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	315344	A. BUILDING _____ B. WING _____	C 08/18/2022

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F 000	INITIAL COMMENTS Complaint #156814 Census: 127 Sample Size: 5 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT SURVEY.	F 000		
F 604 SS=J	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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 treat the resident's medical symptoms. §483.12(a) The facility must-	F 604		8/23/22

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

Electronically Signed | 09/14/2022

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 604	Continued From page 1 §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Complaint#: NJ156814 Based on interviews, medical records review, and review of other pertinent facility documentation on 8/9/2022, 8/15/2022, and 8/18/2022, it was determined that the facility failed to ensure a resident (Resident #2) with a known diagnosis of EX Order 26 § 4b1 Following EX Order 26 § 4b1 on the EX Order 26 § 4b1, who was at risk for EX Order and required EX Ord as needed for safety was free from EX Order 26 § 4b1. On 8/1/2022, Resident #2 exhibited behaviors and was non-compliant with keeping his/her EX Order 26 § 4b1 on the 3:00 p.m. to 11:00 p.m. shift. Since Resident #2 was non-compliant, the Certified Nursing Assistant (CNA #1), who was assigned to Resident #2 until 9:00 p.m., requested CNA #2 to assist her in moving the long table in the dining/recreation room towards the wall. CNA #1 then placed Resident #2 in the Resident's EX Order 26 § 4b1 behind the table and against the wall for safety and to prevent the Resident from EX Order 26 §. CNA #1 left Resident #2 alone and restrained in the	F 604	1. Resident #2 was taken to the hospital for evaluation and is no longer at the facility. CNA #2 was removed from his/her work schedule pending the outcome of the investigation on 08/02/2022. As a result of newly discovered information as part of its investigation, CNA #1 was removed from his/her work schedule by the facility pending the outcome of the investigation on 08/15/2022. 2. All residents have the potential to be affected. All residents at risk for falls and requiring 1:1 supervision as needed have the potential to be affected by this deficient practice. 3. The Administrator and/or his designee immediately began education of staff on 08/03/2022 for restraints and abuse and education began on 08/03/2022 and remains ongoing for 1:1 supervision, person centered care plans, and residents at risk for falls. A behavioral monitoring plan was developed on 8/15/2022 and implemented on 8/18/22 to monitor behaviors of residents utilizing 1:1	

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F 604	Continued From page 2 EX Order 26 § 4b1 from approximately 8:00 p.m to 10:00 p.m. Resident #2 was able to retrieve his/her cell phone from the pocket and called 911. The Police Officers responded to the 911 call at approximately 9:55 p.m. They found Resident #2 sitting in the Resident's EX Order 26 § 4b1 in a dark room and restrained against the wall with a long table to the front of the Resident, three small tables to the front of the long table, and three chairs to the left side, and three chairs to the right side of Resident #2. The Police Officers called the Emergency Medical Services (EMS), and Resident #2 was transferred to the hospital for further evaluation and did not return to the facility. In addition, the facility failed to follow its policies titled "Restraints/Siderail-Bed Systems" and "Resident's Rights." The facility's failure to prevent a physical restraint placed Resident #2 and all other residents experiencing behavioral changes, at risk for falls or required 1:1 Supervision as needed at risk for an Immediate Jeopardy (IJ) situation. This IJ was identified and reported to the facility's Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Assistant, Director of Nursing (ADON) on 8/15/2022 at 3:45 p.m. The Administrator was presented with the IJ template that included information about the issue. The IJ began on 8/1/2022 and continued through 8/15/2022 when CNA #1 was taken off duty pending the completion of the investigation. On 8/18/2022, the Surveyors did a revisit to verify the Removal Plan was implemented. The facility implemented the Removal Plan, which included removing CNA #1 from the schedule, and educating all facility staff on not using furniture as a restraint to prevent residents who are at risk for	F 604	services and will be reviewed weekly for 90 days. Furthermore, the facility's initial orientation and mandatory annual residents rights in-service was revised and implemented on 8/15/2022 will highlight the residents' right to be free from chemical and physical restraints and, to ensure the resident maintains their freedom to retain and exercise all the constitutional, civil and legal rights to which the resident is entitled to by law. Finally, the facility has provided agency contracts to the staff development coordinator on 8/12/22 and 8/23/22 respectively to assure appropriate staffing for resident with 1:1 supervision needs are met at all times. Furthermore, on 8/15/2022 the facility began developing a binder system to monitor behaviors of residents which will be used in conjunction with the facility staffing audit tool for residents with 1:1 supervision needs. 4. The Administrator and/or his designee will review all in-service and new hire orientation educational material related to resident rights, care plans, 1:1 supervision requirements, resident(s) at risk for falls and restraints at least bi-monthly for a period of (5) months. All reports will be furnished to the quarterly quality assurance and performance improvement meeting for a minimum of two quarterly reporting periods. The facility quality assurance and performance improvement committee will review the reports for	

