STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030305	A. BUILDING: _____ B. WING _____	C 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE REHABILITATION AND HEALTHCARE C	255 EAST MAIN ST MOORESTOWN, NJ 08057

(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 #: NJ143783, NJ145736, and NJ146197 Census: 132 Sample Size: 8 TYPE OF SURVEY: Complaint Survey The facility is not in substantial compliance with all the standards in the New Jersey Administrative Code 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 provisions of 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 Intake #NJ145736 and #NJ143783 Based on interviews, facility document review and New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, it was determined the facility failed to ensure staffing ratios were met for 23 of 28 day shifts reviewed. This had the potential to affect all residents. Findings included:	S 560	S560 Mandatory Access to Care 1. No residents were affected by not meeting the State of NJ minimum staffing requirements 2. All residents could be affected by this area of concern. 3. Recruitment efforts continue to include: a. Job fairs	12/14/21

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

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S 560	Continued From page 1 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 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 certified nurse aides, and each direct care staff member shall be signed in to work as a certified nurse aide and perform certified 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 certified nurse aide and perform certified nurse aide duties. 1. A review of the "Nurse Staffing Report," completed by the facility for the weeks of 05/16/2021 - 05/30/2021, revealed staff-to-resident ratios that did not meet the minimum requirement as listed below: 05/16/2021 had 12 CNAs for 103 residents on the day shift, required 13 CNAs. 05/17/2021 had 12 CNAs for 103 residents on the day shift, required 13 CNAs. 05/18/2021 had 10 CNAs for 94 residents on the	S 560	b. Daily staffing meetings c. Sponsored orientees for 45 days toward retention of new hires d. Care Champion mentor program to support retention e. Culture committee to improve and maintain staff morale f. Recruitment bonus and sign-on bonuses offered. 4. To monitor and maintain ongoing compliance the DON or designee will monitor staffing daily for 1 week, weekly for 3 weeks and monthly for 2 months. Results will be presented to the QAPI team monthly for continued review and recommendations.	

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S 560	Continued From page 2	S 560		

day shift, required 12 CNAs.
05/19/2021 had 10 CNAs for 94 residents on the day shift, required 12 CNAs.
05/23/2021 had 12 CNAs for 99 residents on the day shift, required 13 CNAs.
05/25/2021 had 11 CNAs for 104 residents on the day shift, required 13 CNAs.
05/26/2021 had 9 CNAs for 104 residents on the day shift, required 13 CNAs.
05/28/2021 had 10 CNAs for 104 residents on the day shift, required 13 CNAs.
05/29/2021 had 10.5 CNAs for 109 residents on the day shift, required 14 CNAs.

A review of the "Nurse Staffing Report," completed by the facility for the weeks of 09/26/2021 - 10/09/2021, revealed staff-to-resident ratios that did not meet the minimum requirement as listed below:

09/26/2021 had 12 CNAs for 117 residents on the day shift, required 15 CNAs.
09/27/2021 had 8 CNAs for 117 residents on the day shift, required 15 CNAs.
09/28/2021 had 7 CNAs for 117 residents on the day shift, required 15 CNAs.
09/29/2021 had 8 CNAs for 117 residents on the day shift, required 15 CNAs.
09/30/2021 had 12 CNAs for 117 residents on the day shift, required 15 CNAs.
10/01/2021 had 10 CNAs for 116 residents on the day shift, required 15 CNAs.
10/02/2021 had 12 CNAs for 116 residents on the day shift, required 15 CNAs.
10/03/2021 had 14 CNAs for 115 residents on the day shift, required 15 CNAs.
10/04/2021 had 10 CNAs for 115 residents on the day shift, required 15 CNAs.
10/05/2021 had 13 CNAs for 115 residents on the day shift, required 15 CNAs.

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S 560	Continued From page 3 10/06/2021 had 11 CNAs for 115 residents on the day shift, required 15 CNAs. 10/07/2021 had 13 CNAs for 117 residents on the day shift, required 15 CNAs. 10/08/2021 had 10 CNAs for 116 residents on the day shift, required 15 CNAs. 10/09/2021 had 13 CNAs for 113 residents on the day shift, required 15 CNAs. During an interview with the Director of Nursing (DON) on 11/16/2021 at 9:23 PM, she stated that she was aware of the New Jersey mandate regarding staffing ratios. They had been advertising and doing all they could to hire more staff. It had been a real struggle for the facility and other medical offices/facilities to recruit and retain staff during the pandemic. Staff call outs also impacted the staffing ratio when they were not able to call someone else in to work. The facility was trying all they could to hire and train more staff and retain the current staff.	S 560		

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F 000	INITIAL COMMENTS Complaint #: NJ143783, NJ145736, and NJ146197 Census: 132 Sample Size: 8 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record reviews, and facility policy reviews, it was determined that the facility failed to ensure residents' rights to respect, and dignity were upheld by ensuring [redacted] residents were not left undressed in common areas for one (Resident [redacted] of two residents reviewed for dignity on the [redacted] unit. Findings included: 1. A review of Resident [redacted]'s medical record indicated the facility admitted the resident with diagnoses that included [redacted] ([redacted]	F 557	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by Provider of the truth or facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State laws require it. F557 Respect/Dignity/Right to have personal property 1. Resident [redacted] was assisted by a nurses aide with dressing since he had removed	12/14/21

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F 557	Continued From page 1 [redacted] and [redacted]) and [redacted] disease (disease that [redacted]). A review of Resident [redacted]'s baseline care plan, dated [redacted], indicated the resident had an activities of daily living (ADLs) performance deficit due to [redacted]. The care plan indicated the resident needed staff interventions to be able to increase abilities in eating, dressing, and personal hygiene. A review of Resident [redacted]s care plan, dated [redacted], indicated Resident [redacted] used [redacted] a [redacted] medication. Interventions included to monitor/record occurrences for target behavior symptoms, which included disrobing in public and [redacted] During a tour of the [redacted] Unit on 11/16/2021 at 8:45 AM, Resident [redacted] was observed sitting in a reclined chair in the middle of the dining room directly in front of the nurse's station. Ten other residents and five staff members were present. Resident [redacted] had no pants or gown on with adult briefs visible. The resident's gown was on the floor next to the reclined chair. Resident [redacted]s head was leaning off the right side of the chair and the resident had no shirt on; the resident had only a bunched-up sheet covering a portion of the resident's torso. The Administrator walked past the resident, looked at the resident, and continued to walk. The Administrator then turned around to lead the surveyors off the unit and walked past Resident [redacted] again. The Administrator continued to walk towards the exit of the unit and was asked to return to the dining room. During an interview on 11/16/2021 at 8:50 AM,	F 557	his garment and to restore respect and dignity. 2. All residents have the potential to be affected by issues of dignity. 3. All staff educated to monitor and address resident dignity issues. 4. To monitor and maintain ongoing compliance the Unit Manager or designee will observe common areas weekly for 4 weeks and then monthly for 2 months for resident dignity. Results will be presented to the QAPI team monthly for continued review and recommendations.	

