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	315135	A. BUILDING _____ B. WING _____	C 05/11/2022

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CREST POINTE REHABILITATION AND HEALTHCARE CENTER	1515 HULSE ROAD PT PLEASANT, NJ 08742

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F 000	INITIAL COMMENTS Survey Date: 5/11/22 Census: 105 Sample: 22 (plus 3 closed records) 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.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 609		6/15/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/03/2022

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F 609	Continued From page 1 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 F 610 Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to report an allegation of abuse to the New Jersey Department of Health (NJDOH) made by a resident representative who reported the allegation to the Licensed Nursing Home Administrator (LNHA). The resident representative alleged that a staff member had been rude during care of a resident on 4/8/22. This deficient practice was identified for one (1) of two (2) residents reviewed for abuse, (Resident #348) and was evidenced by the following: On 4/21/22 at 10:17 AM, the surveyor interviewed a resident representative (RR) in the room of Resident #348. The RR stated that the resident was recently placed on [redacted] services and was hoping to take the resident home soon, if possible. The RR stated that he/she had an incident during the first week of admission with a Certified Nursing Aide (CNA#2) who had come into the resident's room to render care to the resident. The RR stated that he/she refused to give the name of the CNA because other CNA's, such as the CNA #1 caring for the resident that day, were very good. The RR explained that a CNA#2 was rude, and he/she was uncomfortable with the way the CNA#2 had taken care of the resident. The RR added that he/she was aware that the job of a CNA was difficult but felt the	F 609	F609 SS=D CFR(s): 423.12 (c) (1) (4) – Reporting of Alleged Violations ¿ Resident #348 is no longer in the building. All nursing staff, along with administrator and director of nursing have reviewed and have been reeducated on the regulatory reporting responsibilities in a timely manner as due diligence to the resident, completed by a member of the governing body ¿ Residents of the facility have the potential to be affected. ¿ Administrator, director of nursing, social worker, and another pertinent staff member will meet weekly to complete a secondary review of any incidents/grievances to ensure compliance with this regulation as a multidisciplinary decision for no less than 2 months or until compliance is satisfactory ¿ The contents of the audit above will be reported and reviewed at the quarterly QA meeting by the admin or designee with suggested recommendations made by the committee.	

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CNA#2 was unhappy with having to do her job or she was having a bad day. The RR further explained that the CNA#2 had asked him/her to leave the room when she was going to change the resident and when he/she refused the CNA#2 became annoyed with him/her. The RR stated that he/she saw the CNA#2 had rolled the resident on their side to change the resident and was concerned because there were no bedrails on the bed to prevent the resident from rolling off the bed. The RR stated that he/she felt the CNA#2 spoke very rudely to him/her while she was changing the resident. The RR continued that the CNA#2 was going to leave a soiled linen on the bed after changing the resident until he/she had told the CNA#2 to change it. The RR also stated that the CNA#2 had placed the bedspread on a chair in the room, but part of the bedspread had touched the floor and the CNA#2 was going to put that bedspread back on the bed. The RR stated that he/she had to tell that CNA#2 the bedspread was touching the floor and could not be returned to the resident's bed. The RR stated that the CNA#2 dropped the bedspread on the floor and went to get another bedspread. The RR stated that he/she had spoken to the Licensed Nursing Home Administrator (LNHA) and explained the incident and the LNHA knew who the CNA was. When asked by the surveyor if he/she felt the issue had been resolved, the RR shrugged his/her shoulders. Then, the RR stated that he/she knew that the CNA#2 still worked on the floor but had not taken care of the resident since the incident. The RR was unsure of the exact date.

On 4/22/22 at 10:20 AM, the surveyor interviewed the Director of Nursing (DON) who stated that she was unaware of any issue with Resident

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#348 and had positive interactions with the RR for Resident #348. The DON stated that she would have to check for documentation.

On 4/22/22 at 11:23 AM, the surveyor interviewed the Director of Social Services/Licensed Social Worker (DOSS/LSW) who stated that she had been working at the facility for four (4) months and also had previous experience in long term care as a LSW. The DOSS/LSW stated that any grievance or allegation was required to be investigated. The DOSS/LSW added that if any resident's representative had a complaint or grievance then she would have to take a statement and review with the team to decide whether it was necessary to immediately report to the NJDOH. The DOSS/LSW added that usually she would "err on the side of caution and report more often." The DOSS/LSW added that usually the DON or LNHA had done the reporting to the NJDOH but she could be involved in the decision. The DOSS/LSW was unsure of any incident regarding Resident #348.

On 4/22/22 at 1:14 PM, the surveyor, in the presence of the survey team, interviewed the DON who stated that she felt the incident was presented to her by the LNHA as a customer service issue. The DON stated that she had read the CNA #2's statement and had not thought there was an issue of abuse. The DON added that if the incident was presented as an allegation of abuse, she would have removed the CNA #2 from the floor immediately, reported to the NJDOH immediately and investigated. The DON acknowledged that any complaint regarding a staff member required an investigation to be completed. The DON stated that she could not find any documentation that a report was sent to

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the NJDOH and was unsure if the LNHA had any further documentation.

A review of the documentation provided by the DON revealed an Employee Statement dated 4/8/22, by the CNA #2 which described that the CNA #2 was rendering care and the RR had told the CNA #2 to clean the resident better and the CNA #2 had answered that she wasn't done yet. The description continued that the RR had said she couldn't roll the resident on wet linens but the CNA #2 was tucking in the linens and rolled the resident and put clean linens under. The CNA #2 also wrote that the comforter corner was on the floor and the RR had said it was on the floor, so she put the comforter back on the floor and bagged it up.

Further review revealed an In-Service Meeting Minutes dated 4/8/22, performed by the DON with the CNA #2 on the topic of Customer Service. There was no evidence of documentation of a report sent to the NJDOH.

On 4/25/22 at 10:40 AM, the survey team met with the LNHA. The LNHA stated that he was the grievance officer and the abuse coordinator. The LNHA explained that the grievance process would be to review and investigate by speaking to all the involved parties and it would depend on the type of grievance, or it could be abuse so that would have to be differentiated. The LNHA further explained that differentiating involved how the person "took it" and would make a multidisciplinary decision with the DON and DOSS/LSW.

The LNHA stated that he was aware of the incident involving the RR for Resident #348 and

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the CNA #2. The LNHA stated that there was no further documentation of the incident with Resident #348 and that "was an oversite that it wasn't done." The LNHA stated that he thought the DON had followed up with an investigation. The LNHA stated that a report was not sent to the NJDOH because he did not think this was an allegation of abuse. The LNHA stated that the DON was aware of the incident and that he thought he had told the DOSS/LSW about the incident the next day. The LNHA acknowledged that an investigation was not completed and that a collaboration on the decision whether to report as an abuse allegation had not occurred.

The LNHA explained that he had seen the RR checking in at the facility lobby and the RR looked "sad," so the LNHA approached the RR to see if the RR wanted to talk. The LNHA added that the RR had told him that he/she had an interaction with the CNA #2. The LNHA stated that he felt that the RR was offended when the CNA #2 asked the RR to step out of the room. The LNHA added that the RR also expressed that the CNA #2 was going to place a bedspread that the RR said was touching the floor back on the bed. The LNHA stated that he did not feel that the complaint from the RR was an allegation of any abuse because it had no effect on the resident. The LNHA stated that he and the DON had spoken with the CNA #2 to understand both sides. The LNHA stated that the CNA #2 had a death in the family and felt that the interaction was between the RR and the CNA #2 and had "nothing to do with the resident."

On 5/4/22 at 9:57 AM, the survey team met with the LNHA and DON. The LNHA stated that all policies on abuse and grievances were provided

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F 609	Continued From page 6 and current. A review of the undated policy provided by the LNHA for "Abuse Prevention Program" reflected that all possible incidents of abuse are identified and assessed. In addition, any allegation of abuse is investigated and reported within timeframe's as required by federal requirements. A review of the undated policy provided by the LNHA for "Grievances/Complaints, Recording and Investigating" reflected that "The grievance officer will coordinate actions with the appropriate state and federal agencies, depending on the nature of the allegations. All alleged violations of neglect, abuse and/or misappropriation of property will be reported and investigated under guidelines for reporting abuse, neglect and misappropriation of property, as per state law." N.J.A.C. 8:39-5.1(a)	F 609		
F 610 SS=D	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 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	F 610		6/15/22

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F 610	Continued From page 7 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 F609 Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to thoroughly and timely investigate an allegation of abuse reported to the Licensed Nursing Home Administrator by a resident representative. The deficient practice was identified for one (1) of two (2) residents reviewed for abuse (Resident #348), and was evidenced by the following: On 4/21/22 at 10:17 AM, the surveyor interviewed a resident representative (RR) in the room of Resident #348. The RR stated that the resident was recently placed on Ex.Order 26.4(b)(1) and was hoping to take the resident home soon, if possible. The RR stated that he/she had an incident during the first week of admission with a Certified Nursing Aide (CNA#2) who had come into the resident's room to render care to the resident. The RR stated that he/she refused to give the name of the CNA#2 because other CNA's, such as the CNA #1 caring for the resident that day, were very good. The RR explained that a CNA#2 was rude, and he/she was uncomfortable with the way the CNA#2 had taken care of the resident. The RR added that he/she was aware that the job of a CNA was difficult but felt the CNA#2 was unhappy with having to do her job or she was having a bad day. The RR further explained that the CNA#2 had	F 610	F610 SS=D CFR(s): 423.12 (c) (2) (4) – Investigate/Prevent/Correct Alleged Violations ¿ Resident #348 is no longer in the building. Administrator and director of nursing have reviewed and have been reeducated on the regulation of a proper investigation, including conducting interviews with victim, perpetrator, witness, or anybody pertinent in the incident, in a timely manner as due diligence to the resident and completing a complete comprehensive investigative summary. Completed Date: 05/13/22 ¿ Residents of the facility have the potential to be affected. ¿ Administrator, director of nursing, social worker, and any other pertinent staff member will meet weekly to complete a secondary review of any incidents/grievances to ensure compliance with this regulation as a multidisciplinary decision for no less than 2 months or until compliance is satisfactory ¿ The contents of the audit above will be reported and reviewed at the quarterly QAPI meeting by the admin or designee with suggested recommendations made by the committee.	

