STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315044	A. BUILDING _____ B. WING _____	C 06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOHAWK MEADOWS	1 O'BRIEN LANE LAFAYETTE, NJ 07848

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

COMPLAINT #:
NJ160552, NJ164625
NJ164644, NJ164690
NJ164724

CENSUS: 114

SAMPLE SIZE: 6

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.

During the complaint survey conducted on 6/15/23, 6/20/23, and 6/26/23, the Facility Administration was notified of the following Immediate Jeopardy (IJ) situations identified for F580, F600, and F658.

F580 scope and severity (s/s) of J:

The surveyors identified an immediate jeopardy (IJ) situation for F580 (Notification of Changes) which began on 5/30/23 and was removed on 5/31/23. The facility was notified of the IJ on 6/20/23. The facility provided an acceptable removal plan on 6/20/23 and verified on-site on 6/26/23.

The facility failed to communicate the care needs and services to the Primary Care Physician (PCP) and related Practitioners.

On [redacted] NJ Ex Order 26.4 at approximately 3:45 pm, Resident #2 had a NJ Ex Order 26.4(b)(1)). Resident #2's

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

Electronically Signed | 08/14/2023

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

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roommate (Resident #1) came to the nurse's station and reported that "NJ Ex Order 26.4(b)(1) with [Resident #2]." Resident #2 NJ Exec. Order 26:4.b.1 performed by the U.S. FOIA (b) (6)). The U.S. FOIA (b) (6) immediately called the receptionist to call Licensed Practical Nurse (LPN #1) "STAT" [immediately] for immediate assistance because the resident NJ Exec. Order 26:4.b.1. When LPN #1 responded, Resident #2 was NJ Exec. Order 26:4.b.1 of the resident. The resident was NJ Ex Order 26.4(b)(1) his/her bed and "assessed" by LPN #1 as having a NJ Exec. Order 26:4.b.1 as documented by LPN #1 in the progress notes (PN) on NJ Ex Order 26.4 at 6:29 pm. LPN #1 left the building at approximately 3:59 pm without notifying the U.S. FOIA (b) (6).

According to the resident's U.S. FOIA he was first notified of the NJ Ex Order 26.4(for Resident #2 through text message via cellphone on NJ Ex Order 26.4(at 4:22 pm, which 37 minutes after the NJ Ex Order 26.4(b)

This deficient practice created an IJ to Resident #2 when the U.S. FOIA was not immediately notified of the NJ Ex Order 26.4(at approximately 3:45. LPN #1 left the building without notifying the U.S. FOIA (b) (6) and/or the U.S. FOIA (The Resident had a NJ Ex Order 26.4(b)(1) at approximately 4:15 pm, he/she was NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1

F658 s/s of J:

The surveyors identified an IJ situation for F658 (Services Provided Meet Professional Standards)

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F 000	Continued From page 2	F 000		

which began on 5/30/23 and was removed on 5/31/23. The facility was notified of the IJ on 6/20/23. The facility provided an acceptable removal plan on 6/20/23 which was verified on-site on 6/26/23.

On [redacted] at approximately 3:45 pm, Resident #2 had a NJ Ex Order 26.4(b)(1)). Resident #2's roommate (Resident #1) came to the nurse's station and reported that "NJ Ex Order 26.4(b)(1) [redacted] with [Resident #2]." Resident #2 NJ Exec. Order 26:4.b.1 [redacted] by the U.S. FOIA (b) (6) [redacted] The U.S. FOIA (b) (6) [redacted] immediately called the receptionist to call Licensed Practical Nurse (LPN #1) "STAT" [immediately] for immediate assistance because the resident NJ Exec. Order 26:4.b.1. When LPN #1 responded, Resident #2 was NJ Exec. Order 26:4.b.1 [redacted] the resident. The resident was NJ Ex Order 26.4(b)(1) [redacted] his/her bed and "assessed" by LPN #1 as having a NJ Exec. Order 26:4.b.1 [redacted] as documented by LPN #1 in the progress notes (PN) on NJ Ex Order 26.4 [redacted] at 6:29 pm. LPN #1 left the building at approximately 3:59 pm without notifying the U.S. FOIA (b) (6) and/or to a Registered Nurse (RN), instead, LPN #1 instructed the CNA to stay on the unit and wait until RN #1 (assigned to the resident for the 4:00 pm to 12:00 pm shift) arrived. At approximately 4:05 pm, the U.S. FOIA (b) (6) [redacted] checked on Resident #2 after LPN #1 left the building because RN #1 did not arrive. The U.S. FOIA (b) (6) [redacted] found Resident #2 in bed, NJ Exec. Order 26:4.b.1 [redacted]. The U.S. FOIA (b) (6) [redacted] immediately went to another wing (A2) to ask LPN #2 (3:00 pm -11:00 pm U.S. FOIA (b) (6) [redacted] to check Resident #2. At approximately 4:15 pm, Resident #2 had another NJ Ex Order 26.4(b)(1), he/she was NJ Exec. Order 26:4.b.1

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NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1

There was no indication in the PN that an RN was notified to verify of the resident's [redacted] at 3:45 pm. LPN #1 left the building without reporting to an RN, the [redacted] and/or U.S. FOIA (b) (6) of the resident's [redacted] was first notified of the [redacted] for Resident #2 through text message via cellphone on [redacted] at 4:22 pm, which 37 minutes after the first CIC.

This deficient practice created an IJ to Resident #2 when LPN #1 failed to immediately notify Resident #2's [redacted] to an RN on duty or to the resident's [redacted] Resident#2 was not assessment by an RN to verify the [redacted] at approximately 3:45 pm, LPN #1 left the building without notifying an RN. Resident #2 had NJ Ex Order 26.4(b)(1) [redacted] and was NJ Exec. Order 26:4.b.1 and [redacted] on [redacted]

F600 s/s of J

The surveyors identified an IJ situation for F600 (Free from Abuse/Neglect) which began on 5/30/23 and was removed on 5/31/23. The facility was notified of the IJ on 6/20/23. The facility provided an acceptable removal plan on 6/20/23 which was verified on-site on 6/26/23.

The facility failed to monitor and provide oversight in order to assure that the care and services were implemented by direct care staff to meet the resident's needs. Additionally, the facility failed to ensure staff have competence, knowledge, and skills to assess and communicate relevant resident care information to other staff and the [redacted]

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F 000	Continued From page 4	F 000		

On [redacted] at approximately 3:45 pm, Licensed Practical Nurse (LPN #1) who was at the nurse's station did not respond immediately when Resident #2's roommate (Resident #1) reported that "NJ Ex Order 26.4(b)(1)" to Resident #2 in the [redacted] Instead, LPN #1 instructed the U.S. FOIA (b) (6) [redacted] to check on Resident #2. [redacted] went to check and found Resident #2 [redacted] NJ Exec. Order 26:4.b.1 [redacted]. The [redacted] performed [redacted] in which the resident [redacted] The [redacted] immediately called the receptionist to call LPN #1 "STAT" [Immediately] for immediate assistance. According to LPN #1, when she responded, Resident #2 was NJ Exec. Order 26:4.b.1 [redacted] side. Resident #2 was transferred to his/her bed and "assessed" by LPN #1 as having a [redacted] and remained in bed and [redacted] NJ Exec. Order 26:4.b.1 by CNA #2 for [redacted] as documented by LPN #1 in the progress notes (PN) dated [redacted] at 6:29 pm. At approximately 3:59 pm, LPN #1 instructed the [redacted] to stay on the unit and wait until Registered Nurse (RN #1), assigned to the resident for the 4:00 pm to 12:00 pm shift, arrived and LPN #1 left the building. At approximately 4:05 pm, the [redacted] checked on Resident #2 after LPN #1 left the building because RN #1 did not arrive. The [redacted] found Resident #2 in bed, NJ Exec. Order 26:4.b.1 [redacted]. The [redacted] immediately went to another wing (A2) to ask LPN #2 (3:00 pm -11:00 pm [redacted]) to check Resident #2.

