STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING _____ B. WING _____	C 12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

(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 C #: NJ167461, NJ169331, and NJ169500 Census: 33 Sample Size: 6 THE FACILITY IS NOT IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES, BASED ON THIS COMPLAINT VISIT.	F 000		
F 609 SS=E	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	F 609		1/31/24

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

Electronically Signed | 01/25/2024

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 609	Continued From page 1 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: C #: NJ167461, NJ169331, and NJ169500 Based on interview, medical records (MR) review, and review of pertinent facility documents on 12/7/23, 12/11/23, and 12/12/23, it was determined that the facility failed to report four allegations of resident to resident abuse to the New Jersey Department of Health (NJDOH) and follow their facility policy on "Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Property Prevention" for 4 of 6 sampled residents (Resident #1, Resident #2, Resident 4, and Resident #6) reviewed for incident and accident, investigation and reporting. This deficient practice was evidenced by the following: 1. According to the "Admission Record (AR)," Resident #1 was admitted to the facility with diagnoses which included but were not limited to; EX Order 26.4B1 The Minimum Data Set (MDS), an assessment tool dated EX Order 26.4B1 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) of EX O which indicated the resident's EX Order 26.4B1 EX Order 26.4B1. A Care Plan (CP), initiated on EX Order 26.4B1, reflected	F 609	Tag 0609 1. How the corrective actions will be accomplished for those residents found to be affected by the deficient practice. Residents #1 and #2 were immediately separated from one another. Residents were assessed and NJ Exec. Order 26:4.b.1 noted. AAS-45 was submitted to the DOH and Office of the Ombudsman notifying them of the incident. Care plans for both residents were updated as a result of the incident with interventions to prevent recurrence. Residents #4 and #6 were immediately separated from one another. Residents were assessed after the incidents. AAS 45 was submitted to the DOH and Office of the Ombudsman notifying them of the incident. Care Plans for residents #4 was updated as a result of the incident with interventions to prevent recurrence. Resident #6 has been discharged. 2. The facility identified that all residents have the potential to be affected by the same deficient practice. 3. The measures/systemic changes the	

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F 609	Continued From page 2 that Resident #1 was dependent on staff for meeting EX Order 26.4B1 [redacted]. The CP further reflected that Resident #1 was alert, able to express him/herself, had EX Order 26.4B1 [redacted], and insight, and EX Order 26.4B1 [redacted] According to the AR, Resident #2 was admitted to the facility with diagnoses which included but were not limited to, EX Order 26.4B1 [redacted] The MDS, dated [redacted], revealed Resident #2 had a BIMS of [redacted] which indicated the resident's EX Order 26.4B1 The MDS further indicated that Resident #2 had EX Order 26.4B1 directed towards others. A CP, initiated on [redacted] reflected that Resident #2 drinks EX Order 26.4B1 [redacted] Review of Resident #2's progress notes (PN), dated [redacted] at 11:23 a.m., documented by Licensed Practical Nurse (LPN #1), indicated that Resident #2 was observed EX Order 26.4B1 [redacted] [Resident #2] redirected away from each other. Acting Director of Nursing [ADON] informed. POA [Power of Attorney] contact number 2 informed. Administrator Aware. Resident reminded that touching another resident incapable of or without consent is not allowed in the facility. Resident stated back 'I understand.'"	F 609	facility will put into place to ensure that the deficient practice does not recur: The facility in-serviced all staff on facility policy and procedure for Abuse Prohibition including contacting the police within 24 hours if a crime is suspected and within 2 hours if injury is involved. Abuse may encompass a wide range of behaviors that inflict corporeal injury, including but not limited to kicking, hitting, spitting, scratching, pinching, slapping, shoving, or forcibly pushing a resident's wheelchair, involuntary confinement or seclusion of a resident. Sexual abuse includes harassment, coercion, sexual assault, and the use of language intended to denote sexual connotation. The incident report will start immediately with the nurse in charge and then be given to the DON who will give the information to the Administrator. Each involved resident will be assessed by the nurse if there are any injuries. Statements and witnesses to the event will be added to the file. The staff was re-educated that incidences must be reported to the DOH at 1-800-792-9770, prompt #1 and to the NJ Ombudsman's Office or any State agencies if appropriate. The number for the DOH's office was given to staff. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur: The DON will review the 24hr. daily clinical report if any incidences of abuse	

