STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315426	A. BUILDING _____ B. WING _____	C 02/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT RIDGEWOOD AVENUE	W-90 RIDGEWOOD AVE PARAMUS, NJ 07652

(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 #: NJ 143004 CENSUS: 82 SAMPLE: 3 F600 Based on observations, interview, record review, and review of pertinent facility documents on 2/19/21 and 2/22/21, it was determined that the facility failed to protect a [redacted] resident with multiple behaviors from staff to resident abuse as well as follow the facility's "Abuse Prevention Program" policy. The deficient practice was identified for 1 of 3 residents reviewed for abuse (Resident #1). On [redacted] during the 3:00 PM to 11:00 PM shift, Resident #1 was physically restrained by a [redacted] to his/her [redacted] and not released from the restraint until the following day on [redacted] at 8:00 AM. The Resident was restrained by two Registered Nurses (RN) during two shifts and witnessed by the Certified Nursing Assistant (CNA) on both shifts. Staff failed to notify the physician or supervisor of the resident's condition during this time. This placed all [redacted] residents in immediate jeopardy and at risk for abuse. The Immediate Jeopardy (IJ) ran from 2/10/21 during the 3:00 PM to 11:00 PM shift until 2/11/21, when the Physiatrist alerted the resident's Licensed Practical Nurse (LPN) who immediately removed the restraint and notified facility Administration. The IJ was Past Non-Compliance (PNC).	F 000		

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

Electronically Signed | 03/24/2021

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F 000	Continued From page 1 The PNC IJ was identified from 2/10/21 during the 3:00 PM to 11:00 PM shift which continued until 2/11/21 at 8:00 AM, when the resident was released from this restraint. The facility was back in compliance when they addressed this situation by immediately removing Resident #1 from the restraint, suspending the two RNs upon investigation which led to termination, and in-servicing all staff on abuse and restraints. The facility's LNHA was notified of the PNC IJ on 3/10/21 at 1:45 PM via telephone.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Complaint #: NJ 143004 Based on observations, interview, record review, and review of pertinent facility documents on	F 600	Please be advised that the admission of this plan of correction is not an admission of liability and we are filing as requested.	2/22/21

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F 600	Continued From page 2 2/19/21 and 2/22/21, it was determined that the facility failed to protect a [redacted] resident with multiple behaviors from staff to resident abuse as well as follow the facility's "Abuse Prevention Program" policy. The deficient practice was identified for 1 of 3 residents reviewed for abuse (Resident #1). On [redacted] during the 3:00 PM to 11:00 PM shift, Resident #1 was physically restrained by a [redacted] to his/her [redacted] and not released from the restraint until the following day on [redacted] at 8:00 AM. The Resident was restrained by two Registered Nurses (RN) during two shifts and witnessed by the Certified Nursing Assistant (CNA) on both shifts. Staff failed to notify the physician or supervisor of the resident's condition during this time. This placed all [redacted] residents in immediate jeopardy and at risk for abuse. The Immediate Jeopardy (IJ) ran from 2/10/21 during the 3:00 PM to 11:00 PM shift until 2/11/21, when the Physiatrist alerted the resident's Licensed Practical Nurse (LPN) who immediately removed the restraint and notified facility Administration. The IJ was Past Non-Compliance (PNC). The PNC IJ was identified from [redacted] during the 3:00 PM to 11:00 PM shift which continued until [redacted] at 8:00 AM, when the resident was released from this restraint. The facility was back in compliance when they addressed this situation by immediately removing Resident #1 from the restraint, suspending the two RNs upon investigation which led to termination, and in-servicing all staff on abuse and restraints. The facility's LNHA was notified of the PNC IJ on 3/10/21 at 1:45 PM via telephone. The evidence was as follows:	F 600	Past noncompliance, no additional POC required.	

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F 600	Continued From page 3 1. According to the "Admission Record", Resident #1 was admitted to the facility in [redacted], with diagnoses which included: [redacted] According to the admission Minimum Data Set (MDS), an assessment tool dated [redacted], reflected a Brief Interview for Mental Status (BIMS) unable to be conducted on the resident. The assessment reflected that the resident had both a [redacted] memory problem with [redacted] cognition. According to the MDS in Section [redacted]. Functional Status, the resident had for functional range of motion impairment on [redacted] of his/her [redacted] and impairment on [redacted] of his/her [redacted]. The resident required total dependence of staff with a two person physical assist for bed mobility and transfer. According to the Progress Notes (PN), that from [redacted] through [redacted], the resident was observed continuously removing his/her [redacted] on [redacted] occasions with his/her	F 600		

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F 600	Continued From page 4 [redacted]. A Nursing Note (NN) dated [redacted] at 3:30 PM indicated that the resident had attempted several times to remove his/her [redacted] The note further reflected that the resident was unable to understand this due to [redacted]. A further review of the PN reflected from [redacted] through [redacted], that the resident [redacted]) on [redacted] occasions. The notes included that the doctor was made aware with no new orders. A review of the resident's Care Plan (CP) dated [redacted], included a focus of difficulty communicating related to diagnosis of [redacted] t and cognitive status initiated on [redacted]. Interventions included; to anticipate and meet needs, communicate using yes or no questions when able, refer to therapy plan of treatment in the medical record for more detail, and [redacted] evaluation and treatment. The CP had not reflected the resident's behaviors of removing the [redacted] or [redacted], or [redacted] prior to the incident on [redacted]. A further review of the CP reflected an initiated focus on [redacted], past the incident, for being at risk for behavior symptoms related to [redacted] disability, pulling off [redacted], pulling at [redacted], and pulling at [redacted]. Interventions included; to administer medications per physicians order, observe for mental status and behavioral changes when new medication started or with changes in dosage, [redacted] referral as needed, and use consistent approaches when caregiving. According to the Facility's Reportable Event	F 600		

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(FRE) dated [redacted], with an event date on [redacted], and a time of event at 8:00 AM, revealed the following: Resident #1 was found by a staff nurse with his/her [redacted] to his/her [redacted] at 8:00 AM with a [redacted] to prevent him/her from pulling out their [redacted]. The resident had a history of [redacted]. The FRE indicated that the resident had a history of removing the [redacted] at the facility, and had a BIMS score of [redacted] The report included that two Registered Nurses (RN) were suspended pending further investigation.

The FRE included that the State's Ombudsman and the resident's representative were notified. The FRE did not include that local law enforcement was contacted.

On 2/19/21 at 12:13 PM, the surveyors conducted entrance conference with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The LNHA stated that during the 7:00 AM to 3:00 PM shift on [redacted], the Licensed Practical Nurse (LPN) reported to the DON that th [redacted] was making rounds that morning and observed Resident #1 was physically restrained with a [redacted] tied to his/her [redacted] against the [redacted]. When the LPN was made aware, she immediately went to the resident's room with the [redacted] and untied the resident. The LPN made the RN/Unit Manager (RN/UM) aware of this incident immediately and the DON upon arrival to the facility. An investigation was initiated and it was determined that RN #1 on the [redacted] 3:00 PM to 11:00 PM shift, restrained the resident to prevent

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him/her from removing the [redacted] and that RN #2 on the following [redacted] 11:00 PM to 7:00 AM shift continued to restrain the resident. CNA #1 was the same aide for both shifts, and questioned both nurses if the restraint was okay. The CNA was informed "she was not the nurse" and had not questioned further. The LNHA stated that the nurses had not contacted the physician, and there was no physician's order to restrain the resident. The LNHA stated that upon completion of the investigation, the facility terminated both RN #1 and RN #2's employment and reported the incident to the Nursing Licensing Board as well as the New Jersey Department of Health (NJDOH).

On 2/19/21 at 1:00 PM, the surveyor interviewed CNA #1 via telephone who confirmed that she worked both the 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM shift on [redacted]. The CNA stated that on [redacted], during the 3:00 PM to 11:00 PM shift, she witnessed RN #1 tie Resident #1's [redacted] to the [redacted] with a [redacted]. The CNA stated that during the 11:00 PM to 7:00 AM shift, she observed RN #2 tie Resident #1's [redacted] to the bed side rail with a bed sheet. The CNA stated that she questioned both nurses if restraining the resident was okay, and both nurses told her that it was. The CNA stated that since both nurses had confirmed that this was okay, she had not questioned the restraint further or reported the restraint to the Supervisor or Administration.

On 2/19/21 at 1:20 PM, the surveyor interviewed CNA #2 via telephone who stated that she was Resident #1's aide on the 7:00 AM to 3:00 PM shift on [redacted] The CNA stated that on that morning when she arrived to the unit, another resident had needed assistance so she did that

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first instead of making rounds. The CNA stated that when she was finished with that resident, LPN #1 approached her regarding Resident #1 being restrained. The CNA stated that she had not seen the resident, and if she had, she would have immediately reported that to the LPN.

On 2/19/21 at 1:26 PM, the surveyor interviewed RN #1 via telephone who stated that she had been terminated that day from the facility, but verified that she worked the 3:00 PM to 11:00 PM shift on [redacted]. The RN stated that Resident #1 was [redacted] with a [redacted] that he/she tried to remove and had removed three or four times already which resulted in [redacted] and [redacted]. The RN reported that shift, the resident kept trying to remove his/her [redacted] and she feared for the resident's safety so she tied the resident to his/her [redacted] with a [redacted]. The RN stated that she had [redacted] residents plus one CNA with no supervisor and needed help. The RN confirmed that she had not called the physician or tried any less restrictive interventions prior.

On 2/19/21 at 2:28 PM, the surveyor interviewed RN #2 via telephone who stated that she had been terminated that day from the facility, but worked the 11:00 PM to 7:00 AM shift on [redacted]. The RN stated that Resident #1 always tried to remove his/her [redacted], and she was instructed by the RN/UM to insert a new [redacted] if the resident had removed his/her [redacted]. The RN stated that she knew she could not tie-up the resident, but she had multiple high risk residents that night to care for so she continued with the restraint for his/her safety. The RN stated that there was no supervisor that evening, and that she could not call the physician for a

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restraint order during the evening because it was not considered an emergency.

On 2/19/21 at 2:48 PM, the surveyor interviewed the LNHA who stated that the facility does not have a documented twenty-four hour shift to shift report. The nurses verbally reported anything to the oncoming nurse. The LNHA stated that RN #2 informed her that she verbally told the RN/UM, but the RN/UM denied that. The LNHA stated that RN #2 never informed the RN/UM, and there was no documentation that verified that had occurred.

On 2/19/21 at 3:29 PM, the surveyor interviewed the RN/UM via telephone who stated when she arrived to the facility on [redacted], the supervisor from the 11:00 PM to 7:00 AM shift was on a medication cart so she never received a shift report. The RN/UM stated that she had a nurse callout that morning so she was on a medication cart and never saw Resident #1 that morning and was informed of the restraint by the LPN. The RN/UM denied RN #2 reporting the restraint. The RN/UM stated that lately the resident had behaviors of pulling at his/her [redacted], which the doctor was aware of.

On 2/22/21 at 9:31 AM, the surveyor interviewed the RN Supervisor via telephone who stated that she supervised the whole building on the 11:00 PM to 7:00 AM shift. The RN Supervisor stated that her role as the supervisor was to complete the Midnight Census Report, where she went room to room physically observing and counting residents as well as completing an end of shift report. The RN Supervisor stated on the night of the incident, she was assigned to a medication cart and was unable to make rounds of the

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building. The RN Supervisor stated that she was available the entire shift by telephone, and any staff member could have called her. The RN Supervisor stated that the facility used [redacted] from 7:00 PM to 7:00 AM, and all nurses had access to use this system to communicate with a physician. The RN Supervisor confirmed that night, neither RN #1 or #2 had communicated their concerns or situation with Resident #1 with either her or a physician.

On 2/22/21 at 10:22 AM, the surveyor interviewed the DON in the presence of the Regional DON, who stated that nurses were expected at the end of their shifts to verbally communicate any changes in the resident's status that occurred during that shift. The DON stated that the facility recently had an increase in nurse callouts so the supervisors have been on the medication carts so they have not been completing shift reports.

On 2/22/21 at 10:51 AM, the surveyor interviewed the LPN who stated that she was called in to work on [redacted] the 7:00 AM to 3:00 PM shift, so she arrived late to the facility that day. The LPN stated that she never spoke to RN #2, and that the RN/UM never made her aware about Resident #1 being restrained. During her rounds, the [redacted] approached her about Resident #1's restraint; which she immediately accompanied the [redacted] to the resident's room. She observed the resident's [redacted] restrained to the [redacted] with a [redacted] and immediately untied the resident, and the [redacted] completed a physical assessment. The LPN stated that the resident had [redacted] and would have been unable to untie the restraint with his/her [redacted]. The LPN stated that she immediately reported this to the

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RN/UM and completed a statement regarding the incident.

On 2/22/21 at 11:45 AM, the surveyor observed Resident #1 in bed asleep. The resident had a [redacted] on his/her [redacted] and a [redacted] his/her [redacted]. The RN/UM confirmed that the resident was unable to use his/her [redacted]

On 2/22/21 at 12:17 PM, the DON stated that there was no supervisor on the 3:00 PM to 11:00 PM shift on [redacted], but there were two RNs in the building which included RN #1. The DON stated that she was at the facility until 7:30 PM that evening. She reported that she had not completed any rounds prior to leaving, but she spoke to all the nurses. The DON denied being told by RN #1 that Resident #1 was trying to [redacted] him/herself. The DON stated that the resident had [redacted] themselves once or twice before, but the nurses just inserted a new [redacted]

On 2/22/21 at 1:37 PM, the surveyor interviewed the [redacted] via telephone who stated that on the morning on [redacted], he had gone into Resident #1's room to check on the resident. The [redacted] stated that he observed the resident was asleep in bed with his/her [redacted] tied with a [redacted] to the [redacted], and he immediately left the room to find the resident's nurse. The [redacted] stated that the LPN was unaware why the resident was restrained, but she removed the bed sheet immediately. The [redacted] stated he examined the resident afterwards and that the resident could not have functionally used his/her [redacted] in order to untie it.

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On 2/22/21 at 2:16 PM, the surveyor addressed the concerns with the LNHA, DON, Regional DON, and Director of Quality Assurance. The facility administration acknowledged there was a lack of communication and documentation.

A review of RN#1's education Transcripts reflected that she received education that included abuse and handling behaviors on [redacted], and [redacted]

A review of RN#2's in-services reflected that the nurse received abuse education on [redacted]

A review of the facilities "Abuse Investigation and Reporting" policy dated 2001 and revised July 2017 included; that all alleged violations of abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following agencies, "a. State licensing/certification agency responsible for surveying/licensing the facility; d. Adult Protective Services (where state law provides jurisdiction in long-term care)" and "e. Law enforcement officials" immediately, but no later than two hours if the alleged violation involves abuse or has resulted in serious bodily injury.

A review of the facility's "Abuse Prevention Program" dated 2001 and edited 10/11/17 included; that our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation; which includes but is not limited to corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat resident's symptoms.

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During a post survey interview on 3/10/21 at 10:46 AM, the surveyor interviewed the DON via telephone who stated that she reported the incident to the NJDOH since the resident was restrained without a physician's order or anyone's knowledge. The DON stated that she had not contacted law enforcement. The DON stated that staff are trained on abuse which includes different types of abuse such as sexual, financial, physical, and neglect.

During a post survey interview on 3/10/21 at 1:38 PM, the surveyor interviewed the LNHA via telephone who stated that the police were not called because there was no crime, assault, eminent danger, or sexual abuse. The LNHA stated that she did not "think" this incident was considered abuse because there was no bruising or injury to the resident. The LNHA stated there was no willful abuse, she contacted the NJDOH, and that she stands behind her decisions.

This deficient practice placed Resident #1, as well as all cognitively impaired residents in an Immediate Jeopardy situation. The IJ was identified from 2/10/21 during the 3:00 PM to 11:00 PM shift and continued until 2/11/21 at 8:00 AM, when the resident was released from this restraint. The facility was back in compliance when they addressed this situation by immediately removing Resident #1 from the restraint, suspending the two RNs upon investigation which led to termination, and in-servicing all staff on abuse and restraints. The facility's LNHA was notified of the PNC IJ on 3/10/21 at 1:45 PM via telephone.

NJAC 8:39-4.1(a)(5)

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CARE ONE AT RIDGEWOOD AVENUE	W-90 RIDGEWOOD AVE PARAMUS, NJ 07652

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F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §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 #: NJ 143004 Based on interview and review of facility documents, it was determined that the facility failed to a.) report an allegation of staff to resident abuse within two hours to the New Jersey	F 609	Resident #1 had restraint applied on [redacted] by 3-11 nurse sometime after 3pm and removed by LPN at 8am on [redacted]. Reportable incident submitted to the NJDOH [redacted]. Both nurses suspended immediately pending investigation and later terminated.	2/23/21

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F 609	Continued From page 14 Department of Health (NJDOH) and .b) follow the facility's "Abuse Investigation and Reporting" policy. This deficient practice was identified for 1 of 3 residents reviewed for abuse (Resident #1), and was evidenced by the following. 1. According to the "Admission Record", Resident #1 was admitted to the facility in [redacted] with diagnoses which included: [redacted] According to the admission Minimum Data Set (MDS), an assessment tool dated [redacted] reflected a Brief Interview for Mental Status (BIMS) unable to be conducted on the resident. The assessment reflected that the resident had both a [redacted] memory problem with [redacted]. According to the MDS in Section G. Functional Status, the resident had for functional range of motion impairment on [redacted] of his/her [redacted] and impairment on [redacted] of his/her [redacted]. The resident required total dependence of staff with a two person physical assist for bed mobility and transfer.	F 609	Resident #1 was assessed immediately upon notification and suffered no known adverse effects from the application of the restraint. No other residents were affected. Residents with [redacted] who are difficult to redirect and have a history of [redacted] or other medical devices had the potential to be affected. An in-service with all staff and leadership has been completed concerning types of abuse and any possible or suspected abuse as well as potential abuse issues. Timing of the reporting was also discussed. An Elder Justice Act letter has been sent to facility personnel informing them of their duty to inform the facility or the NJDOH of any suspected abuse issues. Confirmation of the 1-800 WE CARE number is posted throughout the facility prominently displaying call number for any possible/suspected abuse in the building. Department of Health number is also prominently displayed for all staff and vendors to ensure widespread compliance. Administrator or designee will report alleged or actual abuse within the required timeframes. Reportable events to include reporting time frames will be reviewed by the Administrator or designee weekly for two months and monthly for one month and forwarded to the QA team quarterly for	

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F 609	Continued From page 15 On [redacted], the facility submitted a reportable incident to the NJDOH for an event that occurred on [redacted]. The facility reported on [redacted] at 8:00 AM; Resident #1 was found by a staff nurse with his/her [redacted] tied to his/her [redacted] with [redacted] to prevent him/her from pulling out their [redacted]. The report included that two Registered Nurses (RN) were suspended pending further investigation. On 2/19/21 at 12:13 PM, the surveyors conducted entrance conference with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The LNHA stated that on [redacted] at 8:00 AM, th [redacted]) was making rounds discovered Resident #1 was physically restrained with a [redacted] tied to his/her [redacted] the [redacted] The [redacted] found the resident's LPN who was then made aware of the situation and untied the resident. The LPN made the RN/Unit Manager (RN/UM) aware of this incident immediately. The DON was informed of the incident upon arrival to the facility and an investigation was initiated. Both Registered Nurse (RN) #1 and #2 were suspended upon the completion of the investigation, which their employment was then terminated. The LNHA stated that the incident was reported to the Nursing Licensing Board as well as the NJDOH. A review of the facility's "Abuse Investigation and Reporting" policy dated 2001 and revised July 2017, included under Reporting; that all alleged violations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or	F 609	one quarter by the Administrator for further discussion.	

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agencies:including the State licensing/certification agency responsible for surveying/licensing the facility immediately, but no later than two hours if the alleged violation involves abuse or has resulted in serious bodily injury. The policy continued that twenty-four hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury.

During a post survey interview on 3/10/21 at 10:46 AM, the surveyor interviewed the DON via telephone who confirmed that she first contacted the NJDOH on [redacted], via telephone and then by the computerized Long Term Care Reportable Event Survey. The DON stated that she had only held the DON title for a few months and that she was unaware of the time frame for reporting incidents. The DON stated that both the LNHA and the Regional Chief of Nursing offered support and guidance for her.

During a post survey interview on 3/10/21 at 1:38 PM, the surveyor interviewed the LNHA via telephone who confirmed that the DON was the person to contact the NJDOH to report the incident that occurred from [redacted] until [redacted] at 8:00 AM on [redacted] The LNHA stated that the facility had twenty-four hours to report the incident. The LNHA stated that the resident was found restrained, and then the DON needed to investigate the situation prior to reporting the the NJDOH. The LNHA acknowledged upon questioning that the facility could report an incident to the NJDOH prior to the start or completion of an investigation. The surveyor reviewed the facility's "Abuse Investigation and Reporting" policy with the LNHA which indicated alleged violations of abuse were to be reported immediately and no later than two hours. The

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F 609	Continued From page 17 LNHA responded that this situation was not considered abuse because it was not willful and the resident was not harmed or injured. NJAC 8:39-9.4(e)	F 609		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		2/23/21

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F 656	Continued From page 18 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 143004 Based on observation, interview, and record review, it was determined that the facility failed to implement a resident's individualized care plan for the management of behaviors for removing a [redacted]. The deficient practice was identified for 1 of 3 residents reviewed for abuse (Resident #1), and was evidenced by the following: 1. According to the "Admission Record", Resident #1 was admitted to the facility in [redacted] with diagnoses which included: [redacted]	F 656	Resident #1 had behavior care plan added to include [redacted] and [redacted] removal on [redacted] Residents with behaviors including dislodging [redacted] and other medical equipment were at risk for not having a care plan to address target behaviors. Resident care plans for each patient have been updated to reflect interventions if needed. Staff have been inserviced regarding initiating resident specific care plans for resident's with behaviors. Care plans will include target behaviors and resident specific interventions. Director of Nursing or designee will review three resident care plans weekly for four weeks and one resident record weekly for eight weeks for residents with behaviors to validate care plan target behaviors are addressed and interventions initiated. Results will be forwarded to the QA team quarterly for one quarter for further follow up if needed.	

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According to the admission Minimum Data Set (MDS), an assessment tool dated , reflected a Brief Interview for Mental Status (BIMS) unable to be conducted on the resident. The assessment reflected that the resident had both a memory problem with severely impaired cognition.

According to the MDS in Section . Functional Status, the resident had for functional range of motion impairment on of his/her and impairment on of his/her . The resident required total dependence of staff with a two person physical assist for bed mobility and transfer.

According to the Progress Notes (PN), that from through , the resident was observed continuously removing his/her on occasions with his/her . A Nursing Note (NN) dated at 3:30 PM indicated that the resident had attempted several times to remove his/her The note further reflected that the resident was unable to understand this due to A further review of the PN reflected from through that the resident) on occasions. The notes included that the doctor was made aware with no new orders.

A review of the resident's Care Plan (CP) dated , included a focus of difficulty communicating related to diagnosis of and cognitive status initiated on Interventions included; to anticipate and

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meet needs, communicate using yes or no questions when able, refer to therapy plan of treatment in the medical record for more detail, and [redacted] evaluation and treatment. The CP did not reflect the resident's behaviors of removing the [redacted].

