currently any investigations in progress. The DSS stated that he had received a grievance from Resident #182 on [redacted] At that time the DSS provided the surveyor with the copy of the "Facility Name, Grievance/Missing Item Report", which revealed: "Date: [redacted] (untimed), Resident: [#182], Room: [Resident #182's room number]. Complaint Made By: Patient, Complaint Made to: DSS, Statement of Complaint:", "On [redacted] at about lunch time, the patient stated a CNA threw the lid cover on the food/tray table". A handwritten "Addendum" documented directly below the [redacted] "Statement of Complaint" revealed "On [redacted], on the date above, the Patient stated that the same CNA, while on the total lift machine, wanted to be placed in bed ...The statement continued on a blank page which	F 607		

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F 607	Continued From page 31 revealed ... and in need of a change of [his/her] disposable brief, the CNA stated, "Your [sic.] not my only patient, there's no way I'm doing this tomorrow." While in bed, [he/she] was not changed by that CNA. After a while, [he/she] was changed by someone else." The DSS stated that he completed his portion on [redacted], when the FM of Resident #182 brought him into the resident's room to speak with Resident #182, and he confirmed that he took the statement from Resident #182 and stated, "the complaint was made to me". The DSS stated he brought the initial complaint, on [redacted] to the Director of Nursing (DON), because when the complaint involved nursing the DON was responsible for getting statements. The DSS stated that the DON was responsible for the investigation, along with the LNHA, who was the facility was abuse coordinator. The DSS stated, "I would imagine the Director of Nursing has followed up on it [the complaint made by Resident #182]". The DSS stated that he conducted a follow-up interview with Resident #182 on [redacted] and at that time, the resident provided an additional statement that he also documented on the form. At that time, the surveyor requested and the DSS provided the surveyor with a copy of the facility abuse policy. The surveyor inquired to the DSS if what Resident #182 stated to the DSS would fall under the abuse category. The DSS stated, "yes", that "it is verbal abuse, neglect, and it touches many bases". The DSS stated, again, he immediately informed the DON of the allegation made by Resident #182 on [redacted]. The surveyor inquired to the DSS what the process was when an allegation of abuse occurred, and what his involvement was. The DSS stated he was not involved with the abuse investigation, he assisted with grievances, and missing items, and because	F 607		

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F 607	Continued From page 32 the allegation received from the FM and Resident #182 was related to abuse. The DSS stated, "I immediately told the DON" and stated, "I would imagine that the DON has followed up on it". The surveyor asked the DSS if this allegation would be a priority, and he stated, "yes", and the first thing that would be done would be "[CNA #1] would be removed from providing care", and stated "if it is alleged abuse, then she cannot come to the facility until the investigation is completed, because you would not want someone who was alleged to have performed an abusive act working because it could happen again." The DSS stated when he took the initial complaint from Resident #182, he had initially thought it was an allegation of abuse and neglect because CNA #1 failed to perform care for the resident, and then slammed the lid down, was aggressive and possibly violent. The DSS stated he was instructed by the DON to provide the UM with blank statement forms on [redacted], which he had done, and he instructed the UM to get the statements per the DON's instructions. The DSS stated he provided the copy of the grievance form to the UM on [redacted] The surveyor asked the DSS what further involvement he had in the abuse investigation process, and has he received any further communication regarding the allegation been provided by the DON/ LNHA, and he stated, "no", "not to me". An initial review of the Facility "Policy/ Procedure, Abuse Prevention Program", Original Issue Date: 2/2014, Revised: 10/21/22, in the presence of the DSS revealed under Part V, Investigation, Procedure: The administrator who is the APP Coordinator, and the DON will initiate investigations of any allegations of abuse, determine necessary response, and report to the office of the Ombudsman and the Department of Health and	F 607		

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F 607	Continued From page 33 Senior Services, as necessary. The scope of the investigation shall be determined by the Administrator and/or the DON. The Protection Procedure revealed, "When a potential abuse incident is reported to a supervisor, the immediate priority is the safety of the resident, who is to be removed from potential danger. After the supervisor, notifies the administrator and the DON after ensuring the temporary safety of the resident, the administrator and the DON will make permanent arrangements for the resident's safety. Staff members being investigated for possible involvement in abuse will be removed from contact with the resident, such as suspended pending results of the investigation, as necessary." (The policy failed to include a written process to protect the safety of all residents from abuse during an abuse investigation.) On 01/19/23 at 9:50 AM, the surveyor conducted an interview with the UM for the unit that Resident #182 resided on. The surveyor inquired to the UM if he had received any complaints or was currently involved in any investigations regarding any residents. The UM stated that the FM of Resident #182, came to him on [redacted] and informed him that CNA #1 had an attitude, and "she was not nice" to Resident #182. The UM stated that he informed the DON and the DSS the same day of the FM's complaints. The surveyor inquired if the UM had been instructed to do anything because of the complaint. The UM stated, "I was told to take statements", but because the UM found out late in the afternoon on [redacted], that CNA #1 had already left for the day, and he was unable to obtain a statement. The UM confirmed to the surveyor that CNA #1 was the CNA assigned to Resident #182, and	F 607		

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F 607	Continued From page 34 then stated he obtained a statement from CNA #1 on [redacted], which was the following day after the allegation The UM stated that CNA #1 worked her full resident assignment on [redacted] and again on [redacted] At that time, the surveyor reviewed the [redacted], 7:00 AM-3:30 PM assignment sheet for the CNAs, and CNA #1's assignment included nine residents. Resident #182's room had both beds crossed off, and it was replaced with two other beds in another room. The UM stated that when CNA #1 arrived to work on [redacted], that she had started her assignment first, and then he had spoken to her (time not provided by UM) regarding the reason for being removed from providing care to Resident #182. However, the UM confirmed that CNA #1 continued to work and was assigned to a resident care assignment on [redacted] which included nine residents. The assignment was located on the same unit where Resident #182 still resided and had access to Resident #182, and all other residents. The surveyor asked the UM if he had been provided a copy of the grievance from the DSS, and he stated, "yes". The surveyor asked the UM if what was written on the form represented abuse and neglect, and the UM stated, "yes", and stated CNA #1 told him, "it never happened", and that Resident #182 was happy with the care she had provided. The surveyor asked the UM if he had interviewed anyone else regarding the allegation. The UM stated he had interviewed the four CNAs (including CNA #1) that worked on the unit on [redacted], the date when the allegation was received, and the surveyor asked if the UM had interviewed anyone in addition to the CNAs. The UM stated, "no", and the surveyor then asked if the UM had interviewed any residents. The UM stated, "no", and that he provided the statements he had collected from the CNA's to the DON. The	F 607		

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	315357		01/20/2023

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F 607	Continued From page 35 surveyor inquired to the UM if the investigation was still ongoing, and the UM stated "yes". On 01/19/23 at 10:46 AM, the surveyor, in the presence of the survey team, interviewed the DON and LNHA. The surveyor asked to both the DON and LNHA what was supposed to happen if there was an allegation of abuse. The DON stated the process was, if there was an allegation of abuse, an investigation would be started immediately, and stated "right away", after she received the complaint. The surveyor inquired if there had been any recent complaints, or allegations of abuse. The LNHA stated there was a grievance provided by the DSS, and the DON and LNHA confirmed it was provided to both on [redacted] and the LNHA stated she had been made aware by the UM on [redacted] at 4:00 PM. The surveyor asked what the process was when a grievance was received. The DON stated as soon as she received it, that she would identify the caregiver and nurse assigned to the patient, and then she would obtain a statement from the staff that was involved with the resident, including the family, doctor, nurses, and other residents assigned to the staff. The DON stated that the assigned aide to the person who had the complaint would be suspended while the investigation was ongoing, because "we don't want any incident to happen", "we want to protect the resident and any other resident assigned". The surveyor informed the DON and LNHA that CNA #1 had worked on [redacted] which directly contradicted the DON's statement that the staff would be suspended during the investigation. The surveyor then informed the DON and LNHA that the UM had confirmed he was made aware of the allegation on [redacted] and CNA #1 was allowed to work and provided resident care the following	F 607		

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F 607	Continued From page 36 day. The surveyor asked about Resident #182's allegation that CNA #1 threw the lid cover, and the DON stated, "I would say that was an attitude", and the DON stated based on that assumption she took CNA #1 off of Resident #182's assignment. The surveyor asked where "attitude" would fall in the abuse policy and the LNHA stated it was "just sensitivity", and the DON stated the employee could have "burnout" but may not have intended to be insensitive to the resident. The DON stated we would have to investigate to see if there was an intention of abuse. The DON was asked if there had to be intention for abuse and the DON responded to the survey team, "no". The DON then stated that we spoke with the aide on [redacted] (no time provided), after the complaint was made. When the surveyor inquired to the DON when she was informed about the incident from the UM, the DON stated, "I could not even remember what he told me" on [redacted] because "it was late in the afternoon". The surveyor inquired to what time the DON received the statement from CNA #1, and the LNHA stated we found out at 4:00 PM about the allegation, and that was when the statement was written. At that time, the surveyor inquired to the LNHA who had the facility received statements from, and the LNHA confirmed she had a statement from CNA #1, and three other CNAs who worked that day. The DON stated "we didn't" get statements from the nurses that worked that day and stated that they received statements from the four CNAs that worked on [redacted], and the UM. The surveyor inquired to the DON if she had interviewed the resident when she had found out about the allegation made on [redacted], the DON stated "yes", at 3:00 PM, but that was late in the afternoon. The surveyor asked what the DON had asked the resident, and	F 607		

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F 607	Continued From page 37 the DON stated, "how are you today?" and no other specific questions were asked per the DON. The DON stated the UM also spoke with the resident on [redacted] and then confirmed there was no documented evidence of that interaction when inquired by the surveyor. The DON stated that other "alert and oriented" residents would still need to be interviewed to obtain statements, and confirmed the investigation was "not complete yet", that they "cannot just let it go", and "we don't tolerate that". The surveyor asked about residents who were not alert and oriented and the DON stated we would do a body assessment. The surveyor inquired if that was done and the DON stated "no", and the LNHA stated "we could ask the family members about any concerns with the caretaker." The LNHA stated "yesterday was really when the investigation began, and the other day was just a comment". The surveyor inquired if the investigation was completed on [redacted], and the DON stated, "no". The surveyor then asked if it the investigation was not completed, was CNA #1 supposed to work and have a resident assignment on [redacted]. The DON stated, "this was given to us late", and the DON and LNHA did not offer an explanation as to why CNA #1 worked on [redacted] and continued to provide resident care. The surveyor asked why it would be important to interview other staff, and the LNHA stated "to make sure other residents are safe". The surveyor asked what kind of an allegation the statements made by Resident #182 represented, the DON stated, "a complaint". The surveyor asked if the allegation was an allegation of abuse, and the LNHA stated, "yes". The surveyor asked is there anything else that should be done when an allegation of abuse was made. The LNHA stated "I have to report it to the State and Ombudsman within two hours", and	F 607		

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F 607	Continued From page 38 confirmed it was reported to the Stated Department of Health on [redacted], two days later, and not within two hours. On 01/19/23 at 1:02 PM, the surveyor, in the presence of another surveyor, interviewed Resident #182 with the FM present. The surveyor asked Resident #182 about the incident that occurred with CNA #1, and how it made the resident feel. Resident #182 stated it made him/her feel "[redacted]", and he/she was [redacted]", and the resident was concerned for how he/she would receive care the following day after the incident. Resident #182 stated CNA #1 "was mad" and left the room and then stated there was no one present when the CNA was not nice to the resident. The FM stated they now had to hire private care to ensure Resident #182 would receive care. On 01/19/23 at 1:30 PM, the DON provided the "Time Card Report", for CNA #1 which revealed CNA #1 worked [redacted] from 6:55 [AM] to 15:30 [3:30 PM], and on [redacted] from 6:53 [AM] to 15:47 [3:47 PM]. On 01/19/23 at 1:36 PM, surveyor #2 conducted an interview with the UM. Surveyor #2 asked the UM when he was first made aware of the allegations made by Resident #182. The UM stated the FM of Resident #182 told the UM on [redacted], and the UM immediately informed the LNHA and DON. Surveyor #2 asked the UM if he had interviewed Resident #182, and he stated "I just asked how [he/she] was and [he/she] stated fine. On 01/20/23 at 12:33 PM, the survey team completed an exit conference with the facility	F 607		

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F 607	Continued From page 39 administration, which included the LNHA, DON, Regional Quality Assurance Nurse and Corporate Director of Operations (COD). The surveyor asked the facility if the facility quality assurance comittee was aware that the facility abuse policy did not include protection for all residents. The COD stated "no". A further review of the Policy/Procedure: Abuse Prevention Program, Original Issue Date: 2/2014 revealed Policy: This facility prohibits abuse, neglect, involuntary seclusion, and misappropriation of property from residents and will utilize the abuse prevention program to effectively prevent occurrences, screen and train staff, identify, investigate, report, and respond to any occurrences ...Definitions: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish ...Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Forms of resident abuse: Active Forms of Abuse: ...2. Verbal Abuse: Talking to residents in a demanding manner, shouting, cursing, and name-calling..., Passive Forms of Abuse: 1. Emotional Abuse: Deliberately ignoring a resident's request, denying a resident water, food, a bedpan, a call bell, etc. for a period of time., 2. Neglect: The failure of the facility, it's employees, or service provides to provide goods and services	F 607		

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F 607	Continued From page 40 to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress (ex: [example] allowing a resident to lie in urine or feces, ignoring a resident, not providing daily cleanliness, personal hygiene, proper mouth care, shaving, hair washed and combed, dressing a resident inappropriately and or in dirty clothing. Leaving resident exposed during bathing, dressing, changing etc...). Neglect of goods or services may occur when staff are aware of residents' care needs, based on assessment and care planning, but are unable to meet the identified needs due to other circumstances, such as lack of training to perform an intervention (Example-suctioning, transfers, use of equipment". Lack of sufficient staffing to be able to provide the services, lack of supplies, or lack of knowledge of the needs of the resident. Abuse Prevention Program-Part VII- Protection, Procedure: When a potential abuse incident is reported to a supervisor, the immediate priority is the safety of the resident, who is to be removed from potential danger. After the supervisor notifies the administrator and the DON after ensuring the temporary safety of the resident, the administrator and the DON will make permanent arrangements for the resident's safety. Staff members being investigated for possible involvement in abuse will be removed from contact with the resident, such as suspended pending results of the investigation, as necessary. Abuse Prevention Program-Part V1- Identification, Procedure: ...Any unusual occurrence, which may potentially constitute abuse, neglect, or involuntary seclusion, will be identified as a potential abuse incident and investigated as such...Abuse Prevention Program-Part V11 Reporting/Response...When an incident is reported to the supervisor, the	F 607		

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F 607	Continued From page 41 supervisor is responsible for ensuring that the resident is safe and will notify the administrator as well as the DON, or their designees. (The facility Abuse Prevention Program did not include a process to protect all other residents from abuse when an allegation of abuse was reported)	F 607		
F 609 SS=D	N.J.A.C. 8:39-4.1 (a)5,12 Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(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		2/23/23

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F 609	Continued From page 42 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, it was determined that the facility failed to ensure an allegation of abuse was reported timely to the Department of Health. This deficient practice occurred for 1 of 2 residents reviewed for abuse (Resident #182) and was evidenced by the following: Refer to 600J and 600F On 01/19/23 at 8:46 AM, the surveyor contacted the family member (FM) of Resident #182 and conducted a telephone interview. The FM stated Resident #182 had an issue with CNA #1 who had walked into Resident #182's room and was "nasty" to Resident #182 on [redacted]. The FM stated CNA #1 told the resident that she was not going to have to change (provide [redacted] care) the resident again, since Resident #182 was not her only resident. CNA #1 told Resident #182 that she was on her break at the time, and CNA #1 refused to change Resident #182. CNA #1 then proceeded to throw down the food lid with force on Resident#182's over bed table. The FM stated that he/she had made the Director of Social Services (DSS) aware of what happened on the same day, [redacted] On 01/19/23 at 8:46 AM, the surveyor interviewed Resident #182 while the resident was in bed. Resident #182 stated that he/she had a problem with a female Certified Nurse Aide (CNA #1) on [redacted] Resident #182 stated that CNA #1 told him/her that he/she was not her only resident, and CNA #1 also threw the meal tray down. Resident #182 stated that the CNA #1 had	F 609	The facility reported the allegation to the Ombudsman's Office and LTC Complaint Office via email on [redacted] All residents have the potential to be affected. The Administrator and Director of Nursing were inserviced on their role and procedures for abuse allegation reporting by the Director of Education and Quality and the Director of Compliance. Inservice included review of identification of abuse allegations, timeliness of reporting and investigating any allegation of abuse, timeliness of suspending staff pending investigation, if necessary, and how to identify other residents who may have been affected. The Administrator will ensure that all alleged violations involving abuse are reported in a timely manner according to state law. The Director of Compliance will audit a sample of 3 abuse allegations per month. Audit will include proper identification of abuse allegations, timeliness of reporting and investigating any allegation of abuse, timeliness of suspending staff pending investigation, if necessary, and how to identify other residents who may have been affected. Results of these audits will be reported to	

