STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING _____ B. WING _____	C 09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint, #NJ157771, #NJ157773, #NJ157831 SURVEY DATE: 9/21/22 CENSUS: 252 SAMPLE SIZE: 39 + 3 closed records 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. A Recertification Survey was Conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. During a Standard Survey conducted on 09/21/2022, it was determined that effective 09/03/22, the Facility was found to have been in Immediate Jeopardy for F689J, Part A. During a Standard Survey conducted on 09/21/2022, it was determined that effective 05/27/22, the Facility was found to have been in Immediate Jeopardy for F689J, Part B. Part A:	F 000		

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

Electronically Signed | 10/16/2022

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The New Jersey Department of Health sent a Notice of Determination of Immediate Jeopardy of Non-Compliance to the Facility Administrator on 09/07/22, including the Immediate Jeopardy Template.

The Facility failed to:

-ensure that a resident with moderate cognitive impairment who was at risk for elopement was appropriately supervised and monitored to ensure safety and follow the facility's Policy and Procedure for wandering/elopement.

On 9/08/22, the New Jersey Department of Health received an acceptable Removal Plan.

On 9/08/22, the New Jersey Department of Health conducted an onsite survey and determined that the Immediacy of the Jeopardy could be removed effective 9/08/22.

The following Immediate Jeopardy (IJ) situation was identified for F689.

The IJ began on 9/03/22. The facility was notified of the IJ on 9/07/22, and an acceptable Removal Plan was received on 9/08/22. The survey team verified the implementation of the Removal Plan on 9/08/22.

The survey team investigated the exit doors to ensure all doors were secured and ensured that all residents with [redacted] were assessed for wandering/elopement, ambulation, and that their supervison levels were appropriate.

Interviews with the facility staff concluded that

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F 000	Continued From page 2	F 000		

they were educated on the facility's updated Policy and Procedure regarding wandering/elopement. A list of residents who were at risk for wandering/elopement were placed in a binder at each nursing station throughout the facility and also at the front desk.

This deficient practice continues at a lower S/S for no actual harm with the potential for more than minimal harm.

Part B:

The New Jersey Department of Health sent a Notice of Determination of Immediate Jeopardy to the Facility Administrator on 09/13/22, including the Immediate Jeopardy Template.

The Facility failed to:

- provide a resident who was at risk for aspiration pneumonia with the appropriate liquid consistency and follow their facility's Policy and Procedure for thickened liquids.

On 9/14/22, the New Jersey Department of Health received an acceptable Removal Plan.

On 9/14/22, the New Jersey Department of Health conducted an onsite survey and determined that the Immediacy of the Jeopardy could be removed effective 9/14/22.

The following Immediate Jeopardy (IJ) situation was identified for F689.

The IJ began on 5/27/22. The facility was notified of the IJ on 9/13/22, and an acceptable Removal Plan was received on 9/14/22. The survey team

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F 000	Continued From page 3 verified the implementation of the Removal Plan on 9/14/22. The Immediate Jeopardy was identified to be Past Non-Compliance The survey team investigated the delivery of meals and snacks to the residents throughout the facility to verify residents on mechanically altered diets received the appropriate consistency diet as prescribed by their physician. Interviews with the facility staff concluded that they were educated on the facility's updated Policy and Procedure regarding altered diets/liquids. A list of residents who were on altered diets/fluids was placed in a binder at each nursing station throughout the facility.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		12/7/22

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F 584	Continued From page 4 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain the facility in a clean and sanitary environment. This deficient practice was identified for 2 of 6 units, ([redacted] and [redacted] and was evidenced by the following: 1. On the [redacted] unit the surveyor observed the following: - On 9/9/22 at 10:53 AM, the surveyor observed on [redacted] unit hallway (that covered both the [redacted] side), black colored stains on the floor and on the walls. - On 9/9/22 at 11:00 AM, the surveyor observed missing wall tiles in multiple areas of the [redacted]	F 584	F584 Safe/Clean/Comfortable/Homelike Environment F584 CFR(s): 483.10(i)(1)-(7) 483.10(i) Safe Environment. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: -By 10/26/2022 the [redacted] floors and walls will be deep cleaned, stripped, and waxed. -By 10/26/2022 the missing wall tiles on the [redacted] hallway will be repaired	

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F 584	Continued From page 5 hallway. - On 9/9/22 at 11:15 AM, the surveyor observed the [redacted] shower area (the only available shower room on [redacted]) and observed the shower head on the shower stall floor. - On 9/9/22 at 11:15 AM, the surveyor observed a large dark stain on the tile floor of the [redacted] shower stall. - On 09/09/22 at 11:17 AM, the surveyor observed the ceiling of the main shower room with rust marks and chipped paint that was right above where the residents' shower. - On 09/09/22 at 11:20 AM, the surveyor observed some dark stains on the wall tiles in the shower room. - On 09/09 22 at 12:00 PM, the surveyor observed a fish tank in the [redacted] dining/activity room with dirty water inside the tank. The surveyor observed no [redacted] inside the [redacted]. - On 09/12/22 at 11:25 AM, the surveyor observed a few residents' rooms with chipped paint on their exterior door frame. On 9/15/22 at 10:36 AM, during the Resident Council meeting, five of five residents discussed facility environmental concerns on unit [redacted] with a surveyor. The five residents told the surveyor that the game room which is also the [redacted] dining room was not cleaned regularly, broken blinds in the game room and the facility was painting ceiling tiles instead of replacing aluminum tiles in the game room. In addition, the [redacted] shower room had no light, broken shower heads, and the facility staff placed a blanket on the floor to prevent water from flowing into the hallway. A review of the housekeeping schedule from 8/31/22 through 9/15/22, provided by the Director of Nursing revealed that only one housekeeper	F 584	-By 10/26/2022 the shower head in the [redacted] Shower Stall will be repaired. -By 10/26/2022 the large dark stain on the tile floor of the [redacted] shower stall will be cleaned -By 10/26/2022 the ceiling of the main shower room will be cleaned and painted above where the resident shower is. -By 10/26/2022 the [redacted] wall tiles in the shower room will be cleaned. -By 10/26/2022 the [redacted] in the [redacted] dining/activity room will be cleaned and fish were added. -By 10/26/2022 [redacted] residents' rooms exterior doors will be inspected, and chipped paint will be repaired and painted. -By 10/26/2022 [redacted] dining room / game room will be cleaned. -By 10/26/2022 the broken blinds in the [redacted] dining room/ game room will be replaced. -By 10/26/2022 the ceiling tiles in the [redacted] dining room / game room will be replaced. -By 10/26/2022 the [redacted] shower room□s light will be replaced. -By 10/26/2022 the [redacted] shower heads will be repaired. -By 10/26/2022 the [redacted] shower room plumbing will be repaired. -By 10/26/2022 the [redacted] floors and walls will be deep cleaned, stripped, and waxed. -By 12/7/2022 the [redacted] the leak above the nurses□ station was repaired by an outside contractor. 2. How you will identify other residents having potential to be affected by the	

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F 584	Continued From page 6 was assigned on the [redacted] nursing unit. On 9/9/22 at 11:20 AM, the surveyor interviewed the Housekeeper (HK) on unit [redacted] who stated that the HK's responsibility was to sweep and wash the [redacted] unit floors that included the floors inside the residents' rooms and in the hallways. The HK also stated she cleaned the bathrooms and all the high touch areas. She further stated that the [redacted] shower room was being renovated and that all the residents are using the [redacted] shower room. When the surveyor asked the HK when was the last time the Unit [redacted] hallway floors and walls had a deep cleaning, the HK laughed and stated that she can't remember the last time the floors were stripped and waxed. On 9/15/22 at 12:30 PM, the surveyor interviewed the Director of Housekeeping stated that there were usually two housekeepers who worked on the [redacted] unit. The Director pf Housekeeping also stated that there was only one housekeeper for the past few days because of staff shortages and that the facility was unable to do a deep cleaning on the [redacted] nursing unit because they don't have enough overnight staff to strip and wax the [redacted] hallway. The Director of Housekeeping further stated that stripping and waxing can only happen at night because the residents are sleeping and that this process was not done because of staff shortages. The Director of Housekeeping also stated that they were not able to buff the floor until the floors are stripped and waxed and buffing the residents' rooms are possible, but the hallways and the bathrooms are another challenge. The Director of Housekeeping acknowledged that the [redacted] unit had one working shower room and the second shower room was being renovated.	F 584	same practice and what corrective actions will be taken: -All residents have the potential to be affected by this deficient practice. 10/13/2022, the Administrator/designee conducted a visual audit of the Unit [redacted] and [redacted] to identify others that have the potential to be affected to include: 1. [redacted] floors and walls are clean and free of discoloration indicative of lack of cleaning. 2. [redacted] wall tiles hallway are in good repair. 3. [redacted] shower head is in good repair. 4. [redacted] shower tile is clean and free of discoloration indicative of lack of cleaning. 5. [redacted] main shower is clean and painted. 6. [redacted] clean with holding live fish. 8. [redacted] resident room exterior doors are in good repair and painted. 9. [redacted] dining room / game room cleaned and free of dirt and debris indicative of lack of cleaning. 10. [redacted] dining room/ game room blinds are in good repair. 11. [redacted] dining room/ game room ceiling tiles are in good repair. 12. [redacted] shower room□s light is functional. 13. the [redacted] shower heads are in place and functional. 14. the [redacted] shower room plumbing is in good repair and functional. 15. the [redacted] ceiling above the nurses□ station is in good repair with no leaks and was repaired by outside contractor.	

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F 584	Continued From page 7 2. On the [redacted] unit the surveyor observed the following: On 9/09/22 at 11:13 AM, the surveyor observed water leaking from the ceiling that was dripping onto the nursing station. It was leaking next to a computer which was in use by the unit [redacted] nursing staff. At that same time, the surveyor interviewed the Director of Medical Records (DMR) who stated that the leak had been fixed on multiple occasions but tends to return once it rains. The DMR also stated that it rained days ago but because it was a very hard rain, water must have accumulated which caused the current leak. On 9/15/22 at 1:30 PM, the surveyor discussed the above observations and concerns with the administrative staff. There was no additional information provided. NJAC 8:39-31.4 (a)	F 584	3.What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: -10/12/2022 the Administrator/designee reeducated the Housekeeping Director and the Housekeeping staff on the components of this regulation with emphasis on keeping a safe clean comfortable homelike environment for the residents to include; clean hallways, floors, and tiles. -10/07/2022 the Administrator reeducated the Maintenance Director on the components of this regulation with emphasis keeping a safe clean comfortable homelike environment to ensure it is in good repair and has functional equipment to include; plumbing, painted surfaces, tile, shower heads, blinds, light fixtures, and fish tanks 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: -The Administrator/designee will conduct an audit three times weekly X 4 weeks and then weekly X 2 months of random units inspecting that units are clean, sanitary, and good repair to include: 1. Floors and walls are clean and free of discoloration. 2. Wall tiles in the hallways are in good repair.	

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F 584	Continued From page 8	F 584	3. Shower heads are in good repair. 4. Shower tiles are clean and free of discoloration. 5. Shower rooms are clean and painted. 6. Fish tanks are clean. 8. Resident room exterior doors are in good repair and painted. 9. Dining rooms / game rooms are cleaned and free of dirt and debris. 10. Dining rooms/ game rooms blinds are in good repair. 11. Dining rooms/ game rooms ceiling tiles are in good repair. 12. Shower room□s lights are functional. 13. Shower heads are in place and functional. 14. Shower room plumbing is in good repair and functional. 15. 2-A nurses station is leak free -Findings of these audits will be reviewed in the monthly QAPI meeting x 90 days	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the	F 585		10/26/22

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facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for

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example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.

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F 585	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide information and educate residents on the Grievance process. This deficient practice was identified for 5 of 5 residents (Residents #44, #51, #67, #150, and #15) interviewed for the grievance process at the Resident Council meeting conducted on 9/15/22 at 10:30 AM and was evidenced by the following: On 9/15/22 at 10:40 AM, during the resident council meeting with five alert and oriented residents, the surveyor asked the residents if they were aware of what a grievance was and how to file a grievance with the facility if necessary. Five of the five residents present during the meeting told the surveyor they did not know the definition of a grievance or how to file a grievance. When the surveyor reviewed the resident council meeting minutes for June, July, and August 2022, prior to having the resident council meeting, the facility did not provide information regarding grievances. On 9/15/22 at 3 PM, the surveyor reviewed the Resident Admission Packet which did not contain any information explaining a grievance or instructing residents how to file a grievance. At the same time, the surveyor discussed the concern with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). On 9/19/22 at 2:20 PM, the LNHA provided the surveyor with a weekly hand out that was given to each resident. On the back of the first page was a note to educate residents on the grievance	F 585	F585- Grievances Preparation and/or execution of this plan do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. 1. What corrective action will be accomplished for those residents found to have been affected by this practice? -On 9/15/2022, a resident council meeting was held and the Administrator met with Resident # 44 and discussed, reviewed and provided specific instructions on the facility grievance process. -On 9/15/2022, resident council meeting was held and the Administrator met with Resident #51and discussed, reviewed and provided specific instructions on the facility grievance process. -On 9/15/2022, a resident council meeting was held and the Administrator met with Resident #67 and discussed, reviewed and provided specific instructions on the facility grievance process. -On 9/15/2022, a resident council meeting was held and the Administrator met with Resident #150 and discussed, reviewed and provided specific instructions on the	

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process. The surveyor asked the LNHA if that was always in the weekly packet and the LNHA stated, "no, it was added Friday" which was after the surveyor's inquiry.

On 9/20/22 at 12:34 PM, the surveyor reviewed the facility grievance book which included grievances from February 2022 through July 2022, there were none for August 2022. Review of the September 2022 grievances included clothing issues for 4 of the 5 resident council members, all filed by the facility on 9/15/22 after the surveyor's inquiry.

On 9/21/22 at 10:24 AM, the surveyor reviewed the Patient Concern/Grievance policy. The policy was updated 9/22, after the surveyor's inquiry on the grievance process. The facility did not provide the policy that was in place prior to the Resident council meeting.

On 9/21/22 at 10:54 AM, the surveyor interviewed the Social Worker (SW) regarding the grievance process. The SW told the surveyor SW she was a "traveling Social Worker, meaning going from facility to facility for the corporation." The SW had been at the facility one week. The surveyor asked what the grievance process was, and the social worker was unsure how they were completed at the facility, but told the surveyor that the other facilities educate residents on admission. The SW could not speak to what process the previous social worker had in place. The SW stated she would bring the surveyor the social work admission's packet that "usually has the grievance process information included."

On 9/21/22 at 11:40 AM, the surveyor reviewed an undated packet titled "Your Rights and

facility grievance process.

-On 9/15/2022, a resident council meeting was held and the Administrator met with Resident # 15 and discussed, reviewed and provided specific instructions on the facility grievance process.

-On 9/16/2022, the grievance process was posted on all units explaining where to find a grievance form.

-On 9/16/2022, grievance forms were placed nurses stations per the posted explanation of the grievance process.

-On 9/16/2022, an email was sent to families providing the grievance process and how to file a grievance.

-By 09/16/2022, the Regional Administrator reeducated Nursing Administration and Social Services on grievance policy and process.

2. How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken?

-All residents have the potential to be affected by this deficient practice.

-Grievance process will be reviewed monthly at resident council.

-Grievance process has been added to the weekly resident activity packet, provided to each resident in their room

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F 585	Continued From page 13 Protections as a Nursing Home Resident" provided by the SW. The sixth bullet on page one was titled "Make Complaints," which indicated the residents have the right to make a complaint to the staff at the nursing home. It did not include the grievance process or instructions on how to file a grievance. NJAC 8:39-4.1 (a) 35; 13.2 (c)	F 585	weekly by Recreation staff. -Social Services Assistant was assigned as the grievance coordinator, director will ensure grievance process is posted on all units and grievance forms are available at all nurses stations. -Administrator or designee will attend monthly resident council to ensure grievances are documented and prompt efforts made to resolve grievances. 3. What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur? -By 10/26/2022, Regional Administrator re-educated the Administrator, Director of Nursing and Social Workers on the components of this regulation with emphasis on the grievance process and grievance resolution with a focus on completion of documentation of grievances and prompt efforts to resolve grievances. By 10/26/2022, Administrator/Director of Nursing/Designee reeducated facility staff on the components of this regulation related to grievances with emphasis on grievance process, documenting grievances and grievance resolution process. Newly hired employees will be educated on these components as well including documenting Grievances and Resolution of Grievances.	

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F 585	Continued From page 14	F 585	3. How will the corrective action(s) be monitored to ensure the practice will not recur, what quality measures will be put into place? Grievance Officer/designee will review outstanding grievance 1 x per week in morning report with department heads to ensure grievances are addressed and resolved. Findings of these grievances will be reported at the monthly QAPI meeting x 90 days.	
F 609 SS=E	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.	F 609		10/14/22

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F 609	Continued From page 15 §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: REFER TO F610 REFER TO F609 Based on observation, interview, and record review, it was identified that the facility failed to report to the New Jersey Department of Health (NJDOH) and follow facility policy and procedures for reporting: a.) an unwitnessed event which resulted in a major injury for Resident #75, b.) an allegation and investigation of a resident to resident altercation, for Residents #27 and #228, c.) an allegation of abuse made by a resident representative for Resident #99, d.) an injury of unknown origin for Resident #99, and e.) an observed incident and investigation in which serious bodily injury occurred to Resident #191. The deficient practice was identified for five (5) of six (6) residents reviewed for alleged violations, (Resident #27, #75, #99, #191, and #228) and was evidenced by the following: 1. On 9/08/22 at 11:28 AM, the surveyor interviewed the responsible party (RP) for Resident #75 in the presence of a second surveyor. The RP informed the surveyors that Resident #75 sustained a [redacted] which required [redacted]. The RP also stated that this occurred the day after the resident had an incident whereby his/her [redacted] got caught in the	F 609	Preparation and/or execution of this plan do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. F609 Reporting Alleged Violations 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: On 9/15/2022 Nursing reported the investigation to the Department of Health of an allegation of a resident-to-resident altercation for Residents #27 and #228. On 10/14/2022 Nursing reported to the Department of Health the investigation for an unwitnessed event for Resident #75. On 10/14/2022 Nursing reported to the Department of Health, the investigation of an allegation of abuse made by a resident representative for Resident #99.	

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F 609	Continued From page 16 [redacted] which Emergency Services (ES) were required to release by cutting the [redacted]. The RP stated that Resident #75 was sent to the hospital for evaluation of the [redacted] and that the resident complained of [redacted] the next day at the facility. The RP further stated that the Assistant Administrator stated that the hip fracture could have occurred when ES was moving the resident and that no further information was provided. On 9/09/22 at 11:07 AM, the surveyor interviewed Resident #75's regular assigned Certified Nursing Assistant (CNA#1) who stated that the resident required total care although the resident could feed hem/herself. She further stated that the resident was [redacted] and could answer simple questions. On 9/09/22 at 11:39 AM, the surveyor observed Resident #75 in the day room wearing a mask and seated in [redacted] wheelchair. The surveyor reviewed the electronic medical record (EMR) for Resident #75. Review of the residents Admission Record (an admission summary) reflected that the resident had diagnoses which included but were not limited to: [redacted] Review of the annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated that the resident had a [redacted].	F 609	On 10/14/2022 Nursing reported to the Department of Health the investigation for an injury for Resident #99. On 10/14/2022 Nursing reported to the Department of Health an investigation of an observed incident for an injury for Resident #191. 2. How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken: -All residents have the potential to be affected by this deficient practice. -By 10/10/2022, the Administrator conducted an audit of the investigations from the last quarter in order to identify others that have the potential to be affected.The Administrator instructed the Director of Nursing to report the incidents / accidents for residents #75, #227, #228, #99, and #191, to the Department of Health. 3.What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: -10/10/2022 the Administrator reeducated the Director of Nursing on the components of this regulation with emphasis on reporting alleged allegations and alleged violations. -By 10/14/2022 the Administrator reeducated the facility Department Heads	

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F 609	Continued From page 17 Further review of the MDS reflected that the resident required limited assistance ("resident highly involved with activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance") with the physical assistance of two people. Review of the Individual Comprehensive Care Plan (ICCP) reflected a focus area for pain initiated on [redacted] and revised on [redacted] which indicated that the resident had potential for [redacted] related to [redacted] and [redacted]. The ICCP also reflected that on [redacted], the resident had "[redacted]." Interventions initiated on [redacted], included "Monitor/record/report to nurse any s/s (signs/symptoms) of [redacted] ... vocalizations ([redacted]," as well as "Monitor/record/report to nurse, residents' complaints [redacted] Review of Resident #75's Progress Notes reflected the following: On 1/18/22 at 7:32 AM, a Nurses' Note reflected that at 5:45 am nurse on unit called the undersigned supervisor and notified that Resident #75 got [redacted] the bed frame and Resident #75 was unable to get his/her [redacted] r out. Undersigned went to the unit to assess, [redacted] and not able to get out. Resident #75 doesn't know how his/her [redacted] got in the hole. Resident #75 was sleeping and when Resident #75 woke up, Resident #75's [redacted] was stuck. 911 was called, requested for the fire department to come. Fire department, EMT [emergency medical transport] and police arrived, they had to cut the [redacted] to release Resident #75's [redacted]. The [redacted] was assessed and noted	F 609	on the facility policy for reporting accident and incidents. -Newly hired staff will be educated on these components during orientation. -All accident and incident investigations will be reviewed by the Administrator. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: -The Regional Director of Nursing will review all incidents and accident investigations monthly for three months. -Findings of these audits will be reviewed in the monthly QAPI meeting and presented by the Director of Nursing x 90 days.	

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as [redacted], and [redacted]. [Physician] notified, order to transport to emergency room (ER) for further evaluation. [redacted] [name redacted] notified. Resident #75 left the facility at 7:18 AM, all pertinent paperwork was sent with the resident to the ER.

On 1/18/22 at 12:19 PM, a Nurses' Note reflected that the "Resident returned from hospital from [redacted] of the [redacted] ...no c/o (complaint of) [redacted], head to toe completed. [redacted] closest to [redacted] noted, [redacted] done, negative ...New order [redacted] mg (milligrams) [redacted] Q (every) [redacted] hrs. PRN (as needed) ..."

On 1/18/22 at 2:52 PM, Resident #75's primary physician saw and examined Resident #75 and there was no notation of any [redacted] to the [redacted] or any other area of the body.

On 1/19/22 at 9:19 AM, a Nurses' Note reflected that "Nurse notified by [agency] CNA resident c/o [redacted] and [redacted] during AM care, nurse assessed Resident #75 and notified MD (physician), MD rx (prescribed) [redacted] for [redacted] and [redacted] will fu [follow up] with results."

On 1/19/22 at 9:25 AM, there was an Orders-Administration Note which reflected that Resident #75 was administered [redacted] mg of [redacted] due to complaint of [redacted] in the [redacted]

On 1/19/22 at 12:25 PM, a Nurses' Note reflected that the [redacted] results showed a [redacted] to the [redacted] and that the physician and the RP

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F 609	Continued From page 19 were made aware. On 1/19/22 at 2:40 PM, a Nurses' Note reflected that the resident was transported to the hospital and that the RP was present. On 1/26/22 at 7:06 PM, a Nurses' Note reflected that the "Resident returned to facility at approximately 5:45 PM... resident underwent [redacted] procedure of the [redacted] has approximately [redacted] ..." A review of the investigation signed and dated on [redacted] by the Director of Nursing (DON) as "Investigation summary completed" was provided by the Regional Registered Nurse, reflected that it was an "Injury of unknown origin" for a [redacted]." There was no documented evidence of staff or ES personnel statements. The timeline did not include staff names for identification, nor specific time stamped accounts. The conclusions were indicated as follows: "Investigation and interviews revealed that the injury most likely occurred during the incident and transfer which occurred on [redacted] There was no evidence to conclude that [resident] had a [redacted] which resulted in a [redacted] of his/her [redacted] The incident on [redacted] that involved the EMS/Local fire department to break his/her [redacted] release his/her [redacted] and transfer him/her to the ER for evaluation may have possibly caused this injury." There was also no evidence of incidents (per hospital records) that may have occurred while at the hospital. On 9/15/22 at 11:45 AM, the surveyor interviewed the resident's assigned Licensed Practical Nurse/Unit Manager (LPN/UM#1) who stated that the [redacted] and was at high risk for	F 609		

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F 609	Continued From page 20 [redacted]. LPN/UM#1 stated that the resident had an incident that his/her [redacted]r got stuck in the [redacted] and ES had to be called to remove it. LPN/UM#1 stated that the way ES positioned the resident may have caused the [redacted] but that LPN/UM#1 was not there at the time. She also stated that LPN/UM#1 did not conduct the investigation and that "the hospital was trying to figure that out; the facility did not come up with this." LPN/UM#1 also stated that because they figured out what happened this was not considered an injury of unknown origin. At 12:21 PM, the surveyor interviewed the DON and the Chief Nursing Officer (CNO) in the presence of two surveyors. They stated that an injury of unknown origin would prompt an investigation of abuse. At 1:15 PM, the DON acknowledged that the investigation was an injury of unknown origin for a [redacted]. The DON stated that the morning after the resident's [redacted] got stuck in the [redacted] and was sent to hospital, he/she complained of [redacted]. The DON acknowledged there were no statements available within the investigation. The DON stated that the conclusion after the investigation and interviews was that the [redacted] most likely occurred upon Resident #75's transfer on [redacted]. The DON stated that the transfer, may have "possibly" caused injury. The DON acknowledged that there was no documented evidence of interviews with the EMS personnel. In addition, the DON stated that she did not report this incident and could not speak to the rationale. At 1:22 PM, the DON stated that the conclusion was not put together. The DON stated that she	F 609		

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would try to document interviews depending on if she spoke with the person while in the car or in person. The DON stated that interviews could have been conducted by phone or written as well. The DON acknowledged that there was no documented evidence within the investigation of interviews conducted. The DON stated that the occurrence was probably related to and most likely occurred during Resident #75's transfer. She could not produce documented evidence that led to this conclusion.

On 9/16/22 at 12:23 PM, the DON provided the requested medical record information for Resident #75, however, she did not provide any further information related to the investigation.

On 9/20/22 at 11:38 AM, the surveyor conducted a phone interview with the resident's assigned 11-7 CNA#2. The CNA#2 stated that she attempted to perform incontinence care for the resident when she noticed that the resident could not move well and was [redacted]. The CNA#2 stated that the resident implied the [redacted] was in his/her [redacted] The CNA#2 stated that she requested assistance from two other male aides to change the resident's brief. The CNA#2 added that Resident #75 was of large stature and that CNA#2 could not have hurt him/her. The CNA#2 stated that Resident #75 was resistant to care at times and difficult to move. The CNA#2 further stated that the resident was [redacted] and had a history of [redacted] and so she checked on Resident #75 often. The CNA#2 stated that the resident did not have a [redacted] on her shift. She could not recall if she reported this to the nurse and stated that she did not see any bodily injuries on Resident #75. The CNA#2 also stated that she had been educated on abuse and in that event, she should

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report abuse to her supervisor or an administrator staff member. She stated that if a resident had an injury that could not be explained that the facility should have investigated it.

On that same date at 11:47 AM, the Licensed Nursing Home Administrator (LNHA) stated that an injury of unknown origin should have been reported if it occurred in the facility. After reviewing the facility's policy in the presence of the surveyor, the LNHA stated that the facility's policy for reporting should have occurred within 24 hours of the event.

2. On 8/31/22 at 11:02 AM, the surveyor observed Resident #228 in the hallway self-propelling a wheelchair. The resident said hello to the surveyor and stated that he/she would be willing to talk to the surveyor at another time.

On 9/1/22 at 11:09 AM, the surveyor interviewed Resident #228 in their room. The resident stated that he/she has lived in the facility approximately [redacted] and was unable to care for him/herself and that the staff had done a good job caring for him/her.

The surveyor reviewed the medical record for Resident #228.

A review of the resident's Admission Record reflected that the resident had diagnoses which included but were not limited to [redacted].

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F 609	Continued From page 23 A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident had [redacted]. A review of the resident's interdisciplinary care plan revealed a focus area dated [redacted], for "an actual [redacted] with no injury related to [redacted]" with interventions dated [redacted] "sent out via 911 for evaluation." A review of the facility's investigation "Unwitnessed fall" dated [redacted], was provided by the Director of Nursing (DON) and prepared by the Licensed Practical Nurse (LPN#1) and signed by the Assistant Director of Nursing (ADON). The "Incident Description" indicated that "At 7:00 PM, certified nursing aide reported to the nurse that resident was yelling and cursing at other resident. Nurse went to resident and asked what was happening. Resident was very loud, disrespectful, cursing, throwing things, punching at the wall, and threatening to punch somebody. Nurse tried to calm him/her down but resident refused to calm down. He/she continue to wheel around the hallways threatening to hit somebody, throwing things. He/she wheeled himself to room [redacted] one of the patient in that room tried to ask him/her to calm down, he/she tried to hit the resident and the resident ran inside his/her room. A certified nursing aide who was taking care of another resident in that room closed the door to stop him/her from going inside, he/she tried to push the door open, banging on the door, threw him/her self on the floor, rolling on the floor and cursing."	F 609		

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In addition, the attached nursing progress note dated [redacted] at 11:43 PM, was included which indicated, "Resident refused to be redirected or listen to anybody. Supervisor called police, telehealth and the family. The police came and helped get resident up from the floor back to his/her wheelchair. He/she was sent out to hospital for psych evaluation at 9:40 PM."

On 9/12/22 at 11:15 AM, the surveyor interviewed the DON who stated that investigations were discussed with a compliance team which usually consisted of the Licensed Nursing Home Administrator (LNHA), herself and other staff members depending on the individual case such as including the social worker or speech therapist. The DON added that the team discusses whether there was a need to report to the New Jersey Department of Health (NJDOH) which was based on the regulations. The DON explained that the meetings were not documented and the decision whether to report or not was not documented either.

On 9/15/22 at 12:57 PM, the surveyor, in the presence of two other surveyors, interviewed the CNO and the DON regarding the investigation dated [redacted] for Resident #228. The DON stated that she did not report the incident for Resident #228 because the compliance team had not felt that the incident was required to be reported to the NJDOH. The CNO stated that Resident #228 was not intentionally directing his/her actions towards another resident. The DON added that the compliance team had not felt that the incident was a resident-to-resident altercation. The DON stated that she thought the aggression of Resident #228 was more directed at the staff

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members that were trying to calm the resident down and not toward any other resident. The DON explained that she based whether to report immediately on a discussion with whoever was describing the situation and if it fell within guidelines would report immediately. The DON added that the Administrator could report, or she would instruct a supervisor to report to the NJDOH immediately.

At that time, the surveyor read out loud the Nursing Description from the Witnessed Fall investigation form which included, "He/she wheeled him/herself to room [redacted] one of the patient in that room tried to ask him/her to calm down, he/she tried to hit the resident and the resident ran inside his/her room." The CNO then acknowledged that the situation could be interpreted differently.

On 9/15/22 at 2:19 PM, the survey team met with the LNHA and the DON. The LNHA stated that he had become the facility administrator on [redacted] and after reviewing the incident for Resident #228, acknowledged that the incident should have been reported and had the DON send a Reportable Event Record/Report to the NJDOH on [redacted], at 2:17 PM.