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F 557	Continued From page 2 the Administrator stated the condition in which Resident [redacted] was found was not acceptable. The Administrator stated the resident's rights to respect and dignity were not being maintained and asked an unidentified staff member to change Resident [redacted]. The Administrator stated the residents' right to dignity needed to be maintained regardless of what unit the resident was on and regardless of their cognition. The Administrator stated all staff members were responsible for ensuring resident rights were maintained. During an interview on 11/16/2021 at 12:35 PM, Certified Nursing Assistant (CNA) #1 stated residents who were taken to common areas should be fully dressed. CNA #1 stated taking residents out undressed or in a gown was a violation of their rights. CNA #1 stated that at times, due to the staffing limitations, residents were taken out in gowns because there was not enough time to clean and dress everyone in time for breakfast. CNA #1 stated that was not the care the residents deserved, but they needed to eat. A review of the facility's undated policy titled, "Resident Rights," indicated, "Employees shall treat all residents with kindness, respect, and dignity ...Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence. b. be treated with respect, kindness, and dignity; ...h. be supported by the facility in exercising his or her rights" New Jersey Administrative Code: §8:39 - 4.1(a)(12)	F 557		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment	F 584		12/14/21

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F 584	Continued From page 3 CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		

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F 584	Continued From page 4 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ146197 Based on observations, interviews, record reviews, and facility policy review, it was determined the facility failed to ensure three (Resident [redacted], Resident [redacted], and Resident [redacted]) of five resident's personal property was safeguarded from misappropriation by failing to ensure resident's personal belongings were labeled and inventoried. Findings included: A review of the facility's undated policy, titled, "Personal Property," indicated, "Residents are permitted to retain and use personal possessions and appropriate clothing, (as space permits) ...The resident's personal belongings and clothing shall be inventoried and documented upon admission and as such items are replenished...The facility will promptly investigate any complaints of misappropriation or mistreatment of resident property." The policy did not indicate who was responsible for documenting the inventory of items. 1. A review of Resident [redacted]'s medical record indicated the facility admitted the resident on [redacted] with diagnoses that included [redacted] A review of Resident [redacted]'s admission Minimum Data Set (MDS), dated [redacted], indicated the	F 584	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by Provider of the truth or facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State laws require it. F584 Safe/Clean/Comfortable/Homelike Environment (inventory process) 1. Resident [redacted] and [redacted] inventory sheets were reviewed for accuracy and made current. 2. All residents have the potential to be affected. All residents charts were reviewed and inventory sheets validated. 3. Inventory process updated to streamline and ensure accurate documentation. Admissions Director or designee oversees the process to ensure compliance with assistance from Concierge, nursing staff, receptionists, social workers and laundry staff. Those departments received education on the inventory process for resident belongings. 4. To monitor and maintain ongoing compliance the Unit Manager or designee will audit inventory sheets and concierge will review intake of laundry and personal effects weekly for 4 weeks and then monthly for 2 months. Results will be presented to the QAPI team monthly for	

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F 584	Continued From page 5 resident had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating [redacted]. A review of Resident [redacted] quarterly Minimum Data Set (MDS), dated [redacted], indicated the resident had a BIMS score of [redacted], indicating [redacted]. The resident was independent/supervision with ambulation, eating, bed mobility, and transfers. The resident required limited assistance with toileting, and personal hygiene and required extensive assistance with dressing and personal hygiene. A review of a handwritten document, titled, "Inventory Sheets," dated 01/11/2021 with Resident [redacted] name handwritten on it, indicated an inventory of clothing and non-clothing items was taken. The document did not have a staff or resident representative signature. During an observation on 11/16/2021 at 10:00 AM, Resident [redacted] was observed sitting on the edge of the bed. The resident was dressed in a green shirt with flowers and light-colored pants. The resident was unable to be interviewed due to confusion. Clothing was observed hanging in the resident's closet, and a white sweater was on a wheelchair in the corner, unlabeled. Resident [redacted] was not observed to have any jewelry on. During an interview on 11/16/2021 at 2:23 PM, Registered Nurse (RN) #1 stated when clothing was brought in the facility by a resident or family member, the items were put in a bag and sent to laundry. RN #1 stated, "in a perfect world" all items would be inventoried, but at the facility RN #1 did not document clothing in the inventory list. RN #1 stated if a [redacted] resident arrived at the facility with jewelry on, RN #1 would take the	F 584	continued review and recommendations.	

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F 584	Continued From page 6	F 584		

jewelry and place it in a bag and call the Power of Attorney (POA). RN #1 stated there was no set procedure indicating who was responsible for documenting residents' personal belongings. RN #1 did not know what the facility policy stated. RN #1 stated there were so many other things going on in the facility, such as caring for residents, that the inventory list was not a priority. RN #1 stated the purpose of the inventory sheet would be to keep of all belongings.

During an interview on 11/16/2021 at 4:50 PM, CNA #2 stated Resident [redacted] had been at the facility for quite some time and had issues with missing items, but CNA #2 did not recall what items. CNA #2 stated laundry was responsible for labeling clothing. CNA #2 stated that Resident [redacted] had clothing that was unlabeled. The clothing was placed in the resident's wheelchair, but the day shift sent them to laundry. CNA #2 admitted to leaving clothing unlabeled due to not having a label gun and would verbally tell the next CNA, but he could not control who that CNA told the next shift.

During an interview on 11/16/2021 at 5:15 PM, Resident [redacted]'s family member stated Resident [redacted] was admitted with a watch and two necklaces and the jewelry went missing around [redacted]. The jewelry was worth a lot of money. The family member stated the jewelry was not listed on the resident's admission sheet, although the resident was wearing the jewelry on admission. The family member stated the resident had clothing go missing as well. The family member stated the facility had not done anything about the missing jewelry or clothes. The family member stated a picture was shown to the administrator when the jewelry went missing on [redacted]. The family

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F 584	Continued From page 7	F 584		

member stated the administrator informed the family an investigation would be done and the family member would be called back. The family member stated the administrator had not yet called. The family member stated one of the necklaces was an 18-carat gold necklace with a crucifix that Resident [redacted] purchased at the [redacted] in [redacted]

A further review of the handwritten document titled, "Inventory Sheets," dated [redacted] with Resident [redacted]s name handwritten on it, indicated a watch and two necklaces were not listed on the document.

During an interview on 11/16/2021 at 6:00 PM, the Social Worker (SW) denied having a role in residents' personal belongings other than filing grievances and "going through channels." The SW stated Resident [redacted]'s family reported missing items but was not sure the items were really at the facility because the resident was "[redacted]" The SW denied knowing anything else about the incident and stated the administrator was dealing with it.

During an interview on 11/16/2021 at 8:46 PM, the Administrator stated laundry was responsible for labeling clothing and "would assume" the nurses would place items on the inventory sheet during admission. The Administrator stated the purpose of the inventory list was to avoid loss of personal property. The Administrator initially did not remember any issue with missing items for Resident [redacted]. The administrator stated a grievance for Resident [redacted]'s missing jewelry could not be located. Then the Administrator stated, "Actually, I do recall an incident with jewelry." The Administrator confirmed an inventory list was not

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created when the resident was admitted, but the Administrator remembered being shown a picture of Resident [redacted] in the facility wearing a necklace with a crucifix on it and could "attest" that the necklace was at the facility with the resident. The Administrator stated there was no investigation summary available, and the Administrator could not recall the outcome. The Administrator stated the family was to be compensated.