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F 609	Continued From page 43 seemed mad at the time because CNA #1 stated she was on her break. Resident #182 stated he/she had informed the DSS what happened on the same day, [redacted] On 01/19/23 at 9:23 AM, the surveyor conducted an interview with the DSS and inquired if there were currently any investigations in progress. The DSS stated that he had received a grievance from Resident #182 on [redacted]. At that time the DSS provided the surveyor with the copy of the "Facility Name, Grievance/Missing Item Report", which revealed: "Date: [redacted] (untimed), Resident: [#182], Room: [Resident #182's room number]. Complaint Made By: Patient, Complaint Made to: DSS, Statement of Complaint:", "On [redacted] at about lunch time, the patient stated a CNA threw the lid cover on the food/tray table". A handwritten "Addendum" documented directly below the [redacted] "Statement of Complaint" revealed "On [redacted], on the date above, the Patient stated that the same CNA, while on the total lift machine, wanted to be placed in bed ...The statement continued on a blank page which revealed ... and in need of a change of [his/her] disposable brief, the CNA stated, "Your [sic.] not my only patient, there's no way I'm doing this tomorrow." While in bed, [he/she] was not changed by that CNA. After a while, [he/she] was changed by someone else." The DSS stated that he completed his portion on [redacted], when the FM of Resident #182 brought him into the resident's room to speak with Resident #182, and he confirmed that he took the statement from Resident #182 and stated, "the complaint was made to me". The DSS stated he brought the initial complaint, on [redacted], to the Director of Nursing (DON), because when the complaint involved nursing the DON was responsible for	F 609	the Administrator on a monthly basis. Monthly QAPI meetings will analyze all abuse investigations. Analysis will include timelines of reporting and investigation, timelines of suspending staff pending investigation, if necessary, and review if facility identified and protected other residents who may have been affected. Monthly QAPI meetings will occur for the next 6 months and then be re-evaluated	

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F 609	Continued From page 44 getting statements. The DSS stated that the DON was responsible for the investigation, along with the LNHA, who was the facility abuse coordinator. The DSS stated "I would imagine the Director of Nursing has followed up on it [the complaint made by Resident #182]". The DSS stated that he conducted a follow-up interview with Resident #182 on [redacted], and at that time, the resident provided an additional statement that he also documented on the form. At that time, the surveyor requested and the DSS provided the surveyor with a copy of the facility abuse policy. The surveyor inquired to the DSS if what Resident #182 stated to the DSS would fall under the abuse category. The DSS stated, "yes", that "it is verbal abuse, neglect, and it touches many bases". The DSS stated, again, he immediately informed the DON of the allegation made by Resident #182 on [redacted] The surveyor inquired to the DSS what the process was when an allegation of abuse occurred, and what his involvement was. The DSS stated he was not involved with the abuse investigation, he assisted with grievances, and missing items, and because the allegation received from the FM and Resident #182 was related to abuse. The DSS stated "I immediately told the DON" and stated, "I would imagine that the DON has followed up on it". The surveyor asked the DSS if this allegation would be a priority, and he stated, "yes", and the first thing that would be done would be "[CNA #1] would be removed from providing care", and stated "if it is alleged abuse, then she cannot come to the facility until the investigation is completed, because you would not want someone who was alleged to have performed an abusive act working because it could happen again." The DSS stated when he took the initial complaint from Resident #182, he had initially	F 609		

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F 609	Continued From page 45 thought it was an allegation of abuse and neglect because CNA #1 failed to perform care for the resident, and then slammed the lid down which was aggressive and possibly violent. The DSS stated he was instructed by the DON to provide the UM with blank statement forms on [redacted] which he had done, and he instructed the UM to get the statements per the DON's instructions. The DSS stated he provided the copy of the grievance form to the UM on [redacted]. The surveyor asked the DSS what further involvement he had in the abuse investigation process, and had he received any further communication regarding the allegation been provided by the DON/ LNHA, and he stated, "no", "not to me". An initial review of the Facility "Policy/ Procedure, Abuse Prevention Program", Original Issue Date: 2/2014, Revised: 10/21/22, in the presence of the DSS revealed under Part V, Investigation, Procedure: The administrator who is the APP Coordinator, and the DON will initiate investigations of any allegations of abuse, determine necessary response, and report to the office of the Ombudsman and the Department of Health and Senior Services, as necessary. The scope of the investigation shall be determined by the Administrator and/or the DON. The Protection Procedure revealed, "When a potential abuse incident is reported to a supervisor, the immediate priority is the safety of the resident, who is to be removed from potential danger. After the supervisor, notifies the administrator and the DON after ensuring the temporary safety of the resident, the administrator and the DON will make permanent arrangements for the resident's safety. Staff members being investigated for possible involvement in abuse will be removed from contact with the resident, such as suspended pending results of the investigation,	F 609		

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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
F 609	Continued From page 46 as necessary." On 01/19/23 at 9:50 AM, the surveyor conducted an interview with the UM for the unit that Resident #182 resided on. The surveyor inquired to the UM if he had received any complaints or was currently involved in any investigations regarding any residents. The UM stated that the FM of Resident #182, came to him on [redacted] and informed him that CNA #1 had an attitude, and "she was not nice" to the resident. The UM stated that he informed the DON and the DSS the same day of the FM's complaints. The surveyor inquired if the UM had been instructed to do anything because of the complaint. The UM stated, "I was told to take statements", but because the UM found out late in the afternoon on [redacted], CNA #1 had already left for the day and he was unable to obtain a statement. The UM confirmed to the surveyor that CNA #1 was the CNA assigned to Resident #182, and then stated he obtained a statement from CNA #1 on [redacted], which was the following day after the allegation The UM stated that CNA #1 worked her full resident assignment on 01/17/23 and again on [redacted]. At that time, the surveyor reviewed the [redacted], 7:00 AM-3:30 PM assignment sheet for the CNAs, and CNA #1's assignment included nine residents. Resident #182's room had both beds crossed off, and it was replaced with two other beds in another room. The UM stated that when CNA #1 arrived to work on [redacted] that she had started her assignment first, and then he had spoken to her (time not provided by UM) regarding the reason for being removed from providing care to Resident #182. However, the UM confirmed that CNA #1 continued to work and was assigned to a resident care assignment which included nine residents. The assignment	F 609		

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F 609	Continued From page 47 was located on the same unit where Resident #182 still resided and had access to Resident #182, and all other residents. The surveyor asked the UM if he had been provided a copy of the grievance from the DSS, and he stated, "yes". The surveyor asked the UM if what was written on the form represented abuse and neglect, and the UM stated, "yes", and stated CNA #1 told him, "it never happened", and that Resident #182 was happy with the care she had provided. The surveyor asked the UM if he had interviewed anyone else regarding the allegation. The UM stated he had interviewed the four CNAs (including CNA #1) that worked on the unit on [redacted] the date when the allegation was received, and the surveyor asked if the UM had interviewed anyone in addition to the CNAs. The UM stated, "no", and the surveyor then asked if the UM had interviewed any residents. The UM stated, "no", and that he provided the statements he collected to the DON. The surveyor inquired to the UM if it was still an ongoing investigation, and the UM stated "yes". On 01/19/23 at 10:46 AM, the surveyor, in the presence of the survey team, interviewed the DON and LNHA. The surveyor asked what the process was if there was an allegation of abuse. The DON stated the process was, if there was an allegation of abuse, an investigation would be started immediately, and stated "right away" after she received the complaint. The surveyor inquired if there had been any recent complaints, or allegations of abuse. The LNHA stated there was a grievance provided by the DSS, and the DON and LNHA confirmed it was provided to both on [redacted] and the LNHA stated she had been made aware by the UM on [redacted] at 4:00 PM. The surveyor asked what the process was when	F 609		

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F 609	Continued From page 48 a grievance was received. The DON stated as soon as she received it, that she would identify the caregiver and nurse assigned to the patient, and then she would obtain a statement from the staff that were involved with the resident, including the family, doctor, nurses, and other residents assigned to the staff. The DON stated that the assigned aide to the person who had the complaint would be suspended while the investigation was ongoing, because "we don't want any incident to happen", "we want to protect the resident and any other resident assigned". The surveyor informed the DON and LNHA that CNA #1 worked on [redacted] despite the DON stating the staff would be suspended during the investigation, and the surveyor informed the DON and LNHA that the UM had confirmed he was made aware of the allegation on [redacted] and CNA #1 was allowed to work and provide resident care the following day. The surveyor asked about Resident #182's allegation that CNA #1 threw the lid cover, and the DON stated, "I would say that was an attitude", and the DON stated based on that assumption she took CNA #1 off Resident #182's assignment. The surveyor asked where "attitude" would fall in the abuse policy and the LNHA stated it was "just sensitivity", and the DON stated the employee could have "burnout" but may not have intended to be insensitive to the resident. The DON stated we would have to investigate to see if there was an intention of abuse. The DON was asked if there had to be intention for abuse and the DON responded to the survey team, "no". The DON then stated that we spoke with the aide on [redacted] (no time provided), after the complaint was made. When the surveyor inquired to the DON when she was informed about the incident from the UM, the DON stated, "I could not even remember what he	F 609		

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F 609	Continued From page 49 told me" on [redacted] because "it was late in the afternoon". The surveyor inquired to what time the DON received the statement from CNA #1, and the LNHA stated we found out at 4:00 PM about the allegation, and that was when the statement was written. At that time, the surveyor inquired to the LNHA who had the facility received statements from, and the LNHA confirmed she had a statement from CNA #1, and three other CNAs who worked that day. The DON stated "we didn't" get statements from the nurses that worked that day and stated that they received statements from the four CNAs that worked on [redacted], and the UM. The surveyor inquired to the DON if she had interviewed the resident when she had found out about the allegation on [redacted] the DON stated "yes", at 3:00 PM, but that was late in the afternoon. The surveyor asked what the DON had asked the resident, and the DON stated, "how are you today" and no other specific questions per the DON. The DON stated the UM also spoke with the resident on [redacted] and confirmed there was no documented evidence when inquired by the surveyor. The DON stated that other alert and oriented residents would still need to be interviewed to obtain statements, and confirmed the investigation was "not complete yet", that they "cannot just let it go", and "we don't tolerate that". The surveyor asked was anything done for residents who were not alert and oriented and the DON stated we would do a body assessment. The surveyor inquired if that was done and the DON stated "no", and the LNHA stated "we could ask the family members about any concerns with the caretaker." The LNHA stated "yesterday was really when the investigation began, and the other day was just a comment". The surveyor inquired if the investigation was completed on [redacted], and	F 609		

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F 609	Continued From page 50 the DON stated, "no". The surveyor then asked if it the investigation was not completed, was CNA #1 supposed to work and have a resident assignment on [redacted] The DON stated, "this was given to us late", and the DON and LNHA did not offer an explanation as to why CNA #1 worked on [redacted] and provided resident care. The surveyor asked why it was important to interview other staff, and the LNHA stated "to make sure other residents are safe". The surveyor asked what kind of an allegation the statements made by Resident #182 represent, the DON stated, "a complaint". The surveyor asked if the allegation was an allegation of abuse, and the LNHA stated, "yes". The surveyor asked is there anything else that should be done when an allegation of abuse was made. The LNHA stated "I have to report it to the State and Ombudsman within two hours", and confirmed it was reported to the Stated Department of Health on [redacted], [redacted] days later, and not within two hours. A further review of the Policy/Procedure: Abuse Prevention Program, Original Issue Date: 2/2014 revealed Policy: This facility prohibits abuse, neglect, involuntary seclusion, and misappropriation of property from residents and will utilize the abuse prevention program to effectively prevent occurrences, screen and train staff, identify, investigate, report, and respond to any occurrences ...Definitions: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse	F 609		

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F 609	Continued From page 51 of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish ...Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Forms of resident abuse: Active Forms of Abuse: ...2. Verbal Abuse: Talking to residents in a demanding manner, shouting, cursing, and name-calling..., Passive Forms of Abuse: 1. Emotional Abuse: Deliberately ignoring a resident's request, denying a resident water, food, a bedpan, a call bell, etc. for a period of time., 2. Neglect: The failure of the facility, it's employees, or service provides to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress (ex: [example] allowing a resident to lie in urine or feces, ignoring a resident, not providing daily cleanliness, personal hygiene, proper mouth care, shaving, hair washed and combed, dressing a resident inappropriately and or in dirty clothing. Leaving resident exposed during bathing, dressing, changing etc...). Neglect of goods or services may occur when staff are aware of residents' care needs, based on assessment and care planning, but are unable to meet the identified needs due to other circumstances, such as lack of training to perform an intervention (Example-suctioning, transfers, use of equipment". Lack of sufficient staffing to be able to provide the services, lack of supplies, or lack of knowledge of the needs of the resident. Abuse Prevention Program-Part VII- Protection, Procedure: When a potential abuse incident is reported to a supervisor, the immediate priority is the safety of the resident, who is to be removed from potential danger. After the supervisor notifies the administrator and the DON after	F 609		

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F 609	Continued From page 52 ensuring the temporary safety of the resident, the administrator and the DON will make permanent arrangements for the resident's safety. Staff members being investigated for possible involvement in abuse will be removed from contact with the resident, such as suspended pending results of the investigation, as necessary. Abuse Prevention Program-Part V1-Identification, Procedure: ...Any unusual occurrence, which may potentially constitute abuse, neglect, or involuntary seclusion, will be identified as a potential abuse incident and investigated as such...Abuse Prevention Program-Part V11 Reporting/Response...When an incident is reported to the supervisor, the supervisor is responsible for ensuring that the resident is safe and will notify the administrator as well as the DON, or their designees..The administrate and DON will initiate the investigation of the potential abuse incident, determine the necessary response and report to the Department of Health and Senior Services and/or the office of the Ombudsman (if applicable) as per regulations including Peggy's Law. Alleged violates 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 that 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury...The scope of the investigation shall be determined by the administrator and/or the DON... N.J.A.C. 8:39-9.4(f)	F 609		

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F 658	Continued From page 53	F 658		
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 documentation, it was determined that the facility failed to document the administration, or refusal of medications on the Medication Administration Record (MAR). This deficient practice was identified for 1 of 26 residents (Resident #6) reviewed and was evidenced by the following: 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 or 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 regimes 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	F 658	At times, Resident #6 refuses [redacted] medication and treatment as ordered by MD due to her diagnosis of [redacted]. The LPN was rein-serviced on his tasks and responsibilities under the direction of a RN, including documentation of medication and treatment administration and refusals. All residents have the potential to be affected. The facility audited all residents for any refusals of medications and treatment administration. All nurses were in-serviced about documentation of administration and refusals of medication and treatment. Staff nurse on duty will check before the end of shift that they completed the documentation of administration and refusal of medication and treatment. Unit manager will audit the EMAR 10 residents per week on the documentation of administration and refusal of medication and treatment weekly.	2/23/23

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F 658	Continued From page 54 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." On 01/03/23 at 9:51 AM, the surveyor toured the facility [redacted] and observed Resident #6 sitting in a wheelchair in the hall. Resident #6 stated he/she had [redacted]) and needs cream in the morning on his/her [redacted]. Resident #6 further stated that the cream doesn't help the [redacted] Resident #6 showed the surveyor his/her [redacted] with a scar from surgery. A review of the hybrid medical record (records on both the electronic medical record and paper chart) revealed that Resident #6 was admitted with diagnoses which included but were not limited to [redacted]. A review of the most recent Quarterly Minimum Data Set (MDS-an assessment tool), dated [redacted], included but was not limited to [redacted] a Brief Interview for Mental Status (BIMS) of [redacted] which indicated intact cognition. Section N: Medications of [redacted]. The Order Summary Report revealed an order dated 11/4/22 for [redacted] (percent) apply to [redacted] topically every 8 hours for [redacted] management. [redacted] apply to [redacted] topically every 8 hours for [redacted] management. An order dated [redacted] for [redacted] medication) [redacted] milligram (mg) give one tablet by mouth every 12 hours for [redacted].	F 658	The Unit manager will report results of audit and any variances to the Director of Nursing. The Director of Nursing will monitor any trend/pattern and will follow up as indicated. The Director of Nursing will report results of audit at the QA meeting quarterly for the next 6 months.	