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F 604	Continued From page 3 falls and require Supervision. This deficient practice was identified for 1 of 5 residents (Resident #2) and was evidenced by the following: According to the Facility Reportable Event (FRE), a New Jersey Department of Health (NJDOH) document used by the healthcare facilities to report incidents dated 8/2/2022, with an event date of 8/1/2022 and a "time of event" of 10:00 p.m., revealed the following: On 8/1/2022, at approximately 9:55 p.m., the Police Department (PD) entered the facility following a 911 call from someone on the 2nd floor. All staff was unaware of the 911 call made, the PD went to the 2nd floor, but no resident was there, so they proceeded to the 6th floor, where they encountered Resident #2 in the dining/day room. The PD questioned the nursing staff about the tables and chairs surrounding the Resident. The charge nurse began moving a table and was ordered to stop. The PD videotaped the Resident with a cell phone and body cameras. The PD transported Resident #2 to the hospital and arrested CNA #2. Further review of the FRE indicated CNA #2 was suspended pending the outcome of the investigation. Further review of the FRE included a written statement by CNA #1, dated 8/2/2022. According to the statement, Resident #2 was more aggressive and wanted to leave the facility. He/she threw his/her [redacted] on the big table and said he/she was done with his/her job, and he/she needed to call his/her boss because it was time for him/her to leave. The CNA also wrote that Resident #2 called Uber 4 times because he/she wanted to go to the Pharmacy to pick up	F 604	compliance and/or nonconformance and determine the need for additional monitoring after a period of five months. The results of the behavior monitoring review will be presented at the quarterly quality assurance and performance committee meeting and follow up action taken as needed.	

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medications. CNA #1 explained, "I had to sit" with Resident #2; the Resident was strong and could push and move the long table away from him/her. There were two chairs on both sides of the Resident. CNA #1 wrote before she sat with Resident #2, other residents were in the room, and they occupied the chairs next to the Resident, and she used one of the chairs to sit next to the Resident when the other residents were brought to bed. She further wrote, "When I left work at 9:45 p.m., there was only one long table in front of (Resident #2), and (the Resident) was able to stand from his/her position and freely move his/her upper extremities."

According to the Admission Record (AR), Resident #2 was admitted to the facility on EX Order 26 § 4b1 with diagnoses which included but were not limited to EX Order 26 § 4b1 [redacted]

According to the Minimum Data Set (MDS), an assessment tool dated 07/25/2022, Resident # 2 had a Brief Interview of Mental Status (BIMS) score of EX Order 26 § 4b1, which indicated the Resident was EX Order 26 § 4b1. The MDS also showed Resident #2 needed extensive assistance with most EX Order 26 § 4b1 [redacted]

A review of the Resident's Care Plan (CP) initiated on 7/20/2022 revealed under "EX Order 26 § 4b1": that Resident #2 "is at EX Order 26 § 4b1 [redacted] The CP also included under "Goal": Resident "will not sustain (a) serious injury through the review date." Also, under "Interventions": included, "Anticipate and meet needs ...Be sure call light is within reach and

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encourage to use it for assistance as needed. Provide prompt response to all requests for assistance ..."

Further review of Resident #2's CP initiated 08/01/2022, included under "Focus": Resident #2 "has (a) EX Order 26 § 4b1 ." The CP showed under "Goal": Resident #2 "will show decreased episodes of noncompliance and disregard to safety precautions." The CP also showed under "Interventions": "... 1:1 intervention as needed, encourage to participate in activities for diversion and maintain close supervision."

A review of Resident #2's Progress Notes (PNs) revealed the following:

On 7/31/2022 at 6:10 a.m., the PN written by the Registered Nurse (RN #1) revealed Resident #2 "on and off standing up EX Order 26 § 4b1 " The PN also revealed that "redirections were provided, but Resident #2 could not follow the directions due to EX Order 26 § 4b1 ." Further review of the PN showed that the EX Order 26 § 4b1 . Closely supervised. Safety is maintained with the bed in the lowest position. Not in distress. With call bell at reach."

On 7/31/2022 at 2:25 p.m., the PN written by the Unit Manager/Licensed Practice Nurse (UM/LPN) revealed Resident #2 was "alert with period of EX Order 26 § 4b1 , maintained good PO (by mouth) intake. Assisted as needed. Non-compliant with EX Order 26 § 4 , keep removing the EX Order 26 § 4 , redirected,

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safety maintained, endorse to next shift." The PN further showed Resident #2 was educated on EX Order 26 § 4b1 [redacted]. Further review of the PN showed the Resident had EX Order 26 § 4b1 [redacted] noted. The EX Order 26 § 4 was "to be worn when out of bed..."

