STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315010	A. BUILDING _____ B. WING _____	C 09/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORA HILLS HEALTH & REHABILITATION CENTER	**225 W JERSEY STREET ELIZABETH, NJ 07202**

(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 #: NJ146238 Census: 155 Sample Size: 6 The Facility is not in substantial compliance with the requirements of 42 CFR PART 483, SUBPART B, for Long Term Care Facilities based on this complaint visit. A COVID-19 Focused Infection Control Survey was conducted. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		10/21/21

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

Electronically Signed | 10/08/2021

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F 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Complaint Intake: NJ146238 Based on interviews, record reviews, and facility policy review, it was determined that the facility failed to ensure one (Resident [redacted]) out of three residents was treated with respect and dignity by a certified nursing assistant (CNA). This could affect residents by promoting a negative sense of well-being. Findings included: 1. Resident [redacted] was admitted to the facility on [redacted] with diagnoses that included [redacted]	F 550	F550 SS=D 1) All residents on CNA #4 post were interviewed and no complaints or allegations were made. Residents stated CNA #4 made sure their needs were met in a respectful and pleasant manner. CNA # 4 was removed from taking care of resident [redacted] and DON and Administrator followed up with resident to ensure he was ok and there was no harm which he confirmed. 2) All residents can be affected by this	

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F 550	Continued From page 2 Executive Order 26, The admission Minimum Data Set (MDS) dated Executive Order 26, 4.b. revealed a Brief Interview for Mental Status (BIMS) of Executive Order 26, 4 Executive Order 26, indicating Executive Order 26, 4.b.. Resident required assistance of one person for most activities of daily living (ADLs), including showering. Resident had a care plan, dated Executive Order 26, 4.b. for impairment in physical function and to encourage the resident to do as much for self as the resident can do. On 09/17/2021 at 12:21 PM, CNA #2 was interviewed. CNA #2 stated they were taught to always treat the residents with respect and dignity. CNA #2 stated CNA #4 was verbally abusive to residents, and CNA #2 had reported it to her Unit Manager, Registered Nurse (RN) #1. CNA #2 described a recent encounter between a resident (Resident and CNA #4 (date unknown) when CNA #4 was trying to "bully" Resident to take a shower. She stated CNA #4 had worked at the facility for a long time, and this was a change in CNA #4's behavior, but there was no pattern, and it was happening on and off for a while. She continued by stating that CNA #4 provided good care, and that it was mostly the way she talked to both residents and her co-workers. CNA #2 stated, "It needs to stop." On 09/17/2021 at 12:45 PM, CNA #4 was interviewed. CNA #4 stated she had received training on both resident rights and abuse. She stated she knew that when a resident said "No" then she knew to try again because some residents needed encouragement, but that "No	F 550	practice. There were no negative outcomes to the residents. 3) All staff including CNA# 4 were in-serviced on residents rights. 4) DON, ADON or designee will randomly interview residents, weekly x 4 weeks then monthly x 3 months to ensure their needs are being met in a respectful and pleasant manner. DON or designee will report their findings to the QA and IDC team at the Quarterly Quality Assurance Improvement Meeting.	

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F 550	Continued From page 3	F 550		

meant no," and she could not force residents to do anything they didn't want to do. CNA #4 explained she had an incident with Resident [redacted] regarding the way she spoke to the resident about taking a shower. She was called in to talk to the Director of Nursing (DON) and RN #1. CNA #4 stated she received a written warning and education about abuse and resident rights. CNA #4 described herself as having a "strong voice" and stated she was not trying to abuse Resident [redacted] CNA #4 stated, "The same approach that had brought me success, was now bringing me trouble."

On 09/17/2021 at 2:24 PM, RN #1 was interviewed. RN #1 described CNA #4 as someone that can come across as pushy; she says what she's thinking, and she doesn't sugar coat anything. She can be a bit loud, but "we all know that's just who she is." RN #1 continued to describe CNA #4 as a caregiver with a big heart, not rough when providing care, and a good worker who encouraged the residents.

On 09/17/2021 at 3:05 PM, Licensed Practical Nurse (LPN) #3 was interviewed. LPN #3 stated on the day of the incident with Resident [redacted], LPN #3 was working the medication cart. She had heard that Resident [redacted] didn't want to take a shower, but that the resident later agreed to take a shower. LPN #3 stated talking with Resident [redacted] and the resident wanted a different CNA because the resident felt like they were being treated as if they were in the military. LPN #3 believed CNA #4 did not realize how she came across to people because her voice carried. LPN #3 stated a lot of residents really love her and her encouragement.