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asked him/her to leave the room when she was going to render care to the resident and when he/she refused the CNA#2 became annoyed with him/her. The RR stated that he/she saw the CNA#2 had rolled the resident on their side to change the resident and was concerned because there were no bedrails on the bed to prevent the resident from rolling off the bed. The RR stated that he felt the CNA#2 spoke very rudely to him/her while she was changing the resident. The RR continued that the CNA#2 was going to leave a soiled linen on the bed after changing the resident until he/she had told the CNA#2 to change it. The RR also stated that the CNA#2 had placed the bedspread on a chair in the room, but part of the bedspread had touched the floor and the CNA#2 was going to put that bedspread back on the bed. The RR stated that he had to tell that CNA#2 the bedspread was touching the floor and could not be returned to the resident's bed. The RR stated that the CNA#2 dropped the bedspread on the floor and went to get another bedspread. The RR stated that he/she had spoken to the Licensed Nursing Home Administrator (LNHA) and explained the incident and the LNHA knew who the CNA#2 was. When asked by the surveyor if he/she felt the issue had been resolved, the RR shrugged his/her shoulders. Then, the RR stated that he/she knew that the CNA#2 still worked on the floor but had not taken care of the resident since the incident. The RR was unsure of the exact date.

On 4/22/22 at 10:07 AM, the surveyor interviewed the CNA #1 who stated that she was frequently assigned to Resident #348 and was familiar with the resident and the RR. The CNA #1 stated that the resident was nonverbal, on hospice and had to provide total care for the resident. The CNA #1

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also stated that the RR could be demanding but she would try as best as she could to address the RR's concerns and care for the resident. The CNA #1 stated that she was aware of an incident that occurred between the RR and a CNA because the RR had told her that he/she had spoken to the Licensed Nursing Home Administrator (LNHA). The CNA #1 knew that the incident had occurred with CNA #2 because CNA #2 had told her.

On 4/22/22 at 10:12 AM, the surveyor interviewed the CNA #2 who stated that her last day of work at the facility was next Friday because she had resigned to take another job. The CNA #2 added that she was "burning out" because she was hired approximately one year ago as a rehabilitation CNA with a 10AM to 6PM shift and was frequently pulled to be a CNA with a floor assignment and work the 7AM to 3PM shift. The CNA #2 stated that she was familiar with Resident #348 and the RR because the RR was rude to her. The CNA #2 explained that approximately two (2) weeks ago she had to perform care for Resident #348 and asked the RR to leave to provide privacy for the resident and the RR was offended by that. The CNA #2 added that the RR stayed in the room while she changed the resident and "critiqued everything I was doing." The CNA #2 stated that she had to keep telling the RR during care that she was not done yet. The CNA #2 stated that she changed the resident as she would any other resident and that when she went to put the bedspread back on the bed, the RR told her that the bedspread was touching the floor and was not to be put it back on the bed, so she dropped the bedspread on the floor and went to get a new one. The CNA #2 then stated that she then bagged all the linens and left. The CNA #2 stated

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that she felt the RR was very demanding.

The CNA #2 further explained that she was called to the office and was told that the RR made a complaint and she had to write a statement. The CNA #2 stated that she wrote a statement and received an inservice education on customer service. The CNA #2 stated that she was not assigned to care for the resident again and added that she usually was not assigned to that hallway anyway.

On 4/22/22 at 10:20 AM, the surveyor interviewed the Director of Nursing (DON) who stated that she was unaware of any issue with Resident #348 and had positive interactions with the RR for Resident #348. The DON stated that she would have to check for documentation.

On 4/22/22 at 11:47 AM, the surveyor further interviewed the CNA #2 who stated that when she was called to the office, the DON and LNHA were there and told her that the RR had made a complaint. The CNA #2 was unaware as to what the RR had said. The CNA #2 added that she was not sent home that day or suspended.

On 4/22/22 at 11:49 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) who stated that she was familiar with Resident #348 and the RR. The UM/LPN added that she was unaware of any issues with CNA #2. The UM/LPN stated that the RR, DON nor LNHA had not spoken to her regarding any issue with CNA #2.

On 4/22/22 at 11:51 AM, the surveyor interviewed the 3 PM to 11 PM shift Supervisor/LPN (S/LPN) who stated that he was familiar with Resident

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#348 and the RR. The S/LPN added that he was unaware of any issues with CNA #2. The S/LPN stated that the RR, DON nor LNHA had not spoken to him regarding any issue with CNA #2. The S/LPN stated that if he was aware of a complaint by a resident's representative then he would have to bring the complaint to the attention of administration and if the complaint was regarding care, then he would have to remove the staff member immediately from the assignment of the resident and start an investigation.

On 4/22/22 at 11:23 AM, the surveyor interviewed the Director of Social Services/Licensed Social Worker (DOSS/LSW) who stated that she had been working at the facility for four (4) months and had previous experience in long term care as a LSW. The DOSS/LSW stated that any grievance or allegation was required to be investigated. The DOSS/LSW added that if any resident's representative had a complaint or grievance then she would have to take a statement and review with the team to decide whether it was necessary to immediately report to the NJDOH. The SW added that usually she would "err on the side of caution and report more often." The DOSS/LSW added that usually the DON or LNHA was reporting to the NJDOH, but she could be involved in the decision. The DOSS/LSW was unsure of any incident regarding Resident #348.

On 4/22/22 at 11:31 AM, the surveyor interviewed the DON who stated that she had remembered that there was an incident regarding the RR for Resident #348 and had found documentation. The DON added that CNA #2 wrote a statement dated 4/8/22 and the DON performed an inservice educationwith the CNA #2 on "Customer

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Service" dated 4/8/22.

A review of the documentation provided by the DON revealed an Employee Statement dated 4/8/22, by the CNA #2 which described that the CNA #2 was rendering care and the RR had told the CNA #2 to clean the resident better and the CNA #2 had answered that she wasn't done yet. The description continued that the RR had told the CNA #2 that she couldn't roll the resident on wet linens, but the CNA #2 was tucking in the linens and put clean linens under the resident. The CNA #2 also wrote that the comforter corner was on the floor and the RR had told the CNA #2 it was on the floor, so she put the comforter back on the floor and bagged it up. Further review revealed an In-Service Meeting Minutes dated 4/8/22, performed by the DON with the CNA #2 on the topic of Customer Service.

There was no evidence of documentation of a report to the NJDOH or a Grievance Report with an investigation.

On 4/22/22 at 12:06 PM, the survey team met with the DON and the Regional Director of Clinical Services (RDCS). The DON stated that she was not present when the LNHA had spoken with the RR, so she was unsure of what had transpired. The DON was unable to find documentation of the RR's statement. The DON stated that a grievance was usually documented on a Grievance Report and usually all documentation was completed together, but was unsure if the LNHA had additional documentation. The RDCS also stated that all documentation of an investigation of a grievance should be complete and together. The DON added that the LNHA was on high holiday and was unable to be

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reached.

The DON then stated that she thought the LNHA had made the decision that an investigation was not needed. The DON stated that any complaint, grievance, allegation was usually discussed in morning meeting, but was unsure if this was discussed. The DON stated that the discussion would usually include a regional staff member to discuss whether it was necessary to report to the NJDOH. The DON stated that the UM/LPN was probably unaware of any incident because the staffing coordinator with the CNAs on the floor make the assignment schedule so the CNA #2 would not have been assigned to Resident #348. The DON added that she thought the RR "was not a fan of CNA #2" but had not thought it was an abuse situation. The DON added that an allegation of any kind of abuse would require the staff member to be removed from work and an investigation started which would include statements and asking other residents on the staff member's assignment.