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F 609	Continued From page 3 During an interview with the surveyors on 12/7/23 at 11:01 a.m. and 12/10/23 at 11:54 a.m., the Activity Director (AD) revealed that on [redacted], during an activity, unable to recall exact time, she witnessed Resident #2 '[redacted] Resident #1. The AC explained that she witnessed Resident #1, and Resident #2 seated next to each other. Resident #2's [redacted] was observed under Resident #1's [redacted] to Resident's #1's [redacted]. The AC immediately called LPN #1 and separated the residents. The AC further explained that she needed to move Resident #1 from Resident #2 because Resident #2's [redacted] was [redacted] Resident #1's [redacted] that [redacted] for Resident #2's [redacted] to be Resident #1's [redacted] The AC continue to explain that Resident #1's [redacted]," and Resident #1 [redacted]." During an interview with the surveyors on 12/7/23 at 12:51 p.m., the Administrator confirmed that she was aware of the incident involving Resident #1 and Resident #2 on [redacted] The facility was unable to provide documented evidence that the abovementioned incident on [redacted] was reported to NJDOH. 2. According to the AR, Resident #4 was admitted to the facility with diagnoses which included but were not limited to: [redacted] A MDS dated [redacted], revealed that Resident	F 609	or behaviors have occurred. The DON will maintain a log of all incidences and confirm that any allegations of abuse or neglect have been reported to the DOH & Office of the Ombudsman. The Administrator will review and audit the incidents logs daily for 4 weeks then weekly for 5 weeks. The log of incidents will be reported monthly to the QAPI meeting by the DON for 6 QAPI meetings to ensure compliance. The administrator will take corrective action as needed.	

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F 609	Continued From page 4 #4 had a BIMS score of [redacted], which indicated her/his EX Order 26.4B1 The MDS further indicated that Resident #4 had [redacted] EX Order 26.4B1 symptoms directed towards others. A review of Resident #4 CP initiated EX Order 26.4B1 and revised on EX Order 26.4B1 reflected that Resident #4 had EX Order 26.4B1 and had diagnosis of EX Order 26.4B1 . According to the AR, Resident #6 was admitted to the facility with diagnoses which included but were not limited to: EX Order 26.4B1 A MDS, dated EX Order 26.4B1, revealed that Resident #6 had a BIMS score [redacted], indicating the resident's cognition was EX Order 26.4B1. The MDS further indicated that Resident #6 had EX Order 26.4B1 symptoms directed towards others. A review of Resident #6 CP initiated EX Order 26.4B1 reflected that Resident # 6 was on EX Order 26.4B1 related to EX Order 26.4B1 management. The CP initiated on EX Order 26.4B and revised on EX Order 26.4B1 reflected that Resident #6 was care planned for EX Order 26.4B1 . In addition, the CP indicated that Resident #6 had history of EX Order 26.4B1 Review of Resident #4's PN dated EX Order 26.4B1 at	F 609		

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F 609	Continued From page 5	F 609		

3:59 p.m., documented by LPN #2, reflected "[Resident #4] was sitting drinking [his/her] coffee. When resident [Resident #6] started trying [redacted] Resident #4], [redacted]. [Resident #4] [redacted] [Resident #6] [redacted]."

LPN #2 was not available for interview during the survey on 12/7/23, 12/11/23, and 12/12/23.

According to a PN for Resident #4 dated [redacted] at 6:49 p.m., documented by LPN #1, "[Resident #4] became [redacted], [redacted] [Resident #6] [redacted] [Resident #6] [redacted] Both residents redirected by staff members."

Review of Resident #6's PN dated [redacted] at 2:48 p.m., documented by LPN #1, reflected "[Resident #6] [redacted] [Resident #4] and attempted [redacted] at [redacted] in the [redacted]. Nursing staff intervened and [redacted]. Resident [redacted]"

During an interview with the surveyors on 12/11/23 at 2:52 p.m., LPN #1 confirmed the incident on [redacted] involving Resident #4 and Resident #6. The LPN stated that she witnessed Resident #4 [redacted] Resident #6's [redacted], and they [redacted] According to LPN #1, the residents were separated, and the staff were alerted to monitor the two residents. LPN #1 further stated that the incident was reported to the former DON on [redacted].