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F 658	Continued From page 55 A review of the [redacted] MAR revealed a "chart codes /follow up codes" legend for the staff to use to document if a medication was not administered and the reason. The [redacted] MAR revealed the following blank areas. [redacted] mg on 12/23 and 12/29/22 at 2200 (10:00 PM) [redacted] apply to [redacted] topically on 12/4 and 12/13/22 at 0600 (6:00 AM), and 12/23/22 at 2200. [redacted] apply to [redacted] on 12/4 and 12/13/22 at 0600, and 12/23/22 at 2200. There was no documentation on the [redacted] MAR to indicate if the medications were administered or not and /or the reason. A review of the [redacted] MAR (up to [redacted] when provided) revealed a "chart codes / follow up codes" legend for the staff to use to document if a medication was not administered and the reason. The [redacted] MAR revealed the following blank areas. [redacted] mg on 1/12, 1/13, 1/15, and 1/16/23 at 2200. [redacted] apply to [redacted] topically on 1/7 and 1/8/23 at 0600, and 1/12, 1/15, and 1/16/23 at 2200. [redacted] apply to [redacted] on 1/7, 1/8, and 1/17/23 at 0600, and 1/12, 1/15, and 1/16/23 at 2200. There was no documentation on the [redacted] MAR to indicate if the medications were administered, or not and/or the reason.	F 658		

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F 658	Continued From page 56 On 01/19/23 at 8:50 AM, during an interview with the surveyor, the Registered Nurse (RN) on the [redacted] stated that the MARS should be complete with no blanks. She stated that if there were a blank on the MAR, there should be documentation on the back of MAR. On 01/19/23 at 9:24 AM, during an interview with the surveyor, the Director of Nursing (DON) stated the process of documenting in the MAR would be for the nurses to check the orders and check for the correct resident. The DON stated the Unit Manager (UM) would be responsible to review for any blank areas on MAR before the shift ends. Also it would be the nurses responsibility to ensure they documented in the MAR. The DON stated that there should never be any blank areas on the MAR. A review of the facility provided, "Medication Administration Policy", last reviewed 9/2022, included but was not limited to Policy: medications shall be administered in a safe and timely manner, as prescribed. Procedure: 12. The nurse administering the medication must electronically sign, date and time the MAR by selecting "Y" (yes) after giving each medication. 15. If a medication is withheld or refused, the individual administering the medication shall select "N" (no) .... followed by selecting the appropriate reasoning and documentation. A review of the facility provided, "EMR [electronic medical record] Documentation Policy", reviewed 1/2022, included but was not limited to Policy: Our documentation processes will continue to follow all state and federal requirements, as well as standard professional practice requirements. Procedure: Medication and Treatment	F 658		

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F 658	Continued From page 57 Administration Records nurses to document in the facility EMR. A review of the facility provided, "Clinical Charting and Documentation", reviewed 9/2022, included but was not limited to Policy: all services provided to the resident .....shall be documented in the resident's EMR. 1. All observations, medications administered, services performed, etc., must be documented in the resident's EMR. 5. Documentation shall include at a minimum a. the date and time provided, b. the name and title of the individual who provided the care, e. whether the resident refused the procedure/treatment, and g. the signature and title of the individual documenting. The facility failed to follow their policies and Professional Standards of Nursing.	F 658		
F 677 SS=E	NJAC 8:39-29.2(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, review of records, and review of pertinent documents, it was determined that the facility failed to provide appropriate [redacted] care, and personal hygiene care for 6 of 26 residents (Resident #19, #45, #66, #75, #92 and #179) sampled on 2 of 4 resident units, and failed to offer [redacted] and [redacted] care to a dependent resident	F 677	Resident #19 was immediately washed including [redacted] care and provided with [redacted] care and 1 diaper applied by CNA. [redacted] care was done on [redacted] by the RN. Resident # 45 was washed, [redacted] care and [redacted] care provided. Resident #66 was washed and	2/23/23

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F 677	Continued From page 58 (Resident #179). The deficient practice was evidenced by the following: 1. On 01/03/23 at 10:05 AM, the surveyor observed Resident #19 in bed, the head of the bed was elevated, and the resident was able to answer questions. The residents [redacted] appeared very [redacted]. The resident's right hand was contracted. On 01/04/22 at 8:30 AM, the surveyor observed Resident #19 in bed in the dorsal recumbent position (a reclining position with both knees flexed, hips rotated outward, and both soles kept flat on the bed), the resident informed the surveyor that she/he had not been changed. On 01/04/22 at 10:30 AM, the surveyor returned to the room and observed the resident in the same position. The resident indicated that she/he had not been changed. The surveyor observed the resident had not been provided [redacted] care yet. On 01/04/23 at 10:45 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who had Resident #19 on her assignment. The CNA revealed that she reported to work late and was just informed by the UM to care for the resident. She had not yet provided care to Resident #19. On 01/05/22 at 8:15 AM, the surveyor observed Resident #19 in bed. Upon inquiry, the resident stated that he/she had not received care yet. On 01/05/22 at 11:15 AM, the surveyor observed Resident #19 laying on the dorsal recumbent position, the head of the bed was elevated.	F 677	[redacted] care was done with 1 diaper applied by the CNA. Resident #75 was washed and shaved and was OOB to his chair. Resident #92 was washed, [redacted] care done and was [redacted]. Another breakfast tray was ordered from the kitchen and CNA fed the resident. RN did the [redacted] dressing to the [redacted] with the assistance of the CNA. The care plan was updated for ADL self care performance deficit. Resident #179 was washed, [redacted] and [redacted] care provided. CNA repositioned resident in bed. CNA fed the resident and the Unit manager replenished the cup with fresh ice water and dated the cup. All residents with ADL self care deficit have the potential to be affected by the same deficient practice. All CNAs were in-serviced by the Director of Nursing that ADL care be provided for dependent residents to maintain good nutrition, grooming and personal and oral hygiene. All nurses were in-serviced by the Director of Nursing on their responsibilities and accountabilities to take an active role in direct resident assessment and care and including but not limited to ADL care, personal hygiene and psychosocial support. The 11-7 CNAs were in-serviced by the 11-7 supervisor to distribute every night new cups with ice water and date the cup unless contraindicated for residents on NPO, fluid restriction or on thickened	

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ALARIS HEALTH AT CEDAR GROVE	110 GROVE AVE CEDAR GROVE, NJ 07009

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F 677	Continued From page 59 Resident #19 had a [redacted] on the bed frame on the left side. When asked if he/she had been turned and changed, the resident stated, "No". The surveyor informed the Unit Manager (UM). At 11:30 AM, the surveyor entered the room with the UM and the CNA. At the surveyor's request, the resident's [redacted] brief was checked by staff. The resident was observed to be covered with [redacted] from the [redacted]. Resident #19 had a [redacted] which was also covered with [redacted] There was no dressing in place to protect the [redacted]. Further observation revealed that Resident #19 had [redacted] briefs on. The surveyor interviewed the resident in the the presence of the staff, and he/she indicated that he/she had not been changed since the previous night. At 11:45 AM, the Director of Nursing (DON) entered the room and we all observed that Resident #19 had [redacted] briefs on, was soiled with [redacted] the [redacted] was covered with [redacted] and was not protected with a dressing. On 01/05/23 at 11:55 AM, the surveyor interviewed the DON who stated that Resident #19 should not have had [redacted] briefs on as the resident was on a [redacted] mattress and that would defeat the purpose of the [redacted]. The DON acknowledged that Resident #19 needed maximum assist with grooming, hygiene, transferring and toileting, was incontinent of bowel, and had a [redacted] in place for [redacted] healing. The DON further stated that she would address the above concerns.	F 677	liquid. The 7-3 and 3-11 CNAs were in-serviced by the unit managers to replenish the cups with fresh ice water, every shift and as needed, and on offering water to residents. Residents with ADL care deficit were identified. Managers, supervisors, and department heads were assigned residents to check three times per week to ensure proper ADL care provided. Registered Dietitian will audit on a weekly basis for presence of dated and replenished water cup at bedside. Managers, supervisors, and department heads will report results of ADL audit when completed to the Administrator and Director of Nursing. Dietitian will report results of water cup audit to the Director of Nursing and Administrator when completed. The Director of Nursing will monitor any trend/pattern and will follow up as indicated. The DON will report at the QA meeting quarterly for the next 6 months.	

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F 677	Continued From page 60 On 01/05/23 at 1:30 PM, the surveyor interviewed the CNA who cared for Resident #19. The CNA stated that she reported to work at 8:30 AM, and Resident #19 was not on her assignment. Resident #19's Admission Record (AR) revealed, Resident #19 was admitted to the facility with diagnoses which included but were not limited to: [redacted]. The quarterly Minimum Data Set (MDS) assessment tool dated [redacted], revealed that Resident #19 had some [redacted], Resident #19 received a score of [redacted] on the Brief Interview for Mental Status (BIMS). [redacted] of the MDS which referred to Activities of Daily Living (ADLs) revealed that Resident #19 was totally dependent on staff for care. Review of the Care Plan for Resident #19 initiated on [redacted], included a "Focus" for ADL Self Care Performance Deficit related to: [Rationale was not provided]. The goal was for Resident #19 to improve current level of function in bed mobility, transfers, toilet use and personal hygiene through the review date. The interventions were to converse with the resident during care, praise all efforts at self-care, encourage to participate, monitor/document and report reasons for self-care deficit, expected course and declines in function. The care plan did not indicate when staff were to provide care to the resident and the frequency for staff to turn and reposition the resident. 2. On 01/04/23 at 9:16 AM, the surveyor	F 677		

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F 677	Continued From page 61 observed Resident #45 after morning care had been provided with [redacted] and [redacted], [redacted] under neath the [redacted], and Resident #45 was [redacted] On 01/05/23 at 9:18 AM, the surveyor returned to the room and observed that Resident #45 had just completed breakfast. The resident's [redacted] were still [redacted] and not [redacted]. Resident #45 had not been [redacted] On 01/05/23 at 9:19 AM, the surveyor interviewed the resident who stated that he/she would like his/her [redacted] to be [redacted] and [redacted]. On 01/06/23 at 7:45 AM, the surveyor made a care tour with a random CNA. Resident #45's [redacted] brief was soaked with [redacted] On 01/09/23 at 9:27 AM, the surveyor observed Resident #45 in [redacted] were [redacted] Resident #45 was still [redacted] On 01/10/23 at 8:35 AM, the surveyor observed the resident in bed, the resident stated again she/he would like to be [redacted] On 01/11/23 at 7:35 AM, the surveyor entered the room and observed Resident #45 was awake and alert and not [redacted]. Resident #45 stated, "I need everything". The clothing was visibly soiled with [redacted] like [redacted]. A [redacted] odor permeated the room and was stronger while approaching the resident's bed. The surveyor left the room to review the daily assignment and identified the CNA assigned to the resident that day. The surveyor returned to the room at 8:30 AM, and noted that the resident had not been changed and was eating breakfast.	F 677		

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F 677	Continued From page 62 On 01/11/23 the surveyor reviewed Resident #45's medical record which revealed the following: Resident #45 was admitted to the facility with diagnoses which included but were to limited to: [redacted]. According to the MDS) dated [redacted], Resident #45 had a BIMS score of [redacted] indicating that Resident #45 was [redacted]. The MDS also indicated that Resident #45 required extensive assistance for Activities of Daily Living (ADL) and was always [redacted] and [redacted]. However, a conversation with Resident #45 revealed that he/she was [redacted] and able to make his/her needs known. The CNA confirmed that Resident #45 was very [redacted] and able to participate with care. Review of the Care Plan for Resident #45 initiated on [redacted] and last revised [redacted] revealed a focus for ADL self care performance deficit related to [redacted] The goal was for Resident #45 to improve current level of function in bed mobility, transfers, eating, dressing, toilet use and personal hygiene through the review date. The interventions included praise all efforts at self care. Encourage to participate to the fullest extent possible with each interaction. Monitor, document report to MD (Medical Doctor) PRN (as needed) any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. On 01/10/23 at 10:44 AM, the surveyor	F 677		

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F 677	Continued From page 63 interviewed the Regional Nurse regarding the care. She stated that staffing was a challenge for the facility. The agency staff did not report to work on time. She was aware that most of the time there was only one CNA to start the 7:00-3:00 PM shift. On 01/11/23 at 8:30 AM, the surveyor interviewed the CNA who cared mostly for the resident on 01/03, 01/04, 01/05, 01/06, 01/10 and 01/11/23, regarding Resident #45's care. The CNA revealed that Resident #45 was able to feed her/his self after set-up, able to assist with turning and able to make his/her needs known. The CNA went on to state the family brought an [redacted] to assist with [redacted] the resident, however, the razor was not charged and was unable to be used to shave the resident. When asked regarding the resident [redacted] care, the CNA did not have any comments. The surveyor then inquired about the soiled clothing observed on the resident the morning of 01/11/23. The CNA stated, "I dressed the resident yesterday morning with this T-shirt. Two shifts went by and they did not changed the resident. The resident did not have a gown on and had the same T- shirt" that he/she was dressed with the morning of [redacted] The CNA further stated that the resident would be soiled with [redacted] in the morning. She expressed her concerns to the nurse and nothing had been done. Most of the time there was only one CNA to start the 7:00 AM - 3:00 PM shift. The 11:00 PM - 7:00 AM shift staff were gone and she could not get to all residents in a timely manner as she would like to. The facility was aware of the concerns with staffing". 3. Resident #66 was admitted to the facility with	F 677		

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F 677	Continued From page 64 diagnoses which included but were not limited to [redacted] On 01/03/23 at 10:00 AM, the surveyor observed Resident #66 in bed, and reported having [redacted] on [redacted]. The surveyor informed the nurse and Resident #66 was medicated for [redacted] immediately. On 01/04/23 at 10:45 AM, the surveyor observed Resident #66 in bed. Resident #66 had not received care yet. Resident #66 was [redacted] and had [redacted] briefs on when checked with a random CNA. On 01/05/23 at 9:15 AM, the surveyor observed in Resident #66 in bed, resting. The surveyor inquired about the resident. The CNA checked the resident and the resident was [redacted]. On 01/06/23 at 7:15 AM, the surveyor made a care tour with the CNA who worked the 11:00 PM - 7:00 AM shift. Resident #66 was [redacted] and had [redacted] briefs on. An interview with the CNA at 7:30 AM, revealed that all [redacted]" had [redacted] briefs on. The CNA also stated that she had 20 residents on her assignment most of the time and could not provide [redacted] care to all the residents in the morning. On 01/06/23 at 10:30 AM, the surveyor interviewed the nurse who revealed that the facility was aware of the workload and she had no control over staffing.	F 677		

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F 677	Continued From page 65 On 01/09/23 at 9:10 AM, the resident was not in bed and the surveyor observed that the sheets including the blanket and the bed were [redacted] and [redacted]. On 01/09/23 at 11:28 AM, the surveyor interviewed the CNA who revealed that she checked on the resident at 8:00 AM, yet the resident was [redacted]. The CNA stated that Resident #66's [redacted] brief was always [redacted] and she/he had [redacted] briefs on. According to the CNA, the policy was for applying one [redacted] only after [redacted] care and to check on residents every 2 hours and as needed. The CNA further stated that this morning not only did she have to change one of the residents, but she had to scrub to remove all the [redacted] that were left from the 11:00 PM - 07:00 AM shift. On 01/09/23 at 12:15 PM, an interview with the staffing coordinator revealed that she had been working as a staffing coordinator only for 2 weeks and could not comment on the staffing issue. When asked if she was aware of the regulation for the staffing ratio, she stated that the staffing was based on the census and acuity. She could not comment on the staffing ratio sets forth by the regulation. 4. Resident #75 was admitted to the facility with diagnoses which included but were not limited to [redacted]. The Quarterly MDS dated 1[redacted], revealed that Resident #75 had [redacted]. Resident #75 scored [redacted] on the BIMS. On 01/03/23 at 9:50 AM, the surveyor observed Resident #75 in bed, theie eyes closed, and the	F 677		

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F 677	Continued From page 66 sheet including the blanket were yellow stained. On 01/03/23 at 11:30 AM, the surveyor returned to the room, the resident was still in bed and the bedding was still not changed. Resident #75 informed the surveyor that he/she was not changed on the 11:00 PM - 7:00 AM shift. On 01/04/23 at 9:30 AM, the surveyor returned to the room. Resident #75 was awake and informed the surveyor that he/she was not provided with incontinent care last night and he /she reported it to the nurse. Resident #75 also was not [redacted]. On 01/05/23 at 9:09 AM, the surveyor observed the resident in bed, [redacted]. Resident #75 informed the surveyor that he/she would like to be [redacted] again and would like to get out of the bed more often. Resident #75 continued to state that he/she would like to have more therapy. Resident #75 added some days he/she was unable to attend therapy because he/she was in [redacted]. Resident #75 stated clearly, he/she was left in the chair [redacted] and [redacted] for hours (12:00 PM - 8:00 PM). His/her [redacted] were sore and he/she could not get out of the bed for therapy. The staff claimed that he/she refused therapy but the resident stated that he/she did not. The Resident agreed to discuss the above concerns with the surveyor in the presence of the facility's staff. On 01/05/23 at 12:03 PM, the surveyor interviewed the resident with the DON. Resident #75 stated that he/she needed therapy to be able to get better. Resident #75 also expressed concerns over sitting in the chair from 12:00 PM to 8:00 PM and not being changed. The resident added, "Once you get out of the bed, they do not	F 677		

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F 677	Continued From page 67 return you to bed until night time", and that "The staff always stated they are short handed." The DON informed the surveyor that she was not aware of the above concerns with incontinence care and would in-serviced the staff. The DON stated that the staffing was a challenge but could not inform the surveyor of any plan to improve resident care. Resident #75 had a care plan initiated on [redacted] and last revised [redacted], for [redacted] and [redacted]. The goal was for resident #75 not to decline further. The interventions were to use [redacted] briefs, change frequently and as needed. Check and change as required for incontinence. Change clothing as needed after [redacted] episodes. The care plan was not being followed. Resident #75 was not being changed and the bedding was observed [redacted]. Resident #75 informed the surveyor and the DON that [redacted] care had not been provided in a timely manner due to the facility being short handed. 5. On 01/03/23 at 10:30 AM, the surveyor observed Resident #92 in bed facing the wall, and a [redacted] was noted next to the bed. On 01/04/23 at 10:36 AM, the surveyor observed Resident #92 in bed facing the wall. The breakfast tray was on the bedside table untouched. Upon inquiry through the UM, the UM stated that Resident #92 was a late sleeper. On 01/05/23 at 8 :37 AM, the surveyor observed Resident #92 in bed facing the wall. The surveyor observed the breakfast tray on the bedside table untouched. Resident #92's mouth was covered	F 677		

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F 677	Continued From page 68 with a [redacted] food residue was noted between the [redacted] from the [redacted] to the [redacted]. The [redacted] were [redacted] and a [redacted] was noted underneath the [redacted]. 01/05/23 at 9:30 AM, the surveyor entered the room and observed Resident #92 in the same position and observed that [redacted] care had not been provided. Resident #92 had not been turned. The breakfast tray was still on the bedside table untouched. On 01/05/23 at 9:55 AM, the surveyor inquired regarding tray delivery in the morning. The nurse stated that the breakfast trays arrived between 7:45 AM - 7:55 AM. A review of the meal delivery schedule provided by the nurse on 01/05/23 at 9:55 AM, confirmed that the breakfast tray arrived on the unit between 7:45 AM - 7:55 AM. On 01/05/23 at 10:15 AM, the surveyor interviewed the UM regarding her responsibilities. The UM stated that her role was to ensure the care was being delivered, communicate with staff, check assignment, and make rounds. The surveyor then asked the UM if she made rounds this morning. The UM replied, "YES". The surveyor then asked if she observed any care issues. The UM stated, "No". On 01/05/23 at 10:25 AM, the surveyor escorted the UM to Resident #92's room where we both observed the condition of the resident's [redacted]. The nails were [redacted] and a [redacted] was noted underneath the [redacted] The resident was calling out and stated, "help me".	F 677		

