STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315105	A. BUILDING _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL HARBOR REHABILITATION AND HEALTHCARE CENTER	2050 SIXTH AVE NEPTUNE CITY, NJ 07753

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F 000	INITIAL COMMENTS STANDARD SURVEY: 8/22/19 CENSUS: 96 SAMPLE SIZE: 37 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the medical record, it was determined that the facility failed to follow a physician's order for the application of a [redacted] that provides a barrier between the	F 688	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth in the Statement of	9/12/19

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

Electronically Signed | 09/12/2019

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F 688	Continued From page 1 [redacted] for 1 of 2 residents (Resident #47) reviewed for positioning and mobility. The deficient practice was evidenced by the following: According to the Admission Record, Resident #47 was admitted to the facility on [redacted] and had medical diagnoses that included [redacted]. Review of a Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected the resident was [redacted] On 08/16/19 at 11:57 AM, the surveyor toured the [redacted] floor and observed Resident #47 seated in a wheelchair in the day room area next to the nursing station. The resident appeared to have limited range of motion and [redacted] The surveyor attempted to interview Resident #47 regarding any devices used for his/her [redacted] and the resident was [redacted]. During that observation, the surveyor did not observe a [redacted] or other type of device in the resident's [redacted] The surveyor observed the same on 08/21/19 at 10:39 AM. On 08/19/19 at 1:07 PM, the surveyor observed Resident #47 seated in a wheelchair in the dining room area. The surveyor did not observe [redacted] The surveyor observed the same on	F 688	Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State Laws require it. Increase/Prevent decrease in ROM/Mobility Resident #47 was re-evaluated by Occupational Therapy and was treated to trial an alternative [redacted]. Resident #47 did not have a change in function, alteration in skin integrity or any adverse effect. Resident #47□s care plan was updated to reflect self-removal of the [redacted] and interventions for nursing staff to monitor for removal and replace as needed. All residents requiring [redacted] have the potential to be affected. All licensed nurses and CNAs will be re-educated by DON/Designee on application and use of [redacted] in accordance with physicians□ orders, monitoring [redacted] for placement, proper documentation of application and removal, and appropriate notification of physician and therapy with refusals or changes. DON/Designee will conduct 10 random audits to visualize [redacted] placement and observe documentation for residents who utilize [redacted] The audits will be conducted monthly for 3 months. The results of the audits will be presented to the monthly QAPI committee for further review and action as appropriate.	

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F 688	Continued From page 2 08/20/19 at 9:08 AM and 12:49 PM, and again on 08/21/19 at 12:49 PM. On 08/19/19 at 11:45 AM, the surveyor reviewed the Electronic Medical Record (EMR) for Resident #47. The EMR revealed a physician's order dated, 03/23/19, to [redacted] after morning care, and to check [redacted], discomfort and skin integrity every day and evening shift as a preventative measure. Review of Resident #47's Care Plan (CP), initiated on [redacted], revealed a "Focus" for ADL self-care performance deficit related to limited [redacted] The CP further reflected an intervention for "[redacted] Review of Resident #47's August 2019 Treatment Administration Record (TAR) for revealed an order that required the nurse's signatures for the day and evening application of the [redacted] each day. From 08/16/19 to 08/21/19, the TAR revealed that the nurses documented that the [redacted] was applied to Resident #47. On 08/21/19 at 1:10 PM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) that was assigned to care for Resident #47. CNA #1 stated that she was aware that the resident had a [redacted] and that she would [redacted] into the resident's [redacted] if the [redacted] could not be located. On 08/21/19 at 12:57 PM, the surveyor reviewed the 08/21/19 TAR for Resident #47. The TAR reflected that the nurse documented the resident's [redacted] was applied.	F 688		