The facility was unable to provide documented

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F 609	Continued From page 6 evidence that the incident on [NJ Exec. Order 26:4.b.1] and [NJ Exec. Order 26:4.b.1] were reported to NJDOH. During an interview with the surveyor on 12/11/23 and 12/12/23, the Administrator stated that the incidents on EX Order 26.4B1 [EX Order 26.4B1] [redacted]. involving Resident #4 and Resident #6 were considered a resident-to-resident [EX Order 26.4B1] and should have been reported to the NJDOH, however, the administrator admitted that the incidents were not reported to NJDOH because she was not aware. The facility policy titled "Resident Abuse Prohibition Policy," dated 2023, reflected "Physical Abuse encompasses a wide range of behaviors that inflict corporal injury, including but not limited to hitting, kicking, spitting, scratching, pinching, slapping, showing, forcibly pushing a resident's wheel chair, involuntary confinement or seclusion or a resident ...Sexual Abuse includes harassment, coercion, sexual assault, and the use of language intended to denote a sexual connotation...The Administrator will address the situation and report to applicable State Agencies if appropriate ..Abuse or neglect may also be reported by anyone by calling the state Ombudsman's office whose number is posted throughout the facility..." The facility policy titled "Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Property Prevention," dated 2023, reflected under "Reporting/Response: 1. Report all alleged violation and al substantiated incidents to the State agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the	F 609		

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F 609	Continued From page 7 investigation ..."	F 609		
F 610 SS=E	NJAC 8:39-9.4(f) Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: C #: NJ167461, NJ169331, and NJ169500 Based on interview, medical records (MR) review, and review of pertinent facility documents on 12/7/23, 12/11/23, and 12/12/23, it was determined that the facility failed to provide documented evidence that four allegations of resident to resident abuse were thoroughly investigated according to their facility's policies on Reporting Accident and Incident and Resident Abuse Prohibition Policy for 4 of 6 sampled residents (Resident #1, Resident #2, Resident 4	F 610	Tag F610 1. How the corrective actions will be accomplished for those residents found to be affected by the deficient practice. A. During an incident on [redacted] the Activity Director witnessed resident #2 and resident #1 sitting together. Resident #2 put EX Order 26.4B1 [redacted] #1's EX Order 26.4B1 [redacted] #1's [redacted]. The residents were immediately separated by staff. Residents #1 and #2 were separated and redirected away from	1/31/24

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F 610	Continued From page 8 and Resident #6) reviewed for incident and accident investigation and reporting. This deficient practice was evidenced by the following: 1. According to the "Admission Record (AR)," Resident #1 was admitted to the facility with diagnoses which included but were not limited to; EX Order 26.4B1 The Minimum Data Set (MDS), an assessment tool dated EX Order 26.4B1, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) of EX which indicated the resident's EX Order 26.4B1 was EX Order 26.4B1. EX Order 26.4B1 According to the AR, Resident #2 was admitted to the facility with diagnoses which included but were not limited to EX Order 26.4B1 EX Order 26.4B1 The MDS, dated NJ Exec. Order 26:4.b.1, revealed Resident #2 had a BIMS of EX C which indicated the resident's EX Order 26.4B1. The MDS further indicated that Resident #2 had EX Order 26.4B1 EX Order 26.4B1.	F 610	each other. The resident #2's POA was notified. The Administrator informed resident #2 that touching another resident who was incapable of or without consent is not allowed in this facility. MD and Family were notified. Resident #4 was drinking coffee when resident #6 approached resident #4. Resident #4 NJ Exec. Order 26:4.b.1 resident #6. Both residents were re-directed by the staff. Staff monitored the two residents. B. The facility identified that all residents have the potential to be affected by the same deficient practice. C. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur. The facility in-serviced all staff on the importance of investigating all alleged violations, which may encompass a wide range of behaviors that inflict corporeal injury, including but not limited to kicking, hitting, spitting, scratching, pinching, slapping, shoving, or forcibly pushing a resident's wheelchair, involuntary confinement or seclusion of a resident. Sexual abuse includes harassment, coercion, sexual assault, and the use of language intended to denote sexual connotation. The investigation report will start with the nurse in charge and then be given to the DON who will give the information to the Administrator. Statements and witnesses to the event will be added to the file. The staff was re-educated that incidences must be	