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F 677	Continued From page 69 The surveyor asked the UM if she could get a CNA to assist with checking the resident's incontinence brief. The UM asked a CNA to assist. Resident #92's [redacted] were observed by all to be covered with [redacted] and [redacted]. The incontinent brief was saturated with [redacted], and Resident #92 was observed to have had a [redacted]. The [redacted] was covered with [redacted] and there was no dressing in place to protect the [redacted]. The UM stated that she did not make rounds with the night nurse and was not aware that [redacted] care was not provided after dinner. The UM stated that she would have a meeting with all the staff. On 01/05/23 AM at 10:35 AM, the surveyor entered the room with the DON and we all observed that Resident #92 was not being fed, not turned and did not receive [redacted] care. Resident #92 was calling out in a soft voice, "Help me". When asked if he/she was hungry in the presence of the DON and UM he/she stated, "Yes". On 01/05/23 at 11:00 AM, the surveyor interviewed the DON regarding Resident #92's care. The DON stated that she would in-serviced the staff. The DON also added that her expectations were that all residents would be turned and changed every two hours and as needed. On 01/05/23 at 12:30 PM, the surveyor interviewed the CNA regarding incontinence care. The CNA stated that during [redacted] care they would removed the dressing if the dressing was soiled and would inform the nurse. She could not comment on when the dressing to the [redacted] area was removed as Resident #92 had not	F 677		

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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
F 677	Continued From page 70 receive morning care yet. On 01/06/23 at 8:00 AM, the surveyor observed Resident #92 in bed facing the wall. A water cup was observed for the first time on the bedside table. Resident #92 could not access the water cup on the bedside table. On 01/06/23, the surveyor reviewed Resident #92's electronic clinical record. The Admission Face Sheet reflected that Resident #92 had diagnoses which included but were not limited to of history of [redacted] Review of the most recent MDS dated 10/05/22, revealed that Resident #92 was [redacted] and had received a score of [redacted] on the BIMS whch was indicative of [redacted] Review of Resident #92's Comprehensive Care plan provided by the facility on [redacted], revealed that Resident #92 did not have a care plan in place for ADLs self care performance deficit. The comprehensive Care Plan dated [redacted] addressed [redacted] .. The care plan did not address ADL care. Based on the MDS assessment, Resident #92 was totally dependent on staff for care. On 01/11/23, the surveyor reviewed the grievance book provided by the facility and noted that Resident#92's Representative filed a grievance on [redacted], to address [redacted] and [redacted] observed during visitation.	F 677		

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F 677	Continued From page 71 On 01/18/23 at 6:00 PM, the surveyor conducted a telephone interview with Resident #92's Representative. The representative stated she had concerned with the care and was scheduled to meet with the facility on [redacted] The Representative stated over the last 4 months she had noticed a decline in the care. Resident #92 would be left in the room and would cry out because he/she was isolated. The Representative further stated that Resident #92 was sent to the hospital on [redacted], and was informed that she was admitted with [redacted] and had an [redacted] that she was not made aware of prior to admission. On 01/19/23 at 09:30 AM, the surveyor reviewed the facility's in-serviced education binder provided by the facility and noted that in-serviced education regarding over padding, [redacted] brief and [redacted] care were addressed on 04/18/22, 07/19/22 and 11/20/22. The facility management indicated that they were not aware of concerns with [redacted] care and residents wearing [redacted] brief. The above concerns with [redacted] and [redacted] care were discussed with the facility management during the survey and again on 01/19/23. The DON indicated that the staff were in -serviced. The surveyor then asked the facility what had been done to improve the care, if any investigations were done regarding residents not being fed, changed and turned, adn wound not being cared for after [redacted] care was provided. The facility did not have any comment. According to the Facility Policy titled, [redacted] Care" approved 10/04/22 and last revised 10/2022 provided by the facility on	F 677		

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F 677	Continued From page 72 01/06/23, the following were documented: Policy: The facility shall provide care for all incontinent residents. Purpose: To cleanse and refresh residents after each incontinent episode. Under procedure it was noted to check residents at least every two hours. The policy was not being followed. Staff indicated that they were short-handed almost every day and could not changed all residents every two hours. 6. On 01/03/23 at 11:14 AM, Surveyor #2 observed Resident #179 lying in bed awake. Resident #179 did not respond to the surveyor when spoken to. Surveyor #2 observed the resident's [redacted] were [redacted]. There was an [redacted] which contained [redacted] There was no water cup visible in the room. On 01/03/23 at 12:37 PM, the surveyor observed through the doorway that Resident #179 was in bed, with the resident meal tray covered on the overbed table next to the resident. The surveyor entered the room, and heard a noise in the resident's bathroom. There were no other residents assigned to the room. At that time, the door to the bathroom opened and a staff member exited the bathroom holding her cell phone. The staff identified herself as a Certified Nurse Aide (CNA #1) assigned to care for Resident #179. CNA #1 proceeded to explain to the surveyor that she was having some filmily issues and that was why she was on the phone. CNA #1 did not engage the resident, or interact with the resident	F 677		

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F 677	Continued From page 73 at all, including with the meal tray and proceeded to exit the resident's room. On 01/04/23 at 8:35 AM, the surveyor observed Resident #179 with eyes closed, lying in bed and the breakfast meal had not yet arrived on the unit. The surveyor observed a [redacted] food like substance on Resident #179's top [redacted] t [redacted]. The surveyor engaged the resident who opened his/her eyes, looked at surveyor and did not verbally respond. On 01/04/23 at 8:46 AM, Surveyor #2 observed Resident #179 lying in bed. There was no breakfast tray in the room, but there was a [redacted] substance that resembled food on the resident's gown, top [redacted]. There was no water cup visible in the room. Resident #179's [redacted] were still [redacted] in appearance. On 01/04/23 at 10:55 AM, the surveyor observed Resident #179 in bed, with an [redacted] being [redacted] was [redacted] in a [redacted]. The resident was alert, however did not respond to questions. The resident was alone in the room, there was no water cup at bedside and the resident's [redacted] appeared very [redacted]. On 01/04/23 at 11:06 AM, the surveyor while the surveyor was in Resident #179's room, a Certified Nurse Aide (CNA) entered and stated that she had to change the resident's position. The CNA left the room and stated she needed someone else to help, returned and stated she could do it her self. She boosted the resident up, and the CNA did not converse with the resident at that time. The surveyor asked the CNA what type of care she provided for the resident and the CNA	F 677		

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F 677	Continued From page 74 stated "I don't know, I just came in yesterday and stated I change [him/her] and feed [him/her]." The CNA did not mention anything about [redacted] care or offering the resident a drink and there was no water cup or swabs to clean the resident's [redacted] observed in the room. The surveyor timed the interaction, which lasted four minutes and the CNA left without saying anythig to the resident. On 01/04/23 at 11:16 AM, the surveyor interviewed the Unit Manager (UM) about the care that was supposed to be provided for dependent residents. The UM stated bath, feed and report anything that was wrong to the nurse. On 01/04/23 at 12:14 PM, the surveyor observed Resident #179 lying in bed. There was still no water cup visible in the room, but there was an untouched lunch tray out of reach of the resident on the overbed table. On 01/04/23 at 12:28 PM, the CNA set Resident #179 up for the meal and proceeded to use the hand wipe that was on the resident's tray to clean her own hands, and not the resident. The surveyor watched as the CNA began to feed the resident. The surveyor asked the CNA if the resident was offered water, as there was no water at the bedside or on the meal tray. The CNA stated, "I forgot", when the surveyor asked where the water was. The surveyor asked the CNA if she had offered the resident any water during her shift and the CNA confirmed she had not. The CNA then left the resident in the middle of the meal, and did not say anything to the resident and exited the room. On 01/04/23 at12:35 PM, the surveyor asked the UM to come into Resident #179's room. The	F 677		

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F 677	Continued From page 75 surveyor asked the UM about the mouth care as the resident's [redacted] looked very dry. The UM stated [redacted] care should be done and proceeded to look for mouth swabs in resident's drawer. The UM was unable to locate cleaning [redacted] and confirmed they were not there. The surveyor asked the UM if water should also be available for the resident, and the UM stated "yes". The surveyor reviewed Resident #179's Admission Record which revealed diagnoses that included [redacted] A Physician's Progress note, dated [redacted] at 11:25 AM, revealed a problem list that included: [redacted] l) due to poor oral water intake, The Care Plan revealed a Focus: Initiated [redacted] and Revision: [redacted], revealed Resident has a [redacted] problem or potential [redacted] problem r/t (resulted to) ...need for ADL assist...Interventions included: Encourage PO (by mouth) fluids dated [redacted] and Assist resident at meals, dated [redacted]. On 01/04/23 at 1:28 PM, the surveyor observed a [redacted] substance under Resident #179's [redacted]. On 01/04/23 at 1:37 PM, the surveyor interviewed the UM, in the presence of another surveyor. The surveyor asked the UM if he checked the care being provided to the residents by his staff and asked if he had checked if Activity of Daily Living (ADL) care had been provided to Resident #179. The UM stated he did not check the care of	F 677		

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F 677	Continued From page 76 Resident #179 and stated, "I am pretty sure that someone checked it yesterday", and he would have to check the computer for the ADL completion, and stated he had not done that. The surveyor asked the UM if fingernails would be cleaned as part of ADLs and the UM stated, "yes" of course. At that time, both surveyors asked the UM to accompany them to Resident #179's room and look at the resident[redacted] The UM opened Resident #179's[redacted] and stated, "I see" as he observed the[redacted] substance under Resident #179's[redacted] on the[redacted]. On 01/09/23 at 8:55 AM, the surveyor observed an undated, open cup of water in Resident #179's room. There was no ice in the water and the resident's[redacted] and[redacted] looked dry. The resident was alert and responded to the surveyor. At 8:59 AM, a different CNA then previously brought in the meal tray. The surveyor asked the CNA about the open cup. The CNA stated, "it looked like from 11-7 shift", looked like they didn't throw it out, and the cup should be covered with a lid and have a straw inside. The surveyor asked if the cup is usualy dated, and the CNA stated that "they don't tell them to date it". 01/10/23 at 9:18 AM, the surveyor interviewed the UM regarding the water policy. The UM stated that every shift must provide fresh water and as needed. The UM stated the water cups were supposed to be dated because it would be a problem if not dated since you would not know what date it was poured. On 01/01/10/23 at 11:14 AM, the surveyor interviewed the Registered Dietitan (RD) about Resident #179. The RD stated she reviewed the resident's labs and "I put in for PO hydration	F 677		

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F 677	Continued From page 77 encouragement", "which I know they are already doing". The RD stated she had spoken with nursing to encourage water, juices fluid and the resident should have a water cup in the room. The policy for oral hygiene was reviewed and indicated the following: Purpose: Regular oral hygiene will help prevent mouth infections, dental decay and gum disease and will promote personal hygiene. All residents will receive care of the mouth and teeth every morning and night and as needed to maintain good oral hygiene. The policy was not being followed. The policy for ADL care dated 06/18/24 last revised 12/15/17, indicated: "Residents shall receive assistance with activities of daily living (ADL's) every shift, as appropriate", ADLs include: Bathing, Grooming, Dressing, Eating, Oral hygiene, Ambulation, Toilet activities. The Resident Hydration and Prevention of Dehydration Policy, undated revealed: This facility will endeavor to provide adequate hydration and to prevent and treat dehydration, ...4. Nurses' Aides will provide and encourage intake of bedside, snack and meal fluids on a daily and routine base as part of daily care, 5. A 16 oz cup of containing ice water will be placed at each residents' bedside within arm's reach...11. Nursing will monitor fluid intake... A review of the Position Title: Unit Manager job description revealed under responsibilities/accountabilities: 1. Takes an active role in direct resident assessment and care; including but not limite to, ADL care, Personal Hygiene and Pshycho-social support.	F 677		

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F 677	Continued From page 78	F 677		
F 684 SS=E	N.J.A.C. 8:39-27.2 (h) Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure appropriate care and related services were provided, and failed to follow their change in condition policy to identify and assess a resident who had a change in condition, and there was a delay in treatment, and the resident subsequently required hospitalization on [redacted]. This deficient practice occurred for 1 of 26 residents reviewed for care, (Resident #92), and who was transferred to the hospital emergency department via 911, and was diagnosed with [redacted] and was evidenced by the following: During the initial tour of the facility on 01/03/23 at 10:15 AM, the surveyor observed Resident #92 in bed facing the wall. On 01/04/23 at 10:36 AM, the surveyor observed Resident #92 in bed, and was facing the wall. The breakfast tray was on the bedside table and was untouched.	F 684	Resident # 92 was assessed by the RN and was noted with appetite ranging from poor to fair and noted sleepy but responsive, skin warm and dry, breathing easy and non- labored. RN notified the attending physician for change in condition and was sent to the hospital. Resident # 92 was immediately provided with personal hygiene, repositioned, wound dressing done and fed for breakfast. All residents have the potential to be affected by this practice. All nurses were in-serviced by the Director of Nursing on timely identification, assessment and notification of any change in condition to the attending doctor and family/responsible party. Treatment and care will be provided timely according to the professional standards of	2/23/23

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F 684	Continued From page 79 On 01/05/23 at 8:37 AM, the surveyor entered the room and observed Resident #92 in bed and was facing the wall, the breakfast tray was observed on the bedside table. The surveyor removed the lid from the breakfast tray and observed that the breakfast food was untouched. Resident #92's [redacted] was covered with dry food between the [redacted] extended to the [redacted] and [redacted] area. On 01/05/23 at 9:30 AM, the surveyor returned to the room and Resident #92 was observed still in the same position, facing the wall. The breakfast tray was on the bedside table and untouched. The surveyor asked the nurse regarding Resident #92's breakfast tray. The nurse informed the surveyor that Resident #92 was a "late sleeper." On 01/05/23 at 9:50 AM, the surveyor inquired regarding meal tray delivery on the unit. According to the meal delivery log provided by the facility on 01/05/23 at 9:55 AM, the breakfast tray arrived between 7:45 AM- 7:55 AM. There was no evidence that Resident #92 had eaten any breakfast that morning. (This was more that one and one-half hours from the surveyors initial observation) On 01/05/23 at 10:20 AM, the surveyor escorted the Unit Manager (UM) to the room where we both observed the condition of Resident #92's [redacted] and [redacted] At the surveyor's request, Resident #92's incontinence brief was checked. Resident #92's [redacted] and [redacted] area was covered with [redacted]. Resident #92 had a [redacted] that had no dressing coverage, and was covered with feces.	F 684	practice. All Certified Nursing Assistants were in-serviced by the Director of Nursing and/or Regional Quality Assurance Registered Nurse that ADL care be provided for dependent residents to maintain good nutrition, grooming, personal and oral hygiene. The MDS coordinator will audit chart of 5 residents per month who had a transfer to acute care setting for timely identification, assessment and notification of change in condition. Residents with ADL care deficit were identified. Managers, supervisors, and department heads were assigned residents to check three times per week to ensure proper ADL care provided. Managers, supervisors, and department heads will report results of ADL audit when completed to the Administrator and Director of Nursing. MDS coordinator will report results of audit to Director of Nursing monthly. Any variances will be addressed immediately. Results of audits will be reported and discussed at the QAPI meeting by the Director of Nursing quarterly for the next 6 months.	

