STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315387	A. BUILDING _____ B. WING _____	C 08/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLAIRE REHAB & NURSING	**115 DUTCH LANE ROAD FREEHOLD, NJ 07728**

(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 #: NJ00132728, NJ00134389, NJ00135433, NJ00137793 CENSUS: 119 SAMPLE: 10 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 VISIT.	F 000		
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	F 609		9/4/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/03/2020

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

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F 609	Continued From page 1 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 #NJ00135433 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to: a.) notify the New Jersey Department of Health of an injury incident of an unknown origin that resulted in a fracture, and b.) report the results of the investigation to the New Jersey Department of Health within five working days of the incident. This deficient practice was identified for 1 of 3 residents reviewed with facility reportable events (Resident #5). The evidence was as follows: On 8/18/20 at 10:30 AM after the entrance conference with the Licensed Nursing Home Administrator (LNHA), the surveyor requested a list of facility reportable events since 1/1/2020. The surveyor reviewed the list provided by the LNHA at 11:20 AM, which reflected that Resident #5 had a facility reportable event that occurred on [redacted] The surveyor reviewed the medical record for Resident #5. A review of the Admission Record face sheet (an admission summary) reflected that Resident #5 was admitted to the facility with diagnoses which include [redacted].	F 609	" All residents are at risk to be affected by the deficient practice. " Resident #5's report summary was re-submitted to the Department of Health with fax confirmation on 8/28/20 " All facility staff were re-educated on the facility Abuse Investigation and Reporting policy. " DON and ADMIN re-educated on policy as well as preferred means of submission. Ie; E-fax so facility will have ease of access to fax confirmation. " DON/ADMIN will review all reportable events and ensure the policy is being followed and will report weekly to the facility's regional team. Corporate DON or designee will audit one reportable event file per month x 3 months for evidence of appropriate event reporting. " Findings will be submitted for 3 months to the monthly QAPI committee who will determine further interventions as needed.	

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A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted] reflected that Resident #5 had a brief interview for mental status (BIMS) score of [redacted] indicating a [redacted] cognition.

A review of the electronic Progress Notes (ePN) dated [redacted] at 10:57 PM reflected that the resident was noted to be in bed with a [redacted]. The note reflected that the resident was treated for [redacted] using a medication, the Physician was notified and ordered an [redacted] The results of [redacted] revealed [redacted] The physician ordered for the resident to be transported to the emergency department for further evaluation and the family representative was made aware.

A review of the facility's [redacted] report dated [redacted] reflected a [redacted] The report specified, [redacted]

On 8/18/20 at 2:27 PM, the LNHA provided the surveyor a copy of the Reportable Event Record/Report dated [redacted]. There was no record that the reporting documents of the incident that occurred on [redacted] were submitted to the New Jersey Department of Health (NJDOH). The LNHA stated he had no proof of the transmittal of reporting.

On 8/19/20 at 12:34 PM, the surveyor observed Resident #5 in his/her [redacted] room reclining in a

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F 609	Continued From page 3 [redacted]. The surveyor attempted to interview the resident but the resident just stared at the surveyor. On 8/19/20 at 3:00 PM, the Director of Nursing (DON) acknowledged to the survey team she was responsible for the investigations and reporting to the NJDOH. She stated that she faxes reportable events to the NJDOH and that she did not routinely keep a record receipt that a fax was sent to the NJDOH. She confirmed she was unable to find confirmation that it was sent to the NJDOH, but stated that she had spoken to the NJDOH on [redacted] according to her notes. She was unable to provide documented evidence that the reportable event was sent to the NJDOH that the results of the investigation were sent after five working days of the incident. A review of the facility's Abuse Investigation and Reporting policy revised 12/2019 included, "All alleged violations...including injuries of an unknown source.. will be reported by the the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility..." and "All alleged violation...including injuries of an unknown source...will be reported immediately, but not later than: Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or Twenty-Four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury." "Verbal/written notices to agencies may be submitted via special carrier, fax, e-mail, or by telephone." NJAC 8:39-9.4(f); Appx. B	F 609		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		9/4/20

