| STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315200 | A. BUILDING _____ B. WING _____ | C 08/18/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ARISTACARE AT DELAIRE** | **400 W STIMPSON AVE LINDEN, NJ 07036** |

| (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 |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>COMPLAINT #: NJ 136889; NJ 135867; NJ 136419; NJ 135241<br><br>CENSUS: 163<br><br>SAMPLE: 5<br><br>THE FACILITY IS NOT IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES, BASED ON THIS COMPLAINT VISIT. | F 000 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Complaint #: NJ00136889<br><br>Based on observation, interview and record review, it was determined that the facility failed to follow wound protocol to initiate incident report and treatment when there is a new Exec Order 26 identified, in accordance with nursing standards of clinical practice and the facility's pressure ulcer policy.<br><br>This deficient practice was identified for Resident #1, 1 of 1 resident reviewed for pressure ulcer and evidenced by the following:<br><br>Reference: New Jersey Statutes, Annotated Title | F 658 | -LPN #1 and LPN #2 were disciplined due to failure to follow wound protocol by not initiating an incident report and treatment orders to the identified Exec Order 26 § 4b1 of resident #1 on 6/8/2020 and 6/9/2020.<br><br>-The clinical educator/designees will complete a re-education with the nursing staff on the policy and procedures related to wounds in relation to incident report completion and treatment initiation. The Director of nursing/designee will audit the wound reports once a week for 2 months including incident reports and treatment orders to ensure proper procedure is | 9/15/20 |

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

Electronically Signed | 09/03/2020

| STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315200 | A. BUILDING _____ B. WING _____ | C 08/18/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ARISTACARE AT DELAIRE** | **400 W STIMPSON AVE LINDEN, NJ 07036** |

| (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 |
|---|---|---|---|---|
| F 658 | Continued From page 1<br>45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist."<br><br>Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case-finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."<br><br>On 8/18/20 at 9:20 AM, the surveyor observed the NJSA 47 1A-1 reasonable pr and residents' rooms, noted to be clean and with no identified odor.<br><br>On 8/18/20 at 9:11 AM, the Licensed Practical Nurse #1 (LPN#1) informed the surveyor that according to the facility's policy, all residents with incontinence and required assistance with activities of daily living (ADLs) are provided with turning and repositioning (T and P), preventative cream barrier and incontinence care every two hours or as needed. She further stated that the nurse would assess any resident who develops a | F 658 | completed for Exec Order 26 documentation.<br><br>-After the weekly audits x2 months the steering committee will determine continued need/frequency of the audits. These audits will be reported monthly through the Quality Assurance Steering Committee to identify any trends or concerns. | |

| STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315200 | A. BUILDING _____ B. WING _____ | C 08/18/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ARISTACARE AT DELAIRE** | **400 W STIMPSON AVE LINDEN, NJ 07036** |

| (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 |
|---|---|---|---|---|
| F 658 | Continued From page 2 | F 658 | | |

Exec Order 26 § 4b1 individual's health info, initiate an investigation report, report to the physician to obtain a treatment order, and notify the responsible party. LPN#1 informed the surveyor that all the facility residents were on weekly skin monitoring in the Treatment Administration Record (TAR).

At that time, LPN#1 indicated that she was the nurse of Resident #1 in the unit. LPN#1 stated that Resident #1 was Exec Order 26 § 4b1 individual's health info She further stated that she could not remember if she was the one who first identified the Exec Order 26 § 4 and if an investigation was initiated when the new Exec Order 26 § 4 were identified.

Furthermore, LPN#1 informed the surveyor that the Exec Order 26 § 4b1 individual's health info doctor weekly until the resident expired. LPN#1 was unable to remember if there were previous treatment medications before the Exec Order 26 § 4b1 individ.

