STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315087	A. BUILDING ______ B. WING ______	C 10/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT KING JAMES	**1040 ROUTE 36 ATLANTIC HIGHLANDS, NJ 07716**

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F 000	INITIAL COMMENTS COMPLAINT#: NJ145485; NJ148596 CENSUS: 99 SAMPLE SIZE: 6 THE FACILITY IS NOT IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #: NJ145485	F 610	1: Resident #2 was transferred to the hospital the same day.	10/28/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
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(X6) DATE: 10/29/2021

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

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F 610	Continued From page 1 Based on interview and review of facility documents on 10/4/21, it was determined that the facility failed to conduct an investigation for a fall in a timely manner that resulted in a [redacted] This deficient practice was identified for 1 of 3 residents reviewed for falls (Resident #2), and was evidenced by the following: The surveyor reviewed the medical record for Resident #2. A review of the Admission Record face sheet (an admission summary) reflected that Resident #2 was admitted to the facility in [redacted] with diagnoses which included, [redacted] and a history of [redacted] According to the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], reflected a Brief Interview for Mental status (BIMS) score of [redacted], which indicated the resident had a [redacted]. According to the MDS in [redacted] Functional Status, the resident had no functional [redacted] for his/her [redacted] The resident required limited assistance of a one-person physical assist for all transfers. A review of the Progress Notes reflected a General Note dated [redacted] at 6:32 AM, that the writer, a Registered Nurse (RN), heard yelling and went to the room to find Resident #2 on the floor. The resident was able to stand without difficulty at that time and was transferred back to	F 610	2: Any resident who sustains a [redacted] at the center has the potential to be affected. 3: A. The facility reinforced the review of 24 - hour documentation during clinical meetings. B. The facility provided reeducation and in serviced on abuse, neglect, exploitation, or misappropriation: reporting and investigation policy and procedure. C. The facility reeducated and in serviced accident and incidents: reporting and investigation policy and procedure. D. The facility reinforced the Ambassador Program which is a program where residents and patients can provide feedback related to the care they are receiving as well as encourage open communication and any needs that arise during their stay. 4. A. The D.O.N./ Designee will review 24 - hour reports and incident reports daily. An audit will conducted weekly x 4 weeks, then twice monthly for two months related to comparison of the notification and initiation of an event that required investigation (e.g. fall). B. The D.O.N./ Designee will present the results of the audits to the Quality Assurance Performance Improvement Committee for review on a monthly basis for three months. The Committee will review and revise the plan if needed.	

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F 610	Continued From page 2	F 610		

bed with no issues. The RN indicated that a full body assessment was done, and no complaints of pain or discomfort were noted. The RN instructed the resident to remain in bed, despite the resident requesting to be in the wheelchair.

A review of an Incident Report dated [redacted] reflected that an investigation was started at 12:00 PM because Resident #2 informed their Licensed Practical Nurse (LPN) that at 7:00 AM, he/she had a fall and were assisted back to bed. The Incident Report reflected that upon assessment of the resident, the LPN observed a [redacted] on the [redacted] of his/he [redacted] [redacted] [redacted], and that the resident now complained of [redacted]. The Physician was made aware and ordered [redacted] and [redacted] [redacted] to start. The investigation included no evidence of a statement from the resident's assigned Certified Nursing Aide (CNA). This Incident Report was initiated five (5) hours after the fall that occurred at 6:32 AM, and there was no evidence that it was initiated by the RN who found the resident on the floor at that time.

A review of the facility's "Accidents and Incidents - Investigating and Reporting" policy dated edited 4/24/19, included that all accidents and incidents involving residents shall be investigated and reported to the Administrator. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. The policy also indicated to include the following information in the "Report of Incident/Accident" form: date and time accident took place; the nature of the injury/illness (e.g.,

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F 610	Continued From page 3	F 610		

fall); circumstances surrounding the accident or incident; where the accident or incident took place; the name of the witnesses and their accounts of the accident or injury; and date and time Physician and family were notified.