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F 657	Continued From page 4 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Complaint #NJ00135433 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to develop an individualized care plan in a timely manner for a resident who transferred from surface to surface using a [redacted] This deficient practice was identified for 1 of 3 residents reviewed dependent on a [redacted] (Resident #5).	F 657	" All residents are at risk to be affected by the deficient practice. " Resident #5's Care Plan was reviewed for accuracy to ensure reflection of current therapy recommendations. " All Nursing staff were re-educated on facility policy for Managing Falls and Fall Risk as well as Using a [redacted] Machine. " Nursing Administration as well as	

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F 657	Continued From page 5 The evidence was as follows: On 8/18/20 at 10:30 AM after the entrance conference with the Licensed Nursing Home Administrator (LNHA), the surveyor requested a list of facility reportable events since 1/1/2020. The surveyor reviewed the list provided by the LNHA at 11:20 AM, which reflected that Resident #5 had a facility reportable event that occurred on [redacted] The surveyor reviewed the medical record for Resident #5. A review of the Admission Record face sheet (an admission summary) reflected that Resident #5 was admitted to the facility with diagnoses which included [redacted]. A review of a Physical Therapy Evaluation and Plan of Treatment dated [redacted] included a functional assessment that the resident was totally dependent on transfers without attempts to initiate. The evaluation indicated, '[redacted] [redacted] transfer)." A review of the resident's individualized care plan created [redacted] and revised [redacted] included that the resident required, "transfers by 2 staffs for out of bed activities." It did not address the need for a [redacted] for transfers in accordance with the Physical Therapy Evaluation and Plan of Treatment until [redacted]. A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted] reflected that Resident #5 had a brief interview for mental	F 657	Director of Rehabilitation to audit all residents with the transfer and ADL status of dependent as well as all residents care planned for "two-person assist". " These findings will be reported to the interdisciplinary team and appropriate changes will be made based off of findings. " MDS coordinator will audit care plans of all newly admitted residents and all residents with change in transfer status going forward x 3 months. Care plans will continue to be reviewed in entirety for accuracy at each resident's quarterly care conference. " Findings will be submitted for 3 months to the monthly QAPI committee who will determine further interventions as needed.	

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F 657	Continued From page 6	F 657		

status (BIMS) score of [redacted], indicating a [redacted] cognition. It further included that the resident was dependent with surface to surface transfers and required a two person physical assist.

On 8/19/20 at 10:50 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that Resident #5 was transferred via a [redacted] using two staff members. The CNA could not speak to a time in which the resident was not transferred using a [redacted] because she had only worked at the facility since [redacted]

At 11:26 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who had revised the resident's care plan on [redacted] for a two-person transfer. The LPN stated that the staff had been using a two-person [redacted] transfers for Resident #5 for a while. She further stated that she believed at one point "Family did not want [Resident #5] to have a[redacted] She could not speak any further to the resident's care plan or why the [redacted] transfer was not in the resident's care plan in a timely manner based on the Physical Therapy Evaluation and Treatment Plan dated [redacted]. The LPN acknowledged that the resident's representative preferences regarding not wanting Resident #5 to use a [redacted] was also not documented within the resident's individualized care plan.

At 11:30 AM, the surveyor interviewed CNA #2 who stated that she worked full time during the day shift. CNA #2 stated that Resident #5 had required a two person [redacted] but the family didn't want Resident #5 to use a [redacted] for transfers at one point, but they

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F 657	Continued From page 7	F 657		

never said why. She couldn't speak to when the family had made the request to not use a [redacted]

At 11:50 AM, the surveyor interviewed the Occupational Therapist (OT)/Assistant Director of Rehab who stated that he did not work directly with Resident #5 but had familiarity that the resident's representative did not want the resident to use the [redacted] at one point. He could not speak to when or why.

At 12:04 PM, the surveyor interviewed the Physical Therapist (PT) who reviewed the PT Evaluation dated [redacted]. The PT acknowledged that the resident was dependent on a [redacted] for transfers, and that it was possible that he/she had progressed to not needing a [redacted] for transfers. The PT acknowledged it should be recorded in the resident's plan of care.

At 12:34 PM, the surveyor observed Resident #5 in his/her private room reclining in a [redacted]. The surveyor attempted to interview the resident but the resident just stared at the surveyor.

At 3:00 PM, the Director of Nursing (DON) acknowledged to the survey team that nurses were responsible for updating the care plan in a timely manner. She could not speak to why the use of [redacted] transfers was not updated unti[redacted]

At 5:15 PM, the LNHA acknowledged to the survey team that the care plan did not reflect the use of the [redacted] for Resident #5 until [redacted]. He stated that staff were following the resident's plan of care but it just wasn't documented in the care plan in a timely manner.

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F 657	Continued From page 8 He was unable to provide documented evidence within the medical record to indicate why the care plan had still reflected a two person assistance for transfers, when the resident required a two-person assist using a [redacted] for transfers. A review of the facility's Managing Falls and Fall Risk policy revised 12/2019 included, "The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan..." A review of the facility's Using a [redacted] Machine policy revised 12/2019 included to document the type of lift used in the medical record. NJAC 8:39-11.2 (e), (f), (h)	F 657		
F 658 SS=D	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 #NJ0000137793 Based on observation, interview and record review it was determined that the facility failed to: a.) document in the electronic Treatment Administration Record for the accountability of a wound treatment, and b.) ensure a dressing was dated and timed in accordance with professional standards of nursing practice. This deficient practice was identified for 1 of 3 residents reviewed for [redacted] (Resident #2).	F 658	• All residents are at risk to be affected by the deficient practice. • Resident #2's dressing was changed and the date was placed on the dressing. The nurses that missed documentation were identified and re-educated on facility policy. • All Nursing staff were re-educated on the facility's Prevention of [redacted] policy as well as nursing standards of practice. These trainings	9/4/20

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F 658	Continued From page 9 Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The nurse practice act for the State of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities with in the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." The evidence was as follows: On 8/18/20 at 9:27 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) informed the surveyor that Resident #2 had [redacted]. At 9:40 AM, the surveyor observed Resident #2 in bed on an [redacted] mattress. The resident stated to the surveyor that he/she had [redacted] to the [redacted] area. Resident #2 informed the surveyor	F 658	included a) Proper documentation in the Treatment Administration Record b) Proper identification on [redacted] dressing with the date of the dressing change. • DON/ Designee will perform daily audits of TAR records for all residents x 4 weeks and then weekly x 3 weeks. DON/Designee will check 3 dressings per week for date/time x 4 weeks. • Findings will be submitted for 3 months to the monthly QAPI committee who will determine further interventions as needed.	

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that he/she would often not allow certain nurses perform a [redacted] treatment for various reasons. The resident was unable to provide the names of particular nurses. The resident independently turned to his/her left side to show the surveyor the [redacted], and the surveyor observed a large dressing on the [redacted]. There was no date or time written on the dressing indicating when it had been placed on the resident.

The surveyor reviewed the medical record for Resident #2.

A review of the Admission Record face sheet (an admission summary) reflected that the resident had diagnoses which included [redacted]

A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] included that the resident had a brief interview for mental status score of [redacted], indicating a [redacted] cognition. IT further included that the resident had [redacted] that were present upon admission to the facility.

A review of the resident's individualized care plan dated [redacted] included that Resident #2 had [redacted] and that the resident refused weekly [redacted] measures and skin assessments. The care plan revised on [redacted] further included that that the resident refused to have a [redacted] clinic and [redacted] physician follow the management of the [redacted]. Interventions included to "Administer

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treatment as ordered by physician and monitor for deterioration and improvement" and "Monitor behavior episodes and attempt to determine underlying cause...Document behavior and potential causes."

A review of the Physician Order Summary Report for [redacted] included two physician orders (PO) dated [redacted] to cleanse the [redacted] "with [redacted] and apply [redacted] cream to the [redacted], with [redacted] to the [redacted] area. Cover with gauze or sponge every day shift."

A review of the electronic Treatment Administration Record (eTAR) for [redacted] reflected the corresponding PO dated [redacted] for the treatments to the [redacted] The treatments were plotted to be administered during the day shift (7 AM-3 PM). The eTAR reflected blanks for the administration of the treatment on both the [redacted] on 7/16/20, 7/25/20, 7/29/20, and 7/31/20.

A review of the corresponding electronic Progress Notes (ePN) dated [redacted] at 11:41 AM and 3:24 PM reflected that the resident refused to have the [redacted] treatments performed despite multiple attempts. Further review of the ePN dated 7/25/20, 7/29/20, and 7/31/20 did not reflect documented evidence that the [redacted] treatment was performed or that Resident #2 had refused the treatment to the [redacted].

On 8/19/20 at 8:20 AM, the surveyor interviewed the LPN/UM who stated that the resident was independent with care but required assistance with [redacted] dressing changes to the [redacted]

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F 658	Continued From page 12 [redacted]. The LPN/UM stated that the resident had a history of non-compliance and refusing [redacted] treatments. She stated that nurses attempt to perform the dressing changes multiple times during the days, but sometimes the resident refuses to get back into bed and will stay out of bed until midnight sometimes. She stated that if the resident refused a [redacted] dressing change, it should be documented in the eTAR. At 8:55 AM, the surveyor interviewed the medication LPN. The LPN stated that the resident had a history of refusing [redacted] treatments, but that the resident would often allow her to do the treatments during her shift. She stated that the resident would often require repeated attempts to perform the treatment and sometimes would not allow a nurse to do a treatment. She confirmed that if the resident refused it should be documented in the eTAR or progress notes. The surveyor showed the LPN the eTAR for July 2020 with the blanks on 7/16/20, 7/25/20, 7/29/20 and 7/31/20. The LPN stated that it may have been left blank because the resident refused the treatment and it was left open for the next shift to try. She confirmed there should then be a progress note for the day shift that he/she refused the treatment. At 9:15 AM, the surveyor interviewed Resident #2 a second time. The resident informed the surveyor that the day shift "always" performed the [redacted] treatment during their shift, and was unable to provide a name of a nurse that did not perform a [redacted] treatment as ordered by the physician. The resident confirmed he/she refused a [redacted] treatment dressings at times as well. At 9:24 AM, the surveyor observed the Registered Nurse (RN) perform a [redacted]	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315387	A. BUILDING _____ B. WING _____	C 08/19/2020

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F 658	Continued From page 13	F 658		

treatment dressing change to the [redacted] for Resident #2. The surveyor observed that the old dressing was not signed with a date and time. The surveyor interviewed the Registered Nurse who confirmed that there was no date or time written on the old dressing. She stated that she had performed a dressing change the day before and put a date and time on it so that it must have been the night shift that had changed the dressing and didn't put the date and time on it. The RN confirmed the date and time should always be written on the dressings during application in accordance with professional standards of nursing practice. The RN also informed the surveyor that the resident had a history of refusing dressing changes with various nurses and that when he/she refused the treatment, it was supposed to be documented in the eTAR and that there should be an electronic progress note. She stated that if the resident refused a treatment it wouldn't be documented anywhere else.

On 8/19/20 at 5:10 PM, the surveyor interviewed the Licensed Nursing Home Administrator in the presence of the survey team. The LNHA stated that the resident had a history of refusing treatments often by the nurses and noncompliance with other aspects of his/her [redacted] treatment. He stated that the resident had a care plan for his/her noncompliance. The LNHA stated that the refused the [redacted] treatment on 7/25/20, 7/29/20 and 7/31/20, but that it just wasn't documented in the eTAR or the ePN's. He acknowledged that there should have been documentation in the resident's medical record that he/she refused the treatment on those dates. The LNHA acknowledged that the date and time should be documented on the wound dressing in accordance with professional

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F 658	Continued From page 14 standards of nursing practice. A review of the facility's policy Prevention of [redacted]/Injuries revised 12/2019 included, that staff were to "Evaluate, report, and document..." in the resident's medical record. The policy did not address recording the date or time on the wound dressing upon the dressing change. NJAC 8:39-11.2(a), 27.1(b), 29.2(b)	F 658		