According to the Facility's Reportable Event (FRE) dated [redacted] with an event date on [redacted] and a time of event at 8:00 AM, revealed the following: Resident #1 was found by a staff nurse with his/her [redacted] tied to his/her [redacted] at 8:00 AM with a [redacted] to prevent him/her from pulling out their [redacted]. The resident had a history of [redacted]. The FRE indicated that the resident had a history of removing the [redacted] at the facility, and had a BIMS score of [redacted]. The report included that two Registered Nurses (RN) were suspended pending further investigation.

On 2/19/21 at 1:20 PM, the surveyor interviewed the Certified Nursing Aide (CNA) via the telephone who stated that Resident #1 had a behavior of pulling at his/her [redacted]. The CNA stated that the resident remained in bed so staff turned and repositioned him/her every two hours.

On 2/19/21 at 1:26 PM, the surveyor interviewed RN #1 via telephone who stated that the resident was confused and tried to remove his/her [redacted]. The RN stated that the resident on at least [redacted] r occasions had [redacted] The RN stated that because of this, the resident had increased

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[redacted]. The RN stated that she had informed the RN/Unit Manager (RN/UM) that the resident needed an intervention such as [redacted] to prevent this.

On 2/19/21 at 2:28 PM, the surveyor interviewed RN #2 via telephone who stated that the resident had a behavior of trying to [redacted] him/herself or remove the [redacted]. The RN stated that staff were aware of this behavior. The RN stated that she had spoke to the RN/UM in the past about the resident needing an intervention such as a [redacted] to prevent this.

On 2/19/21 at 3:29 PM, the surveyor interviewed the RN/UM via the telephone who stated that the resident lately had a behavior of pulling at his/her [redacted]. This week, the resident started pulling at his/her [redacted]. The RN/UM stated that the doctor was aware of this behavior. The RN/UM stated that she "thinks" a nurse spoke to her about the resident needing "something" to prevent this.

On 2/22/21 at 10:55 AM, the surveyor interviewed the [redacted]) who stated that the resident had limited to no use of his/her [redacted], but had mobility with their [redacted] The resident tended to pull his/her [redacted] with their [redacted] The facility tried to explain to the resident that he/she needed to keep the [redacted] on, but the resident did not have the comprehension ability to understand. The [redacted] stated that the resident had [redacted] themselves several times, including one time in her presences. The [redacted] stated that she had documented this incident, but she was unaware if any interventions were put in place.

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F 656	Continued From page 22 On 2/22/21 at 11:45 AM, the surveyor observed Resident #1 in bed asleep. The resident had a mitten on his/her [redacted] and a [redacted] on his/her [redacted] The RN/UM confirmed that the resident was unable to use his/her left arm. On 2/22/21 at 12:17 PM, the surveyor interviewed the Director of Nursing (DON), who stated that the resident had [redacted] themselves one or two times before, but the nurses just inserted a [redacted]). The DON stated that there were no interventions put into place for this behavior. A further review of the CP reflected an initiated focus on [redacted], for being at risk for behavior symptoms related to [redacted] Interventions included; to administer medications per physicians order, observe for mental status and behavioral changes when new medication started or with changes in dosage, [redacted] referral as needed, and use consistent approaches when caregiving. A review of the facility's "Behavioral Assessment, Intervention and Monitoring: policy with dated 2001 and revised 2/19, included that the facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The policy also included for management that the interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly.	F 656		

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F 656	Continued From page 23 The policy also included that interventions will be individualized and that the care plan will include at minimum: a description of the behavioral symptoms; targeted and individualized interventions for behavioral and/or psychosocial symptoms; the rationale for the interventions and approaches; specific and measurable goals for the targeted behaviors; and how the staff will monitor for effectiveness of the interventions. On 2/22/21 at 1:45 PM, the surveyor interviewed the DON in the presence of the Regional DON and the Licensed Nursing Home Administrator (LNHA) who confirmed that the resident was not care planned for the behaviors of removing the [redacted] and no interventions were put into place prior to the incident that began on [redacted]. Both the DON and the Regional DON acknowledged that the resident should have been care planned for these behaviors. The Regional DON stated that as soon as you were aware of the behaviors, interventions should have been put in place. NJAC 8:39-11.2(e); 27.1(a)	F 656		