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F 610	Continued From page 9 A CP, initiated on EX Order 26.4B1, reflected that Resident #2 EX Order 26.4B1 Review of Resident #2's progress notes (PN), dated NJ Exec. Order 26.4B at 11:23 a.m., documented by Licensed Practical Nurse (LPN #1), indicated that Resident #2 was observed EX Order 26.4B1 r resident's EX Order 26 and EX Order 26.4B1 [his/her] EX Order 26.4B1 [Resident #2] EX Order 26.4B1 . Acting Director of Nursing [ADON] informed. POA [Power of Attorney] contact number 2 informed. Administrator Aware. Resident reminded tha EX Order 26.4B1 . Resident stated back EX Order 26.4B1 ." During an interview with the surveyors on EX Order 26.4B1 EX Order 26.4B1 ., the Activity Director (AC) revealed that on NJ Exec. Order 26.4B, during an activity, unable to recall exact time, she witnessed Resident #2 EX Order 26.4B1 " Resident #1. The AC explained that she witnessed Resident #1, and Resident #2 seated next to each other. Resident #2's EX Order 26.4B1 was EX Order 26.4B1 Resident #1's EX Order 26.4B1 to Resident's #1's EX Order 26.4B1. The AC immediately called the LPN #1 and separated the residents. The AC further explained that she needed to move Resident #1 from Resident #2 because Resident #2's EX Order 26.4B1 EX Order 26.4B1 Resident #1's EX Order 26 and that EX Order 26.4B1 EX Order 26.4B1 for Resident #2's EX Order 26.4B1 Resident #1's EX Order 26 The AC continue to explain that Resident #1's EX Order 26.4B1 and Resident #1 EX Order 26.4B1 EX Order 26.4B1 ."	F 610	thoroughly investigated. D. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. The DON will ask according to the 24 hour daily clinical report if any incidences of alleged violation have been thoroughly investigated. The DON will see that all incidences of abuse have been thoroughly investigated. The DON will record a list of incidences and confirm that they have been investigated. The Administrator will review the investigation daily for one week and then weekly for 3 weeks. The list of investigations will be recorded and reported quarterly to the QAPI meeting by the DON.	

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F 610	Continued From page 10 During an interview with the surveyors on 12/7/23 at 1:06 p.m., LPN #1 confirmed the incident on [NJ Exec. Order 26.4] being witnessed by the AC. The LPN stated that the AC called her to intervene an incident. LPN #1 explained that on [EX Order 26.4B1], unable to recall exact time, she witnessed Resident #2's EX Order 26.4B1 Resident #1's EX Order 26.4B1 The LPN revealed that the residents were separated and being monitored to make sure that they were not to be close to each other. LPN #1 stated that the Administrator was made aware of the incident. During an interview with the surveyors on 12/7/23 at 12:51 p.m., the Administrator confirmed that she was aware of the incident involving Resident #1 and Resident #2 on [EX Order 26.4B1]. The Administrator stated that the staff reported that Resident #2's hand was EX Order 26.4B1 orEX Order 26.4B1 ." The Administrator explained "the facility had not done anything because they are friends." According to the Administrator, the incident was not investigated because Resident #1 was [EX Order 26.4B1]" and that EX Order 26.4B1, she/he did not say EX Order 26.4B1.'" to Resident #2. The Administrator admitted that she did not know Resident #1's BIMS score, however, the Administrator stated that Resident #1 was 'EX Order 26.4B1 [she/he] EX Order 26.4B1 [she/he] EX Order 26.4B1, [her/his] [EX Order 26.4B1] EX Order 26.4B1 [she/he] knows what's EX Order 26.4B1 [she/he] [EX Order 26.4B1]." The Administrator stated Resident #2 was EX Order 26.4B1 and she instructed Resident	F 610		

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LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