On 4/22/22 at 1:14 PM, the surveyor, in the presence of the survey team, interviewed the DON who stated that she felt the incident was presented to her by the LNHA as a customer service issue. The DON stated that she had read the CNA #2 statement and had not thought there was an issue of abuse. The DON added that if the incident was presented as an allegation of abuse, she would have removed the CNA #2 from the floor immediately, reported to the NJDOH immediately and investigated. The DON stated that she should have communicated to the UM/LPN that there was an issue. The DON acknowledged that any complaint regarding a staff member required an investigation to be

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completed. The DON stated that she could not find any documentation that a report was sent to the NJDOH and was unsure if the LNHA had any further documentation. The DON also stated that after hearing the CNA #2 had expressed that she was "burning out," the DON had sent the CNA #2 home.

On 4/25/22 at 10:40 AM, the survey team met with the LNHA. The LNHA stated that he was the grievance officer and the abuse coordinator. The LNHA explained that the grievance process would be to review and investigate by speaking to all the involved parties and it would depend on the type of grievance, or it could be abuse so that would have to be differentiated. The LNHA further explained that differentiating involved how the person "took it" and would make a multidisciplinary decision with the DON and DOSS/LSW.

The LNHA stated that he was aware of the incident involving the RR for Resident #348 and the CNA #2. The LNHA stated that there was no further documentation of the incident with Resident #348 and that "was an oversite that it wasn't done." The LNHA stated that he thought the DON had followed up with an investigation. The LNHA stated that a report was not sent to the NJDOH because he did not think this was an allegation of abuse. The LNHA stated that the DON was aware of the incident and that he thought he had told the DOSS/LSW about the incident the next day. The LNHA acknowledged that an investigation was not completed and that a collaboration on the decision whether to report as an abuse allegation had not occurred.

The LNHA explained that he had seen the RR

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checking in at the facility lobby and the RR looked "sad," so the LNHA approached the RR to see if the RR wanted to talk. The LNHA added that the RR had told him that he/she had an interaction with the CNA #2. The LNHA stated that he felt that the RR was offended when the CNA #2 asked the RR to step out of the room. The LNHA added that the RR also expressed that the CNA #2 was going to place a bedspread that the RR said was touching the floor back on the bed. The LNHA stated that he did not feel that the complaint from the RR was an allegation of any abuse because it had no effect on the resident. The LNHA stated that he and the DON had spoken with the CNA #2 to understand both sides. The LNHA stated that the CNA #2 had a death in the family and felt that the interaction was between the RR and the CNA #2 and had "nothing to do with the resident."

On 4/29/22 at 2:11 PM, the survey team met with the administrative team. The Regional LNHA stated that an investigation was completed for a care concern from the RR of Resident #348 after surveyor inquiry. The LNHA provided a Grievance Report dated 4/26/22 which included an in-person interview and follow-up with the CNA #2 which revealed that at the time of the incident the CNA #2 had had a death in the family and had been in an accident which entailed an increase in costs for the CNA #2. The investigation also included as an action taken to perform a competency with the CNA #2. In addition, alert and oriented residents on the assignment of CNA #2 were interviewed regarding any interactions with the CNA #2.

A review of the undated policy provided by the LNHA for "Abuse Prevention Program" reflected

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F 610	Continued From page 16 that all possible incidents of abuse are identified and assessed. In addition, any allegation of abuse is investigated and reported within timeframes as required by federal requirements. A review of the undated policy provided by the LNHA for "Grievances/Complaints, Recording and Investigating" reflected that "Upon receiving a grievance and complaint report, the grievance officer will begin an investigation into the allegations." Further review of the policy reflected what the investigation and report should include and that the report will be filed with the administrator within five (5) working days of the incident. In addition, the resident or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended. N.J.A.C. 8:39-4.1(a)(5), 5.1(a), 9.4(e)(3)(i)	F 610		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F 623		6/15/22

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F 623	Continued From page 17 paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal	F 623		

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F 623	Continued From page 18 hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).	F 623		

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F 623	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined that the facility failed to notify the resident or resident representative, and the Ombudsman's office in writing for a facility-initiated transfer to the hospital. This deficient practice was identified for five of five resident's, (Resident #41, #45, #75, #85, and #99) reviewed for hospitalization. The deficient practice was evidenced by the following: 1. On 4/22/22 at 9:40 AM, the surveyor reviewed the hybrid medical records (paper and electronic) of Resident # 99. The New Jersey Universal Transfer Form (NJUTF) and nurse progress notes revealed that the resident was transferred to the hospital on Ex.Order 26.4(. According to the Discharge Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 2/5/22, reflected that Resident # 99 was discharged to the hospital with a return not anticipated to the facility. A review of the facility's "Notice of Intent to Transfer/Discharge Resident with less than 30 day notice" dated 2/5/22, reflected that the resident was transferred to the hospital and that the discharge or transfer to the hospital was necessary for the resident's welfare and the facility could not meet the resident's needs at the time of transfer. There was no documentation that the facility had notified the resident or resident representative in writing regarding the reason for transfer and that the New Jersey (NJ) Long-Term Care Ombudsman's Office was made aware of the resident's transfer to the hospital.	F 623	F623 SS=C CFR(s): 483.15 (c) (3) (6) (8) – Notice Requirements Before Transfer/Discharge ¿ The social worker was in-serviced on the notice requirements before transfer and discharge. ¿ All residents who discharge or transfer from the facility have the potential to be affected. ¿ The social worker completed an audit of all transfers in the last 30 days to ensure that timely notification of transfer of a resident was completed ¿ The LHNA or designee will audit 5 transfers/discharges monthly for no less than 2 months or until compliance is satisfactory to ensure notification are made to the appropriate parties and the proper forms are completed. The contents of the audit will be reported and reviewed at the quarterly QAPI meeting by the admin or designee with suggested recommendations made by the committee.	

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F 623	Continued From page 20 On 4/22/22 at 11:39 AM, the surveyor interviewed the Social Worker (SW) who stated that the notification of reason for transfer to the hospital to resident or resident's representative was done over the phone and documented by the SW in the electronic medical record (EMR). The SW stated she did not provide written notification and did not provide a copy of notice to the Ombudsman office as she was not aware that she had to do that. On 4/22/22 at 11:55 AM, the surveyor interviewed the Director of Admissions (DA) who stated she does not provide written notification for reasons of transfer to the hospital, as it was not something she was assigned to do. The DA stated she was not aware who was responsible for providing the notification. On 4/26/22 at 10:09 AM, the surveyor interviewed the Administrator who stated the SW was responsible for providing written notification for reason of transfer and the bed hold policy. The Administrator stated the written notification to the resident or resident representative and the Ombudsman's office was not being provided and that the SW wasn't aware it was her responsibility. 2. On 04/25/22 at 9:50 AM, the surveyor observed Resident #45 lying in bed on a functional air mattress. The surveyor asked the resident how he/she was feeling, and the resident stated, "I don't know." The surveyor reviewed the medical record for Resident #45.	F 623		

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A review of the resident's Admission Record (An Admission Summary) reflected that the resident had resided at the facility for over Ex.Order 26.4(b)(1) and had diagnoses which included but were not limited to Ex.Order 26.4(b)(1) and Ex.Order 26.4(b

A review of the resident's progress notes dated 9/20/21 and timed at 22:30 (10:30 PM) revealed that the resident was admitted to the hospital with diagnoses of Ex.Order 2 and Ex.Order 26.4(b)(1).

Further review of the resident's progress notes dated 9/24/21 and timed at 22:36 (10:36 PM) indicated that the resident was readmitted back to the facility from the hospital and was made clean and comfortable by staff upon return to the facility.

A review of the facility's, "Notice of Intent to Transfer/Discharge Resident with less than 30 day notice," dated 9/20/21 and timed at 17:45 (5:45 PM) reflected that the discharge or transfer to the hospital was necessary for the resident's welfare and the facility could not meet the resident's needs at the time of transfer. Further review of the facility's, "Notice of Intent to Transfer/Discharge Resident with less than 30 day notice" did not reflect that the New Jersey (NJ) Long-Term Care Ombudsman's Office was made aware of the resident's transfer to the hospital. There was no documentation that the facility had notified the resident or resident

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representative in writing regarding the reason for transfer and that the New Jersey (NJ) Long-Term Care Ombudsman's Office was made aware of the resident's transfer to the hospital.

On 04/28/22 at 10:55 AM, the surveyor interviewed the resident's Licensed Practical Nurse/Unit Manger (LPN/UM) who stated that she did not recall specifics on when the resident was admitted to the hospital. The LPN/UM stated that when the resident was transferred or discharged to the hospital the resident's nurse would notify the resident's representative and doctor. The LPN/UM could not speak to if the NJ Long-Term Care Ombudsman's Office was made aware of the resident's transfer to the hospital and stated that she thought the SW would have been responsible for notifying the Ombudsman.

3. On 4/25/22 at 9:41 AM, the surveyor reviewed the hybrid medical records of Resident # 75. The NJUTF and nurse progress notes revealed that the resident was transferred to the hospital on Ex.Order 26.4(b)(. Review of the MDS dated 1/29/22, indicated Resident # 75 was discharged to the Ex.Order 26.4(b)(with a return anticipated.