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F 688	Continued From page 3 On 08/21/19 at 1:25 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) regarding Resident #47. LPN #1 stated that the resident required extensive assistance with ADLs; however, the resident could feed him/herself. The surveyor inquired if there was any care provided to the resident's [redacted]. LPN #1 reviewed the EMR in the presence of the surveyor and stated the resident had a [redacted] that was supposed to be applied to his/her [redacted] At that time, LPN #1 observed the [redacted] of Resident #47 and confirmed that the resident did not have a [redacted] applied to his/her [redacted]. On 08/21/19 at 1:25 PM, the surveyor observed LPN #1 walk down the hallway to apply a [redacted] of Resident #47. Review of Resident #47's Progress Notes revealed there was no documentation that Resident #47 removed the [redacted] on 08/16/19, 08/19/19, or 08/20/19. On 08/22/19 at 9:15 AM, the surveyor interviewed the Regional Director of Clinical Services (RDCS). The RDCS stated that Resident #47 removed the [redacted] when staff applied it to his/her [redacted] Review of Resident #47's Progress Notes revealed there was no documentation that Resident #47 removed the [redacted] on 08/16/19, 08/19/19, or 08/20/19. After survey inquiry, the surveyor noted that an Occupational Therapy Progress Note, dated 08/21/19 at 17:03 (5:03 PM), revealed the Occupational Therapist assessed the [redacted] for	F 688		

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F 688	Continued From page 4 appropriateness for [redacted] advanced [redacted]. The note reflected, "patient is resistant to use and due to lack of support strap is able to pull device off. An improved [redacted] shown to Rehab Manager with secure strap to hold in [redacted] area more easily without slippage [redacted] Recommend AM aide staff clean [redacted] thoroughly daily to minimize odor and bacteria build-up in [redacted]." During a subsequent interview at on 08/22/19 at 11:14 AM, in the presence of the Administrator, Director of Nursing (DON) and survey team, the RDCS reiterated that the resident removed the [redacted] when staff applies it to his/her [redacted]. The RDCS also stated that the nurses signed the TAR when they applied the [redacted] to Resident #47's [redacted]. Further, the RDCS stated it was known that the resident regularly removed the [redacted] but it had not been documented by the nurses. On 08/22/19 at 11:16 AM, the DON stated the nurses should have documented that Resident #47 had been removing the [redacted]. NJAC 8:39-27.1 (a)	F 688		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).	F 730		9/12/19

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F 730	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to provide the required annual Dementia training for 2 of 5 Certified Nurse Aides (CNA) that were reviewed for mandatory CNA education requirements. This deficient practice was evidenced by the following: Review of the in-service records provided by the facility for five randomly selected CNAs revealed that two of the five did not have the required Dementia training by their employment anniversary date. 1. CNA #1 had a date of hire of [redacted]. There was no documented training on Dementia from [redacted] 2. CNA #2 had a date of hire of [redacted]. There was no documented training on Dementia from [redacted]. On 08/22/19 at 9:30 AM, the Administrator provided a staff In-service sign-in sheet, dated [redacted], for the Topic: Dementia Care. The Administrator confirmed that neither CNA #1 nor CNA #2 attended the in-service. On 08/22/19 at 12:30 PM, the Regional Director of Clinical Services provided evidence of annual Dementia training for CNAs #3, #4 and #5 and stated there was no evidence of Dementia training for CNAs #1 and #2. NJAC 8:39-43.17 (b)	F 730	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the Provider of the truth of the 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. Nurse Aide Performance Review-12hr/yearly In-service CNA #1 and CNA #2 received annual Dementia training on 9/11/19 which was conducted by a Dementia-Certified Physician. All residents have the potential to be affected. Dementia training is scheduled to be provided on a bi-monthly basis throughout the year for all facility staff, including all CNAs. The training will be conducted by a Dementia-Certified Physician. DON/Designee will conduct audits of 5 employee files to monitor compliance with required annual Dementia training. The audits will be conducted monthly for 3 months. The results of the audits will be presented to the monthly QAPI committee for further review and action as appropriate.	