There was no indication in the PN that an RN was immediately notified of the resident's [redacted]

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F 000	Continued From page 5 occurred of the first episode at 3:45 pm. LPN #1 left the building without reporting to an RN, the U.S. FOIA (b) (6) or U.S. FOIA (b) (6) of the resident's NJ Ex Or instead, LPN #1 had instructed U.S. FOIA (b) (6) to stay at the nurse's station until the 4:00 pm -12:00 pm RN arrived. According to the U.S. FOIA he was first notified of the NJ Ex Or for Resident #2 through text via cellphone on NJ Ex Order 26.4 at 4:22 pm, which 37 minutes after the NJ Ex Order 26.4(b) This deficient practice created an immediate jeopardy to Resident #2 when the facility failed to ensure resident care policies and procedure were implemented to ensure the necessary provision of care and services for residents and to ensure staff have competence, the knowledge, and skills to assess, notify the physician, and initiate interventions for residents who had a NJ Ex Ord LPN #1 failed to follow her job description which indicated to notify the U.S. FOIA (b) (6) when there is a NJ Ex Or of resident. This deficient practice places all residents who had a NJ Ex Or at risk for serious harm, impairment, or death. The non-compliance for F580, F600, and F658 remained at a level D on 6/1/23 for no actual harm with the potential for more than minimal harm that is not IJ.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-	F 580		7/28/23

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F 580	Continued From page 6	F 580		

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various

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F 580	Continued From page 7 locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: REF: F600IJ Complaint #: NJ00164724 Based on interviews and record review, as well as the review of pertinent facility documents on 6/15/23, 6/20/23, and 6/26/23, it was determined that the facility failed to communicate the care needs and services to the Physician and related Practitioners of a change in the Resident's [redacted] in accordance with the current standards of practice for a Resident who had a [redacted] for 1 of 3 residents (Resident #2) reviewed for [redacted]. On [redacted] at approximately 3:45 p.m., the Licensed Practical Nurse (LPN #1), who was at the nurse's station, did not respond immediately when Resident #2's roommate (Resident #1) reported that "[redacted]" to Resident #2 in the [redacted] Instead, LPN #1 instructed the [redacted] to check on Resident #2. [redacted] went to check and found Resident #2 sitting in a [redacted]. The [redacted], to which the resident [redacted] The [redacted] immediately called the receptionist to call LPN #1 "STAT" [Immediately] for immediate assistance. When LPN #1 responded, Resident #2 was [redacted] esident #2 was [redacted] his/her bed and "assessed" by LPN	F 580	F580 - Notification of Changes Element One □ Corrective Actions 1. LPN #1 was suspended on [redacted] and [redacted]. 2. LPN #1 was temporarily removed from patient care and extensively educated on June 20, 21, and 22, 2023 on immediately notifying the primary care physician (PCP) and a Registered Nurse of significant change in resident condition, as well as on the scope of practice, specifically, that assessment must be done by a professional registered nurse. 3. LPN #1 was also educated that should she leave the building after the noted change in resident condition, she must notify Nursing Supervisor and RN if the Nursing Supervisor is not an RN before leaving the building. 4. On June 26, 2023, LPN #1 completed an LPN Competency Skills evaluation including resident evaluation and knowledge of scope of practice. 5. In addition, LPN #1 was monitored by the Director of Nursing (DON) / designee	

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F 580	Continued From page 8 #1 as having a NJ Exec. Order 26:4.b.1 as documented by LPN #1 in the progress notes (PN) dated NJ Ex Order 26.4 at 6:29 p.m. Resident #2 remained in bed and closely monitored by a Certified Nursing Assistance (CNA #2) for safety. At approximately 3:59 p.m., LPN #1 instructed the U.S. FOIA (b) (6) to stay on the unit and wait until Registered Nurse (RN #1) assigned to the resident for the 4:00 p.m. to 12:00 p.m. shift arrived. LPN #1 left the building without notifying the resident's U.S. FOIA (b) (6) of the first resident's NJ Exec. Order 26 NJ Ex Order 26.4(b)(1). At approximately 4:10 p.m., the U.S. FOIA (b) (6) checked on Resident #2 after LPN #1 left the building because RN #1 did not arrive. The U.S. FOIA (b) (6) found Resident #2 in bed, NJ Exec. Order 26:4.b.1 The U.S. FOIA (b) (6) immediately reported to the 3:00 p.m. to 11:00 p.m. shift Supervisor (LPN #2). Resident #2 had a NJ Ex Order 26.4(b)(1). He/she was NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 The facility's failure to immediately address Resident #2's NJ Exec. Order 26:4.b.1 NJ Ex O and notify the resident's U.S. FOIA of the changes posed a likelihood of serious harm to the health and wellbeing of Resident #2 and potentially all other residents assigned to LPN #1 in an Immediate Jeopardy (IJ) situation. The IJ was identified and reported to the facility on 6/20/23 at 7:14 p.m. The IJ began on 5/30/23 and continued until 5/31/23. The facility provided an acceptable removal plan on 6/20/23. On 6/26/2023, the Surveyor returned to the facility to ensure the Removal Plan was implemented. The facility implemented the Removal Plan, which included educating staff. The non-compliance remained on 6/01/23 for no actual harm with the	F 580	for 30 days throughout her shift, starting June 26, 2023 through July 28, 2023, and continuing. Element Two - Identification of at-Risk Areas All residents have the potential to be affected by the same deficient practice. Element Three □ Systemic Change 1. The following policies were reviewed and updated: (a) Change of Condition Policy and (b) Emergency Care. 2. Nursing staff education/re-education was initiated on June 20, 2023, and ongoing on the following policies and procedures: (a) Change of Conditions Policy □ to immediately notify regarding change in resident condition the following persons: i. The primary care physician (PCP) and related practitioners (or if unable to contact PCP, the Medical Director), ii. Nursing Supervisor, and iii. RN on duty (if the Nursing Supervisor is not an RN) □ if there is no RN on duty, the APN as well as the DON -- to initiate interventions for residents who had a change in condition; and -- should nurse leave the building after the noted change in resident condition, they must notify Nursing Supervisor and RN if the Nursing Supervisor is not an RN before leaving the building;	

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F 580	Continued From page 9 potential for more than minimal harm that is not an IJ. A review of cellphone text messages (CTM) provided to the Surveyor by the U.S. FOIA on 6/15/23 at 2:55 p.m. reflected that on NJ Ex Order 26.4, the following text was received from LPN #1, at 4:22 p.m. "[Resident #2] NJ Exec. Order 26:4.b.1 FYI [for your information]," at 5:01 p.m., the U.S. FOIA responded and asked the LPN "Anymore?" At 5:15 p.m., the LPN responded, "Yes, NJ Exec. Order 26:4.b.1]." The Surveyor conducted a telephone interview with the U.S. FOIA on 6/15/23 at 2:44 p.m.; the U.S. FOIA stated that he was first notified of the NJ Exec. Order 26 NJ Ex Or through text message on NJ Ex Order 26.4 at 4:22 p.m. The U.S. FOIA stated that the facility is expected to call him immediately if a resident has a NJ Ex Ord The U.S. FOIA explained that timing is very important and that 'NJ Ex Order 26.4(b)(1)." The facility's policy titled "CHANGE OF CONDITION," dated 12/2020, indicated under "POLICY: All staff members shall communicate any information about resident status change to appropriate licensed personnel immediately upon observation. DEFINITIONS...Acute: a.) Sudden Onset b.) A marked change...Uncharacteristic: Any unusual a typical symptom that is not of the ordinary for a resident. PROCEDURE...6. Notification of physician, time, and date (month, day, and year) are to be documented in the nurse's notes. The licensed nurse must speak directly to the physician: you may not leave a message with the answering service or receptionist. The physician must call back..." NJAC 8:39-13.1 (d)	F 580	(b) Assessment Policy □ an assessment is made by an RN to verify the change in condition subject of notification; and (c) Emergency Care. 3. The U.S. FOIA was educated about the responsibilities of her job position as well the actions to be taken as outlined in the Change of Conditions Policy. 4. RN and LPN Competency Skills forms were evaluated and updated, and RN and LPN competency evaluations were started immediately and are ongoing. 5. Weekly results of LPN and RN audits for 30 days were tracked and trended at weekly QAPI meetings for four weeks. Element Four □ Quality Assurance The DON or designee will audit and monitor once a week for two months LPN and RN compliance with change in condition notification and intervention requirements to ensure that the PCP is immediately notified of a resident□s change in condition, that the Nursing Supervisor and RN are likewise immediately notified of the change in condition -- if there is no RN on duty, the APN as well as the DON -- and that no unit nurse leaves the building without first notifying the Nursing Supervisor and RN as well as the PCP when a resident on the unit has had a change in condition. Data obtained will be reported at the	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 10 NJAC 8:39-27.1 (a) NJAC 8:39- 5.1 (a)	F 580	monthly QAPI meeting. Completion Date: July 28, 2023	
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Complaint #: NJ00164724 Based on interviews, review of medical records (MRs), and other pertinent facility documents on 6/15/23, 6/20/23, and 6/26/23, it was determined that the facility failed to provide services necessary to prevent [redacted] of a resident (Resident #2) after [redacted], follow the facility's policies titled "CHANGE OF CONDITION" and "Abuse Prevention and Prohibition Program," and the "LICENSED PRACTICAL NURSE" job description. On [redacted] at approximately 3:45	F 600	F600 - Free from Abuse/Neglect Element One □ Corrective Actions 1. LPN #1 was suspended on [redacted] and [redacted]. 2. LPN #1 was temporarily removed from patient care and extensively educated on June 20, 21, and 22, 2023 on the scope of practice, specifically, that assessment must be done by a professional registered	7/28/23