On 7/31/2022 at 3:34 p.m., the PN written by the UM/LPN showed that Resident #2 "noted EX Order 26 § 4b1 [redacted] EX Order 26 § 4b1 [redacted] According to the PN, Resident #2 used his/her cell phone and called the police to inform them that he/she was in the hospital, was being held "hostage," and did not receive "breakfast." Further review of the PN showed Resident #2 was kept safe at all times, with one-on-one Supervision maintained due to the Resident continuously removing his/her EX Order 26 § 4b1 [redacted] "

On 7/31/2022 at 10:26 p.m., the PN written by RN #1 showed Resident #2 was"in bed awake, alert x 2 EX Order 26 § 4b1 and no discomfort noted. EX Order 26 § 4b1 [redacted] in room air. Patient [Resident] kept standing up EX Order 26 § 4b [redacted]; health education provided ... advantages/ disadvantages of EX Order 26 § 4b1, [Resident] verbalized understanding, but he/she is EX Order 26 § 4b1. Closely monitored and frequently redirected..." Closely monitored for safety. With call bell in reach."

On 8/1/2022 at 6:16 a.m., the PN written by the

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RN showed Resident #2 "was in bed awake, alert x 2 with EX Order 26 § 4b1, no discomfort noted. Breathing pattern easy and unlabored on room air. Closely monitored and frequently redirected re (regards to) EX Order 26 § 4b1." All needs attended. Safety was maintained with the bed in the lowest position, with the call bell in reach."

On 8/1/2022 at 2:53 p.m., the PN written by the Licensed Practice Nurse (LPN) revealed Resident #2 EX Order 26 § 4b1 ... non-compliant w/(with) EX Order 26 § 4b1, kept removing his/her EX Order 26 § 4b1, redirected. Educated on EX Order 26 § 4b1

A review of the facility's Assignment Sheet for 8/1/2022, on the 3:00 p.m. - 11:00 p.m. shift revealed that two CNAs were assigned on the 6th floor, CNA #1 and CNA #2, and Resident #2 was assigned to CNA #1.

During an interview on 8/9/2022 at 12:04 p.m., the UM/LPN stated when Resident #2 arrived, " ...he/she had a EX Order 26 § 4b1, was alert and oriented x 3 and always carried EX Order 26 § 4b1 " She continued to say, "I think on 7/31/2022, he/she was becoming more EX Order 26 § 4b1 I think the aide was CNA #1."

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In the same interview, the UM/LPN stated CNA #1 sat in a chair to watch Resident #2 in the activity room while the Resident sat in the [redacted]. The Resident called the police and said he/she was in the hospital; the Resident would not let me touch the phone. I gave the police the room number, and the police came. She stated, "residents are never left alone in the day room. Usually, an aide or recreation is in there."

During a telephone interview on 8/9/2022 at 12:35 p.m., in the Administrator's presence, CNA #2 stated that Resident #2 was not on her assignment. She said that she was not familiar with the Resident and was unaware of when CNA #1 left the floor as she was giving patient care at the time. CNA #2 continued to say the police arrived on the floor and questioned her as to why Resident #2 was in the dining room, and she replied that the Resident was a [redacted], and then the police arrested her. In the same interview, CNA #2 stated Resident #2 had '[redacted]

During a telephone interview on 8/9/2022 at 1:50 p.m., CNA #1 stated that on 8/1/2022, Resident #2 was on her assignment, and she agreed to work until 9:00 p.m. because the facility was short-staffed. CNA #1 stated, "in the evening, around 6:00 p.m.-7:00 p.m., Resident #2 became [redacted] and wanted to go to a Pharmacy to get a package. She explained Resident #2 "tried to go to the elevator, tried to hit me, and kept saying I'm at work and wanted to leave the job site, go home and get a package ..." Resident #2 "kept getting out of the

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chair, throwing his/her EX Order 26 § 4b off, kept standing up, (and) trying to walk ..." to get a taxi to go home to get the package." CNA #1 stated that she would walk with Resident #2 and redirect the Resident to the EX Order 26 § 4b1. She said, "I got help from the Nurse and the aide to put him/her back in the EX Order 26 § 4b1, then he/she would jump up out of the EX Order 26 § 4b1 after a half a minute, he/she was very EX Order 26 § 4b1."