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F 550	Continued From page 4 On 09/17/2021 at 3:30 PM, Resident [redacted] was interviewed. Resident [redacted] stated the morning of the incident, date unknown, CNA #4 entered the room without knocking, woke up Resident [redacted] and demanded Resident [redacted] "Get up now," and "You're taking a shower." Resident [redacted] stated she sounded like a bully. "She's an excellent nurse, but she was way too pushy." Resident [redacted] continued by stating that the concern was for the residents who couldn't fight back. CNA #4 was disrespectful. Overall, she's got a very aggressive attitude, per Resident [redacted] To quote Resident [redacted], Executive Order 26, 4.b. Executive Order 26, 4.b., [redacted] Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. Plenty of people are fearful of her." The resident stated reporting the behavior to the DON because the resident did not want any other residents to feel intimidated by her. The resident reported asking for CNA #4 to not be assigned to Resident [redacted] care. Lastly, Resident [redacted] stated, "I felt like she was a drill sergeant." On 09/17/2021 at 3:58 PM, the DON was interviewed. The DON stated the expectation was that all residents were treated with respect and dignity. Regarding the incident between Resident [redacted] and CNA #4, the DON said she was in early one morning when Resident [redacted], on the resident's way out the door for an appointment, stopped by the DON's office to make the DON aware of what happened. The resident didn't want to get CNA #4 in trouble because she was a good nurse, but she could be intimidating. Resident [redacted] was not intimidated by her, but someone should talk to her. The DON indicated CNA #4 could come across tough, and the way	F 550		

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F 550	Continued From page 5 she walked into a room could be intimidating. The DON stated that in her interview with Resident [redacted], the resident stated not being intimidated or scared, so an investigation for potential of abuse/resident rights was not completed. The DON had not suspended CNA #4 pending any type of an investigation because an investigation was not completed. Because the DON had never received a complaint about CNA #4 before, she said she did not feel as though an investigation needed to be completed. On 09/17/2021 at 4:38 PM, the Nursing Home Administrator (NHA) was interviewed. The NHA stated he spoke with Resident [redacted] after the incident. Resident [redacted] explained to the NHA that CNA #4 was a good nurse, but Resident [redacted] did not like the way CNA #4 spoke to the resident. The NHA stated he thought the DON and himself acted quickly by talking with CNA #4 and completing re-education with her. He stated he was shocked to think they should have investigated for abuse, because he felt the facility would have received more complaints about CNA #4 if she was truly being intimidating. He was surprised none of CNA #4's co-workers had brought this issue to his attention. The facility policy, titled, Resident Rights, dated June 2021, read, in part: Physical and Personal Environment - To be treated with courtesy, consideration and respect for your dignity and individuality. New Jersey Administrative Code § 8:39-4.1(a)(12)	F 550		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		11/12/21

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F 610	Continued From page 6 §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: NJ146238 Based on interviews, record reviews, and facility policy review, it was determined that the facility failed to ensure an allegation of intimidation was investigated for potential abuse for one (Resident [redacted]) out of 3 residents reviewed for abuse. Findings included: 1. The surveyor entered the facility on 09/17/2021 to investigate an anonymous complaint for an allegation of abuse. Resident [redacted] was admitted to the facility on [redacted] with diagnoses that included [redacted]	F 610	F610 SS=D 1) All residents on CNA #4 post were interviewed and no complaints or allegations were made. Residents stated CNA #4 made sure their needs were met in a respectful and pleasant manner. CNA # 4 was removed from taking care of resident [redacted] and DON and Administrator followed up with resident to ensure he was ok and there was no harm which he confirmed. 2) All residents can be affected by this practice. There were no negative	

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F 610	Continued From page 7 Executive Order 26, The admission Minimum Data Set (MDS) dated Executive Order 26, 4.b. revealed a Brief Interview for Mental Status (BIMS) of Executive Order 26, 4 indicating Executive Order 26, 4.b.. Resident Executive Execu required assistance of one person for most activities of daily living (ADLs), including showering. Resident Execu had a care plan, dated Executive Order 26, 4.b. for impairment in physical function and to encourage the resident to do as much for self as the resident can do. On 09/17/2021 at 12:21 PM, CNA #2 was interviewed. CNA #2 stated they were taught to always treat the residents with respect and dignity. CNA #2 stated CNA #4 was verbally abusive to residents, and CNA #2 had reported it to her Unit Manager, Registered Nurse (RN) #1. CNA #2 described a recent encounter between a resident (Resident Execu) and CNA #4 (date unknown) when CNA #4 was trying to "bully" Resident Execu to take a shower. She stated CNA #4 had worked at the facility for a long time, and this was a change in CNA #4's behavior, but there was no pattern, and it was happening on and off for a while. She continued by stating that CNA #4 provided good care, and that it was mostly the way she talked to both residents and her co-workers. On 09/17/2021 at 12:45 PM, CNA #4 was interviewed. CNA #4 stated she had received training on both resident rights and abuse. She stated she knew that when a resident said "No" then she knew to try again because some residents needed encouragement, but that "No meant no," and she could not force residents to	F 610	outcomes to the residents. 3) All staff including CNA # 4 were in-serviced on all forms of abuse. All staff including VNA # 4 were in-serviced on reporting abuse. 4) DON, ADON or designee will randomly interview residents, weekly x 4 weeks then monthly x 3 months to ensure their needs are being met in a respectful and pleasant manner. DON or designee will report their findings to the QA and IDC team at the Quarterly Quality Assurance Improvement Meeting.	

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F 610	Continued From page 8	F 610		

do anything they didn't want to do. CNA #4 explained she had an incident with Resident [redacted] regarding the way she spoke to the resident about taking a shower. She was called in to talk to the Director of Nursing (DON) and RN #1. CNA #4 stated she received a written warning and education about abuse and resident rights. CNA #4 described herself as having a "strong voice" and stated she was not trying to abuse Resident [redacted]. CNA #4 stated, "The same approach that had brought me success, was now bringing me trouble."

On 09/17/2021 at 2:24 PM, RN #1 was interviewed. RN #1 described CNA #4 as someone that can come across as pushy; she says what she's thinking, and she doesn't sugar coat anything. She can be a bit loud, but "we all know that's just who she is." RN #1 continued to describe CNA #4 as a caregiver with a big heart, not rough when providing care, and a good worker who encouraged the residents. RN #1 stated Resident [redacted] told her CNA #4 had "an intimidating way about her. Although Resident [redacted] was not intimidated, others may be [intimidated]."

On 09/17/2021 at 3:05 PM, Licensed Practical Nurse (LPN) #3 was interviewed. LPN #3 stated on the day of the incident with Resident [redacted], LPN #3 was working the medication cart. She had heard that Resident [redacted] didn't want to take a shower, but that the resident later agreed to take a shower. LPN #3 stated talking with Resident [redacted] and the resident wanted a different CNA because the resident felt like they were being treated as if they were in the military. LPN #3 believed CNA #4 did not realize how she came across to people because her voice carried. LPN

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F 610	Continued From page 9 #3 stated a lot of residents really love her and her encouragement. On 09/17/2021 at 3:30 PM, Resident [redacted] was interviewed. Resident [redacted] stated the morning of the incident, date unknown, CNA #4 entered the room without knocking, woke up Resident [redacted] and demanded Resident [redacted] "Get up now," and "You're taking a shower." Resident [redacted] stated she sounded like a bully. "She's an excellent nurse, but she was way too pushy." Resident [redacted] continued by stating that the concern was for the residents who couldn't fight back. CNA #4 was disrespectful. Overall, she's got a very aggressive attitude, per Resident [redacted] To quote Resident [redacted] Executive Order 26, 4.b. [redacted] Executive Order 26, 4.b.." The resident stated reporting the behavior to the DON because the resident did not want any other residents to feel intimidated by her. The resident reported asking for CNA #4 to not be assigned to Resident [redacted] care. Lastly, Resident [redacted] stated, "I felt like she was a drill sergeant." On 09/17/2021 at 3:58 PM, the DON was interviewed. Regarding the incident between Resident [redacted] and CNA #4, the DON said she was in early one morning when Resident [redacted], on the resident's way out the door for an appointment, stopped by the DON's office to make the DON aware of what happened. The resident didn't want to get CNA #4 in trouble because she was a good nurse, but she could be intimidating. Resident [redacted] was not intimidated by her, but someone should talk to her. The DON indicated CNA #4 could come across tough, and the way	F 610		

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F 610	Continued From page 10	F 610		

she walked into a room could be intimidating. The DON stated that in her interview with Resident [redacted] the resident stated not being intimidated or scared, so an investigation for potential of abuse/resident rights was not completed. The DON had not suspended CNA #4 pending any type of an investigation because an investigation was not completed. Because the DON had never received a complaint about CNA #4 before, she said she did not feel as though an investigation needed to be completed.

On 09/17/2021 at 4:38 PM, the Nursing Home Administrator (NHA) was interviewed. The NHA stated he spoke with Resident [redacted] after the incident. Resident [redacted] explained to the NHA that CNA #4 was a good nurse, but Resident [redacted] did not like the way CNA #4 spoke to the resident. The NHA stated he thought the DON and himself acted quickly by talking with CNA #4 and completing re-education with her. He stated he was shocked to think they should have investigated for abuse, because he felt the facility would have received more complaints about CNA #4 if she was truly being intimidating. He was surprised none of CNA #4's co-workers had brought this issue to his attention.

The facility policy, titled, Abuse/Neglect Policy and Procedure, dated February 2021, read in part: Section V. B. Notification 1. Any staff member witnessing or receiving an allegation of abuse/neglect of any resident shall notify the nursing supervisor immediately after witnessing the incident or receiving the allegation of abuse/neglect. 5. The administrator or his/her designee will immediately notify the resident/resident representative of (a) the alleged

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F 610	Continued From page 11 abuse/neglect, (b) that an investigation has been initiated, and (c) once complete, inform them of the results of the investigation. New Jersey Administrative Code § 8:39-5.1(a)	F 610		