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	315044	A. BUILDING _____ B. WING _____	C 06/26/2023

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p.m., Resident #2's roommate (Resident #1) went to the Nurse's station and reported to the Nurse that "NJ Ex Order 26.4(b)(1) with [Resident #2]." The Nurse in charge (Licensed Practical Nurse - LPN #1) instructed the U.S. FOIA (b) (6) to check Resident #2 in the Solarium. The U.S. FOIA (b) (6) found Resident #2 sitting NJ Exec. Order 26:4.b.1 performed by U.S. FOIA (b) (6). The U.S. FOIA (b) (6) immediately called the U.S. FOIA (b) (6) to call LPN #1 "STAT" [Immediately] for immediate assistance because the resident NJ Exec. Order 26:4.b.1. When LPN #1 responded, she observed Resident #2 was NJ Exec. Order 26:4.b.1. Resident #2 was then transferred to bed by the U.S. FOIA (b) (6) CNA #2, and CNA #3 and "assessed" by LPN #1, who identified the Resident as having a NJ Exec. Order 26:4.b.1 Resident #2 remained in bed, and LPN #1 instructed the U.S. FOIA (b) (6) to notify a nurse and/or the U.S. FOIA (b) (6)) "in case NJ Ex Order 26.4(b)(1) to [Resident #2]." LPN #1 also assigned CNA #2 to remain outside the Resident's room to ensure that Resident #2 did not get out of bed. LPN #1 then left the building without reporting to a Registered Nurse (RN), the U.S. FOIA (b) (6), and/or the U.S. FO of the Resident's NJ Exec. Order 26 NJ Ex Ord In addition, LPN #1 instructed the U.S. FOIA (b) (6) to stay at the Nurse's station until the 4:00 p.m. - 12:00 a.m. nurse arrived. At Approximately 4:10 p.m., Resident #2 had another NJ Exec. Order 26:4.b.1 / NJ Ex Ord he/she was NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1

The facility's failure to immediately address Resident #2's NJ Exec. Order 26:4.b.1 / NJ Ex O and notify the nurse, as well as on immediately notifying a Registered Nurse and the primary care physician of any significant changes in resident condition to immediately address the change in resident condition.

3. LPN #1 was educated on her job description which included notifying the RN / Nursing Supervisor when there is a change in condition of resident.

4. LPN #1 was educated that she should have asked an RN, instead of a CNA, to monitor the change of condition.

5. LPN #1 was educated that she should not leave the building after noting a change in condition of a patient without first notifying the PCP and reporting to the Nursing Supervisor and RN if the Nursing Supervisor is not RN.

6. On June 26, 2023, LPN #1 completed an LPN competency Skills evaluation including resident evaluation and knowledge of scope of practice including assessment to be done by an RN at minimum.

7. In addition, LPN #1 was monitored by the Director of Nursing (DON) / designee for 30 days throughout her shift, starting June 26, 2023 through July 28, 2023, and continuing.

8. Residents were reeducated through a special residents meeting on resident rights and how to report abuse and neglect.

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appropriate staff of the changes posed a likelihood of serious harm to the health and well-being of Resident #2 and potentially all other residents assigned to LPN #1 in an Immediate Jeopardy (IJ) situation.

The IJ was identified and reported to the facility on 6/20/23 at 7:14 p.m. The IJ began on 5/30/23 and continued until 5/31/23. The facility provided an acceptable removal plan on 6/20/23. On 6/26/2023, the Surveyor returned to the facility to ensure the Removal Plan was implemented. The facility implemented the Removal Plan, which included educating staff. The non-compliance remained on 6/01/23 for no actual harm with the potential for more than minimal harm that is not an IJ.

This deficient practice was identified for 1 of 3 residents (Resident #2) and was evidenced by the following:

According to the facility "ADMISSION RECORD" (AR), Resident #2 was admitted on NJ Exec. Order 26:4 and discharged on NJ Exec. Order 26:4 with a diagnosis that included but was not limited to NJ Exec. Order 26:4.b.1

The Minimum Data Set (MDS), an assessment tool, dated NJ Ex Order 26:4(revealed a Brief Interview of Mental Status (BIMS) of NJ Exec, which indicated the Resident's NJ Exec. Order 26:4.b.1 and the Resident needed NJ Exec. Order 26:4.b.1 with Activity of Daily Living. The MDS indicated that Resident #2 had NJ Exec. Order 26:4.b.1.

A review of the Care Plan (CP), initiated on NJ Ex Order 26:4, included Resident #2 was at NJ Exec. Order 26:4.b.1 due to NJ Exec. Order 26:4.b.1. The intervention included but was not limited to NJ Exec. Order 26:4.b.1

Element Two - Identification of at-Risk Areas

All residents have the potential to be affected by the same deficient practice.

Element Three □ Systemic Change

1. The following policies were reviewed and updated: (a) Change of Condition Policy - that if the LPN needs to leave the building, they must notify the RN before leaving the building, and to ask an RN to monitor resident□s change in condition, and (b) Emergency Care.

2. Nursing staff education/re-education was initiated on June 20, 2023, and are ongoing on the following policies and procedures to prevent neglect of a resident after change of condition: a) Change of Conditions Policy □ to immediately address a change in condition, to notify the first change in condition to Nursing Supervisor and RN on duty if the Nursing Supervisor is not an RN, and the resident□s PCP; to not leave the building without notifying Nursing Supervisor and an RN if the Nursing Supervisor is not an RN; and to ask an RN to monitor resident□s change in condition; (b) Assessment Policy □ that an assessment shall be made by an RN to verify the first change in condition; and (c) Emergency Care.