(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 610	Continued From page 11 #2 to EX Order 26.4B1 Resident #1 EX Order 26.4B1 and that Resident #2's Representative (RR) was made aware. However, the Administrator further stated that Resident #1 was not interviewed/investigated because "EX Order 26.4B EX Order 26.4B1" At 4:45 p.m., the Administrator stated that she will call Resident #1's RR because Resident #1 EX Order 26.4B1 . The facility was unable to provide documented evidence that the incident on EX Order 26.4B1 was thoroughly investigated according to the facility policy. 2. According to the AR, Resident #4 was admitted to the facility with diagnoses which included but were not limited to EX Order 26.4B1 A MDS dated EX Order 26.4B1 revealed that Resident #4 had a BIMS score of EX O which indicated her/his EX Order 26.4B1 . The MDS further indicated that Resident #4 had NJ Exe directed towards others. A review of Resident #4 CP initiated EX Order 26.4B1 and revised on EX Order 26.4B1 reflected that Resident #4 had r and had diagnosis of EX Order 26.4B1 According to the AR, Resident #6 was admitted to the facility with diagnoses which included but were not limited to: EX Order 26.4B1	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING _____ B. WING _____	C 12/12/2023

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LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

(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 610	Continued From page 12 A MDS, dated [redacted], revealed that Resident #6 had a BIMS score [redacted] indicating the resident's [redacted]. The MDS further indicated that Resident #6 had [redacted] directed towards others. A review of Resident #6 CP initiated [redacted] reflected that Resident # 6 was on [redacted] related to [redacted]. The CP initiated on [redacted] and revised on [redacted] reflected that Resident #6 was care planned for [redacted] because he/she had diagnoses of [redacted] In addition, the CP indicated that Resident #6 had history of [redacted]. Review of Resident #4's PN dated [redacted] at [redacted] documented by LPN #2, reflected "Resident was sitting drinking his coffee. When resident [Resident #6] started trying to move [Resident #4], [redacted]. [Resident #4] [redacted] [Resident #6] [redacted]." LPN #2 was not available for interview during the survey on 12/7/23, 12/11/23, and 12/12/23. According to a PN for Resident #4 dated [redacted] at 6:49 p.m., documented by LPN #1, Resident #4 became [redacted] room, grabbed another resident [Resident #6] [redacted] [Resident #6] [redacted] Both residents redirected by staff members."	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING _____ B. WING _____	C 12/12/2023

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F 610	Continued From page 13 Review of Resident #6's PN dated 11/29/23 at 2:48 p.m., documented by LPN #1, reflected "Resident [#6] approached another resident [Resident #4] and attempted EX Order 26.4B1 EX Order 26.4B1 hours EX Order 26.4B1 .] in the EX Order 26.4B1 Nursing staff intervened and prevented physical contact. Resident redirected." During an interview with the surveyors on 12/11/23 at 2:52 p.m., LPN #1 confirmed the incident on NJ Exec. Order 26:4.b.1 at 6:49 p.m. involving Resident #4 and Resident #6. The LPN stated that she witnessed that Resident #4 NJ Exec. Orde [redacted] to each other. According to LPN #1, the residents were separated, and the staff were alerted to monitor the two residents. LPN #1 further stated that the incident was reported to the former DON on NJ Exec. Order 26:4.b.1 The facility was unable to provide documented evidence that the incident on NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 were thoroughly investigated according to the facility policy. During an interview with the surveyor on 12/11/23 and 12/12/23, the Administrator stated that the incidents on NJ Exec. Order 26:4.b.1 at 3:59 p.m. and NJ Exec. Order 26:4.b.1 at 6:49 pm and NJ Exec. Order 26:4 3 at 2:48 p.m. involving Resident #4 and Resident # 6 were considered resident-to-resident EX Order 26.4B1 and should have been thoroughly investigated. The facility policy titled Reporting Accident and Incident, dated 2023, reflected "Procedure: 1. The Incident and Accident Reporting System will include a comprehensive process which will allow	F 610		

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	315467	A. BUILDING _____ B. WING _____	C 12/12/2023

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F 610	Continued From page 14 for: a. Collection of the incident and accident occurrences; b. Investigate incidents and accidents...2. The Incident Report will be completed by the on-duty nurse at the time of the event. 3. The investigation will be initiated by the Charge Nurse as soon as the resident is stabilized....The DON will add statements from witnesses to the file...will provide an environment that is free from accident hazards over which [facility] has control and provides supervision and assistive devise to each resident to prevent avoidable accidents..." The facility policy titled Resident Abuse Prohibition Policy, dated 2023, reflected under "Investigation of alleged Abuse When any situation is recognized as potentially or actually abusive, the first priority of the observer is to immediately remove the resident from possible harm...The Director of Nursing will follow up by promptly investigating every instance of suspected abuse and report findings to the Administrator. In the Director of Nursing's absence, the Administrator will complete the investigation...." NJAC 8:39-4.1 (a) (5)	F 610		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		1/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315467	A. BUILDING _____ B. WING _____	C 12/12/2023