During an interview on 11/16/2021 at 9:04 PM, the Director of Nursing (DON) stated the facility had a concierge who worked daily from 9:00 AM to 5:00 PM. The DON stated the concierge was responsible for going through the bags of the residents' personal belongings and logging the items. The DON stated any items other than clothing were not inventoried. The DON stated if a resident or family member reported missing clothing, the facility would just believe them and often compensate the resident. The DON stated items other than clothing reported missing would need to have a grievance form filed. The DON stated the grievances were then handled by the SW or Administrator. The DON denied knowing anything about lost items or grievances for Resident [redacted]. The DON stated the purpose of the inventory list was to keep an accurate account of belongings and to avoid conflict by knowing what was stolen or truly missing.

2. A review of Resident [redacted]'s medical record indicated the facility admitted the resident on [redacted] with diagnoses that included [redacted]

A review of Resident [redacted]'s quarterly Minimum Data Set (MDS), dated [redacted], indicated the

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resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted], which indicated the resident was [redacted]. There was no inventory list created or updated from [redacted] through [redacted]

During an observation and interview on 11/16/2021 at 10:00 AM, Resident [redacted] was observed sitting at the edge of the bed wearing a blue shirt and blue shorts. In front of the resident's bed was an open box with crafts inside and two blue plastic storage containers under the box. Resident [redacted] stated all the resident's personal belongings were in the containers because that made it harder to have items stolen. Resident [redacted] stated the facility did not take an inventory of personal belongings upon admission. Resident [redacted] stated the facility did not follow the proper procedures for resident belongings and would refuse to inventory items when asked. Resident [redacted] stated the social worker (SW) took a coffee maker and a [redacted] grill from the resident's room due to safety concerns. Resident [redacted] stated the SW was asked by the resident to provide a receipt for the items taken and the SW refused. Resident [redacted] stated a grievance was filed because the SW later denied having the items. Resident [redacted] stated the items were lost and never reimbursed.

A review of the facility's "Grievance Report," from [redacted] to [redacted], indicated nine different residents, including Resident [redacted], filed grievances for "missing items."

A review of the facility's "Grievance Summaries," dated 10/20/2021, indicated a grievance was filed for Resident [redacted]'s "[redacted]." The summary of the grievance investigation indicated

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the SW asked all departments about the grill and nobody knew where the grill was. The summary of actions taken indicated the original box for Resident [redacted]'s grill was in the SW's possession. The summary indicated the SW would look up the price and inform the Administrator to reimburse the resident.

During an interview on 11/16/2021 at 6:00 PM, the Social Worker (SW) admitted to having Resident [redacted]'s pot, but stated it was a water heating pot, not a coffee pot. The SW stated Resident [redacted] was told to put in a grievance for the grill. The SW stated the resident was informed the grill would be compensated, but the SW did not know when. The SW stated the Administrator had the water heating pot and was going to handle the issue.

During an interview on 11/16/2021 at 8:46 PM, the Administrator stated laundry was responsible for labeling clothing and "would assume" the nurses would place items on the inventory sheet during admission. The Administrator stated the purpose of the inventory list was to avoid loss of personal property. The Administrator stated the SW was dealing with Resident [redacted]s grievance about lost items, and the Administrator was waiting for an invoice to compensate Resident [redacted].

During an interview on 11/16/2021 at 9:04 PM, the Director of Nursing (DON) stated the facility had a concierge who worked daily from 9:00 AM to 5:00 PM. The DON stated the concierge was responsible for going through the bags of the residents' personal belongings and logging the items. The DON stated any items other than clothing were not inventoried. The DON stated if a resident or family member reported missing

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clothing, the facility would just believe them and often compensate the resident. The DON stated items other than clothing reported missing would need to have a grievance form filed. The DON stated the grievances were then handled by the SW or Administrator. The DON denied knowing anything about lost items or grievances for Resident [redacted]. The DON stated the purpose of the inventory list was to keep an accurate account of belongings and to avoid conflict by knowing what was stolen or truly missing.

3. A review of Resident [redacted]'s medical record indicated the facility admitted the resident on [redacted] with diagnoses that included need for assistance with personal care and [redacted].

Resident #5's 5-day Minimum Data Set (MDS), dated [redacted] indicated the resident had a BIMS score of [redacted] which indicated the resident was [redacted].

A review of Resident [redacted]s medical record indicated an inventory list was not completed from [redacted] to [redacted]. There was no inventory list in the record.

During an interview on 11/16/2021 at 2:17 PM, Resident [redacted] stated the facility had lost all the resident's clothes, "put it in laundry and it won't come back." Resident [redacted] stated personal items were always missing and the resident was forced to put locks on the closet doors. Resident [redacted] stated no one in the facility knew who was responsible for keeping track of resident belongings, and if something was missing, the facility staff would blame each other. Resident [redacted] stated multiple grievances had been filed for lost

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items and nothing had been resolved.

During an interview on 11/16/2021 at 6:00 PM, the Social Worker (SW) denied having a role in residents' personal belongings other than filing grievances and "going through channels."

During an interview on 11/16/2021 at 8:46 PM, the Administrator stated laundry was responsible for labeling clothing and "would assume" the nurses would place items on the inventory sheet during admission. The Administrator stated the purpose of the inventory list was to avoid loss of personal property. The Administrator was not aware of any grievance for Resident #5 but would talk to the SW.

During an interview on 11/16/2021 at 9:04 PM, the Director of Nursing (DON) stated the facility had a concierge who worked daily from 9:00 AM to 5:00 PM. The DON stated the concierge was responsible for going through the bags of the residents' personal belongings and logging the items. The DON stated any items other than clothing were not inventoried. The DON stated if a resident or family member reported missing clothing, the facility would just believe them and often compensate the resident. The DON stated items other than clothing reported missing would need to have a grievance form filed. The DON stated the grievances were then handled by the SW or Administrator. The DON denied knowing anything about lost items or grievances for Resident [redacted]. The DON stated the purpose of the inventory list was to keep an accurate account of belongings and to avoid conflict by knowing what was stolen or truly missing.

4. During a facility tour on 11/16/2021 at 8:35 AM,

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multiple residents' rooms were observed to have electronic tablets on beds, small personal electronics on bedside tables, and clothing hanging from open closets. Labels or names of residents were not visibly written on the items observed.

During an interview on 11/16/2021 at 10:35 AM, Licensed Practical Nurse (LPN) #1 stated inventory lists were not always created during admission, and the LPN did not know who was responsible for updating the lists. LPN #1 stated items were not added to the inventory list if brought in after admission.

During an interview on 11/16/2021 at 10:38 AM, Laundry Personnel (LND) #1 stated resident clothing brought in during admission would be placed in a plastic bag and given to the facility receptionist to give to LND #1. LND #1 stated the bag of clothing would then be washed and labeled with the resident's name. LND #1 stated the clothing would then be delivered to the resident. LND #1 was unsure who was responsible for documenting the items in the resident's inventory sheet. LND #1 stated if items were sent to the laundry without a name, they would be washed and placed on a rack and stored. LND #1 pointed to a rack which had bags of clothing hanging from both ends and a green shirt and brown pants. LND #1 stated the items on the rack had not been labeled and would likely just stay on the rack. LND #1 stated if a resident or family member complained about missing clothing, they were welcome to look through racks of unlabeled clothing in the laundry room. LND #1 stated all clothing should be labeled, and accurate inventory prevented residents from losing their clothes and having to wear "charity

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clothing."