On 9/19/22 at 10:05 AM, the surveyor attempted to conduct a telephone with LPN#1 who had completed the Witnessed Fall form and was unsuccessful.

3. On 9/9/22 at 11:30 AM, the surveyor observed Resident #99 being wheeled by a Certified Nursing Aide (CNA#3) who stated to the resident that she was taking him/her to his/her room for

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F 609	Continued From page 26 changing before he/she was to go out with a resident representative. The surveyor reviewed the medical record for Resident #99. A review of the resident's Admission Record revealed diagnoses which included [redacted] (a [redacted] that affects a person's [redacted]. A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], reflected the resident had a BIMS score of [redacted] indicating that the resident had a [redacted]. In addition, the MDS Section [redacted] completed for Hearing, Speech and Vision reflected that the resident was usually able to make themselves understood and was usually able to understand others. A review of the resident's interdisciplinary care plan (IDCP) revealed a "Focus" dated as initiated 6/19/2014, and revision on [redacted], for "[redacted]." "Resident #99 is [redacted]. He/she has a [redacted]. He/she has a diagnosis of [redacted]. He/she has been noted as [redacted]." The "Interventions/Tasks" included "Communicate with the resident/family/caregivers regarding residents capabilities and needs." Further review of the IDCP revealed a "Focus" dated as initiated [redacted], and revision on	F 609		

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F 609	Continued From page 27 [redacted], for "Resident has a [redacted] problem, able to [redacted] but has difficulty understanding others, this is due to diagnosis of dev[redacted] issues." A review of a Grievance/Concern Form dated 3/30/22 provided by the DON for Resident #99 revealed "[Resident representative (RR)] reported that Resident #99 has [redacted]-he/she said staff[redacted] his/her [redacted] In addition, an "Unknown" investigation dated [redacted] was provided by the DON which was completed by the Licensed Practical Nurse/Unit Manager (LPN/UM#1) included an "Incident Description" which indicated, "While resident on home visit, resident representative noticed [redacted] on [redacted]. RR stated, when he/she asked Resident #99 stated, while dressing him/her they [redacted] his/her [redacted]. When nurse spoke with Resident #99, he/she stated, sometimes when he/she [redacted], he/she does [redacted] him/herself. Head to assessment completed no other changes in [redacted]ntact. Vital signs blood pressure [redacted] heart rate [redacted] respirations [redacted] temperature [redacted] no pain or discomfort noted. Physician made aware, [redacted] to [redacted] for 5 days. Will continue to monitor." On 9/12/22 at 11:15 AM, the surveyor interviewed the DON who stated that investigations were discussed with a compliance team which usually consisted of the LNHA, herself and other staff members depending on the individual case such as including the social worker or speech therapist. The DON added that the team discusses whether there was a need to report to the NJDOH that was based on the regulations.	F 609		

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The DON explained that the meetings were not documented and the decision whether to report or not was not documented either.

On 9/15/22 at 11:30 AM, the surveyor attempted to interview Resident #99 who answered yes and no to questions and would not elaborate and preferred to not answer any more questions. The resident answered no when asked if he/she had any issues or concerns with the staff, medications or living at the facility.

On 9/15/22 at 11:40 AM, the surveyor interviewed the LPN/UM#1 who stated that she had completed the "Unknown" investigation dated [redacted] and gave it to the DON and the DON completed the Grievance/Concern Form dated [redacted]. The LPN/UM#1 added that the resident was not comfortable speaking with people he/she doesn't know and would get annoyed and doesn't like being bothered. The LPN/UM#1 stated that she was unsure if an investigation with statements was needed because it was known that the incident was related to the resident. The LPN/UM#1 stated that the resident can tell you if something was bothering him/her. The LPN/UM#1 stated that when she asked the resident what had happened, the resident told her that he/she [redacted] and [redacted] his/her [redacted], so she didn't think that statements from staff were needed. The LPN/UM#1 then stated that the resident was not [redacted] but [redacted] and was "fairly reliable." The LPN/UM#1 could not speak to reporting abuse.

On 9/15/22 at 12:57 PM, the surveyor, in the presence of two other surveyors, interviewed the CNO and the DON regarding the Grievance /Concern Form dated [redacted], and investigation

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dated [redacted], for Resident #99. The DON stated she was involved in reporting to the NJDOH and would initiate an investigation of abuse for any resident concern that falls under the abuse policy and any and all allegations of abuse or injury of unknown origin. The DON added that the process for an allegation of abuse was if reportable then assess if resident safe in immediate moment, do an investigation and speak with the person or resident, take staff off assignment depending on the allegation. The CNO stated that Resident #99 was able to articulate what had happened then it was not an allegation of abuse. The DON added that she felt the resident could speak for themselves. The DON explained that she based whether to report immediately on a discussion with whoever was describing the situation and if it fell within guidelines would report immediately. The DON added that the Administrator could report, or she would instruct a supervisor to report to the NJDOH immediately if needed. The CNO and DON would not speak to the RR statement that he/she was told by Resident #99 that the [redacted] were from staff.

4. On 9/9/22 at 11:30 AM, the surveyor observed Resident #99 being wheeled by a CNA#3 who stated to the resident that she was taking him/her to his/her room for changing before he/she was to go out with a resident representative.

The surveyor reviewed the medical record for Resident #99.

A review of the resident's Admission Record revealed diagnoses which included [redacted] a group of

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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 the resident had a BIMS score of [redacted] out of [redacted], indicating that the resident had a [redacted] In addition, the MDS Section [redacted] completed for Hearing, Speech and Vision reflected that the resident was usually able to make themself understood and was usually able to understand others.

A review of the resident's IDCP revealed a "Focus" dated as initiated [redacted], and revision on [redacted], for "Cognition" indicated "Resident #99 is [redacted] He/she has a [redacted]. He/she has a diagnosis of [redacted]. He/she has been noted as [redacted]" The "Interventions/Tasks" included "Communicate with the resident/family/caregivers regarding residents capabilities and needs."

Further review of the IDCP revealed a "Focus" dated as initiated [redacted], and revision on [redacted], for "Resident has a [redacted], able to verbalize basic needs but has difficulty [redacted], this is due to diagnosis of [redacted], [redacted]

A review of an "[redacted]" investigation report dated [redacted], provided by the DON and completed by the LPN#2 revealed an "Incident Description" which indicated, "Writer notified

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F 609	Continued From page 31 [resident representative] regarding [redacted] on base of the [redacted]. No signs of bleeding noted. No break in skin. [redacted]. Resident is unsure about how [redacted] occurred. Presently denies pain/discomfort at site." On 9/12/22 at 11:15 AM, the surveyor interviewed the DON who stated that investigations were discussed with a compliance team which usually consisted of the LNHA, herself and other staff members depending on the individual case such as including the social worker or speech therapist. The DON added that the team discusses whether there was a need to report to the NJDOH that was based on the regulations. The DON explained that the meetings were not documented and the decision whether to report or not was not documented either. On 9/15/22 at 11:30 AM, the surveyor attempted to interview Resident #99 who answered yes and no to questions and would not elaborate and preferred to not answer any more questions. The resident answered no when asked if he/she had any issues or concerns with the staff, medications or living at the facility. On 9/15/22 at 11:40 AM, the surveyor interviewed the LPN/UM#1 who stated that she had not completed the [redacted]" investigation report dated [redacted], but she was aware of it. The LPN/UM#1 added that the resident was not comfortable speaking with people he/she doesn't know and would get annoyed and doesn't like being bothered. The LPN/UM#1 stated that she was unsure if an investigation with statements was needed because it was known that the [redacted] was from the [redacted]. The	F 609		

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LPN/UM#1 added that she knew the [redacted] was from the [redacted] because the physician had assessed the [redacted]. The LPN/UM#1 then stated that the resident was not confused but very [redacted] and was "fairly reliable." The LPN/UM#1 could not speak to reporting abuse.

On 9/15/22 at 12:57 PM, the surveyor, in the presence of two other surveyors, CNO and the DON regarding the investigation dated [redacted] for Resident #99. The DON stated she was involved in reporting to the NJDOH and would initiate an investigation of abuse for any resident concern that falls under the abuse policy and report any and all allegations of abuse or injury of unknown origin. The DON added that the process for an allegation of abuse was for a reportable to assess if resident was safe in the immediate moment, do an investigation and speak with the person or resident and take staff off assignment depending on the allegation. The DON stated that the physician assessed that the [redacted] was from the [redacted] around Resident #99's [redacted]. The DON added that she did not think the incident should be reported because the source of the [redacted] was known. The DON explained that she based whether to report immediately on a discussion with whoever was describing the situation and if it fell within the guidelines would report immediately. The DON added that the Administrator could report, or she would instruct a supervisor to report to the NJDOH immediately if needed. The CNO and DON would not speak to the unknown origin of the [redacted] on Resident #99.

On 9/19/22 at 11:53 AM, the surveyor attempted to conduct a telephone interview with LPN#2 and was unsuccessful.

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A review of the facility's Abuse Investigating and Reporting Policy and Procedure revised 05/2022 included, "All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and/or injuries of unknown source ("abuse") shall be promptly reported to local state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported."

In addition, the policy included "1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported to the facility Administrator, or his/her designee, to the following persons or agencies: a. State licensing certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman; c. The Resident Representative (Sponsor) of Record; d. Law enforcement officials; The resident's Attending Physician 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but no later than: a. Two (2) hours if the alleged violation involves abuse or has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury."

REFER to F689

5. On 9/01/22 at 11:32 AM, the surveyor observed Resident #191 reclining back in his/her [redacted] in their room. The surveyor attempted to interview the resident. The resident was able to

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communicate his/her name to the surveyor.

The surveyor reviewed the medical record for Resident #191.

A review of the resident's Admission Record reflected that Resident #191 had resided at the facility for about a year and had diagnoses which included but were not limited to [redacted].

A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], reflected that Resident #191 had a Brief Interview for Mental Status score of [redacted], which indicated Resident #191 had [redacted]. Further review of Resident #191's MDS, Section [redacted] Swallowing/Nutritional Status did not indicate that Resident #191 was on a mechanically altered diet that would require a change in texture of foods or liquids.

A review of a Progress Note (PN) dated [redacted], and timed at 14:30 (2:30 PM) indicated that while Resident #191 was in the dayroom during snack time, staff informed nursing that Resident #191 was [redacted] and [redacted]. The PN further explained that Resident #191 had a Physician's Order (PO) for [redacted]

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thickened liquids and was given thin milk by an unknown staff member. The PN revealed that Resident #191 was evaluated by the Licensed Practical Nurse (LPN#3). Upon evaluation, the LPN#3 heard [redacted] the resident's [redacted], the resident's vital signs were abnormal, and the resident's physician was notified immediately. Upon notification of the physician, the physician provided the LPN#3 with physician orders for Resident #191 to be administered [redacted] and a [redacted] treatment. The PN further indicated that the physician came to the unit, assessed Resident #191 and decided to send Resident #191 to the hospital.

A further review of Resident #191's PN dated [redacted] and timed at 22:35 (10:25 PM) reflected that Resident #191 was admitted to the hospital with possible [redacted] (occurs when food or liquid is [redacted]).

A review of the resident's hospital discharge paperwork from [redacted] through [redacted] reflected a discharge diagnosis of [redacted] which was identified on a [redacted]. A further review of Resident #191's hospital paperwork indicated that Resident #191 required placement of a [redacted]

A review of Resident #191's Order Audit Report throughout Resident's #191's stays at the facility revealed a PO dated [redacted], and timed at 10:37 AM for regular diet [redacted] texture, [redacted] thickened liquid consistency.

A review of Resident #191's Diet Order Timeline indicated that on [redacted], the Speech

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Language Pathologist (SLP) recommended downgrading Resident #191's diet to [redacted] texture, [redacted] thick liquid consistency. Upon the SLP recommendation, the order was approved by the physician.

A review of the facility's Investigation of the incident dated [redacted], and signed by the DON indicated that in conclusion Resident #191 was provided regular thin liquids when his/her current diet indicated [redacted] thickened liquids. The investigation revealed Resident #191 received the incorrect fluid consistency during snack time and the incident most likely occurred due to lack of knowledge by staff regarding proper protocols in verifying fluid consistencies.

On 9/15/22 at 11:30 AM, the surveyor interviewed Resident #191's Registered Nurse (RN) who stated anything that resembles abuse should be reported immediately to supervisory staff. The RN was unsure of time frames for reporting abuse and incidents and accidents that resulted in physical harm to a resident.

On 9/15/22 at 11:52 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM#2) who stated that abuses needed to be reported and investigated immediately. The LPN/UM#2 further stated that an incident or accident that occurred that caused a resident distress and required hospitalization would be reported to the facility management immediately by LPN/UM and LPN/UM would in-service staff on the event to prevent further incidents from occurring. The LPN/UM#2 could not speak to time frames for reporting to the NJDOH.

On 9/15/22 at 12:57 PM, the surveyors

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interviewed the CNO and the DON and asked the question, "How long after a serious bodily injury occurred to a resident would it be reported?" The CNO and DON did not know and stated that they would have to get back to the surveyors with that answer. The surveyors never received a response from the CNO and DON. The DON stated that DON did not report the incident for Resident #191 because the incident involved one Certified Nursing Assistant (CNA#4), an investigation was initiated and the staff member was re-educated that day.

On 9/20/22 at 11:28 AM, the surveyor interviewed the facility's Administrator (Admin) who stated the DON was the head abuse investigator at the facility and was "in charge."

At 11:50 AM, the Admin stated that if Resident #191 had serious bodily injury due to abuse, then it would be reported to the NJDOH within two hours according to the facility's abuse policy and procedure. The Admin told the surveyor that Resident #191 was harmed and had an adverse reaction due to being administered whole thin milk, but it was not based off carelessness or lack of education because the CNA#4 was educated prior to the event. The Admin stated that the incident occurred due to, "human error." The Admin did not speak to the proper procedure the CNA#4 should have performed based off the prior education the CNA#4 received.

A review of the facility's Abuse Investigating and Reporting Policy and Procedure revised 05/2022 included, "All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and/or injuries of unknown source ("abuse") shall be promptly

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F 609	Continued From page 38 reported to local state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported." In addition, the facility's Abuse Investigating and Reporting Policy and Procedure revised 05/2022 indicated, "1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported to the facility Administrator, or his/her designee, to the following persons or agencies: a. State licensing certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman; c. The Resident Representative (Sponsor) of Record; d. Law enforcement officials; The resident's Attending Physician 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but no later than: a. Two (2) hours if the alleged violation involves abuse or has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse and has not resulted serious bodily injury." NJAC 8:39-9.4(e)(f)	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §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	F 610		10/14/22

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F 610	Continued From page 39 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: REFER to 609 Based on interview, observation, and record review, it was determined that facility failed to conduct a timely and through investigation, as well as, follow their own facility policy on Abuse Investigation and Reporting was consistently implemented for five [redacted] residents (Resident #27, #75, #99, #102 and #228) reviewed for alleged violation investigations. This deficient practice was evidenced by the following: 1. On 9/08/22 at 11:28 AM, the surveyor interviewed the responsible party (RP) for Resident #75 in the presence of a second surveyor. The RP informed the surveyors that Resident #75 sustained a [redacted] which required surgery. The RP stated that this occurred the day after Resident #75 had an incident whereby his/her [redacted]r got caught in the [redacted] which Emergency Services (ES) were required to release by cutting the [redacted]	F 610	F 610 Investigations Preparation and/or execution of this plan do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. 1. What corrective action will be accomplished for those residents found to have been affected by this practice? -Investigations reviewed and reported to the Department of Health for residents; #27, #75, #99, #102, and #228. Additional data cannot be retroactively collected and examined due to the passage of time. 2. How will you identify other residents having the potential to be affected by the same practice, and what corrective action	

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F 610	Continued From page 40 [redacted]. The RP stated that Resident #75 was sent to the hospital for evaluation of the [redacted] and that the resident complained of pain the next day at the facility. The RP further stated that the Assistant Administrator (AA) stated that the [redacted] could have occurred when ES was moving the resident and that no further information was provided. On 9/09/22 at 11:07 AM, the surveyor interviewed the resident's regular assigned Certified Nursing Assistant (CNA#1) who stated that Resident #75 required total care although the resident could feed him/herself. She further stated that the resident was confused and could answer simple questions. On 9/09/22 at 11:39 AM, the surveyor observed Resident #75 in the day room wearing a mask and was seated in a [redacted] wheelchair. The surveyor reviewed the electronic medical record (eMAR) for Resident #75. Review of the Admission Record (an admission summary) reflected that the resident had diagnoses which included but were not limited to [redacted] Review of the annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated that the resident had [redacted]. Further review of the MDS reflected that the resident required limited assistance	F 610	will be taken? (b) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken? -All residents have the potential to be affected by this practice. 10/10/2022, the Administrator conducted an audit of the investigations from the last quarter in order to identify others that have the potential to be affected. The Administrator instructed the Director of Nursing to report the existing investigations for residents, #75, #99-1, #99-2, and #102 to the Department of Health. 3. What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur? 10/10/2022, the Regional Director of Nursing verbally reeducated the Director of Nursing on the components of this regulation, with emphasis on reporting results of all investigations to the Administrator and to other officials within 5 working days of the incident. 10/10/2022, the Regional Director of Nursing verbally reeducated Administrator, Director of Nursing, and Unit Managers, on the components of this regulation with emphasis on completing comprehensive investigations at the time of the occurrence, interviewing witnesses to an incident, interviewing staff members	

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F 610	Continued From page 41 ("resident highly involved with activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance") with the physical assistance of two people. Review of the Individual Comprehensive Care Plan (ICCP) reflected a focus area for [redacted] initiated on [redacted] and revised on [redacted], which indicated that the resident had potential for [redacted] related to [redacted] and frequent [redacted]. It also reflected that on [redacted] the resident had "[redacted]." Interventions initiated on [redacted], included "Monitor/record/report to nurse any s/s (signs/symptoms) of [redacted]"... "[redacted] " and "Monitor/record/report to nurse, residents' complaints of [redacted] Review of Resident #75's Progress Notes reflected the following: On [redacted] at 7:32 AM, a Nurses' Note reflected that at "5:45 am nurse on unit called the undersigned supervisor notifying that patient got [resident] [redacted] in the [redacted]) in the [redacted] and [resident] is unable to get his [redacted] out. Undersigned went to the unit to assess, [redacted] and not able to get out. Patient report [resident] doesn't know how [resident] [redacted] got in the hole [resident] was sleeping and when [resident] woke up, [resident] [redacted] was stuck. 911 called, requested for the fire department to come. Fire department, EMT (emergency medical transport) and police arrived, they had to cut the [redacted] of the [redacted] to release [resident] [redacted] noted [redacted] and [redacted] and [redacted]. [Physician] notified, order to transport to ER (emergency room) for further evaluation.	F 610	on all shifts who had contact with the resident(s) involved in an incident, and reviewing all events leading up the alleged incident. Regional Director of Nursing and Administrator will review all investigations ensuring the investigations are complete including statements from witnesses of the incident(s). 4. How will the corrective action(s) be monitored to ensure the practice will not recur, what quality measures will be put into place? -The Regional Director of Nursing will review all incidents and accident investigations monthly for three months. -Findings of these audits will be reviewed in the monthly QAPI meeting and presented by the Director of Nursing x 90 days.	

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F 610	Continued From page 42 Spouse [name redacted] notified. All pertinent paperwork sent with patient to ER left facility at 7:18 am." On [redacted] at 12:19 PM, a Nurses' Note reflected that "Resident returned from hospital from [redacted] r of the [redacted] ...no c/o (complaint of) [redacted], head to toe completed. [redacted] and [redacted] to [redacted] closest to [redacted], [redacted] noted, [redacted] done, negative ...New order [redacted] mg (milligrams) [redacted] Q (every) [redacted] hrs. PRN (as needed) ..." On [redacted] at 2:52 PM, Resident #75's primary physician saw and examined Resident #75 related to Resident #75's [redacted] and there was no notation of any [redacted] to the [redacted] or any other area of the body. On [redacted] at 9:19 AM, a Nurses' Note reflected that "Nurse notified by [agency] CNA resident c/o [redacted] and [redacted] during AM care, nurse assessed Resident #75 and notified MD (physician), MD rx (prescribed) [redacted] and [redacted] will fu (follow up) with results." On [redacted] at 9:25 AM, there was an Orders-Administration Note which reflected that Resident #75 was administered [redacted] mg of [redacted] due to Resident #75's complaint of [redacted] in the [redacted]. On [redacted] at 12:25 PM, a Nurses' Note reflected that the [redacted] y results showed a [redacted] to the [redacted] and that the physician and the RP was made aware. On 1/19/22 at 2:40 PM, a Nurses' Note reflected	F 610		

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that Resident #75 was transported to the hospital and that the RP was present.

On [redacted] at 7:06 PM, a Nurses' Note reflected that "Resident returned to facility approximately at 5:45 PM... resident underwent operative procedure of the [redacted], post op site has approximately [redacted] ..."

Review of the investigation provided by the Regional Registered Nurse (RRN) on 9/12/22 at 12:56 PM, reflected that it was an "Injury of unknown origin" for a [redacted]" There was no documented evidence of staff or ES personnel statements. The timeline did not include staff names for identification, nor specific time stamped accounts. The conclusions were indicated as follows: "Investigation and interviews reveal that the injury most likely occurred during the incident and transfer which occurred on [redacted]. There is no evidence to conclude that [resident] had a fall which resulted in a [redacted] his/her [redacted]. The incident on [redacted] that involved the EMS/Local fire department to break his/her [redacted], release his/her [redacted] and transferred him/her to ER for evaluation may have possibly caused this injury. There was also no documented evidence of incidents (per hospital records) that may have occurred while at the hospital." This was signed and dated by the Director of Nursing (DON) as "Investigation summary completed" on [redacted]

On 9/15/22 at 11:45 AM, the surveyor interviewed Resident #75's assigned Licensed Practical Nurse/Unit Manager (LPN/UM). She stated Resident #75 had [redacted] and was at high risk for falls. The LPN/UM stated that Resident #75 had an incident that his/her [redacted]

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got stuck in the [redacted] and the ES had to be called to remove it. The LPN/UM also stated that the way ES positioned Resident #75 may have caused the [redacted] but that the LPN/UM was not there at the time. The LPN/UM further stated that LPN/UM did not conduct the investigation and that "the hospital was trying to figure that out; the facility did not come up with this." The LPN/UM stated that because they figured out what happened this was not considered an injury of unknown origin.

On that same date at 12:21 PM, the surveyor interviewed the DON and the Chief Nursing Officer (CNO) in the presence of two additional surveyors. They stated that an injury of unknown origin would prompt an investigation of abuse.

On that same date at 1:15 PM, the DON acknowledged that the investigation was an injury of unknown origin for a [redacted]. The DON stated that the morning after Resident #75's [redacted] got stuck in the [redacted] and was sent to hospital, he/she complained of [redacted] The DON acknowledged there were no statements available within the investigation. The DON stated that the conclusion after the investigation and interviews was that the [redacted] most likely occurred upon Resident #75's transfer on [redacted]. The DON stated that the transfer, may have "possibly" caused injury. The DON acknowledged that there was no documented evidence of interviews with the EMS personnel.

On that same date at 1:22 PM, the DON stated that the conclusion was not put together. The DON stated that she would try to document interviews depending on if she spoke with the person while in the car or in person. The DON

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stated that interviews could have been conducted by phone or in person. The DON acknowledged that there was no documented evidence within the investigation that interviews were conducted. The DON stated that the occurrence was probably related to and most likely occurred during Resident #75's transfer. The DON could not provide any documented evidence that led to this conclusion. She further stated, "I would have to check that."

On 9/16/22 at 12:23 PM, the DON provided the requested medical record information for Resident #75, however, she did not provide any further information related to the investigation.

On 9/20/22 at 11:38 AM, the surveyor conducted a phone interview with Resident #75's 11-7 assigned Certified Nursing Assistant (CNA#2). The CNA#2 stated that she attempted to perform incontinence care for Resident #75 when she noticed that Resident #75 could not move well and was [redacted] in [redacted]. The CNA#2 stated that Resident #75 implied the [redacted] was in his/her [redacted]. The CNA#2 stated that she requested assistance from two other male aides to change Resident #75's briefs. The CNA#2 added that Resident #75 was of large stature and that [redacted] could not have hurt him/her. The CNA#2 stated that Resident #75 was resistant to care at times and difficult to move. The CNA#2 further stated that Resident #75 was confused and had a history of [redacted] and so she checked on Resident #75 often. The CNA#2 stated that Resident #75 did not have a fall on CNA#2's shift. She could not recall if she reported this to the nurse and stated that she did not see any bodily injuries on Resident #75. The CNA#2 also stated that she had been educated on abuse and in that event

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she should report abuse to her supervisor or an Administrative staff member. She stated that if a resident had an injury that could not be explained that the facility should have investigated it.

At 12:32 PM, the surveyor interviewed the AA who stated that he interviewed Resident #75 and the RP but could not speak to any other aspect of the investigation.

2. On 8/31/22 at 11:02 AM, the surveyor observed Resident #228 in the hallway self-propelling a wheelchair. Resident #228 said hello to the surveyor and stated that he/she would be willing to talk to the surveyor at another time.

On 9/1/22 at 11:09 AM, the surveyor interviewed Resident #228 in their room. Resident #228 stated that he/she has lived in the facility approximately [redacted] years and was unable to care for him/herself and that the staff has done a good job caring for him/her.

The surveyor reviewed the medical record for Resident #228.

A review of Resident #228's Admission Record reflected that Resident #228 had diagnoses which included but were not limited to [redacted].

A review of Resident #228's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted] reflected that Resident #228 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated Resident #228 had a

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A review of Resident #228's Interdisciplinary Care Plan (IDCP) dated [redacted], included "an actual fall with no injury related to [redacted]" with interventions dated [redacted], "sent out via 911 for evaluation."

A review of the facility's investigation "Unwitnessed fall" dated [redacted] was provided by the Director of Nursing (DON) and prepared by the Licensed Practical Nurse (LPN#1) and signed by the Assistant Director of Nursing (ADON). The "Incident Description" indicated that "At 7:00 PM, certified nursing aide reported to the nurse that Resident #228 was [redacted] at other resident. Nurse went to Resident #228 and asked what was happening. Resident #228 was very loud, disrespectful, [redacted] throwing things, punching at the wall, and threatening to punch somebody. Nurse tried to calm him/her down but Resident #228 refused to calm down. He/she continue to wheel around the hallways threatening to hit somebody, throwing things. He/she wheeled [redacted] f to room [redacted], one of the patients in that room tried to ask him/her to calm down, he/she tried to hit the resident and the resident ran inside his/her room. A certified nursing aide who was taking care of another resident in that room closed the door to stop him/her from going inside, he/she tried to push the door open, banging on the door, threw him/her self on the floor, rolling on the floor and [redacted]."

Included in the investigation was a statement from a Certified Nursing Aide (CNA#3) which reflected "At 7 PM, I was in room [redacted] putting patient to bed, Resident #228 was at the door

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hitting the door and [redacted] patient. I ask Resident #228 to go to his/her room, he/she refused to leave. I call the nurse and the nurse call the supervisor." A fall risk evaluation, an updated IDCP, and a Possession, Consumption, or Intent to sell unauthorized or illegal substances policy and signature of the resident accepting and agreeing to the policy were also included in the investigation report. In addition, the nursing progress notes dated [redacted] at 11:43 PM were included with additional information that reflected "Resident refused to be redirected or listen to anybody. Supervisor called police, telehealth, and the family. The police came and helped get Resident #228 up from the floor back to his/her wheelchair. He/she was sent out to hospital for [redacted] evaluation at 9:40 PM."

On 9/15/22 at 11:00 AM, the surveyor interviewed Resident #228 who stated that he/she would rather not discuss the incident that occurred on [redacted]. Resident #228 stated that the incident was all his/her fault and that the facility staff responded appropriately and that he/she was very embarrassed.

On 9/15/22 at 11:08 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that LPN/UM was not working on the day of the incident but had heard that Resident #228 was verbally abusive and had a fall. The LPN/UM stated that when Resident #228 returned from the hospital with a diagnosis of [redacted] that LPN/UM and the social worker (SW) had spoken to Resident #228 and he/she admitted to being [redacted] and agreed to sign the facility policy. The LPN/UM stated that LPN/UM did not know how Resident #228 obtained the [redacted] because Resident #228 had

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not left the facility and thought an investigation was performed. The LPN/UM added that Resident #228 was embarrassed and had not discussed again with Resident #228 because he/she was very apologetic and had been compliant. The LPN/UM stated that LPN/UM could not speak to how the investigation was completed. The LPN/UM then stated that the investigation report goes to the DON.

On 9/15/22 at 11:24 AM, based on the room number indicated on the facility investigation report dated [redacted], the surveyor interviewed Resident #27 who stated that he/she remembered an incident that had occurred and had given a statement to the police that day. Resident #27 stated that Resident #27 had not spoken to any other staff member about the incident except the CNA#3 that was in his/her room and was seen after that day by his/her [redacted] for a regular visit. Resident #27 also stated that he/she had a roommate on that day but that the roommate had since expired. Resident #27 explained that there was a resident who was in the hallway yelling and he/she had heard a lot of noise coming from the hallway. Then, Resident #27 added that he/she was in his/her room with a CNA#3 who protected him/her by keeping the door closed because Resident #228 was in the hallway and kept banging on the door so hard that the door was shaking. Resident #27 stated "He/she scared the hell out of me." when speaking about Resident #228 banging on the door. Resident #27 stated that he/she was thankful that there was CNA#3 in the room with him/her. Resident #27 added that he/she was fine when it was all over and felt protected and was able to self-propel through the hallways by him/herself.

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The surveyor reviewed the medical record for Resident #27.

A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted] reflected that Resident #27 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated Resident #27 had an [redacted].

There was no progress note for Resident #27 indicating that Resident #27 was involved in any incident or was spoken to by any staff member.

On 9/15/22 at 12:57 PM, the surveyor in the presence of two other surveyors, interviewed the CNO and the DON regarding the investigation dated [redacted] for Resident #228. The DON stated that DON thought the aggression of Resident #228 was more directed at the staff members that were trying to calm Resident #228 down and not toward any other resident. The DON acknowledged that the investigation was not completed and had not included a statement from the residents' in the room where the CNA#3 had kept the door closed, CNA statements who cared for Resident #228 that day, any staff that had observed the incident, the police report, or the hospital report.

On 9/16/22 at 11:47 AM, the survey team met with the LNHA and DON. The LNHA stated that he became the facility administrator on [redacted] and after reviewing the incident for Resident #228, had the DON send a Reportable Event Record/Report to the NJDOH on 9/15/22 at 2:17 PM, which included additional investigation information such as statements from Resident

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#27 and a SW's statement which was not included in the [redacted] Witnessed Fall investigation. The DON acknowledged that the investigation was incomplete and in addition had not included how Resident #228 obtained the [redacted]

On 9/19/22 at 10:05 AM, the surveyor attempted to conduct a telephone interview with the LPN#1 who had completed the Witnessed Fall form and was unsuccessful.

On 9/19/22 at 11:25 AM, the surveyor was provided by the DON additional investigation information dated 9/16/22 for the incident which occurred on [redacted] which included CNA statements, police report information, the hospital report, and a conclusion as to how Resident #228 obtained [redacted] and a plan for follow-up. The DON acknowledged that the additional information should have been completed in the investigation dated [redacted]

On 9/20/22 at 9:56 AM, the surveyor interviewed the CNA#3 via telephone who stated that CNA#3 worked for an agency and had not worked at the facility since the beginning of [redacted]. The CNA#3 recalled that CNA#3 had seen Resident #228 "going crazy in the hallway" and explained that Resident #228 was wheeling him/herself around hitting things, pushing things over and tipped over the linen cart. The CNA#3 added that CNA#3 was assigned Resident #27 and was taking care of Resident #27. The CNA#3 stated "I had to lock the door so Resident #228 would not come inside and hurt my resident." The CNA#3 also stated that Resident #27 was scared and that after the incident spoke with the police. The CNA#3 then said that CNA#3 had to write a statement. The

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CNA#3 added that Resident #228 was not on Resident #228's assignment and lived far down the hallway. The CNA#3 was unsure if there were any other residents in the hallway but knew that other staff members had been seen but was unable to recall which staff members.

3. On 9/9/22 at 11:30 AM, the surveyor observed Resident #99 being wheeled by a Certified Nursing Aide (CNA#4) who stated to Resident #99 that CNA#4 was taking him/her to his/her room for changing before he/she was to go out with a resident representative.

The surveyor reviewed the medical record for Resident #99.

A review of Resident #99's Admission Record revealed diagnoses which included [redacted],

A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], reflected Resident #99 had a brief interview for mental status (BIMS) score of [redacted] indicating that Resident #99 had a [redacted] cognition. In addition, the MDS Section [redacted] completed for Hearing, Speech, and Vision reflected that Resident #99 was usually able to make themself understood and was usually able to understand others.

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A review of the resident's IDCP revealed a "Focus" dated as initiated [redacted] and revision on [redacted] for "Cognition" which indicated "Resident #99 is [redacted]. He/she has a [redacted]. He/she has a diagnosis of [redacted]. He/she has been noted as forgetful." The "Interventions/Tasks" included "Communicate with the resident/family/caregivers regarding residents capabilities and needs."

Further review of the IDCP revealed a "Focus" dated as initiated [redacted] and revision on [redacted] for "Resident has a [redacted] able to verbalize basic needs but has difficulty [redacted] others, this is due to diagnosis of [redacted]."

A review of a Grievance/Concern (G/C) Form dated [redacted], provided by the DON for Resident #99 revealed "[Resident representative (RR)] reported that Resident #99 has [redacted]-he/she said staff [redacted] his/her legs."

In addition, the G/C Form included a list of attempts made to resolve the problem "Resident #99 interviewed by two staff. He/she stated he/she [redacted] him/herself. He/she confirmed that the staff member has not harmed him/her or tries to [redacted] his/her [redacted]

Also, the G/C Form had a section "For Social Work Department Completion:" which was blank.

Attached with the G/C Form was an "Unknown" investigation report dated [redacted], which was completed by the LPN/UM and included an "Incident Description" which indicated "While

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resident on home visit, [resident representative (RR)] noticed [redacted] marks on [redacted]. RR stated, when he/she asked Resident #99 stated, while dressing him/her they [redacted] his/her [redacted]. When nurse spoke with Resident #99, he/she stated, sometimes when he/she feels [redacted] he/she does [redacted] him/herself. Head to toe assessment completed no other changes in skin, skin intact. Vital signs blood pressure [redacted] heart rate [redacted] respirations [redacted] temperature [redacted] no pain or discomfort noted. Physician made aware,[redacted] to[redacted] for 5 days. Will continue to monitor." The investigation included nursing progress notes dated [redacted] at 6:37 PM which was the same as the Incident Description, a skin observation tool dated [redacted] at 6:38 PM, an updated IDCP and a social service note dated [redacted] at 9:40 AM which indicated "SW [Social Worker] received call from RR requesting to cancel meeting with myself and other administrative personal at this time. RR stated he/she will let me know when he/she would like to reschedule."

On 9/12/22 at 9:30 AM, the surveyor interviewed the SW who stated that for the grievance process, the facility uses the G/C Form that "anyone" can fill out and submit to the SW. The SW then stated that SW would forward the form to the involved department which SW explained as an example if there was a broken television then the form would be given to the Maintenance Department and once completed, the form would be returned to the SW for filing.

On 9/12/22 at 11:15 AM, the surveyor interviewed the DON who stated that investigations were discussed with a compliance team which usually consisted of the LNHA, DON, and other staff

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members depending on the individual case such as including the SW or speech therapist.

On 9/15/22 at 11:30 AM, the surveyor attempted to interview Resident #99 who answered yes and no to questions and would not elaborate and preferred to not answer any more questions. Resident #99 answered no when asked if he/she had any issues or concerns with the staff, medications or living at the facility.

On 9/15/22 at 11:40 AM, the surveyor interviewed the LPN/UM who stated that LPN/UM had completed the "Unknown" investigation dated [redacted], and gave it to the DON and the DON completed the Grievance/Concern Form dated [redacted]. The LPN/UM added that Resident #99 was not comfortable speaking with people he/she doesn't know and would get annoyed and doesn't like being bothered. The LPN/UM stated that LPN/UM was unsure if an investigation with statements was needed because it was known that the incident was related to the resident. The LPN/UM stated that Resident #99 can tell you if something was bothering him/her. The LPN/UM stated that when LPN/UM asked Resident #99 what had happened, Resident #99 told her that he/she felt [redacted] and [redacted] his/her [redacted] so LPN/UM didn't think that statements from staff were needed. The LPN/UM then stated that Resident #99 was not confused but very [redacted] and was "fairly reliable."

On 9/15/22 at 12:57 PM, the surveyor, in the presence of two other surveyors, interviewed the CNO and the DON regarding the G/C Form dated [redacted] and investigation dated [redacted] for Resident #99. The DON stated she was involved in reporting to the NJDOH and would initiate an

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investigation of abuse for any resident concern that falls under the abuse policy and any and all allegations of abuse or injury of unknown origin. The DON added that the process for an allegation of abuse was if reportable then assess if the resident is safe in the immediate moment, do an investigation, and speak with the person or resident, take staff off the assignment depending on the allegation. The CNO stated that Resident #99 was able to articulate what happened so it was not an allegation of abuse. The DON acknowledged that the investigation was not complete. The DON could not speak to the G/C Form not being completed by SW.

On 9/15/22 at 2:19 PM, the survey team met with the LNHA, CNO, and the DON. The LNHA stated that he had become the facility administrator on 9/5/22. The LNHA stated that he would report any allegation of abuse and would call within the timeframe's and expect a full investigation to be done.

On 9/20/22 at 12:11, the surveyor was provided additional information for the "Unknown" investigation for Resident #99. The DON stated that the investigation was incomplete.

4. On 9/9/22 at 11:30 AM, the surveyor observed Resident #99 being wheeled by CNA#4 who stated to Resident #99 that CNA#4 was taking him/her to his/her room for changing before he/she was to go out with a resident representative.

The surveyor reviewed the medical record for Resident #99.

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A review of Resident #99's Admission Record revealed diagnoses which included [redacted]

A review of the quarterly MDS, an assessment tool used to facilitate the management of care dated [redacted], reflected Resident #99 had a BIMS score of [redacted], indicating that Resident #99 had a [redacted] cognition. In addition, the MDS Section [redacted] completed for Hearing, Speech, and Vision reflected that Resident #99 was usually able to make themself understood and was usually able to understand others.

A review of Resident #99's IDCP revealed a "Focus" dated as initiated [redacted], and revision on [redacted] for [redacted] which indicated "Resident #99 is [redacted], [redacted]. He/she has a [redacted]. He/she has a diagnosis of [redacted]. He/she has been noted as [redacted]." The "Interventions/Tasks" included "Communicate with the resident/family/caregivers regarding residents capabilities and needs."

Further review of the IDCP revealed a "Focus" dated as initiated [redacted], and revision on [redacted] 2, for "Resident has a [redacted], able to verbalize basic needs but has difficulty [redacted] others, this is due to diagnosis of [redacted]"

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A review of an [redacted]" investigation report dated [redacted], by the LPN#2 revealed an "Incident Description" which indicated "Writer notified by [resident representative (RR)] regarding [redacted] on base of the [redacted]. No signs of bleeding noted. No break in skin. [redacted] measures [redacted] cm. Resident is unsure about how [redacted] occurred. Presently denies pain/discomfort at site."

On 9/12/22 at 11:15 AM, the surveyor interviewed the DON who stated that investigations were discussed with a compliance team which usually consisted of the LNHA, DON, and other staff members depending on the individual case such as including the SW or speech therapist.

On 9/15/22 at 11:40 AM, the surveyor interviewed the LPN/UM who stated that LPN/UM had not completed the [redacted]" investigation report dated [redacted] but was aware of it. The LPN/UM added that Resident #99 was not comfortable speaking with people he/she doesn't know and would get annoyed and doesn't like being bothered. The LPN/UM stated that she was unsure if an investigation with statements was needed because it was known that the [redacted] was from the [redacted]. The LPN/UM added that she knew the [redacted] was from the [redacted] because the physician had assessed the [redacted] The LPN/UM then stated that Resident #99 was not confused but very [redacted] and was "fairly reliable."

On 9/15/22 at 12:57 PM, the surveyor, in the presence of two other surveyors, interviewed the CNO and the DON regarding the investigation dated 7/24/22, for Resident #99. The DON stated she was involved in reporting to the NJDOH and

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would initiate an investigation of abuse for any resident concern that falls under the abuse policy and report any and all allegations of abuse or injury of unknown origin. The DON added that the process for an allegation of abuse was for a reportable to assess if resident was safe in the immediate moment, do an investigation, speak with the person or resident, and take staff off assignment depending on the allegation. The DON stated that the physician assessed that the abrasion was from the [redacted] around Resident #99's [redacted] and therefore thought the origin was not unknown. The DON acknowledged that the investigation was incomplete.

There was no G/C Form provided for the [redacted]" investigation although the "Incident Description" indicated that "Writer notified by [resident representative (RR)] regarding [redacted] on base of the [redacted]

On 9/15/22 at 2:19 PM, the survey team met with the LNHA, CNO, and the DON. The LNHA stated that he had become the facility administrator on [redacted] The LNHA stated that he would report any allegation of abuse and would call within the timeframe's and expect a full investigation to be done.

On 9/19/22 at 11:53 AM, the surveyor attempted to conduct a telephone interview with LPN#2 who had completed the [redacted] investigation and was unsuccessful.

On 9/20/22 at 12:11, the surveyor was provided additional information for the [redacted] investigation for Resident #99. The DON stated that the investigation was incomplete.

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MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

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A review of the Grievances & Patient Concern Policy that was provided by the DON with a revised date of 8/31/22 included "Policy: This policy is to ensure that concerns are properly communicated and reported to the proper department in a timely fashion by streamlining the investigation process. Procedure: 1. If a resident/family member has a concern they can approach/contact any facility staff member or a resident concern form can be filled out. The concern will then be forwarded to social services. 2. Social Services will give each concern a number for reference and log each one for investigation in the Grievance Log kept in the Social Services office and follow up ...4. At Morning Meeting/Department Head meeting, Social Services will discuss all outstanding concerns and/or resolutions. 5. At the completion of each concern investigation, Social Services will enter the resolution into the concern log ...."

A review of the facility policy dated as revised 5/2022, for Abuse Prevention Program provided by the CNO and DON included that as part of the resident abuse prevention, the administration will: "Identify and assess all possible incidents of abuse;" and "Investigate and report any allegations of abuse within timeframe's as required by federal requirements;"

A review of the facility policy dates as revised 5/2022 for Abuse Investigation and Reporting provided by the CNO and DON included that "All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and/or injuries of unknown source ("abuse") shall be promptly reported to local state and federal agencies (as defined by current regulations) and thoroughly investigated by facility

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management."

In addition, the Abuse Investigation and Reporting policy included that the individual conducting the investigation will, as a minimum: "Interview any witnesses to the incident; Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; Interview the resident's roommate; Review all events leading up to the alleged incident." Also, "Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member, and have him/her sign and date it."

5. On 8/31/22 at 11:02 AM, the surveyor observed Resident#102 laying on the bed with the responsible party (RP) at the bedside. The RP stated that Resident#102 was [redacted], [redacted] appropriately "but" able to utilize the [redacted] for communication. The RP further stated that at times the concern was with the 11-7 shift staff who think Resident#102 is [redacted] because Resident#102 is [redacted] due to [redacted]

On 9/02/22 at 10:40 AM, the surveyor observed Resident#102 laying on the bed with the RP at the bedside. The RP showed the surveyor Resident#102's call bell. The RP stated that the [redacted]" was specific for Resident#102 because Resident#102 was a [redacted] due to [redacted] and that the call bell should be placed just

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below Resident#102's [redacted] for Resident#102 to be able to call when needed. The RP further stated that there was an incident "a while ago." The RP was unable to remember the exact date and the name of the Certified Nursing Aide (CNA) involved. The RP stated that the unknown CNA told the RP that Resident#102's call bell was not placed appropriately during the 11-7 shift. The RP told the surveyor this was immediately reported to the facility's management and the social worker.

Furthermore, the RP stated that the problem did not arise not until a week ago and was unable to remember the exact date and the name of the 11-7 shift CNA. The RP further stated that it was Resident#102 who informed the RP that the call bell was not placed where the resident would be able to use it. The RP indicated that it was reported to the SW.

On 9/02/22 at 11:18 AM, the surveyor asked the Registered Nurse/Unit Manager (RN/UM) for a copy of the resident's grievance reports and the RN/UM stated that she would get back to the surveyor.

The surveyor reviewed Resident #102's medical records:

The Admission Record (an admission summary), indicated that Resident#102 had diagnoses that included [redacted].

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F 610	Continued From page 63 A review of Resident # 102's IDCP revealed a focus area for [redacted] initiated on [redacted], and revised on 11/24/21, which indicated "has [redacted] t due [redacted] r/t (related to) dx (diagnosis) of [redacted]; [redacted] can speak [redacted] but his/her [redacted]; he/she communicates with an [redacted] the [redacted] of his/her [redacted]" The interventions included to ensure that Resident#102's [redacted] for communication is functioning initiated on [redacted], and revised on [redacted], and and provide a [redacted] in reach at all times initiated on [redacted], and revised on [redacted] The [redacted], Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, indicated a BIMS score of [redacted], which reflected that Resident#102's cognition was [redacted] According to the [redacted] Grievance/Concern Form (G/C Form) that was provided by the LNHA showed that Resident#102 emailed the SW about the incident on [redacted] at 5:00 AM when the 11-7 shift CNA moved Resident#102's call bell away where Resident#102 was unable to reach it. The [redacted] G/C Form included a list of attempts made to resolve the problem as follows: -Met with RP/resident -Trial specialty breath-bell (stationary difficult to move) -Right side preferred for [redacted] call bell -Stat in-service On 8/26/22, G/C Form showed that the "For Social Work Department Completion:" information below was left blank that was signed	F 610		

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F 610	Continued From page 64 by the SW: Resolved: Unresolved: Date: The [redacted] G/C Form attachments included the following: a. [redacted] Nurses' Notes about UM (Unit Manager) discussed with RP that the preferred placement of the [redacted] call bell is the right side of the [redacted] and the [redacted] trial was conducted and ineffective. b. Communication care plan intervention for right side preferred for [redacted] call bell was initiated on [redacted]. c. In-service Sign-in Sheet dated [redacted] with Topic about Resident#102's call bell placement. There was 8 staff from the 7-3 shift and one who worked the 7-3 and 3-11 shift signed the in-service. d. Patient Concern/Grievance Policy copy that was updated on 1/2022. e. Grievance/Concern Form copy (blank form). Further review of the [redacted] G/C Form revealed the following: - The CNA's name was not able to be identified and there was no statement from the alleged CNA. - The In-service Sign-in Sheet did not include the 11-7 shift staff when the alleged violation was concerning the 5 AM CNA. - The part where the SW should complete was blank.	F 610		

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On 9/9/22 at 1:28 PM, the surveyor interviewed the DON and discussed the above concerns. The DON acknowledged that the [redacted], G/C Form and the investigation were incomplete.

On 9/12/22 at 9:30 AM, the surveyor interviewed the SW who stated that in the grievance process, the facility uses the Grievance/Concern Form that "anyone" can fill out the form and submit to the SW, then the SW will forward it to the involved department "like if a broken TV," the form will be given to the Maintenance Department, then once completed, it will be returned to the SW for filing.

On that same date and time, the SW stated that in the area where the Social Work Department Completion, "I put a checkmark" to the resolved item and it was not necessary to put additional notes. When the surveyor asked the SW why the [redacted] G/C Form was not completed and there was no checkmark to indicate it was resolved, the SW stated, "I don't know."

At that same time, the surveyor asked the SW who was the alleged CNA on the [redacted], grievance and the SW responded that she did not know who the CNA was. The SW further stated that she did not know why there was no statement from the CNA when the grievance form was sent back to the SW for filing.

Furthermore, the SW stated that she was not aware of what happened to the alleged CNA on the [redacted] grievance. She further stated, "They do not share that piece of information with me." The surveyor then asked the SW if the social worker department was part of the ID (Interdisciplinary) team and if grievances were being discussed as part of the ID team meeting.

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The SW stated, "yes, and the ID team never discussed the investigation with me with regard to staff, they keep it very private here for the privacy of the employees."

On 9/12/22 at 10:43 AM and 2:15 PM, the surveyor asked the DON for the name of the CNA from the [redacted] grievance. The DON stated that she would get back to the surveyor.

On 9/13/22 at 8:45 AM, the DON provided CNA's name and phone number on the [redacted] grievance.

On 9/13/22 at 11:44 AM, the surveyor interviewed the RN/UM regarding the [redacted] grievance report. The RN/UM informed the surveyor that on [redacted], the SW received an email that an incident occurred at 5:00 AM regarding a CNA who went to Resident#102's room and moved the call bell away from Resident#102. The RN/UM indicated that the SW sent an email to the DON and stated,"I think the LNHA was included in the email" regarding the incident.

On that same date and time, the RN/UM informed the surveyor that she was off on [redacted], and when she came back to work on [redacted], she immediately talked to Resident#102 and the RP about the [redacted] incident. The surveyor asked the RN/UM if she was able to identify the alleged CNA and the RN/UM stated, "no, I asked all of the staff on that date and no one admitted to it." The surveyor asked the RN/UM if she documented the conclusion of the investigation and the RN/UM stated it was not documented and there were no written statements obtained from the staff.

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On 9/15/22 at 9:17 AM, the surveyor informed the DON regarding the above concerns with the [redacted] investigation. The surveyor asked the DON how she was able to identify the CNA's name when the RN/UM indicated that the conclusion of the investigation did not specify who the alleged CNA was. The surveyor asked the DON why there were only eight (8) 7-3 shift staff who were given an in-service about the placement of the call bell when the incident happened on the 11-7 shift. The DON stated that she would get back to the surveyor.

On 9/15/22 at 2:19 PM, the survey team met with the LNHA, CNO, and DON and they were made aware of the above concerns.

On 9/20/22 at 10:23 AM, the surveyor attempted to conduct a telephone interview with the alleged CNA for the second time but was unable to.

On 9/20/22 at 11:59 AM, the surveyor interviewed the DON in the presence of the Assistant Nursing Home Administrator (ADON). The DON stated that on 9/15/22, the alleged CNA was in-serviced via telephone on call bell placement and confirmed that the alleged CNA was the assigned CNA for Resident #102 on the 11-7 shift.

On 9/20/22 at 1:56 PM, the survey team met with the LNHA, DON, and ADON and discussed the above concerns. There was no additional information provided.

A review of the Grievances & Patient Concern Policy that was provided by the DON with a revised date of 8/31/22 included "Policy: This policy is to ensure that concerns are properly communicated and reported to the proper

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department in a timely fashion by streamlining the investigation process. Procedure: 1. If a resident/family member has a concern they can approach/contact any facility staff member or a resident concern form can be filled out. The concern will then be forwarded to social services. 2. Social Services will give each concern a number for reference and log each one for investigation in the Grievance Log kept in the Social Services office and follow up ...4. At Morning Meeting/Department Head meeting, Social Services will discuss all outstanding concerns and/or resolutions. 5. At the completion of each concern investigation, Social Services will enter the resolution into the concern log ...."

A review of the facility policy dated as revised 5/2022 for Abuse Prevention Program provided by the CNO and DON included that as part of the resident abuse prevention, the administration will: "Identify and assess all possible incidents of abuse;" and "Investigate and report any allegations of abuse within timeframe's as required by federal requirements;"

A review of the facility policy dates as revised 5/2022 for Abuse Investigation and Reporting provided by the CNO and DON included that "All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and/or injuries of unknown source ("abuse") shall be promptly reported to local state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management."

In addition, the Abuse Investigation and Reporting policy included that the individual conducting the investigation will, as a minimum: "Interview any

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F 610	Continued From page 69 witnesses to the incident; Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; Interview the resident's roommate; Review all events leading up to the alleged incident." Also, "Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member, and have him/her sign and date it." NJAC 8:39-4.1(a)(5), 27.1(a)	F 610		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to accurately assess and properly code residents' status in the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care. This deficient practice was identified for [redacted] residents (Residents #13, #69, #102, #106, #177, #198 and #206) reviewed under Section [redacted] for cognition. This deficient practice was evidenced by the following: According to the CMS's (Centers for Medicare & Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual dated October 2019 Section [redacted]: Cognitive Patterns included "Coding Tips .....If the resident interview was not	F 641	F641 Accuracy of Assessments Preparation and/or execution of this plan do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. On 9/16/2022 resident #69's Clinical Assessment Section ([redacted]) BIMS was	10/26/22

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F 641	Continued From page 70 conducted within the look-back period (preferably the day before or the day of) the ARD (Assessment Reference Date), item [redacted] must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items." 1. During an observation on 8/31/22 at 10:54 AM by the surveyor, the Certified Nursing Aide (CNA) was inside the resident's room while providing morning care to the resident. The surveyor reviewed the medical records of Resident #69. The Admission Record (admission summary) reflected that Resident #69 was admitted to the facility with diagnoses that included but were not limited to [redacted] The quarterly MDS (MDS) ARD [redacted], indicated a Brief Interview for Mental Status (BIMS) score of [redacted] which reflected that Resident #69's cognition [redacted]. The [redacted] was coded [redacted], and signed by Social Worker #1 (SW#1) on [redacted]. The above [redacted], MDS was signed by SW#1, 19 days before the ARD. The [redacted], Quarterly Assessment in the Assessment tab of the electronic medical record showed that Section [redacted] for the BIMS was not completed.	F 641	entered by Social Worker for an assessment with a BIMS of [redacted] On 10/10/2022 resident #102's Clinical Assessment Section ([redacted]) BIMS was entered by a Registered Nurse for a re-admission assessment with a BIMS of [redacted] By 10/26/2022 MDS Coordinator was reeducated by Regional MDS Coordinator regarding documentation of resident #177, to properly reference data collected in the Clinical Assessment Section ([redacted]) BIMS as it pertains to accuracy of Section ([redacted] of the MDS. Resident #206's no longer resides in the facility. Resident #198's no longer resides in the facility. By 10/14/2022 resident #106's Clinical Assessments Section ([redacted]) BIMS were entered with a BIMS of [redacted] On 10/14/2022 Resident #13's Clinical Assessment Section ([redacted]) BIMS was entered with a BIMS of [redacted] 2. How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken. -All residents have the potential to be affected by this deficient practice.	

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F 641	Continued From page 71 Review of the Progress Notes (PN) for Social Service Note (SSN) in the electronic medical record showed that the last documented note was dated [redacted]. 2. On 8/31/22 at 11:02 AM, the surveyor observed Resident#102 laying on the bed with the responsible party (RP) at the bedside. The RP stated that the resident is [redacted], appropriately "but" able to utilize the [redacted] for communication. The RP further stated that Resident#102 was [redacted] due to [redacted]. The surveyor reviewed the medical records of Resident #102. The Admission Record reflected that Resident#102 was admitted to the facility with diagnoses that included but were not limited to [redacted]. The MDS ARD dated [redacted], indicated a BIMS score of [redacted], which reflected that the resident's cognition was [redacted]t. The [redacted] was coded [redacted], and signed by SW#2 on [redacted]. The above [redacted], MDS was signed by SW#2, 11 days after the ARD.	F 641	-By 10/26/2022 the MDS Coordinator will conduct an audit of 10 random charts with emphasis on most recent MDS coding in section [redacted] and cross referenced the entry with the MDS assessment conducted by Social Work during the 7-day look back period. This audit will be conducted to identify other residents that may have been affected in the last quarter. - All concerns identified will be immediately addressed. 3. What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur. -By 10/26/2022, The Regional MDS Coordinator reeducated the facility Social Workers on the components of this regulation with an emphasis on accuracy and timeliness of Section [redacted]) of the MDS assessment during the look back period. -By 10/26/2022, the Regional MDS Coordinator reeducated the facility MDS Coordinators on the components of this regulation with emphasis on accuracy and timeliness of assessments and coding of Cognitive Pattern in section [redacted] of the MDS assessment during the look back period. Newly hired MDS staff and Social Work staff will be educated on these components during orientation. 4. How the corrective action(s) will be	

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F 641	Continued From page 72 The [redacted], quarterly Assessment in the Assessment tab of the electronic medical record showed that Section [redacted] for the BIMS was not completed. Review of the PN for SSN in the electronic medical record showed that the last documented note was dated [redacted] On 9/7/22 at 12:53 PM, two surveyors interviewed the Director of Social Worker (DSW). The DSW stated that the initial assessment was being documented in the electronic medical record in the Assessment tab and that all notes were in the electronic medical record and nothing was on paper. The DSW further stated that the quarterly assessments were "exactly" the same as MDS. The DSW indicated that it was the MDS Coordinator (MDSC) who initiates the MDS assessment in the Assessment tab and the SW is responsible for sections [redacted], and [redacted]. Furthermore, the DSW stated that DSW had been doing the MDS for over 10 years. On that same date and time, the DSW informed the surveyors that assessments are due on Thursdays and the expectation was for the DSW to finish by Friday. The surveyor asked the DSW why the assessments were not completed accordingly and accurately. The DSW stated that before the pandemic, there were three and a half full-time Social workers in the facility and then, after the pandemic, the DSW was the only one who worked full time as a SW and the two other staff were part-time and per diem. The DSW acknowledged that the look-back period of Section [redacted] was seven days and should have been followed. The DSW stated, "I feel bad that the	F 641	monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place. -The MDS Coordinator/designee will conduct a weekly audit x 4 weeks and then every month x 2 months of at least 5 residents most recent MDS assessments for accuracy of coding with emphasis on section [redacted] as it pertains to Cognitive Patterns in the look back period. -The findings of these audits will be reported to the QAPI meeting monthly for 90 days.	

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assessment was not getting done."

On 9/8/22 at 10:12 AM, two surveyors interviewed MDS Coordinator. The surveyor asked the MDS Coordinator if she checked for the coding accuracy entered in the MDS within the ARD period before locking the MDS assessment for submission. The MDS Coordinator could not provide an answer and stated, "It is the best we can do."

On 9/15/22 at 2:19 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Chief Nursing Officer (CNO), and discussed the above findings. There was no additional information provided.

3. On 9/9/22 at 12:25 PM, the surveyor observed Resident #177 in his/her room out of bed and sitting on his/her wheelchair, [redacted], [redacted] and appropriately responded to the surveyor's inquiry.

The surveyor reviewed the medical records of Resident #177.

The Admission Record revealed that Resident #177 was admitted to the facility with diagnoses that included but not limited to [redacted]

The admission MDS (AMDS) with an ARD date of [redacted], indicated a BIMS score of [redacted]

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under Section [redacted], which indicated that the resident had an [redacted] cognition.

Review of the [redacted] BIMS assessment section in the Assessment tab of the electronic medical record reflected a BIMS score of [redacted], which did not accurately reflect the coding in the [redacted], AMDS under Section [redacted].

The surveyor could not locate a BIMS interview that supported the coding under Section [redacted] in the [redacted] AMDS, within the look-back period in the resident's electronic medical records (EMR).

4. On 9/1/22 at 10:54 a.m., the surveyor observed Resident #206 sitting in his/her wheelchair in the hallway in front of his/her room door awake, alert, calm, and appropriately responded to the surveyor's inquiry during a unit tour.

The surveyor reviewed the medical records of Resident #206.

The Admission Record reflected that Resident #206 was admitted to the facility with diagnoses that included but were not limited to [redacted]).

The quarterly MDS ARD dated [redacted] indicated a

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F 641	Continued From page 75 BIMS score of [redacted], which reflected that the resident's cognition was moderately impaired. Section C [redacted] was coded [redacted] and was signed by the SW#1 on [redacted]. The above [redacted], quarterly MDS was signed by SW#1, [redacted] days after the ARD. Review of the [redacted], quarterly Assessment in the Assessment tab of the EMR reflected that Section C for the BIMS was not completed. Review of the PN for SSN in the EMR reflected that the last documented note was dated [redacted]. The quarterly MDS ARD date of [redacted] indicated a BIMS score of [redacted], which indicated that the resident had [redacted] cognition. Section [redacted] was coded [redacted], yes," and signed by the SW#3 on [redacted]. The above [redacted], quarterly MDS was signed by the DSW, [redacted] days after the ARD. Review of the [redacted] quarterly assessment in the Assessment tab of the EMR reflected that section [redacted] for the BIMS was not completed. Review of the annual MDS ARD dated [redacted] indicated a BIMS score of [redacted], which indicated that the resident had [redacted] cognition. Section [redacted] was coded [redacted] " and signed by the SW#3 on [redacted]. On 9/8/22 at 10:12 AM, two surveyors interviewed MDS Coordinator. The surveyor asked the MDS Coordinator if she checked for coding accuracy entered in the MDS within the ARD period before locking the MDS assessment for submission. The MDS Coordinator could not provide an answer	F 641		

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and stated, "It is the best we can do."

Furthermore, the MDS Coordinator stated that she was aware that the BIMS in the Assessment tab in EMR was not being completed. The surveyor asked the MDS Coordinator who was responsible for checking if the BIMS interviews in the Assessment tab were completed. The MDS Coordinator stated, "we were in the middle of figuring that out." she acknowledged that all interview sections in the MDS assessments should have been conducted and completed within the ARD look-back period, not after the ARD.

On 9/15/22 at 2:19 p.m., the survey team met with the LNHA, DON, and CNO and discussed the above MDS findings. There was no additional information provided.

5. On 9/01/22 at 11:56 AM, the surveyor observed Resident #198 who was [redacted] and self-propelling in his/her wheelchair.

The surveyor reviewed the Medical Records for Resident #198.

The Admission Record reflected that Resident #198 was admitted to the facility with diagnoses that included but not limited to [redacted]

A review of the quarterly MDS ARD dated [redacted], indicated a BIMS score of [redacted],

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which indicated that the resident had moderately impaired cognition. Section [redacted] was coded [redacted]" and signed by SW#1 on [redacted]

The above [redacted], quarterly MDS was signed by SW#1 [redacted] days after the ARD.

Review of the [redacted], quarterly Assessment in the Assessment tab of the electronic medical record showed that Section [redacted] for the BIMS was not completed.

Review of the PN for SSN in the electronic medical record showed the last documented note was on [redacted]

6. On 9/01/22 at 12:03 PM, the surveyor observed Resident #106 sitting in an electric wheelchair watching television.

The surveyor reviewed the Medical Records for Resident #106.

