STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315213	A. BUILDING _____ B. WING _____	C 06/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW SPRINGS REHABILITATION AND HEALTHCARE CTR	**1049 BURNT TAVERN ROAD BRICK, NJ 08724**

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F 000	INITIAL COMMENTS Complaint #: NJ143724, NJ146017, NJ144700, NJ144134, NJ143427, NJ144790, and NJ145841 Census: 131 Sample Size: 13 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 551 SS=D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the	F 551		7/9/21

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

Electronically Signed | 07/07/2021

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F 551	Continued From page 1 resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: Complaint Intake: NJ144700 Based on record reviews and staff interviews, it was determined that the facility failed to honor the	F 551	1. Resident #2 identified in the Statement of Deficiencies (SOD) was monitored for 5 days post incident with no signs or symptoms adverse reactions.	

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F 551	Continued From page 2 decision the responsible party (RP) made to decline the COVID-19 vaccination for a resident and failed to obtain consent from the responsible party for the COVID-19 vaccination for 1 (Resident #2) of 3 residents reviewed for immunizations. Findings include: 1. Resident #2 was admitted to the facility on Executive Order 26, 4.b. with diagnoses Executive Order 26, 4.b. [redacted] A review of the admission Minimum Data Set (MDS), dated Executive Order 26, 4.b., indicated the resident was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) Executive Order 26, 4.b. [redacted] The resident had adequate hearing, clear speech, sometimes understood, sometimes understanding others, and had adequate vision. A review of the facility Resident Rights, and Advanced Directive Acknowledgement Certificate dated Executive Order 26, 4.b. [redacted], revealed a "Signature of Responsible Party," signed by Resident #2's spouse. A review of the facility admission agreement read the agreement was "effective as of Executive Order 26, 4.b. [redacted] ("effective date") by and between Facility and [Resident #2's name here] ("Resident") and [signature of spouse here] (Legal Representative)." A review of the nurse practitioner note dated Executive Order 26, 4.b. [redacted] revealed Resident #2 was Executive Order 26, 4.b. [redacted]	F 551	There were no negative outcomes noted. MD was notified on Executive Order 26, 4.b. [redacted] and no change in plan of care was needed. In-service education to honor the decision the responsible party (RP) were provided to the Unit Manager identified in the SOD. 2. All residents with RP have the potential to be affected. An audit of all residents with RPs was completed and no concerns were noted. 3. The Director of Nursing will re-educate all licensed staff on obtaining consent from an RP and carrying out the care and/or treatment as per consent. 4. The Director of Nursing will complete audits for all residents with RPs weekly for four weeks and then monthly for 3 months. Results of the audits will be reported to the monthly Quality Assurance Performance Improvement committee for review. The Quality Assurance Performance Improvement committee will determine the need for further and continued action.	

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F 551	Continued From page 3	F 551		

but did communicate a few simple needs.

A review of the [redacted] note dated [redacted] revealed the Director of Rehab spoke with the [redacted] about [redacted] and the [redacted]

During the COVID-19 pandemic, the social worker and the Director of Rehab were assisting by discussing the vaccine with families/powers of attorney and getting consent forms signed.

A review of the physician's progress note dated [redacted] revealed Resident #2 [redacted]

A review of the nurse's note dated [redacted] revealed Resident #2 was [redacted]

A review of the [redacted] informed consent dated [redacted], and the printed name read, [Resident #2's first name twice (e.g., [redacted], [redacted])] and was signed with the resident's initials (e.g., [redacted]

A review of the nurse's note dated [redacted] revealed Resident #2 received the [redacted]. A copy of the signed consent form was placed in the chart.

A review of the [redacted] dated [redacted], revealed Resident #2 was [redacted]. The resident had a Brief Interview for Mental Status [redacted]

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F 551	Continued From page 4 A review of the nurse's note dated Executive Order 26, 4.b. revealed Resident #2 was Executive Order 26, 4.b. [redacted] A review of the Executive Order 26, 4.b. dated Executive Order 26, 4.b. revealed the Executive Order 26, 4.b. [redacted] dated [redacted] and the earlier date had been lined through and a new date of Executive Order 26, 4.b. was written in. A review of the nursing note dated Executive Order 26, 4.b. revealed Resident #2 Executive Order 26, 4.b. [redacted] During an interview with the Director or Rehab on 06/17/2021 at 1:15 PM, she stated when she called to update the family about therapy, she probably asked if they wanted the resident to receive the vaccine. She further stated once she had any information it went in an email to the team, so they were all are aware. During a follow up interview on 06/18/2021 at 9:31 AM, the Director of Rehab stated she could not find the email of 01/15/2021. She stated 99% of the time she sends an email but maybe she verbally communicated this in a morning meeting or verbally to the infection control person at that time. She stated the infection control nurse was no longer working at the facility. During an interview with the current Infection Control Nurse on 06/17/2021 at 1:21 PM, she stated if a resident were not alert and oriented, the facility would have called the first family contact and got verbal authorization over the phone. She stated she was not in the facility in January but in reviewing the consent for Resident	F 551		