During an interview on 11/16/2021 at 2:23 PM, Registered Nurse (RN) #1 stated when clothing was brought in the facility by a resident or family member, the items were put in a bag and sent to laundry. RN #1 stated "in a perfect world" all items would be inventoried, but at the facility RN #1 did not document clothing in the inventory list. RN #1 stated there was no set procedure indicating who was responsible for documenting residents' personal belongings. RN #1 did not know what the facility policy stated. RN #1 stated there were so many other things going on in the facility, such as caring for residents, that the inventory list was not a priority. RN #1 stated the purpose of the inventory sheet would be to keep of all belongings.

During an interview on 11/16/2021 at 2:44 PM, Certified Nursing Assistant (CNA) #1 stated clothing was placed in a plastic bag and sent to laundry. CNA #1 stated not everyone updated the inventory list, but the CNA felt it was important to do so. CNA #1 stated there was a big discussion in the facility over who would be responsible for updating the inventory lists, and no one was ever designated. CNA #1 stated reports of missing resident belongings were a daily occurrence at the facility. CNA #1 stated the laundry department was two to three weeks behind in washing resident clothing. CNA #1 stated there were residents in the facility that had been admitted with two suitcases full of clothing and had none left, forcing the CNAs to dress them from the "charity clothing." CNA #1 stated nothing was being done to fix the system, and administration did not care.

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F 584	Continued From page 15 During an interview on 11/16/2021 at 6:00 PM, the Social Worker (SW) denied having a role in residents' personal belongings other than filing grievances and "going through channels." During an interview on 11/16/2021 at 8:46 PM, the Administrator stated laundry was responsible for labeling clothing and "would assume" the nurses would place items on the inventory sheet during admission. The Administrator stated the purpose of the inventory list was to avoid loss of personal property. During an interview on 11/16/2021 at 9:04 PM, the Director of Nursing (DON) stated the facility had a concierge who worked daily from 9:00 AM to 5:00 PM. The DON stated the concierge was responsible for going through the bags of the residents' personal belongings and logging the items. The DON stated any items other than clothing were not inventoried. The DON stated if a resident or family member reported missing clothing, the facility would just believe them and often compensate the resident. The DON stated items other than clothing reported missing would need to have a grievance form filed. The DON stated the grievances were then handled by the SW or Administrator. The DON stated the purpose of the inventory list was to keep an accurate account of belongings and to avoid conflict by knowing what was stolen or truly missing. New Jersey Administrative Code: §8:39 - 4.1(a)(15)	F 584		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		12/14/21

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F 610	Continued From page 16 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ146197 Based on observations, interviews, record reviews and facility policy reviews, it was determined that the facility failed to investigate the misappropriation of property for one (Resident [redacted]) of five sampled residents reviewed for misappropriation of property. Specifically, the facility had no investigation related to Resident [redacted] missing jewelry. Findings included: 1. A review of Resident [redacted]'s medical record indicated the facility admitted the resident on [redacted] with diagnoses that included [redacted]	F 610	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by Provider of the truth or facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State laws require it. F610 Investigate/Prevent/Correct Alleged Violation 1. Resident [redacted] grievance investigation was concluded with reimbursement to the responsible party for missing items. 2. All residents have the potential to be impacted by grievance investigations not being completed and documented. All open grievances were reviewed for	

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F 610	Continued From page 17 A review of Resident [redacted]'s admission Minimum Data Set (MDS), dated [redacted], indicated the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating [redacted]. A review of Resident [redacted] quarterly Minimum Data Set (MDS), dated [redacted], indicated the resident had a BIMS score of [redacted] out of [redacted], indicating [redacted] A review of a handwritten document, titled, "Inventory Sheets," dated [redacted] with Resident [redacted]'s name handwritten on it, indicated an inventory of clothing and non-clothing items was taken. The document did not have a staff or resident representative signature. During an observation on 11/16/2021 at 10:00 AM, Resident [redacted] was observed sitting on the edge of the bed with. The resident was dressed in a green shirt with flowers and light-colored pants. The resident was unable to be interviewed due to confusion. Clothing was observed hanging in the resident's closet, and a white sweater was on a wheelchair in the corner, unlabeled. Resident [redacted] was not observed to have any jewelry on. During an interview on 11/16/2021 at 4:50 PM, CNA #2 stated Resident [redacted] had been at the facility for quite some time and had issues with missing items but CNA #2 did not recall what items. CNA #2 stated laundry was responsible for labeling clothing. CNA #2 stated that Resident [redacted] had clothing that was unlabeled. The clothing was placed in the resident's wheelchair, but the day shift sent them to laundry. CNA #1 admitted to leaving clothing unlabeled due to not having a label gun and could verbally tell the next CNA, but he could not control who that CNA told.	F 610	adherence to policy. 3. Administrator and grievance officer/social worker reviewed grievance investigation policy and procedure to ensure compliance. 4. To monitor and maintain ongoing compliance the grievance officer will review investigative steps for grievances weekly for 4 weeks and then monthly for 2 months. Results will be presented to the QAPI team monthly for continued review and recommendations.	

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F 610	Continued From page 18 During an interview on 11/16/2021 at 5:15 PM, Resident [redacted]'s family member stated Resident [redacted] was admitted with a watch and two necklaces and the jewelry went missing around [redacted]. The jewelry was worth a lot of money. The family member stated the jewelry was not listed on the resident's admission sheet, although the resident was wearing the jewelry on admission. The family member stated the resident had clothing go missing as well. The family member stated the facility had not done anything about the missing jewelry or clothes. The family member stated a picture was shown to the administrator when the jewelry went missing on [redacted]. The family member stated the administrator informed the family an investigation would be done and the family member would be called back. The family member stated the administrator had not yet called. The family member stated one of the necklaces was an 18-carat gold necklace with a crucifix that Resident [redacted] purchased at the [redacted]. A further review of the handwritten document titled, "Inventory Sheets," dated [redacted] with Resident [redacted] name handwritten on it, indicated a watch and two necklaces were not listed on the document. During an interview on 11/16/2021 at 6:00 PM, the SW denied having a role in residents' personal belongings other than filing grievances and "going through channels." The SW stated Resident [redacted]'s family reported missing items but wasn't sure the items were really at the facility because the resident was [redacted]." The SW denied knowing anything else about the incident and stated the Administrator was dealing with it.	F 610		

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During an interview on 11/16/2021 at 8:46 PM, the Administrator stated laundry was responsible for labeling clothing and "would assume" the nurses would place items on the inventory sheet during admission. The Administrator stated the purpose of the inventory list was to avoid loss of personal property. The Administrator initially did not remember any issue with missing items for Resident [redacted]. Then the administrator stated, "Actually, I do recall an incident with jewelry." The administrator stated the missing jewelry was not reported to state agencies by the facility because the facility was not sure the items were ever at the facility. The Administrator confirmed an inventory list was not created when the resident was admitted, but the administrator remembered being shown a picture of Resident [redacted] in the facility wearing a necklace with a crucifix on it and could "attest" that the necklace was at the facility with the resident. The administrator stated there was no investigation summary available, and the Administrator could not recall the outcome. The Administrator stated the family was to be compensated.