The Admission Record reflected that the resident was admitted to the facility with diagnoses that included and not limited to [redacted]

A review of the QMDS ARD dated [redacted] indicated a BIMS score of [redacted], which indicated that the resident had an [redacted] cognition. Section [redacted] was coded [redacted]," and signed by SW#1 on [redacted].

The above [redacted], QMDS was signed by SW#1 [redacted] days after the ARD.

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F 641	Continued From page 78 Review of the [redacted] quarterly Assessment in the Assessment tab of the electronic medical record showed that Section [redacted] for the BIMS was not completed. Review of the PN for SSN in the electronic medical record showed the last documented note was dated [redacted]. 7. On 9/01/22 at 12:10 PM, the surveyor observed Resident #13 in bed sleeping. The surveyor reviewed the Medical Records for Resident #13. The Admission Record reflected that the resident was admitted to the facility with diagnoses that included and not limited to [redacted]). A review of the quarterly MDS ARD dated [redacted] indicated a BIMS score of [redacted] which indicated that the resident had [redacted]. Section [redacted] was coded "[redacted]," and signed by SW#1 on [redacted]. The above [redacted], quarterly MDS was signed by SW#1, [redacted] days after the ARD. A Review of the electronic medical record showed that there were no quarterly Assessments completed on [redacted] Review of the PN for SSN in the electronic medical record showed the last documented note was dated [redacted].	F 641		

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	NJAC 8:39-11.1			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		10/26/22

§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.
(B) The resident's preference and potential for

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F 656	Continued From page 80 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: Based on observation, interview, and record review, it was determined that the facility failed a.) to implement a comprehensive person-centered care plan intervention with regard to communication and b.) to develop a comprehensive person-centered care plan to address a behavior. The deficient practice was identified for [redacted] residents reviewed for care plans, (Residents #102 and #150), and evidenced by the following: 1. On 8/31/22 at 11:02 AM, the surveyor observed Resident#102 laying on the bed with the responsible party (RP) at the bedside. The RP stated that Resident#102 was [redacted], [redacted] "but" able to utilize the [redacted] for communication. The RP further stated that he/she had a concern that the 11-7 staff think Resident#102 was [redacted] because Resident#102 was unable to talk properly due to [redacted] responsible for [redacted]. On 9/02/22 at 10:40 AM, the surveyor observed Resident#102 was laying on the bed with RP at	F 656	F656 Develop/Implement Comprehensive Care Plan Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: By 10/14/2022 resident #102's care plan was reviewed and updated to reflect that resident approved a sign to be posted at bedside stating that resident #102 "uses a [redacted] to communicate and to see nurse for further instruction". By 10/14/2022 resident #102's care plan was reviewed and updated to reflect that resident approved a sign to be posted at bedside stating that "[redacted] call bell must be placed at [redacted]".	

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F 656	Continued From page 81 the bedside. The RP showed the surveyor Resident#102's call bell. The RP stated that the '[redacted]" was specific for Resident#102 because Resident#102 was [redacted] due to [redacted] and that the call bell should be placed just below Resident#102's [redacted] for Resident#102 to be able to [redacted] with his/her [redacted] when needed. The RP stated that there was an incident "a while ago" that the RP was told by a Certified Nursing Aide (CNA) that Resident#102's call bell was not placed appropriately during the 11-7 shift. The RP was unable to remember the exact date and the name of the CNA but stated that he/she had immediately reported the incident to the management and the Social Worker (SW). Furthermore, the RP stated that the same problem happened again "a week ago," but was unable to remember the exact date and the name of the 11-7 shift CNA. The RP further stated that it was Resident#102 who informed the RP of the concern with the call bell that was not placed where Resident#102 would be able to use it. The RP added that the recent incident was reported to the SW. On 9/02/22 at 11:18 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) regarding Resident#102's call bell. The RN/UM stated that the call bell should be placed within Resident#102's [redacted]. Then the surveyor asked the RN/UM if RN/UM was aware that according to the RP, Resident#102's call bell should not be placed on the [redacted] because it would not be accessible to Resident#102. The RN/UM stated that "I have to get back to you about it." The RN/UM further stated that the call bell and the interventions should be in the Care Plan (CP) to follow.	F 656	By 10/14/2022 resident #150's care plan was reviewed and updated to reflect that (Inform when shower is refused and where is it documented) 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: By 10/26/2022, the Director of Nursing /designee will conduct a random audit of 10 active residents' care plans to ensure they accurately reflect the needs of the residents to identify those who have the potential to be affected with emphasis on: 1. Ensuring that comprehensive person-centered care plan and interventions are present in the plan of care for residents using electronic [redacted]ommunication devices as it relates to communication. 2. Ensuring that a comprehensive person-centered care plan, and interventions are in place to address refusal of care as it relates to personal hygiene. Any concerns will be identified were immediately addressed. 3. What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur: By 10/26/2022, the Director of Nursing/designee will reeducate the	

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F 656	Continued From page 82 The surveyor reviewed Resident #102's medical records: The Admission Record (admission summary), indicated that the resident had diagnoses that included but not limited to [redacted] Resident#102's person-centered focus care plan for [redacted] showed "has [redacted] deficit due [redacted] r/t (related to) dx (diagnosis) of [redacted] he/she can [redacted] but his/her [redacted]; he/she communicates with an [redacted]) via a [redacted] at the [redacted] of his/her [redacted]" (initiated on [redacted] and revision date of [redacted]) with interventions that included to ensure that resident's [redacted] for communication is functioning (date initiated [redacted] and revision date on [redacted] and provide a [redacted] call bell in reach at all times (initiated on [redacted] and revision date on [redacted]. According to the "Investigation report of [redacted] and [redacted] claims" that was provided by the Director of Nursing (DON), showed that on the day of [redacted] the RP came to the nursing office to discuss two areas of recent concern of the RP and Resident#102. Included in the [redacted] concern was CNA#1 placed Resident#102's call bell on top of Resident#102's [redacted] instead of near the [redacted] where	F 656	Interdisciplinary team and nursing staff on the components of this regulation with emphasis on: a. Ensuring that comprehensive person-centered care plan and interventions are present in the plan of care for residents using electronic communication devices as it relates to communication. b. Ensuring that a comprehensive person-centered care plan, and interventions are in place to address refusal of care as it relates to personal hygiene. -During the daily clinical meeting the Interdisciplinary Team will review newly admitted residents with emphasis on those who have a history of refusal of care and communication needs. The team will update the care plan as needed. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing /designee will utilize data collected in clinical meeting for at least 2 new admissions per week to track and audit residents' care plans, and progress notes for accuracy with emphasis on, usage of [redacted] communication devices and residents who have a history of refusing care as it relates to personal hygiene.	

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F 656	Continued From page 83 Resident#102 can use the call bell to call for help. The investigation revealed that CNA#1 denied Resident#102's claim and CNA#1 was removed from Resident#102's assignment. The 8/26/22 Grievance/Concern Form that was provided by the Licensed Nursing Home Administrator (LNHA) showed that Resident#102 emailed the SW about an incident on [redacted] at 5:00 AM when the 11-7 shift CNA#2 moved Resident#102's call bell away where Resident#102 was unable to reach it. On 9/8/22 at 6:21 AM, the surveyors interviewed CNA#2. CNA#2 stated that Resident #102 is [redacted] with [redacted]. The surveyor asked CNA#2 if Resident#102's [redacted] was being utilized when communicating with Resident#102. CNA#2 responded that CNA#2 was aware of Resident#102's [redacted] and not sure about using the [redacted] as a means of communication because CNA#2 followed the paper instruction that was posted in Resident#102's room for the list of Resident#102's questions when Resident#102 uses the call bell. During an interview on 9/12/22 at 9:30 AM with the surveyor to the SW, the SW stated that SW was unaware that Resident #102 was able to communicate [redacted] until SW had received an email on [redacted] about the CNA#1 who had moved the resident's call bell away. On 9/12/22 at 11:11 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who signed the "Investigation of [redacted] and [redacted] claims" of Resident #102. The surveyor asked the	F 656	This data will be brought to the monthly QAPI meeting x 90 days.	

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F 656	Continued From page 84 ADON if ADON asked Resident#102 to respond to ADON's interview about the [redacted] and [redacted] investigations with the use of Resident#102's [redacted]. The ADON responded "I don't recall" utilizing the [redacted] for an interview. On 9/13/22 at 11:39 AM, the surveyor interviewed CNA#3. CNA#3 stated that Resident#102 was [redacted], [redacted], and uses the call bell. CNA#3 further stated that Resident#102 was able to communicate through [redacted] and [redacted]. The surveyor asked CNA#3 if CNA#3 was aware that Resident#102 was able to communicate with the use of Resident#102's [redacted] and CNA#3 stated "I'm not sure." On 9/15/22 at 02:19 PM, the survey team met with the LNHA, Chief Nursing Officer (CNO), and DON and were made aware of the above concerns. On 9/20/22 at 10:23 AM, the surveyor called CNA#4 for the second time concerning the [redacted], Grievance concern and there was no callback. On 9/20/22 at 01:56 PM, the survey team met with the LNHA, DON, and Assistant Nursing Home Administrator. There was no additional information provided. NJAC 8:39-11.2(f) 2. On 9/14/22 at 11:45 AM, during the Resident Council meeting Resident #150 told the surveyor	F 656		

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that he/she had never received a shower at the facility.

On 9/16/22 at 11:21 AM, the surveyor observed Resident #150 lying in bed awake and alert watching television. There was a basin filled with water and a washcloth was on resident's bedside table. Resident #150 stated that he/she gets a bed bath daily. He/she was able to wash most of his/her body and then the Certified Nursing Assistant (CNA) would assist and finish washing the area on his/her body that he/she couldn't reach. Resident #150 stated that he/she washes his/her own hair in bed and added, "but it would feel so good to have my hair washed in the shower." The resident further stated that he/she was only offered a shower once since he/she arrived at the facility. The resident stated that he/she would prefer a shower but had not been offered a shower since that one time.

The surveyor reviewed Resident #150's medical records:

A review of the Admission Record (admission summary), indicated that the resident had diagnoses that included but not limited to [redacted].

A review of the annual MDS dated [redacted]

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reflected the resident had a BIMS score of [redacted] which indicated that the resident had a [redacted] cognition. Review of Section [redacted] for Functional Status indicated the resident was totally dependent on staff with personal hygiene and bathing requiring one person assistance and totally dependent with transfers requiring two person assistance.

A review of the Physician's Order (PO) dated [redacted], indicated weekly showers every [redacted] 7-3 shift. Complete skin observation tool; everyday shift and every [redacted] for hygiene.

A review of the [redacted] Treatment Administration Record (TAR) reflected the above corresponding PO's. Further review of the TAR indicated a check mark with staff initials indicating that the resident received a shower on [redacted] and [redacted].

A review of the "Tasks" section in the Electronic Medical Record (EMR) reflected that there were no check marks under the sections titled, ADL (activities of daily living) "Bathing and/or Resident Refused" that would indicate bathing was performed. There was no documented evidence of the resident's refusal of ADL/Bathing/shower weekly on [redacted] for the month of [redacted].

A review of the Care Plan (CP) indicated a Focus area initiated on [redacted] and revised on [redacted] for ADL's which indicated the resident had decreased function in all areas of ADL's due to: [redacted]. The CP goals indicated that the resident will

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maintain/improve ADL's and functional mobility through the next review date. The CP interventions/tasks indicated to assist with baths and showers. There were no CP interventions reflecting the [redacted] PO's for weekly showers every [redacted]. In addition, there was no documented evidence in the CP indicating the resident's preference for a shower or that the resident refused showers when offered.

On 9/16/22 at 11:26 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) on unit [redacted] who stated that the resident was offered a shower weekly on [redacted] during the 7-3 PM shift, but the resident "always" refused the shower. She further stated that the resident "never" requested a shower and that the resident was "certainly able to have a shower." The LPN/UM stated that the resident was [redacted] but the unit had a [redacted] to transfer the resident into the shower. The LPN/UM stated that there was no shower binder on the unit. There was no documented evidence that the resident refused showers on [redacted]

On 9/16/22 at 1:51 PM, the surveyor interviewed the resident's assigned CNA who stated that the resident was offered a shower every [redacted] on the 7-3 PM shift but the resident "always" refused the shower. The CNA stated that the staff encouraged the resident to take a shower and to maintain his/her hygiene. She further stated that the resident receives a bed bath daily and would also "sometimes" refuse the bed bath. The CNA stated that she did not document the resident's refusal of showers or bed baths.

On 9/19/22 at 1:51 PM, the surveyor in the

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F 656	Continued From page 88 presence of the LPN/UM reviewed the resident's [redacted] TAR. The LPN/UM stated that the check marks on [redacted] and [redacted], indicated that the resident was "bathed but not necessarily showered." The LPN/UM stated that "if the resident preferred a shower, or refused a shower, bed bath, or any hygiene, then that concern should have been included in the resident's care plan." On 9/19/22 at 2:19 PM, the surveyor in the presence of the survey team interviewed the DON who provided the surveyor with documentation that the resident refused "bathing" on [redacted] and [redacted] The DON stated that if a resident had behaviors of refusing showers then it should be care planned. There was no additional information provided.	F 656		
F 657 SS=D	NJAC 8 39-11.2(f) Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §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	F 657		10/14/22

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F 657	Continued From page 89 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: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to update and revise an Interdisciplinary Comprehensive Care Plan (IDCCP) to include interventions for [redacted] residents, (Resident #121), reviewed for accidents. This deficient practice was evidenced by the following: On 9/13/22 at 11:10 AM, the surveyor observed Resident #121 who was [redacted], and seated in a wheelchair watching television. The surveyor reviewed the medical record for Resident #121. The Admission Record reflected that Resident #121 was admitted to the facility with diagnoses that included but not limited to [redacted]	F 657	F657 Care Planning, Timing, and Revision Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: -10/10/2022 Resident #121 care plan was updated to reflect [redacted] incident that occurred on [redacted] -10/10/2022 Resident #121 was re-educated on [redacted] agreement. [redacted] agreement uploaded to electronic medical record.	

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A review of the Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted] revealed that Resident #121 had a Brief Interview Mental Status (BIMS) score of [redacted] which indicated that the resident had [redacted] cognition.

A review of Resident #121's progress notes (PN) dated 6/22/22 at 21:14 (9:14 PM) revealed a nurses note: "Resident discovered by orientee nurse in the bathroom [redacted]. The nurse went into room and found a [redacted] in the toilet. The nurse could not locate alleged matches or possible [redacted]. Resident #121 continues to exhibit behaviors out of baseline. The nurse has attempted to collect [redacted] multiple times to no affect. Resident #121 continues to throw away what left in toilet. Replaced 4 times. Resident #121 awaiting [redacted] consult. Labs to be drawn in the morning. Supervisor made aware. Education rendered to Resident #121. Monitoring in progress."

A review of the Facility's investigation dated [redacted] revealed that Resident #121 was discovered [redacted] in the bathroom while a staff member was conducting rounds on the evening of [redacted]. The staff member entered the room and smelled [redacted]. The staff member asked Resident #121 if they were [redacted] Resident #121 stated that Resident #121 was [redacted] that Resident #121 had left over from the previous [redacted] break. Resident #121 stated that they used a [redacted] from a [redacted]. Resident #121 had [redacted] left and

2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:

-All residents have the potential to be affected by this deficient practice.

-10/10/2022 Director of Nursing Services/designee conducted an audit of active residents' who [redacted] Care plan were reviewed to reflect resident is an active [redacted] and that the facility [redacted] agreement was noted in the resident medical record.

-Any concerns identified were immediately corrected.

3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:

-10/14/2022, the Director of Nursing/designee re-educated the Department Directors, Social Services staff, Rehab, Recreation staff and Nursing staff on the components of this regulation with emphasis on ensuring care plans are revised as needed to accurately reflect any incidents of [redacted]

-Department Directors will educate any new staff to report incidents of [redacted] in non-designated areas to Administration.

4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance

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F 657	Continued From page 91 that they flushed the [redacted] down the toilet. Resident #121 allowed the nurse and the night supervisor to inspect Resident #121's room for [redacted] and a [redacted]. The nurse and the night supervisor were unable to find anything. Resident #121 was educated about the facility [redacted] policy and that [redacted] inside the facility was prohibited. The investigational report also had an interview from the Assistant Administrator (AA) who met with Resident #121 on [redacted] Resident #121 was re-educated regarding the facility's [redacted] policy. Resident #121 was also warned that if they were caught [redacted] inside the facility that Resident #121 will lose their [redacted] privileges. The AA and the Administrator (Admin) also conducted another search of Resident #121's room. The facility conducted two more searches and was unable to find any [redacted] A review of [redacted] Assessments dated [redacted] and [redacted] revealed that Resident #121 is a safe [redacted] and that Resident #121 are safe to [redacted] unsupervised. A review of Resident #121's Care Plan (CP) was revealed there was no documentation in CP regarding Resident #121 [redacted] in their room on [redacted] with no interventions preventing this from happening again. The Care Plan Reflected the following: They were a focus area for [redacted] with an initiation date of [redacted], and a revision date of [redacted] which had a goal that Resident #121 will not suffer injury through the next review date. The [redacted] care plan revealed the following interventions:	F 657	program will be put into place: -The Director of Recreation/designee will audit list of resident [redacted] list, monthly x 3 months to ensure the plan of care accurately reflects the residents' current [redacted] status and any incidents of [redacted] in non-designated areas are noted. Findings of these audits will be brought to the facility monthly QAPI x 3 months.	

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F 657	Continued From page 92 "-Assist resident with set up as needed. -Educate about [redacted] risk/hazards and about the availability for cessation. -Educate resident about the facility policy on [redacted]: appropriate places to [redacted], times, concerns, facility rules and regulations. -Resident can [redacted] unsupervised -Monitor resident to ensure continued safety while [redacted]. Observe clothing and skin for signs of [redacted]s. -Notify MD and family of any injury related to [redacted] [redacted] supplies are stored according to facility policy: Staff hold and distribute." On 9/20/22 at 12:45 PM, the surveyor interviewed Resident #121 who stated that after the [redacted] incident on [redacted] that Resident #121 was re-educated about the facility [redacted] policy and that if Resident #121 broke the rules again that Resident #121 will lose their [redacted] privileges. Resident #121 stated that they will never [redacted] inside the facility again. On 9/20/22 at 1:10 PM, the surveyor interviewed Resident #121's Certified Nursing Assistant (CNA) who stated that Resident #121's behaviors have been good the past few months. The CNA also stated that at the time of the [redacted] incident Resident #121 was experiencing a lot of behaviors including being [redacted] and [redacted]. The CNA noted that they never saw Resident #121 [redacted] or even [redacted] in Resident #121's room but heard that another staff member found a [redacted] in Resident #121's toilet. On 9/20/22 at 1:15 PM, the surveyor interviewed the [redacted] Unit Manager (UM) who stated that UM	F 657		

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remembered Resident #121's [redacted] incident and it occurred at a time when Resident #121 was experiencing a lot of behaviors. UM also noted that the facility already notified the [redacted] regarding Resident #121's behaviors and that Resident #121 was being monitored. UM also stated that when Resident #121 was caught [redacted] the facility in-serviced Resident #121 regarding the facility [redacted] policy and Resident #121 was warned if Resident #121 [redacted] again in their room that Resident #121 will lose their [redacted] privileges. The facility also did room checks and found no [redacted] material inside Resident #121's room. When the surveyor asked the UM if the facility should have implemented a CP for this incident, the UM stated that UM didn't feel that Resident #121 should be CP for a one time incident.

On 9/20/22 at 2:30 PM, the surveyor interviewed the Recreation Director (RD) regarding the facility's [redacted] program. The RD stated that the recreation department are responsible for supervising the [redacted] activity during the 9:30 AM, 1:30 PM, and the 3 PM [redacted] times. The recreation department will bring a locked cart that contain the residents' [redacted]. The recreation department will distribute the [redacted] to the residents', and they will only give out two at a time. The recreation department have no [redacted] on[redacted], the residents[redacted] their [redacted] from a[redacted] that's mounted on the exterior wall. Recreation staff will also observe to make sure that residents are [redacted] safely, don't have their own [redacted] and that they are not bringing [redacted] back into the facility. If the recreation department catches a resident with their own [redacted] the facility will confiscate the [redacted] and re-educate that resident regarding the

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facility [redacted] policy. RD that the facility policy was to warn on the first incident and if it happened again that resident would either lose their[redacted] privileges or they will be discharged from the facility. RD further stated that Resident #121 only had one incident and that if a resident is caught breaking the [redacted] policy RD's department will either be notified in the morning meeting or through email.

On 9/21/22 at 9:30 AM, the surveyor observed the smoking activity and observed recreation staff members distributed [redacted] to the residents. Inside the [redacted] cart contained individual boxes that were locked and contained the [redacted] for specific residents. The surveyor observed staff give out no more than two [redacted]. The residents were observed [redacted] their [redacted] from an exterior wall mounted [redacted]

On 9/21/22 at 9:40 AM, the surveyor interviewed a Recreation staff member who stated that at the start of the [redacted] activity that resident's will line up and that staff will distribute their [redacted]. The [redacted] cart contained no[redacted] [redacted]s. Resident must [redacted] their [redacted] from the wall mounted[redacted]. The recreation staff will observe the residents, to make sure that they are [redacted] safely and if they were observed using a [redacted] the facility will confiscate and re-educate the resident regarding the facility's[redacted] policy.

On 9/21/22 at 10:57 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that Resident #121 was re-educated regarding the facility [redacted] policy and the facility conducted three room checks to

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make sure that Resident #121 was compliant with the facility [redacted] policy. LNHA did state that a CP could have been updated to reflect this incident.

On 9/21/22 at 11:08 AM, the surveyor interviewed the AA who stated that both the AA and the LNHA at the time of the incident met with the resident the day after the [redacted] incident. AA stated that Resident #121 was re-educated and that Resident #121 allowed them to do a room check and they found no [redacted]. The AA and LNHA advised Resident #121 that if they broke the facility's [redacted] policy again that Resident #121 could lose their [redacted] privileges. The AA acknowledged that AA doesn't know much about care planning and that a CP was created and updated by either the UM or the Director of Nursing (DON). AA stated that they probably didn't update the CP because it was a one time incident.

On 9/21/22 at 1:30 PM, the surveyor met with the DON and the LNHA and no further information was provided by the facility.

A review of the facility's policy titled [redacted] Policy-Residents that was dated 8/31/22 and was provided by the DON included the following:

Under Policy Interpretation and Implementation. "7. Any [redacted]-related privileges, restrictions and concerns shall be noted on the care plan, IDT note in the resident medical record, and all personnel caring for the resident shall be aware of these issues."

"11. [redacted] articles for residents with or without independent [redacted] privileges:

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F 657	Continued From page 96 e. [redacted] shall not be permitted in bed or the facility, at any time." "13. The facility staff will check periodically to determine if residents have any [redacted] articles among their possessions or on their person in violation of our [redacted] policies. Staff shall confiscate any such articles and shall notify the Charge Nurse/Unit Manager that they have done so, and the IDT will meet with the resident and document in the IDT section of the medical record. The Administrator and Director of Nursing will be made aware of any infractions of the [redacted] policy." NJAC 8:39-11.2 (1), (2), 12.1, 27.1 (a)	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, it was determined that the facility failed to accurately transcribe a physician's order for a	F 686	[redacted]	10/26/22

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F 686	Continued From page 97 [redacted] treatment to a [redacted] onto the Treatment Administration Record (TAR) for 1 of 4 residents (Resident #181) reviewed for [redacted] care. The deficient practice was evidenced by the following: On 9/09/22 at 11:13 AM, the surveyor observed Resident #181 lying in bed with head of bed elevated and bed covers on and up to Resident #181's waist. Resident#181 was awake and watching television. A review of Resident #181's Electronic Medical Record (EMR) indicated that Resident #181 was admitted to the facility with a diagnosis that included, but not limited to, [redacted] and A review of Resident #181's quarterly Significant Change Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], reflected Resident #181 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating Resident #181's cognition was [redacted].	F 686	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: [redacted] Treatment Order related to Resident #181's [redacted] treatment was identified and updated to reflect twice daily. Resident #181's [redacted] was assessed, treatment orders reviewed and there were no negative outcomes related to incorrect physician's order. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: All residents have the potential to be affected by deficient practice. By 10/26/2022, the Director of Nursing /designee will conduct an audit of active residents receiving treatments for pressure injuries requiring dressing changes or treatments to ensure treatments were being provided per physician orders, and transcribed correctly in the treatment order. This audit was to identify other residents that have the	

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F 686	Continued From page 98 Review of Section G for , Functional Status indicated Resident #181 did not [redacted], and was totally [redacted] Section M of the MDS for Skin Conditions indicated that Resident #181 had a [redacted]. A review of Resident # 181's current Physician orders (PO) indicated a PO dated [redacted], for [redacted] miscellaneous: Apply to [redacted] topically every day shift for [redacted] care. Cleanse [redacted], pat dry. Apply [redacted] to [redacted], and cover with [redacted]. Place a [redacted] dressing over. Change BID [twice a day] and when soiled. A review of the [redacted] Care Nurse Practitioner progress notes titled, "Physician Recommendation Details [redacted] Orders and Treatment Recommendations," dated [redacted] indicated to change [redacted] dressing twice daily or when soiled. A review of the [redacted] Treatment Administration Record (TAR) revealed that the [redacted] treatment was plotted for once daily on the day shift. During an interview with the surveyor on 9/13/2022 at 10:36 AM, Resident #181's assigned Licensed Practical Nurse (LPN#1) employed at the facility since [redacted] reviewed Resident #181's [redacted] care orders with the surveyor. The surveyor asked the LPN, "how often was the resident's [redacted] treatment being administered and the dressing changed?" The LPN stated, "twice a day or when soiled." The	F 686	potential to be affected. Any concerns identified will be immediately addressed. 3. What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur: By 10/26/2022 the Director of Nursing / designee will educate all licensed nursing staff on the components of this regulation with emphasis on ensuring treatments are provided per physician orders and documented in the clinical record. All new licensed nursing staff will be educated on the components of this regulation. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing /designee will conduct a weekly audit of 5 residents x 4 weeks and then 5 residents per month x 2 months for resident requiring dressing changes to ensure treatments are transcribed correctly and are provided per physician orders. Findings of these audits will be presented at the monthly QAPI meeting x 3 months.	

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F 686	Continued From page 99	F 686		

surveyor showed the LPN that Resident #181's TAR indicated that the [redacted] treatment was signed as administered "once" daily on the 7-3 shift. The LPN stated that Resident #181 is [redacted], so the [redacted]l dressing is "probably" changed more than once a day.

During an interview with the surveyor on 9/15/2022 at 11:10 AM, Resident #181's assigned LPN#2 reviewed the PO's order for Resident #181's [redacted] treatment. The LPN#2 stated that the PO indicated to change the dressing [redacted] and when soiled. The LPN#2 then reviewed Resident#181's TAR in the EMR (electronic medical record) and stated that Resident #181's [redacted] order was transcribed to be done "once" daily on the 7-3 shift. The LPN#2 further stated that Resident #181's TAR should have indicated that the [redacted] treatment to be administered twice a day as per the physician's ordered. The surveyor asked LPN#2 what were the times for a [redacted] treatment? The LPN#2 stated she would have to clarify Resident #181's PO for the [redacted], and also clarify with the Unit Manager (UM) about the correct times to put in the TAR for BID treatments.

On 9/15/22 at 11:21 AM, the surveyor interviewed the Unit Manager (UM) on unit [redacted] who stated that the resident's [redacted] care was done daily. The surveyor asked the UM to review Resident #181's PO and TAR for the sacral [redacted] treatment in the presence of the surveyor. The UM read the PO and stated that the order indicated to change [redacted] and when soiled. The UM then reviewed the TAR and stated that it indicated to change the [redacted] "once" daily on the 7-3 shift. The

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F 686	Continued From page 100 UM further stated that the TAR indicated that the [redacted] care was done once during the 7-3 shift, but the resident was [redacted] and was sure the [redacted] dressing was changed a second time during the day due to being soiled from [redacted]. The UM stated that the resident's [redacted] order was changed to daily and/or when soiled, and she forgot to change the "verbiage" in the order details when transcribing the PO onto the TAR. The UM further stated that if a physician ordered a resident's [redacted] dressing to be changed [redacted]), he/she would transcribe the physician's [redacted] care order in the TAR to be done daily on the 7AM-3 PM day shift and the 3 PM-11 PM evening shift. On 9/16/22 at 11:47 AM, in the presence of the survey team, the Director of Nursing (DON) stated that the resident's [redacted], PO indicated the [redacted] to be changed BID and when soiled. The Licensed Nursing Home Administrator (LNHA) and DON acknowledged that the sacral wound care treatment was not transcribed onto the [redacted] TAR according to the [redacted] physician's order.	F 686		
F 689 SS=J	NJAC 8:39-27.1 (a) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		10/26/22

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F 689	Continued From page 101 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint, #NJ157771, #NJ157773, #NJ157831 Based on observations, interviews, record review, and review of other pertinent facility documentation, it was determined that on 09/21/22, the facility failed to ensure: a.) a resident with [redacted] impairment, who was at risk for [redacted], and had a known history of [redacted] behavior was appropriately supervised and monitored to ensure safety, prevent [redacted] or exiting of the building, and staff failed to follow their facility's policy and procedure on [redacted]. This deficient practice was identified for one of five residents, (Resident #206) reviewed, who had [redacted], and were at risk for [redacted]. This placed Resident #206 as well as all other residents with [redacted], who were at risk for or had a known history of [redacted] and/or [redacted] in Immediate Jeopardy (IJ). On 09/03/22, Resident #206 was able to exit the building unsupervised through an unlocked door at 10:12 AM, was found by the police, and subsequently expired on [redacted] at 4:19 PM. The IJ for Resident #206, occurred on 09/03/22, and was identified on 09/07/22 at 4:20 PM, when the Facility's Administrator (Admin) and the Director of Nursing (DON) were notified of the IJ situation. The survey team provided the facility with an IJ template on 09/07/22. The facility provided an acceptable Removal Plan (RP), on	F 689	F689 Accidents/Supervision - [redacted] Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: -Resident #206 no longer resides in the facility. -The facility cannot retroactively correct the deficient practice as it relates to Resident #206. -On 9/3/2022-Immediately upon recognition of the unsecured exit on [redacted], staff were re- assigned to provide 24-hour monitoring of the exit, continuously up until the lock was repaired and functioning properly on [redacted]. All other exit doors were checked to ensure they were secure. -Resident #191 no longer resides in the facility. -The facility cannot retroactively correct	

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F 689	Continued From page 102 09/08/22 at 10:16 AM to remove the immediacy. The facility further failed to ensure: b.) staff provided a resident who was at risk for [redacted] with the correct liquid consistency to prevent [redacted] (an infection caused by a [redacted]), and staff failed to follow the facility's policy and procedure for the administration of [redacted]. This deficient practice was identified for one of three residents, (Resident #191) reviewed for accidents related to mechanically altered diets. On 05/27/22, Resident #191 was provided with thin liquids when the resident had a physician's order for thickened liquids. This placed Resident #191 as well as all other residents who received a mechanically altered diet at risk for Immediate Jeopardy (IJ). The IJ for Resident #191 started on 05/27/22, and was identified by the survey team on 09/13/22. The survey team provided the facility with an IJ template on 09/13/22. The IJ was identified as past non-compliance from 05/27/22 through 05/31/22 when the facility provided the survey team with an acceptable Plan of Correction. This deficient practice was further evidenced by the following: Part A The surveyor reviewed the medical record for Resident #206. The surveyor reviewed the "Admission Record" (AR), Resident #206 was admitted to the Facility with diagnoses which included but were not limited to: [redacted]	F 689	the deficient practice as it relates to Resident #191. -On 5/27/2022 Immediately upon recognition of the employee□s error, the employee was in-serviced and given a disciplinary warning. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: - All residents have the potential to be affected by these deficient practices. -Residents who are [redacted] and able to independently ambulate are at risk. -Chart audits were initiated on 9/7/22 to identify all residents with cognitive impairment and ability to ambulate independently to ensure the care plans reflect the correct level of supervision required to ensure their safety. -All residents with altered diets are at risk. 3. What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur: -Immediately upon recognition of the unsecured exit on 9/3/22, staff was assigned to provide 24-hour monitoring of the exit, continuously up until the lock was repaired and functioning properly on 9/5/22.	

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F 689	Continued From page 103 [redacted]. Review of the quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] revealed that Resident #206 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated that Resident #206 had [redacted]. Further review of the MDS in Section [redacted] for functional status, indicated that Resident #206 was independent with transfers, locomotion on the unit, and ambulation. Review of the Care Plan (CP), with a documented resolved date of [redacted] revealed a focus area that Resident #206 was at risk for [redacted] due to [redacted] related to [redacted], [redacted]. The goal was that Resident #206 would not leave the facility unsupervised. The interventions included: to assess for change in behavior, to observe for [redacted], to provide with a program of activities that minimize the potential for [redacted] in place [redacted], observe for [redacted], and [redacted] each shift. This CP was resolved and discontinued with the date of [redacted], which indicated that Resident #206 was no longer at risk for [redacted]. Review of the Physician's Progress Note (PN) dated [redacted] at 03:48 PM, revealed the resident was on the [redacted] medication, [redacted] milligrams two times daily and had [redacted] with [redacted] behavior with [redacted] instability.	F 689	-All other exit doors were checked to ensure they were secure. -The facility policy that addresses [redacted] behaviors was reviewed to ensure it includes a requirement to update the care plan based on the potential risk for [redacted] related to [redacted] status and [redacted] status. -Re-education on the policy that addresses [redacted] behaviors was initiated on 9/7/22 with all staff. -All exit doors will be checked monthly by Maintenance Director/Designee. -Staff were in-serviced on the updated Policy and Procedure regarding altered diets/fluids and was initiated on [redacted]. -A list of residents who were on altered diets was placed in a binder at each nursing station. This was an additional precaution to the policy and procedure that was already in place. The policy in place was to identify patients with the facility DOT system and if a staff member was unsure, they were told to ask the nurse on the unit. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:	

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F 689	Continued From page 104 Review of the Medication Administration Record (MAR) dated [redacted], revealed the nurses were monitoring Resident #206's behaviors to include; [redacted], and [redacted]. During a review of a Facility Reportable Event (FRE) form dated [redacted] at 09:13 AM, sent into NJ Department of Health (DOH) from the DON. On [redacted], the Certified Nursing Assistant (CNA #1) assigned to Resident #206 left unit [redacted] where he/she resided and went on break without giving report or asking someone to monitor their residents. During the break, Resident #206 was able to independently exit the facility unattended, without the staff's knowledge, through an unlocked door in unit [redacted], and wandered off the facility grounds onto the main road. Resident #206 made it across the main road and was later found by police at 3:52 PM, laying on the ground at the [redacted]. The policeman immediately performed [redacted] and Resident #206 was later reported to have expired at 4:16 PM. The last time Resident #206 was observed within the facility was at 10:12 AM on video surveillance walking the hallway and exited through an unlocked door on unit [redacted]. The Licensed Practical Nurse/Unit Manager (LPN/UM #1) observed an empty wheelchair in the hallway of [redacted] which had a tag with Resident #206's name on it. This initiated a "CODE GREY" and all staff started a search of the interior of the facility then moved to the exterior of the facility. When Resident #206	F 689	-The Administrator and Director of Nursing will monitor compliance with the staff education to ensure all staff receive the re-education as it pertains to a resident with [redacted] as it pertains to [redacted]. -The Director of Nursing, Assistant Director of Nursing, and Unit Managers will continue to audit 10 random charts and care plans monthly of residents with mild cognitive impairment, to ensure compliance. The findings of these audits will be presented at monthly QAPI x 90 days or until the committee feels the results of these audits are sufficient. -All exit doors will be checked weekly x3 months and then monthly thereafter by the Maintenance Director / Designee. -All residents on altered diets will be monitored weekly x 4 weeks and monthly x 2 months by the Food Services Director / Designee to ensure no thin liquids were given to residents. The findings will be presented at the monthly QAPI x 90 days or until the committee feels the results of these audits are sufficient.	

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was not found within the facility's grounds, the LPN/UM #2 initiated a call to the police at 12:14 PM on [redacted], to report Resident #206 missing. The facility searched for Resident #206, but was unaware of the whereabouts of Resident #206 until he/she was found by police on [redacted] at 03:52 PM.

On 09/06/22 at 11:53 AM, the surveyors observed Stairwell #4 on the [redacted] in the presence of the facility's Admin, Assistant Admin, and Maintenance Director (MD). The Admin stated this was the door that Resident #206 exited the facility from at approximately 10:10 AM on [redacted], and Resident #206 was not wearing a [redacted]. The surveyors observed a horizontal metal bar on the top of the door and a keypad next to the door. The door was observed to be locked. The MD waved a tool by the keypad and an alarm sounded which indicated that the [redacted] keypad system was functioning. The Admin stated the door was a delayed egress maglock and either the maglock system malfunctioned or the keypad itself malfunctioned when Resident #206 exited the building. The Admin told the surveyors that since Resident #206 exited the facility, the keypad, and the maglock were both replaced and were now, "new". The surveyors exited the door that Resident #206 exited from and observed a parking lot with woods surrounding. The Admin told the surveyors that the office next to the door Resident #206 exited from was closed because it was a [redacted], and no cars were in the parking lot because no one was in the area that day. The Admin further stated that a Dietary Aide (DA) observed Resident #206 trying to open the patio door. Resident #206 had asked the DA to open the door and the DA stated that he/she could not

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F 689	Continued From page 106 open the door. On 09/06/22 at 12:53 PM, the surveyors interviewed the DA, who stated that he/she worked at the facility since [redacted], and worked in the kitchen, the day Resident #206 left the facility. The DA stated that when he/she left the kitchen, it was to drop off and pick up meal trays. The DA stated that he/she had observed Resident #206 by the patio trying to open the door. Resident #206 asked the DA to open the door. The DA told Resident #206 that he/she could not, so the resident continued walking toward the unit. The DA told the surveyors that it was not the first time that DA had seen Resident #206 and had observed the resident on [redacted] when he/she dropped off the meal trays. The DA stated that he/she did not think it was an odd behavior for Resident #206 to ask the DA to open the door because he/she figured Resident #206 wanted to sit outside. The surveyors asked the DA approxiamtely what time he/she saw Resident #206 trying to exit onto the patio. The DA stated that it had to be before 12:00 PM because that was when he/she left the facility for the day. The DA stated that a nurse asked when he/she last saw Resident #206, so the DA provided the nurse with their observation and a statement. The surveyors asked when the DA was last educated on [redacted] and the DA said they learned about [redacted] in orientation, but was unable to speak to specifics, and stated that it was common sense to go look for the person, if they went missing. On 09/06/22 at 1:22 PM, the surveyors reviewed the video surveillance from [redacted] from 10:07 AM to 10:10 AM. There were two cameras which provided the video surveillance. Both cameras were located on the [redacted] floor. One of the	F 689		

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MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

(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 689	Continued From page 107 cameras was in hallway [redacted] with views of the hallway and patio entrance. The second camera faced the adjoining hallway between the facility and another outside organization. The Admin stated that there were no cameras outside of the facility. On 09/03/22 at 10:07 AM, the video showed the DA walked to [redacted] unit. At 10:08 AM, the surveyors observed Resident #206 self-ambulate from [redacted] unit, pointed at the [redacted] area, observed the DA walk past Resident #206, and then observed Resident #206 ambulate toward the adjoining hallway. At 10:08, the surveyors observed the DA walk towards the kitchen and returned food trays to the kitchen. At 10:09 AM, the surveyors observed the DA leave the dietary area. At 10:10 AM, the surveyors observed Resident #206 walk down the adjoining hallway when the DA was no longer in view of the camera. Resident #206 was observed in the video surveillance, walking toward the double doors that entered the adjoining area. The video ended when Resident #206 exited the door, and was no longer visible on the surveillance video. On 09/06/22 at 1:55 PM, the survey team interviewed the Admin in the presence of the DON and asked, "What should be done if the resident has [redacted] behavior and was confused?" The Admin stated that residents had [redacted] behaviors, but it did not indicate that the resident was [redacted].	F 689		

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F 689	Continued From page 108 On 09/06/22 at 1:56 PM, the survey team interviewed the DON in the presence of the Admin and asked, "What does it mean when a resident wanders?" The DON stated that a definition of [redacted] meant that a resident did not always remain in one space. The DON further stated that interventions to decrease [redacted] behavior included; to re-direct the resident, provide diversional activities, provide time in day room, provide the resident with verbal cues as to where they are. The DON told the survey team that if the resident had a history of [redacted] displayed that behavior, it should be included in the resident's CP. The DON further stated that a [redacted] assessment should be completed for a resident upon admission, quarterly, and annually. On 09/06/22 at 3:52 PM, the surveyors interviewed the Admin who stated that the cameras were accurately time stamped, could not be edited, and the cameras captured live time. On 09/06/22 at 3:56 PM, the survey team interviewed Resident #206 's Primary Care Physician (PCP), who stated that they had taken care of Resident #206 while he/she resided at the facility. The PCP did not take care of Resident #206 when he/she lived at home. The survey team asked the PCP to describe Resident #206. The PCP stated Resident #206 had a [redacted]t [redacted] with day-to-day tasks, but was easily re-directed when Resident #206 was [redacted]. The PCP stated that they never knew Resident #206 to have [redacted] at the facility, however, during the COVID-19 Pandemic there were a lot of room changes and Resident #206 would get [redacted] and needed to be re-directed	F 689		

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back to the location of their room, so staff placed a [redacted] on Resident #206. The surveyors asked if the PCP knew when the [redacted] was discontinued and the PCP could not recall specific dates, however, stated when PO's were discontinued, the nurse performed an assessment and PCP based the determination of discontinuing orders, off the nurse's assessment. The PCP stated that Resident #206 never expressed that he/she wanted to leave the facility. The PCP knew Resident #206's history prior to admission to the nursing facility. The PCP told the surveyors that Resident #206 was the primary caretaker of his/her [redacted] became ill, and went to the hospital, and when the [redacted] was in the hospital, Resident #206 stayed at home and [redacted] around their home. The PCP stated that they never observed Resident #206 [redacted] g and did not hear from staff that Resident #206 [redacted] and would assume that was why the [redacted] was discontinued, because for the most part Resident #206 stayed in their room. The PCP stated that Resident #206's behavior of [redacted] was not exactly a chronic issue, it was an issue Resident #206 had in the past. The PCP gave the example of high blood pressure and stated that if [redacted] was in a resident's history, just like high blood pressure, that would always be something that should be monitored. The PCP further stated that they thought Resident #206's [redacted] should have been included in their plan of care because it would make Resident #206 challenging to go home without 24/7 supervision.

On 09/07/22 at 11:07 AM, LPN/UM #2 unit [redacted] stated that he/she was working on [redacted] when Resident #206 [redacted]. LPN/UM #2 stated that Resident #206 did not have behaviors. Resident

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#206 would come out of the room and sit in the doorway and sometimes Resident #206 liked to sit in [redacted]. The [redacted] was closed a few weeks ago because it was under construction. Resident #206 would go to the [redacted] because he/she saw other people there and would just come back to the unit. The LPN/UM #2 stated Resident #206 was confused and could not put a complete sentence together. The LPN/UM #2 stated they had known Resident #206 for about a year and had never observed Resident #206 self-ambulate without an assistive device. The LPN/UM #2 saw Physical Therapist (PT) work with Resident #206 to use a [redacted] and Resident #206 was also assessed for use of a wheelchair. Even when Resident #206 stood in the room, he/she had an [redacted]. Assistance of one person with care, would always need help. The LPN/UM #2 added that the [redacted] Nurse Practitioner (PNP) recently decreased Resident #206's [redacted] because he/she was not having behaviors. There were no noted changes in Resident #206's behavior or mood.

At one point, Resident #206 did have a [redacted] r [redacted] in place, although LPN/UM #2 did not recall when it was removed but stated that they put the [redacted] on Resident #206 when he/she was getting acclimated to the facility. Resident #206 and their [redacted] lived at the facility. Resident #206's [redacted] always expressed that they wanted to go home. That was why the facility put the [redacted] on Resident #206. After Resident #206 was oriented to the facility and had a history of going to different areas on the [redacted] floor, Resident #206 never tried to exit the elevator, and was not exit seeking to the LPN/UM #2's knowledge. When asked about Resident #206's [redacted], LPN/UM #2 stated when they

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asked Resident #206 something, he/she had a hard time to gather the words to answer the questions. Resident #206 knew the mealtimes, med times, staff, and other residents, but the resident would not have been safe to live in community based on their [redacted] status. Resident #206 needed oversite- direction for showers and from the LPN/UM #2's experience, they did not identify Resident #206 as an [redacted] risk.

On 09/07/22 at 11:21 AM, the surveyor interviewed the Security Supervisor (SS) who stated that he/she was the head of the security for the facility and was employed by a security company that was subcontracted by the facility. The SS stated that there was no keypad to the left of the stairwell #4 door prior to [redacted], the day the repairs were done. The SS stated that "There was not a keypad on that exit door prior to [redacted]." The SS also stated that "The facility had just installed that keypad on [redacted]." The SS added that prior to [redacted], there was no lock on the door, and you could just walk out. The SS added that the security guards that were assigned to work at the facility had no responsibility of monitoring cameras and thought that the cameras were county property and unsure if they were working. The SS stated that the county personnel and visitors to the county clinic entered the adjoining hallway and used that same exit door to freely access the clinic, which was located on the [redacted] floor.

On 09/07/22 at 12:15 PM, the surveyor interviewed Resident #206's PNP who stated that he/she saw Resident #206 last week to follow up on their [redacted] medications and laboratory review. The PNP further stated that Resident

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#206 was first placed under [redacted] care because he/she had behaviors of refusing medications and care. The PNP told the surveyor that Resident #206 had diagnoses of [redacted] and was [redacted]. The surveyor asked the PNP if Resident #206 had [redacted] awareness of where they lived. The PNP stated that Resident #206 had periods of knowing where he/she was and at times did not. The PNP stated that he/she remembered that Resident #206 had a past history of [redacted], but they never verbalized or displayed behavior indicating that Resident #206 wanted to leave the facility. The PNP stated that they were surprised that Resident #206 walked out of the wheelchair because PNP always observed Resident #206 in their wheelchair.

On 09/07/22 at 02:32 PM, the surveyor interviewed the technician (tech) via telephone who stated that he/she provided a service on Monday Labor Day, [redacted]. The tech stated he/she was called on [redacted] but could not come and told the facility to call someone else but then he/she was called back and was able to come on [redacted]. The tech stated he/she was told that the [redacted] keypad was not working meaning that the [redacted] keypad was not keeping the door locked at all times. The tech added he/she was not an expert on [redacted] but had worked with them and knew they had more than one function and confirmed that the [redacted] was not keeping the door locked. The [redacted] was working when a [redacted] was in the vicinity because it would lock the door, but the relay to keep the door locked was not working. The tech referred to the new keypad he/she installed, on the left wall

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F 689	Continued From page 113 of the door, and a code had to be put in to unlock it. The tech added that there was no keypad on the left wall of the door before they put one in. When asked by the surveyor why the invoice had "replaced" keypad, the tech stated, "I sort of replaced it", you say "new" and I say "replaced," because I sort of replaced the keypad because they had a [redacted] keypad. The [redacted] keypad was on the opposite wall before the door. Review of the document titled "Police Department Investigation Report," dated [redacted], revealed that the police were called at 12:20 PM on 09/03/22. Once the police received a description of Resident #206, the police requested mutual aid from the sheriff's office, K-9 unit, as well as the utilization of the drone unit. " After review of the facility's video, the police concluded that Resident #206 was last seen at approximately 10:12 AM walking down the dietary hallway of the facility, on the [redacted] floor, and walking through the exit door but it was undetermined from the video surveillance, which direction Resident #206 continued to walk. The police found Resident #206 on [redacted] at 3:52 PM, and Resident #206 expired at 4:19 PM on the same day. A review of the facility's policy titled; "[redacted] Policy" with the revised dated of 01/2022, included; "It is the objective of this facility to ensure the safety and protection of wandering residents by preventing their exit from the building." Under Policy Interpretation and Implementation; Section 1. Upon admission, annually, and when there is a significant change in status, resident will be assessed for wandering/elopement using the "[redacted] risk" form. Any resident identified to be a risk for	F 689		

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[redacted] either by preadmission history and/or observed behavior will be provided with a [redacted] and an appropriate plan of care will be developed.

Section 6- The Admin or in his/her absence the DON will notify Department of Health (DOH) if the resident is NOT FOUND as per DOH guidelines.

The facility's policy also did not indicate a specific time frame to notify DOH after a search for a missing resident that had not been found within the facility or on the facility's grounds.

This deficient practice placed Resident #206 and all other residents with [redacted] cognitive [redacted] who were at risk for or had a known history of [redacted] and/or exit seeking behavior, in an Immediate Jeopardy (IJ) situation. The IJ was identified on [redacted] at 4:15 p.m., when the Admin and DON were notified of the IJ situation, which ran from 09/03/22 until 09/05/22, when the door was monitored and repaired. The facility provided an acceptable removal plan on 09/08/22 at 10:16 AM, to remove the Immediacy.

The Removal Plan was verified by the survey team on 09/08/21 at 10:40 AM, the sixth day of the survey. This deficient practice continues at a lower S/S for no actual harm with the potential for more than minimal harm.

Part B

Refer to F609

On 09/01/22 at 11:32 AM, the surveyor observed Resident #191 reclining back in his/her reclining chair in their room. The surveyor attempted to

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interview the resident. The resident was able to communicate his/her name to the surveyor.

The surveyor reviewed the medical record for Resident #191.

A review of the resident's Admission Record, reflected that the resident had resided at the facility for about a year and had diagnoses which included but were not limited to; [redacted]

A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], reflected that the resident had a Brief Interview for Mental Status score of [redacted] which indicated the resident had [redacted]. A further review of the resident's MDS, Section [redacted] - Functional Status for activities of daily living reflected that the resident required supervision and setup for eating and drinking.

A review of the resident's "Order Audit Report," throughout Resident's #191's stays at the facility, revealed a Physicians Order (PO) dated [redacted], and timed at 10:37 AM, for regular diet puree texture, [redacted] thickened liquid consistency.

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F 689	Continued From page 116 According to a review of an incident investigation dated [redacted], completed by the facility's DON indicated on [redacted] at 2:30 PM Resident #191 was in the [redacted] dayroom during snack time. The resident's (Licensed Practical Nurse) LPN was informed by an activity aide that Resident #191 was [redacted] and [redacted]. The resident had a PO for [redacted] thickened liquids and was provided thin whole milk by his/her primary CNA2. The resident was immediately evaluated by the LPN. Upon evaluation, the LPN heard [redacted] throughout the resident's [redacted] and determined the resident's vital signs were abnormal. The LPN notified the residents (Primary Care Physician) PCP who gave physician orders for the administration of [redacted] and [redacted] treatments, quickly came to the unit, assessed the resident, and sent the resident to the hospital for an evaluation. Resident #191 was admitted with aspiration [redacted] in the hospital. A further review of the incident investigation dated [redacted], revealed Resident #191 was incorrectly provided regular thin liquids during snack time when his/her current diet order indicated [redacted] thick liquids. The DON further concluded that the incident most likely occurred due to lack of knowledge regarding proper protocols in verifying fluid consistencies. A review of a Progress Note (PN) dated [redacted], and timed at 14:30 (2:30 PM), indicated that while Resident #191 was in the dayroom during snack time, staff informed nursing that the resident was [redacted] and [redacted]. The PN further explained that the resident had a PO for [redacted] thickened liquids and was given thin milk by an unknown	F 689		

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staff member. The PN revealed that the resident was evaluated by the LPN. Upon evaluation, the LPN heard [redacted] the resident's [redacted] the resident's vital signs were [redacted] and the resident's physician was notified immediately. Upon notification of the physician, the physician provided the LPN with physician orders for the resident to be administered [redacted] and a [redacted] treatment. The PN further indicated that the physician came to the unit, assessed the resident, and decided to send the resident to the hospital.
A further review of the resident's PN, dated [redacted], and timed at 22:35 (10:25 PM), reflected that the resident was admitted to the hospital with possible [redacted]

A review of the resident's hospital discharge paperwork from [redacted] through [redacted], reflected a discharge diagnosis of [redacted] which was identified on a [redacted]. A further review of the resident's hospital paperwork indicated that the resident required placement of a [redacted]. The hospital discharge paperwork dated [redacted], by the Speech Language Pathologist (SLP) at the hospital indicated, "[Resident arrives via ambulance from [facility] with [blood pressure] [redacted]." The hospital discharge paperwork further indicated as per Emergency Medical Services the resident was normally on a thickened liquid but was administered unthickened milk at some point, [redacted] on it.

A review of the facility's Investigation of the incident that took place on [redacted] was dated, [redacted] and signed by the DON. The investigation indicated that video surveillance dated [redacted] and timed at 1426 (2:26 PM),

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"shows [CNA2] passing out snacks in the dayroom. He opens and places what appears to be a milk carton in from of [Resident #191]. [Resident #191] is seen sitting at the table drinking milk. Three other employees are present in the dayroom. [Activity aide] appears to be checking on [Resident #191], leaves the dayroom and returns with [LPN] (pulling the vital sign machine)."

The Investigation revealed that the DON interviewed the staff members that were present in the dayroom. A review of the interview with the resident's LPN revealed that a staff member saw the resident drinking milk and then start coughing. The LPN went into the dayroom, evaluated the resident, and observed that the resident was [redacted] The LPN told the DON that she [redacted]) and heard [redacted] The LPN then notified the resident's PCP who gave her physician orders for [redacted] and [redacted] treatments. The LPN interview indicated that the resident's PCP came to the unit and decided to call 911 because the resident's vital signs were [redacted]

A review of the interview with the resident's CNA2 indicated that he did not recall passing out the milk to Resident #191 but recalled seeing the resident drinking the milk and being surprised that the resident was on regular milk fluid consistency. The investigative report revealed that the DON asked the CNA2 the process for identifying residents on alternative fluid consistencies, the CNA2 responded that he knew by the dots by the resident's bedroom doors.

A review of the interview with the activity aide

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indicated that she saw the resident drinking milk out of a red carton. The activity aide told the DON that she did not know who gave the resident the milk and the resident was [redacted] liquid and [redacted]. When the DON asked the activity aide the process for identifying residents on alternative fluid consistencies the activity aide stated that she did not know.

A review of the interview with the facility's Corporate Food Service Director revealed that on [redacted] at 10:31AM, the kitchen received a PO for [redacted] thick liquids for the resident.

A review of the Investigation conclusion indicated the resident was provided regular thin liquids when his/her current diet indicated [redacted] thickened liquids. A further review of the Investigation revealed the DON concluded Resident #191 received the incorrect fluid consistency during snack time and the incident most likely occurred due to lack of knowledge by staff regarding proper protocols in verifying fluid consistencies.

A review of Nurse Staffing for the [redacted] unit on [redacted] revealed that the CNA2 that provided Resident #191 with the thin whole milk was the resident's primary care CNA for that day.

A review of the CNA2's personnel file revealed that on [redacted], the CNA2 who provided the resident with thin whole milk received a verbal warning by the facility's DON. The verbal warning indicated that the CNA2 failed to follow instructions. "Incorrect Diet" was documented on the verbal warning work rule violation. Additionally, a Dietary Inservice was provided to the CNA2 by the DON. The Dietary Inservice

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indicated, "Explained DOT system and importance of checking dietary restrictions prior to feeding. DOT system hanging in nurses station and dayroom. Specific colored DOT placed near resident's name plate by room door. No fluids left at bedside of residents on a [redacted] and with [redacted]. Residents requiring thickened liquids will receive tray with empty mug and coffee thickener packet. Dietary will send up carafe of hot water for staff to use to make the coffee. Demonstrated how to use Coffee thickener packets- [redacted] and [redacted] thick. Jello and ice cream are considered thin liquids. When unsure- STOP! And ask nurse before giving anything."

A further review of the CNA2's personnel file indicated that on [redacted], the CNA2 was terminated due to performance issues, absenteeism, and poor work quality.

A review of the resident's Care Plan, revised [redacted], reflected a focus area for nutrition. The goal of the resident's Care Plan was that the resident would follow diet as ordered. Interventions in Resident #191's Nutrition Care Plan included; provide me my diet as ordered and provide me with my supplements as ordered.

On 09/09/22 at 11:42 AM, the surveyor interviewed the facility's Registered Dietician (RD) who stated that a resident was placed on an altered diet or liquid consistency after being evaluated by the SLP. The RD stated that she observed resident's during mealtimes and if she noticed that a resident was having difficulty [redacted] or suspected weight loss due to [redacted] difficulties she would include the nursing department, SLP, the resident representative, and the PCP in her assessment of

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the resident. The RD further stated that the system the facility currently used for identifying residents who were on an altered diet consistency was the "dot system." The RD explained that the dot system meant if a resident was on a mechanically altered diet, the facility would place dots by the resident's bedroom doors. For example, a red dot meant that the resident received a mechanically altered diet, yellow dot meant Nothing Per Mouth (NPO), and a blue dot meant that the resident was on a thickened liquid. The RD told the surveyor that there were different types of liquid consistencies which consisted of regular/thin liquids, nectar, honey, and pudding and the purpose of providing a resident with a thickened liquid was because the resident had a [redacted] difficulty that would place them at risk for [redacted]. The RD stated that the [redacted] did not differentiate between the different types of liquid consistencies. The RD further explained that the facility utilized a diet binder on each unit in which the dietary aide or herself would send a list of residents to each unit every day which included their diet and liquid consistencies. The surveyor asked, "How is that information disseminated to the staff working on the unit?" The RD explained that she would also e-mail the Unit Manager, Unit Clerk, and DON the resident's diets daily and the Unit Mangers would communicate the resident's diet and liquid consistencies to the staff and speak to them directly if there were changes. The RD further stated that when the resident received his/her meal tray, the meal tray would come with a ticket of the resident's diet and liquid consistency and the ticket would match the food and drinks that were served on the tray. The RD did not speak to how the snacks were delivered to the unit.

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On 09/12/22 at 10:56 AM, the surveyor interviewed the Food Service Director (FSD) who stated that the products that came into the kitchen already thickened nectar and honey consistency were milk, water, apple, orange, and cranberry juice. The FSD stated that coffee and tea had to be thickened by the staff with thickening packets. The FSD explained that when the facility had a new/re-admission or a diet change PO, the nurse would document the diet change in the computer system, an e-mail would be sent to the FSD, Diet Technicians (DT), and RD. Next, the DT would create the new diet ticket in the meal tracker system, and they would double check to make sure the PO in the meal tracker system matched the diet order in the resident's electronic medical record.

On 09/12/22 at 11:00 AM, the surveyor interviewed the CNA3 on [redacted] unit who stated that she had been working at the facility for [redacted] years, one year as a CNA and knew the resident. The CNA3 stated that the resident could be [redacted] at times, was confused, had difficulty [redacted] and received a thickened liquid. The CNA3 explained that she knew that a resident was on a thickened liquid by the by the dot by the resident's bedroom door, the nurses would communicate it to them, and they would review the meal ticket that came on the tray before providing the resident with their meal tray. The CNA3 stated that snacks were delivered with the resident's name on it and the CNAs were familiar with the residents and knew who was on what type of diet. The CNA3 stated that the snack tray was brought to the unit by the dietary department and the CNAs were responsible for handing out the food and drinks to the residents at snack time.

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F 689	Continued From page 123 On 09/12/22 at 11:06 AM, the surveyor interviewed the CNA4 on [redacted] unit who stated that she worked at the facility for two years, knew the resident, the resident was on [redacted], would sometimes be on her assignment, and she provided care to the resident. The CNA4 stated that the resident was [redacted] and [redacted] at times, had trouble [redacted] and was on thickened liquids. The CNA4 told the surveyor that the snack tray would come to the unit around 2:15 PM - 2:30 PM and the snacks would have the resident's name on them. The CNA4 told the surveyor that the CNA2 who gave the resident the thin whole milk did not work at the facility anymore. On 09/12/22 at 11:13 AM, the surveyor interviewed the CNA5 on [redacted] unit who stated that she had worked at the facility for a year and two months, knew the resident and provided care to him/her. The CNA5 stated that the resident was confused and had behaviors of trying to take food from other resident's trays after the resident had a [redacted] placed and was [redacted]. The surveyor asked if the resident ever took food from other residents prior to the [redacted] placement and the CNA5 stated that it was only after the [redacted] was placed that the resident had that behavior and prior to the [redacted] placement the resident had a poor appetite and didn't eat much. The CNA5 told the surveyor that during snack time, a tray would come from the kitchen with snacks with the resident's names on them, the residents sat in the dayroom, and the CNAs would distribute the food and drinks to the residents on the unit. The CNA5 further stated that an activity aide would be in the dayroom, but they did not give food or drinks to the residents.	F 689		

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F 689	Continued From page 124 On 09/12/22 at 11:20 AM, the surveyor interviewed the resident's Registered Nurse (RN) who stated she had been working on the unit for a few months and had taken care of the resident prior to the resident's death. The RN stated that she was not working on the unit in [redacted], but had heard of the incident where Resident #191 was provided with the wrong liquid consistency and had [redacted]. The RN told the surveyor that the resident would become [redacted] from time to time and had a behavior of trying to take food and drinks from other resident's trays. The surveyor asked if the resident had that behavior prior to the [redacted] placement and the RN stated that when she had worked on the unit before the [redacted] was placed and took care of the resident, the resident never tried to take food from other residents. The RN stated that snacks and drinks had the resident's names on them when they were delivered to the unit. On 09/12/22 at 11:39 AM, the DON stated that the CNA who gave the resident the thin whole milk no longer worked at the facility. The DON could not speak to specifics regarding the CNA ending employment at the facility. On 09/12/22 at 11:42 AM, the surveyor interviewed the DT in the presence of the FSD who stated that she started working as a fulltime DT about two weeks ago and was taught the process for resident diet changes in the computer system by the RD. The dietary technician explained that she was responsible for updating the resident's diet, any dietary changes, snack entry's, food preferences, and allergies into the computer system. The DT further stated she was also responsible for printing out the meal tickets, snack labels, and reports. The DT told the	F 689		

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surveyor that she downloaded a list of the residents on thickened liquids daily and e-mailed the list to the Unit Managers, DON, Infection Control Nurse, and RD.

On 09/13/22 at 11:01 AM, the surveyor interviewed the SLP in the presence of another surveyor. The SLP stated all new and re-admissions were screened by speech therapy upon admission to the facility. The SLP stated that she would look through the resident's medical record for a history of [redacted] or [redacted]) to determine if services were needed. The SLP told the surveyors that long term care residents need for speech therapy services were usually communicated through nursing and the RD when it was noted that the resident had a weight loss. The SLP stated that once the resident was screened and it was identified that they had signs and symptoms of [redacted], difficulty eating, the treatment might include dietary modifications or compensatory strategies (techniques for modifications in behavior) for alert and oriented residents. The SLP explained that the purpose in assessment was to assess why a resident was having difficulty [redacted] and gave the example that perhaps it was because they could not chew. The SLP told the surveyors that discontinuation of therapy services occurred when the resident reached their maximum potential and stated that if there were no further signs of [redacted], if the interventions we put in place helped, and the resident stabilized, the resident would be discharged from therapy. The surveyors asked, "What the facility's process was for notifying staff of a change in diet." The SLP stated that if the Unit Manger or primary nurse was present, she would verbally let them know.

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The SLP told the surveyors that in May, the facility updated their process by implementing a diet binder, she would change the diet manually in the diet binder, the nurses would update the resident's diet in their electronic medical record and a handwritten dietary requisition form would be brought to the dietary department. The SLP further stated the Unit Manager would put a green dot by the resident's door "N" for nectar "H" for honey.

At 11:14 AM, the surveyors reviewed Resident #191's Speech Therapy Plan of Care documentation from [redacted] through [redacted], with the SLP. The SLP stated that the referral for the resident was made at that time due to weight loss status post COVID-19 infection. At the time, the resident was on a regular diet with thin liquids and after therapy the resident continued with regular diet thin liquids. The SLP stated that the [redacted] was documented as oral ([redacted]) phase due to fatigue from COVID-19.

The surveyors reviewed the Speech Therapy Plan of Care documentation from [redacted] through [redacted] with the SLP, who explained that she was verbally told by the nursing department that the resident had [redacted] episodes times two, where the resident was able to [redacted] the food after he/she started [redacted] The SLP stated that at the time the resident was assessed, he/she was on regular thin liquids and then she downgraded the diet to puree thin liquids. The SLP further stated at that time she assessed the resident to have [redacted]

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The surveyors reviewed the Speech Therapy Plan of Care documentation from [redacted] through [redacted] with the SLP, who told the surveyors that the resident was a re-admission to the facility on [redacted], and she followed up with the resident post re-admission from the hospital. The SLP stated that the resident was put on a regular diet, thin liquids in the hospital, and she felt upon re-evaluation on [redacted], that the resident's diet should be downgraded to pureed diet, [redacted] thick liquids. The SLP explained that she saw the resident the next day on [redacted], and it was, "very obvious" the resident was having a hard time [redacted]. So, at that point she recommended puree diet, [redacted] thickened liquids. The surveyors provided the SLP with a copy of her note and she reviewed it in the presence of the surveyors. The SLP stated she assessed the resident, nursing was there with her, she identified the resident had a lot of [redacted] and was unable to follow the command to make a [redacted], so she downgraded the liquid consistency to [redacted]. She stated she further communicated with nursing to make the resident's PCP aware because she was unsure if resident would be able to continue [redacted] the resident had no other means of nutrition at that time, and then was subsequently sent out to the hospital after [redacted] that afternoon.

The surveyors reviewed the Speech Therapy Plan of Care documentation from [redacted] through [redacted] with the SLP, who stated that the resident was re-admitted to the facility status [redacted] with a new [redacted] The SLP stated that she reviewed the hospital records and placed the resident on therapy services. The SLP stated that the resident came back to the facility with PO for [redacted]

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[redacted] and the [redacted] was for nutritional purposes. The surveyors asked the SLP, "What is the risk for someone who has [redacted] if they are given an improper liquid consistency?" The SLP replied that the individual could most likely develop [redacted] and can become very sick. The SLP explained that in Resident #191's case, his/her [redacted] was [redacted] like it should have because the anatomy of the [redacted] and if the [redacted] was not working properly, food would get into the [redacted]. The SLP stated that it was documented that the resident had [redacted], so the food and drink was d[redacted] Also, the resident had a diagnosis of [redacted] so that further interrupted his/her [redacted] process.

On 09/13/22 at 12:39 PM, the surveyors interviewed the DON, who stated that the process for notifying staff of dietary changes was the nurse was notified, then the PCP would be notified, and a PO would be obtained and documented in the resident's medical record. Next, a dietary slip would be filled out by nursing, brought to the dietary department and the resident's care plan would be updated to reflect the change in diet consistency. The DON further stated that if the SLP was not involved, the SLP would be made aware of the diet change so they could assess the resident. The DON explained the facility's system for identifying residents on an altered diet. The process consisted of dots being placed by the resident's bedroom doors indicating that they were on an altered diet. The DON stated

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that they had a paper up in the dayroom on the units as a reference to the staff, so they knew what the dots meant. The DON told the surveyors that the residents snacks came from the kitchen labeled with a sticker on them. The DON stated that the CNA2, who provided Resident #191 with the wrong liquid consistency, failed to ask the nurses what diet the resident was on. The DON further stated the CNA2 gave the resident the wrong liquid consistency and that was what caused him/her to [redacted]. The DON explained, there were many things that the CNA2 could have done, he could have asked the nurse and he could have double checked.

On 09/13/22 at 01:24 PM, the surveyor conducted a telephone interview with the resident's PCP who stated that the resident had [redacted] and his/her condition had been declining. The PCP stated that he was told that Resident #191's CNA2 had administered a thin liquid to the resident and the resident had [redacted]. The PCP explained that when he arrived on the [redacted] unit to assess the resident, he identified that the resident was [redacted]. The PCP further stated that upon [redacted] of the resident's [redacted], he heard [redacted]. The PCP told the surveyor that he further assessed the resident with having [redacted]). The PCP stated that the resident was not allowing the

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F 689	Continued From page 130 [redacted] to be placed on his/her face, so he called the Resident #191's representative to make them aware of the situation and explained to the resident representative the reason for the hospital transfer. The PCP stated that he knew the resident was being followed by the SLP and had a history of [redacted]. On 09/16/22 11:13 AM, the surveyor conducted a telephone interview with the resident's assigned LPN on [redacted], the day the incident occurred. The LPN told the surveyor that she had been employed at the facility per diem and had stopped working there a few months ago. The LPN remembered the resident and the incident. The LPN stated that Resident #191 was [redacted] had behaviors, and was sweet. The LPN told the surveyor that she recalled the SLP and physician had downgraded the residents diet from [redacted] to [redacted] thickened liquids the day of the incident. The LPN further stated that someone gave the resident regular milk, the activity aide told her the resident was [redacted] so she took the residents vital signs. The LPN explained that upon evaluation, the resident was unable to [redacted] the [redacted], she heard [redacted] and called the resident's PCP. The LPN stated that she told the PCP the resident was presenting the way he/she was because someone gave the resident the wrong liquid consistency and they both made the decision after speaking to the resident representative that the resident should go to the hospital. The LPN stated that earlier that day she had overheard the conversation between SLP and the supervisor, so she was aware of the diet change. The LPN stated, "I was blown away that the resident drank the regular milk. I knew that the resident couldn't stay at the facility and needed help."	F 689		

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F 689	Continued From page 131 On 09/13/22 at 10:37 AM, and on 09/16/22 at 11:12 AM, the surveyor placed a telephone call to the activity aide, and she was unavailable for an interview On 09/13/22 at 10:39 AM, and on 09/16/22 at 11:22 AM, the surveyor placed a telephone call to the CNA2, and he was unavailable for an interview On 09/20/22 at 11:50 AM, the surveyor interviewed the facility's Administrator who acknowledged that Resident #191 was sent to the hospital after drinking whole thin milk, but it was not based on carelessness or lack of education because the CNA2 was educated prior to the event. The Administrator did not speak to if the CNA2 was educated to Resident #191's diet change on [redacted] The Administrator did not speak to proper procedure the CNA2 should have performed based off the education he received. The Administrator stated that the incident occurred due to, "human error." A review of the facility's "Thickened Liquids Policy and Procedure" updated 05/2022, revealed the methods to identify residents who cannot tolerate liquids unless thickened included a dot system would be placed on the door name tag with the letter "N" or "H" to indicate nectar or honey thickened liquids and the dot system legend could be located at the nursing station and dayroom. The Thickened Liquid Procedure further indicated, "1. If a resident has an order for thickened liquids- Nursing, Dietary, Recreation and Rehab are informed. 2. Dietary meal tickets will indicate fluid consistency. 3. List of residents on altered consistency diets will be maintained	F 689		

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daily and as needed at the nursing station. 4. Speech therapy evaluation will be conducted to determine type of fluid consistency needed and if any change is necessary."

This deficient practice placed Resident #191, with an altered diet liquid consistency in an Immediate Jeopardy situation and at risk for [redacted]

The Immediate Jeopardy (IJ) situation as Past Non-Compliance was identified for 05/27/2022. The facility's Administrator and DON were notified of the IJ situation on 09/13/2022 at 3:00 PM. An acceptable Plan of Correction was received on 09/14/2022 at 3:00 PM which included:

1. Resident #191's vital signs immediately obtained by LPN.

2. The resident was assessed by the physician who ordered [redacted] and transferred the resident to the Emergency Room for further evaluation.

3. Immediately upon recognition of the employee's error on [redacted], the employee was in-serviced and given a disciplinary warning.

4. All residents with altered diets were identified as at risk.

5. The facility's "Thickened Liquids Policy and Procedure" was updated on 5/31/22.

6. Staff were in-serviced on the updated Policy and Procedure regarding altered diets/fluids starting on 5/31/22.

7. A list of residents who were on altered diets/fluids was placed in a binder at each nursing

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

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F 689	Continued From page 133 station. 9. QAPI was initiated and all residents on altered diets/fluids were audited as well as weekly audits X4 weeks and then quarterly thereafter to ensure residents received the appropriate diet/consistency and that staff were aware of the residents altered diets/fluid. NJAC 8:39-17.4(a)1,2 NJAC 8:39-27.1(a)	F 689		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation it was identified that the facility failed to: a.) follow the Physician's Order (PO) for the use of [redacted] equipment b.) appropriately store portable [redacted] tank to the back of resident wheelchair and c.) store [redacted] equipment in a way to prevent the spread of infection. This deficient practice was identified for [redacted] residents' reviewed for [redacted] care, (Resident #111, #159 and #191) and was evidenced by the following:	F 695	F695 - Respiratory/Tracheostomy Care and Suctioning Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. 1. What corrective action(s) will be accomplished for those residents found to	10/26/22

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F 695	Continued From page 134 The surveyor observed Resident #111. 1. On 9/01/22 at 11:32 AM, the surveyor observed the resident sitting in their [redacted] wheelchair in their room watching TV. The surveyor observed an [redacted] in Resident #111's room next to Resident #111's bed. The [redacted] was running and set at [redacted] and Resident #111 was wearing their [redacted]. The [redacted] and [redacted] bottle were not labeled and dated. The surveyor also observed a [redacted] hanging from the wheelchair handle on the back of Resident #111's [redacted] wheelchair. The [redacted] was not in a holder or attached to the wheelchair with a strap. It was hanging freely by a green handle approximately 18 inches off the ground. On 9/07/22 at 01:12 PM, the surveyor observed the resident in their room sleeping in their [redacted] wheelchair. The surveyor observed the [redacted] in front of the wheelchair. The [redacted] was running and set at [redacted] and the resident was wearing their [redacted]. The [redacted] and [redacted] were not labeled and dated. The surveyor also observed a [redacted] hanging from the wheelchair handle on the back of the resident [redacted] wheelchair. The [redacted] was not in a holder or attached to the wheelchair with a strap. It was hanging freely by a green handle approximately 18 inches off the ground. On 9/19/22 at 11:32 AM, the surveyor observed the resident sitting in their [redacted] wheelchair in their room getting ready to eat lunch. Again, the surveyor observed the [redacted] in Resident #111's room next to the residents bed. The [redacted] was running and set [redacted]	F 695	have been affected by the practice: -On 9/19/2022 For Resident (#111) [redacted] was placed in a bag changed, labeled and dated, and [redacted] was changed, labeled, and dated. LPN Unit Manager and RN #1 were verbally educated by Director of Nursing on the components of this regulation with an emphasis on labeling and dating [redacted] -On 9/19/2022 For Resident (#111) [redacted] was place in a secured container. RN Unit Manager, CNA #1 and RN #1 were verbally re-educated by Director of Nursing on the components of this regulation with an emphasis on storing [redacted] in a secure container. -On 9/21/2022 Resident (#111) was assessed with no concerns noted and Physicians Order was updated to [redacted] LPN Unit Manager and RN #1 were verbally re-educated by the Director of Nursing on the components of this regulation with an emphasis on following physicians orders related to the administration of [redacted] -On 09/19/2022 Resident (#159) was assessed with no concerns noted and Physicians Order was updated to continuous [redacted]. LPN Unit Manager was verbally re-educated by the Director of Nursing on	

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F 695	Continued From page 135 [redacted] and the resident was wearing their [redacted] (device used to [redacted] through the [redacted]. The [redacted] did not have a label or date on it. The surveyor also observed a [redacted] hanging from the wheelchair handle on the back of the residents [redacted] wheelchair with a [redacted] attached to it. The [redacted] was not dated or in a bag. It was wrapped around Resident #111's wheelchair handle open to the environment. The [redacted] was not in a holder or attached to the wheelchair with a strap. It was hanging freely by a green handle approximately 18 inches off the ground. On 09/15/22 11:52 AM, the surveyor interviewed the Certified Nursing Aide (CNA#1) who stated, "I receive report from the nurses for my assignment in the morning. When I have a resident with [redacted] I make sure [redacted] from the [redacted], The nurses do the vital signs and check the orders." On 09/15/22 11:52 AM, the surveyor interviewed the Registered Nurse (RN#1) who stated, "I make sure and check the order, check on the patient to make sure they are wearing their [redacted] and check that the [redacted] is on the correct setting of [redacted]." On 09/19/22 11:56 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manger (LPN/UM) who was also the staff nurse caring for Resident #111 on this day. The LPN/UM stated that Resident #111 had [redacted] and was on [redacted]. He/She was forgetful but easily redirected and removed his/her [redacted] at times. The LPN/UM explained that when Resident #111 wore his/her [redacted], their [redacted]	F 695	the components of this regulation with an emphasis on following physicians□ orders related to the administration of [redacted] -On the afternoon of [redacted] at approximately 3:50pm, the resident #191 was no longer an active resident of the facility. -On 09/21/2022 verbal education was provided as it pertains to Resident #191; RN #2 and LPN Unit Manager were re-educated on the components of this regulation with an emphasis on following, physicians□ orders related to the administration of [redacted] and maintaining infection control. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: -All residents have the potential to be affected by this practice. -By 10/12/2022, the Director of Nursing/designee conducted an observational audit of active residents receiving [redacted] therapy to ensure [redacted] and [redacted] has been appropriately and timely changed and dated with orders in place. -Any concerns identified were immediately addressed. 3. What measures will be put into place or what systemic changes you will make to	

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F 695	Continued From page 136 [redacted] (the percentage [redacted] d) was [redacted] and when the [redacted] was removed the [redacted] dropped to [redacted]. The LPN/UM further stated that the nightshift nurses performed the [redacted] and [redacted] with labeling on [redacted]. The surveyor and LPN/UM proceeded to go in Resident #111's room. The surveyor asked the LPN/UM if the [redacted] and [redacted] should be hanging on the back of the chair with the [redacted] exposed and wrapped around the handle? The LPN/UM stated, "No, this should be in a portable cart or attached to [the residents] wheelchair and the [redacted] should be in labeled and dated in a patient bag." The surveyor proceeded to ask the LPN/UM to show the surveyor where the PO was for the [redacted] the LPN/UM was unable to find the PO and stated that it had been discontinued in [redacted]. The LPN/UM stated, "That is funny because [the resident] has been on [redacted] since I started working here in March of 2021." The surveyor reviewed the medical record for Resident #111. A review of the resident's Admission Record reflected that they had resided at the facility since [redacted] and had diagnoses which included but were not limited to [redacted] (a condition in which you lack enough healthy [redacted]), [redacted] a condition in which the [redacted] and [redacted] as well as they should), and [redacted] (is a complex	F 695	ensure that the practice does not recur: By 10/26/2022, the Director of Nursing/ designee will re- educate licensed nursing staff on the components of this regulation with emphasis on: Ensuring [redacted] is changed and dated appropriately and timely for residents requiring [redacted] therapy with physicians order in place, following physician orders related to [redacted], and storage of resident [redacted] equipment. -Newly hired licensed nurses will receive education during orientation. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: -The Director of Nursing /designee will conduct a weekly audit of 5 residents x 4 weeks and then monthly x 2 months to ensure: Residents receiving [redacted] therapy have had their [redacted], and [redacted] changed appropriately and timely, physician orders are in place, observation review reflects the residents current [redacted] per physicians orders and the plan of care updated as appropriate, residents who have suctioning orders, that staff are maintaining infection control practices during [redacted] and the plan of care is updated as appropriate. -The findings of these audits will be	

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F 695	Continued From page 137 disease involving an [redacted]. A review of the residents most recent significant change Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident had [redacted]. A review of the resident [redacted] through [redacted] Order Recap Report (ORR) revealed a PO dated [redacted], to give [redacted] to maintain [redacted] or above as needed for [redacted]. It showed discontinuation under order status. A review of the residents Active Orders as of [redacted], on the Order Summary Report (OSR) revealed no active or current orders for continuous or PRN (as needed) [redacted] for the resident . A review of the facility's [redacted] Administration Policy and Procedure revised 01/2022, included under Preparation, "Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for [redacted] administration." Further review of the facility's [redacted] Administration Policy and Procedure revised 01/2022, included under equipment and supplies that the [redacted] should be stored in a secured container, "Strapped to the stand." 2. On 08/31/22 at 10:25 AM, during the initial tour	F 695	reported to the monthly QAPI monthly x 90 days.	

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F 695	Continued From page 138 of the facility Resident #159 was out of bed in a wheelchair. Resident #159 could not be interviewed due to a [redacted]. The resident was wearing [redacted] connected to a [redacted] on the back of the wheelchair. There was also a [redacted] in the room, but the [redacted] was not connected to Resident #159 at the time of the observation. A review of the resident's Admission Record reflected that Resident # 159 was admitted to the facility on [redacted], with diagnoses which included but not limited to [redacted] A review of the admission MDS dated [redacted], reflected the resident had a BIMS score of [redacted] out of [redacted], indicating that the resident had [redacted]. Review of Section [redacted] for functional status, indicated that Resident #159 had a functional status of a 2-person assistance for transfer and toileting and a one-person assistance for dressing, eating, and hygiene. A review of the [redacted] PO's revealed an active PO for [redacted] dated [redacted]. The PO was for [redacted] every shift for [redacted] if [redacted] meaning the [redacted] would be checked every shift for Resident #159 and if the reading was less than [redacted] the [redacted] would then be applied. A review of the [redacted] Medication Administration Record (MAR) indicated the above corresponding PO for the use of [redacted]. The MAR reflected that the staff signed every shift that	F 695		

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F 695	Continued From page 139 Resident #159 was wearing [redacted] On 9/02/22 at 10:00 AM, the surveyor reviewed the vital signs/graphic section of the Electronic Medical Record (EMR) which showed the following [redacted] (noninvasive monitoring of [redacted]) documentation. After review of the documented [redacted] levels, the resident was never below [redacted] and the [redacted] was still applied to the resident. 9/2/2022 12:11 PM [redacted] via [redacted] 9/1/2022 06:14 PM 9/1/2022 04:52 PM [redacted] via [redacted] 9/1/2022 08:18 AM [redacted] via [redacted] 9/1/2022 08:17 AM [redacted] via [redacted] 9/1/2022 02:18 AM [redacted] via [redacted] 8/31/2022 07:15 PM [redacted] 8/31/2022 05:19 PM [redacted] via [redacted] 8/31/2022 02:15 PM [redacted] 8/31/2022 03:06 AM [redacted] via [redacted] A review of the resident's Care Plan (CP) initiated on [redacted], indicated a focus area for [redacted] therapy related to medical diagnosis [redacted] The goal was to have no signs and symptoms of [redacted] levels and the interventions implemented included changing positions, administering [redacted] and medications as ordered by physician and to monitor for side effects.	F 695		

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F 695	Continued From page 140 On 9/08/22 at 11:10 AM, the surveyor observed Resident #159 in bed with eyes closed. Resident #159 was wearing [redacted] connected to an [redacted] and it was set at [redacted] 0 9/09/22 at 11:55 AM, the surveyor observed Resident #159 in the room in a wheelchair. Resident #159 was wearing [redacted] via [redacted] via a [redacted] On 9/15/22 at 12:45 PM, Resident #159 was in the bed wearing [redacted] at [redacted]. The surveyor interviewed the unit Licensed Practical Nurse (LPN) who was taking care of Resident #159 and asked what the orders for the [redacted] were. The LPN told the surveyor that Resident #159 was ordered to wear [redacted] (meaning the resident wore the [redacted]). The surveyor then interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that the resident wears [redacted]. On 9/15/22 at 2:20 PM, the surveyor presented the [redacted] concern to the Director of Nursing (DON), and the DON acknowledged that the PO for the use of the [redacted] needed to be clarified with Resident #159's physician. 9/21/22 at 11:00 AM, the surveyor reviewed the [redacted] Administration Policy and Procedure dated 1/2022, which included to verify that there was a physician order for the [redacted] and to review the physicians' orders or facility protocol for [redacted] administration.	F 695		

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F 695	Continued From page 141 3. On 9/01/22 at 11:32 AM, the surveyor observed Resident #191 reclining back in his/her [redacted] in their room. The surveyor attempted to interview Resident #191. Resident #191 was able to communicate his/her name to the surveyor. The surveyor observed an [redacted] in Resident #191's room next to Resident #191's bed. The [redacted] was not running at the time of the surveyor observation. The surveyor observed the [redacted] laying on the floor next to the [redacted] and further observed the [redacted] draped over the [redacted] with the [redacted] of the [redacted] in direct contact with the back of the [redacted]. The surveyor saw that Resident #191 had [redacted]. One of the [redacted] was placed on top of the [redacted] and the other [redacted] was on top of the [redacted]. The surveyor saw a [redacted] wand in direct contact with the windowsill. None of the [redacted] equipment was stored in a plastic bag. On 9/02/22 at 10:00 AM, the surveyor entered Resident #191's unoccupied room and observed the [redacted] in the room. The [redacted] was stored in a plastic bag and attached to the [redacted] The surveyor further observed a [redacted] not stored in a plastic bag and in direct contact with windowsill. The surveyor saw the [redacted] not placed in plastic bag and in direct contact with the windowsill. On 9/09/22 at 11:32 AM, the surveyor interviewed CNA#2 who stated that CNA#2 took care of Resident #191, Resident #191 was [redacted], and was able to [redacted] needs. The	F 695		

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F 695	Continued From page 142 CNA#2 told the surveyor that Resident #191 received [redacted] and Resident #191 never touched the [redacted]. The CNA#2 further stated that CNA#2 did not touch the [redacted] because it was the primary nurse's responsibility. On 9/09/22 at 11:35 AM, the surveyor interviewed Resident #191's RN#2 who stated Resident #191 was confused and needed total care with activities of daily living. RN#2 further stated that Resident #191 had received [redacted] on an as needed basis and received [redacted] treatments if he/she was [redacted] or [redacted]. RN#2 stated that the [redacted] equipment should have been stored in a plastic bag for infection control purposes. On 9/09/22 at 11:55 AM, the surveyor interviewed the LPN/UM who stated Resident #191's [redacted] equipment should have been stored in a plastic bag to keep it sanitary. The surveyor reviewed the medical record for Resident #191. A review of the resident's Admission Record reflected that Resident #191 had resided at the facility for about a year and had diagnoses which included but were not limited to [redacted] a [redacted], and [redacted]	F 695		

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F 695	Continued From page 143	F 695		

A review of Resident #191's most recent significant change Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], reflected that Resident #191 had a BIMS score of [redacted] which indicated Resident #191 had [redacted].

A review of Resident #191's [redacted] Order Summary Report (OSR) revealed a PO dated [redacted] to give [redacted] to maintain [redacted] of [redacted] or above as needed for [redacted]. A further review of the [redacted] OSR revealed a PO dated [redacted], for [redacted] milligrams (MG)/([redacted]) milliliter (ML) [redacted] via [redacted] every [redacted] hours for [redacted] and [redacted].

A review of Resident #191's [redacted] Treatment Administration Record (TAR) reflected a PO dated [redacted] to give [redacted] of [redacted] to maintain [redacted] of [redacted] or above as needed for [redacted]. A review of the [redacted] Medication Administration Record (MAR) reflected a PO dated [redacted], for [redacted] milligrams (MG)/([redacted]) milliliter (ML) [redacted] via [redacted] every [redacted] hours for [redacted] and [redacted] A further review of the [redacted] MAR indicated that the nurses were signing at 0000 (12:00 AM), 0400 (4:00 AM), 0800 (8:00 AM), 1200 (12:00 PM), 1600 (4:00 PM), and 2000 (8:00 PM) that the resident was administered the [redacted] treatment.

A review of Resident #191's Care Plan (CP) revised [redacted] did not reflect a focus area for

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F 695	Continued From page 144 the use of as needed [redacted] or for the care of [redacted] equipment. A review of the facility's [redacted] Administration Policy and Procedure revised 01/2022 indicated to, "replace entire set-up every seven days. Date and store in treatment bag when not in use."	F 695		
F 755 SS=E	NJAC 8:39-27.1(a) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate	F 755		10/26/22

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F 755	Continued From page 145 reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure that a.) medications that were ordered by the physician were available for administration during the months of [redacted], and [redacted] for one (1) of [redacted] residents, (Resident #99) reviewed for medication management, b.) medications were observed as accurately and timely administered to one [redacted] residents, (Resident #121) reviewed for medication administration, and c.) a treatment medication was accurately administered and properly stored for one (1) of [redacted] residents, Resident #69, reviewed for treatment medications. The deficient practices were evidenced by the following: 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 and potential physical and emotional health problems, through such services as case finding, 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	F 755	F755 Pharmacy Services Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: -Information related to Resident #99's medication administration omission was identified in a historical record review. -Resident #99 has been assessed with no ill effects noted related to medication omission from April, May and July of 2022. -Information related to Resident #99's medication administration being giving accurately and timely was identified in a historical record review. -Resident #99 has been assessed with no ill effected noted related to receiving medications after returning from out on pass.	

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F 755	Continued From page 146 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 within 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." 1. On 9/9/22 at 11:30 AM, the surveyor observed Resident #99 being wheeled by a Certified Nurses Aide (CNA#1) who stated to the resident that she was taking him/her to his/her room for changing before he/she was to go out with a resident representative. The surveyor reviewed the medical record for Resident #99. A review of the resident's Admission Record revealed diagnoses which included [redacted] a group of disorders that [redacted] A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the	F 755	-On 9/13/2022 Resident #121 was provided medication as per physicians' order. -On 9/13/2022 Unit [redacted] Unit Manager and LPN #1 were verbally re-educated on the components of this regulation with emphasis on ensuring medications are not left at bedside and the nurse remains with the resident while medications are taken unless otherwise evaluated, with a physician order, to self-administer medications. -On 09/09/2022 [redacted] solution was removed from Resident #69's room immediately. -On 9/09/2022 CNA #2, LPN #2, and Unit Manager were verbally re-educated on the components of this regulations with emphasis on medications should not be left at a resident's bedside and that the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: All residents have the potential to be affected by this deficient practice. -By 10/26/2022, the Director of Nursing Services/designee will conduct a review of 5 random residents for the last 14 days of residents' clinical records, MAR/TAR and medication availability in the nurses' carts	

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F 755	Continued From page 147 management of care dated [redacted], reflected the resident had a brief interview for mental status (BIMS) score of [redacted], indicating that the resident had a [redacted]. In addition, the MDS included in Section [redacted], completed for Hearing, Speech and Vision that the resident was usually [redacted]. A review of the [redacted] EMAR revealed a physician's order (PO) dated [redacted] for [redacted] (a medication used to relieve [redacted]) capsule [redacted] micrograms (MCG), give one capsule by mouth two times a day for [redacted] The [redacted] PO had an entry of [redacted]" for administration which corresponded to the chart code of "other/see nurses notes" on [redacted] at 6 PM, [redacted] at 9 AM and [redacted] at 9 AM A review of the corresponding nursing progress notes were as follows: -dated [redacted] at 8:14 PM revealed that for [redacted], "pharmacy called, awaiting pharmacy delivery. Patient made aware." -dated [redacted] at 10:08 AM revealed for [redacted], "Prior authorization in progress, MD and family aware." -dated [redacted] at 8:05 PM revealed for [redacted], "Awaiting delivery from pharmacy." -dated [redacted] at 9:39 AM revealed for [redacted], "Prior authorization in progress, medication administered from back up supply." On 9/13/22 at 12:09 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that Resident #99 had a resident representative that was very involved in	F 755	to identify any medications not administered as ordered by the physician or medications not available for administration as ordered by the physician. By 10/26/2022, the Director of Nursing Services/designee conducted an observational review of nurses administering medications to ensure medications were administered as ordered by the physician. Any concerns identified will be addressed immediately. 3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: By 10/26/2022, the Director of Nursing Services/designee will provide re-education to the licensed nursing staff on the components of this regulation with emphasis on: 1. Ensuring medications are administered per physician orders. 2. Medications administered are documented in the clinical record accurately. 3. Ensuring that medications are available for administration in accordance with physician orders. 4. All drugs and biologicals are stored in a safe, secure, and orderly manner. Newly admitted residents or residents returning to the facility, will be reviewed in	

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F 755	Continued From page 148 the resident's care. The LPN/UM added that the resident had been on [redacted] for [redacted] and the resident's representative had spoken with the physician to try [redacted] instead of [redacted]. The LPN/UM stated that there was an insurance issue with obtaining [redacted] but thought that the resident was receiving [redacted] until the [redacted] was delivered by pharmacy. The LPN/UM stated that if a medication was not available the nurse should call the pharmacy, check the back up supply and if needed call the physician for follow up orders if the medication was not available. Further review of the [redacted] EMAR revealed a PO dated [redacted] with a discontinue order of [redacted] for '[redacted] capsule [redacted] MCG, give [redacted] capsule by mouth one time a day for [redacted]." The [redacted] was discontinued after the [redacted] morning dose. On 9/15/22 at 11:30 AM, the surveyor attempted to interview Resident #99 who answered yes and no to questions and would not elaborate and preferred to not answer any more questions. The resident answered no when asked if he/she had any issues or concerns with the staff, medications or living at the facility. The surveyor further reviewed the medical record for Resident #99. A review of the [redacted] EMAR revealed a physician's order (PO) dated [redacted] for [redacted] (a medication used to [redacted] tablet [redacted] milligrams (MG), give one tablet by mouth every [redacted] hours for [redacted]." On [redacted] at 2 PM, and [redacted] at 2 PM the [redacted] PO had an entry of "9" for administration which corresponded to	F 755	the morning clinical meeting to ensure medications are available for administration per physician orders. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing Services/designee will conduct a weekly audit of 2 residents medication orders x 4 weeks and then every month X 2 months to ensure: 1. Medications are administered per physician orders. 2. Medications administered are documented in the clinical record. 3. Medications are available for administration in accordance with physician orders. 4. All drugs and biologicals are stored in a safe, secure, and orderly manner. Findings of these audits will be brought to monthly QAPI meeting x 90 days.	