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F 551	Continued From page 5 #2, Executive Order 26, 4.b. [redacted] During an interview with the LSW on 06/17/2021 at 1:49 PM, she stated she had Executive Order 26, 4.b. [redacted] She stated apparently, the resident had voiced they wanted the vaccine. The resident was Executive Order 26, 4.b. [redacted] During an interview with Unit Manager #1 on 06/17/2021 at 2:59 PM, she stated the resident was not groggy at any time. The resident was awake but Executive Order 26, 4.b. [redacted]. During an interview with the Administrator on 06/17/2021 at 3:52 PM, he stated admissions was dealing with the spouse. Admissions and nursing are two different departments, and the resident was Executive Order 26, 4.b. [redacted] and when (name of pharmacy) came in on 01/19/2021, they addressed the resident with a staff person and the resident said they wanted the vaccine. The resident Executive Order 26 [redacted]. He stated he realized the Executive Order 26, 4.b. [redacted] but again, admissions was a different department than nursing. During an interview with Licensed Practical Nurse (LPN) #2 on 06/17/2021 at 4:10 PM, she stated she did not really remember the resident but if she wrote that the resident was oriented to person and place, then the resident knew him/herself and where the resident was, but could not make decisions about anything. During an interview with Unit Manager #1 on	F 551		

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F 551	Continued From page 6 06/17/2021 at 4:21 PM, she stated she did rounds with the pharmacist and spoke with Resident #2 the same as she did with other residents and told Resident #2 why she and the pharmacist were there. They talked to the resident about COVID-19 and asked if the resident wanted the vaccine. The resident said yes. She stated some days the resident was more talkative. She indicated the Brief Interview for Mental Status Executive Order 26, 4.b., but the resident had good days. During a follow-up interview on 06/18/2021 at 9:54 AM, the Administrator stated even if the family member signed as the responsible party on the admission paperwork, the resident was not deemed incompetent, even if the resident was confused. He further stated the admissions office often times just deals with the family member and not the resident. He also stated the facility did not have any paperwork related to the spouse being the power of attorney.	F 551		
F 677 SS=D	New Jersey Administrative Code: 8:39 - 5.1(a) ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Complaint Intake: NJ144134 Based on observations, record review, interviews, and facility policy review, the facility failed to turn and reposition a dependent resident every 2	F 677	1.Resident #3 identified in the Statement of Deficiencies (SOD) had a Executive assessment completed and no changes in Executive integrity were found. There were no negative outcomes noted. MD was	7/9/21

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F 677	Continued From page 7 hours for 1 of 3 residents (Resident #3) reviewed for activities of daily living (ADLs). Findings include: 1. Resident #3 was admitted to the facility on Executive Order 26, 4.b. Resident #3's care plan, Executive Order 26, 4.b. on Executive Order 26, 4.b., included Executive Order 26, 4.b. The care plan also included a Executive Order 26, 4.b. Resident #3's Minimum Data Set (MDS), dated Executive Order 26, 4.b., revealed Executive Order 26, 4.b., with the need for total assistance from staff for all ADLs. The resident was admitted Executive Order 26, 4.b. An observation of Resident #3 was conducted on Executive Order 26, 4.b. at 8:38 AM. Resident #3 was lying on their back, on an air mattress, with the head of bed elevated 30 degrees. Linens were covering the resident up to abdomen/chest area. There was the appearance of the legs elevated. A Executive Order 26, 4.b. was hung on side of the bed and partly rested on a lower bed support. On Executive Order 26, 4.b. at 10:53 AM and again at 11:31 AM, Resident #3 remained in the same position. The bed covers, and Executive Order 26, 4.b. remained in the same position.	F 677	notified and no change in plan of care was needed. In-service education on skin care which included turning and repositioning was provided to nurses and CNAs that was identified in the SOD. 2. All residents with turning and positioning orders have the potential to be affected. An audit of all residents with turning and positioning orders was completed, and no concerns noted. 3. The Director of Nursing will re-educate all nursing staff on skin integrity and Turning and Repositioning 4. The Director of Nursing will complete audits for all residents with turning and repositioning orders daily for one weeks weekly and then weekly for 3 months. Results of the audits will be reported to the monthly Quality Assurance Performance Improvement committee for review. The Quality Assurance Performance Improvement committee will determine the need for further and continued action.	

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F 677	Continued From page 8 On 06/16/2021 at 11:35 AM, an interview was conducted with LPN #1 who stated Resident #3 Executive Order 26, 4.b. . The LPN stated she had not assisted with turning and repositioning for Resident #3 as of this time. On 06/16/2021 at 1:45 PM, an interview was conducted with Certified Nurse Assistant (CNA) #1. The CNA stated she had given Resident #3 a bath after lunch. The CNA stated she did not know when she had previously changed Resident #3 before the bath, but since Resident #3 required Executive Order 26, 4.b. , the head of the bed was always elevated. The resident was Executive Order 26, 4.b. [redacted] incontinent care or a bath. The CNA stated she was unable to turn the resident from side to side unless it was during incontinent care or bath. On 06/17/2021 at 2:54 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she expected residents to be turned and repositioned according to their care plan, ideally that would occur every two hours. The facility policy, undated, titled, "Repositioning," included under interventions 3. Residents who are in bed should be on at least every two-hour repositioning schedule. New Jersey Administrative Code: 8:39-27.2(b)	F 677		