In the same telephone interview, CNA #1 stated, "it was time for me to go home around 9:40 p.m.-9:45 p.m., so the other aide helped me place him/her behind the long table in the dining room, and there was a chair to the left and a chair to the right of the Resident, where I sat until I left. There was nothing in front of the table." She further stated I told CNA #2 I was going and left Resident #2 in the dining room with the chair next to him/her for safety. Resident #2 "was placed there for safety with his/her cell phone in his/her pocket and he/she was able to stand up with the table in front of him/her. " CNA #1 also stated, "I was not aware that putting a resident behind a table was [considered] a EX Order 26 § 4b1." However, the Surveyor reviewed the "Time Card Report" for CNA #1 dated 8/1/2022 and revealed CNA #1 clocked out of work on 8/1/2022 at 8:00 p.m., indicating she did not work until 10:00 p.m. but until 8:00 p.m.

During a telephone interview on 8/9/2022 at 2:51 p.m., Police Officer (PO #1), who responded to Resident #2's 911 call on 8/1/2022, stated the following: "We received a call around 10:00 p.m. from someone saying he/she was being held captive in the dining room; we opened the door to the dining room, located a person in a EX Order 26 § 4b1 against the wall with a large conference room

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table in front of the person over his/her knees, with 3 other tables in front of the large table with 3 chairs to the left and 3 chairs to the right of him/her."

During a second telephone interview on 8/9/2022 at 3:20 p.m., CNA #2 stated CNA #1 "asked me to help her move the table from against the wall because she wanted to leave to go home." CNA #2 continued to say that she did not see CNA #1 put Resident #2 behind the table, and the next time she saw the Resident was when the police came to the dining room.

During an interview on 8/9/2022 at 4:07 p.m., RN #2 stated, "after dinner, Resident #2 [redacted] The Resident was ambulating on the unit without the [redacted] and trying to get on the elevator while CNA #1 was watching him/her." She continued to say the last time she saw Resident #2 was when she administered the Resident his/her 9:00 p.m. medications. The RN said Resident #2 was in his/her [redacted] in the hallway by the Nurse's station when she administered the Resident the medications. She continued to say, "I knew the Resident was there for awhile. Honestly, I don't know how long," The RN stated the next time she saw Resident #2 was when the police approached her to ask her about the Resident. According to the RN, Resident #2 was "in the day room in his/her [redacted] and the [redacted] was against the wall with his/her back against the wall, a long table in front of him/her, 3 chairs on each side of the resident, and 3 small tables, 2 circulars and 1 table in front of the long table." In the same interview, when the Surveyor asked the RN if Resident #2 was able to move the long table, she stated, "it would take a lot of strength to

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move it, and the problem was the 3 tables in front of the long table." RN #2 continued saying, " I think that it was a restraint."

During an interview on 8/9/2022 at 4:42 p.m., in the presence of the Administrator, the Surveyor asked when the tables were in front of Resident #2, and the chairs were placed to the left and right side of the Resident were restraints. The ADON stated, "of course, it was considered a restraint with tables and chairs around the resident because he/she could not walk."

During a second interview on 8/15/2022 at 9:45 a.m., CNA #1 stated she was getting ready to leave to go home on 8/1/2022, so at 9:30 p.m., she and CNA #2 placed Resident #2, who was in his/her EX Order 26 § 4b1 behind the long table in the day room to prevent the Resident from falling.

During an interview on 8/15/2022 at 10:35 a.m. in the presence of the Director of Nursing (DON), the ADON stated when CNA #1 left at 9:45 p.m., Resident #2 should not have been left alone in the day room, and it is not common practice for residents to be placed behind a table. During the same interview at 10:35 a.m., the DON stated, "until the whole investigation was done, staff should not be in the building ...a restraint is considered an allegation of abuse."

During an interview on 8/15/2022 at 12:47 p.m., the Staffing Coordinator (SC), when the Surveyor showed her the "Time Card Report (TCR)" for CNA #1, she stated the clocking out process is done when the person is leaving the building for their shift; staff are paid for the shift they worked, no extras. The SC continued to say that "the time clock is correct." According to the SC, she asked

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CNA #1 to work until 9:00 p.m. on 8/1/2022, and she did not know what happened after that time; "the CNA did not say she couldn't work. I believe she left at 8:00 p.m."

During a second interview on 8/15/2022 at 1:02 p.m., when the Surveyor asked CNA #1 about her TCR showing a clock out time of 8:00 p.m. on 8/1/2022, CNA #1 stated, "I didn't clock out, and I left the floor at 9:30 p.m." However, no documentation was provided at the time of the survey indicating CNA #1 left at 9:30 p.m.