Review of the "Notice of Intent to Transfer/Discharge Resident with less than 30 day notice" dated, 1/29/22, reflected that the transfer to the Ex.Order 26.4(b)(1 was necessary for the

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resident's welfare and the facility could not meet the resident's needs at the time of transfer. Further review of the facility's "Notice of Intent to Transfer/Discharge Resident with less than 30 day notice" did not reflect that the NJ Long-Term Care Ombudsman's Office was made aware of the resident's transfer to the hospital. There was no documentation that the facility had notified the resident or resident representative in writing regarding the reason for transfer and that the New Jersey (NJ) Long-Term Care Ombudsman's Office was made aware of the resident's transfer to the hospital.

On 4/27/22 at 11:41 AM, the surveyor requested a list of residents who had an emergency transfer to the hospital that was faxed to the Ombudsman office on a monthly basis.

On 4/27/22 at 2:02 PM, the surveyor interviewed the SW who stated that she "just started" sending a facsimile list to the Ombudsman office a list of residents who had an emergency transfer to the hospital. She confirmed that she had not done so prior to surveyor inquiry.

On 4/25/22 at 10:02 AM, the surveyor reviewed the hybrid medical records for Resident # 41.

Review of the NJUTF and the nurse progress notes dated 4/6/22, revealed that the resident was transferred to the hospital on Ex.Order 26.4(b

Review of the Discharge MDS dated 4/6/22, reflected that the resident was discharged to the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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Ex.Order 26.4(b)(1) with a return anticipated.

A review of the facility's "Notice of Intent to Transfer/Discharge Resident with less than 30 day notice," dated 4/6/22, indicated an inaccurate transfer/discharge date of 4/5/22. In addition, the notice reflected that the transfer to the hospital was necessary for the resident's welfare and the facility could not meet the resident's needs at the time of transfer. Further review of the facility's "Notice of Intent to Transfer/Discharge Resident with less than 30 day notice" did not reflect that the NJ Long-Term Care Ombudsman's Office was made aware of the resident's transfer to the hospital. There was no documentation that the facility had notified the resident or resident representative in writing regarding the reason for transfer and that the NJ Long-Term Care Ombudsman's Office was made aware of the resident's transfer to the hospital.

On 4/25/22 at 10:38 AM, the surveyor reviewed the hybrid medical records of Resident # 85.

Review of the NJUTF's and the nurse progress notes dated 12/30/21, 1/29/22, and 3/23/22, revealed that the resident was transferred to the hospital.

Review of the "Notice of Intent to Transfer/Discharge Resident with less than 30 day notice," dated 1/29/22 and 3/23/22, reflected that the resident was transferred to the hospital and that the discharge or transfer to the hospital was necessary for the resident's welfare and the facility could not meet the resident's needs at the time of transfer. There was no documentation

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that the facility had notified the resident or resident representative in writing regarding the reason for transfer and that the New Jersey (NJ) Long-Term Care Ombudsman's Office was made aware of the resident's transfer to the hospital.

On 4/26/22 at 12:47 PM, the surveyor interviewed the SW who stated that she was never told or instructed to send a written notification to the resident or resident representative or the Ombudsman office whenever a resident was transferred to the hospital. She further stated that at her previous employment it was always the admissions department that would send the written notifications. "It was on me. I didn't send them." The SW further stated that she documented in the resident's electronic medical record regarding a resident transfer/discharge but acknowledged that she did not send any written notifications to the resident or resident representative and the Ombudsman's office.

The surveyor reviewed the facility's undated policy titled, "Transfer or Discharge Notice", which indicated the facility should provide a resident and/or resident's representative with a thirty-day written notice of an impending transfer or discharge and as soon as practicable for immediate transfers. The written notification would include reason for transfer or discharge, effective date of transfer or discharge, location to which resident is being transferred or discharged, the facility bed hold policy and the statement of the resident's rights to appeal the transfer or discharge. The policy also indicated a copy of the notice would be sent to the Office of the State Long-Term Care Ombudsman.

Ex.Order 26.4(b)(1)

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F 623	Continued From page 26	F 623		
	NJAC 8:39-4.1(a)(32)			
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined that the facility failed to provide the	F 625	F625 SS=E CFR(s): 483.15 (d) (1) (2) (8) – Notice of	6/15/22

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F 625	Continued From page 27 resident or resident representative written notification of the facility's bed hold policy prior to transfer to the hospital for 2 of 4 residents (Resident # 99 and 75) reviewed for hospitalizations. The deficient practice was evidenced by the following: 1. On 4/22/22 at 9:40 AM, the surveyor reviewed the hybrid medical records (paper and electronic) of Resident # 99. The New Jersey Universal Transfer Form (NJUTF) and nurse progress notes revealed that the resident was transferred to the hospital on Ex.Order 26.4(b) Review of the the electronic medical record (EMR), revealed a document titled "Notice of Intent to Transfer Resident with less than 30 Days" completed by the Social Worker (SW), dated Ex.Order 26.4(, which indicated that the bed hold policy was not provided to the resident or resident representative. There was no documented evidence in the hybrid medical record that written notification of the facility's bed hold policy was provided upon the resident's transfer to the hospital. On 4/22/22 at 11:39 AM, the surveyor interviewed the SW, who stated that the notification of the facility's bed hold policy of a resident's transfer to the hospital was done over the phone and documented by the SW in the EMR. The SW stated she didn't provide written notification of the bed hold policy upon resident's transfer to the Ex.Order 26.4(b)(1. The SW added that the written bed hold policy was reviewed with the resident or resident representative upon admission as part of the admission packet.	F 625	Bed Hold Policy Before/Upon Transfer ¿ The social worker was in-serviced on the notice of requirements for bed hold policy before sending a resident to the hospital, duration of stay and upon return ¿ All residents requiring a bed hold or transfer can be affected ¿ The social worker completed an audit of all transfers to the hospital in the last 30 days to ensure the notice of bed hold/policy was completed accurately ¿ The LHNA or designee will audit 5 transfers to the hospital monthly for no less than 2 months or until compliance is satisfactory to ensure proper notifications were completed, including written notifications and the contents of the audit will be reported and reviewed at the quarterly QAPI meeting by the admin or designee with suggested recommendations made by the committee.	

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On 4/22/22 at 11:55 AM, the surveyor interviewed the Director of Admissions (DA), who stated the written notice for the bed hold policy was reviewed with the resident or the resident's representative upon admission and would be reviewed with the resident representative over the phone upon transfer to the hospital.

2. On 4/25/22 at 9:41 AM, the surveyor reviewed the hybrid medical records of Resident # 75. The NJUTF and nurse progress notes revealed that the resident was transferred to the Ex.Order 26.4(b)(1 on Ex.Order 26.4(b)(. Review of the MDS dated 1/29/22, indicated Resident # 75 was discharged to the Ex.Order 26.4(b)(1 with a return anticipated.

Review of the "Notice of Intent to Transfer/Discharge Resident with less than 30 day notice" dated, 1/29/22, reflected that the transfer to the hospital was necessary for the resident's welfare and the facility could not meet the resident's needs at the time of transfer. Further review of the facility's "Notice of Intent to Transfer/Discharge Resident with less than 30 day notice" reflected that the bed hold policy was checked as "not applicable" to provide to the resident or responsible party.

On 4/26/22 at 10:09 AM, the surveyor interviewed the Administrator, who stated the DA reviewed the written bed hold policy with the resident or resident representative upon resident's admission, it is signed and filed in the resident's EMR. The Administrator stated the resident's representatives were not receiving written

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F 625	Continued From page 29 notification of the bed hold policy upon transfer to the hospital and that the SW was not aware it was her responsibility to complete. The surveyor reviewed the facility's policy titled "Bed-Holds and Returns", modified on 1/4/22, which indicated prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed hold and return policy. The policy also indicated a resident and resident's representative would be provided written notification of the facility's bed hold policy, including reserve bed payment and the details of the transfer. The surveyor reviewed the facility's undated policy titled, "Transfer or Discharge Notice" which indicated that the facility shall provide to the resident and/or representative a written notification of the facility's bed-hold policy.	F 625		
F 641 SS=D	NJAC 8:39-4.1(a)(32) 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 code resident's Minimum Data Set (MDS), an assessment tool used to facilitate the management of care. This deficient practice was identified for two (2) of 25 residents, (Resident #16 and Resident #54) reviewed for accurate	F 641	F641 SS- D • The MDS for Resident's numbers 16 and 54 were modified and submitted. • All resident MDS's have the potential to affected. An audit was conducted by the MDS coordinator/designee on all MDS's completed over the last 30 days, to	6/15/22

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F 641	Continued From page 30 coding of MDS's and was evidenced by the following: 1. On 4/21/22 at 10:20 AM, the surveyor observed Resident #54 sleeping in bed with his/her eyes closed. The surveyor further observed a sign over the resident's bed that indicated the resident was to wear nonskid socks at all times. The surveyor did not attempt to interview the resident because the resident was observed sleeping. On 4/25/22 at 9:42 AM, the surveyor observed the resident lying in bed. The surveyor asked the resident how he/she was feeling, and the resident lifted his/her right hand and shook it from side to side, indicating so, so. The surveyor asked the resident if he/she had a fall, and the resident lifted his/her hand and shook it the same way. The surveyor asked the resident if he/she got hurt when they fell and the resident shook his/her head, no. The surveyor reviewed the medical record for Resident #54. A review of the resident's Admission Record (An Admission Summary) reflected that the resident had resided at the facility for several years and had diagnoses which included but were not limited to EX Order 26 § 4b1 [redacted]. A review of the facility's, "Full QA Report" dated 11/30/21 and timed at 5:00 PM, revealed that the resident had an unwitnessed fall in his/her	F 641	ensure that accurate coding per RAI manual for falls and immunizations. • The MDS coordinator has been educated on proper coding guidelines per RAI manual. • The MDS coordinator/designee will audit 5 MDS a week for 2 months to ensure falls and immunizations are coded correctly per the RAI manual the results of the audits will be submitted to the quarterly QAPI committee to determine if continued audits are required.	