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F 657	Continued From page 15 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: C #: NJ167461, NJ169331, and NJ169500 Based on interview, medical records (MR) review, and review of pertinent facility documents on 12/7/23, 12/11/23, and 12/12/23, it was determined that the facility failed to revise residents care plans (CP) for 4 of 6 sampled residents (Resident #1, Resident #2, Resident #4, and Resident #6) reviewed for CP revision. The deficient practice was evidenced by the following: 1. According to the "Admission Record (AR)," Resident #1 was admitted to the facility with diagnoses which included but were not limited to: EX Order 26.4B1	F 657	Tag F657 1 How the corrective actions will be accomplished for those residents found to be affected by the deficient practice: A. Care plans for residents #1 and #2 were updated on EX Order 26.4B1 by the Social Worker. Care plans for resident #4 was updated on NJ Exec. Order 26.4.b.i by the Social Worker. Resident #6 is no longer in the facility. The Administrator was aware of resident #2 EX Order 26.4B1 EX Order 26.4B1 #1s EX Order 26 The Administrator stated she spoke to resident #2 and instructed EX Order not to	

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	315467	A. BUILDING _____ B. WING _____	C 12/12/2023

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F 657	Continued From page 16 The Minimum Data Set (MDS), an assessment tool dated [redacted], revealed Resident #1 had a Brief Interview for Mental Status (BIMS) of [redacted] which indicated EX Order 26.4B1 [redacted]. The MDS further revealed that Resident #1 had a fall prior to the MDS assessment. A Care Plan (CP), initiated on [redacted], reflected that Resident #1 was NJ Exec. Order 26:4.b.1 [redacted]. The CP, dated [redacted] further reflected Resident #1 was alert and able to express him/herself, had NJ Exec. Order 26:4.b.1 [redacted] throughout the day. The CP initiated on [redacted] and revised on [redacted], indicated the Resident was [redacted] for [redacted] related to [redacted]. Review of the progress notes (PN), dated [redacted] at 5:30 p.m., documented by the former Director of Nursing (FDON), indicated Resident #1 had a [redacted] and acquired a [redacted] on her/his [redacted] head and EX Order 26.4B1. Resident #1 was transferred to the hospital for further [redacted] on [redacted]. Resident #1's CP was not updated to reflect the [redacted] on [redacted] and did not include a new intervention to prevent future [redacted] 2. According to the AR, Resident #2 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted] EX Order 26.4B1 [redacted].	F 657	touch resident #1 because it was not appropriate. The Administrator called resident #2's POA and made him aware of the situation. Resident #1's POA was called and made aware of the situation. Resident #4 was sitting in the day room and [redacted] resident #6 walking by and NJ Exec. Order 26:4.b.1. Both residents were separated and redirected by staff. B. The facility identified that all residents have the potential to be affected by the same deficient practice. C. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: The DON and Social Worker were reeducated by the Administrator that the Care Plan needs to be updated for a resident's change in condition, falls, alterations, weight loss and transfers on the same day or next day as needed. D. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur: The DON/Designee will review that care plans have been completed based on the 24 hour clinical daily report of changes in a resident's condition. The DON, SW, MDS coordinator will update New Admission care conference. These will be done daily and given to the Administrator by the DON for one week, weekly for three weeks. The DON will give report of the updated care plans to the QAPI quarterly for the next 3 QAPI meetings.	

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F 657	Continued From page 17 The MDS, dated [redacted], revealed Resident #2 had a BIMS of [redacted] which indicated the resident's [redacted]t. The MDS further indicated that Resident #2 had no[redacted] directed towards others. A CP, initiated on [redacted] reflected that Resident #2 [redacted] Review of Resident #2's progress notes (PN), dated [redacted] documented by Licensed Practical Nurse (LPN #1), indicated that Resident #2 was observed [redacted] [his/her] [redacted] [Resident #2] redirected away from each other. Acting Director of Nursing [ADON] informed. POA [Power of Attorney] contact number 2 informed. Administrator Aware. Resident reminded that touching another resident incapable of or without consent is not allowed in the facility. Resident stated back 'I understand.'" The CP for Resident #1 and Resident #2's were not updated to reflect the abovementioned incident on [redacted]. Furthermore, the CP did not include new interventions to prevent the recurrence of the incident. 3. According to the AR, Resident #4 was admitted to the facility with diagnoses which included but were not limited to: [redacted] The MDS, dated [redacted], revealed that Resident #4 had a BIMS score of [redacted] which	F 657		

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F 657	Continued From page 18 indicated resident has EX Order 26.4B1 EX Order 26.4B1. A review of Resident #4 CP initiated 0 EX Order 26.4B1 and revised on EX Order 26.4B1 reflected that Resident #4 had EX Order 26.4B1 and had diagnosis of EX Order 26.4B1. The PN dated NJ Exec. Order 26:4.b.1 at 6:49 p.m., LPN # 1 documented, EX Order 26.4B1 in the dayroom, EX Order 26.4B1 and EX Order 26.4B1." Review of Resident #4's PN dated EX Order 26.4B1 EX Order 26.4B1 documented by LPN #2, reflected "[Resident #4] was sitting drinking [his/her] coffee. When resident [Resident #6] started trying EX Order 26.4B1 [Resident #4] EX Order 26.4B1. [Resident #4] EX Order 26.4B1 [Resident #6] EX Order 26.4B1." A review of Resident #4 CP for NJ Exec. Order 26:4.b.1, initiated EX Order 26.4B1 and revised on EX Order 26.4B1 showed the CP was not updated to reflect the incidents on EX Order 26.4B1. Furthermore, the CP did not include new interventions to prevent the recurrence of the abovementioned incident. 4. According to AR, Resident #6 was admitted to the facility with diagnoses which included but were not limited to: EX Order 26.4B1, EX Order 26.4B1 EX Order 26.4B1 A MDS, dated EX Order 26.4B1 revealed that Resident #6 had a BIMS score EX O indicating the resident's EX Order 26.4B1. The MDS further indicated that Resident #6 had EX Order 26.4B1 EX Order 26.4B1 directed towards others.	F 657		

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F 657	Continued From page 19 A review of Resident #6 CP initiated EX Order 26.4B1 reflected that Resident # 6 was on EX Order 26.4B1 related to EX Order 26.4B1. The CP initiated on EX Order 26.4B1 and revised on EX Order 26.4B1 reflected that Resident #6 was care planned for EX Order 26.4B1 because he/she had diagnoses of EX Order 26.4B1, and history of EX Order 26.4B1. In addition, the CP indicated that Resident #6 had history of EX Order 26.4B1, EX Order 26.4B1 The PN dated NJ Exec. Order 26:4.b.1 at 2:48 pm, LPN#1 documented, EX Order 26.4B1 the dayroom ..." A CP for Resident #6 with a focus of EX Order 26.4B and EX Order 26.4B1 initiated EX Order 26.4B1 and revised on EX Order 26.4B1, the CP was not updated to reflect the incident on EX Order 26.4B1.and did not include any interventions to prevent repeat issues of this nature. During an interview with the surveyors on 12/12/2023 at 10:36 am to 1:03 pm, the Administrator stated that the DON and/or the Social Worker were responsible to update the care plan for any resident's changes in condition, incidents, falls, altercations, weight loss, and transfers on the same day or the next day and as needed. During an interview with the surveyors on	F 657		

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F 657	Continued From page 20 12/12/2023 at 12:25 pm, the Acting DON stated she did not update the CP to reflect the aforementioned incidents. A review of the facility's policy titled "Resident Rights-Comprehensive Resident-Centered Care Plans" revised 2023, under Updating Care Plans (1) "care plans are modified between care plan conference, when appropriate, to meet the resident's current needs, problems, and goals." N.J.A.C: 8:39-11.2 (i)	F 657		

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
315467 Y1	A. Building B. Wing Y2	2/29/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE BROOK NURSING AND CONVALESCENT HOME	78 SLIKER ROAD CALIFON, NJ 07830

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0609	Correction	ID Prefix F0610	Correction	ID Prefix F0657	Correction
Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed
LSC	01/31/2024	LSC	01/31/2024	LSC	01/31/2024
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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/12/2023	☐ YES ☐ NO