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F 684	Continued From page 80 On 01/05/23 at 11:00 AM, the surveyor entered the room with the Director of Nursing (DON), the UM and the Certified Nursing Aide (CNA). The DON instructed the nurse to assist the CNA and to clean the [redacted] On 01/06/23 at 10:30 AM, the surveyor observed Resident #92 in bed, and was positioned at the edge of the bed. Resident #92 had no device in place to prevent Resident #92 from sliding off of the bed. The surveyor informed the nurse who was in the hallway. The regional nurse was also in the hallway and stated that she also had observed that Resident #92 was at the edge of the bed. The regional nurse stated she had applied a [redacted] to prevent Resident #92 from sliding off the bed. On 01/09/23 at 9:00 AM, the surveyor observed Resident #92 in bed with their eyes closed. Around 11:30 AM, the surveyor went to the dayroom and observed Resident #92 sitting in a wheelchair with his/her head down toward his/her chest. The nurse attempted to wake up the resident for lunch, however, the resident was unable to keep his/her head up and could not open his/her eyes. The surveyor then observed that the nurse wheeled the resident to the room and had returned Resident #92 to bed. On 01/10/23 at 9:30 AM, Resident #92 was observed as not in their room. During a conversation with the UM, she had stated that Resident #92 was transferred to the hospital, and was admitted with [redacted] On 01/10/23 at 11:00 AM, the surveyor reviewed Resident #92's medical record.	F 684		

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F 684	Continued From page 81 The Admission Face Sheet reflected that Resident #92 had diagnoses which included but were not limited to; [redacted] Review of the most recent Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that Resident #92 received a score of [redacted] out of [redacted] on the Brief Interview for Mental Status (BIMS), indicative of a [redacted]. Review of Resident #92's, undated Comprehensive Care plan that was provided by the facility on [redacted] revealed: A focus area for nutrition. The goal was for Resident #92 to tolerate oral intake 50-100%, meet nutritional needs for [redacted] maintain moist mucous membranes, and good skin turgor. A focus area for [redacted] revealed a goal that Resident #92 will be free of symptoms of [redacted] The interventions included: Assist resident at meals. Encourage oral intake. Administer medications as ordered. Monitor/document medications side effects. Encourage to drink fluids of choice. Ensure Resident #92 has access to fluids i.e. cold water, milk, tea. Offer frequent small amount of liquid. The surveyor observed Resident #92 in bed, facing the wall on 01/03, 01/04, and 01/05/23. During those observations, there was no water or fluid at the bedside. A cup of liquid was noted on the bedside table on 01/06/23, but was out of reach and was not accessible to the resident. There was no documented assessment for	F 684		

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F 684	Continued From page 82 Resident #92 in the medical record which included observations made by the surveyor on 01/03, 01/04 and 01/05/23, when the surveyor observed Resident #92 in bed, with the breakfast meal untouched, and no fluid at the bedside. There was no documentation regarding the [redacted] that was observed by the surveyor and UM to be covered with [redacted] and, and there was no dressing to protect the [redacted] Additional documentation revealed: A late entry dated 01/09/23 at 7:32 AM, revealed, "During morning care Resident noticed with change in condition. [redacted]. Applied pressure dressing, packed with gauze. Primary physician paged, awaiting call back." 01/09/23 at 12:40 PM, Awaiting phone call back. (this was five hours later from the original call to the physician) 01/09/23 at 15:16 PM [3:16 PM], received in bed, sleepy, appetite with breakfast poor, consumed 10% liquid, 20% solid. Appetite remained poor with lunch, [redacted], blood pressure [redacted], temperature [redacted], pulse [redacted], respiration [redacted], [redacted], called the physician and updated with change in condition, left message with receptionist. (This was almost eight hours after the initial call was placed to the physician) Vital signs rechecked, oxygen saturation [redacted] (3rd call) to the physician, new order received to transfer Resident #92 to the Emergency Department for evaluation, 911 called. (On [redacted] timed 7:32 AM, the documentation was not clear to a full assessment regarding the change in condition, other than that Resident #92 had a [redacted]	F 684		

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F 684	Continued From page 83 and the physician was paged.) On 01/18/23 at 10:15 AM, during an interview with the DON regarding Resident #92's change in condition, the DON stated "that staff were responsible for observing, assessing, documenting and notifying the physician of any change in health condition." On 01/18/23 at 12:30 PM, the surveyor reviewed the readmission hospital record and the following entry dated [redacted], was noted regarding the [redacted]: "Images for [redacted] open [redacted]. [redacted] properties: Date first assessed [redacted]. Time first assessed 23:35 PM [11:35 PM]. Date [redacted] acquired: [redacted] Present on hospital admission :Yes. Primary wound type: Open [redacted] Location: [redacted] -- [redacted] Description (Comments): [redacted], [redacted]." Prior to the hospital admission on [redacted], there was no supporting documentation of symptoms or a nursing assessment to indicate how the [redacted] appeared, or an assessment completed to determine if there were symptoms of a potential infection. The documentation addressed only poor oral intake and fair appetite. On 01/18/23 at 6:00 PM, the surveyor conducted a telephone interview with Resident #92's representative. The representative stated she "had concerns with the care" at the facility and was scheduled to meet with the facility on [redacted] The representative stated over the last [redacted] months she had noticed a decline in the care	F 684		

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F 684	Continued From page 84 that was provided to the resident. The representative stated that Resident #92 had been left in the room alone and would cry out because he/she was isolated. The representative further stated that Resident #92 was sent to the hospital on [redacted], and the hospital informed the representative that the Resident was admitted with [redacted] and had an [redacted] and unable to be [redacted] due to [redacted] that the representative had not been made aware of prior to admission to the hospital. On 01/19/22 at 10:30 AM, during an exit conference with the administrative staff regarding Resident #92's diagnoses of [redacted], the Administrator stated that the wound had worsened at the hospital. However, the readmission record revealed that Resident #92 was admitted with [redacted]) and [redacted]. [redacted] level was [redacted] milligram per deciliter (mg/dl). Resident #92's [redacted] had to be [redacted]) at the hospital. The Resident returned to the facility with [redacted]). A Note Text dated [redacted], entered by the Dietitian revealed, Readmit/significant change in status with hospitalization for [redacted] .. Discussed with nursing, oral intake had been fair since readmit and receiving 1:1 assistance with	F 684		

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F 684	Continued From page 85 meals. A review of the facility's policy titled, "Change in Condition", dated 10/91 and last revised 09/23/22 indicated the following: Policy: The purpose of this policy is to take timely action to identified any change in resident condition and to notify the resident physician/ practitioners and responsible family members or legal representative of the change in condition as soon as possible, or within 24 hours. Resident changes in condition should include significant changes in physical, mental and psychosocial status as well as any incidents/accidents. Procedure: When a resident change in condition is noted, the nurse assigned to the resident shall document the onset and symptoms in the resident's medical chart. The assigned nurse to the resident shall also review the resident medical history and complete an evaluation of the resident in regards to the identified change. The assigned nurse shall also document any pertinent additional information and interventions on the medical record as well as note the change in hour report. NJAC 8:39-27.1(a)	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		2/23/23

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F 689	Continued From page 86 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of pertinent documentation, it was determined that the facility failed to a.) provide adequate supervision, b.) follow the facility accident policy and initiate new fall prevention interventions in response to falls, and c.) implement existing interventions to prevent falls [redacted] reviewed were determined that the resident was left unsupervised). These failures resulted in Resident #92 sustaining multiple falls including a fall on [redacted] that required an emergency room transfer on [redacted], when Resident #92 fell out of a wheelchair, hit a tray table, sustained [redacted], and was admitted to the hospital with a [redacted] without obvious [redacted]". This deficient practice occurred for 1 of 1 residents reviewed for falls (Resident #92) with injury and was evidenced by the following: On 01/06/23 at 10:20 AM, the surveyor entered the room and observed Resident #92 in bed, positioned on the right side at the edge of the bed, with no device in place to prevent him/her from sliding off of the bed. The surveyor left the room and alerted the staff that Resident #92 was at the edge of the bed. At 10:30 AM, the Regional Nurse informed the surveyor she had observed the same positioning of the resident and she had placed a [redacted] to prevent Resident #92 from sliding off of the bed. The surveyor later returned to the room, and observed Resident #92 in a	F 689	Resident # 92 was sent to the hospital after the fall incident on [redacted] for evaluation and management and was admitted with [redacted]. Resident #92 returned from the hospital on [redacted] resident was put on physical and occupational therapy and speech therapy. Fall interventions were reviewed by the interdisciplinary team. All residents with fall incidents have the potential to be affected. All RNs, LPNs, and CNAs were in-serviced on the facility accident policy by the Director of Nursing. The IDT team will review all resident fall incidents at the clinical meeting to discuss incident and resident appropriate interventions for fall prevention. Care plan will be updated with new fall prevention interventions. The Director of Nursing will audit resident falls on a monthly basis to assure fall interventions. Audit will include analysis of whether previous interventions were followed as planned. The Director of Nursing will report results of audit to the Administrator on a monthly basis. Any variances will be addressed immediately. The Director of Nursing/designee will	

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F 689	Continued From page 87 recliner chair inside the room. On 01/09/23 at 11:30 AM, the surveyor observed Resident #92 in the dining room seated at a table. The nurse attempted to assist Resident #92 with the lunch meal, Resident #92 could not open their eyes or his/her mouth to eat. The Licensed Practical Nurse (LPN) attempted to stimulate the resident, she was calling the resident's name and asked the resident to wake up. The LPN was unsuccessful. Resident #92 was transferred to bed and the physician was contacted. On 01/10/23 at 9:15 AM, the Unit Manager informed the surveyor that Resident #92 was transferred to the hospital and was admitted. On 01/10/23 at 12:05 PM, a follow up interview was conducted with the nurse who was observed in the dining room with the resident on 01/09/23. She stated that she was assigned to Resident #92 on 01/09/23 during the day shift. The nurse stated a Certified Nursing Assistant (CNA) was having difficulty getting her/him to eat and drink. Resident #92 would eat a bite or two, and then his/her alertness would come and go. The physician was called and Resident #92 was admitted to the hospital with [redacted] On 01/10/23 at 12:30 PM, the surveyor requested all fall investigations for Resident #92 and a timeline for review from the Director of Nursing (DON). On 01/10/23 at 1:30 PM, the surveyor reviewed Resident #92's medical record. The Admission Face Sheet reflected that Resident #92 had diagnoses which included but were not limited to;	F 689	present the results at the quarterly QA meeting and follow up if indicated for the next 6 months.	

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F 689	Continued From page 88 [redacted]. Review of the the most recent Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that Resident #92 received a score of [redacted] out of [redacted] on the Brief Interview for Mental Status (BIMS) indicative of [redacted]. A review of the facility provided Fall Risk Assessment dated [redacted], revealed Resident #92 scored [redacted] which indicated the resident was a [redacted]. Review of Resident #92's undated Comprehensive Care plan provided by the facility on 01/09/23, revealed: A focus area: "Resident #92 has a history of frequent [redacted] related to [redacted] and [redacted], had a prior fall prior to hospitalization sustained [redacted]. Readmit [redacted], with fall incident at facility [redacted], sustained [redacted] no other abnormalities noted ." The goal was that Resident #92 will resume usual activities without further incident through the review date. The interventions /Tasks included: Check range of motion. Continue on the at-risk plan. Keep needed items, water, etc, in reach. Monitor side effects of medication. Monitor/document /report PRN [as needed] x 72 hours to physician for sign/symptoms: pain, bruises, change in mental status, new onset: confusion, inability to maintain posture, agitation. Pharmacy consultant to evaluate medications.	F 689		

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F 689	Continued From page 89 Provide activities that promote exercise and strength building where possible. Provide 1:1 activities if bedbound. Physical therapy consult for strength and mobility. Rehab [rehabilitation] screen. Sent the Resident to Emergency Department for evaluation. Staff to assist Resident #92 back to bed before 11:00 PM. Anticipate and meet needs. Be sure call light is within reach and encourage to use it for assistance as needed. Provide prompt response to all requests. keep residents in common areas for increased observation. Place patient close to the nursing station for monitoring. Further review of the Care Plan revealed that Resident #92 sustained falls at the facility on the following dates: 1. 09/28/21 at 5:45 AM, Found on the floor and had a [redacted] on the [redacted]. A review of the incident report revealed that Resident #92 received the following medications [redacted], an [redacted] medication at 12:48 AM. [redacted] an [redacted] for [redacted] at 12:50 AM. Resident #92 was left in the room in the wheelchair unsupervised. According to the facility, the contributing factor was behavior. 2. 11/08/21 at 9:25 PM, fell from wheelchair in the dayroom sustained [redacted] on the [redacted] measuring 4 [redacted]. Resident unable to recall what happened. Transfer to hospital for evaluation. Contributing factors: Resident #92 was [redacted]	F 689		

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F 689	Continued From page 90 [redacted]. The surveyor reviewed the Medication Administration Record (MAR) and noted that Resident #92 was medicated with [redacted] (an [redacted] medication) used as a [redacted] at times, and was left unsupervised in the dayroom in the wheelchair. A review of the history and physical from the hospital record dated [redacted], revealed the following: "Presented to the Emergency Department (ED) for evaluation after patient fell out of a wheelchair, hitting a tray table, sustained a [redacted]. The diagnosis was: "[redacted] with [redacted] and [redacted]". The surveyor did not observe any updated interventions on the Care Plan specific for the [redacted] fall. 3. 04/25/22 at 11:00 PM, heard resident calling out for help. Was found sitting on the floor leaning on the bed, in front of the wheelchair. Resident #92 informed the staff that he/she was trying to self transfer to bed, but could not do it. Prior to the fall at 9:00 PM , Resident #92 received [redacted] and [redacted] mg. Resident #92 was left unsupervised in the wheelchair in the room. Contributing factors: [redacted] Interventions: Staff to assist patient back to bed before 11:00 PM. A Drug regimen review completed by the Consultant Pharmacy and dated [redacted], documented, "Resident found on the floor on	F 689		

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F 689	Continued From page 91 [redacted] leaning on the bed in front of wheelchair. Resident #92 claimed to have fallen while trying to transfer to bed." Resident is on [redacted] and frequently takes [redacted] which can both contribute to [redacted]. Please encourage to call for assistance when needing to transfer to and from bed. There was no documentation in the medical record that Resident #92 was being monitored after being medicated with the above medications. 4. 05/16/22 at 9:00 PM, Resident #92 slipped out of the wheelchair while in the room. Resident unable to describe what happened. Resident #92 received [redacted] mg orally and was left in the wheelchair unsupervised. Interventions: Keep bed in the lowest position, [redacted] to the floor. [redacted] applied to wheelchair. Rehabilitation screen. 5. 07/21/22 at 11:05 PM, the nurse was sitting at the desk, heard patient screaming, I am on the floor, help me, help me... Resident #92 was found on the floor on the right side next to the wheelchair. The care plan did not include any new interventions in response to this fall, to prevent further falls, or to ensure Resident #92's safety in the event of further falls. A Drug Regimen Review from the Consultant pharmacy dated [redacted], again documented, "Staff responded to Resident screaming from room, Resident claimed to have "slid from wheelchair." Resident is on routine Desyrel/ [redacted] which may increase risk for [redacted] and [redacted]. Resident also has orders for PRN [As	F 689		

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F 689	Continued From page 92 needed] [redacted] and [redacted] which may further contribute to falls. 6. 11/29/22 at 13:20 PM [1:20 PM], found on the floor mat next to the bed, [redacted] noted to the [redacted] Patient transferred to nursing station for close supervision. Resident #92's MAR dated November 2022, revealed that Resident #92 received the following medications at 21:00 [9:00 PM]: [redacted] mg, [redacted] mg, [redacted] mg, [redacted] mg and [redacted] mg prior the fall.. The interventions /Tasks included: Check range of motion. Continue on the at-risk plan. Keep needed items, water, etc, in reach. Monitor side effects of medication. Monitor/document /report PRN [as needed] x 72 hours to physician for sign/symptoms: pain, bruises, change in mental status, new onset: confusion, inability to maintain posture, agitation. Pharmacy consultant to evaluate medications. Provide activities that promote exercise and strength building where possible. Provide 1:1 activities if bedbound. Physical therapy consult for strength and mobility. Rehab screen. Sent the Resident to Emergency Department for evaluation. Staff to assist Resident #92 back to bed before 11:00 PM. Anticipate and meet needs. Be sure call light is within reach and encourage to use it for assistance as needed. Provide prompt response to all requests. keep residents in common areas for increased	F 689		

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F 689	Continued From page 93 observation. Place patient close to the nursing station for monitoring. On 01/13/23 at 10:30 AM, the surveyor interviewed the Director of nursing (DON). The DON reported that the Interdisciplinary Team (IDT) which included all the department heads, met once a week to discuss, [redacted] medications. She stated that on [redacted], the IDT had met and discussed Resident #92's fall that occurred on [redacted]. She indicated that the IDT team did not discuss the use of the [redacted] medication as a contributing factor for Resident #92's fall nor suggested that Resident #92 should be returned to bed after being medicated for [redacted] The DON stated that Resident #92 would refuse to go to bed, however there was no documented evidence that staff offered Resident #92 to be returned to bed after being medicated, or that he/she had refused. On [redacted] the fall investigation documented the following under Resident Description, "Patient said, he/she was getting up to transfer to his/her bed and could not do it". On 01/19/23 at 9:30 AM, the surveyor interviewed the Registered Nurse (RN) who worked on the 11:00 PM -7:00 AM shift regarding the protocol after any resident received [redacted] medication and other medications used to [redacted]. The RN stated that staff were to check residents after 30 minutes for the effectiveness of the medication and the residents should be in bed to prevent falls. The RN could not remember the exact incident but she remembered she administered [redacted] and [redacted] to Resident #92, after the surveyor presented her with the	F 689		

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F 689	Continued From page 94 investigation report dated [redacted] for review. She indicated that Resident #92 reported having [redacted] and was [redacted] She stated that she "should have" documented it in her notes the resident's response after the medication was administered. When asked if she had tried non-pharmacological approach prior to administering the [redacted], she stated that she could not recall. The nurse also stated that she didn't know why she did not document that Resident #92 was reassessed 30 minutes after the medication was administered. On 01/19/23 at 9:42 AM, the surveyor interviewed the Unit Manager (UM) regarding the facility's fall protocol. The UM stated that all residents identified to be high risk for falls, were to be closely supervised. When prompted regarding the protocol after [redacted] medication and [redacted] medications had been administered, she replied, "Residents should be in bed and closely monitored for safety". The surveyor then asked the UM who was responsible to monitor the dayroom when residents were in attendance. The UM stated that activity staff were to be with residents in the dayroom. The surveyor then escorted the UM to the dayroom and we both observed 7 residents sitting in the dayroom, and there was no staff monitoring the residents. A review of the facility's policy titled, "Accident/ Incident Report" dated 02/12 and last revised 12/15/17, reveled the following: Policy: The facility has a system whereby all residents incidents/accidents are reported to the department supervisor and implementation of timely interventions to establish a reduction of repeated incidents/accidents.	F 689		

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F 689	Continued From page 95 Procedure: Carry out physician orders and ensure appropriate interventions are in place. Update care plan with new interventions as appropriate. All incident/accident reports are tracked and reviewed by the IDCP team for trends and appropriateness of current interventions. A summary of all incidents/accidents will be reviewed quarterly by the QAPI Committee for trends, locations, times and related hazards. If a trend is identified, the IDCP team will assess the system for additional and necessary interventions.	F 689		
F 711 SS=E	NJAC 8:39-27.1 (a) Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other pertinent documentation, it was determined that the facility failed to enter signed progress	F 711	The physician's progress notes of resident #6, #41, #90, #118, #278, #11, #106, #46 and #181 were signed by the	2/23/23

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F 711	Continued From page 96 notes (PN) in the hybrid medical record (electronic or paper) at each visit. This deficient practice was identified on 4 of 4 units and was evidenced by the following. On 01/11/23 through 01/13/23, the surveyor began to review the hybrid medical records of sampled residents. The surveyor reviewed the following: The [redacted] Resident #6: hybrid record revealed late entries: Effective Date (the date the resident was seen by the practitioner): [redacted]; Department: Physicians; Position: Physician; Created By: a physician's name was entered; Created Date: [redacted]. This represented an 11-day delay in the Progress Note (PN) being entered into the hybrid record. Effective Date: [redacted]; Department: Physicians; Position: Physician; Created By: a physician's name was entered; Created Date: [redacted]. This represented a 25-day delay in the PN being entered into the hybrid record. Effective Date: [redacted]; Department: Physicians; Position: NP Created By: the NP's name was entered; Created Date: [redacted]. This represented a 5-day delay in the PN being entered into the hybrid record. Resident #41: hybrid record revealed late entries: Effective Date: [redacted]; Department: Physicians Position: NP (Nurse Practitioner)" the NP's name was entered; Created Date:	F 711	respective attending physician and viewable to team in electronic record. All physicians and nurse practitioners were in-serviced by Administrator on timely documentation of visits in the medical record. All residents have the potential to be affected by this practice. All physicians and nurse practitioners were in-serviced by Administrator on timely documentation of visits in the medical record. The Medical Records Coordinator will audit a sample of 10 charts per week to assure timely completion of physician visits and prompt completion of record to maintain all information pertaining to the performance of the services. The Medical Records Coordinator will submit results of the audit to the Administrator on a weekly basis. Any variances will be address by the Administrator. The Medical Records Coordinator will report the findings at the quarterly QA meeting for the next 6 months.	

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F 711	Continued From page 97 [redacted]. This represented an 8-day delay in the PN being entered into the hybrid record. Effective Date: [redacted]; Department: Physicians; Position: NP, the NP's name was entered; Created Date: [redacted] This represented a 10-day delay in the PN being entered into the hybrid record. Effective Date: [redacted] Department: Physicians; Position: Physician; Created By: the physician's name was entered; Created Date: [redacted] This represented a 15-day delay in the PN being entered into the hybrid record. Effective Date: [redacted]; Department: Physicians; Position: Physician; Created By: the physician's name was entered; Created Date: [redacted] This represented a 26-day delay in the PN being entered into the hybrid record. Resident #90: hybrid record revealed late entries: Effective Date: [redacted]; Department: Physicians; Position: NP, the NP's name was entered; Created Date: [redacted]. This represented an 8-day delay in the PN being entered into the hybrid record. Effective Date: [redacted]; Department: Physicians: Position: Physician; Created By: the physician's name was entered; Created Date: [redacted] This represented a 15-day delay in the PN being entered into the hybrid record. Effective Date: [redacted] Department: Physicians: Position: Physician; Created By: the physician's name was entered; Created Date: [redacted]. This represented a 25-day delay in the PN being	F 711		

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F 711	Continued From page 98 entered into the hybrid record. Effective Date: [redacted]; Department: Physicians: Position: NP; Created By: the NP's name was entered; Created Date: [redacted]. This represented a 6-day delay in the PN being entered into the hybrid record. Resident #118: hybrid record revealed late entries: Effective Date: [redacted]; Department: Physicians; Position: NP, the NP's name was entered; Created Date: [redacted]. This represented an 8-day delay in the PN being entered into the hybrid record. Effective Date: [redacted]; Department: Physicians; Position: Physician; Created By: the physician's name was entered; Created Date: [redacted]. This represented an 11-day delay in the NP being entered into the hybrid record. Effective Date: [redacted] Department: Physicians; Position: Physician; Created By: the physician's name was entered; Created Date: [redacted]. This represented a 26-day delay in the PN being entered into the hybrid record. Effective Date: [redacted]; Department: Physicians: Position: Physician; Created By: the physician's name was entered; Created Date: [redacted]. This represented a 5-day delay in the PN being entered into the hybrid record. Resident #278: hybrid record revealed late entries: Effective Date: [redacted]; Department:	F 711		

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F 711	Continued From page 99 Physicians; Position: NP; Created By: the NP's name was entered; Created Date: [redacted]. This represented a 7-day delay in the PN being entered into the hybrid record. Effective Date: [redacted]; Department: Physicians; Position: Physician; Created By: the physician's name was entered; Created Date: [redacted]. This represented an 11-day delay in the PN being entered into the hybrid record. Effective Date: [redacted] Department: Physicians; Position: Physician; Created By: the physician's name was entered; Created Date: [redacted] This represented a 15-day delay in the PN being entered into the hybrid record. Effective Date: [redacted]; Department: Physicians; Position: Physician; Created By: the physician's name was entered; Created Date: [redacted]. This represented a 25-day delay in the PN being entered into the hybrid record. Effective Date: [redacted]; Department: Physicians; Position: NP; Created By: the NP's name was entered; Created Date: [redacted]. This represented a 4-day delay in the PN being entered into the hybrid record. Effective Date: [redacted]; Department: Physicians; Position: Physician; Created By: the physician's name was entered; Created Date: [redacted]. This represented a 4-day delay in the PN being entered into the hybrid record. On 01/11/23 at 10:16 AM, during an interview with the surveyor, the Registered Nurse Unit Manager (RN UM) stated all physician, and NP progress notes were located in the eMR on the [redacted] and	F 711		

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F 711	Continued From page 100 not the chart. The RN UM further stated the progress notes would be entered when the physician or NP were there to see the resident so that staff could access the notes if needed. The RN UM further stated that the nursing supervisor or MDS (Minimum Data Set) nurse would review the charts to monitor if notes were entered. On 01/11/23 at 11:26 AM, during an interview with two surveyors, the MDS Coordinator stated that physicians would document their progress notes in a resident's hybrid chart. The MDS Coordinator stated there was no physician logbook or any other place that the NP or physician would document or that the facility would be able to keep track of the visits. On the Green unit: Resident #11: hybrid record revealed late entry. Effective Date: [redacted] Department: Physicians; Position: NP; Created By: the NP's name was entered; Created Date: [redacted]. This represented a 5-day delay in the PN being entered into the hybrid record. Resident #106: hybrid record revealed late entry. Effective Date: [redacted]; Department: Physicians; Position: NP; Created By: the NP's name was entered; Created [redacted] This represented a 5-day delay in the PN being entered into the hybrid record. On the Pink unit: Resident #46: hybrid record revealed late entry.	F 711		

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F 711	Continued From page 101 Effective Date: [redacted]; Department: Physicians; Position: NP; Created By: the NP's name was entered; Created Date: [redacted]. This represented a 12-day delay in the PN being entered into the hybrid record. Effective Date: [redacted]; Department: Physicians; Position: NP; Created By: the NP's name was entered; Created Date: [redacted]. This represented an 11-day delay in the PN being entered into the hybrid record. Effective Date: [redacted]; Department: Physicians; Position: NP; Created By: the NP's name was entered; Created Date: [redacted]. This represented an 8-day delay in the PN being entered into the hybrid record. On the Blue unit: Resident #181: hybrid record revealed late entry. Effective Date: [redacted]; Department: Physicians; Position: Physician; Created By: the physician's name was entered; Created Date: [redacted]. This represented a 2-day delay in the PN being entered into the hybrid record. On 01/13/23 at 10:31 AM, during a phone interview with the survey team, the physician and Medical Director for the [redacted] stated that the physicians and NP's in his group would go to the [redacted] at the facility twice a week. The physician stated the visit notes were entered into the electronic medical record and that he would expect the physicians in their group to enter the progress notes immediately. The physician further stated the rationale was so the all the team could reference the visit for continuity of	F 711		

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F 711	Continued From page 102 care. The physician stated that his office would monitor to be sure the staff were entering the notes immediately. On 01/13/23 at 10:34 AM, during a phone interview with the survey team, the physician and Medical Director for the remaining three units, stated the physicians and NP's in his group would dictate PNs in their own system. The physician stated that those PNs should be faxed to the unit the same day. The physician further stated, "I am not sure if anyone monitors this." The physician stated the importance of having the progress notes right away was so that others may see what was done and for continuity of care. On 01/13/23 10:52 AM, during an interview with the survey team, the Licensed Nursing Home Administrator (LNHA) stated some doctors and NP's document electronically and some in written form. When asked about any concerns with them not being able to access the eMR, the LNHA stated she would know if there were problem with the access. The LNHA stated that the PNs on BHU would be eMR. The surveyor inquired when the PNs should be on the eMR or chart. The LNHA stated when the physician or NP completed the resident visit, the PN should be entered at that time to be able to be used for communication. The LNHA stated the nurses on the units should be monitoring if the physician and NP notes were being entered before they leave the unit. The LNHA acknowledged again that the expectation for the physician and NP notes was to document that same day before they leave. On 01/13/23 at 11:34 AM, during an interview with the survey team, the Director of Nursing (DON)	F 711		

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F 711	Continued From page 103 stated all physicians or NP's who see residents were to write or enter notes when they were at the facility for timely documentation. The DON further stated some physicians and NP's write notes in their office and fax or scan to the appropriate unit and that was expected to be done immediately as well. A review of the facility provided, "EMR [electronic medical record] Documentation Policy", reviewed 01/2022, included but was not limited to primary physicians/practitioners may document ...progress notes in the EMR system or on paper filed in the resident's hard chart. Consultant physicians/practitioners documentation are filed in the resident's hard chart. A review of the facility provided, "Administrative Services Agreement", signed by the [redacted] Medical Director and dated 07/06/22, included but was not limited to Article III Time Records: The parties (facility and physician) agree that the physician shall record promptly and maintain all information pertaining to the performance of the services. Appendix A, 7. Provide a copy of your clinical report for inclusion in patient records. A review of the facility provided, "Administrative Services Agreement", signed by the facility Medical Director and dated 01/08/20, included but was not limited to Article III Time Records: The parties (facility and physician) agree that the physician shall record promptly and maintain all information pertaining to the performance of the services. On 01/20/23, the above concerns were brought to the attention of the facility administration. The facility had no additional information to provide.	F 711		

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F 711	Continued From page 104 NJAC 8:39-27.1(a)	F 711		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation it was determined that the facility failed to provide sufficient and competent staff to provide: a.) nursing and related services to meet the residents's needs as	F 725	The Director of Nursing will review staffing daily for the following day with the Staffing Coordinator to ensure adequate staffing. Time off requests will be reviewed by the Director of Nursing and	2/23/23

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F 725	Continued From page 105 determined by resident assessments and individual plans of care and b.) sufficient staffing numbers to meet minimum staffing requirements. This deficient practice was identified on 2 of 4 nursing units and for 6 of 23 sampled residents, Resident #19, #45, #66, # 72, #92 and #179, reviewed for care related services. The deficient practice was evidenced by the following. Refer to F677 and F 689 1.) On 01/03/23 at 10:05 AM, on 01/04/23 at 8:15 AM, and on 01/04/23 at 10:30 AM, the surveyor observed Resident #19 in bed in [redacted] position. The resident indicated that he/she had not been turned and had not been provided with [redacted] care. Resident #19's [redacted] was [redacted] white substance was noted around the [redacted] On 01/05/23 at 11:30 AM, the surveyor observed during a care tour, that the resident had not been changed and was noted soiled with [redacted] from the [redacted]. On 01/05/23 at 1:30 PM, the surveyor interviewed the Certified Nursing Assistant (CNA) who cared for Resident #19. The CNA stated that she reported to work at 8:30 AM, and had not had the time to check on the resident prior to entering the room with the Unit Manager (UM) at 11:30 AM. 2.) On 01/04/23 at 9:16 AM, and on 01/05/23 at 9:18 AM, the surveyor observed Resident #45 after morning care was provided. The surveyor observed the resident with [redacted] and [redacted] and the resident was [redacted]. On 01/11/23 at 7:15 AM, the surveyor observed	F 725	approved or denied based on facility needs to meet staffing ratios. Multiple staff will not be approved to be off on the same day, same shift based on the facility need. The facility is actively recruiting staff, and providing recruiting and sign on bonus. facility job postings were updated. The facility began using a second staffing agency to supplement current staffing levels. All residents have the potential to be affected by this practice. The Director of Nursing or designee will review staffing daily for the following day to assure staffing needs are met. Facility will continue recruitment with ads placed to hire new Certified Nursing Assistants. A second staffing agency was added to supplement staffing levels. Residents with ADL care deficit were identified. Managers, supervisors, and department heads were assigned residents to check three times per week to ensure proper ADL care provided. Managers, supervisors and department heads will report results of ADL audit when completed to the Administrator and Director of Nursing. The Director of Nursing will report results of staffing review to the Administrator on a daily basis. The Director of Nursing will report staffing to the QA Committee quarterly for the next 6 months.	

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F 725	Continued From page 106 Resident #45 in bed, their clothing was visibly soiled with a [redacted] substances. The surveyor noted a [redacted] while approaching the resident's bed. At the surveyor's request, the resident's [redacted] brief was checked by the staff and the resident was found to be soiled with [redacted] On 01/11/23 at 8:23 AM, the surveyor interviewed the CNA who cared for the resident. The CNA revealed that the resident would be soiled with [redacted] most of the time in the morning. The CNA stated that she expressed her concerns to the nurse and nothing had been done. The CNA further stated that most of the time there was only one CNA to start the 07:00 AM-3:00 PM shift. The 11:00-07:00 AM shift staff were gone and she could not get to all residents in a timely manner as she would like to. The facility was aware of the concerns with staffing. 3.) On 01/04/23 at 10:45 AM, on 01/05/23 at 9:15 AM, and on 01/06/23 at 7:15 AM, the surveyor observed Resident #66 in bed. Resident #66 had not received morning care yet. Resident #66 was noted to be [redacted] and had [redacted] briefs on when checked with a random CNA. On 01/05/23 at 9:15 AM, the surveyor observed the resident in bed, resting. The surveyor inquired about [redacted] care. The CNA checked the resident and the resident was [redacted]. An interview on 01/05/23 at 10:47 AM with the CNA, revealed she worked mostly during the 07:00 AM-3:00 PM shift and they were often short handed. The CNA stated they were short staffed, people called out and there was no back up plan	F 725		

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F 725	Continued From page 107 for call outs. On 01/06/23 at 7:15 AM, the surveyor made a care tour with the CNA who worked the 11:00 PM-07:00 AM shift. Resident #66 was [redacted] with [redacted] and had [redacted] briefs on. An interview with the CNA who worked the 11:00 PM-07:00 AM shift, revealed that all "heavy wetters" had [redacted] briefs on. The CNA also stated that she had 20 residents on her assignment most of the time and could not provide [redacted] care to all the residents in the morning. The last round was made around at 5:00 AM. On 01/06/23 at 10:30 AM, the surveyor interviewed the nurse regarding [redacted] care. The nurse revealed that the facility was aware of the workload and she had no control over staffing. 4.) On 01/03/23 at 9:50 AM, and 11:30 AM, and on 01/04/23 at 9:30 AM, the surveyor observed Resident #75 in bed, eyes closed, and the sheet including the blanket were [redacted]. An interview with the resident revealed that [redacted] care had not been provided during the night and the nurse was made aware. The resident further stated that he/she had been left sitting in the wheelchair [redacted] and [redacted] for hours. The staff indicated they were short handed. On 01/05/23 at 12:03 PM, Resident #75 informed the surveyor in the presence of the DON that [redacted] care was not provided in a timely manner due to the facility being short staffed.	F 725		

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F 725	Continued From page 108 5.) On 01/04/23 at 10:36 AM, and on 01/05/23 at 8:37 AM, the surveyor observed Resident #92 in bed, facing the wall. The breakfast tray was observed on the bedside table untouched. Resident #92's mouth was covered with a [redacted] and [redacted] food residual was noted in between the [redacted] and [redacted]. The [redacted] and a [redacted] substance was noted underneath the [redacted]. On 01/05/23 at 10:30 AM, Resident #92 was observed soiled with [redacted]. Resident #92 had a sacral wound that was not protected with a dressing. The CNA stated that this morning not only did she have to change one of the residents, but she had to scrub to remove all the [redacted] that were left from the lack of [redacted] care during the 11:00 PM-07:00 AM shift. On 01/10/23 at 10:44 AM, the surveyor interviewed the Regional Nurse regarding the care. She stated that staffing was a challenge for the facility. She went on to state that the agency staff did not report to work on time. She was aware that most of the time there was only one CNA to start the 07:00 AM-3:00 PM shift. She did not discuss or elaborate on what measures the facility would implement to improve resident care. On 01/10/23 at 11:30 AM, the surveyor interviewed the Unit Clerk/Scheduler who stated that she had been in this position for 2 weeks. The Unit Clerk indicated that she had not been trained on how to calculate the staffing ratio but was aware of the staffing ratio requirements. The Unit Clerk indicated that she prepares the schedule and tries to cover the units but the facility would be short handed due to a lot of call outs with agency staff. The Unit Clerk further	F 725		

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F 725	Continued From page 109 stated they are short staffed on some days due to call outs, and on some occasions no one available to come in. An interview on 01/17/23 at 10:00 AM with the Director of Nursing (DON), revealed it was her expectation that residents be checked and changed as needed every 2 hours and more often if required. The DON also stated their staffing levels were challenging and they were not where she wanted them to be and hoped that with hiring staff it would enable her to increase the number of Nursing Assistants. A review of the facility's census and staffing on the assigned unit where the above concerns were noted, revealed that the facility failed to meet the staffing ratio almost daily. The census for most of the day during the survey was [redacted] on the Unit. The facility would have sometimes 4 CNA and other times 3 CNA for the 07:00 AM -3:00 PM shift and 2 CNA assigned to the 11:00 PM -07:00 AM shift. During the survey from 01/04/23 to 01/20/23, the surveyor observed several residents in the dayroom watching TV. There were no staff observed around to supervise or engage the residents in some forms of activities. On 01/19/23, the surveyor observed 7 residents in the dayroom, there was no staff in the hallway nor at the nursing station. The surveyor asked the Unit Manager who was assigned to the dayroom to monitor the residents about the supervision and she could not comment. Upon further inquiry, the nurse stated, "If I was in charge I would have someone to supervise the dayroom". The surveyor escorted the Unit Manager to the dayroom where we both observed the residents	F 725		

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F 725	Continued From page 110 sitting in the dayroom. The census was [redacted] and only 3 CNA were assigned to care for the residents. The dayroom was left without supervision. (This failure resulted in the staff not being able to meet the residents' needs in a timely manner. This deficient practice had the potential to affect all residents who resided in the dayroom.) 6. On 01/03/23 at 11:14 AM, Surveyor #2 observed Resident #179 lying in bed awake. Resident #179 did not respond to the surveyor when spoken to. Surveyor #2 observed the resident's [redacted] were very dry. There was an [redacted] which contained [redacted] There was no water cup visible in the room. On 01/04/23 at 8:35 AM, the surveyor observed Resident #179 with eyes closed, lying in bed and the breakfast meal had not yet arrived on the unit. The surveyor observed a [redacted] food like substance on Resident #179's top [redacted]. The surveyor engaged the resident who opened his/her eyes, looked at surveyor and did not verbally respond. On 01/04/23 at 8:46 AM, Surveyor #2 observed Resident #179 lying in bed. There was no breakfast tray in the room, but there was a [redacted] substance that resembled food on the resident's gown, [redacted]. There was no water cup visible in the room. Resident #179's [redacted] were still very dry in appearance. On 01/04/23 at 11:06 AM, the surveyor while the surveyor was in Resident #179's room, a Certified Nurse Aide (CNA) entered and stated that she had to change the resident's position. The CNA left the room and stated she needed someone	F 725		

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F 725	Continued From page 111 else to help, returned and stated she could do it her self. She boosted the resident up, and the CNA did not converse with the resident at that time. The surveyor asked the CNA what type of care she provided for the resident and the CNA stated "I don't know, I just came in yesterday and stated I change [him/her] and feed [him/her]." The CNA did not mention anything about mouth care or offering the resident a drink and there was no water cup o[redacted] to clean the resident's [redacted] observed in the room. The surveyor timed the interaction, which lasted four minutes and the CNA left without saying anything to the resident. On 01/04/23 at 11:16 AM, the surveyor interviewed the Unit Manager (UM) about the care that was supposed to be provided for dependent residents. The UM stated bath, feed and report anything that was wrong to the nurse. On 01/04/23 at 12:14 PM, the surveyor observed Resident #179 lying in bed. There was still no water cup visible in the room, but there was an untouched lunch tray out of reach of the resident on the overbed table. On 01/04/23 at 12:28 PM, the CNA set Resident #179 up for the meal and proceeded to use the hand wipe that was on the resident's tray to clean her own hands, and not the resident. The surveyor watched as the CNA began to feed the resident. The surveyor asked the CNA if the resident was offered water, as there was no water at the bedside or on the meal tray. The CNA stated, "I forgot", when the surveyor asked where the water was. The surveyor asked the CNA if she had offered the resident any water during her shift and the CNA confirmed she had not. The CNA then left the resident in the middle of the	F 725		

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F 725	Continued From page 112 meal, and did not say anything to the resident and exited the room. (Surveyor observations over approximately a four hour period revealed that the Resident had not been offered water, which was confirmed by the CNA who was assignened to the resident) On 01/04/23 at 12:35 PM, the surveyor asked the UM to come into Resident #179's room. The surveyor asked the UM about the [redacted] care as the resident's mouth looked very dry. The UM stated [redacted] care should be done and proceeded to look for [redacted] in resident's drawer. The UM was unable to locate cleaning [redacted] and confirmed they were not there. The surveyor asked the UM if water should also be available for the resident, and the UM stated "yes". The surveyor reviewed Resident #179's Admission Record which revealed diagnoses that included [redacted] A Physician's Progress note, dated [redacted] at 11:25 AM, revealed a problem list that included: [redacted], presented with recurrence of [redacted] with probable [redacted] c [redacted] The Care Plan revealed a Focus: Initiated [redacted] and Revision: [redacted], revealed Resident has a nutritional problem or potential nutritional problem r/t (resulted to) ...need for ADL assist...Interventions included: Encourage PO (by mouth) fluids dated [redacted] and Assist resident at meals, dated [redacted] On 01/04/23 at 1:28 PM, the surveyor observed a [redacted] under Resident #179's [redacted]	F 725		

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F 725	Continued From page 113 [redacted]. On 01/04/23 at 1:37 PM, the surveyor interviewed the UM, in the presence of another surveyor. The surveyor asked the UM if he checked the care being provided to the residents by his staff and asked if he had checked if Activity of Daily Living (ADL) care had been provided to Resident #179. The UM stated he did not check the care of Resident #179 and stated, "I am pretty sure that someone checked it yesterday", and he would have to check the computer for the ADL completion, and stated he had not done that. The surveyor asked the UM if [redacted] would be cleaned as part of ADLs and the UM stated, "yes" of course. At that time, both surveyors asked the UM to accompany them to Resident #179's room and look at the resident [redacted] The UM opened Resident #179's hands and stated, "I see" as he observed the [redacted] under Resident #179's [redacted] on the [redacted] On 01/09/23 at 8:55 AM, the surveyor observed an undated, open cup of water in Resident #179's room. There was no ice in the water and the resident's [redacted] looked dry. The resident was alert and responded to the surveyor. At 8:59 AM, a different CNA then previously brought in the meal tray. The surveyor asked the CNA about the open cup. The CNA stated, "it looked like from 11-7 shift", looked like they didn't throw it out, and the cup should be covered with a lid and have a straw inside. The surveyor asked if the cup is usually dated, and the CNA stated that "they don't tell them to date it". 01/10/23 at 9:18 AM, the surveyor interviewed the UM regarding the water policy. The UM stated that every shift must provide fresh water and as	F 725		

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F 725	Continued From page 114 needed. The UM stated the water cups were supposed to be dated because it would be a problem if not dated since you would not know what date it was poured. On 01/01/10/23 at 11:14 AM, the surveyor interviewed the Registered Dietitian (RD) about Resident #179. The RD stated she reviewed the resident's labs and "I put in for PO hydration encouragement", "which I know they are already doing". The RD stated she had spoken with nursing to encourage water, juices fluid and the resident should have a water cup in the room. The policy for oral hygiene was reviewed and indicated the following:Purpose: Regular oral hygiene will help prevent mouth infections, dental decay and gum disease and will promote personal hygiene. All residents will receive care of the mouth and teeth every morning and night and as needed to maintain good oral hygiene. The policy was not being followed. The policy for ADL care dated 06/18/24 last revised 12/15/17, indicated: "Residents shall receive assistance with activities of daily living (ADL's) every shift, as appropriate", ADLs include: Bathing, Grooming, Dressing, Eating, Oral hygiene, Ambulation, Toilet activities. The Resident Hydration and Prevention of Dehydration Policy, undated revealed: This facility will endeavor to provide adequate hydration and to prevent and treat dehydration, ...4. Nurses' Aides will provide and encourage intake of bedside, snack and meal fluids on a daily and routine base as part of daily care, 5. A 16 oz cup of containing ice water will be placed at each	F 725		

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F 725	Continued From page 115 residents' bedside within arm's reach...11. Nursing will monitor fluid intake... A review of the Position Title: Unit Manager job description revealed under responsibilities/accountabilities: 1. Takes an active role in direct resident assessment and care; including but not limited to, ADL care, Personal Hygiene and Psycho-social support. On 01/13/23 at 9:35 AM, an unsampled resident on the Blue Unit requested to speak with the surveyor. The resident stated "the short staffing is abominable, even with the state [Department of Health] in the building." On 1/19/21 at 8:54 AM, the surveyor reviewed the Blue Unit assignment sheet with the Unit Manager (UM), there were two Certified Nurse Aides listed for the 7:00 AM to 3:00 PM assignment. The surveyor asked the UM what the resident census was and he stated [redacted] residents and confirmed there were only two CNAs. The surveyor asked if that was the normal staffing and the UM stated there were normally 5 to 6 CNAs. He stated that he was not sure who had called out for the day.	F 725		
F 865 SS=D	NJAC 8:39-5.1(a) QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the	F 865		2/23/23

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F 865	Continued From page 116 outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices;	F 865		

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F 865	Continued From page 117 §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.	F 865		

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F 865	Continued From page 118 §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, and review of pertinent documents, it was determined that the facility failed to a) identify through their Quality Assurance Performance Improvement (QAPI) program, that their abuse prevention program did not incorporate a component to protect all residents from potential abuse. The deficient practice was evidenced by the following. Refer to F 600 J and F 607 F On 01/03/23 at 10:26 AM, the facility provided the survey team with a copy of their, "Abuse Prevention Program", revised 10/21/22. On 01/19/23 at 8:27 AM, the survey team reviewed an allegation of abuse reported by a resident's family member. The abuse allegation referred to a Certified Nursing Assistant (CNA) being abusive towards a resident on the 7:00 AM	F 865	The facility reviewed the Abuse Prevention Program and incorporated the component to protect all other residents from potential abuse and who and when to obtain statements from all associated staff and residents. All residents have the potential to be affected. The Director of Compliance in-serviced the Administrator and Department Heads on the QAPI program. The facility QAPI Committee will review all abuse allegations and subsequent investigations to assure Abuse Prevention Program is being followed. The facility will conduct an annual review of the Abuse Prevention Program and update as necessary. The facility QAPI committee will analyze	

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F 865	Continued From page 119 to 3:00 PM shift on 01/17/23. On 01/19/23 at 8:46 AM, a surveyor interviewed the resident who confirmed on 01/17/23, a CNA was "nasty", threw down a meal tray, and refused to provide incontinent care. The resident stated that the incident had been reported to the Director of Social Services (DSS) on [redacted] (no time provided). On 01/19/23 at 9:23 AM, a surveyor interviewed the DSS who stated that he was made aware of the situation on [redacted] The DSS stated he went to see the resident and took information down on the facility, "Grievance/Missing Item Report". The DSS provided the report to the survey team which was dated [redacted], but not timed. The DSS stated that he immediately told the Director of Nursing (DON) because he had to do with nursing allegations, and it was the DON's responsibility to investigate and obtain statements from the nursing staff. The DSS acknowledged that the situation constituted an allegation of abuse. The CNA had completed the 7:00 AM to 3:00 PM shift on [redacted] On 01/19/23 at 9:50 AM, the Unit Manager (UM) on the resident's unit, stated that he was informed by the family member on [redacted], but was unsure of the time. The UM stated that he informed the DON that day as well. The UM further stated he was told only to take statements, but the CNA in mention had left for the day before the UM could obtain her statement. The UM confirmed that the CNA in mention, worked on the same unit on [redacted], but not caring for the resident. The UM confirmed that the statement he read constituted abuse.	F 865	performance to identify and follow up areas of opportunity for improvement, identify gaps, feedbacks, data systems and monitoring on a quarterly basis. The facility will conduct an annual review of the Abuse Prevention program and update as necessary and will continually monitor performances for improvement and will be reviewed at quarterly QA meeting. The Administrator will report results of the abuse allegation reviews at the QAPI meeting for the nest 6 months.	

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F 865	Continued From page 120 On 01/19/23 at 10:46 AM, both the DON and the Licensed Nursing Home Administrator (LNHA) acknowledged they were made aware in the afternoon of [redacted]. The LNHA further stated that during an allegation of abuse investigation, the staff member (CNA) would be suspended until the investigation was complete. The LNHA and DON both acknowledged the CNA worked on the same unit as the resident on [redacted]. The CNA had access to the resident who made the allegation as well as other residents on the unit who were not interviewed to determine if anything had happened to them by the same CNA. The residents were not protected during the investigation. On 01/20/23 at 9:23 AM, during an interview with the survey team, the LNHA stated that abuse was not part of QAPI but would be moving forward. She further stated that it was not in the policy, but the facility would move forward with having the Social Worker to start obtaining statements immediately including residents and nursing staff. A review of the facility provided, "Abuse Prevention Program", revised 10/21/22, included but was not limited to Part II - Prevention: staff and resident will be protected from retaliation. Part V - Investigation: the administrator and the DON will initiate investigations, determine necessary response, and report to the Ombudsman and Department of Health and Senior Services as necessary. Employees involved in the investigation will be reminded of the prohibition on breach of confidentiality and retaliation. Part VII - Protection: staff members being investigated for possible involvement in abuse will be removed from contact with the resident, as necessary. Staff, family, and	F 865		

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F 865	Continued From page 121 residents will be protected from retaliation due to their reporting of possible abuse. Part VIII - Reporting / Response: when an incident is reported to the supervisor, the supervisor is responsible for ensuring that the resident is safe. Coordination with QAPI: review would allow the committee to determine whether the resident is protected. Whether there is further need for systemic action such as: needed revisions to the policies and procedures. The Abuse Prevention Program Policy and Procedure did not address obtaining statements from all associated staff and residents on the unit; who would be responsible to obtain statements and when that should begin; and how to protect all other residents on the unit and or in the facility. On 01/11/23 at 12:44 PM, a review of the QAPI meetings scheduled for 2022, revealed fourth quarter [redacted], first quarter [redacted], second quarter [redacted] and third quarter [redacted]. The meetings included but were not limited to the following. Fourth quarter: abuse in-service will be done on all staff. There was no mention of the Abuse Prevention Program being addressed. First quarter: There was no mention of the Abuse Prevention Program being addressed. Second quarter: There was no mention of the Abuse Prevention Program being addressed. There was no mention of the [redacted] Third quarter: There was mention of incidents on the [redacted] There were no mentions of the Abuse Prevention Program Policy and Procedure in the QAPI meetings.	F 865		

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F 865	Continued From page 122 On 01/20/23 at 9:42 AM, the LNHA provided the survey team with a revised QAPI, dated [redacted] in response to the allegation of abuse. The revised QAPI failed to address a plan to protect all residents from potential abuse. A review of the facility provided, "Quality Assurance and Performance Improvement Plan", undated, included but was not limited to Design and Scope: A vision of creating an environment where care, treatment, and services contribute to .....safety and quality of life for the residents. The QAPI committee analyzes performance to identify and follow up ....areas of opportunity for improvement. QAPI focuses on systems and processes, the emphasis is on identifying gaps. Feedback, Data Systems and Monitoring: on a quarterly basis, data will be collected and reported to QAPI from the following areas: any area identified as important to report to team. Performance Improvement Projects (PIP): QAPI committee annually prioritizes activities, endorses or re-endorses policies and procedures measurement of performance. .....continually monitors for improvement. System Analysis and Systemic Action: the executive leadership and center management teams, along with QAPI committee, will conduct a facility wide systems evaluation utilizing the QAPI self-assessment.	F 865		
F 880 SS=E	NJAC 8:39-31.6 (g); 33.1 (d); 33.2 (a)(b)(c) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		2/23/23

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F 880	Continued From page 123 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 880		

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F 880	Continued From page 124 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interview, record reviews, and review of pertinent documents, it was determined that the facility failed to: a.) implement infection control practices and adhere to the facility's policy in regards to hand hygiene during medication administration, b.) store a [redacted] bag in a manner to prevent infection for 1 of 1 residents reviewed for [redacted] (Resident #19), c.) ensure a visitor was educated and instructed to wear a mask while in the facility, d.) wear Personal Protective Equipment (PPE) while in the room of a residents on transmission-based droplet precautions for 2 of 4, and use hand hygiene prior to donning (putting on) PPE on 1 of 4 units, and	F 880	a. The RN was in-serviced on the facility's policy and procedure of handwashing during medication administration. b. The CNA was rein-serviced on proper storage of the [redacted] c. The dietary aide and the receptionist were rein-serviced to ensure the visitor wears the mask before leaving the reception desk. d. The CNA and RN were rein-serviced on the use of Personal Protective Equipment to enter the room of the residents on transmission based precautions and use	

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F 880	Continued From page 125 e.) follow their Covid-19 Outbreak Response Plan and Policy for Infection Control, and follow the latest guidance from the Centers for Disease Control and Prevention (CDC) for the surveillance of Healthcare Personnel (HCP) to prevent the spread of infection. This deficient practice was observed during medication administration and was evidenced by the following: a.) On 01/06/23 at 7:30 AM, Surveyor #1 observed the Registered Nurse (RN) preparing Insulin (an injectable medication used to treat diabetes) for Resident #42 an unsampled resident. The RN donned (put on) gloves, administered the Insulin, returned to the medication cart, removed the gloves and documented in the electronic medical record on the medication administration record (MAR). The RN did not perform hand hygiene with soap and water before exiting the room nor use Alcohol Based Hand Rub (ABHR) upon returning to the medication cart. The surveyor observed that ABHR was easily accessible in the hallway and a bottle of ABHR was noted on top of the medication cart. On 01/06/23 at 8:05 AM, the RN prepared and administered medications to Resident #5 an unsampled resident. The RN did not perform hand hygiene with soap and water before exiting the room nor use ABHR upon returning to the medication cart. On 01/06/23 at 8:17 AM, the RN returned to the medication cart and started preparing medication for Resident #18 an unsampled resident. The RN informed the surveyor she needed to check Resident #18's [redacted] before medication administration. The RN went to the nursing	F 880	of hand hygiene prior to donning PPE. e. The Director of Housekeeping was rein-serviced to report to the Director of Nursing/Administrator immediately if he is experiencing signs and symptoms of COVID-19, to complete the screening form accurately and he will be sent home and will not be allowed to work with COVID-19 signs and symptoms even if with negative test result. All residents and staff have the potential to be affected. All staff were rein-serviced by Director of Nursing and Nursing Supervisors on the policies on a. PPE during the the COVID-19 Public Health Emergency, b. Donning and Doffing Personal Protective Equipment, c. Handwashing/Hand Hygiene, d. [redacted] Storage, and e. Screening for COVID - 19. The Infection Preventionist Nurse will observe 5 staff members per week perform handwashing, proper use of PPE in rooms at Transmission Based Precautions, and donning and doffing PPE. The Infection Preventionist Nurse will audit 3 residents per month for proper storage of [redacted]. The Infection Preventionist Nurse will observe 5 visitors and 5 staff per week at the reception desk to assure proper compliance with mask use and screening. The Infection Preventionist Nurse will report results of audits and any variance	

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F 880	Continued From page 126 station and returned with a bag which contained a blood pressure cuff and a pulse oximeter. The RN went to the room, checked the resident's vital signs, and returned the blood pressure cuff and the digital pulse oximeter to the bag prior to exiting the room. Then the RN retrieved the key from her scrub top pocket, opened the medication cart, placed the bag in the bottom drawer, then prepared and administered medications to Resident #18. The RN exited the room and did not perform hand hygiene. On 01/06/23 at 8:22 AM, the RN returned to the medication cart and was about to pour medication for another resident when the surveyor stopped the RN and informed her that she had not used ABHR or performed hand hygiene between residents. The RN stated, "OH, I forgot". The RN went to the sink and washed her hands with soap and water. On 01/06/23 at 8:45 AM, an interview with the RN revealed that she had received in- service education on hand hygiene but could not remember the date. The RN stated that she should have used ABHR between residents and performed hand hygiene with soap and water after the third resident. She apologized for not washing her hands. On 01/17/23 at 12:30 PM, the facility was made aware of the above observations. The Director of Nursing (DON) stated that she was made aware by the RN and the RN was reeducated on hand hygiene. b.) Resident #19 was admitted to the facility with diagnoses which included but were not limited to: [redacted] from [redacted] with [redacted]	F 880	at the morning meeting. The Infection Preventionist Nurse will present results quarterly at the QA meeting for review and follow up as indicated for the next 6 months.	

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F 880	Continued From page 127 [redacted]. Resident #19 had a [redacted]) in place for [redacted]. On 01/03 at 10:05 AM, the Surveyor #1 observed Resident #19 in bed, the [redacted] was observed in a [redacted] and hung on the bedframe. On 01/13/23 at 11:24 AM, the surveyor observed Resident #19 in a recliner chair next to the bed. Resident #19 did not have a [redacted] on. The surveyor observed a [redacted] stored in a plastic bag which was hung on the rail in the bathroom. The [redacted] was not [redacted] and the bag was not dated. On 01/18/23 at 10:40 AM, the surveyor entered the room and observed Resident #19 in the recliner chair in the room. Resident #19 had a leg bag on and the [redacted] was observed in a plastic bag hung on the rail in the bathroom. The [redacted] was not [redacted]. The bag was not dated. On 01/18/23 at 11:15 AM, the surveyor interviewed the Unit Manager (UM) regarding storage of the [redacted]. The UM stated that the bag should be cleaned and rinsed from any [redacted]. The UM further stated that the [redacted] should be [redacted] to prevent infection. The surveyor then inquired about the timing for changing the [redacted]. The UM added that the [redacted] was changed weekly on the 11:00 PM- 07:00 AM shift and the bag should	F 880		

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F 880	Continued From page 128 be dated to remind staff when the bag was last changed. On 01/18/23 at 11:30 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who cared for Resident #19. The CNA stated that the [redacted] was changed daily and the [redacted] was changed weekly. The CNA stated that she washed and rinsed the [redacted] of [redacted] and stored the [redacted] in a plastic bag in the bathroom. The CNA was not aware that the [redacted] was to be [redacted] to prevent infection. On 01/18/23 at 12:30 PM, the surveyor entered the room with the UM and observed the nurse assigned to the [redacted] Unit [redacted] was in the room. The surveyor escorted the UM to the bathroom where we all observed the [redacted] stored in the bathroom and the [redacted] was not [redacted] On 01/19/23 at 9:30 AM, the UM informed the surveyor that the [redacted] was discarded and the staff was in-serviced. Review of the facility's policy titled, "Handwashing/Hand Hygiene" dated 10/18 and last revised 12/22, documented the following: Policy: Provide guidelines for effective handwashing/hand hygiene in order to prevent the transmission of bacteria, germs and infection. Guidelines: Handwashing will be performed by staff as follows 1. When coming on duty. 2. Before and after contact with patients and between patient contacts. 3. Before gloving and after gloves are removed.	F 880		

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F 880	Continued From page 129 The nurse failed to adhere to the facility's policy for hand hygiene. On 01/19/23 at 10:25 AM, the DON provided a policy titled, [redacted] r Care [redacted] " dated 10/09 and last revised 12/22, which revealed the following: Policy: It is the policy of the facility to prevent [redacted] infections and to maintain the dignity and privacy of our residents utilizing [redacted] . Maintain clean technique when handling or manipulating the [redacted] or [redacted] bag. The policy did not address the storage of the [redacted] . c.) On 01/09/23 at 8:57 AM, Surveyor #2 observed a lady walking down the hall from the reception area, down the hall where the rehabilitation gym was located, into the [redacted] unit nursing desk area, and down the [redacted] unit [redacted] Surveyor #2 observed that the lady was not wearing any mask. Surveyor #2 observed the lady stop within arm's length of another resident and speak to that resident. At that time, Surveyor #2 stopped and questioned the lady who was identified as a visitor. Surveyor #2 asked the visitor if she had been offered a surgical mask when she entered the facility. The visitor stated she didn't think so and that she would go back to the reception area to get a mask. The visitor walked back down both areas of the [redacted] unit, down the rehabilitation gym hall, and to the reception desk to obtain a surgical mask. On 01/09/23 at 9:02 AM, during an interview with Surveyor #2, the staff member at the reception desk identified herself as normally working in the Business office but was working at the reception area. The staff member stated she had been	F 880		

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F 880	Continued From page 130 outside at the time the visitor entered the facility and that a dietary aide (DA) had been at the reception desk. On 01/09/23 at 9:05 AM, Surveyor #2 interviewed the DA who was at the reception desk regarding the visitor. The DA stated that a mask was given to the visitor but that she wasn't watching and had no idea if the visitor put the mask on. The DA further stated the visitor should have had a mask on prior to entering the facility. On 01/09/23 at 9:37 AM, during an interview with Surveyor #2, the DON was informed about the situation. The DON stated the visitor should have been instructed to wear a mask prior to go into facility. The DON stated the visitor could expose others or be exposed to COVID-19. The DON stated the DAs responsibility did not end by just handing the visitor a mask. d.)1. On 01/18/23 at 12:14 PM, Surveyor #2 observed a resident room on the [redacted] unit with signage for Droplet Precautions and a bin containing PPE inside of the door. Surveyor #2 observed a staff member inside the room within arm's length of Resident #280. The staff member was wearing a surgical mask and eye protection. The staff member had no other PPE on and was delivering and helping to set up the resident's lunch tray. The resident was sitting on the side of his/her bed with no mask on. The staff member exited the room and was interviewed by Surveyor #2 at that time. The staff member was identified as a Registered Nurse (RN) who stated she was "just bringing the tray in" to Resident #280. The RN stated that the resident was a new admission, and the facility	F 880		

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F 880	Continued From page 131 was waiting to learn of the resident's COVID-19 status. The RN further acknowledged that the transmission-based precaution signs were visible on the resident's door and that she should have been wearing full PPE. On 01/18/23 at 12:27 PM, the LNHA was observed on the [redacted] unit and was made aware of the above situation. On 01/18/23 at 12:49 PM, Surveyor #2 interviewed the facility RN Infection Preventionist (RN IP) who stated that a new admission and unsure of their vaccination status, would be placed as a PUI for 7 days droplet precaution isolation. She stated that with droplet transmission-based precaution, the staff should wear an N95 mask, full PPE gown, gloves and eye protection, and use hand sanitizer. The RN IP stated that the PPE bins should be kept in front of the resident door for PUI, and stated, "I don't know why we keep PPE outside the door", and "I would expect to see them (staff) in PPE" as per the signage on the door. A review of Resident #208's hybrid medical record revealed an Admission Record revealed that the resident was admitted on [redacted] with no diagnoses listed. The Order Summary Report revealed an order dated [redacted] for transmission-based droplet precautions until [redacted]. A review of the Immunizations revealed only a [redacted] administered on [redacted] A review of the Medication Administration Record (MAR) for [redacted] revealed an order for [redacted] precautions every shift for 5 days and had been signed off on [redacted] by the RN who had been in the room without all the required PPE. A review	F 880		

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	315357		01/20/2023

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F 880	Continued From page 132 of the on-going Care Plan (CP) revealed a focus area dated [redacted], is at risk for COVId-19 infection due to no history of vaccine cards, transmission droplet base precaution times seven days; interventions included but were not limited to maintain transmission-based precautions.....use PPE per CDC guidelines. A review of the facility provided, "Handwashing Competency Checklist", dated 08/01/22, revealed the RN was deemed competent to perform handwashing tasks independently and without supervision. A review of the facility provided, "PPE Use When caring for Patients with Confirmed or Suspected COVID-19 Competency", dated 08/01/22, revealed the RN had been deemed competent in PPE Donning (putting on) and PPE Doffing (taking off). A review of the facility provided, "Cohorting and PPE during the COVID-19 Public Health Emergency", revised 03/22/22, included but was not limited to new or readmitted asymptomatic residents who are not up to date with all recommended COVID-19 vaccine doses ... . Precautions to take included N95 mask or higher-level respirator, gloves, gown, and goggles or shield. 2. On 01/04/23 at 11:25 AM, the surveyor observed a Certified Nurse Aide (CNA) wearing a cloth mask, a surgical mask over the cloth mask and an N95 Respirator mask with only one strap secured, and was outside Resident #279's room that had Droplet Precaution sign and a large STOP sign posted on the outside of the room do to being on observation for COVID-19. The signs also indicated how to put on a respirator,	F 880		

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F 880	Continued From page 133 "Position your respirator correctly and check the seal to protect yourself from COVID-19", "Do not allow facial hair, jewelry, glasses, clothing, or anything else to prevent proper placement or to come between your face and the respirator". The CNA then put on a disposable gown, secured the back, and proceeded to put gloves on without first performing hand hygiene. At 11:29 AM, the CNA exited the room holding a cup and went to the ice machine to get ice for the cup. Upon return the surveyor interviewed the CNA about the purpose of the white respirator mask. The CNA stated it was for the isolation rooms, and she was told how to wear it. On 01/04/23 at 11:34 AM, the surveyor interviewed the Unit Manager (UM) and asked him to observe the CNA with three masks on, including the unsecured N95 Respirator and asked him what should be worn in the isolation room and informed him of the surveyor's observation. The UM confirmed that the N95 Respirator was unsecured and stated "she shouldn't" be wearing the N95 over another mask. On 01/06/23 at 10:27 AM, the surveyor interviewed the Director of Nursing (DON) regarding what personal protective equipment (PPE) was worn in the observation rooms. The surveyor asked the DON what ppe is worn in observation rooms. The DON stated and N95, face mask. The surveyor asked why do people need to wear N95 masks and the DON stated it protects from exposure to Covid and it should be fit tested to give them a good seal.The surveyor asked how is should be worn. The DON staed both straps have to be on and if not it won't maintain a proper fit. Asked if the mask could be	F 880		

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F 880	Continued From page 134 worn over other masks and the DON stated "no" will affect the fit and the effectiveness of the mask. The survyor informed the DON of the observation and asked if it was okay. The DON stated "no", that is not okay and the CNA had been educated on the masks, and "she needs to follow the proper way to don and doff, must use alcohol based hand sanitizer before putting on gloves". e.) On 01/05/2023, a review of the facility's Covid-19 Pandemic Exposure Control and Response Plan indicated that the facility requires employees to report immediately to their immediate supervisors if they are experiencing signs and symptoms of Covid-19. In addition: 1) If an employee develops any signs or symptoms of Covid-19 or a respiratory illness, such as fever, an atypical cough or shortness of breath, they must: not report to work, notify their immediate supervisor, self-isolate and consult with their healthcare provider. 2) All employees will be screened for signs and symptoms of Covid-19 on a daily basis prior to the start of their shifts, which screening will also include a daily temperature check. 3) Any employee exhibiting signs and symptoms of Covid-19 will not be permitted to work and will be immediately sent home to self-isolate and/or seek medical attention. On 01/05/2023, a review of the facility's Infection Control policy: Protocol for an Outbreak revised and dated 09/06/2022, indicated that staff exhibiting signs and symptoms of Covid-19, to inform the facility prior to coming to work and	F 880		

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F 880	Continued From page 135 follow Department of Health (DOH) guidelines for return to work. Staff, both vaccinated and unvaccinated, with signs and symptoms must be tested. The policy also indicated to refer to current Centers for Disease Control and Prevention (CDC) guidance for ongoing testing recommendations. On 01/05/2023, a review of the CDC's guidance titled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) during the Covid-19 Pandemic," last updated on 09/23/2022, recommends for HCP to monitor themselves for fever or symptoms consistent with Covid-19, and not report to work when ill. Any HCP who develop fever or symptoms consistent with Covid-19, should immediately self-isolate and contact their established point of contact to arrange for medical evaluation and testing. Facility staff with signs or symptoms must be tested, regardless of Covid-19 vaccination status. Symptomatic HCP who test negative for Covid-19 should be excluded from work. On 01/06/2023 at 09:38 AM, in the presence of the survey team, the Director of Housekeeping (DH), wearing an N95 mask, stated that he would have to sit away from the surveyors because he had been sick and his voice still "sounded funny." This surveyor observed the DH's voice to sound hoarse with an occasional cough and clearing of throat while talking to the surveyors. On 01/06/2023 at 11:31 AM, the Director of Nursing (DON) stated that she was unaware that the DH was sick or had any symptoms. The DON stated that the DH should have been tested right away and sent home. The DON also added that	F 880		

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F 880	Continued From page 136 the DH was due to be tested for Covid-19 on 01/06/2023 because he is unvaccinated. On 01/06/2023 at 12:03 PM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with a negative Covid-19 rapid test result for the DH dated 01/06/2023. The surveyor observed that the DH's negative test result did not indicate the time the Covid-19 test was performed. The LNHA stated that the facility's testing form to document Covid-19 testing results only indicated a date of the testing, not a time that the testing was performed. The LNHA and DON confirmed that the DH was unvaccinated, that the DH did not notify them of having symptoms, and the DH was not tested for Covid-19 prior to entering the facility before surveyor inquiry. On 01/10/2023 at 12:32 PM, in the presence of the survey team, the LNHA stated that the DH should have notified administration about symptoms and tested prior to entering the facility. The LNHA added that all testing was done at the beginning of the shift to be sure staff are not positive before entering the facility to work. The LNHA stated that the day shift Nursing Supervisor was responsible for the testing and the DON was responsible to follow up on the testing. The LNHA and DON were asked what the facility policy was for staff that test negative for Covid-19 but are still symptomatic? The LNHA and DON were unable to clearly state the facility policy. The LNHA stated, "I will have to check the policy to see what should be done for symptomatic staff." On 01/11/23 at 9:39 AM, the surveyor interviewed the LNHA regarding if the DH was currently at the facility. The LNHA stated he was not there today or yesterday. The surveyor inquired if he was sent	F 880		

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F 880	Continued From page 137 home on 01/06/23, the day he reported to the surveyors that he had been ill. The LNHA stated "no", he wasn't sent home because it was the end of the day. The surveyor asked the LNHA if scratchy throat was a symptom of COVID-19. The LNHA stated "yes", it is a symptom. On 01/17/2023 at 11:00 AM, the LNHA provided the surveyor with the DH's Staff /Visitor Screening form for Covid-19 dated 01/06/2023. The surveyor observed that the DH indicated "NO" for signs or symptoms of Covid-19. The LNHA stated that both the LNHA and DON monitor the Staff/Visitor Screening Form for Covid-19. On 01/20/23 at 9:43 AM, during an interview with the surveyor, the DH, employed at the facility for 7 months, stated that on 01/06/2023 he only had a scratchy throat which made him have a raspy voice. The DH added that he indicated no symptoms on the Covid-19 Screening Form because he didn't have a fever and had no symptoms other than a scratchy throat. The DH stated that he had been educated about notifying the facility if having any symptoms and, if having symptoms or feeling sick to get tested prior to entering the facility. The DH confirmed that on 01/06/23 he should have notified the LNHA about his symptom of a scratchy throat and should and been tested before coming to work. The Policy/Procedure: PPE during the COVID-19 Public HealthEmergency, Revised 09/10/21 revealed in Observation rooms (New or Readmission), the Type of PPE Needed for Droplet Precautions: N95 Mask, Gloves, Gown, Goggles or shield. The Donning and Doffing Personal Protective	F 880		

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F 880	Continued From page 138 Equipment (PPE) policy, undated revealed It is the policy of this facility to follow the CDC guidelines for donning and doffing of PPE. Procedure: See attached CDC donning and doffing sequence. 2. Mask or Respirator, secure elastice bands at middle of head and neck, Fit flexible band to nose bridge, Fit snug to face and below chin, Fit check respirator Handwashing/Hand Hygiene Policy, Reviewed 12/2022, Policy: To provide guidelines for effective handwashibng/hand hygiene, in order to prevent the transmission of bacteria, germs and infections. Guidelines: Handwashing/Hand hygiene will be performed by staff as follows: ...Before gloving and after gloves are removed... NJAC 8.39-19.4 (a)	F 880		