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F 600	Continued From page 13 NJ Exec. Order 26:4.b.1 . A review of the Progress Note (PN) documented by LPN #1, dated NJ Ex Order 26.4 at 6:29 p.m., revealed Resident #2 had NJ Exec. Order 26:4.b.1 at approximately 3:45 p.m. According to the PN, Resident #2 was at the NJ Ex Order 26.4(b) in her/his wheelchair and NJ Exec. Order 26:4.b.1 The PN indicated that the Resident was NJ Ex Order 26.4(b)(1) to his/her bed, NJ Ex Order 2 at the Nurse to NJ Ex Order 26.4(b)(1) and to NJ Ex Order 26.4(b)(1) . The PN indicated Resident's VS were NJ Ex Order) NJ Exec. Order 26 , NJ Ex Order 26.4(b)(1)) NJ Ex NJ Ex Order), NJ Ex Order 26.4(b)(1) NJ Exec NJ Ex Orde temperature (T) NJ Exec. Or Fahrenheit (F), and NJ Ex Order 26.4) was NJ Exec. Or . The PN further indicated that Resident #2 had NJ Exec. Order 26:4.b.1 and needed to be kept in bed NJ Exec. Order 26:4.b.1 The PN indicated that the resident's U.S. FOIA (b) (6)) was made aware of NJ Exec. Order 26:4.b.1 . At approximately 4:15 p.m., the Resident had NJ Exec. Order 26:4.b.1 The PN revealed VS were NJ Ex NJ Exec. Order 26 , NJ Ex NJ Exec NJ Ex Orde NJ NJ Exec NJ Ex Orde NJ Ex Order 26.4 NJ Exec. Or NJ Ex Order 26.4(b) NJ Exec. Order 26:4 was placed on the Resident, and transport was arranged to the NJ Exec. Order 26:4.1 while the Resident was being NJ Exec. Order 26 by staff. Resident #2 was transported to NJ Exec. Order 26:4.b.1 at 5:00 p.m. The PN indicated that the U.S. FOIA and residents' family members were notified. Further review of the PN showed no documented evidence that an RN and/or the U.S. FO was notified of the Resident's first NJ Exec. Order 26:4.b.1 NJ Ex Or at 3:45 p.m.	F 600	3. The DON was educated about the responsibilities of her job position as well the actions to be taken as outlined in the Change of Conditions Policy. 4. RN and LPN Competency Skills forms were evaluated and updated, and RN and LPN competency evaluations were started immediately and are ongoing. 5. Weekly results of LPN and RN audits for 30 days were tracked and trended at weekly QAPI meetings for four weeks. Element Four □ Quality Assurance The DON or designee will audit and monitor once a week for two months LPN and RN compliance with change in condition notification, monitoring, and intervention requirements to monitor and provide oversight to assure that the care and services were implemented by direct care staff to meet the resident□s needs, and to ensure staff have competence, the knowledge, and skills to assess and communicate relevant resident care information to other staff and the physician. Data obtained will be reported at the monthly QAPI meeting. Completion Date: July 28, 2023	

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A review of the cellphone text messages (CTM) provided to the Surveyor by the U.S. FOIA on 6/15/23 at 2:55 p.m. reflected that on NJ Ex Order 26.4(, the following text was received from LPN #1, at 4:22 p.m. "[Resident #2] had NJ Exec. Order 26:4.b.1 FYI [for your information]," at 5:01 p.m., the U.S. FOIA responded and asked the LPN "Anymore?" At 5:15 p.m., the LPN responded, "Yes, NJ Exec. Order 26:4.b.1]."

The Surveyor conducted a telephone interview with the U.S. FOIA on 6/15/23 at 2:44 p.m.; the U.S. FOIA stated that he was first notified of NJ Exec. Order 26:4.b.1 /NJ Ex Or through text message on NJ Ex Order 26.4(at 4:22 p.m. The U.S. FOIA stated that the facility is expected to call him immediately if a resident has a NJ Ex Ord The U.S. FOIA explained that timing is very important and that "NJ Ex Order 26.4(b)(1)

Review of the Transportation Company run sheet (TCRS) report, dated NJ Ex Order 26.4 at 4:28 p.m., the TCRS received a call from the facility and was dispatched for NJ Exec. Order 26:4.b.1 The TCRS revealed the chief complaint was: NJ Exec. Order 26:4

A second TCRS report, dated NJ Ex Order 26.4 at 4:29 p.m., revealed the TRCRS received a call at 4:29 p.m. and was dispatched for NJ Exec. Order 26:4.b.1. The report further showed, "PT [patient] is reported to NJ Exec. Order 26:4.b.1 as per staff at the facility. PT is noted to have NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1. PT is assessed and treated in NJ Exec. Order 26:4.b.1 ..."

A review of Resident #2's NJ Exec. Order 26:4.b.1 dated NJ Ex Order 26.4 at 5:40 p.m. indicated that Resident #2 presented to the NJ Exec. Order 26:4 in NJ Exec. Order

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minutes, or having more than NJ Exec. Order 26:4.b.1 minutes period, without returning NJ Exec. Order 26:4.b.1 and was seen immediately on presentation, NJ Exec. Order 26:4.b.1

A review of the "EMPLOYEE WARNING REPORT" (EWR), dated NJ Ex Order 26.4, written by the former U.S. FOIA (b) (6)), indicated that LPN #1 had a violation of misconduct and failed to perform her duty. The EWR further revealed the following: "On NJ Ex Order 26.4 at 4:00 p.m., the U.S. FOIA (b) (6) was notified by [Resident #1] that [Resident #2] NJ Ex Order 26.4(b)(1), the nurse [LPN #1] knew about it, and someone needed to check on her/him stat." The U.S. FOIA wrote on the EWR that she did not see anyone at the Nurse's station, and a CNA was sitting in a chair outside Resident #2's room. The CNA stated, "She was watching the patient, who was NJ Exec. Order 26:4.b.1 [LPN #1] was paged, and another CNA [QACNA] notified management that [LPN #1] had 'stepped out of the building to do something for NJ Ex Order 26.4 and would be right back' but asked her [CNA] to 'sit at the nurse station to wait for [RN #1]' which was the incoming Nurse. [LPN #1] did not notify nursing management that she was leaving the building at any time. There was no nursing coverage on the unit." The EWR further indicated that Resident #2 needed an NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 The EWR indicated, "[LPN #1] reported that [Resident #2] had a NJ Exec. Order 26:4 at about 3:55 pm, and she left the

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building at exactly 4:00 pm...[LPN #1] further stated that she meant to call the U.S. FOIA (b) (6)] to notify that she needed to leave the building but doesn't 'know what happened'. As a Licensed Practical Nurse at [facility], it is your duty to ensure that you make an effort to provide safe patient care to all patients and especially upon NJ Ex Order 26.4(b)(1). During this incident you showed failure to perform the duties of your job classification by knowingly leaving the facility after one of your assigned patients had a NJ Ex Order 26.4(b)(1) and failure to notify your supervisor or management. Failure to provide safe patient care/conditions will result in disciplinary action up to and including termination. 2 DAY SUSPENSION to take place at this time." The EWR was signed by the former DON #1 on 5/31/23, and LPN #1 refused to sign the EWR.

A review of LPN #1's statement, dated 6/5/23, revealed that on NJ Ex Order 26.4 at approximately 3:45 p.m., she was called by the U.S. FOIA (b) (6) in the NJ Ex Order 26.4(b) because Resident #2 was NJ Exec. Order 26:4.b.1 Resident #2 was NJ Ex Order 26.4(b)(1) to bed by 3 CNAs (U.S. FOIA (b) (6) CNA #2, and CNA #3). LPN #1 further indicated that "immediately following the NJ Ex Order 26.4(the patient [Resident #2] became NJ Exec. Order 26:4.b.1 self...I explained to [him/her that he/she] would need to stay in bed for the rest of the night and [he/she] should try to get some rest...At about 3:57 [p.m.]. I returned to the patient's room to check on [the Resident] again and observed [him/her] in bed with [his/her] eyes open...I returned to the desk, looked at my watch, and noted it was 3:59 [pm]. I picked up the desk phone to page a supervisor to inform them I'd be stepping out of the building when [U.S. FOIA (b) (6)

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walked into my view. Distracted by U.S. FOIA (b) (6) I put the phone down and said to U.S. FOIA (b) (6) 'I need to step out. Would you sit here at the desk for a minute or two because [RN #1] should be here any second?' U.S. FOIA (b) (6) agreed and sat at the Nurse's station. On my way out of the building, I stopped in the lobby where I saw [LPN #2], a U.S. FOIA (b) (6), in the short A2 hallway...and I said to her, 'I am stepping out for a brief time. Do you need anything[?].' She said ok. I left the building and was back by 4:17 [pm] /4:18 [pm]. When I returned...they were sending [Resident #2] to NJ Exec. Order 26:4.b.1 I then went to check on the patient, who appeared to be NJ Exec. Order 26 . The EMTs eventually were on the unit, followed by the paramedics. They transferred [Resident #2] out at approximately 5 p.m. [5:00 p.m.]..."