A review of the resident's Face Sheet (an admission summary), disclosed that the resident had diagnoses that included, but was not limited to, Exec Order 26 § 4b1 individual's health info

A review of the 11/8/19 Comprehensive Minimum Data Set (CMDS) and Exec Order 26 § 4b1 individual's hea

| STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315200 | A. BUILDING _____ B. WING _____ | C 08/18/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ARISTACARE AT DELAIRE** | **400 W STIMPSON AVE LINDEN, NJ 07036** |

| (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 |
|---|---|---|---|---|
| F 658 | Continued From page 3 | F 658 | | |

Exec Order 26 § 4b1 individual's health info The CMDS and Quarterly MDS both revealed that the resident had no Exec Order 26 § 4b1 individual's he.

A review of the Incident Report (IR), provided by the Medical Record Staff (MRS), showed that the resident was noted with a Exec Order 26 § 4b1 individual's health info by LPN#2. The 6/8/20 IR summary showed that the physician and the family were notified of the new Exec Order 26 §.

A review of the Nurses Note showed that on 6/9/20 at 15:06 (3:06 PM), LPN #1 informed Resident #1's responsible party about the Exec Order 26 § 4b1 individual's health info.

A review of the IR provided by the MRS showed no investigation was initiated for the 6/9/20 identification of the Exec Order 26 § 4b1 individual's health info.

The surveyor reviewed the New Order Review of the physician for June 2020, which revealed that Resident #1 had a physician's order, dated 6/11/20, Exec Order 26 § 4b1 individual's health info

Further review of the New Order Review of the physician for June 2020 showed an order for daily care skin protectant ointment to apply to the Exec Order 26 § 4b1 individual's health info area every shift for skin protectant with a start date on 2/22/18 and discontinued on 6/11/20.

There was no physician's order noted for the Exec Order 26 § 4b1 individual's health info identified on 6/8/20.

| STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315200 | A. BUILDING _____ B. WING _____ | C 08/18/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ARISTACARE AT DELAIRE** | **400 W STIMPSON AVE LINDEN, NJ 07036** |

| (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 |
|---|---|---|---|---|
| F 658 | Continued From page 4 | F 658 | | |

During a phone conversation on 8/18/20 at 11:50 AM, LPN#2 declined to talk to the surveyor.

On 8/18/20 at 1:24 PM, the Director of Nursing (DON) informed the surveyor that it was expected for the nurses who identified a new Exec Order 26 § 4b1 individual's to initiate an investigation, notify the physician to obtain a treatment order, notify the responsible party and document according to the facility protocol and policy with regards to Exec Order 26 § 4b1 individual's health info. She further stated that preventative treatments were in place and that the Exec Order 26 § 4 were unavoidable due to the resident's comorbidities.

On that same date at 2:48 PM, the DON informed the survey team that LPN#1 and LPN#2 were disciplined due to failure to follow Exec Order 26 § protocol by not initiating an incident report and treatment orders to the identified Exec Order 26 § 4b1 of Resident #1 on 6/8/20 and 6/9/20. The DON provided a copy of the Disciplinary Action Report dated 8/18/20 addressed to LPN#1 and LPN#2.

A review of the undated Pressure Ulcers/Skin Breakdown-Clinical Protocol Policy that was provided by the Licensed Nursing Home Administrator (LNHA) reflected, "The physician will authorize pertinent orders related to wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings, and application of topical agents."

A review of the undated Pressure Ulcer Risk Assessment Policy provided by the LNHA revealed that "Risk Assessment-a pressure ulcer

| STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER: | (X2) MULT PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315200 | A. BUILDING _____ B. WING _____ | C 08/18/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ARISTACARE AT DELAIRE** | **400 W STIMPSON AVE LINDEN, NJ 07036** |

| (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 |
|---|---|---|---|---|
| F 658 | Continued From page 5<br>risk assessment will be completed...Monitoring: nurses are to be notified to inspect the skin if skin changes are identified ...report other information in accordance with facility policy and professional standards of practice."<br><br>NJAC 8:39-11.2 (b) | F 658 | | |