On 10/4/21 at 12:29 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated that the RN was an Agency Nurse who was employed at the facility from [redacted] and that the LPN who initiated the Incident Report at 12:00 PM, no longer worked at the facility as well.

On 10/4/21 at 1:02 PM, the surveyor interviewed the LPN/Unit Manager (LPN/UM) who stated that the typical process for Incident Reports was that they get initiated at the time of the incident, and include pertinent statements from the resident's nurse, CNA, and anyone else who may have been a witness to the incident. The LPN/UM stated that on [redacted], the resident's LPN informed her that the resident was [redacted] that he/she stated was from a fall that morning at the change of shift. The LPN/UM stated that as soon we found out around noon, the Assistant Director of Nursing (ADON) assessed the resident, the Physician and family were notified, and the investigation was started. The resident received an [redacted] which indicated that the resident had a [redacted], so the resident was discharged to the hospital for [redacted].

On 10/4/21 at 1:29 AM, the surveyor conducted a phone interview with the ADON who stated that the RN was an Agency Nurse at the time of the incident. The ADON confirmed that despite the RN being an Agency Nurse, she should have

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F 610	Continued From page 4 known to follow the facility protocol regarding initiating timely investigations and notifying the appropriate parties. The ADON stated that when the RN was questioned, the ADON thought that it was communicated that "she forgot" to inform someone of the fall. On 10/4/21 at 2:24 PM, the surveyor interviewed the LNHA and the Director of Nursing (DON) who both acknowledged that the Agency Nurse should have initiated a fall investigation at the time of the fall, and not because the resident had to inform another staff member five hours later. NJAC 8:39-4.1(a)5	F 610		

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S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 15 out of 42 shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a	S 560	1: No residents were identified. 2: Any resident has the potential to be affected. 3: A. The facility has implemented a significant above market rate for nurses and certified nursing assistants. B. The facility conducts jobs fairs with immediate interviews and contingency offers. C. The facility implemented an implemented an expediated on boarding process for new hires. D. The D.O.N./ Designee will review any call outs daily and proactively make every effort to replace staff members. Licensed nurses from the leadership team will assist in covering open shifts as needed. F. The facility reviewed the call out policy and has re-educated staff. G. The facility offers referral and sign on bonuses. 4. A. The D.O.N./ Designee will monitor C.N.A. staffing ratios daily and document weekly a review of the daily staffing x 4 weeks then twice monthly for two months to monitor. The audits will be presented to the administrator. B. The D.O.N./ Designee will present the results of the audits to the Quality Assurance Performance Improvement Committee for review on a monthly basis	10/28/21

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S 560	Continued From page 1 CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 9/5/21 to 9/11/21 and 9/12/21 to 9/18/21, the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift; half of all staff on the evening shift to be CNAs as documented below: 9/5/21 had 6 CNAs for 84 residents on the day shift (Required no more than 8 residents to each CNA). 9/5/21 had 5 CNAs to 12 total staff on the evening shift (Required to have half of total staff to be CNAs). 9/6/21 had 6 CNAs for 84 residents on the day shift. 9/7/21 had 8 CNAs for 84 residents on the day shift. 9/8/21 had 7 CNAs for 84 residents on the day shift. 9/9/21 had 9 CNAs for 84 residents on the day shift. 9/10/21 had CNAs for 84 residents on the day shift. 9/11/21 had 8 CNAs for 84 residents on the day shift. 9/12/21 had 6 CNAs for 84 residents on the day shift. 9/13/21 had 10 CNAs for 89 residents on the day shift. 9/14/21 had 10 CNAs for 89 residents on the day shift. 9/15/21 had 10 CNAs for 89 residents on the day shift. 9/16/21 had 9 CNAs for 88 residents on the day shift. 9/17/21 had 9 CNAs for 88 residents on the day shift.	S 560	for three months. The Committee will review and revise the plan if needed.	

New Jersey Department of Health

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S 560	Continued From page 2 9/18/21 had 7 CNAs for 88 residents on the day shift. NJAC 8:39-5.1(a)	S 560		