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F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interviews and review of facility documentation, it was determined that the facility failed to maintain a safe and sanitary environment, specifically a courtyard and a housekeeping closet that was accessible by residents. This deficient practice was evidenced by the following: On 08/20/19 at 4:42 PM, the surveyor observed Resident #85, unsupervised, emerge from an area in the back left corner of the facility courtyard. On 08/21/19 at 9:13 AM, the surveyor observed the courtyard area where Resident #85 was observed emerging from during the observation on the previous day. A walkway led to an area which contained the following: a large door size piece of wood, a weathered wood pallet on the ground, a large snow shovel propped up against the side of the building, two large black hooks (typically used to hang decorations) propped up against a white fence, two white cups, a cigarette butt, varied sized branches and many brown leaves, and plastic debris on the ground. On 08/21/19 at 9:28 AM, two surveyors toured the rear area of the resident courtyard with the Administrator. The Administrator confirmed the	F 921	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the Provider of the truth of the 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. F921 D All debris in the courtyard area noted on the Statement of Deficiencies was discarded on 8/21/19 by the Director of Environmental Services/designee. All items in the courtyard storage room housekeeping closet noted on the Statement of Deficiencies were sanitized or discarded as indicated, removed from the floor and stored safely and sanitarily. A new storage lock that can't be manually unlocked was placed on the courtyard storage room closet to ensure it remains secure at all times. This was completed by 9/13/19 by the Director of Environmental Services/designee. All residents have the potential to be affected by this practice. The Director of Environmental Services/designee rounded on the entire facility to inspect for any areas that were not maintained in a	9/16/19

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F 921	Continued From page 7 surveyors observations and stated that the area should be clean. She also confirmed that the facility residents have access to that area of the courtyard. On 08/21/19 at 9:31 AM, the tour continued and the surveyors observed an exterior metal door located in the rear of the courtyard. The Administrator stated the door led to a housekeeping storage closet. The surveyor opened the unlocked door in the presence of the Administrator and second surveyor. The Administrator stated the door should have been locked. Inside the closet, the surveyors observed various debris on the floor and items which included the following: On the left side of the closet, two large white wrapped bundles of new linen, identified by the Administrator, were stored directly on the floor. Three additional bundles of linen were stored directly on top of and to the rear of the two bundles stored on the floor, which were located next to a housekeeping mop bucket. The Administrator stated that the linen should not have been stored on the floor. Directly opposite those linen bundles and stored on top of a pallet and bottles of water, there were two bundles of linen that were open and exposed to air. The Administrator stated the bundles were new washcloths. The washcloths were stored in close proximity to multiple bags of ice melt, adjacent to two mechanical floor cleaners and amongst other various debris. The Administrator stated she was unaware of the condition of the closet and the closet should not look like that. On 08/22/19 at 11:15 AM, the Senior Administrator (SA), in the presence of the survey team, Administrator and Regional Director of Clinical Services, stated the outside grounds	F 921	safe and sanitary manner. Any issues noted were immediately addressed. New daily cleaning schedules were implemented for the courtyard and closet areas noted on the Statement of Deficiencies. Included in the schedule is to confirm that the courtyard storage room closet door is secure. In-service education was provided by the Administrator/designee to all environmental staff on the importance of maintaining a safe and sanitary environment, including the need to keep the courtyard and closet area safe and sanitary and the importance of adhering to the new daily cleaning schedule. The Administrator/Designee will randomly round weekly on the courtyard and closet area noted on the Statement of Deficiencies to ensure that they are being maintained in a safe and sanitary manner. Any issues noted will be addressed. All findings will be presented at the monthly QAPI committee meeting for follow up and monitoring until the committee indicates otherwise.	

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F 921	Continued From page 8 were on a weekly cleaning schedule. The SA provided a copy of an Outside Ground Clean Log, which revealed that the Back Courtyard was cleaned on 08/15/19. The SA confirmed that the residents had access to the area in the back of the courtyard where the debris was observed and was unable to explain the current state of the courtyard and housekeeping closet. NJAC 8:39-31.4 (a)	F 921		