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F 755	Continued From page 149 the chart code of "other/see nurses notes." A review of the following corresponding nursing progress notes revealed: -dated [redacted] at 2:42 PM "due meds were given as ordered" -dated [redacted] at 2:44 PM for [redacted], "resident out on pass with family member." -dated [redacted] at 3:04 PM for [redacted], "out on pass with family member, will return 6:00 PM." -dated [redacted] at 3:33 PM "all due meds were given as ordered." A review of the [redacted] EMAR revealed a PO dated [redacted] for [redacted] tablet [redacted] MG, give one tablet by mouth every eight hours for [redacted]" On 5/18/22 at 2 PM the [redacted] PO had an entry of "[redacted] for administration which corresponded to the chart code of "other/see nurses notes." A review of the corresponding nursing progress notes dated [redacted] at 3:27 PM revealed "out on pass with family member." Further review of the [redacted] 2022 EMAR revealed a PO dated [redacted] for [redacted] (a medication used for [redacted] capsule [redacted] MG, [redacted]), give one capsule by mouth one time a day for [redacted] On 5/16/22 at 9 AM the [redacted] PO had an entry "[redacted]" for administration which corresponded to the chart code of "other/see nurses notes." A review of the nursing progress note dated [redacted] at 12:48 PM revealed that for [redacted] "resident's family member took resident prior to	F 755		

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medication administration."

On 9/16/22 at 9:55 AM, the surveyor interviewed the Consultant Pharmacist (CP) who stated that there have been issues with medications not being available. The CP stated that she recently had done an inservice and there were medications that were not available and was told by the nurses that there was an issue with the pharmacy delivering. The CP stated that the Director of Nursing (DON) was aware and that there may be an issue with the provider pharmacy. The CP added that she has told the nurses that they should check the back up supply first and if the medication was not there then call the pharmacy for a STAT (immediate) delivery and also to call the physician to make them aware if the time needed to be changed or follow up orders. The CP added that the nurses should not enter in the EMAR that a medication was not administered without documentation as to why and the follow-up from a physician.

On 9/16/22 at10:24 AM, the CP provided the surveyor with a Medication Pass Observation Worksheet dated [redacted] which she stated she had just completed yesterday and had an issue with medications not being available. The CP added that she uses this form when performing a medication administration observation and also to educate the nurses when she does inservices. The surveyor with the CP reviewed the worksheet which reflected criteria that was to be observed during the medication observation which included "Resident observed to ensure medication is swallowed," "Medications administered at correct time," and "No medications omitted."

On 9/19/22 at 11:25 AM, the surveyor was

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provided a list by the Director of Nursing (DON) regarding the dates and reasons for the above medications not being administered to Resident # 99. The list indicated that the #9 entered on the EMAR for the [redacted], and [redacted] was indicated in nursing notes that the resident was out on pass. In addition, the list indicated that [redacted] was discontinued on [redacted] started on [redacted] discontinued [redacted] and [redacted] started [redacted].

On 9/19/22 at 11:45 AM, the surveyor interviewed the LPN/UM who stated that the resident representative for Resident #99 usually came the same time every day and that the nurses were aware that the resident's medications were to be administered before leaving or upon return to the facility. The LPN/UM added that if the timing of the medication administration was going to be greater than one hour before or one hour after the time of administration noted on the EMAR then the physician was to be called for follow up instructions as to whether to administer the medication or hold it.

On 9/19/22 at 2:08 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON. The DON stated that when a resident goes out on pass the medications that were to be administered during that time should be worked out by nursing or the physician should be notified for follow up. The DON added that she thought the resident representative for Resident #99 was very involved and was well aware of the resident's medications and usually would have the resident back before medications were needed or had them administered before leaving. The DON was unable to speak to why the medications were not administered. In addition,

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the DON was unable to speak to the discrepancy of the [redacted] not being administered and would have to check further.

On 9/21/22 at 9:58 AM, the surveyor interviewed the CP who stated that she had done a medication observation inservice in [redacted] but was unable to find the sign in sheet for attendance. The CP added that she uses the Medication Pass Observation Worksheet as a guide for the inservice.

On 9/21/22 at 12:35 PM the survey team met with the LNHA and DON who both stated that they had nothing further to present for the medications not being administered.

A review of the facility policy dated as revised 12/2021 for "Administering medications" reflected that "Medications shall be administered in a safe and timely manner, and as prescribed." In addition, "Medications must be administered in accordance with the orders, including any required time frame."

2. On 9/13/22 at 11:10 AM, the surveyor observed Resident #121 who was [redacted] and [redacted] seated in a wheelchair watching television. The surveyor observed a medication cup on the resident's overbed table that contained two (2) pills. The surveyor interviewed the resident who stated that the two (2) medications in the cup were [redacted] (medication to treat [redacted]) and [redacted]r and that she/he was allowed to take it when they were ready.

On 9/13/22 at 11:20 AM, the surveyor showed the

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2 A unit Registered Nurse/Unit Manager (RN/UM) the medication cup that contained the two (2) pills. The RN/UM stated that no medication should have been left for the resident to take and that the medications should have been administered in the presence of a nurse. The RN/UM took the medication cup that contained the two pills and brought it back to the medication room to be destroyed in a drug disposal system. The RN/UM stated that the medication nurse was on break and would have to re-educate the nurse regarding the facility medication administration policy.

On 9/13/22 at 12:00 PM, the surveyor interviewed the the Licensed Practical Nurse (LPN#1) who was Resident #121's medication nurse. LPN #1 stated that medications should never be left with a resident unattended and that residents should only be administered their medications in the presence of a nurse. The LPN#1 stated that she administered the medications to Resident #121, but failed to make sure that the resident swallowed their pills. She stated that she would have to make sure that her residents swallowed their pills by asking them to open their mouth after she had given the resident their medications.

The surveyor reviewed the medical record for Resident #121.

The Admission Record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to [redacted] (a disorder that [redacted] (condition of [redacted] (long

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term [redacted]) and [redacted] disorder (disorder of [redacted]

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

A review of the interdisciplinary care plan revealed that there was no focus area that indicated that the resident could self-administer their medications.

A review of the Order Summary Report (OSR), dated [redacted], had not included a PO that the resident was able to self-administer medications. The OSR revealed a PO dated [redacted] for [redacted] milligram (MG) tablet to give one tablet in the morning for [redacted] and a PO dated [redacted] for [redacted] MG to give one tablet two times daily for [redacted]

A review of the [redacted] Electronic Medication Administration Record (EMAR) revealed a PO dated [redacted] for [redacted] MG tablet to give [redacted] tablet by mouth in the morning with an administration time of 9 AM. The administration time of 9 AM on 9/13/22 for the [redacted] was signed by the LPN as being administered.

In addition, the EMAR also revealed a PO dated [redacted] for [redacted] MG 1 tablet by mouth twice daily with administration times of 8 AM and 5 PM. The administration time of 8 AM on 9/13/22 for the [redacted] was signed by

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F 755	Continued From page 155 the LPN as being administered. On 9/15/22 at 2:00 PM, the survey team met with the LNHA, Chief Nursing Officer and DON and no further information was provided by the facility. On 9/16/22 at 9:55 AM, the surveyor interviewed the Consultant Pharmacist (CP) who stated that she would make recommendations that [redacted] be given at 8 AM with food and that nurses should be aware that medications should not be left at a resident's bedside, and this is part of her in-service when she does medication pass observations. On 9/16/22 at 10:24 AM, the CP provided the surveyor with a Medication Pass Observation Worksheet dated [redacted] which she stated she had just completed yesterday with another nurse. The CP added that she used this form when performing a medication administration observation and also to educate the nurses. The surveyor with the CP reviewed the worksheet which had criteria she used to evaluate the medication observation which included "Resident observed to ensure medication is swallowed." In addition, the worksheet indicated "Medications administered at correct time." On 9/21/22 at 9:58 AM, the surveyor interviewed the CP who stated that she had done a medication observation in-service in [redacted] but was unable to find the sign in sheet for attendance. The CP added that she used the Medication Pass Observation Worksheet as a guide for the inservice. The CP added that she does frequent medication observations for the facility and medications being left at the bedside was not allowed.	F 755		

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F 755	Continued From page 156 A review of the facility's policy for Administering Medications that was dated 12/21 and was provided by the DON indicated the following: "Policy Statement- Medications shall be administered in a safe and timely manner, and as prescribed." Under Policies Interpretation and Implementation. "3. Medications must be administered in accordance with the orders, including any required time frame." "24. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary Care planning team, has determined that they have the decision-making capacity to so safely." 3. On 8/31/22 at 10:43 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM). The RN/UM stated that "I am not sure" if the [redacted] unit had residents with [redacted] During an observation on 8/31/22 at 10:54 AM by the surveyor, the Certified Nursing Aide (CNA#2) was inside the resident's room with a privacy curtain in use while providing morning care. The surveyor observed the resident with an [redacted]. The surveyor reviewed the medical records of Resident #69.	F 755		

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F 755	Continued From page 157 The Admission Record (admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to [redacted] that affects all or part of the [redacted], and [redacted] and [redacted] (a [redacted] that causes [redacted] The [redacted] Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, indicated a brief interview for mental status (BIMS) score of [redacted], which reflected that the resident's [redacted] was intact. The Order Summary Report (OSR) for [redacted] included the following wound care orders: Start Date (SD) [redacted] Cleanse [redacted] apply [redacted] (an [redacted] alternating or every other day one time a day every two days. SD [redacted] (an [redacted] combination cream used on the skin) apply to [redacted] topically every day and evening shift for [redacted] care cleanse with [redacted] pat dry. SD [redacted] topically every day and evening shift for [redacted] cleanse [redacted] pat dry. SD [redacted] ointment (a [redacted] and [redacted] medicine) [redacted] apply to [redacted]) [redacted] topically every day and evening shift for a [redacted]. Apply following all care/incontinence opportunities PRN (as needed).	F 755		

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F 755	Continued From page 158 A review of the Progress Notes showed an [redacted]) Note signed by a Registered Nurse (RN) that indicated that the resident was seen for a weekly [redacted] visit by NP (Nurse Practitioner). The [redacted] Note reflected that there was a [redacted]) and [redacted] with an order of cleansing with [redacted] and applying [redacted] BID (twice a day). On 9/2/22 at 10:32 AM, the surveyor observed the resident laying in bed while watching television. The resident stated that the [redacted] on their [redacted] were getting better, the nurse does [redacted] care every day and there was no concern. On 9/9/22 at 11:05 AM, the surveyor observed the CNA#2 providing morning care to the resident with a privacy curtain in use. There was a quarter strength [redacted] milliliters (mls) bottle of [redacted] cleanser that is gentle to the skin) with approximately [redacted] mls left inside the bottle that was on top of the resident's nightstand. The CNA#2 stated that she did not know who left the bottle of [redacted] in the resident's room. There was no other resident at that time inside the room except for Resident #69. Then the CNA#2 called the nurse. On 9/9/22 at 11:22 AM, the surveyor interviewed the Licensed Practical Nurse (LPN#2). The LPN#2 stated that she was not sure who [redacted] inside the resident's room. The LPN#2 further stated that the medication should have been stored inside the treatment cart. On 9/9/22 at 11:41 AM, the surveyor interviewed	F 755		

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the RN/UM and made her aware of the above concern. The RN/UM stated that [redacted] should not be in the resident's room and should be stored inside the treatment cart. The surveyor asked the RN/UM if the resident had an order for [redacted] and the RN/UM stated that she will get back to the surveyor.

On 9/15/22 at 9:17 AM, the surveyor informed the DON of the above concern with [redacted] solution that was left in the resident's room and that the resident had no order for the medication. The DON stated that she will get back to the surveyor.

On 9/15/22 at 02:19 PM, the survey team met with the LNHA, Chief Nursing Officer, and DON and were made aware of the above concerns.

On 9/16/22 at 9:55 AM, the surveyor interviewed the Consultant Pharmacist (CP) who stated that the nurses should know that medications should not be left at a resident's bedside and that was part of her in-service when she does medication pass observations.

On 9/20/22 at 12:44 PM, the DON acknowledged that there was no order for [redacted] solution for Resident #69 and the medication should have been stored inside the treatment cart.

On 9/20/22 at 01:56 PM, the survey team met with the LNHA, DON, and Assistant Nursing Home Administrator. The facility administrative team had no additional information provided.

A review of the facility's Storage of Medications Policy that was provided by the LNHA with a reviewed/revised date of 1/2022 included "Policy Statement: The facility shall store all drugs and

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F 755	Continued From page 160 biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: ...2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner ...8. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents ...."	F 755		
F 758 SS=E	NJAC 8:39-11.2(b), 27.1(a), 29.2(d), 29.4(g)(h) Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758		10/26/22

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F 758	Continued From page 161 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to document non-drug interventions that were attempted and the need for an as needed [redacted] medication [redacted] to be administered according to documented behaviors from [redacted], [redacted]. The deficient practice was identified for one [redacted]) of five [redacted] residents (Resident #101) reviewed for unnecessary medications, and was evidenced by the following:	F 758	F758 - Free from Unnecessary [redacted] Meds/PRN Use Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. 1. What corrective action(s) will be	

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F 758	Continued From page 162 On 9/1/22 at 11:24 AM, the surveyor observed Resident #101 in a wheelchair in the Day Room. The resident waved the surveyor over to him/her. The resident stated that he/she wanted to get up and would then be able to walk out of the room. At that time, a Certified Nursing Aide (CNA) came over to the resident and asked if the resident would like to be taken somewhere else. On 9/1/22 at 11:26 AM, the CNA stated that the resident was confused and unable to stand on their own and often asked to be taken home. The CNA added that the resident had a behavior of [redacted] and does get [redacted] but was able to redirect the resident. On 9/2/22 at 11:12 AM, the surveyor observed Resident #101 in the Day Room sitting at a table with a group of other residents coloring a picture. On 9/9/22 at 12:48 PM, the surveyor observed Resident #101 in his/her room in bed with an already eaten lunch tray on the overbed table in front of the resident. The resident stated that lunch was good. The resident was pleasant but was unable to answer any other questions because the resident had [redacted] expressed. On 9/13/22 at 11:26 AM, the surveyor interviewed the Licensed Practical Nursing (LPN#1) who stated that she was familiar with Resident #101. The LPN#1 stated that she had not administered any as needed (PRN) [redacted] medication for behaviors but thought the resident had a current physician's order because the resident's [redacted] had passed away recently the beginning of	F 758	accomplished for those residents found to have been affected by the practice: -Resident #101's PRN [redacted] medication was reviewed as appropriate, interventions were identified as appropriate, and additional data cannot be retroactively collected and examined due to the passage of time. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: -By 10/26/2022 all residents with PRN [redacted] medications were identified. -Behavioral monitoring in Electronic Medical Record will be added to provide an option for supplemental documentation to chart specific interventions attempted before utilizing PRN [redacted] medication. 3. What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur: -By 10/26/2022, the Director of Nursing/designee will re-educate the licensed nursing staff on the components of F758 Free of unnecessary [redacted] medications with emphasis on ensuring residents with an order for PRN [redacted] medications, have been provided non-pharmacological interventions before using a PRN [redacted] medication, and	

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F 758	Continued From page 163 [redacted]. The LPN#1 added that the resident usually had no behaviors requiring a PRN medication but does need a lot of explanation as to what was happening. The LPN#1 explained that today the resident had to have blood drawn and was nervous so she had stayed with the resident to keep him/her calm. The LPN#1 also explained that she would have to write a progress note if the resident was having behaviors to explain what the behaviors were and what had happened and in the behavior monitoring section on the electronic medication administration record (EMAR) she would indicate a number of how many times the resident had the identified behaviors during her shift. The LPN#1 added that she would document the behaviors in progress notes whether she administered a PRN medication or not. The LPN#1 also stated that the facility had a [redacted] Nurse Practitioner who came to the facility and reviewed the behavior notes to assess how the residents were doing. On 9/13/22 at 12:09 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that the facility had a Psychiatric group who came in on a regular basis to review all residents on a [redacted] medication. The LPN/UM added that the group reviewed the behavior monitoring and asked the nurses how the resident was doing. The LPN/UM stated that there were no monthly summaries regarding the resident's behaviors or to indicate the number of times a PRN [redacted] medication was used. The LPN/UM added that the EMAR had the behaviors described and did not think the nurses had to write progress notes when the behaviors occurred. The LPN/UM also stated that if the physician's order (PO) indicated to administer when the resident had [redacted], she	F 758	interventions provided are documented. -Newly hired licensed nurses will receive education during orientation. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: -The Director of Nursing /designee will conduct a weekly random audit of 5 resident records x 4 weeks and then every month x 2 months to ensure residents with an order for PRN [redacted] medications have been provided non-pharmacological interventions before using a PRN [redacted] medication, and interventions provided are documented utilizing the behavioral monitoring / supplemental documentation option in the Electronic Medical Record. -The findings of these audits will be reported to the QAPI meeting monthly x 3 months.	

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did not think the nurses would have to describe what the [redacted] behaviors were in the progress notes because the PO indicated [redacted]

On 9/15/22 at 2:19 PM, the surveyor team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON) and Chief Nursing Officer (CNO). The DON stated that for behavior monitoring charting in the EMAR a "Y" meant that the resident was monitored for a behavior and an "N" meant that a behavior was observed and would expect to see a progress note describing the behavior. The DON could not speak to why numbers were entered for behavior monitoring. The CNO stated that she would expect to see a progress note if there were behaviors. In addition, the LNHA stated that if a PRN [redacted] medication was used for a behavior, then there should be a progress note explaining.

The surveyor reviewed the medical record for Resident #101.

A review of the resident's Admission Record revealed diagnoses which included [redacted].

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

A review of Individual Patient's Controlled Drug Record (IPCDR) for [redacted] milligram (MG)

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tablets dated as received [redacted] revealed that one tablet of [redacted] had been removed from inventory on the following dates and times and was administered to Resident #101 by the following nurses:
-on 4/22/22 at 10:14 AM by LPN #2.
-on 4/23/22 at 6:18 PM by RN#2.
-on 5/5/22 at 9 PM by LPN#3.
-on 6/29/22 at 8 PM by RN#1.
-on 7/2/22 at 9 AM by RN#1.
-on 7/2/22 at 8 PM by RN#1.
-on 7/3/22 at 10 AM by RN#1.
-on 7/3/22 at 7 PM by RN#1.

A review of the [redacted] EMAR had a PO dated [redacted], for [redacted] milligram (MG), give one tablet by mouth every [redacted] hours as needed (PRN) for [redacted]. The PO had a discontinue date of [redacted]. In addition, there was the [redacted] administration documentation that corresponded with the IPCDR for the dates of 4/22, 4/23 and 5/5.

A review of the corresponding nursing progress notes for the [redacted] dates of the [redacted] administration on the IPCDR revealed the following:

-on 4/22/22 at 10:49 AM LPN#2 indicated an administration note '[redacted] tablet [redacted] MG, give one tablet by mouth every [redacted] hours as needed for [redacted]
- on 4/22/22 at 3:28 PM LPN#2 indicated an administration note [redacted] tablet [redacted] MG, give one tablet by mouth every [redacted] hours as needed for [redacted]. PRN administration was: Effective."

-on 4/23/22 at 6:25 PM RN #2 indicated an administration note [redacted] tablet [redacted] MG, give

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F 758	Continued From page 166 one tablet by mouth every [redacted] hours as needed for anxiety, given at 6:25 PM for [redacted] - on 4/23/22 at 7:53 PM RN #2 indicated an administration note [redacted] tablet [redacted] MG, give one tablet by mouth every [redacted] hours as needed for [redacted], given at 6:25 PM for [redacted]. PRN administration was: Effective" -on 5/5/22 at 5:39 PM by LPN#3 indicated an administration note "Behaviors-monitoring for the following (specify) [redacted], [redacted]. Every shift for monitoring document "Y" if any of the above observed, specify behavior in progress notes. Document "N" if no behaviors observed, [redacted] and increase in [redacted] -on 5/5/22 at 8:53 PM by LPN#3 indicated an administration note "[redacted] tablet [redacted] MG, give one tablet by mouth every [redacted] hours as needed for [redacted] -On 5/5/22 at 9:30 PM by LPN#3 indicated an administration note [redacted] tablet [redacted] MG, give one tablet by mouth every [redacted] hours as needed for [redacted]. PRN administration was: Effective." A review of the [redacted] EMAR had a PO dated [redacted] for "[redacted] MG, give one tablet by mouth every [redacted] hours PRN for [redacted] for 14 days." In addition, there was the [redacted] administration documentation that corresponded with the IPCDR for the dates of 6/29, 7/2 and 7/3. A review of the corresponding nursing progress notes for the [redacted] dates of the [redacted] administration on the IPCDR revealed the following:	F 758		

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F 758	Continued From page 167 -on 6/29/22 at 6:00 PM by RN#1 indicated an administration note "[redacted] tablet [redacted] MG, give one tablet by mouth every [redacted] hours as needed for [redacted] for 14 days." - on 6/29/22 at 6:39 PM by RN#1 indicated an administration note "[redacted] tablet [redacted] MG, give one tablet by mouth every [redacted] hours as needed for [redacted] for 14 days. PRN administration was: Effective." -on 7/2/22 at 8:44 AM by RN#1 indicated an administration note "[redacted] tablet [redacted] MG, give one tablet by mouth every [redacted] hours as needed for [redacted] for 14 days." - on 7/2/22 at 11:26 AM by RN#1 indicated an administration note "[redacted] tablet [redacted] MG, give one tablet by mouth every [redacted] hours as needed for [redacted] PRN administration was: Effective." -on 7/2/22 at 5:38 PM by RN#1 indicated an administration note [redacted] tablet [redacted] MG, give one tablet by mouth every [redacted] hours as needed for [redacted] for 14 days." - on 7/2/22 at 6:35 PM by RN#1 indicated an administration note [redacted] tablet [redacted] MG, give one tablet by mouth every [redacted] hours as needed for [redacted] for 14 days. PRN administration was: Effective." -on 7/3/22 at 10:11 AM by RN#1 indicated an administration note [redacted] tablet [redacted] MG, give one tablet by mouth every [redacted] hours as needed for [redacted] for 14 days." - on 7/3/22 at 11:04 AM by RN#1 there were two entries that indicated an administration note "Was a behavior observed: YES." - on 7/3/22 at 11:05 AM by RN#1 indicated an	F 758		

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F 758	Continued From page 168 administration note [redacted] tablet [redacted] MG, give one tablet by mouth every [redacted] hours as needed for [redacted] for 14 days. PRN administration was: Effective." -on 7/3/22 at 6:18 PM by RN#1 indicated an administration note [redacted] tablet [redacted] MG, give one tablet by mouth every [redacted] hours as needed for [redacted] for 14 days." - on 7/3/22 at 6:18 PM by RN#1 9:15 PM indicated an administration note [redacted] tablet [redacted] MG, give one tablet by mouth every [redacted] hours as needed for [redacted] for 14 days. PRN administration was: Effective." A review of the [redacted] EMAR's revealed a behavior monitoring entry dated [redacted] with a discontinue date of [redacted] for "Behaviors-Monitor for the following: [redacted], [redacted] Every shift for monitoring document "Y" if any of the above observed, specify behavior in progress notes. Document "N" if no behaviors observed." The following entries were noted on the corresponding dates of PRN [redacted] administration: -for 4/22/22 and 4/23/22 there was zero "0" entered for the day, evening and night shifts. -for 5/5/22 there was zero "0" entered for the day, evening and night shifts. A review of the [redacted] EMAR's revealed a behavior monitoring entry dated 6/17/22 for "Behaviors-Monitor for the following:	F 758		

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F 758	Continued From page 169 [redacted]. Every shift for monitoring document "Y" if any of the above observed, specify behavior in progress notes. Document "N" if no behaviors observed." The following entries were noted on the corresponding dates of PRN [redacted] administration: -for 6/29/22 there was [redacted] entered for the day, evening and night shifts. - for 7/2/22 there was [redacted]" entered for the day, evening and night shifts. -for 7/3/22 there was [redacted]" entered for the day shift, [redacted]" entered for the evening shift and zero "[redacted] entered for the night shift. There was no progress note indicating as to which behaviors were exhibited on 7/3/22 with the entry [redacted] for the day sift. On 9/16/22 at 9:55 AM, the surveyor interviewed the Consultant Pharmacist (CP) who stated that the facility had a [redacted] group that came to the facility frequently and reviewed all the [redacted] medications and has seen that they do gradual dosage reductions and had diagnoses which warranted the use of the [redacted] medications. The CP added that the EMAR had the behaviors that were being monitored and those were decided upon by nursing. The CP stated that if a resident had behaviors during a nurses shift then there would be a number in the behavior monitoring on the EMAR and a corresponding progress note describing the	F 758		

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behaviors. The CP was unsure if a progress note was needed for the use of a PRN [redacted] for [redacted]. The CP added that if a PRN [redacted] was administered then the EMAR behavior monitoring should correspond for that day and time. The CP also stated that non-drug interventions should be attempted before administering the PRN [redacted] medication and thought that would be in the progress notes. The surveyor reviewed with the CP the PRN [redacted] for Resident #101 and the CP stated that she would have to review further.

On 9/19/22 at 9:36 AM, the surveyor interviewed the Registered Nurse (RN #1) via telephone who stated that she worked as an agency nurse per diem (when needed) approximately two days a week at the facility and was familiar with Resident #101. The RN#1 stated that she had administered PRN [redacted] to the resident. The RN#1 stated that the resident had anxiety and would fight with his/her spouse who resided in the facility. The RN#1 added that the resident would yell and want someone to stay with them all the time and would request to go home frequently. The RN#1 stated that there should be a progress note describing the resident's behavior and thought that maybe she missed writing the progress note. The RN#1 stated that there was a lot happening and working at the facility was very busy and may not have completed a progress note. The RN#1 stated that she had tried non-drug interventions such as distracting the resident, offering a snack, reassuring the resident and talking calmly. The RN#1 added that she would document the number of behaviors in the EMAR and that should correlate with the PRN Ativan that was administered.

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F 758	Continued From page 171 On 9/19/22 at 1:38 PM, the surveyor interviewed the LPN#2 who stated that she had administered [redacted] on 4/22/22, because the resident was [redacted] over being administered a [redacted] The LPN#2 stated that the resident had not received a [redacted] on 4/22/22, because there was a problem, and the [redacted] was done on [redacted] The LPN#2 stated that she had not written a progress note because the [redacted] was to calm the resident for a [redacted] and had not thought she needed to write a progress note. On 9/19/22 at 2:08 PM, the survey team met with the LNHA and DON. The DON acknowledged that the behavior monitoring was inconsistent, and the documentation had not correlated with the use of PRN [redacted]. The DON stated that she had no further information for the use of the PRN [redacted] The DON added that the use of a PRN medication should have a progress note that would indicate the need for use and if the medication was being used for behaviors, then the behavior monitoring should also correlate with the administration of the medication. On 9/20/22 at 11:49 AM, the surveyor interviewed the RN#2 via the telephone who stated that she had administered the PRN [redacted] to Resident #101 on 4/23/22. The RN#2 stated that she was told by the technician who was going to be doing the [redacted] to administer the [redacted] because the resident was [redacted] The RN#2 stated that she thought she had written a progress note and that the resident was always [redacted]. The RN#2 added that she had to stay with the resident during the [redacted] to keep the resident [redacted]. The RN#2 stated that she thought that she had written a	F 758		

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progress note.

On 9/20/22 at 12:24 PM, the surveyor interviewed LPN#3 who stated that she had administered the PRN [redacted] on 5/5/22. The LPN#3 stated that the resident was frequently [redacted] with his/her [redacted]. The LPN#3 also stated that she was an agency nurse and would ask other staff who were familiar with the resident before administering a PRN medication. The LPN#3 added that she tried to change the resident's environment, offered a snack and tried to distract the resident before administering a medication. The LPN#3 stated that she documented the occurrence in the [redacted] communication log which does not remain for more than 2 days. The LPN#3 could not speak to documentation in the progress notes.

On 9/21/22 at 9:58 AM, the CP stated that she was unable to speak to the process of behavior monitoring and documentation because that was the responsibility of the CNO. The CP added that she had not done any in services on behavior monitoring or documentation since she was not involved in that process.

A review of the facility policy Behavior Assessment, Intervention and Monitoring dated as revised 1/2022 provided by the DON reflected that the "General Guidelines" included "1. Behavior is the response of the individual to a wide variety of factors. These factors may include medical, physical, functional, psychosocial, emotional, psychiatric or environmental causes. 2. Behavior is regulated by the brain and is influenced by past experiences , personality traits, environment, and interactions with other people. Behavior can be a way for an individual in

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F 758	Continued From page 173 distress to communicate unmet needs, indicate discomfort, or express thoughts that cannot be articulated. 4. Appropriate assessment and treatment of behavioral symptoms requires differentiating between behavioral symptoms that can be managed by treating underlying factors, and those that cannot. 5. Current guidelines recommend the use of non-pharmacological interventions for behavioral or psychological symptoms of dementia." In addition, for "Monitoring" the policy reflected that "If the resident is being treated for altered behavior or mood, any improvements or worsening in the individual's behavior, mood, function will be documented in the clinical record." In addition, "The IDT will monitor the progress of individuals with impaired cognition and behavior until stable. New or emergent symptoms will be documented and reported." NJAC 8:39-27.1(a), 29.2 (d)	F 758		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F 842		10/26/22

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that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-

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F 842	Continued From page 175 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to maintain complete and readily accessible medical records. This deficient practice was identified for [redacted] residents, (Resident #159 and Resident #177), and was evidenced by the following: 1. On 9/13/22 at 11:00 AM, the surveyor reviewed Resident #159 physician progress notes in the electronic medical record (EMR). In review of the physician notes the surveyor noted that all the resident's progress notes were written by an Advanced Practice Nurse (APN). The surveyor could not locate any notes written by the attending physician within the medical record. The surveyor then asked the Director of Nursing (DON) to provide all the resident's physician progress notes for [redacted]. The surveyor reviewed the admission Minimum Data Set (MDS), an assessment tool dated [redacted]. Medical diagnoses included [redacted], a condition involving [redacted] and [redacted] which sometimes requires [redacted]),	F 842	F842 Medical Records Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Resident #159 was identified and no longer resides in the facility. By 10/15/2022 Resident #177 was seen and examined by the attending physician. Medical record was updated. By 10/15/2002, the facility attending physicians assigned to Resident #159 and Resident #177 were reeducated by the Medical Director on the components of this regulation with an emphasis on	

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F 842	Continued From page 176 [redacted]). Review of the Brief Interview of Mental Status (BIMS) indicated the resident had a BIMS of [redacted] which indicated the resident was [redacted] Review of section [redacted] showed the resident had a functional status of 2-person assist for transfer and toileting and a one-person assist for dressing eating and hygiene On 9/15/22 at 11:15 AM, the surveyor reviewed the resident's progress notes for [redacted]. Resident #159 was admitted to the facility on [redacted], the first progress note was the admission note dated [redacted] written by the APN. The resident had physician progress notes for 14 more visits in [redacted] and all visits were submitted by the APN. Review of the [redacted] progress notes showed that the resident was seen [redacted] times in [redacted] and all notes were submitted by the APN. The surveyor could not locate any progress notes completed by the attending physician. On 09/19/22 at 1:30 PM, surveyor placed calls to the attending physician and the APN. On 09/19/22 at 2:15 PM, the surveyor asked the DON if the attending physician of Resident #159 provided documentation of visits to the facility for the months of [redacted] and the DON stated "I have a call out to the doctor." On 09/19/22 at 3:05 PM, the surveyor received a call back from the attending physician for Resident #159 regarding visits and documentation of progress notes. The physician told the surveyor he saw the patient and had the documentation and was going to put it in the (EMR) but was "not a good typist." The physician had not given the surveyor an exact date of when	F 842	maintaining complete and readily accessible medical records as it relates to physician visits. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: By 10/26/2022, the Director of Nursing/designee will conduct a review of 10 random resident records to ensure: a. Attending physicians have documentation within the medical record to support frequency of visits. b. Physician documentation is complete and readily accessible within the medical record. Issues or concerns will be addressed as they are identified. 3. What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur: By 10/26/2022, the Administrator/designee will re-educate the Medical Director on the components of this regulation with an emphasis on maintaining complete and readily accessible medical records as it relates to physician visits. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance	

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F 842	Continued From page 177 he last rounded in the facility to see his residents. On 09/20/22 at 2:30 PM, the DON was asked if any progress notes from the attending physician were received by the facility, and the DON said she needed to place another call out to the physician. 2. On 9/1/22 at 10:50 AM., the surveyor observed Resident #177 in his/her room out of bed and sitting on his/her wheelchair, [redacted], and appropriately responded to the surveyor's inquiry. A review of the Admission Record (an admission summary) revealed that Resident #177 was admitted to the facility on [redacted], with diagnoses that included but not limited to [redacted]. A review of the Admission MDS with an Assessment Reference Date (ARD) of [redacted] reflected that the resident had a BIMS score of [redacted] out of [redacted], which indicated that the resident was [redacted]. A review of Resident #177's hybrid (paper and electronic) medical records reflected no available progress notes from the attending physician. The EMR reflected "Physician's Progress Notes" all written by the APN. On 9/14/22 at 9:45 a.m., the surveyor asked the DON to provide all the resident's physician	F 842	program will be put into place: The Director of Nursing/designee will conduct a weekly review of 5 residents X 4 weeks and then every month x 2 months to ensure: c. Attending physicians have documentation within the medical record to support frequency of visits d. Physician documentation is complete and readily accessible within the medical record Findings of these reviews will be presented at the monthly QAPI meeting 90 days.	

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F 842	Continued From page 178 progress notes for [redacted] through the most current in [redacted]. On 9/15/22 at 9:35 a.m., the surveyor interviewed the DON regarding Resident #177's physician visits and documentation. The DON was informed that the surveyor could not find the attending physician's notes in the resident's hybrid medical records. During the interview, the surveyor reviewed the electronic "Physician's Progress Notes" with the DON. The DON acknowledged that there was no documentation written by the resident's attending physician. She further acknowledged that the attending physician's progress notes should be readily accessible in the resident's medical records. On the same day at 2:19 p.m., the survey team met with the LNHA, DON, and the Chief Nursing officer and they were made aware of the above concerns. There was no additional information provided. On 9/19/22 at 3:05 p.m., the surveyor interviewed Resident #177's attending physician regarding his resident visits and documentation records. The primary physician stated that he saw Resident #177 and had the progress notes in his possession. He further stated that he was going to put his documentation in the resident's electronic medical record but was "not a good typist." During an interview with the DON on 9/20/22 at 9:54 AM, she stated that she had not received the progress notes from the resident's attending physician. The surveyor asked the DON who was	F 842		

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F 842	Continued From page 179 responsible for overseeing to ensure that the physicians were documenting on the resident's medical records. The DON stated that she did not know but she would "double check who's responsible." On 9/21/22 at 12:36 p.m., the Licensed Nursing Home Administrator (LNHA) and DON met with the survey team. The DON was asked if the facility received progress notes from the attending physician. The DON stated that they have not received progress notes from him. There was no additional information provided by the facility. A review of the facility policies titled "Physician Visits" and regarding the protection of all the facility's medical records. However, both did not speak of medical records accessibility.	F 842		
F 880 SS=D	NJAC 8:39-35.2 (d)(5), (g) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		10/26/22

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	315303	A. BUILDING _____ B. WING _____	C 09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

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F 880	Continued From page 180	F 880		

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents

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F 880	Continued From page 181 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a.) ensure that appropriate hand hygiene was performed by 2 of 13 staff observed during dining and [redacted] care observation, and b.) disinfect the table for 1 of 2 staff observed for [redacted] treatment in accordance with the Centers for Disease Control and Prevention (CDC) guidelines for infection control and facility policies. This deficient practice was evidenced by the following: According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers for Hand Hygiene and COVID-19, page last reviewed 1/8/2021 included, "..When to Perform Hand Hygiene? Multiple opportunities for hand hygiene may occur during a single care episode. Following are the clinical indications for hand hygiene: Use an Alcohol-Based Hand Sanitizer: Immediately before touching a patient...Hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom. Immediately after glove	F 880	F880 – Infection Control Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: -On 9/16/2022, CNA#1 and LPN were verbally re-educated on infection control practices with emphasis on hand hygiene as the primary mean to prevent the spread of infection. On 9/16/2022, LPN was re-educated and completed a hand washing competency on the [redacted] care policy with emphasis on providing a clean field before rendering treatment.	

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F 880	Continued From page 182 removal....." 1. On 9/9/22 at 12:29 PM, the surveyor observed that there were 8 (eight) residents and one Certified Nursing Aide#1 (CNA#1) inside the 2 A dining area. The CNA#1 provided a plastic bib (an item of clothing tied around the neck to protect clothes from getting dirty when eating) to four out of eight residents. The CNA#1 had direct contact with four residents while applying the bib and then immediately donned (applied) a new pair of gloves without performing hand hygiene. On that same date and time, CNA#1 used the hand wipes to help Resident#162 in performing hand hygiene by holding the resident's both hands and wiping back and forth, discarded the used hand wipes to the plastic cup that the CNA#1 was also holding on her right hand, then immediately went to Resident#804 without removing the used gloves and without performing hand hygiene in between residents, used another piece of hand wipes to help the resident perform hand hygiene by directly touching the resident's both hands. When the CNA#1 was about to do the same thing to Resident #231, the surveyor called the attention of the CNA#1 to the side while two other staff entered the 2 A dining room. At that time, the surveyor interviewed CNA#1 about hand hygiene. The CNA#1 informed the surveyor that hand hygiene should be performed before and after direct contact with the residents, before and after applying gloves and PPE (personal protective equipment). Then the surveyor asked the CNA#1 if she had direct contact with the residents in the dining area and what she should have done at that time. The CNA#1 stated, "yes, and I should have performed	F 880	On 09/16/2022 the Infection Preventionist and Director of Nursing completed an observational audit of facility staff members washing their hands to ensure proper hand hygiene techniques are being performed and to identify other residents having the potential to be affected. On 9/16/2022 the Infection Preventionist and Director of Nursing reviewed [redacted] care competency to ensure proper clean techniques were being performed with emphasis on utilizing a clean field before rendering treatment and maintaining appropriate infection control. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: -All residents' have the potential to be affected by this deficient practice. -Hand washing competencies will be completed for nursing staff annually and periodically as needed. -Wound care competencies will be completed on monthly basis for 1 nurse per unit per month. 3. What measures will be put into place or what systemic changes will make to ensure that the practice does not recur: -By 10/26/2022 Director of Nursing / Designee will educate the nursing staff on the components of this regulation with	

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F 880	Continued From page 183 hand hygiene before putting on my gloves." Afterward, the surveyor asked the CNA#1 if she did change her gloves in between direct contact with the residents and if should she perform hand hygiene between direct contact with Residents#162 and #804. The CNA#1 responded "no," and that she stated that should have removed the used gloves, performed handwashing, and applied a new pair of gloves before going to the next resident. Furthermore, the surveyor asked CNA#1 why she did not perform hand hygiene, and the CNA#1 had no answer. The CNA#1 indicated that she's been working in the facility for two and half years and was educated about hand hygiene by the Infection Preventionist Nurse (IPN). 2. During an observation on 8/31/22 at 10:54 AM by the surveyor, CNA#2 was inside the resident's room while providing morning care to the resident. The surveyor reviewed the medical records of Resident #69. The Admission Record (admission summary) reflected that the resident was admitted to the facility with diagnoses that included [redacted]) The Quarterly Minimum Data Set (QMDS) ARD [redacted], an assessment tool used to facilitate the management of care, indicated a Brief Interview for Mental Status (BIMS) score of [redacted],	F 880	emphasis on performing proper hand hygiene as it pertains to infection control and universal precautions. -By 10/26/2022 Director of Nursing / designee will re-educate the licensed nursing staff on the components of this regulation with emphasis on maintaining a clean field when performing [redacted] care as it pertains to infection control. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, i.e., what quality assurance program will be put into place. - Director of Nursing/ designee will conduct an observational audit of 5 staff members 1 x weekly x 4 weeks then monthly x 2 months of facility staff to ensure infection control techniques are maintained with emphasis on appropriate hand hygiene and providing a clean field when performed wound care. -Findings of these audits will be reviewed in the QAPI meetings monthly x 90 days	

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F 880	Continued From page 184 which reflected that the resident's [redacted] was [redacted] The Order Summary Report (OSR) for [redacted] included the following wound care orders: - Start Date (SD) [redacted] Cleanse [redacted] with [redacted]) apply [redacted] (an [redacted] used to [redacted]) [redacted]) alternating or every other day one time a day every two days. - SD [redacted] (is a prescription medication used on the [redacted] apply to [redacted] topically every day and evening shift for [redacted] care cleanse with [redacted] pat dry. - SD [redacted] apply to [redacted] topically every day and evening shift for [redacted] cleanse [redacted], pat dry. - SD [redacted] ointment ([redacted] and preventative medicine) [redacted] apply to [redacted] [redacted] topically every day and evening shift for a [redacted] condition. Apply following all care/incontinence opportunities PRN (as needed). A review of the Progress Notes showed an [redacted] Note signed by a Registered Nurse (RN) that indicated that the resident was seen for a weekly [redacted] visit by NP (Nurse Practitioner). The [redacted] Note reflected that there was a [redacted] ([redacted]) and [redacted] with an order of cleansing with [redacted] and applying [redacted] BID (twice a day). On 9/2/22 at 10:32 AM, the surveyor observed the resident laying in bed while watching television. The resident stated that the [redacted] on	F 880		

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F 880	Continued From page 185 their [redacted] were getting better, the nurse does [redacted] care every day and there was no concern. On 9/9/22 at 11:22 AM, the surveyor observed CNA#2 and Licensed Practical Nurse (LPN) during [redacted] treatment observation. The side table that was used for [redacted] care was not disinfected as evidenced by a white spot and a liquid on some part of the table with no barrier used when the [redacted] protectant container, a box of gloves, a tube of [redacted] dressing were found on top of the table. There were also resident's personal belongings on top of the table which included drinking cups and papers. On that same date and time, the surveyor observed the LPN removing gloves and performing handwashing for 11 seconds after the wound care treatment. The LPN informed the surveyor that handwashing and scrubbing hands should be at least 20 seconds. The surveyor asked the LPN if she washed her hands for 20 seconds and the LPN stated, "I think so," then the surveyor told the LPN that the surveyor observed the LPN scrubbing her hands for 11 seconds and the LPN responded, "Oh, I am sorry." Furthermore, during an interview with the surveyor, the LPN stated that she did not disinfect the table "because I know it was being clean in the morning." Afterward, the LPN further stated that she should have disinfected the table before putting the supplies. On 9/9/22 at 11:41 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) regarding the above concern. The RN/UM stated that the LPN should have washed her hands for	F 880		

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F 880	Continued From page 186 20 seconds and that she was educated by the IPN on hand hygiene. On 9/15/22 at 11:53 AM, the surveyor interviewed and asked the IPN who is responsible for hand hygiene, PPE, and [redacted] treatment competencies in the facility. The IPN stated that she was responsible for hand hygiene and PPE competencies. She further stated that "I think it was the Unit Manager who's responsible for the [redacted] treatment competency, but I will get back to you with that." At that time, the surveyor asked the IPN about the wound treatment process and hand hygiene. The IPN informed the surveyor that the staff should use the [redacted] (disinfecting wipes) in wiping the table before setting up "we want to make sure that nothing on the table come in to contact dirty area," that it was a nonsterile procedure "but want to maintain as clean as possible." She further stated that handwashing should be scrubbing for 20 seconds. The IPN indicated that when staff had direct contact with residents, staff should change gloves and perform hand hygiene. On that same date and time, the surveyor informed the IPN of the above concerns with CNA#1 and the LPN. The IPN acknowledged that the LPN should have washed her hands for 20 seconds, must disinfect the table before use, and should have followed the facility policy about putting a liner on top of a clean table before placing the [redacted] care products and supplies. She further stated that CNA#1 should have changed gloves and performed hand hygiene in direct contact with a resident in the dining area. The IPN stated that she will re-educate the LPN	F 880		

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F 880	Continued From page 187	F 880		

and CNA#1.

On 9/15/22 at 02:19 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Corporate Chief Nurse, and the Director of Nursing (DON) and discussed the above concerns.

On 9/20/22 at 12:44 PM, the DON informed the surveyor that there was no negative effect on the resident's buttocks.

A review of the facility's Handwashing/Hand Hygiene Policy that was provided by the DON with a reviewed/revised date of 8/2022 included "Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation:....7. Use an alcohol-based hand rub containing at least 62% alcohol; or , alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:...b. Before and after direct contact with residents;....i. After contact with with a resident's intact skin;...Washing Hands 1. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under a moderate stream of running water, at a comfortable temperature..."

A review of the [redacted] Care policy that was provided by the DON with a reviewed/revised date of 12/2021 included "Purpose: The purpose of this procedure is to provide guidelines for the care of [redacted] to promote healing ....Steps in the Procedure: 1. Use disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table. Place all items to be used during procedure on the clean field ....."

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F 880	Continued From page 188 On 9/20/22 at 01:56 PM, the survey team met with the LNHA, DON, and Assistant Nursing Home Administrator and there was no additional information from the facility. NJAC: 8:39-19.4(a)(b)(l)(n)	F 880		

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	061411	A. BUILDING: _____ B. WING _____	C 09/21/2022

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and a review of pertinent facility documentation, it was determined that the facility failed to a.) maintain the required minimum direct care staff to resident ratios for 3 of 14-day shifts as mandated by the state of New Jersey and b.) ensure that the Infection Preventionist who was assigned to oversee the infection prevention and control program met the requirement that the facility designates a full-time employee in the infection control prevention role with no other responsibilities as mandated by the State of New Jersey. This deficient practice was identified and the findings were as follows: Reference: New Jersey Department of Health (DOH) memo, dated 01/28/2021, "Compliance	S 560	S560 Mandatory Access to Care Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: -There was no negative outcome to residents the shifts identified as not meeting the NJ staffing requirements during the 8/14/22 on the day shift,	10/26/22

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

Electronically Signed | 10/16/22

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S 560	Continued From page 1 with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. A review of the "Nursing Staffing Report" completed by the facility for the weeks of 8/14/22 through 8/20/22 and 8/21/22 through 8/27/22, revealed the staffing to residents ratio did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below: - 8/14/22 had 22 CNAs for 249 residents on the day shift, required 31 CNAs. - 8/21/22 had 27 CNAs for 247 residents on the day shift, required 31 CNAs. - 8/22/22 had 30 CNAs for 247 residents on the day shift, required 31 CNAs.	S 560	8/21/22 on the day shift, and 8/22/22 on the day shift. 10/13/2022, the facility Staffing Coordinator was reeducated by the Licensed Nursing Home Administrator (LNHA) on the components of this regulation with an emphasis on CNA to resident ratios. 10/14/2022, the facility Infection Preventionist was reeducated on the job role of overseeing the infection prevention and control program with no other responsibilities. 10/14/2022, Administrator re-assigned staff education to be divided between staff in roles such as Administrators, Department Directors, Managers, Supervisors, or designees. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: -All residents have potential to be affected by this deficient practice. 3. What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur: -To increase CNA staffing: Jobs posted on internet job boards and purchase the add to be elevated, professional recruiters are actively recruiting, provide incentive bonuses for staff who refer CNA's, contacted local schools to recruit new	

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S 560	Continued From page 2 On 9/19/22 at 10:08 AM, the surveyor interviewed the Staffing Coordinator (SC) who acknowledged the new minimum staffing requirements for nursing homes. The SC stated "we are meeting the ratios unless there are call outs. I do what I can regarding someone not coming in. I contact agencies." Review of the facility's "Staffing" policy reviewed/revised 1/2022, and provided by the Licensed Nursing Home Administrator, indicated "Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with regulations, resident care plans and the facility assessment...Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services, staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care, direct care staffing information per day (including agency and contract staff) is submitted to the CMS payroll-based journal system on the schedule specified by CMS, but no less than once a quarter." There was no additional information provided. 2. On 8/31/22 at 10:09 AM, during the entrance conference, the Director of Nursing (DON) stated that the Infection Preventionist Nurse (IPN) was employed full time which was 40 hours per week. DON further stated that the IPN is also the Staff Development And Employee Health Coordinator. The Regional Registered Nurse (RRN) provided a Certified in Associate-Infection Prevention and Control (a-IPC) certification of the IPN that was	S 560	graduates, schedule job fair, utilize agency staff, pay for transportation, contracted bus company to assist with transportation. -Staff education unrelated to the Infection Prevention category will be divided between staff in roles such as Administrators, Department Directors, Assistant Directors, Managers, Supervisors, or designees. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: -The Licensed Nursing Home Administrator/designee will conduct an audit 2 x weekly for 4 weeks and then 2 x monthly x2 months of the staffing schedule. -The findings of these audits will be reported to the monthly QAPI meeting x 3 months. -The Administrator/designee will review staff education the facility QAPI meeting x 3 months to ensure the full time Infection Preventionist is dedicated to the role as stated and supporting disciplines are implementing other required education to new and existing staff. -The findings of these audits will be reported to the monthly QAPI meeting x 3 months.	

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S 560	Continued From page 3 issued on 5/20/22 and will expire on 5/31/25. The RRN also provided the IPN's completed Certificates of Training for modules from the Nursing Home Infection Preventionist Training Course dated 11/25/21. A review of the Position Title: Infection Preventionist that was provided by the IPN included a Job Summary and Non-essential Functions that was signed by the IPN on 10/25/21. The Non-Essential Functions indicated performing other duties as assigned. On 9/02/22 at 12:07 PM, the surveyor interviewed the IPN who stated that her job description included staff development, employee health, and infection control. The IPN explained that staff development included educating all staff on mandatory in-services such as blood-borne pathogens, abuse, and resident rights. The IPN further explained that employee health included keeping track of new hire physicals and orientation. In addition, the IPN stated that IPN was the infection control person for the facility. The IPN acknowledged that IPN had additional responsibilities other than infection control. On that same date and time, the surveyor asked the IPN if the facility complied with the state regulation specific to the Infection Preventionist who was assigned to oversee the infection prevention and control program must meet the requirement that the facility designates a full-time employee in the infection control prevention role with no other responsibilities as mandated by the State of New Jersey, and the IPN stated that "I had to verify that with the regional." On 9/7/22 at 9:29 AM, the surveyor interviewed CNA#1. CNA#1 stated that it was the IPN who	S 560		

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provided in-service and mandatory training about Dementia and abuse. CNA#1 further stated that it was also the IPN who was responsible for orienting and training the new employees of the facility.

On 9/15/22 at 9:17 AM, the surveyor informed the DON about the concern with the IPN having multiple job responsibilities other than Infection Control. The surveyor also informed the DON about the interview of the above CNA#1 confirming the multiple job responsibilities of the IPN. The surveyor asked the DON if DON was aware of the state regulation specific to the Infection Preventionist who was assigned to oversee the infection prevention and control program must meet the requirement that the facility designates a full-time employee in the infection control prevention role with no other responsibilities as mandated by the State of New Jersey and DON stated that DON will get back to the surveyor.

On 9/15/22 at 11:25 AM, the surveyor interviewed CNA#2. CNA#2 stated that CNA#2 received in-service from the IPN about infection control and other education regarding alternative diets, thickened liquids, and policy changes.

On 9/15/22 at 02:19 PM, the surveyors met with the Licensed Nursing Home Administrator (LNHA), Corporate Chief Nurse (CCN), and the DON, and discussed the above concerns. The CCN stated that there was difficulty to hire. The CCN further stated that the IPN works at least 40 hours and also helps with the additional tasks identified above. The LNHA stated that the IPN works 40 hours a week and over, the other hours were being utilized for additional tasks other than infection control.

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S2775	8:39-39.3(a) Mandatory Social Work (a) The facility shall provide an average of at least 20 minutes of social work services per week for each resident, which requires at least one full-time equivalent social worker for every 120 residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide the required social services hours per week (20 minutes of social work services per week per resident) for each resident and at least one full-time equivalent social worker for every 120 residents. This deficient practice was identified for 3 of 5 residents (Residents#69, 102, and 206) reviewed for social services assessments. This deficient practice was evidenced by the following: 1. On 8/31/22 at 10:09 AM, during an Entrance Conference of the surveyors with the Director of Nursing (DON), the DON stated the census was 252 and that there were four social workers in the facility. There were two full time staff in the Social Services department to include the Director of Social Worker (DSW) and the Assistant Social Worker (ASW), along with two per diem Social Workers (PDSW#1 and PDSW#2). During an observation on 8/31/22 at 10:54 AM by the surveyor, the Certified Nursing Aide (CNA) was inside Resident#69's room with a privacy curtain in use while providing morning care. The surveyor reviewed the medical records of	S2775	S2775 - Mandatory Social Work Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: On 10/14/2022, the facility Administrator and Social Services Department was educated by the Regional Administrator on the components of this regulation requiring at least one full-time equivalent social worker for every 120 residents. On 10/14/2022, an updated quarterly evaluation/assessment in the assessment tab of the electronic medical record for Resident (#69) was carried out by Social Services to ensure completion of the BIMS score of 15 was indicated and reflected the resident's current condition. On 10/14/2022, an updated Progress Notes (PN) for Social Service Note (SSN)	10/26/22

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S2775	Continued From page 6 Resident #69. The Admission Record (admission summary) reflected that Resident #69 was admitted to the facility with diagnoses that included paraplegia unspecified (paralysis that affects all or part of the trunk, legs, and pelvic organs) and Multiple sclerosis (a neurological disease that causes dizziness, mobility problems, numbness, and fatigue.) The quarterly Minimum Data Set (QMDS) ARD (assessment reference date) 6/23/22, an assessment tool used to facilitate the management of care, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which reflected that the resident's cognition was intact. The C0100 was coded 1, yes, which means that the BIMS interview was conducted and signed by PDSW#2 on 6/4/22. The above 6/23/22 quarterly MDS was signed by PDSW#2, 19 days before the ARD. The 3/24/22 and 6/23/22 quarterly Assessment in the Assessment tab of the electronic medical record showed that Section C for BIMS was not done. The Progress Notes (PN) for Social Service Note (SSN) in the electronic medical record showed that the last note was on 4/19/22. 2. On 8/31/22 at 11:02 AM, the surveyor observed Resident#102 laying on the bed with the responsible party (RP) at the bedside. The RP stated that Resident#102 was cognitively intact, unable to speak appropriately "but" able to utilize	S2775	was carried out to reflect the resident's current condition. On 10/17/2022, Resident (#102) annual/ assessment will be modified to reflect the resident's BIMS. On 10/17/2022, an updated quarterly evaluation/assessment in the assessment tab of the electronic medical record will be carried out by Social Services to ensure completion of the BIMS score was indicated and reflected the resident's current condition. On 10/17/2022, an updated Progress Notes (PN) for Social Service Note (SSN) will be carried out to reflect the resident's current condition. Resident (#206) is no longer residing in the facility. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: By 10/26/2022, the Social Services Director/designee will conduct a review of resident records to ensure: 1. A quarterly evaluation/assessment in the assessment tab of the electronic medical record is accurate indicating the resident's current condition to include BIMS if applicable. 2. A recent Progress Notes (PN) for Social Service Note (SSN) was present within the medical record and reflects the resident's current condition. Issues or concerns were addressed as	

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S2775	Continued From page 7 the personal computer for communication. The RP further stated that Resident #102 was unable to talk properly due to ALS (Amyotrophic lateral sclerosis is a rare neurological disease that primarily affects the nerve cells responsible for controlling voluntary muscle movements like chewing, walking, and talking). The surveyor reviewed the medical records of Resident #102. The Admission Record reflected that Resident #102 was admitted to the facility with diagnoses that included but were not limited to ALS, quadriplegia (a symptom of paralysis that affects all limbs and body from the neck down), anemia (low blood count), dysarthria, and anarthria (anarthria is a severe form of dysarthria. Dysarthria is a motor speech disorder that occurs when someone can not coordinate or control the muscles used for speaking). The quarterly MDS ARD 8/18/22 indicated a BIMS score of 15 out of 15, which reflected that Resident #102's cognition was intact. The C0100 was coded 1, yes, and signed by PDSW#3 on 8/29/22. The above 8/18/22 quarterly MDS was signed by PDSW#3, 11 days after the ARD. The 5/19/22 Annual/Significant Change Assessment and 8/11/22 quarterly Assessment in the Assessment tab of the electronic medical record showed that Section C for BIMS was not done. The PN for SSN in the electronic medical record showed that the last note was on 3/10/22.	S2775	they were identified. 3. What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur: On 10-14-22, the facility hired an additional full time Social Services position to equal (x3) full time staff members. By 10/26/2022, the facility Social Services Department will be educated by the MDS Coordinator on the completion, timeliness, and accuracy of section (C) of the Minimum Data Set, the quarterly evaluation/assessment in the assessment tab of the electronic medical record, and the Progress Notes for Social Service Note. 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The facility Social Services Director/designee will conduct at least a weekly audit on 5 resident records per week X 4 weeks and then 5 resident records per month x 2 month to ensure the following: 1. The residents Minimum Data Set remains timely based on ARD date. 2. A quarterly evaluation/assessment in the assessment tab of the electronic medical record is accurate indicating the resident's current condition to include BIMS if applicable. 3. A recent Progress Notes for Social Service Note was present within the	

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S2775	Continued From page 8 3. On 9/1/22 at 10:54 AM, the surveyor observed Resident#206 sitting in their wheelchair in front of their room door. Resident#206 was alert and responded appropriately to the surveyor's inquiry. The surveyor reviewed the medical records of Resident #206. The Admission Record reflected that Resident#206 was admitted to the facility with diagnoses that included but were not limited to epilepsy unspecified (a brain disorder that causes recurring, unprovoked seizures), unspecified dementia, anxiety, depression, and hypertension (elevated blood pressure). The quarterly MDS ARD 5/05/22 indicated that the C0100 attempt to interview the resident was coded 0, no (resident is rarely/never understood), the staff assessment was done and signed by the DSW on 5/14/22. The quarterly MDS ARD 8/4/22 indicated a BIMS score of 8 out of 15, which reflected that Resident#206's cognition was moderately impaired. The C0100 was coded 1, yes, and signed by PDSW#2 on 8/13/22. The above 5/05/22 and 8/4/22 quarterly MDS was signed by DSW and PDSW#2, 9 days after the ARD. The 11/4/21 Annual/Significant Change Assessment and 02/03/22, 5/05/22, and 8/04/22 quarterly Assessments in the Assessment tab of the electronic medical record showed that Section C for BIMS was not done. The PN for SSN in the electronic medical record showed that the last note was on 10/29/21.	S2775	medical record and reflects the resident's current condition. The Administrator/designee will review the Social Services Department hours weekly x 4 weeks, then monthly x 2 months to ensure the facility maintains one full-time equivalent social worker for every 120 residents. Findings of these audits will be reviewed in the monthly QAPI meeting until such time as the committee has determined substantial compliance has been achieved.	

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S2775	Continued From page 9 A review of the provided Employee Punch History of the following Social Workers that was provided by the DSW and the LNHA from October 2021 through September 2022 showed the following: Month/year Social Workers' Name and Total hours/month DSW PDSW#2 ASW PDSW#4 PDSW#1 PDSW#5 Oct 2021 176.93hours 0 0 151.21 0 0 Nov 2021 166.46 19.0 0 7.70 0 0 Dec 2021 136.53 44.5 0 0 0 0 Jan 2022 163.41 14.5 0 0 0 0 Feb 2022 137.52 16.5 0 0 80.62 156.47 Mar 2022 188.06 26.0 0 0 185.16 33.45 Apr 2022 137.84 17.5 0 0 172.03 terminated May 2022 179.16 9.0 0 0 144.96 June 2022 119.49 9.0 0 0 158.69 July 2022 146.85 16.5 0 0 81.49 Aug 2022 138.61 8.5 81.96 0 39.02 Sept 2022 35.72 0 36.11 0 8.12 (9/1-9/7/22) A review of the provided census from October 2021 through August 2022 showed the following average census/month:	S2775		

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S2775	Continued From page 10 October 2021=256 November 2021=257 December 2021=254 January 2022=253 February 2022=260 March 2022=260 April 2022=257 May 2022=257 June 2022=254 July 2022=248 August 2022=252 On 9/7/22 at 12:53 PM, two surveyors interviewed the DSW. The DSW stated that the initial assessment is being documented in the electronic medical record in the Assessment tab and that all notes were in the electronic medical record and nothing was on paper. DSW further stated that the quarterly assessments are "exactly" the same as MDS. The DSW indicated that it was the MDSC who initiated the MDS assessment in the Assessment tab and the SW is responsible for sections A, C, D, and Q that correspond to the MDS. Furthermore, the DSW stated that DSW had been doing the MDS for over 10 years. On that same date and time, the DSW informed the surveyors that assessments are due on Thursdays and the expectation was for the DSW to finish by Friday. The surveyor asked the DSW why the assessments were not being done accordingly and accurately. The DSW further stated that before the pandemic, there were three and a half full-time Social workers in the facility and then, after the pandemic, DSW was the only one who worked full time as a SW and the two other staff were part-time and per diem.	S2775		

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S2775	Continued From page 11 Furthermore, The DSW was aware that the look-back period of Section C for seven days should have been followed. The DSW stated, "I feel bad that the assessment is not getting done." On 9/15/22 at 02:19 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Corporate Chief Nurse, and made aware of the above concerns regarding quarterly Assessments not being done and the accuracy of MDS specific to Section C not according to the look-back period. The surveyor informed the facility management that according to the DSW, assessment is not getting done because of staffing concerns in the Social Service department. On 9/20/22 at 11:59 AM, the surveyor asked the DON in the presence of the Assistant Nursing Home Administrator (ANHA) regarding the concern of the surveyor concerning the MDS and social worker's assessments. The DON stated that the Social Service department was aware of the concerns. The surveyor asked for PDSW#1 and PDSW#2's phone numbers for the surveyor to interview the SW and the DON stated that DON will get back to the surveyor. On 9/20/22 at 12:29 PM, the surveyor interviewed the LNHA in the presence of the survey team in the conference room regarding the copy of the census provided from October 2021 through September 2022 versus the employee punch detail provided by the facility, and if the facility was meeting the required social worker hours. The LNHA stated that the facility was not meeting the requirements. On 9/20/22 at 01:56 PM, the survey team met with LNHA, DON, and the ANHA. There was no	S2775		

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S2775	Continued From page 12 additional information provided by the facility. The DON did not provide PDSW#1's and PDSW#2's phone numbers.	S2775		