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bathroom which resulted in no injury.

A review of the facility's progress notes dated 12/2/21, indicated that the interdisciplinary team met to discuss Resident #54's fall that occurred on 11/30/21. The progress note revealed that the resident was wearing non-skid socks, had the ability to self-propel himself/herself in the wheelchair and transferred himself/herself into the bathroom without asking for assistance from staff. The progress notes further reflected that the resident sustained no injuries from the fall and the fall occurred because of poor safety awareness and impulse control. The staff educated the resident to ask for assistance prior to transferring himself/herself to the bathroom and the resident communicated understanding with a head nod.

A review of the resident's Care Plan dated 4/02/20, reflected a focus area that the resident was at risk for falls related to Ex.Order 26.4(b)(1) [redacted] The goal of the resident's care plan was the resident would have a decreased risk of falls with injury through the next review date. The interventions for the resident's Care Plan included to anticipate the residents needs, educate the resident and family about safety awareness, and to wear non-skid socks every shift.

A review of the quarterly MDS dated 3/01/22, indicated that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated the resident's EX Order 26 § 4b1 [redacted]. A review of the resident's MDS, Section J1800 - Any Falls Since Prior Assessment indicated that the resident had one fall. A further review of Section J1900 - Number

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of Falls Since Prior Assessment indicated that the resident had one fall with no injury and one fall with major injury. The documentation in the MDS contradicted the resident's history of falls. The resident had one fall with no injury.

On 4/27/22 at 12:41 PM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that she regularly cared for Resident #54 and to her knowledge, the resident had never had a fall which resulted in a major injury.

At 10:51 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that she had been regularly providing care to the resident for nine months and the resident had not had a fall with a major injury.

At 10:54 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that the resident had no falls with injury.

At 11:04 AM, the surveyor reviewed the 3/01/22, quarterly MDS in the presence of the MDS Coordinator who stated that the MDS reflected that the resident had two falls, one with no injury and one with major injury.

At 11:19 AM, the surveyor conducted a follow up interview with the MDS Coordinator who stated that the resident had one fall with no injury and the MDS was coded incorrectly.

According to the (Resident Assessment Instrument) RAI Manual 3.0, falls are the leading cause of morbidity and mortality among nursing home residents and previous falls, especially recurrent falls and falls with injury, are the most

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important predictor of future falls and injurious falls. A further review of the RAI Manual 3.0 provides coding instructions for falls and indicates to code zero (0), none: if the resident had no major injurious falls since prior assessment.

2. On 4/22/22 at 1:00 PM, the surveyor reviewed the immunization record for Resident #16. The electronic medical record did not contain evidence that the resident had been offered the influenza vaccination.

A review of the resident's quarterly MDS, dated 1/15/2022, reflected that the facility did not offer the influenza vaccine to Resident #16.

During an interview with the surveyor on 5/02/22 at 9:28 AM, the Regional Administrator presented the "Influenza Immunization Informed Consent" form signed by the spouse of Resident #16 and witnessed by the LPN. The form indicated that Resident #16 received the influenza vaccine on 10/21/2021. This contradicted what was coded in the quarterly MDS, dated 1/15/22.

During an interview with the surveyor on 5/04/22 at 11:34 AM, the Regional MDS Coordinator stated the PRN (as needed) MDS Coordinator had made, "some mistakes" while coding the MDS.

According to the RAI Manual influenza - associated mortality results not only from pneumonia, but also from subsequent events arising from cardiovascular, cerebrovascular, and other chronic or immunocompromising diseases that can be exacerbated by influenza.

NJAC 8:39-33.2(d)

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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, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to a.) follow the appropriate Physician's Order (PO) in accordance with professional standards of practice for the treatment of a pressure ulcer, and b.) follow their facility's Policy and Procedure for Dressings, Dry/Clean. This deficient practice was identified for one (1) of three (3) residents, (Resident #59) reviewed for pressure ulcers and was evidenced by the following: On 4/26/22 at 9:29 AM, the surveyor observed Resident #59 sitting upright at the edge of his/her bed on a functional air mattress eating cheerios for breakfast. The surveyor observed that the resident had light brown adhesive bandages attached to both feet. The brown adhesive bandage on the resident's right foot was dated "4/26." The surveyor further observed that the light brown adhesive bandage had detached from	F 686	F686 SS=D CFR(s): 483.25 (b) (1) (i) (ii) – Treatment/Services to Prevent/Heal Pressure Ulcer ¿ Nurses that were identified for not following the doctor's order for completing the treatment, accordingly, were in-serviced on following a physician's order ¿ Medical Doctor/ Nurse Practitioner notified of incorrect treatment for resident #59 ¿ All residents with skin impairment can be affected ¿ An audit was completed facility wide to ensure each treatment was completed consistent with professional standard of practice. ¿ The director of nursing or designee will complete wound Competencies will be completed twice a week for no less than 2	6/15/22

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F 686	Continued From page 35 the residents left foot, and the residents foot remained placed on top of the adhesive bandage that was no longer adhered to the residents left foot. At that time, the surveyor exited the room and interviewed the Licensed Practical Nurse (LPN#1) who stated that the treatment to the resident's bilateral lower extremities had already been done by the nurse that morning. The surveyor reviewed the medical record for Resident #59. A review of the resident's Admission Record (An Admission Summary) reflected that the resident had resided at the facility for approximately three years and had diagnoses which included but were not limited to EX Order 26 § 4b1 [redacted] A review of the resident's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated, 1/28/22, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated the resident was EX Order 26 § 4b1. A further review of the residents quarterly MDS, Section M - [redacted] Conditions indicated that the resident was at risk for developing EX Order 26 § 4b1. A review of the resident's April 2022 Order Summary Report (OSR) reflected a PO dated	F 686	months or until compliance is satisfactory on random nurses to ensure the treatment is completed per physician's order and consistent with professional standard of practice ¿ The director of nursing or designee will complete an audit, bi-weekly for no less than 2 months or until compliance is satisfactory, consisting of at least 4 residents to ensure the proper treatment is in place and consistent with professional standards of practice ¿ Findings of audits will be reported to quarterly QAPI committee by director of nursing or designee with suggested recommendations made by the committee.	

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4/9/22, Ex.Order 26.4(b)(1) , apply EX Order 26 § 4b1 EX Order 26 § 4b1 . A further review of the resident's April 2022 OSR reflected an additional PO dated 4/9/22, to cleanse EX Order 26 § 4b1

On 4/27/22 at 9:23 AM, the surveyor observed the resident seated on the edge of his/her bed eating breakfast. The surveyor observed that the resident had white cling wrapped around his/her EX Order 26 § 4b1 .

At 11:24 AM, the surveyor in the presence of another surveyor observed the Licensed Practical Nurse/Unit Manger (LPN/UM) perform the wound care treatments for Resident #59. The surveyors observed the LPN/UM remove the white cling wrap from the resident's EX Order 26 § 4b1 . The surveyors observed that the resident had a light brown adhesive bandage attached to his/her EX Order 26 § 4b1 .

At 11:32 AM, the LPN/UM stated that when she removed the white cling dressing from the resident's EX Order 26 § 4b1 there was no ABD pad on the resident's heel.

At 11:35 AM, the surveyors observed the LPN/UM remove the white cling dressing from the residents Ex.Order 26.4(b)(1 At that time, the surveyors observed that the resident had a light brown adhesive bandage attached to the bottom of his/her Ex.Order 26.4(b)(1

At 12:16 PM, the surveyor interviewed LPN#1 who stated that when the nurse performed the

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wound care treatment, the nurse should follow the PO that were prescribed by the physician.

At 12:17 PM, the surveyor interviewed the LPN/UM who stated that the expectation was to follow the appropriate PO for treatments that were ordered for the resident. The LPN/UM further stated that if for whatever reason, the original dressing or topical medication was not available, the nurse would call the physician to make the physician aware and change the PO to reflect the care provided to the resident.

On 4/28/22 at 10:32 AM, the surveyor interviewed LPN#2 who stated that she performed the [redacted] treatments on Resident #59 on 4/26/22. LPN#2 told the surveyor that she cleansed the resident's [redacted] The surveyor asked LPN#2 what type of dressing she applied to the resident's [redacted]. LPN#2 stated, "The border gauze, the ones that stick." LPN#2 further stated that she then wrapped the cling around the [redacted] on the resident. LPN#2 told the surveyor that she performed the [redacted] way because that was the way the previous nurse had performed the treatment on the resident.

On 04/29/22 at 12:14 PM, the surveyor interviewed the Director of Nursing who stated that when a nurse was performing a wound care treatment, they should absolutely follow the PO and if there was an issue with supplies or something needed to be changed, the nurse should notify the resident's physician.

A review of the resident's April 2022 electronic

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treatment administration record (eTAR) revealed that the nurses were signing at 0900 (9:00 AM) and 1700 (5:00 PM) from 4/9/22 to 4/27/22 that they had cleansed the resident's EX Order 26 § 4b1 [redacted] A further review of the resident's April 2022 eTAR revealed that the nurses were signing at 0900 (9:00 AM) and 1700 (5:00 PM) from 4/9/22 to 4/28/22, that they had cleansed the resident's EX Order 26 § 4b1 [redacted]

A review of the residents undated Care Plan revealed a focus area that the resident had a Ex.Order 26.4(b)(1) and Ex.Order 26.4(b)(1) [redacted] that would close and reopen frequently. The goal of the resident's Care Plan was to maintain skin integrity and to keep EX Order 26 § 4b [redacted] The interventions of the resident's Care Plan indicated to provide wound treatment as ordered and for the treatment nurse and podiatry nurse to evaluate discoloration.

A review of the facility's undated Dressings, Dry/Clean Policy and Procedure indicated to verify that there was a physician's order for the treatment and to check the treatment order in preparation for performing the treatment. The facility's Dressings, Dry/Clean Policy and Procedure further indicated, "Apply the ordered dressing and secure with tape or bordered dressing per order."

NJAC 8:39-27.1(a)

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F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication observation performed on 4/25/22 and 4/26/22, the surveyor observed four (4) nurses administer medications to seven (7) residents. There were 28 opportunities, and three (3) errors were observed which calculated to a medication administration error rate of 10.71 %. This deficient practice was identified for three (3) of seven (7) residents, (Resident #40, #54 and #84), that were administered medications by two (2) of four (4) nurses. The deficient practice was evidenced as follows: 1. On 4/26/22 at 8:27 AM, during the medication pass, the surveyor observed the Licensed Practical Nurse (LPN #1) preparing to administer eight (8) medications to Resident #40 which included two EX Order 26 § 4b1 [redacted] On 4/26/22 at 8:35 AM, the surveyor observed the LPN #1 place EX Order 26 § 4b1 on the resident's left and then right shoulder. The surveyor reviewed the medical record for	F 759	F759 SS=D CFR(s): 483.45 (f) (1) – Free of Medication Errors Rates 5% or More ¿ The nurses that were identified not in compliance with standard of care with medication administration were in-serviced on the 6 rights of drug administration. ¿ All residents have the potential to be affected. ¿ The nurses that were identified not in compliance with standard care of medication administration were med passed by the pharmacy consultant to ensure competency ¿ Medical Doctor/ Nurse Practitioner notified of incorrect medication administration standards of practice for residents # 40, #54, and #80 ¿ The pharmacy consultant will perform 2 med passes a month on two different nurses for no less 2 months or until compliance is satisfactory to ensure competency with medication administration and findings will be reported to the quarterly QAPI committee with suggested recommendations made by the committee.	6/15/22

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F 759	Continued From page 40 Resident #40. A review of the Admission Record revealed diagnoses which included Ex.Order 26.4(b)(1) EX Order 26 § 4b1 A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 2/15/22, reflected the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, indicating that the resident had EX Order 26 § 4b1 . A review of the April 2022 Order Summary Report reflected a physician's order (PO) with a start date of 11/11/21 for EX Order 26 § 4b1 apply Ex.Order 26.4 [redacted] hours then remove and remove per schedule." A review of the April 2022 electronic medication administration record (EMAR) revealed a PO with a start date of 11/12/21 for "EX Order 26 § 4b1 Ex.Order 26.4([redacted] hen remove and remove per schedule." The EMAR indicated that the Lidocaine patch was applied at 8:00 AM and removed at 8:00 PM. There was no PO to apply the EX Order 26 § 4b1 EX Order 26 to the EX Order 26 § 4b1 . On 4/26/22 at 10:05 AM, the surveyor with the LPN #1 reviewed the EMAR which revealed the PO for the EX Order 26 § 4b1 to be applied to the Ex.Order 26.4(b)(1) the PO had included the EX Order 26 § 4b1 in the order. The LPN #1 could not find a PO for the EX Order 26 § 4b1 to be applied to the EX Order 26	F 759		

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F 759	Continued From page 41 Ex.Order 26.4(b)(1). The LPN #1 added that she was unsure why the PO did not include the Ex.Order 26.4(b)(1) because she thought the resident had a PO for Ex.Order 26.4(b)(1) in the past. ERROR#1 On 4/26/22 at 12:15 PM, the surveyor interviewed the Consultant Pharmacist (CP) who stated that she does not always come every month because she works as a team with other Pharmacists but was able to speak to the process. The CP added that her company had been the CP since the beginning of February 2022. The CP stated that the PO and EMAR was an "integrated system" with the provider pharmacy, meaning that "when the PO is electronically entered, it goes to the provider in real time." The CP was unsure if nurses entered PO and deferred to the DON for the process of entering a PO. The CP acknowledged that the nurses were to follow PO and a medication was not to be administered without a PO. On 4/26/22 at 1:44 PM, the surveyor interviewed the Director of Nursing (DON) and Risk Management Regional Nurse who stated that the provider pharmacy had been changed in January 2022 and the CP was changed in 2022. The DON stated that she would have to review the EX Order 26 § 4b1 PO for Resident #40. On 4/28/22 at 1:10 PM, the survey team met with the administrative team. The Licensed Nursing Home Administrator (LNHA) stated that the undated policies that were provided were current. On 4/29/22 at 12:00 PM, the survey team met with the DON. The DON stated that the nurses were responsible for entering PO electronically. The DON also stated that the EX Order 26 § 4b1 PO	F 759		

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for Resident #40 was "lost in translation" and unsure of what had happened. The DON acknowledged that there was no PO for [EX Order 26 § 4b1] to be administered to the [Ex.Order 26.4(b)(1)]. The DON added that the LPN #1 was inserviced and the PO was clarified.

A review of the undated facility policy for "Administering Medications" provided by the LNHA on entrance revealed that the medications were administered as prescribed. In addition, "Medications are administered in accordance with prescriber orders, including any required time frames." Further review reflected, "The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

2. On 4/26/22 at 8:42 AM, during the medication pass, the surveyor observed LPN #1 preparing to administer medications to Resident #54. The LPN #1 stated that the resident had a PO for [EX Order 26 § 4b1] which was an over the counter /house stock (OTC/HS) medication, meaning that the facility obtained the medication. The LPN #1 added that she was preparing two [EX Order 26 § 4b1] (MG) tablets as ordered for Resident #54.

The surveyor reviewed the medical record for Resident #54.

A review of the Admission Record revealed diagnoses which included unspecified [EX Order 26 § 4b1] and [Ex.Order 26.4(b)(1)]

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F 759	Continued From page 43 A review of the quarterly MDS dated 3/1/22, reflected the resident had a BIMS score of [redacted] out of 15, indicating that the resident had a [redacted]. A review of the April 2022 Order Summary Report reflected a PO with an order date of 2/19/21 for "[redacted], [redacted] A review of the April 2022 EMAR revealed a PO with a start date of 2/20/21 for "[redacted] by mouth every 12 hours for pain, do not exceed [redacted] of [redacted]." On 4/26/22 at 10:07 AM, the surveyor interviewed the LPN #1 who stated that she had in her medication cart, as part of her OTC/HS, [redacted] The LPN #1 also stated that she had administered two (2) [redacted] during the medication pass in the morning and had not administered any other type or dose of [redacted]. At that time, the surveyor with the LPN #1 reviewed the EMAR for Resident #54 which revealed the PO dated 2/19/21 for [redacted] The LPN #1 stated "I should have administered the [redacted]. Sorry, I made a mistake." ERROR#2 On 4/29/22 at 12:00 PM, the survey team met with the DON. The DON added that the LPN #1 was inserviced regarding the six rights of	F 759		

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medication administration: right patient, right medication, right dose, right route, right time, and right documentation.

A review of the undated facility policy for "Administering Medications" provided by the LNHA on entrance revealed that the medications are administered as prescribed. In addition, "Medications are administered in accordance with prescriber orders, including any required time frames." Further review reflected, "The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

3. On 4/26/22 at 8:49 AM, during the medication pass, the surveyor observed the LPN #2 at the medication cart in front of the doorway to the room for Resident #84. The LPN #2 stated that she had already administered oral medications to Resident #84 and was about to administer Ex.Order 26.4(b)(1) to the resident.

At that time, the surveyor observed the LPN #2 apply three (3) EX Order 26 § 4b1 patches onto resident's EX Order 26 § 4b1 .

Upon returning to the medication cart, the LPN #2 stated that she was moving onto the next resident for the medication pass. The surveyor had not observed the LPN #2 electronically sign the EMAR.

The surveyor reviewed the medical record for Resident #84.

A review of the Admission Record revealed

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diagnoses which included EX Order 26 § 4b1 [redacted]

A review of the quarterly MDS dated 3/22/22, reflected the resident had a BIMS score of [redacted] out of 15, indicating that the resident had a EX Order 26 § 4b1 .

A review of the April 2022 Order Summary Report revealed that there was no PO for EX Order 26 § 4b1 patches to be applied.

A review of the April 2022 EMAR also revealed that there were no PO for EX Order 26 § 4b1 to be applied.

On 4/26/22 at 10:10 AM, the surveyor interviewed the LPN #2 who stated the resident had been on EX Order 26 § 4b1 [redacted] on the knees and back and that had been discontinued. The LPN #2 added that she thought the EX Order 26 § 4b1 had been ordered to replace the gel.

At that time, the surveyor with the LPN #2 reviewed the EMAR for Resident #84. The LPN #2 stated that she could not find a PO for the application of the Ex.Order 26.4(b)(1). The LPN #2 added that she was unsure why there was no PO. The LPN #2 stated that she would have to enter a PO for the EX Order 26 § 4b1. ERROR#3

On 4/26/22 at 12:15 PM, the surveyor interviewed the Consultant Pharmacist (CP) who stated that she does not always come every month because she works as a team with other Pharmacists but was able to speak to the process. The CP added

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that her company has been the CP since the beginning of February 2022. The CP stated that the PO and EMAR was an "integrated system" with the provider pharmacy, meaning that "when the PO is electronically entered, it goes to the provider in real time." The CP was unsure if nurses entered PO and deferred to the DON for the process of entering a PO. The CP acknowledged that the nurses were to follow PO and a medication was not to be administered without a PO.

On 4/26/22 at 1:44 PM, the surveyor interviewed the DON and Risk Management Regional Nurse who stated that the provider pharmacy had been changed in January 2022 and the CP was changed in 2022. The DON stated that she would have to review the PO for Resident #84.

On 4/28/22 at 1:10 PM, the survey team met with the administrative team. The LNHA stated that the undated policies provided were current.

On 4/29/22 at 12:00 PM, the survey team met with the DON. The DON stated that the nurses were responsible for entering PO electronically. The DON stated that she was unsure what had happened with the EX Order 26 § 4b1 not having a PO. The DON added that the LPN #2 was inserviced regarding the six rights of medication administration: right patient, right medication, right dose, right route, right time, and right documentation.

A review of the undated facility policy for "Administering Medications" provided by the LNHA on entrance revealed that the medications are administered as prescribed. In addition, "Medications are administered in accordance with

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F 759	Continued From page 47 prescriber orders, including any required time frames." Further review reflected, "The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. Also, "As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. the date and time the medication was administered, b. the dosage, c. the route of administration ...g. the signature and title of the person administering the drug." NJAC 8:39-11.2(b), 29.2(d)	F 759		
F 880 SS=D	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: §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	F 880		6/15/22

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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 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

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F 880	Continued From page 49 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, record review, and review of pertinent facility documentation, it was determined that the facility staff failed to appropriately perform hand hygiene for one (1) of four (4) nurses during the medication pass for one (1) of seven (7) residents being administered medications. These deficient practices were evidenced by the following: According to the U.S. CDC guidelines for Hand Hygiene in Healthcare Settings Hand Hygiene Guidance, updated 1/30/20, included Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices Before moving from work on a soiled body site to a clean body site on the same patient After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in	F 880	F880 SS=D CFR(s): 483.80 (1) (2) (4) (e) (f) Infection Prevention and Control ¿ The nurse identified to allegedly be out of compliance with CDC guidelines for hand washing and proper glove use according to standard precautions was in-serviced and completed a competency to ensure standards of practice were completed properly ¿ All residents have the potential to be affected ¿ Medical Doctor/Nurse Practitioner notified of alleged concerns regarding hand hygiene and proper glove usage and handwashing for resident #40 ¿ The Director of Nursing, Infection Preventionist, or designee will perform 5 random audits on Hand Hygiene and proper glove use via direct observation/return demonstration Weekly for no less than 2 months or until compliance is satisfactory. ¿ The findings will be reported and reviewed with the QAPI committee. When the committee determines the problem no longer exists, audits will be conducted on a random basis.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315135	A. BUILDING _____ B. WING _____	C 05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST POINTE REHABILITATION AND HEALTHCARE CENTER	1515 HULSE ROAD PT PLEASANT, NJ 08742

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F 880	Continued From page 50 most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands. In addition, included guidelines as to when and wear to wear gloves: Wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur. Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment. Perform hand hygiene immediately after removing gloves. Change gloves and perform hand hygiene during patient care, if gloves become damaged, gloves become visibly soiled with blood or body fluids following a task, moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs. On 4/26/22 at 8:27 AM, during the medication pass, the surveyor observed the Licensed Practical Nurse (LPN) preparing to administer Ex.Order 26.4(b)(1) to Resident #40 which included Ex.Order 26.4(b)(1) , [redacted] On 4/26/22 at 8:35 AM, the surveyor observed the LPN bring the medications to be administered into the resident's room and stated that she had	F 880	ROOT CAUSE ANALYSIS 1) EVENT: Annual Survey May 11, 2022 2) TEAM FACILITATORS: Administrator, Director of Nursing, Infection Preventionist (IP) GOVERNING BODY: Quality Assurance Performance Improvement (QAPI) Committee 3) PROBLEMS IDENTIFIED: ¿ The facility staff allegedly failed to appropriately perform hand hygiene properly, as they were deficient in practiced according to CDC guidelines and wear gloves according to standard precautions. 4) CONTRIBUTING FACTORS: ¿ The nurse did not change her gloves and perform hand hygiene prior to pulling down the lower lid of the eye for the administration of the eye drops ¿ The nurse also used the same tissue to pat both eyes ¿ The nurse did not do hand hygiene after removing gloves 5) ROOT CAUSES: ¿ Lack of knowledge that of when to don/doff gloves ¿ Lack of knowledge that gloves are not a substitute for hand hygiene. ¿ Facility could have increased education and competencies of glove use and hand hygiene 6) CORRECTIVE ACTIONS: ¿ The nurse identified with improper technique regarding hand hygiene and	

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F 880	Continued From page 51 to fix the resident's position. The surveyor observed the LPN reposition the resident. The LPN then put on gloves and placed the Ex.Order 26.4(b)(1) on the resident's Ex.Order 26.4(b)(1) and Ex.Order 2. Using the same gloves, the LPN helped the resident with his/her oral medications using a spoon and held the resident's Styrofoam cup with a straw so that the resident was able to take the oral medications. Then, the LPN administered the Ex.Order 26.4(b)(1) to the Ex.Order 26.4(b)(1) and administered the resident's Ex.Order 26.4(b)(1). During the Ex.Order 26.4(b)(1) administration the LPN used her gloved fingers to facilitate Ex.Order 26.4(b)(1) administration by pulling down under the Ex.Order 26.4(b)(1). In addition, the LPN used a tissue after Ex.Order 26.4(b)(1) administration to pat the left Ex.Order 2 and turned the tissue over and patted the Ex.Order 26.4(b)(1). The LPN then removed the gloves that were used during the entire medication administration for Resident #40. The surveyor had not observed the LPN use hand hygiene after repositioning the resident and before putting on gloves. The surveyor had not observed the LPN change gloves or use hand hygiene before Ex.Order 26.4(b)(1) administration. Upon returning to the medication cart, the LPN used an alcohol-based hand rub for hand hygiene. On 4/26/22 at 8:46 AM, the surveyor interviewed the LPN who stated that she was inserviced on proper hand hygiene techniques by the Infection Preventionist (IP)/LPN. The LPN stated that hand hygiene should be performed before and after putting on gloves. The LPN then stated that she had performed hand hygiene after the last resident that she had completed med pass before starting Resident #40. When asked if the LPN was supposed to change gloves at any time	F 880	proper glove use was in-serviced and completed a competency to ensure standards of practice was completed properly ¿ The Director of Nursing, Infection Preventionist or designee will conduct competencies with return demonstration of hand hygiene and proper glove use on random employees to ensure standard practice is being carried out to prevent healthcare-associated infections. 7) MONITORING/EVALUATIONS: The Director of Nursing, Infection Preventionist, or designee will perform 5 random audits on Hand Hygiene and proper glove use via direct observation/return demonstration Weekly for no less than 2 months or until compliance is satisfactory and the findings will be reported and reviewed with the QAPI committee. When the committee determines the problem no longer exists, audits will be conducted on a random basis. 8) List of education completed and staff that completed each area of education: • Core Competencies for Public Health Professionals- Top Line Staff & Infection Preventionist • Keep Covid-19 Out- Viewed by Frontline Staff • Clean Hands- Viewed by Frontline Staff • Closely Monitor Residents for	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 52 during the medication pass, the LPN stated "I didn't. I was supposed to." The LPN acknowledged that she had put on gloves and had not changed the gloves during the medication pass for Resident #40. The LPN stated that she usually wore gloves for the Ex.Order administration for Resident #40 because the resident sometimes had Ex.Order 26.4(b)(1) The surveyor reviewed the medical record for Resident #40. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 2/15/22, reflected the resident had a brief interview for mental status (BIMS) score of Ex.O out of 15, indicating that the resident's EX Order 26 § 4b1 · 26 § 4b1 . On 4/28/22 at 1:10 PM, the survey team met with the Administrative team. The Director of Nursing (DON) stated that she would expect nurses to perform hand hygiene before and after putting on and taking off gloves. In addition, the DON stated that the gloves should have been changed and hand hygiene should have been performed before administering Ex.Order 26.4(b)(1) to the resident. On 4/29/22 at 12:00 PM, the survey team met with the DON. The DON stated that the LPN #1 was inserviced regarding when administering Ex.Order perform proper hand hygiene prior to and after administration and to change gloves. On 5/2/22 at 11:11 AM, the surveyor, in the presence of the survey team, interviewed the IP/LPN who stated that she had been doing the inservices regarding hand hygiene because there	F 880	Covid-19- Viewed by Frontline Staff • PPE Lessons- Viewed by Frontline Staff • Nursing Home Infection Preventionist Training Course Module 5 – Outbreaks- Top Line Staff & Infection Preventionist • Nursing Home Infection Preventionist Training Course Module 4 - Infection Surveillance-Top Line Staff & Infection Preventionist • Nursing Home Infection Preventionist Training Course Module 7 - Hand Hygiene- All Staff Including Top Line Staff & Infection Preventionist • Nursing Home Infection Preventionist Training Course Module 6A - Principles of Standard Precautions- All Staff Including Top Line Staff & Infection Preventionist • Nursing Home Infection Preventionist Training Course Module 6B - Principles of Transmission Based Precautions- - All Staff Including Top Line Staff & Infection Preventionist	