During an interview on 8/18/2022 at 10:35 a.m., the DON stated, "a one to one Supervision was done for his/her behavior episode, I don't know the patient [Resident #2], the CNA should notify the Nurse or aide if Resident is on one on one, closely monitoring means putting a resident in the dining room and an aide is with the Resident."

During a telephone interview on 8/18/2022 at 4:40 p.m., PO #2 stated on 8/1/2022, he responded to a call about a male/female being held against his/her will. The PO explained they located the person on the 6th floor. He observed the lights were off in the cafeteria and the Resident was sitting in the EX Order 26 § 4b1 pushed up against the wall. PO #2 further stated a large table was pushed into Resident #2's stomach holding the Resident in place. He said there were round and square tables around the Resident to secure him/her and 3 chairs to the left and 3 chairs to the right.

On 8/18/2022, the Surveyors did a revisit to verify the Removal Plan was implemented. The facility implemented the Removal Plan, which included removing CNA #1 from the schedule, and

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educating all facility staff on not using furniture as a restraint to prevent residents who are at risk for falls and require Supervision. So, the noncompliance remained on 08/15/2022 as a level D for "no actual harm with the potential for more than minimal harm that is not immediate jeopardy" based on the following: Resident #2 was taken to the hospital for evaluation and is no longer at the facility.

A review of the facility policy titled "Restraints/Siderail-Bed Systems" dated 4/29/2022 revealed the following: Under "Philosophy:" included "This Facility will promote and encourage a restraint free environment for all residents. Our goal is to achieve and maintain the optimum independence and dignity of our residents while providing a safe and secure environment, but also to deliver the highest quality care that promotes quality of life and independence." "Policy:" "To reach this goal, this facility believes that an interdisciplinary approach provides the best assessment of resident needs. Physical restraints will only be utilized after less restrictive alternatives have been attempted and considered a last resort ...At no time will a restraint be utilized for staff convenience or Resident discipline." "Definitions:" ..."Physical restraints are defined as "any manual method or physical or mechanical device, material or equipment attached to or adjacent to the resident's body that the individual cannot easily remove which restricts freedom of movement or normal access to one's body" ...Convenience is defined as "any action taken by the facility to control a resident's behavior or manage a resident's behavior with a lesser amount of effort by the facility and not in the resident's best interests."

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F 604	Continued From page 14 A review of the updated facility policy titled "Resident's Rights", revealed the following: " I. Each Resident shall be entitled to the following rights: ...6. To be free from chemical and physical restraints, unless they are authorized by a physician or an advanced practice nurse for a limited period of time to protect the Resident or others from injury. Under no circumstances shall the Resident be confined in a locked room or restrained for punishment, for the convenience of the nursing home staff ..."	F 604		
F 656 SS=D	N.J.A.C.: 8.39- 4.1 (6) Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		8/22/22

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F 656	Continued From page 15 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Complaint#: NJ156814 Based on interviews, medical record review, and review of other pertinent facility documents on 8/09/2022, 8/15/2022 and 8/18/2022, it was determined that the facility failed to follow care plan interventions for a resident (Resident #2) who had EX Order 26 § 4b1, was at risk for EX Order and requiring EX Order 26 § 4b1 as needed for safety. The facility also failed to follow its policy title, "Comprehensive Care Plan (CCP)." This deficient practice was identified for 1 of 5 care plans reviewed and as evidenced by the	F 656	1. Resident #2 was taken to the hospital for evaluation and is no longer at the facility. 2. All residents have the potential to be affected. All residents at risk for falls and requiring 1:1 supervision as needed have the potential to be affected by this deficient practice. 3. All nursing staff were in-serviced on care plan interventions for residents who had behavioral changes including the need for 1:1 supervision and the Comprehensive Care Plan policy.	

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F 656	Continued From page 16	F 656	4. A weekly audit for 90 days will be conducted by the ADON of all residents with behavioral care plans to assure all care plan interventions including the need for 1:1 supervision are being followed. The results of the audits will be reviewed at the quarterly quality assurance and performance improvement committee meeting and followed up if necessary.	

following:

Review of the Electronic Medical Record (EMR) was as follows:

According to the Admission Record (AR), Resident #2 was admitted to the facility on EX Order 26 § 4b1 with diagnoses which included but were not limited to EX Order 26 § 4b1 [redacted]

A review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 7/25/2022, Resident #2 had a Brief Interview of Mental Status (BIMS) score of EX Ord 7/15, which indicated the resident was EX Order 26 § 4b1. The MDS also showed Resident #2 needed extensive assistance with most Activities of Daily Living (ADLs).

A review of the Resident's Care Plan (CP) initiated on 7/20/2022 revealed under "Focus": that Resident #2 "is at risk for EX Order r/t (related to) EX Order 26 § 4b1." The CP also included under "Goal": Resident "will not sustain (a) serious injury through the review date." Also, under "Interventions": included, "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 for assistance ..."

Further review of Resident #2's CP showed that the CP was updated on 8/01/2022, which showed under "Focus": Resident #2 "has (a) high risk for injury r/t noncompliance to wear EX Order 26 § 4b and disregard to safety." The CP showed under

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"Goal": Resident #2 "will show decreased episodes of noncompliance and disregard to safety precautions." The CP revealed under "Interventions": that Resident #2 required "... 1:1 intervention as needed, encourage to participate in activities for diversion and maintain close supervision."

A review of Resident #2's Progress Notes (PNs) dated 7/21/2022 at 9:56 a.m., written by the Licensed Practical Nurse (LPN), revealed Resident #2 " non-compliant with [EX Order 26 § 4], trying to get OOB (out of bed) without [EX Order 26 § 4] and regard to safety, health teaching reinforced. All needs attended. Contact/droplet isolation maintained. Call bell within reach. Will continue to monitor."

A review of Resident #2's PNs dated 7/22/2022 at 1:51 a.m., revealed Resident #2 "was non-compliant with [EX Order 26 § 4], trying to get OOB(out of bed) without [EX Order 26 § 4] and regard to safety, health teaching reinforce. All needs attended. Contact/droplet isolation maintained. Call bell within reach. Will continue to monitor."

A review of the PNs dated 7/29/2022 at 2:05 p.m., revealed Resident #2 "noted with [EX Order 26 § 4b1] [redacted], looking for his/her family, cars, and bag, stated he/she is a doctor, 1:1 Supervision provided."

A review of PNs dated 7/31/2022 at 3:34 p.m., revealed Resident #2 "kept safe at all times, 1:1 Supervision maintained due to the patient(Resident #2) continuously removing his/her protective [EX Order 26 § 4b] and attempting to stand up without regard to safety. Medication taken with increased redirection, fair appetite noted."

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During an interview on 8/9/2022 at 1:50 p.m., the Certified Nursing Assistant (CNA #1) informed the Surveyor that on 8/1/2022 at around 5:30 p.m., Resident #2 began EX Order 26 § 4b1 , was EX Order 26 § 4b1 with keeping his/her EX Order 26 § 4 on, and sitting in the EX Order 26 § 4b1 . CNA #1 further informed the Surveyor that she was scheduled to be off duty at 9:00 p.m. and asked CNA #2 for assistance in moving a long table in the dining/ recreation room. CNA #1 then placed Resident #2 in the resident's EX Order 26 § 4b1 behind the table and against the wall. Both CNAs then placed the table in front of Resident #2. CNA #1 stated she placed Resident #2 with the long table in front of him/her because the resident was a fall risk and for the resident's safety. According to CNA #1's "Time Card Report," she punched out at 8:00 p.m., leaving Resident #2 alone in the dining/recreation room without an assigned 1:1 Supervision.

During an interview on 8/18/2022 at 2:40 p.m., in the presence of the Director of Nursing (DON), the Assistant Director of Nursing (ADON) stated that she updated Resident #2's CP on 8/1/2022 due to Resident #2's increased aggression and combative behavior on the weekend. The ADON said, "I told the staff to monitor Resident #2 and if his/her aggression increased, to put the resident on EX Order 26 § 4b1 or send him/her to the EX Order 26 § 4b EX Order 26 § 4b1 ".

Review of the "Comprehensive Care Plan" dated 8/1/2022 under "Policy" reveals: "The interdisciplinary team will utilize the Comprehensive Care Plan (CCP) process to address resident strengths, need and or problems as identified on the MDS, on the RAP

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F 656	Continued From page 19 summary profile, as well as other professional assessments. The CCP is developed to provide individualized plans of care that will address the resident's identified needs and assist the resident to achieve her or his highest practicable quality of life." N.JA.C.: 8:39-11.2(e)(2) REF: F604, F835	F 656		
F 835 SS=D	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Complaint#: NJ156814 Based on interviews, a review of the medical records, and other pertinent facility documents on 8/9/2022, 8/15/2022, and 8/18/2022, it was determined that the facility's Administration failed to complete a thorough investigation within 5 days per the facility's policy titled "Abuse Prevention Program" wherein The Administrator who is the APP (Abuse Prevention Program) Coordinator will	F 835	1. Resident #2 was taken to the hospital for evaluation and is no longer at the facility. A thorough investigation of the allegation of abuse was completed on 08/22/22. 2. All residents have the potential to be affected. All residents at risk for falls and requiring 1:1 supervision as needed have the potential to be affected by this deficient practice. 3. The Administrator and ADON were	8/22/22

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F 835	Continued From page 20 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 facility also failed to follow the Administrator's Job Description. This deficient practice was identified for 1 of 5 residents (Resident #2) and was evidenced by the following: According to the Facility Reportable Event (FRE), a New Jersey Department of Health (NJDOH) document used by the healthcare facilities to report incidents dated 8/2/2022, with an event date of 8/1/2022 and a "time of event" of 10:00 p.m., revealed the following: On 8/1/2022, at approximately 9:55 p.m., the Police Department (PD) entered the facility following a 911 call from someone on the 2nd floor. All staff was unaware of the 911 call made, the PD went to the 2nd floor, but no resident was there, so they proceeded to the 6th floor, where they encountered Resident #2 in the dining/day room. The PD questioned the nursing staff about the tables and chairs surrounding the Resident. The charge nurse began moving a table and was ordered to stop. The PD videotaped the Resident with a cell phone and body cameras. The PD transported Resident #2 to the hospital and arrested CNA #2. Further review of the FRE indicated CNA #2 was suspended pending the outcome of the investigation. Further review of the FRE included a written statement by CNA #1, dated 8/2/2022. According to the statement, Resident #2 was more aggressive and wanted to leave the facility. He/she threw his/her [redacted] on the big table and said he/she was done with his/her job, and he/she needed to call his/her boss because it was	F 835	educated on 08/18/22 regarding the investigation and reporting of abuse allegations. The Administrator and DON will conduct a thorough investigation of any allegations of abuse within five days of the incident and report to the Department of Health and Office of the Ombudsman(if applicable). 4. The ADON will maintain a log of all abuse allegations and review weekly for four weeks for the completion of investigations and reporting to assure the Abuse Prevention policy is followed. The log of allegations of abuse and the results of the weekly reviews will be reviewed at the quarterly quality assurance and performance improvement committee meeting and follow up action taken as necessary.	

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time for him/her to leave. The CNA also wrote that Resident #2 called Uber 4 times because he/she wanted to go to the Pharmacy to pick up medications. CNA #1 explained, "I had to sit" with Resident #2; the Resident was strong and could push and move the long table away from him/her. There were two chairs on both sides of the Resident. CNA #1 wrote before she sat with Resident #2, other residents were in the room, and they occupied the chairs next to the Resident, and she used one of the chairs to sit next to the Resident when the other residents were brought to bed. She further wrote, "When I left work at 9:45 p.m., there was only one long table in front of (Resident #2), and (the Resident) was able to stand from his/her position and freely move his/her upper extremities."

Review of the Electronic Medical Records (EMRs) was as follows:

According to the Admission Record (AR), Resident #2 was admitted to the facility on EX Order 26 § 4b1 with diagnoses which included but were not limited to EX Order 26 § 4b1 [redacted]

According to the Minimum Data Set (MDS), an assessment tool dated 07/25/2022, Resident #2 had a Brief Interview of EX Order 26 § 4b1 score of [redacted], which indicated the Resident was NJ Exec. Order 26:4.b.1. The MDS also showed Resident #2 needed extensive assistance with most EX Order 26 § 4b1 [redacted]

A review of Resident #2's Care Plan (CP) initiated on 7/20/2022 revealed under "Focus": Resident

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#2 "is at risk for falls related to unsteady gait." The CP also included under "Goal": Resident "will not sustain a serious injury through the review date." Also, under "Interventions,": included "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 for assistance [...]."

Further review of Resident #2's CP initiated 08/01/2022, included under "Focus": Resident "has a high risk for injury related to noncompliance to wear [redacted] and disregard to safety." The CP showed under "Goal": Resident "will show decreased episodes of noncompliance and disregard to safety precautions." The CP also showed under "Interventions: [...] 1:1 intervention as needed, encourage to participate in activities for diversion and maintain close supervision."

During an interview on 8/9/2022 at 10:10 a.m., the Surveyor asked about the outcome of the investigation and who restrained Resident #2 behind the table. The Administrator stated, "the investigation is ongoing," and he did not know how the tables and chairs "got there" and stated they should not have been "like that."

During an interview on 8/9/2022 at 4:42 p.m., in the presence of the Administrator, the Surveyor asked when the tables were in front of Resident #2, and the chairs were placed to the left and right side of the Resident were restraints. The ADON stated, "of course, it was considered a restraint with tables and chairs around the resident because he/she could not walk."