The statement further revealed that on NJ Ex Order 26.4 , at 2:15 p.m., DON #1 told LPN #1, " ...'you are here today because you left the building yesterday without telling anyone, left a patien NJ E , and now [he/she] is NJ Exec. Order 26:4.b.1 LPN #1 responded " ...that was not the truth, that the patient was NJ Exec. Order 26:4.b.1, the patient was, in fact, NJ Exec. Order 26:4.b.1 self. I also reminded her that I did NOT leave the building without telling 'anyone' and that I informed U.S. FOIA (b) (6) and was sure she was at the Nurse's station awaiting [RN #1's] arrival, which should have been within literally one or two minutes. I attempted to remind her about seeing [LPN #2] in the hallway, but she [DON #1] kept interrupting and would not give me much of an opportunity to speak. I also mentioned the patient has a NJ Exec. Order 26:4.b.1 along with multiple other NJ Exec. Order 26:4.b.1, and I had seen on

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Epic the patient was NJ Exec. Order 26:4.b.1 ..." LPN 1# explained in the statement, "It is not uncommon practice to ask aid to sit at the desk while a nurse steps out. I also informed [LPN #2], the nursing supervisor, that I was stepping out...I can say with full certainty that there was absolutely NO DELAY in the care the patient received. In fact, when the patient [resident] was found to be having a NJ Exec. Order 26:4.b.1, there was an aide sitting right outside the patient's [resident's] room watching [Resident #2]. I left the building at 3:59 p.m. with U.S. FOIA (b) (6) sitting at the desk and the patient NJ Exec. Or There were [approximately] 6 other nurses in the building..."

Review of the investigation report (IR), conducted by the U.S. FOIA (b) (6) dated 6/6/23. The IR's conclusion was "the nurse [LPN #1] had informed another nurse/nurse supervisor before stepping out of the building, that [LPN #1] put measures in place to keep watch of [Resident #2] by assigning an aide by the resident and instructing the aid to notify a nurse/nursing supervisor in case something happens to [Resident #2]."

The IR did not indicate that LPN #1 informed LPN #2 and/or an RN of the Resident's NJ Ex Order 26.4(before leaving the building.

A review of the U.S. FOIA (b) (6) statement, dated 6/5/2023, indicated, "Around 3:35 p.m. I found [Resident #2] NJ Exec. Order 26:4.b.1 in the NJ Ex Order 26.4(b)(I called [LPN #1] to come and check [Resident #2]. We put the Resident back to bed with the help of 3-11 [3:00 p.m. to 11:00 p.m.] aids...[LPN #1] checked [Resident #2] vitals, and [Resident #2] was talking at that time. [LPN #1] said vitals were NJ Exec. Orde that's when we left the room. [CNA #2 and

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CNA #3] stay [stayed] with [Resident #2]...An aide stay [stayed] by the room. At that time, I went to the desk, and [LPN #1] asked me to stay and wait for [RN #1], which was around 4 p.m. [4:00 p.m.]..."

During an interview on 6/15/23 at 10:00 a.m., Resident #1 stated that on [NJ Ex Order 26.4] at approximately 3:38 p.m. (unsure exact time), he/she found Resident #2 in the [NJ Ex Order 26.4(b)(] NJ Exec. Order 26:4.b.1 Resident #1 further stated that he/she ran (with the rollator) to the Nurse's station and asked for help. According to Resident #1, QACNA and LPN #1 were at the Nurse's station, and Resident #1 notified them that Resident #2 was NJ Exec. Order 26:4.b.1 Then, Resident #2 was [NJ Ex Order 26.4(b)(1)] to bed. Resident #1 further stated that a few minutes later (unable to recall the time), he/she saw Resident #2's NJ Exec. Order 26:4.b.1 and immediately [NJ Ex Order 26.4(b)(1)]. Resident #1 further stated that he/she did not find staff at the Nurse's station; he/she went to the front to look for staff and found the former DON #1 in the dining room lobby and told her, "[Resident #2] is [NJ Exec. Order 26] According to Resident #1, the DON immediately went to see Resident #2.

During an interview with [U.S. FOIA (b) (6)] on 6/20/23 at 12:22 p.m. The [U.S. FOIA (b) (6)] stated that she was at the Nurse's station with LPN #1 (who was on the phone) on [NJ Ex Order 26.4] at approximately 3:30 p.m. to 3:40 p.m., Resident #1 came to the Nurse's station and reported that Resident #2 was [NJ Exec. Order] The QACNA further stated that LPN #1 gestured to check Resident #2 in the [NJ Ex Order 26.4(b)(U.S. FOIA (b) (6)] found Resident #2 sitting in a NJ Exec. Order 26:4.b.1 . Resident #2

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	315044	A. BUILDING _____ B. WING _____	C 06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOHAWK MEADOWS	1 O'BRIEN LANE LAFAYETTE, NJ 07848

(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 600		F 600		

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NJ Exec. Order 26:4.b.1 performed by U.S. FOIA (b) (6) The U.S. FOIA (b) (6) immediately called the U.S. FOIA (b) (6) to call LPN #1 "STAT" [immediately] for immediate assistance because the Resident NJ Exec. Order 26:4.b.1 When LPN #1 responded, Resident #2 was NJ Exec. Order 26:4.b.1. A few seconds later, Resident #2 started NJ Exec. Order 26:4.b.1 According to the U.S. FOIA (b) (6) resident was transferred to his/her bed, and the LPN took the Resident's V/S. The U.S. FOIA (b) (6) stated that according to the LPN, VS was NJ Exec. Order 26:4.b.1 and there was NJ Exec. Order 26:4.b.1 The U.S. FOIA (b) (6) left, and 2 CNAs stayed; the U.S. FOIA (b) (6) returned to the Nurse's station to continue her duty. The U.S. FOIA (b) (6) stated that LPN #1 checked on Resident #2 twice and said the NJ Exec. Order 26:4.b.1. A few minutes later, LPN #1 instructed U.S. FOIA (b) (6) to stay on the unit and wait until RN #1 arrived. LPN #1 then left the building. The U.S. FOIA (b) (6) checked on Resident #2 after LPN #1 left, while RN #1 did not arrive yet. The U.S. FOIA (b) (6) found Resident #2 "in bed, NJ Exec. Order 26:4.b.1 but NJ Exec. Order 26:4.b.1." The U.S. FOIA (b) (6) immediately went to another wing (A2) to ask LPN #2 (3:00 p.m. -11:00 p.m. Nursing Supervisor) to check Resident #2. LPN #2 responded to the emergency along with a few licensed nurses.

During an interview on 6/20/23 at 10:34 a.m. LPN #1 stated that on NJ Ex Order 26.4(b) she was at the Nurse's station with the U.S. FOIA (b) (6) when Resident #1 came to the Nurse's station. LPN #1 heard Resident #1 say, 'NJ Ex Order 26.4(b)(1) with [Resident #2] in the NJ Ex Order 26.4(b)(1) While on the phone with the pharmacy, LPN #1 instructed the U.S. FOIA (b) (6) to check on Resident #2. According to LPN #1, after a few seconds, she followed the U.S. FOIA (b) (6) to the NJ Ex Order 26.4(b)(NJ Ex Order 26.4(b) LPN #1 found Resident #2 in the sitting NJ Exec. Order 26:4.b.1

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F 600		F 600		

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NJ Exec. Order 26:4.b.1 and Resident #2 looked NJ Exec. Order 26:4.b.1 The LPN further stated that the Resident was transferred to his/her bed with 3 CNAs (U.S. FOIA (b) (6) CNA #2, and CNA #3). LPN #1 took Resident's VS. While performing VS, Resident #2 was NJ Ex Order 26.4(b)(1). The LPN further stated that she explained to the Resident that she/he had NJ Exec. Order 26:4.b.1 to the LPN, "I thought NJ Exec. Order 26:4.b.1 that had NJ Exec. Order 26 I am not a doctor; I can't diagnose." The LPN further stated that when Resident #2 was being NJ Ex Order 26.4(b)(1) bed, Resident #2 was NJ Exec. Order 26:4.b.1 when called. LPN #1 stated a few minutes later. She instructed the U.S. FOIA (b) (6) to stay at the Nurse's station until RN #1 (Nurse from 4:00 p.m. to 12:00 p.m.) arrived. LPN #1 then left the unit, and on the way out, she saw the Nursing Supervisor (LPN #2), who told her, "I have to step out for a minute. Do you need anything?" LPN #2 responded, "Fine," and left the building. LPN #1 confirmed that she did not endorse or report the Resident's NJ Ex O to the Nursing Supervisor or any facility staff because, according to LPN #1, "the patient was NJ Exec. Orde me, NJ Exec. Order 26:4.b.1 to me, [Resident #2] went back immediately NJ Exec. Order 26:4.b.1. When I left, I told U.S. FOIA (b) (6) and [LPN #2] that I'm leaving." LPN #1 stated that she notified the U.S. FOIA via text message. However, LPN #1 could not verify that the U.S. FOIA was notified of the NJ Ex Order 26.4(at approximately 3:45 p.m. LPN #1 confirmed that an LPN should report to an RN or the Resident's U.S. FOIA to verify the assessment for any NJ Ex Ord