During an interview on 11/16/2021 at 9:04 PM, the Director of Nursing (DON) stated the facility had a concierge who worked daily from 9:00 AM to 5:00 PM. The DON stated the concierge was responsible for going through the bags of the residents' personal belongings and logging the items. The DON stated any items other than clothing were not inventoried. The DON stated if a resident or family member reported missing clothing, the facility would just believe them and often compensate the resident. The DON stated items other than clothing reported missing would need to have a grievance form filed. The DON

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F 610	Continued From page 20 stated the grievances were then handled by the SW or Administrator. The DON denied knowing anything about lost items or grievances for Resident [redacted] The DON stated the purpose of the inventory list was to keep an accurate account of belongings and to avoid conflict by knowing what was stolen or truly missing. A review of the facility's undated policy titled "Resident Rights," indicated "Federal and State laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to ...c. be free from abuse, neglect, misappropriation of property, and exploitation". An abuse policy was requested from the facility, but the policy was not provided.	F 610		
F 658 SS=D	New Jersey Administrative Code: §8:39 - 5.1(a) 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 Intake #NJ143783 Based on interviews and record reviews, it was determined that the facility failed to provide care and services that adhered to professional standards of quality as outlined by the resident's comprehensive care plan on the treatment of two pressure ulcers present on admission for one	F 658	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by Provider of the truth or facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State laws require it.	12/14/21

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F 658	Continued From page 21 (Resident #1) of three residents. Findings included: 1. A review of Resident [redacted]'s medical record indicated the facility admitted the resident on [redacted] with diagnoses that included [redacted] Resident [redacted]s admission Minimum Data Set (MDS), dated [redacted], indicated the resident had a Brief Interview for Mental Status score of [redacted], which indicated the resident was cognitively intact. The MDS indicated Resident [redacted] was able to ambulate, reposition, and get in and out of bed independently with oversight and supervision from staff. A review of Resident [redacted] Scale (measurement for a resident's risk of developing [redacted] dated [redacted] at 3:24 PM, indicated the resident had a score of [redacted], which meant the resident was not at risk. A review of Resident [redacted]'s admission nursing evaluation, dated [redacted] at 3:25 PM, indicated the resident had a [redacted] on the [redacted] measuring [redacted] and a [redacted] on the [redacted] measuring [redacted]. The nursing evaluation did not indicate what stage the [redacted] were. The evaluation did not indicate Resident [redacted] physician or responsible party were notified about the [redacted]. A review of Resident [redacted]'s health status notes, dated [redacted] at 5:23 PM, indicated the resident had a "[redacted] on [redacted] and [redacted]."	F 658	F658 Services provided meet professional standards 1. Resident [redacted] was discharged from the facility [redacted]. 2. All residents have the potential to be affected by not following professional standards of care. All new admissions were reviewed for assessment, orders and care plans. 3. Licensed staff received education for completion of new admission process including admission chart audit, care plans and physician orders. Unit Manager or licensed designee completes weekly skin assessments, which monitors for changes in skin condition (i.e [redacted]). 4. To monitor and maintain ongoing compliance the DON or Designee will audit weekly skin assessments for completion weekly for 4 weeks and then monthly for 2 months. Results will be presented to the QAPI team monthly for continued review and recommendations.	

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F 658	Continued From page 22 A review of Resident [redacted]'s progress notes, dated [redacted], did not indicate the physician or responsible party was called and informed about the presence of the [redacted] on Resident [redacted]. A review of Resident [redacted]s physician's orders, dated [redacted], indicated the resident was to have weekly skin checks on Mondays during the 3:00 PM to 11:00 PM shift. A review of Resident [redacted]s physicians' orders, dated [redacted], indicated no orders were written to treat the [redacted]. A review of Resident [redacted] baseline care plan, dated [redacted], indicated a care plan was implemented for the potential for [redacted] development. A care plan for Resident [redacted] was not developed. A review of Resident [redacted]'s medical record, from [redacted] to [redacted], indicated skin assessments were not documented as completed, per physician's order. A review of Resident [redacted]'s care plan meeting note, dated [redacted] (no time included), indicated the responsible party was present for the meeting. The notes indicated the responsible party was provided an update about Resident [redacted] health condition, which did not include mention of the [redacted]. A review of Resident [redacted]'s progress notes on the day of discharge, [redacted], revealed there was no documentation regarding [redacted]	F 658		

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During an interview on 11/16/2021 at 4:50 PM, Certified Nurse Aide (CNA) #2 Resident [redacted] was admitted to the facility with a [redacted]. CNA #2 was assigned to help admit Resident [redacted] and helped with getting the resident changed and situated. CNA #2 did not recall what the nurse said the [redacted] of the [redacted] was.

During an interview on 11/16/2021 at 5:30 PM, Licensed Practical Nurse (LPN) #2 (a charge nurse) stated the facility had a [redacted] care team that would assess and treat residents on Tuesdays and Wednesdays. LPN #2 stated that if a resident needed a dressing changed or a new [redacted] was found on the days the wound care team was not in the facility, the nurses would provide [redacted] care and assess and measure new wounds. LPN #2 stated [redacted] needed to be assessed and measured weekly to see if they were improving or needed different treatment orders. LPN #2 reviewed Resident [redacted] medical record and could not locate any documentation from the [redacted] care team, indicating the [redacted] care team did not see Resident [redacted] LPN #2 stated that if a [redacted] was discovered upon admission or during a [redacted] check, the doctor and responsible party had to be notified. LPN #2 stated the notification was necessary, so the family knew exactly what was going on and to obtain orders to treat the [redacted] and have the [redacted] care team assess the resident. LPN #2 stated the admission nurse should have notified the doctor and responsible party.

During a concurrent interview and record review on 11/16/2021 at 9:04 PM, the Director of Nursing (DON) reviewed Resident [redacted] s admission nursing evaluation, dated [redacted] at 3:25 PM, and

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confirmed Resident [redacted] arrived at the facility with a [redacted] on the [redacted] and a [redacted] on the [redacted]. The DON confirmed the [redacted] were not properly assessed. The DON stated accurate and detailed information was important to be able to get an idea of what the wounds looked like and track if they were healing. The DON was not able to find documentation indicating the physician or responsible party was notified of the [redacted]. The DON stated physician notification was necessary to ensure orders to treat were received. The DON stated it was important to notify the responsible party of the presence of wounds to inform them the [redacted] were there on admission and so they knew what was going on with their family member. The DON stated the admission nurse should have notified the physician and responsible party. The DON then reviewed Resident [redacted]s baseline care plan, dated [redacted], and confirmed a care plan was not implemented for the [redacted]. The DON reviewed Resident [redacted] physicians orders, dated [redacted] and confirmed an order was written for [redacted] checks weekly on Mondays. The DON confirmed no orders were written to treat the [redacted]. The DON reviewed Resident [redacted] [redacted] check documentation and confirmed no [redacted] checks were documented during the resident's stay. The DON stated orders to treat the [redacted] should have been obtained and a care plan implemented so the staff would know how to care for the resident. The DON stated the weekly [redacted] assessments should have been done to track the [redacted] to see if they were improving or if treatment needed to be changed. The DON stated the care plan should have been created within the day of admission by the admission nurse or supervisor.

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F 658	Continued From page 25 The DON could not recall whether [redacted] were discussed during the care planning meeting on [redacted]. A review of the facility's policy, titled, "Prevention of [redacted] Injuries," dated 2019, indicated, "Conduct a comprehensive[redacted] assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors, and prior to discharge." The Administrator did not have a policy on the treatment of [redacted] or [redacted] assessments available and only provided the policy for prevention. A review of the facility's undated policy, titled, "Change in Resident's Condition or Status," indicated, "Our facility shall promptly notify the resident, his or her Attending Physician and representative (sponsor) of changes in the resident's medical/mental condition and/or status ...1. The nurse will notify the resident's Attending Physician on call when there has been a(an): a. accident or incident involving the resident; b. discovery of injuries of unknown source."	F 658		
F 677 SS=D	New Jersey Administrative Code: §8:39 - 5.1(a) ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ145736	F 677	Preparation and/or execution of this plan	12/14/21

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F 677	Continued From page 26 Based on interviews, observation, record reviews, and review of facility policies, it was determined that the facility failed to provide activities of daily living (ADL) care for two (Resident [redacted] and Resident [redacted]) of four residents reviewed for ADL care. Findings included: 1. A review of Resident [redacted]'s medical record indicated the facility admitted Resident [redacted] with diagnoses including [redacted] and [redacted]. A review of Resident [redacted]s quarterly Minimum Data Set (MDS) dated [redacted], indicated that Resident [redacted] had a Brief Interview for Mental Status (BIMS) score of [redacted] out of [redacted] indicating that the resident was [redacted]. Resident [redacted] required extensive assistance for bed mobility, locomotion on and off the unit, dressing, toilet use, and personal hygiene. The resident was totally dependent on staff for transfers and needed supervision (set up help) for eating. A review of Resident [redacted]'s care plan dated [redacted], revealed that staff would try to keep the resident comfortable with adjusting their position. Resident [redacted] stated in an interview on 11/16/2021 at 10:05 AM that staffing was always a problem. It was frequently 11:00 AM before staff got the resident out of bed. The resident was observed in bed during the interview. Due to extreme pain that was worse when in bed, Resident [redacted] stated that sitting in a chair helped to relieve the [redacted].	F 677	of correction does not constitute an admission or agreement by Provider of the truth or facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State laws require it. F677 ADL Care provided for Dependent Residents 1. Resident [redacted] expired in the facility on [redacted] DON completed an assessment of Resident [redacted] to ensure predetermined ADL schedule is being followed. Resident ADL status meets his current needs and preferences. [redacted] was not adversely affected by the delay in ADL care. 2. All residents have the potential to be affected by not providing activities of daily living to maintain good nutrition, grooming and personal and oral hygiene per personal preference. All resident task lists were reviewed and updated to reflect their individualized preferences. 3. Staff received education for timeliness and completion of activities of daily living and process for notification to Unit Manager/Supervisor when unable to complete ADL care. 4. To monitor and maintain ongoing compliance the Unit Manager(s) or Designee will audit the timeliness of care weekly for 4 weeks and then monthly for 2 months. Results will be presented to the QAPI team monthly for continued review and recommendations.	

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Resident [redacted] stated that there were too few aides working, that although they work hard, they (the aides) could not get everything done. Due to the schedule, Resident [redacted] was not getting out of bed very often. Some days there were only two aides working but staff had told the resident there should have been at least four, but that it would be better for everyone if there were five or six aides. Resident [redacted] stated that often it took at least half an hour or more before call bells were answered. Resident #[redacted] stated it was not unusual to wait 30 to 60 minutes to be changed. The resident mostly had concerns with the 7:00 AM to 3:00 PM shift.

Registered Nurse (RN) #1 stated in an interview on 11/16/2021 at 10:29 AM that call bells took too long to be answered at times, probably making residents wait half an hour at least. RN #1 stated that licensed practical nurses (LPNs) and RNs frequently had to do patient care in addition to their nursing assignments just to get resident care completed. For the most part, residents were turned about every two hours per RN #1. RN#1 stated that Resident [redacted] had reported to her that [redacted] had to wait to get repositioned or to get out of the bed on a regular basis. When RN #1 had worked that floor, RN #1 ensured that Resident [redacted] was out of bed as early as possible. CNAs had been reminded to get the resident up early when asked to.

Certified Nursing Assistant (CNA) #2 stated in an interview on 11/16/2021 at 4:39 PM that when the facility reopened the unit about a month ago, the number of CNAs were then spread out more over the building. This had caused the level of care to drop even more. In addition to providing care, CNAs must also make sure that residents stayed

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F 677	Continued From page 28	F 677		

in the correct areas and be sure to keep an eye on the residents with behaviors and there were some residents who wanted to fight. CNA #2 stated that they could not provide quality care at 100%, but maybe only 85% because of staff shortages. Also, there were new staff who were not doing as much as they should. CNA #2 stated that sometimes residents did not get what they needed. Residents had to wait too long for the call bell to be answered. CNA #2 stated that tolerance of some staff was low for new residents with how they wanted to be cared for immediately rather than wait for the CNA to finish with another resident. CNA #2 stated that Resident [redacted] liked to get up early and often it was not possible to get the resident up due to other residents that were being taken care of and getting breakfast delivered to all residents on the hall.

On 11/16/2021 at 5:11 PM, Licensed Practical Nurse (LPN) #2 stated in an interview that residents were not always changed in a timely manner.

The Director of Nursing (DON) stated in an interview on 11/16/2021 at 9:23 PM that it was her expectation that all incontinent residents were checked every two hours and changed when needed and all residents who needed assistance with Activities of Daily Living (ADLs) were provided what was needed in a timely manner The DON stated that staff did not always have time. The facility was trying to hire new staff; they were not using agency staff but had recently contacted an agency.

2. A review of Resident [redacted]s medical record indicated the facility admitted Resident [redacted] with diagnoses including [redacted],

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F 677	Continued From page 29 [redacted].	F 677		

A review of Resident [redacted]'s quarterly Minimum Data Set (MDS) dated [redacted], indicated that Resident #8 had a Brief Interview for Mental Status (BIMS)score of [redacted], indicating that the resident was [redacted]. Resident [redacted] required extensive assistance for bed mobility, transfers, dressing, toilet use, and personal hygiene. The resident required total dependence for transfers, and needed supervision (set up help) for locomotion on and off the unit and eating.

During an interview with Resident [redacted] on 11/16/2021 at 10:10 AM, the resident stated they had not gotten out of the bed since [redacted] Resident [redacted] was usually gotten out of bed every other day, but stated with the staff being shorthanded, that did not always happen. Resident [redacted] stated that the call bell could take between 30 to 60 minutes to be answered. Resident [redacted] stated that they had to wait for staff to get to them when they needed assistance and it was frustrating to wait that long to be changed. Resident [redacted] always tried to wait as long as possible to ask for help.

Registered Nurse (RN) #1 stated in an interview on 11/16/2021 at 10:29 AM that call bells took too long to be answered at times, probably making residents wait half an hour at least. RN #1 stated that licensed practical nurses (LPNs) and RNs frequently had to do patient care in addition to their nursing assignments just to get resident care completed. RN #1 stated that due to not having enough staff, residents were not able to get care in a timely manner. The staffing was not enough for the number of residents. For the most

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F 677	Continued From page 30	F 677		

part, residents are turned about every two hours per RN #1. RN #1 stated that no one wanted to work, and the facility was understaffed, and it was very challenging.

Certified Nursing Assistant (CNA) #2 stated in an interview on 11/16/2021 that when the facility reopened the unit about a month ago, the number of CNAs were then spread out more over the building. This had caused the level of care to drop even more. In addition to providing care, CNAs must also make sure that residents stayed in the correct areas and be sure to keep an eye on the residents with behaviors and there were some residents who wanted to fight. CNA #2 stated that they could not provide quality at 100%, but maybe only 85% because of staff shortages. Also, there were new staff who were not doing as much as they should. CNA #2 stated that sometimes residents did not get what they needed. Residents had to wait too long for the call bell to be answered. CNA #2 stated that tolerance of some staff was low for new residents.

On 11/16/2021 at 5:11 PM, Licensed Practical Nurse (LPN) #2 stated in an interview that residents were not always changed in a timely manner.

The Director of Nursing (DON) stated in an interview on 11/16/2021 at 9:23 PM that it was her expectation that all incontinent residents were checked every two hours and changed when needed and all residents who needed assistance with ADLs were provided what was needed in a timely manner. The DON stated that staff did not always have time. The facility was trying to hire new staff. They were not using agency staff but had recently contacted an agency.

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F 677	Continued From page 31 New Jersey Administrative Code: §8:39 - 27.2(l)	F 677		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Complaint Intakes #NJ143783 and #NJ145736 Based on observations, resident and staff interviews, and facility policy review, it was	F 725	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by Provider of the truth or facts alleged or conclusion set	12/14/21

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F 725	Continued From page 32 determined that the facility failed to provide adequate staff to care for residents that required assistance with activities of daily living (ADLs) care for four (Resident [redacted], Resident [redacted] Resident [redacted] and Resident [redacted]) of four residents dependent on staff for care. Findings included: 1. During an interview on 11/16/2021 at 10:00 AM, Resident [redacted] (who was [redacted] with Brief Interview for Mental Status (BIMS) score of [redacted] stated call lights were frequently unanswered for hours. Resident [redacted] stated the nurses would not help all the residents in a timely manner. Resident [redacted] stated if water or ice were needed, the resident would have to go to the nurses' station and get ice water because the nurses would not answer. Resident [redacted] (who was [redacted] with a BIMS score of [redacted]) stated in an interview on 11/16/2021 at 10:05 AM that staffing was always a problem. It was frequently 11:00 AM before staff got the resident out of bed. Resident [redacted] was observed still in bed during the interview. Due to [redacted] that was worse when in bed, Resident [redacted] stated that sitting in a chair helped to relieve the [redacted]. Resident [redacted] stated that there were too few aides working. Although they work hard, they (the aides) could not get everything done. Due to the schedule, Resident [redacted] was not getting out of bed very often. Some days there were only two aides working but staff had told the resident there should be at least four, but that it would be better for everyone if there were five or six aides. Resident [redacted] stated that often it took at least half an hour or more before call bells were answered. Resident [redacted] stated it was not unusual	F 725	forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State laws require it. F725 Sufficient Nursing Staff 1. DON assessed and interviewed Residents [redacted] and [redacted] and none were adversely affected by the staffing on the days observed. 2. All residents have the potential to be affected by staffing inconsistencies. 3. Recruitment efforts continue to include: a. Job fairs b. Daily staffing meetings c. Licensed professionals assigned to aide in performance of ADL care. d. Sponsored orientees for 45 days toward retention of new hires e. Care Champion mentor program to support retention f. Culture committee to improve and maintain staff morale g. Recruitment bonus and increased sign-on bonuses offered. h. Contracted with outside agency 4. To monitor and maintain ongoing compliance the DON or designee will monitor staffing daily for 1 week, weekly for 3 weeks and monthly for 2 months. Results will be presented to the QAPI team monthly for continued review and recommendations.	

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to wait 30 to 60 minutes to be changed. The resident mostly had concerns with the 7:00 AM to 3:00 PM shift.

During an interview with Resident [redacted] (who was [redacted] with BIMS score of [redacted]) on 11/16/2021 at 10:10 AM, the resident stated they had not gotten out of the bed since [redacted]. Resident [redacted] was usually gotten out of bed every other day, but stated with the staff being shorthanded, that did not always happen. Resident [redacted] stated that the call bell could take between 30 to 60 minutes to be answered. Resident [redacted] stated that they had to wait for staff to get to them when they needed assistance and it was frustrating to wait that long to be changed. Resident [redacted] always tried to wait as long as possible to ask for help.

Registered Nurse (RN) #1 stated in an interview on 11/16/2021 at 10:29 AM that call bells took too long to be answered at times, probably making residents wait half an hour at least. RN #1 stated that licensed practical nurses (LPNs) and RNs frequently had to do patient care in addition to their nursing assignments just to get resident care completed. For the most part, residents were turned about every two hours per RN #1. RN#1 stated that Resident [redacted] had reported to her that [redacted] had to wait to get repositioned or to get out of the bed on a regular basis. When RN #1 had worked that floor, RN #1 ensured that Resident [redacted] was out of bed as early as possible. CNAs had been reminded to get the resident up early when asked to.

During an observation of the [redacted] Unit on 11/16/2021 at 2:10 PM, two call lights were flashing and audibly alarming in the nurse's

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station. RN #1 and LPN #3 were sitting in the station as the call lights were flashing and alarming. At 2:20 PM another call light began to sound. RN #1 and LPN #3 remained seated. At 2:35 PM the call lights stopped alarming.

During an interview on 11/16/2021 at 2:32 PM, RN #1 stated all staff members were responsible for answering the call lights. RN #1 stated "in a perfect world the call lights would be answered immediately, but if other residents were receiving care, then it would take longer." RN #1 was not sure how long the call lights were ringing but felt it was not that long. RN #1 stated licensed nurses were included in those responsible for answering call lights.

During an interview on 11/16/2021 at 2:35 PM, CNA #1 stated there was a big problem with staffing in the facility, and the assignments were not safe. CNA #1 stated that on an average day the CNA had [redacted] residents to care for, which would make it impossible to answer call lights in a timely manner, turn the residents every two hours, or change their briefs in a timely manner. CNA #1 stated each work shift was spent "putting out fires" and just "trying to keep them alive until 3:00 PM." CNA #1 stated the time spent with each resident was minimal, and the CNA had sat down to calculate the exact time with each resident a shift. CNA #1 stated each resident was seen by CNA #1, "4 minutes and 15 seconds per day." CNA #1 stated this was not the care the residents deserved, but it was all they could do with the limited staff. CNA #1 stated the care provided consisted of changing a resident and moving on.

Certified Nursing Assistant (CNA) #2 stated in an

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interview on 11/16/2021 at 4:39 PM that when the facility reopened the unit about a month ago, the number of CNAs were then spread out more over the building. This had caused the level of care to drop even more. In addition to providing care, CNAs must also make sure that residents stayed in the correct areas and be sure to keep an eye on the residents with behaviors and there were some residents who wanted to fight. CNA #2 stated that they could not provide quality care at 100%, but maybe only 85% because of staff shortages. Also, there were new staff who were not doing as much as they should. CNA #2 stated that sometimes residents did not get what they needed. Residents had to wait too long for the call bell to be answered. CNA #2 stated that tolerance of some staff was low for new residents with how they wanted to be cared for immediately rather than wait for the CNA to finish with another resident. CNA #2 stated that Resident [redacted] liked to get up early and often it was not possible to get the resident up due to other residents that were being taken care of and getting breakfast delivered to all residents on the hall.

During an interview on 11/16/2021 at 6:15 PM, Resident [redacted] (who was [redacted] with BIMS score of [redacted]) stated call lights were never answered in a timely fashion. Resident [redacted] stated the average wait was between 30 minutes to 1 hour. Resident [redacted] stated this was the same throughout all shifts. At 6:20 PM, Resident [redacted] pushed the call light to provide an example of the normal response time. At 6:35 PM the call light was still unanswered.

On 11/16/2021 at 5:11 PM, Licensed Practical Nurse (LPN) #2 stated in an interview that residents were not always changed in a timely

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manner.

During an interview on 11/16/2021 at 9:04 PM, the DON stated everybody was responsible for answering call lights. The DON stated the appropriate wait time for a call light to be answered was 10 to 15 minutes. The DON stated it was important to answer call lights timely in case the residents needed urgent attention.

The Director of Nursing (DON) stated in an interview on 11/16/2021 at 9:23 PM that it was her expectation that all incontinent residents were checked every 2 hours and changed when needed. It was also expected that all residents had their needs met by staff when they were unable to do things for themself. The DON stated that staff do not always have time. The facility was trying to hire new staff. They were not using agency staff but have recently contacted an agency.

The undated "Staffing" policy revealed, "Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with the resident care plans and facility assessment ...2. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's care plan."

The undated "Answering the Call Light" policy revealed, "The purpose of this procedure is to ensure timely responses to the resident's requests and needs."

New Jersey Administrative Code § 8:39-5.1(a)

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F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ143783 Based on interviews, record reviews, and review of facility policies and references, it was determined that the facility failed to follow the insulin (a significant medication that is required to be given at specific times in relation to meal times) administration schedule as ordered by the physician for one (Resident [redacted] of two residents reviewed for timely medication administration. Findings included: Reference: A review of the American [redacted] Association's website ([redacted] retrieved on [redacted] indicated, [redacted] can be a serious problem if you don't treat it, so it's important to treat as soon as you detect it. If you fail to treat [redacted] could occur. [redacted] develops when your body doesn't have enough [redacted] Without [redacted] your body can't use [redacted] so your [redacted]." 1. A review of Resident [redacted] medical record indicated the facility admitted the resident with diagnoses that included [redacted] and [redacted]	F 760	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by Provider of the truth or facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State laws require it. F760 Medication Errors 1. DON assessed and interviewed Resident [redacted] and communicated findings to the Practitioner. Resident [redacted] was not adversely affected by late administration of diabetic medication orders. 2. All diabetic residents have the potential to be affected. All resident□s orders were audited to assure that administration time was appropriate. 3. Licensed staff educated on medication administration and physician notification process when giving a medication outside of parameters. 4. To monitor and maintain ongoing compliance the DON or Designee will audit diabetic medication administration weekly for 4 weeks and then monthly for 2 months. Results will be presented to the QAPI team monthly for continued review and recommendations.	12/14/21

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F 760	Continued From page 38 [redacted] Resident [redacted] quarterly Minimum Data Set (MDS) dated [redacted], indicated the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident was [redacted]. A review of Resident [redacted]s comprehensive care plan, dated [redacted], indicated a care plan was in place for [redacted] problems related to [redacted]. The care plan indicated Resident [redacted] was to be maintained between [redacted]. The care plan indicated interventions to maintain Resident [redacted] levels in the therapeutic range included [redacted] three times a day. A review of Resident [redacted]s physicians' orders, dated [redacted], indicated the resident was to receive [redacted] of [redacted] every morning. The resident was to receive [redacted] of [redacted] at bedtime, as of orders dated [redacted]. A review of Resident [redacted] physicians' orders, dated [redacted], indicated the resident was to receive [redacted] of [redacted] before meals at 8:00 AM, 11:00 AM, and 4:00 PM. A review of Resident [redacted] levels for the month of [redacted] 2021 were: [redacted] at 8:00 AM = [redacted] at 11:00 AM = [redacted] at 4:00 PM = [redacted] at 9:00 PM = [redacted] at 8:00 AM = [redacted] at 11:00 AM = [redacted] at 4:00 PM = [redacted]	F 760		

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A review of Resident [redacted]'s Medication Administration Record (MAR) for [redacted] given the month of [redacted] were:
On [redacted], the 11:00 AM [redacted] dose was given at 12:51 PM
On [redacted], the 9:00 PM [redacted] dose was given on [redacted] at 12:19 AM
On [redacted], the 8:00 AM [redacted] dose was given at 10:32 AM.
On [redacted], the 8:00 AM [redacted] dose was given at 10:26 AM
On [redacted] the 11:00 AM [redacted] dose was given at 12:31 PM
On [redacted], the 11:00 AM [redacted] dose was given at 1:51 PM

During an interview on 11/16/2021 at 10:00 AM, Resident [redacted] stated medications were often given late. The time frame in which medications should be given was one hour before or one hour after they were scheduled. The resident stated ordered [redacted] was not administered in a timely fashion. Resident [redacted] stated the day prior ([redacted]), the resident was made to wait two hours for the resident's [redacted] and that was not the first time the [redacted] was given late. The resident stated it was not good for the resident's health to be in [redacted] or to have [redacted]. Resident [redacted] stated their [redacted] levels were out of control, and it was because the nurses were not giving the resident their [redacted] when they needed to. Resident [redacted] stated [redacted] levels could lead to a [redacted].

During a concurrent interview and record review on 11/06/2021 at 5:30 PM, Licensed Practical Nurse (LPN) #2 stated medications could be administered one hour before or one hour after the scheduled time. LPN #2 stated this allowed

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time for nurses to pass medications to all the residents. LPN #2 stated [redacted] administration could vary, depending on the resident and the [redacted]. LPN #2 stated if the [redacted] was [redacted] should be given on time. LPN #2 stated it was important to give scheduled [redacted] on time to ensure [redacted] were controlled. LPN #2 stated [redacted] levels could be dangerous. LPN #2 reviewed Resident [redacted] medication administration record for the month of [redacted] and confirmed Resident [redacted] was given late and stated it needed to be given timely due to the resident's [redacted].

During a concurrent interview and record review on 11/16/2021 at 9:04 PM, the Director of Nursing (DON) stated the window for medication administration was one hour before or one hour after. The DON stated it was important to give [redacted] on time to avoid [redacted] levels. The DON stated [redacted] levels could be dangerous for health. The DON reviewed Resident [redacted] levels for [redacted] and stated the resident tended to have [redacted] levels and needed to have [redacted] administered on time. The DON reviewed Resident [redacted]s MAR and confirmed the resident was not receiving the ordered [redacted] and [redacted] in the medication administration time window. The DON stated it was not appropriate to administer medications late and doing so could affect control of [redacted] and could lead to [redacted].

A review of the facility's undated policy titled, "Administering Medications," indicated "Medications are administered in a safe and

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F 760	Continued From page 41 timely manner, and as prescribed...Medications are administered in accordance with prescriber orders, including any required time frames." New Jersey Administrative Code § 8:39 - 29.2(d)	F 760		