During an interview on 8/9/2022 at 4:07 p.m., RN #2 stated, "after dinner, Resident #2 was agitated

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and called an Uber from his/her cell phone. The Resident was ambulating on the unit without the EX Order 26 § 4 and trying to get on the elevator while CNA #1 was watching him/her." She continued to say the last time she saw Resident #2 was when she administered the Resident his/her 9:00 p.m. medications. The RN said Resident #2 was in his/her EX Order 26 § 4b1 in the hallway by the Nurse's station when she administered the Resident the medications. She continued to say, "I knew the Resident was there for a while. Honestly, I don't know how long," The RN stated the next time she saw Resident #2 was when the police approached her to ask her about the Resident. According to the RN, Resident #2 was "in the day room in his/her EX Order 26 § 4b1 and the EX Order 26 § 4b1 was against the wall with his/her back against the wall, a long table in front of him/her, 3 chairs on each side of the resident, and 3 small tables, 2 circulars and 1 table in front of the long table." In the same interview, when the Surveyor asked the RN if Resident #2 was able to move the long table, she stated, "it would take a lot of strength to move it, and the problem was the 3 tables in front of the long table." RN #2 continued saying, " I think that it was a restraint."

During an interview on 8/9/2022 at 12:35 p.m., CNA #2 stated she did not have Resident #2 on her assignment on 8/1/2022. She stated that she did not see Resident #2 during the 3:00 p.m. - 11:00 p.m. shift until the Police Officer led her to the day room, and that is when she saw how Resident #2 was EX Order 26 § 4b1 .

During an interview on 8/15/2022 at 10:15 a.m., CNA #1 stated that she wheeled Resident #2 behind the table in the day room, sat next to Resident #2 and stayed longer than 9:00 p.m.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315344	A. BUILDING _____ B. WING _____	C 08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE CASTLE HILL	615 23RD ST UNION CITY, NJ 07087

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because Resident #2 had behaviors and the other CNA would be left alone.

During a second interview on 8/15/2022 at 11:15 a.m., CNA # 1 stated that she worked on 8/2/2022 and, on 8/3/2022, was asked by the Assistant Director of Nursing(ADON) to stay home for an investigation. As per CNA #1, she resumed work from 8/4/2022 through 8/8/2022 and, took her vacation on 8/9/2022, returned to work on 8/15/2022.

During an interview on 8/15/2022 at 1:02 p.m., CNA #1 stated that she did not clock out on 8/1/2022 and stayed at the facility until 9:45 p.m.

A review of the facility's Assignment Sheet for 8/1/2022, on the 3:00 p.m. - 11:00 p.m. shift, revealed that two CNAs were assigned on the 6th floor, CNA #1 and CNA #2. Resident #2 was assigned to CNA #1.

A review of the facility's electronic "Time Card Report" reveals that CNA #1 worked on 8/1/2022, clocked in at 6:56 a.m., and clocked out at 8:00 p.m., a discrepancy compared to CNA #1's statements to the surveyors.

Review of the facility's "Job Descriptions, Position Title: Administrator" under "Position Summary" reveals: "The Administrator is responsible for planning and is accountable for all activities and departments of facility subject to rules and regulations promulgated by government agencies to ensure proper health care services to residents. The Administrator administers, directs, and coordinates all activities of the facility to assure that the highest degree of quality of care is consistently provided to the residents."

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315344	A. BUILDING _____ B. WING _____	C 08/18/2022

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Review of facility policy titled "Abuse Prevention Program" revised on 7/27/2022, included the following: under: "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." The document further reveals under "Definitions: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical, harm, pain, or mental anguish." Under "Passive forms of abuse: [...] 4. Involuntary Seclusion: The separation of a resident from his or her room against his or her will." Under "Investigation" included: Procedure: The Administrator, who is the APP (Abuse Prevention Program) Coordinator, and the DON (Director of Nursing) 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."

Further review of the policy reveals under "Protection, Procedure: [...] Staff members being investigated for possible involvement in abuse will be removed from contact with the resident, such as suspended pending the results of the investigation, as needed." Under "Responding, Procedure: [...] The Administrator 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. [...] The results of the investigation are reported within 5 working days of the incident."

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315344	A. BUILDING _____ B. WING _____	C 08/18/2022

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315344 Y1	A. Building B. Wing Y2	9/22/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE CASTLE HILL	615 23RD ST UNION CITY, NJ 07087

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0604	Correction	ID Prefix F0656	Correction	ID Prefix F0835	Correction
Reg. # 483.10(e)(1), 483.12(a)(2)	Completed	Reg. # 483.21(b)(1)	Completed	Reg. # 483.70	Completed
LSC	08/23/2022	LSC	08/22/2022	LSC	08/22/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
8/18/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO