STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315316	A. BUILDING _____ B. WING _____	C 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BRAKELEY PARK, LLC	290 RED SCHOOL LANE PHILLIPSBURG, NJ 08865

(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 COMPLAINT #: NJ165331, NJ167365, NJ168017 CENSUS: 117 SAMPLE SIZE: 3 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT SURVEY.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint #: NJ165331, NJ167363, NJ168017 This deficient practice was evidence as follow: Based on interviews, medical records reviews, and review of other pertinent facility documentation on 10/5/2023 and 10/10/2023, it was determined that the facility failed to ensure that an NJ Exec Order 26.4b1 was prevented because care plan interventions were not followed during the transfer from the bed to a	F 689	Resident #2 no longer resides at the facility. No other residents were affected by this deficient practice. All residents have the potential to be affected by this deficient practice. DON/Designee audited all current resident lift assessments and care plans/ door tags for accuracy completed on 9/7/2023. Education of all nursing employees regarding safe resident	10/11/23

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

Electronically Signed | 10/20/2023

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F 689	Continued From page 1 shower chair for Resident #2. The resident was transferred out of bed by 2 Certified Nurses Aides (CNA) who failed to use the NJ Exec Order 26.4b1 as indicated in the plan of care. The staff could not place the resident in the shower chair and had to lower Resident #2 to the floor on NJ Exec Order 26.4b1 . Resident #2 was sent to the Hospital Emergency Room and was found to have NJ Exec Order 26.4b1 The facility also failed to follow its policy titled "Care Plans, Comprehensive Person-Centered and Safe Resident Handling/ Transfers" for 1 of 3 residents reviewed (Resident #2) as evidenced by the following: According to the Facility Reportable Event (FRE), a New Jersey Department of Health (NJDOH) document used by the healthcare facilities to report incidents on NJ Exec Order 26.4b1, with an event date of NJ Exec Order 26.4b and a "time of event" 9:00 P.M. On NJ Exec Order 2 CNA [Certified Nursing Assistant] were assisting Resident #2 to transfer from his/her bed to a shower chair in preparation for them to receive a shower. Resident NJ Exec Order 26.4b1, and resident was lowered to NJ Exec Order 26.4b1 on the floor by the CNAs. One CNA continued to support the resident while the other got the nurse. Resident #2 was guided the rest of the way to the floor and then assisted to bed. The Resident was assessed and noted a NJ Exec Order 26.4b1. Resident #2 did NJ Exec Order 26.4b1. On call telehealth clinician was notified and assessed the patient and ordered NJ Exec Order 2. Several hours later Resident #2 was noted to have NJ Exec Order 26.4b1 and on call telehealth was again notified, resident was reassessed and sent to the hospital for evaluation. Resident #2 has multiple comorbidities including NJ Exec Order 26.4b1	F 689	handling was initiated by second floor unit manager on 9/6/23 and completed by staff educator by 9/15/2023. Random transfer lift audits began on 9/8/2023 by the DON and continue as per QAPI project. The staff members involved were immediately suspended. The staff members were terminated as of 9/8/23. DON/Designee will complete audits of compliance for safe resident transfers weekly on at least 2 residents for 8 weeks to ensure compliance with safe resident transfers. Then audits will be conducted monthly on at least 2 residents for two additional months. All findings will be reported and reviewed by the QAPI committee monthly. Completion Date: 10/11/23	

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F 689	Continued From page 2	F 689		

NJ Exec Order 26.4b and NJ Exec Order 26.4b1 [redacted]

Review of the medical record (MR) was as follows:

According to the Admission Record (AR), Resident #2 was admitted to the facility on NJ Exec Order 26.4b1 with diagnoses which included but were not limited to NJ Exec Order 26.4b1 [redacted]

According to the Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, Resident # 2 had a Brief Interview of Mental Status (BIMS) score of NJ Ex/15, which indicated the Resident was NJ Exec Order 26.4b1. The MDS also showed Resident #2 was a NJ Exec Order 26.4b1 [redacted] and NJ Exec Order 26.4b1 assist with all Activities of Daily Living (ADLs).

A review of the Resident's Care Plan (CP) initiated on NJ Exec Order 26.4b1 revealed under "Focus": that Resident #2 "is at ris NJ Exec Order 26.4b1 [redacted] "Under "Goal," indicated "Resident will have NJ Exec Order 26.4b1 for 90 day and revised on NJ Exec Order 26.4b1 with a target date of NJ Exec Order 26.4b1." Under "Interventions" included: "Assist resident getting in and out of bed with NJ Exec O [redacted]

During an interview on 10/5/2023 at 12:18 P.M., the CNA assisting with the transfer of Resident #2 stated "during the transfer, I was holding the

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F 689	Continued From page 3	F 689		

shower chair and the guy [CNA assigned to Resident #2] was embracing the resident as he tried to transfer the resident to the shower chair." The CNA further stated, "I think the CNA thought he could manage the resident, but he could not, so he lowered the resident to the floor while still embracing him/her." When asked by the Surveyor if she knew Resident #2's transfer status, the CNA said, "usually there is a sticker on the resident's room door tag that indicate how the resident transfers. NJ Exec on the door tag will indicate the resident is a NJ Exec Order 26.4b1 . The CNA continued to state "I don't recall if I saw the sign on Resident #2's room door tag. I've never transferred Resident #2." The CNA acknowledged that if a resident has a NJ Exec sticker on his/her room door tag, that resident should be transferred via NJ Exec Order 26.4b1 with two persons.

During an interview on 10/10/2023 at 11:31 A.M., the Licensed Practical Nurse (LPN) assigned to Resident #2 stated she was called to Resident #2's room by a CNA. She continued to state, upon entering she observed Resident #2 on NJ Exec Order 26.4b1 "I asked the assigned CNA what had happened, but my focus was on Resident #2 to ensure the resident was ok." We than transferred Resident #2 back to their bed via the NJ Exec Order 26.4b1 When asked by the Surveyor if the CNAs were familiar with Resident #2's NJ Exec Order 26.4b1 the LPN said, "Yes, both CNAs were familiar with Resident #2 and knew he/she was a complete care and required a NJ Exec Order 26.4b1 with two persons for transfer." She further informed the Surveyor stating each resident requiring assistance with transfer has a sticker on their room door tags indicating the level of transfer required. Resident #2 had a sticker on their room door tag indicating

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F 689	Continued From page 4 NJ Exec, meaning "NJ Exec Order 26.4b of two persons for transfers. The LPN continued to say all NJ Exec Order 26.4b1 should be carried out by two staff. When asked by the Surveyor if Resident #2's CP was followed and implemented on the day of the incident [NJ Exec Order 26.4b], the LPN said, "No, they [the CNA] did not follow Resident #2's CP that day. The LPN further said the expectation is for all residents CP to be followed and always implemented. During the survey, the Surveyor attempted to reach the CNA assigned to Resident #2 for an interview but was unsuccessful. During an interview on 10/5/2023 at 12:30 P.M., the Director of Nursing (DON) stated NJ Exec Order 26.4b1 means a NJ Exec Order 26.4b1 with all transfers in and out of bed. Two person or more are required for NJ Exec Order 2 transfers." When asked by the Surveyor if one person is allowed to do a NJ Exec Order 2, the DON said, "No, absolutely not, there should be no time that the CNAs are transferring a resident who is a NJ Exec Order 26 alone or without using a NJ Exec Order 26.4b1 for transfer." She continued to say it is clearly communicated to the CNAs by the Nurses on the unit on how a resident should be transferred. She further stated, "Resident #2 had a NJ Exec Order 26.4b1 sticker on their room door tag and closet door, indicating how the resident should be transferred." There is also report given by the Nurses to the CNAs at the beginning of the shift on the level of care and transfer needed for their assigned residents. During the same interview, the DON stated that the CNA assigned to Resident #2 on the day of the incident [NJ Exec Order 26.4b1] was familiar with him/her and knew he/she was a NJ Exec Order 26. The DON further said, "I would say it was a bad	F 689		

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F 689	Continued From page 5	F 689		

decision the CNA made that day when he attempted to transfer the resident (Resident #2) without following the CP intervention for [redacted] with two-person transfer."

During the exit conference on 10/10/2023 at 2:19 P.M., the DON, in the presence of the Administrator and Regional Clinical Director, acknowledged that a [redacted] implies the use of a [redacted] for all transfers in and out of bed with the use of 2 or more staff as needed.

Review of the facility policy titled "Care Plans-Comprehensive Person-Centered" with a revision date 10/2022 revealed the following: Under "Policy": included: "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident." Under "Policy Interpretation and Implementation" ...4. Each resident's comprehensive person-centered care plan will be consistent with the resident's right to participate in the development and implementation of his or her plan of care, including the right to: g. Receive the services and /or items included in the plan of care:8. The comprehensive, person-centered car plan will: a. Include measurable objectives timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being;."

Review of the facility's policy titled "Safe Resident Handling/ Transfers" Under "Policy" reveals: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks of injury and provide and promote

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F 689	Continued From page 6 a safe, secure and comfortable experience for the resident while keeping the employes safe in accordance with current standards and guidelines." Under "Policy Explanation" reveals: "All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and employees that assist them. While manual lifting techniques may be utilized dependent upon the resident's condition and mobility, the use of mechanical lifts are safer alternative and should be used." Under "Compliance Guidelines." ...3. "Mechanical lifting equipment or other approved transferring aids will be used based on the resident's needs to prevent manual lifting except in medical emergencies. 10. Two staff members must be utilized when transferring residents with mechanical lift. 11. Staff will be educated on the use of safe handling/transfer practices to include use of mechanical lift devices upon hires, annually and as need arises or changes in equipment occur. 14. Resident lifting and transferring will be performed according to the resident's individual plan of care." N.JA.C.: 8:39-11.2(e)(2) N.J.A.C.: 8.39- 27.1 (a)	F 689		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315316	A. Building B. Wing	10/31/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BRAKELEY PARK, LLC	290 RED SCHOOL LANE PHILLIPSBURG, NJ 08865

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 F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 10/11/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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
10/10/2023

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**