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F 880	Continued From page 53	F 880		

was no Assistant Director of Nursing. The surveyor reviewed the process that the LPN had used for Resident #40 during the medication pass and the IP stated, "That should not have happened." The IP added that after repositioning the resident the LPN should have performed hand hygiene and gloves should have been changed prior to eye drop administration with hand hygiene before and after putting on the gloves.

A review of the facility policy dated 2/10/22 for "Handwashing/Hand Hygiene" reflected that the facility considers hand hygiene the primary means to prevent the spread of infections. In addition, the facility policy reflected that use of alcohol-based hand rub or soap, and water should be done before and after direct contact with residents, after contact with resident's intact skin, after removing gloves. "The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections."

NJAC 8:39-19.4(a)(l)(n)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061502	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST POINTE REHABILITATION AND HEALTHCARE	1515 HULSE ROAD PT PLEASANT, NJ 08742

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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 review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shifts and the overnight shifts as mandated by the state of New Jersey. This was evidenced for 14 of 14 day shifts and 4 of 14 overnight shifts reviewed. Findings include: Reference: New Jersey Department of Health (DOH) memo, dated 01/28/2021, "Compliance 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	S 560	S560 8:395.1 (a) Mandatory Access to Care ¿ No residents were identified ¿ Residents of the facility have the potential to be affected ¿ Director of Nursing, Staffing Coordinator and Administrator will meet daily during the week to review recruitment efforts, staffing for next day, and staffing for upcoming week. ¿ The facility has developed a Culture Committee focused on recruitment. and retention of staff along with customer service and the employee experience. ¿ The facility has implemented the Care	6/15/22

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

Electronically Signed | 06/03/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 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. A review of the "Nursing Staffing Report" completed by the facility for the weeks of 4/3/22 through 4/9/22 and 4/10/22 through 4/16/22, revealed the staffing to residents' ratios did not meet the minimum requirement of one CNA to eight residents for the day shift and one CNA to 14 residents for the overnight shift as documented below: - 04/03/22, had 9 CNAs for 102 residents on the day shift, required 13 CNAs. - 04/03/22, had 7 total staff for 102 residents on the overnight shift, required 8 total staff. - 04/04/22, had 10 CNAs for 101 residents on the day shift, required 13 CNAs. - 04/05/22, had 10 CNAs for 101 residents on the day shift, required 13 CNAs. - 04/06/22, had 10 CNAs for 101 residents on the day shift, required 13 CNAs. - 04/07/22, had 8 CNAs for 101 residents on the day shift, required 13 CNAs.	S 560	Champion Program to mentor new employees which has been proven to raise retention rates. ¿ The facility participates in an interdisciplinary Quality Care Resource call to review open positions, recruitment tactics, and changes to improve outcomes. ¿ Contract staff utilization is reviewed bi-weekly to identify trends and opportunities. ¿ The facility has contracts in place with multiple staffing agencies as an effort to provide additional staff when needed. ¿ The facility has implemented a multifaceted approach for recruitment and retention of employees, Job fairs, Flexible scheduling, Increased utilization of PRN staff, Implementation of OnShift, Multimedia advertisements, Partnership with schools, Sign on bonuses, Referral bonuses, Pick-up shift bonuses, Boomerang campaign to rehire staff that have resigned, Rate adjustments, Benefit adjustments, Contract staff utilization, Implementation of Temporary Nurse Aide program, Text message campaigns. ¿ The administrator/designee will review the minutes from resident council to determine whether any concerns regarding care and services are identified monthly for two months and then quarterly. ¿ The results of Resident Council minutes as well as recruitment data will be reviewed by the Administrator or designee at the quarterly QAPI meeting.	

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S 560	Continued From page 2 - 04/08/22, had 8 CNAs for 105 residents on the day shift, required 14 CNAs. - 04/09/22, had 9 CNAs for 105 residents on the day shift, required 14 CNAs. - 04/10/22, had 9 CNAs for 105 residents on the day shift, required 14 CNAs. - 04/10/22, had 7 total staff for 105 residents on the overnight shift, required 8 total staff. - 04/11/22, had 10 CNAs for 101 residents on the day shift, required 13 CNAs. - 04/12/22, had 8 CNAs for 101 residents on the day shift, required 13 CNAs. - 04/13/22, had 8 CNAs for 101 residents on the day shift, required 13 CNAs. - 04/14/22, had 11 CNAs for 101 residents on the day shift, required 13 CNAs. - 04/14/22 had 7 total staff for 101 residents on the overnight shift, required 8 total staff. - 04/15/22 had 9 CNAs for 104 residents on the day shift, required 13 CNAs. - 04/16/22, had 10 CNAs for 104 residents on the day shift, required 13 CNAs. - 04/16/22, had 7 total staff for 104 residents on the overnight shift, required 8 total staff. On 5/2/22 at 10:27 AM, the surveyor interviewed the staffing coordinator who acknowledged and was able to speak to the minimum staffing ratios for each shift. She acknowledged that there are staffing issues for the 7-3 shifts due to call outs. She stated she is "working on recruitment and retention." She further stated, "I would reach out to our staff as well as agency if we are short and I would jump in because I am a CNA. I'm doing the best I can with the staff we have." In addition, she stated that the facility stopped using agency staff in March of 2022 "because we had had enough staff." On 5/2/22 at 10:51 AM, the surveyor interviewed	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 3 the Licensed Nursing Home Administrator (LNHA) who acknowledged and was able to speak to the minimum staffing ratios. He stated that "sometimes we are not meeting the minimum on the 7-3 shift because of call outs, but we are doing everything we can to be within the minimum staffing requirements. Right now we don't have any agency staff, but in the past we were using agency staff, but in March of 2022; we were able to hire staff and some staff came back so we stopped using agency staff." Review of the facility policy for "Staffing" provided by the LNHA indicated that the facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. The LNHA stated that the facility does not have a facility policy specific for the minimum staffing ratio.	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315135 Y1	A. Building B. Wing Y2	8/2/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST POINTE REHABILITATION AND HEALTHCARE CENTER	1515 HULSE ROAD PT PLEASANT, NJ 08742

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0609	Correction	ID Prefix F0610	Correction	ID Prefix F0623	Correction
Reg. # 483.12(c)(1)(4)	Completed	Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.15(c)(3)-(6)(8)	Completed
LSC	06/15/2022	LSC	06/15/2022	LSC	06/15/2022
ID Prefix F0625	Correction	ID Prefix F0641	Correction	ID Prefix F0686	Correction
Reg. # 483.15(d)(1)(2)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed
LSC	06/15/2022	LSC	06/15/2022	LSC	06/15/2022
ID Prefix F0759	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.45(f)(1)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	06/15/2022	LSC	06/15/2022	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/11/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061502 Y1	A. Building B. Wing Y2	8/2/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST POINTE REHABILITATION AND HEALTHCARE CENTER	1515 HULSE ROAD PT PLEASANT, NJ 08742

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 06/15/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 5/11/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ **YES** ☐ **NO**