During an interview with the current U.S. FOIA (b) (6) #2) and the U.S. FOIA (b) (6) on

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F 600	Continued From page 22 6/20/23 at 11:47 a.m., the [U.S. FOIA (b) (6)] stated that the standard of practice for [NJ Ex Ord] was for the LPN to evaluate the Resident's [NJ Ex Ord] and LPN then reported to the RN to determine the [NJ Ex Ord]. The [U.S. FOIA (b) (6)] further stated that LPNs were not allowed to assess; the RN needed to verify and cosign the LPN's assessment. They both agreed that the facility's protocol for [NJ Ex Ord] was for the LPN to report to an RN. They further agreed that it was not their practice to leave a patient when there is [NJ Ex Ord] without reporting to the U.S. FOIA (b) (6). In addition, they also stated that the LPN should have asked another licensed nurse to monitor the [NJ Ex Ord] instead of a CNA. Review of the Licensed Practical Nurse job description, dated 4/2021, included under "PRIMARY FUNCTIONS...7. Notes changes in condition of residents...Notifies Supervisor of findings..." The facility's policy titled "CHANGE OF CONDITION," dated 12/2020, indicated under "POLICY: All staff members shall communicate any information about Resident status change to appropriate licensed personnel immediately upon observation. DEFINITIONS...Acute: a.) Sudden Onset b.) A marked change...Uncharacteristic: Any unusual a typical symptom that is not of the ordinary for a resident. PROCEDURE: 1. The Resident's change of condition shall be reported immediately to the nursing supervisor...6. Notification of Physician, time, and date (month, day, and year) are to be documented in the Nurse's notes. The licensed Nurse must speak directly to the Physician: you may not leave a message with the answering service or Receptionist. The Physician must call back...8. Serious conditions call for nursing assessment	F 600		

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F 600	Continued From page 23 skills and expertise to move the Resident to acute care surroundings, then the Resident shall be transferred to an acute care hospital, emergency transport service. This decision shall be made by the nursing supervisor in the situation that the patient's condition is so acute that time does not permit waiting for the Physician's response. 9. Director of Nursing and Administrator are to be immediately notified of a serious change of condition...12. Any persistent or recurrent condition change shall be placed on the patient's care plan with appropriate approaches to care until the problem is resolved..." The facility's policy titled "Abuse Prevention and Prohibition Program," dated 1/26/2022 is indicated under "Policy I. Each Resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, and misappropriation of property. The facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property..." NJAC 8:39-13.1 (a) NJAC 8:39-27.1 (a)	F 600		
F 658 SS=J	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: COMPLAINT#: NJ00164724 REF: F600IJ	F 658	F658 - Services Provided Meet Professional Standards	7/28/23

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F 658	Continued From page 24 Based on interviews, review of medical records (MRs), and other pertinent facility documents on 6/15/23, 6/20/23, and 6/26/23, it was determined that the facility failed to follow the professional standards of nursing practice to a.) notify the U.S. FOIA (b) (6)), b.) the policy titled, "CHANGE OF CONDITION," and c.) the "LICENSED PRACTICAL NURSE" (LPN) job description. On NJ Ex Order 26.4 at approximately 3:45 p.m., the LPN left a resident (Resident #2) unattended and in the care of Certified Nursing Assistants (CNA) during NJ Exec. Order 26:4.b.1 NJ Ex Order 26.4(b)(1) . Resident #2's roommate (Resident #1) went to the Nurse's station and reported to the Nurse that "NJ Ex Order 26.4(b)(1) with [Resident #2]." The Nurse in charge (LPN #1) instructed the U.S. FOIA (b) (6) to check Resident #2 in the NJ Ex Order 26.4(b)(1) The U.S. FOIA (b) (6) found Resident #2 sitting NJ Exec. Order 26:4.b.1 performed by U.S. FOIA (b) (6) The U.S. FOIA (b) (6) immediately called the U.S. FOIA (b) (6) to call LPN #1 "STAT [Immediately]" for immediate assistance because the Resident was NJ Exec. Order 26:4.b.1 . When LPN #1 responded, she observed Resident #2 was NJ Exec. Order 26:4.b.1 . Resident #2 was then transferred to the bed by the U.S. FOIA (b) (6) CNA #2, and CNA #3 and "assessed" by LPN #1, who identified the Resident as having NJ Exec. Order 26:4.b Resident #2 remained in bed, and LPN #1 instructed the U.S. FOIA (b) (6) to notify a nurse and or the U.S. FOIA (b) (6)) "in case something happens to [Resident #2]." LPN #1 also assigned CNA #2 to remain outside the Resident's room to ensure that Resident #2 did not get out of bed.	F 658	Element One □ Corrective Actions 1. LPN #1 was suspended on NJ Ex Order 26.4 and NJ Ex Order 26.4(b)(1) . 2. LPN #1 was temporarily removed from patient care and extensively educated on June 20, 21, and 22, 2023 on immediately notifying a Registered Nurse and the primary care physician of any significant changes in resident condition. LPN #1 was likewise educated on the scope of practice, specifically, that assessment must be done by a professional registered nurse. 3. LPN #1 was also educated that should she leave the building after the noted change in resident condition, she must notify Nursing Supervisor and RN if the Nursing Supervisor is not an RN before leaving the building. 4. On June 26, 2023, LPN #1 completed an LPN competency skills evaluation including resident evaluation and knowledge of scope of practice. 5. In addition, LPN #1 was monitored by the Director of Nursing (DON)/ designee for 30 days throughout her shift, starting June 26, 2023 through July 28, 2023, and continuing. Element Two - Identification of at-Risk Areas	

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F 658	Continued From page 25 LPN #1 then left the building without reporting to a Registered Nurse (RN), the U.S. FOIA (b) (6)), and/or the U.S. Fo of the Resident's NJ Exec. Order 26 NJ Ex Ord In addition, LPN #1 instructed the U.S. FOIA (b) (6) to stay at the Nurse's station until the 4:00 p.m. - 12:00 a.m. nurse arrived. At Approximately 4:10 p.m., Resident #2 had another NJ Exec. Order 26:4.b.1 / NJ Ex Ord he/she was NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 The facility's failure to immediately address Resident #2's NJ Exec. Order 26:4.b.1 / NJ Ex O and notify the appropriate staff of the NJ Ex O posed a likelihood of serious harm to the health and wellbeing of Resident #2 and potentially all other residents assigned to LPN #1 in an Immediate Jeopardy (IJ) situation. The IJ was identified and reported to the facility on 6/20/23 at 7:14 p.m. The IJ began on 5/30/23 and continued until 5/31/23. The facility provided an acceptable removal plan on 6/20/23. On 6/26/2023, the Surveyor returned to the facility to ensure the Removal Plan was implemented. The facility implemented the Removal Plan, which included educating staff. The non-compliance remained on 6/01/23 for no actual harm with the potential for more than minimal harm that is not an IJ. This deficient practice was identified for 1 of 3 residents (Resident #2) and was evidenced by the following: Reference: New Jersey Board of Nursing Law 45:11-23, revised on 8/14/2020. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered	F 658	All residents have the potential to be affected by the same deficient practice. Element Three □ Systemic Change 1. The following policies were reviewed and updated: (a) Change of Condition Policy and (b) Emergency Care. 2. Nursing staff education/re-education was initiated on June 20, 2023, and ongoing on the following policies and procedures: (a) Change of Conditions Policy □ to immediately notify regarding change in resident condition the following persons: i.Nursing Supervisor; ii. RN on duty (if the Nursing Supervisor is not an RN) □ if there is no RN on duty, the APN as well as the DON; and iii. The primary care physician and related practitioners (or if unable to contact PCP, the Medical Director) -- to initiate interventions for residents who had a change in condition; and -- should nurse leave the building after the noted change in resident condition, they must notify Nursing Supervisor and RN if the Nursing Supervisor is not an RN before leaving the building; (b) Assessment Policy □ an assessment is made by an RN to verify the change in condition subject of notification; and (c) Emergency Care. 3. The DON was educated about the	

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professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized Physician or dentist...The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program. Through health teaching, health counseling, and provision of supportive and restorative care under the direction of a registered nurse or licensed or otherwise legally authorized Physician or dentist."

The Surveyor conducted a telephone interview with the U.S. FOIA on 6/15/23 at 2:44 p.m.; the U.S. FOIA stated that he was first notified of NJ Exec. Order 26:4.b.1 / NJ Ex O through text message on NJ Ex Order 26.4(at 4:22 p.m. The U.S. FOIA stated that the facility is expected to call him immediately if a resident has a NJ Ex Ord The U.S. FOIA explained that timing is very important and that "NJ Ex Order 26.4(b)(1)."

During an interview on 6/20/23 at 10:34 a.m. LPN #1 stated that on NJ Ex Order 26.4, she was at the Nurse's station with the U.S. FOIA (b) (6) when Resident #1 came to the Nurse's station. LPN #1 heard Resident #1 say, "S NJ Ex Order 26.4(b)(1) with [Resident #2] in the NJ Ex Order 26.4(b)(1) While on the phone with the pharmacy, LPN #1 instructed the U.S. FOIA (b) (6) to check on Resident #2. According to LPN #1, after a few seconds, she followed the U.S. FOIA (b) (6) to the NJ Ex Order 26.4(b)(NJ Ex Order 26.4(b) LPN #1 found Resident #2 in the sitting NJ Exec. Order 26:4.b.1

responsibilities of her job position as well the actions to be taken as outlined in the Change of Conditions Policy.

4. RN and LPN Competency Skills forms were evaluated and updated, and RN and LPN competency evaluations were started immediately and are ongoing.

5. Weekly results of LPN and RN audits for 30 days were tracked and trended at weekly QAPI meetings for four weeks.

Element Four □ Quality Assurance

The DON or designee will audit and monitor once a week for two months LPN and RN compliance with change in condition notification requirements to ensure that LPNs immediately notify an RN on duty and resident□s PCP regarding a resident□s change in condition, and that an assessment is made by an RN to verify the change in condition subject of notification. Data obtained will be reported at the monthly QAPI meeting.

Completion Date: July 28, 2023

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NJ Exec. Order 26:4.b.1 and Resident #2 looked NJ Exec. Order 26:4.b.1 The LPN further stated that the Resident was transferred to his/her bed with 3 CNAs (U.S. FOIA (b) (6) CNA #2, and CNA #3). LPN #1 took Resident's VS. While performing VS, Resident #2 was NJ Ex Order 26.4(b)(1). The LPN further stated that she explained to the Resident that she/he had NJ Exec. Order 26:4.b.1 According to the LPN, "I thought she/had a NJ Exec. Order 26:4.b.1 I'm not a doctor; I can't diagnose." The LPN further stated that when Resident #2 was being transferred to bed, Resident #2 was NJ Exec. Order 26:4.b and did NJ Exec. Order 26:4.b.1 when called. LPN #1 stated a few minutes later. She instructed the U.S. FOIA (b) (6) to stay at the Nurse's station until RN #1 (Nurse from 4:00 p.m. to 12:00 p.m.) arrived. LPN #1 then left the unit, and on the way out, she saw the NS (LPN #2) and told her, "I have to step out for a minute. Do you need anything?" LPN #2 responded, "Fine," and left the building. LPN #1 confirmed that she did not endorse or report the Resident's NJ Exec. Order 26:4.b.1 NJ Ex Or to the U.S. FOIA (b) (6) or any facility staff because, according to LPN #1, "the patient was NJ Exec. Orc me, NJ Exec. Order 26:4 and NJ Exec. Order 26:4.b.1 to me, [Resident #2] went back immediately to NJ Exec. Order 26:4 When I left, I told U.S. FOIA (b) (6) and [LPN #2] that I'm leaving." LPN #1 stated that she notified the U.S. FOIA via text message. However, LPN #1 could not verify that the U.S. FOIA was notified of the NJ Exec. Order 26:4.b.1 NJ Ex Or at approximately 3:45 p.m. LPN #1 confirmed that an LPN should report to an RN or the Resident's U.S. FOIA to verify the assessment for any NJ Ex Ord

During an interview with the current U.S. FOIA (b) (6) #2) and the U.S. FOIA (b) (6) on 6/20/23 at 11:47 a.m., the U.S. FOIA stated that the standard of

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F 658	Continued From page 28	F 658		

practice for [NJ Ex Ord] was for the LPN to evaluate the Resident's [NJ Ex Ord] and the LPN then reported to the RN to determine the [NJ Ex Ord]. The [U.S. FOIA] further stated that LPNs were not allowed to assess; the RN needed to verify and cosign the LPN's assessment. They both agreed that the facility's protocol for [NJ Ex Ord] was for the LPN to report to an RN. They further agreed that it was not their practice to leave a patient when there is a [NJ Ex Ord] without reporting to the [U.S. FOI]. In addition, they also stated that the LPN should have asked another licensed nurse to monitor the [NJ Ex Ord] instead of a CNA.

The facility's policy titled "CHANGE OF CONDITION," dated 12/2020, indicated under "POLICY: All staff members shall communicate any information about Resident status change to appropriate licensed personnel immediately upon observation. DEFINITIONS...Acute: a.) Sudden Onset b.) A marked change...Uncharacteristic: Any unusual a typical symptom that is not of the ordinary for a resident. PROCEDURE: 1. The Resident's change of condition shall be reported immediately to the nursing supervisor...6. Notification of Physician, time, and date (month, day, and year) are to be documented in the Nurse's notes. The licensed Nurse must speak directly to the Physician: you may not leave a message with the answering service or Receptionist. The Physician must call back...8. Serious conditions call for nursing assessment skills and expertise to move the Resident to acute care surroundings, then the Resident shall be transferred to an acute care hospital, emergency transport service. This decision shall be made by the nursing supervisor in the situation that the patient's condition is so acute that time does not permit waiting for the Physician's response. 9.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315044	A. BUILDING _____ B. WING _____	C 06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOHAWK MEADOWS	1 O'BRIEN LANE LAFAYETTE, NJ 07848

(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 658	Continued From page 29 Director of Nursing and Administrator are to be immediately notified of a serious change of condition...12. Any persistent or recurrent condition change shall be placed on the patient's care plan with appropriate approaches to care until the problem is resolved..." NJAC 8:39-13.1 (a) NJAC 8:39-27.1 (a)	F 658		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		6/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315044	A. BUILDING _____ B. WING _____	C 06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOHAWK MEADOWS	1 O'BRIEN LANE LAFAYETTE, NJ 07848

(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 761	Continued From page 30 by: Based on observation, interview, and review of medical records and other pertinent facility documentation on 6/15/23, 6/20/23, and 6/27/23, it was determined that the facility failed to follow professional standards of clinical practice for a). the administration of medications and b.) following a physician's orders, and c). adhering to the facility's policy for using the Medication Administration Record for 1 of 2 residents (Resident #1) reviewed for medication administration. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." On 6/15/23 at 9:36 a.m., during the Resident's interview, the Surveyor observed 2 medicine cups filled with medications were found on Resident #1's breakfast table. According to the admission record, Resident #1 was admitted on [redacted] with diagnoses that included but was not limited to [redacted]	F 761	F761 - Labeling/Storage of Drugs and Biologicals Element One – Corrective Actions LPN #3 was immediately educated to not leave the medications at the bedside, that if a resident is sleeping, the Nurse should try to wake up the resident or if unable to wake the resident, the Nurse should not have left the medications at the bedside and instead, should have taken the medications with her and returned later, that she should not have signed the Medication Administration Record (MAR) because the Resident did not take the medications. Element Two - Identification of at-Risk Areas All residents have the potential to be affected by the same deficient practice. Element Three – Systemic Change Nurse staff were re-educated that drugs and biologicals must be stored in locked compartments under proper temperature controls, that medications shall not be left at the bedside per facility policy on medication administration, and that the Medication Administration Record must not be signed unless the medication was in fact administered.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315044	A. BUILDING _____ B. WING _____	C 06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOHAWK MEADOWS	1 O'BRIEN LANE LAFAYETTE, NJ 07848

(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 761	Continued From page 31 The Minimum Data Set (MDS), an assessment tool, dated [NJ Ex Order 2], revealed a BIMS of [NJ Exec] which indicated the Resident's [NJ Exec. Order 26:4.b.1] and [NJ Exec. Order 26:4.b.1] during care with Activity of Daily Living. A Care Plan (CP), initiated on [NJ Ex Order 26] included that the Resident was [NJ Exec. Order 26:4.b.1] due to a diagnosis of [NJ Exec. Order 26:4.b.1]. The intervention included but was not limited to Administering medication as ordered. The "PHYSICIAN'S ORDER" (PO) for [NJ Ex Order 26] reflected the following Physician's orders: On [NJ Ex Order 26.4], [NJ Exec. Order 26:4.b.1] scheduled to be given at 6:00 a.m., [NJ Exec. Order 26:4.b.1] scheduled to be given at 9:00 a.m. and 5:00 p.m., [NJ Exec. Order 26:4.b.1], to be given at 9:00 a.m., [NJ Exec. Order 26:4.b.1] t 9:00 a.m. On [NJ Ex Order 26.4(b], [NJ Exec. Order 26:4.b.1] every morning for [NJ Exec. Order 26:4.b.1], to be given at 9:00 a.m. On [NJ Ex Order 26.4(b], [NJ Exec. Order 26:4.b.1] and [NJ Exec. Order 26:4.b.1] mg, give [NJ Exec. Order 26:4.b.1] for [NJ Exec. Order 26], to be given at 9:00 a.m. On [NJ Ex Order 26.4], [NJ Exec. Order 26:4.b.1], give [NJ Exec. Order 26:4] by mouth daily for [NJ Exec. Order 26:4.b.1] at 9:00 a.m. On [NJ Ex Order 26.4(b], [NJ Exec. Order 26:4.b.1], give [NJ Exec. Order 26:4] by mouth [NJ Exec. Order 26:4.b.1] for the [NJ Exec. Order 26:4.b.1] at 10:00	F 761	Element Four – Quality Assurance The DON or designee will monitor once a week for two months Nurse staff to ensure professional standards of clinical practice for the administration of medications, physician's orders, and policy for using the Medication Administration Record are adhered to. Data obtained will be reported at the monthly QAPI meeting. Completion Date: June 27, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315044	A. BUILDING _____ B. WING _____	C 06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOHAWK MEADOWS	1 O'BRIEN LANE LAFAYETTE, NJ 07848

(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 761		F 761		

Continued From page 32

a.m. and 5:00 p.m.

The "Routine Medication" (RM) for the month of [redacted] confirmed the aforementioned physician orders. The RM further indicated that the aforementioned medications were signed by LPN #3, indicating that the medications were administered to Resident #1 on [redacted] according to the schedule.

During an interview on 6/15/23 at 9:40 a.m., LPN #3 stated that when she attempted to administer the medications scheduled to be given at 9:00 a.m., Resident #1 was sleeping. The LPN further stated that she left the medications on the Resident's breakfast table because she was running late. According to LPN #3, she should have taken the medications with her and returned later; she added that she should not have signed the MAR because the Resident did not take the medications.

During an interview on 6/15/23 at 4:52 p.m., the [redacted] stated that nurses were not to leave any medications in the Resident's room. The [redacted] added that if a resident is sleeping, the Nurse should try to wake up the Resident or return to reapproach later.

A review of LPN #3's competency dated 5/18/23 indicated that LPN was able to administer medication according to facility procedure.

The facility's policy titled "Medication - Administration," dated 1/20/22, indicated "To provide practice standards for safe administration of medications for residents in the facility...VIII. Medications will not be left at the bedside..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315044	A. BUILDING _____ B. WING _____	C 06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOHAWK MEADOWS	**1 O'BRIEN LANE LAFAYETTE, NJ 07848**

(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 761	Continued From page 33 NJAC 8:39-29.4 (h)	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061902	A. BUILDING: _____ B. WING _____	C 06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOHAWK MEADOWS	1 O'BRIEN LANE LAFAYETTE, NJ 07848

(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) COMPLETE DATE
S 000	Initial Comments COMPLAINT #: NJ160552, NJ164625 NJ164644, NJ164690 NJ164724 CENSUS: 114 SAMPLE SIZE: 6 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long-Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
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: COMPLAINT #: NJ160552, NJ164625 NJ164644, NJ164690 NJ164724 Based on interviews, and review of pertinent facility documentation, it was determined that the	S 560	S560 Mandatory Access to Care – Minimum Direct Care Staff-to-Resident Ratios Element One – Corrective Actions 1. The certified nurse aides (CNA)	6/27/23

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

Electronically Signed | 08/14/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061902	A. BUILDING: _____ B. WING _____	C 06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOHAWK MEADOWS	1 O'BRIEN LANE LAFAYETTE, NJ 07848

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S 560	Continued From page 1 facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This deficient practice was evidence by the following. shifts reviewed. 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 CNA and perform CNA duties. A review of the "Nurse Staffing Report" completed by the facility for the weeks of 5/28/23 and 6/4/23, revealed the staffing to resident ratios did not meet the minimum requirement. The facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows:	S 560	staffing issue has been and is being addressed by placing ads online – indeed.com and apploi.com. 2. For the past six months, the facility has hired eight (8) CNAs, the most recent hire date being May 15, 2023. 3. This summer, some CNAs went on vacation / leave of absence – the most recent date of CNA return from vacation being August 1, 2023. Element Two - Identification of at-Risk Areas All residents have the potential to be affected by the same deficient practice. Element Three – Systemic Change 1. Staff re-education was initiated and is ongoing to ensure that the staffing reports are provided daily to the Administrator and Director of Nursing (DON), specifying the number of CNAs and professional nurses on each shift. Staffing will be according to the acuities of residents in-house, and facility will continue to staff according to State mandatory regulations. 2. The facility continues to offer overtime, sign-on bonuses, and referral bonuses to attract new employees and to maintain at least minimum staffing levels. Element Four – Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061902	A. BUILDING: _____ B. WING _____	C 06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOHAWK MEADOWS	1 O'BRIEN LANE LAFAYETTE, NJ 07848

(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) COMPLETE DATE
S 560	Continued From page 2 -05/28/23 had 13 CNAs for 114 residents on the day shift, required 14 CNAs. -06/02/23 had 12 CNAs for 113 residents on the day shift, required 14 CNAs. -06/03/23 had 13 CNAs for 113 residents on the day shift, required 14 CNAs. -06/04/23 had 12 CNAs for 113 residents on the day shift, required 14 CNAs. -06/10/23 had 13 CNAs for 110 residents on the day shift, required 14 CNAs. NJAC 8:39-5.1(a)	S 560	Staffing levels will be monitored once a week for three months through the staffing reports that are given to the Administrator and DON. These reports will specify the number of CNAs and professional nurses on each shift. Staffing will be according to the acuities of residents in house. Data obtained will be reported at the quarterly QAPI meeting. Completion Date: June 27, 2023	

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
315044 Y1	A. Building B. Wing Y2	8/22/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MOHAWK MEADOWS	1 O'BRIEN LANE LAFAYETTE, NJ 07848

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 F0580	Correction	ID Prefix F0600	Correction	ID Prefix F0658	Correction
Reg. # 483.10(g)(14)(i)-(iv)(15)	Completed	Reg. # 483.12(a)(1)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	07/28/2023	LSC	07/28/2023	LSC	07/28/2023
ID Prefix F0761	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/28/2023	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	
6/26/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061902 Y1	A. Building B. Wing Y2	8/22/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MOHAWK MEADOWS	1 O'BRIEN LANE LAFAYETTE, NJ 07848

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/28/2023	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	
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	
6/26/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO