DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES			FO	RM APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		TE SURVEY MPLETED
		315279	B. WING			2/08/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ē	
				10 BRUNSWICK AVENUE		
JFK HARI	WYCK AT EDISON ESTA	ATES		EDISON, NJ 08817		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 0	00		
	Standard Survey: 2/8	3/18				
	Census: 214					
	Sample size: 35 + 3 c	closed records				
F 656		comprehensive Care Plan	F 6	56		2/22/18
SS=E	CFR(s): 483.21(b)(1)					
	implement a compreh care plan for each res resident rights set fort §483.10(c)(3), that ind objectives and timefra medical, nursing, and needs that are identifi assessment. The com describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that v under §483.24, §483. provided due to the re under §483.10, includ treatment under §483 (iii) Any specialized so rehabilitative services provide as a result of recommendations. If a	cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ied in the comprehensive hprehensive care plan must g- tre to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse 6.10(c)(6). ervices or specialized a the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. h the resident and the tive(s)-				
ABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATUR	 ۶	TITLE		(X6) DATE

**Electronically Signed** 

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

02/20/2018

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/15/ FORM APPRO OMB NO. 0938-0
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		315279	B. WING		02/08/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COI	DE
				10 BRUNSWICK AVENUE	
JFK HAR	IWYCK AT EDISON EST	AIES		EDISON, NJ 08817	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETE E APPROPRIATE DATE
F 656	Continued From pag	e 1	F 65	56	
	desired outcomes.		1 00		
		eference and potential for			
		cilities must document			
		's desire to return to the			
		essed and any referrals to			
	-	es and/or other appropriate			
	entities, for this purp				
		in the comprehensive care			
		in accordance with the			
		h in paragraph (c) of this			
	section.				
	This REQUIREMEN	T is not met as evidenced			
	by:				
		on, interview and record		656E 1. Residents #120,	247, 249,
	review, it was determ	nined that the facility failed to		250, 115, 79, 152, 168, 36 ha	ad their
	develop and impleme	ent a comprehensive		comprehensive care plans (C	CCP),
	person-centered care	e plan for each resident, that		reviewed and updated by the	\$
		objectives and timeframe to		Interdisciplinary Team (IDT)	as
	meet a resident's me	dical and nursing needs that		appropriate to include measu	
		comprehensive assessment		centered objectives with time	
		(Resident #36, #79, #115,		order to meet the medical, nu	ursing,
	#120, #152, #168, #2	247, #249, #250) reviewed.		mental & psychosocial needs	
				residents. (#115, 152, 168 fo	
		e was evidenced by the		oxygen; # 79 for continuous	
	following:			well as indwelling urinary cat	
	1. 0= 1/00/10 - 1.0 =			rear closing seat belt; #120 h	
		5 AM, the surveyor observed		#247 for a lap belt; #249 for i	<u> </u>
		in bed in the resident's room.		urinary catheter; #250 for bila	
		ned the surveyor that they		mittens; #36 for antibiotic the	
		care for Stage 4 Cancer.		<ul><li>urinary tract infection and pn</li><li>2. CCP of facility residents a</li></ul>	
		ed Resident #120's records		reviewed by members of the	
		nt #120 was admitted to the		assure all included measural	
		inder Hospice care with		centered objectives with time	
	diagnoses that includ			order to meet the medical, nu	
				mental, & psychosocial need	-
	The surveyor review	ed the resident's Baseline		residents.	
	-	d current comprehensive		3. The IDC members were r	reeducated on
		ch had no coordination of		the process of initiating and o	

Facility ID: 61205

If continuation sheet Page 2 of 18

## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 315279 B. WING 02/08/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **10 BRUNSWICK AVENUE** JFK HARTWYCK AT EDISON ESTATES EDISON, NJ 08817 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 656 Continued From page 2 F 656 care between Hospice and the facility. CCP to include medical, nursing, mental & psychosocial needs of the residents. 2. On 01/29/18 at 9:40 AM, the surveyor 4. The facility Director of Social Work and observed Resident #247 sitting in a wheel chair in the Nursing Supervisor will perform 18 the resident's room. Resident #247 was monthly random audits to assure CCP are observed with a lap belt which could not be reviewed and updated at to include opened by the resident. measurable person centered objectives with timetables in order to meet the The surveyor reviewed Resident #247's records medical, nursing, mental, & psychosocial on 02/5/18. Resident #247 was admitted to the needs of the residents. The Social Work facility on 01/8/18 with diagnoses that included Director and the Nursing Supervisor will Cerebral Infarction affecting right dominant side submit these results to the Director of and history of falls. Nursing monthly who will report the findings to Nursing Professional Practice The surveyor reviewed the resident's Baseline Committee monthly. and current comprehensive CP titled "Fall / Safety Precaution" which revealed no Preparation and/or execution of this Plan documentation related to the use of the lap belt. of Correction does not constitute admission/agreement of the provider of 3. On 01/29/18 at 9:30 AM, the surveyor the truth of the facts alleged or observed Resident #249 lying in bed with a conclusions set forth in any statement of hanging covered urinary bag on the left side of deficiencies. the bed. The surveyor reviewed the resident's This Plan of Correction is prepared and/or records on 2/1/18. executed solely because it is required by the provisions of Federal or State Law. Resident #249 was admitted to the facility on 1/25/18 with diagnoses that included Urinary Tract Infection and Juvenile Bladder. The surveyor reviewed the resident's Baseline and comprehensive CPs. A review of the 1/25/18 Baseline CP indicated that Resident #249 had a foley catheter (indwelling urinary catheter), but no documentation of how to care for the resident with an indwelling urinary catheter was included in the interventions. 4. On 01/29/18 at 10:00 AM, the surveyor

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/15/2018 / APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>				(X3) DATE	
		315279	B. WING				02/	08/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CO	DDE	•	
JFK HAR	WYCK AT EDISON EST	ATES			0 BRUNSWICK AVENUE EDISON, NJ 08817			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD B HE APPROPRIA		(X5) COMPLETION DATE
F 656	were covered with cu resident had tube fee #250 was awake but The surveyor reviewer on 02/6/18. Resident facility on 01/22/18 wi Cerebral Vascular Act Dysphasia. The surveyor reviewer Physician's Orders th "Bilateral Mittens for r surveyor reviewed the comprehensive CPs of related to the use of h On 02/6/18 at 10:00 A the CNA who explain were used to prevent out the gastric tube, u 5. On 1/29/18 at 9:45 Resident #115 sitting The resident was reconsal cannula at 2 lite On 1/30/18 at 9:00 Al Resident #115's reconsal admitted to the facility on 1/22/18 with diagon Pneumonia. The surveyor reviewer Physician's Orders da new order for continu Ipratropium-Albuterol	<ul> <li>250 lying in bed, both hands shioned mittens and the ding in progress. Resident not alert or oriented.</li> <li>ad Resident #250's records #25 was admitted to the ith diagnoses that included cident, Aphasia, and</li> <li>ad the February 2018 at revealed an order for non purpose pulling." The eresident's Baseline and which had no documentation hand mittens.</li> <li>AM, the surveyor interviewed ed that the hand mittens Resident #250 from pulling used for feeding the resident.</li> <li>AM, the surveyor observed up on the side of the bed. eiving Oxygen (O2) via ers per minute (LPM).</li> <li>M, the surveyor reviewed rd. The resident was y on 4/4/17 and readmitted</li> </ul>	F	656				

Facility ID: 61205

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/15/2018 MAPPROVED D. 0938-0391
STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE	
		315279	B. WING _			02/	08/2018
NAME OF PRO	VIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
JFK HARTW	YCK AT EDISON ESTA	TES			0 BRUNSWICK AVENUE DISON, NJ 08817		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
t t t t t t t f f c c f f t t f f c c f f t t f f t f t	imes a day. The surveyor reviewer care plans. When the o the facility on 1/22/- or continuous O2, the care plan with interver 3. On 01/29/18 10:40 Resident #79 out of bu- ising oxygen by way of The surveyor observer cat belt. The surveyor reviewer 2/2/18. Resident #79 on 5/4/16 and readmit liagnoses which inclue Pulmonary Hypertens Prostate and Urinary I The surveyor reviewer Physician's Orders which and an order for a fole indwelling urinary catt .PM and for a rear co The surveyor reviewer evealed the facility dinterventions for Resider continuous O2, the cat catheter and the use of 7. On 01/29/18 at 11: observed Resident #1	rs inhalation 5 via nebulizer d Resident #115's current resident was re-admitted 18 with a physician's order e facility failed to develop a ntions for the use of the O2. AM, the surveyor observed ed seated in the wheelchair of nasal cannula at 2 LPM. d the resident wearing a d Resident #79's records on was admitted to the facility ted on 1/14/18 with ded History of Pneumonia, ion, Dementia, Enlarged Retention. d the February 2018 hich revealed the resident ey catheter care (an necting seat belt (RCSB). d Resident #79's CPs which d not develop CPs with dent #79's use of re of the indwelling urinary of the RCSB.	F 6	56			

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		D HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/15/2018 / APPROVED ). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN		STRUCTION		(X3) DATE COMF	SURVEY LETED
		315279	B. WING			_	02/	08/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
JFK HART	WYCK AT EDISON ESTA	ATES			NSWICK AVENUE N, NJ 08817			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD E ICED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	9 5	F 6	56				
	<ul> <li>2/5/18. Resident #152 on 9/22/17 with diagn Pulmonary Fibrosis. A 2018 Physician's Ord continuous O2 at 2LP</li> <li>The surveyor reviewe CPs which revealed th for the resident's use</li> <li>On 02/5/18 at 9:26 AI Minimum Data Set (M to the long term care oversees the complet developement of CPs MDS Coordinator stat have been done.</li> <li>8. On 01/29/18 at 11 observed Resident # who was receiving O2 LPM.</li> <li>The surveyor reviewe on 02/5/18. Resident facility on 7/7/17 with Pulmonary Embolism</li> <li>The surveyor reviewe Physician's Order tha an order for continuou surveyor reviewed the</li> </ul>	A review of the February ers revealed an order for 'M by way of nasal cannula. d Resident #152 current here was no CP developed of continuous O2. M, the surveyor spoke to the IDS) Coordinator assigned unit. The MDS Coordinator ion of the MDS and for each resident. The ted that the CPs should 227 AM, the surveyor 168 in bed with eyes closed 2 via nasal cannula at 2 d Resident #168's records #168 was admitted to the diagnoses which included d the February 2018 t revealed the resident had us O2 at 2LPM. The e resident's current care care plan developed for the						
		veyor interviewed the nurse ent who stated that a care						

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		MEDICAID SERVICES				O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		· · /	E SURVEY IPLETED
		315279	B. WING		02	2/08/2018
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
	TWYCK AT EDISON EST	ATES		BRUNSWICK AVENUE ISON, NJ 08817		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	Continued From page	e 6	F 656			
	plan for O2 therapy s and she could not loo	hould have been created cate a care plan.				
	reviewed the residen Resident #36 was ad	•				
	1/26/18 and 2/1/18 th	ed physician's orders dated nat revealed Resident #36 tibiotic for a Urinary Tract Pneumonia.				
	which revealed there to address the reside	ed Resident #36's care plans was no care plan developed nt's need for antibiotic ated to the diagnoses of UTI				
	above care plan cond and Director of Nursi	ere were no care plans				
	NJAC 8:39- 11.2 (d)					
F 657 SS=D			F 657			2/22/18
	be-	prehensive care plan must 7 days after completion of ssessment.				

Facility ID: 61205

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/15/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		315279	B. WING		02/08/2018
NAME OF PI	ROVIDER OR SUPPLIER	·	s	STREET ADDRESS, CITY, STATE, ZIP CODE	•
		ATES	1	0 BRUNSWICK AVENUE	
	WYCK AT EDISON EST	Ales	E	EDISON, NJ 08817	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 657	resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent prace the resident and the resident and their An explanation must medical record if the and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by th (iii)Reviewed and rev team after each asse comprehensive and co assessments. This REQUIREMENT by: Based on observation review, it was determ review, revise and up 35 residents (Resident reviewed. The deficient practices following: On 01/29/18 at 11:08 Resident #80 in bed of a pressure reducing reviewed.	hited to ysician. e with responsibility for the responsibility for the d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident oresentative is determined e development of the e staff or professionals in ined by the resident's needs the resident. ised by the interdisciplinary ssment, including both the quarterly review T is not met as evidenced on, interview and record ined that the facility failed to odate care plans (CP) for 3 of int #80, #142, #168) e was evidenced by the e a.m., the surveyor observed with eyes closed and lying on mattress.	F 657	657D 1. Residents #80, 142, 168 had th comprehensive care plans (CCP), reviewed and updated by the Interdisciplinary Team (IDT) as appropriate, (#80 DTI and treatment alteration in skin integrity & risk for #168 kidney failure/dialysis). 2. CCP of facility residents were by members of the IDC to assure updated with appropriate intervent well being updated at the last IDC meeting. Any discrepancies were corrected a s needed.	ent, #142 r injury, reviewed all were tions as
	02/6/18. Resident #	ed Resident #80's records on 80 was admitted to the readmitted on 11/2/16 with		<ul><li>corrected a s needed.</li><li>3. The IDC members were reedu</li><li>the process of reviewing and update</li></ul>	

Event ID: QTFW11

Facility ID: 61205

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 315279 B. WING 02/08/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **10 BRUNSWICK AVENUE** JFK HARTWYCK AT EDISON ESTATES EDISON, NJ 08817 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 657 Continued From page 8 F 657 diagnoses which included Alzheimer's Disease CCP at the IDC meetings and PRN. and Dementia. 4. The facility MDS coordinator will perform 12 monthly random audits to The surveyor reviewed the Multi Wound Chart assure CCP are reviewed and updated at Details dated 1/26/18 for Resident #80 that IDC meetings and PRN with any changes revealed the resident had been assessed to have as needed. The MDS coordinator will a left heel deep tissue injury (DTI) and the submit these results to the Director of Nursing monthly who will report the recommended treatment was to apply betadine daily. findings to Nursing Professional Practice Committee monthly. The surveyor reviewed Resident #80's current care plan (CP) titled "Risk for alteration in skin Preparation and/or execution of this Plan integrity related to: Incontinence." The CP was of Correction does not constitute developed on 9/13/17 and was revised on admission/agreement of the provider of 12/13/17. There was no indication that the care the truth of the facts alleged or plan had been updated to include the resident's conclusions set forth in any statement of DTI that was observed on 1/26/18. deficiencies. This Plan of Correction is prepared and/or The surveyor reviewed Resident #80's current CP executed solely because it is required by titled "Alteration in mental status related to: the provisions of Federal or State Law. Confusion, disorientation, sensory deprivation, memory loss and lack of motivation." The CP was developed on 9/13/17 and there was no indication that the CP had been reviewed and updated since that date. At 11:40 a.m., the surveyor interviewed the nurse assigned to the resident who stated that the care plans should have been updated at least quarterly. 2. On 01/29/18 at 11:13 a.m., the surveyor observed Resident #142 in bed with a low air loss mattress and 1/2 padded side rails. The resident was observed with mitts on both hands. The surveyor reviewed Resident #142's records

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/15/2018 / APPROVED ). 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION		(X3) DATE	
		315279	B. WING				02/	08/2018
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE,	ZIP CODE	-	
	TWYCK AT EDISON ESTA	ATES			0 BRUNSWICK AVENUE DISON, NJ 08817			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIV CROSS-REFERENCE	N OF CORRECTION E ACTION SHOULD BI D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 657	on 02/6/18. Resident facility on 6/22/17 with lleostomy Status and The surveyor reviewe CPs titled "Alterations lleostomy" and "Risk related to: decreased behavior secondary to were developed on 6/ 10/4/17. There was no care plans had been 10/4/17. There was no been reviewed, revise 10/4/17. There was no been reviewed, revise 10/4/17. At 12:55 a.m., the su assigned to the reside plans should have be 3. On 01/29/18 at 11:: observed Resident #1 who was receiving ox at 2 liters per minute of The surveyor reviewe on 2/5/18. Resident # facility on 7/7/17 with	<ul> <li>t #142 was admitted to the h diagnoses which included Dementia.</li> <li>ed Resident #142's current is in skin integrity related to: for injury, use of restraint cognition and impulse o Dementia." Both CPs /22/17 and were revised on o indication that both of the reviewed and updated since</li> <li>ed Resident #142's current ic drug use related to: iveness." The CP was 7 and was revised on no indication that the CP had ed and updated since</li> <li>erveyor interviewed the nurse ent who stated that the care en updated.</li> <li>27 AM, the surveyor 168 in bed with eyes closed tygen (O2) via nasal cannula (LPM).</li> <li>ed Resident #168's records #168 was admitted to the diagnoses which included ease and Dependence on resident received</li> </ul>	F	657				

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					OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		315279	B. WING		02/08/2018
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
IFK HAR	WYCK AT EDISON EST	ATES		0 BRUNSWICK AVENUE EDISON, NJ 08817	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 657	The surveyor reviewe	ed Resident #168's current	F 657		
	related to Kidney Fail care plan was develo	r alterations in fluid status ure/ Hemodialysis." The ped on 7/7/17 and was e was no indication that the eviewed, revised and			
At 10:40 AM, the surveyor interviewed th assigned to the resident who stated that a plan for the Kidney Failure should have b updated.		ent who stated that a care			
	above care plan conc	PM, the surveyor discussed ern with the Administrator ng (DON). There was no provided.			
	NJAC 8:39-27.1(a)				
F 658 SS=E		eet Professional Standards (i)	F 658		2/22/18
	as outlined by the cor must- (i) Meet professional	d or arranged by the facility, nprehensive care plan,			
	by: Based on observatio review, it was determ maintain professional practice by not follow document urinary out	n, interview and record ined that the facility failed to standards of clinical ing physicians orders to puts for residents with heters for 3 of 35 residents and #249) reviewed.		<ul> <li>658 E</li> <li>1. Residents #79, 159, 249 had their urinary drainage output documented on their Treatment Administration Records (TAR) for each shift.</li> <li>2. All residents with urinary drainage devices had their output documented on their TARs for each shift.</li> <li>3. The facility Nursing staff was</li> </ul>	

Event ID: QTFW11

Facility ID: 61205

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STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315279	B. WING		02/08/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
JFK HAR	TWYCK AT EDISON EST	ATES		10 BRUNSWICK AVENUE EDISON, NJ 08817			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE COMPLET		
F 658	following: 1. On 1/29/18 at 9:30 observed Resident # hanging covered urint the bed. The surveyor records on 2/4/18. R to the facility on 1/25. included Urinary Trace Bladder. Resident #2 dated 1/25/18 to "Re- shift." The surveyor reviewor February 2018 Treate (TAR). The January nurses did not docum 1/26, 1/27, 1/28, 1/29 shift, there was no do outputs on 1/25, 1/29 shift and there was and 1/27 for the 3-11 February 2018 TAR r document urinary out 3-11 shift. At 11:50 AM, the surveyor surveyor interviewed explain why the urina documented in the Tr 2. On 01/29/18 at 9:30 observed Resident #	20 a.m., the surveyor 249 lying in bed with a ary bag on the left side of or reviewed the resident's esident #249 was admitted (18 with diagnoses that et Infection and Juvenile 249 had a physician's order cord Foley Output every ed the January 2018 and ment Administration Records 2018 TAR revealed that the nent urinary output on 1/25, 0, 1/30 and 1/31 for the 11-7 ocumentation of urinary 6, 1/28, 1/29 and 1/30 for the as no documentation on 1/25 shift. A review of the revealed that nurses did not toputs on 2/1 and 2/3 for the stant (CNA) who stated that he urinary bag is measured med of the amount. The the nurse who could not rry out puts were not AR.	F 658	<ul> <li>re-inserviced on the facility policy all residents with urinary drainage to have their urine output docume their TAR each shift.</li> <li>The Nursing Infection Preventi perform monthly audits on all Res with urinary drainage devices to a each shift has documented urine on the Residents TAR. Results of audits will be submitted monthly to Director of Nursing at Nursing Professional Practice by the supe</li> <li>Preparation and/or execution of th of Correction does not constitute admission/agreement of the provi the truth of the facts alleged or conclusions set forth in any stater deficiencies.</li> <li>This Plan of Correction is prepare executed solely because it is requ the provisions of Federal or State</li> </ul>	e devices inted on onist will idents issure output these o the rvisor. his Plan der of nent of ed and/or uired by		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 03/15/2018 1 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	
		315279	B. WING		_	02/	08/2018
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
JFK HAR	WYCK AT EDISON ESTA	ATES		0 BRUNSWICK AVENUE EDISON, NJ 08817			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	to the facility on 2/16/ included Neurogenic Kidney Stones. The surveyor reviewer 10/1/2017 to "Record shift." The surveyor r 2018 and February 20 The January 2018 TA did not document urin 1/31 for the 11-7 shift documentation of urin 1/15 1/16, 1/19, 1/22, and 1/29 for the 7-3 s documentation on 1/1 1/23, 1/24, 1/25, 1/26 A review of the Febru nurses did not docum for the 11-7 shift, ther urinary outputs on 2/1 was no documentatio 3-11 shift. On 02/5/18 at 10:30 A interviewed the CNA document the urinary nurse of the amount. 3. On 01/29/18 at 10 observed Resident #7 wheelchair. The resid belt on and was non surveyor. The surveyor reviewer	esident #159 was admitted 2016 with diagnoses that Bladder and history of ed a physician's order dated Suprapubic Output every eviewed both the January 018 TARs. AR revealed that the nurses hary output on 1/20, 1/21 and , there was no hary outputs on 1/4, 1/5, 1/6, 1/23, 1/24, 1/25, 1/26, 1/27 hift, and there was no , 1/4, 1/12, 1/13, 1,18, 1/22, and 1/29 for the 3-11 shift. ary 2018 TAR revealed that tent urinary outputs on 2/4 e was no documentation of 1 for the 7-3 shift and there n on 2/1, 2/2, 2/3, 2/4 for the AM, the surveyor who stated that they output and informs the	F 658				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/15/2018 / APPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		(X3) DATE	
		315279	B. WING				02/	08/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STAT	E, ZIP CODE		
JFK HART	WYCK AT EDISON ESTA	ATES			10 BRUNSWICK AVENUE EDISON, NJ 08817			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 658 F 695 SS=E	an order for a "Foley of monitor the output even A review of the Janua TARs revealed that the urinary output on 1/15 1/30 for the 11-7 shift documentation of urin 1/20, 1/22, 1/23,1/24, shift and there was no 1/15, 1/21, 1/28 and 1 review of the Februar nurses did not docume and 2/3 for the 7-3 sh At 11:30 a.m, the surve who stated that she re the nurse for docume On 02/6/18 at 2 p.m., above concern regard documentation for the each shift with the Ad of Nursing. There was provided. NJAC 8:39-27.1	tted on 1/14/18 with ed Aphasia, Enlarged Retention. d the February 2018 at revealed the resident had Catheter" with instructions to ery shift. ry 2018 and February 2018 he nurses did not document 5, 1/16 and 1/18 through to , there was no hary outputs on 1/14, 1/16, 1/25 and 1/27 for the 7-3 o documentation on 1/14, 1/31 for the 3-11 shift. A y 2018 TAR revealed that ent urinary outputs on 2/1 ift. veyor interviewed the CNA eports the urinary output to ntation. the surveyors discussed the ding the lack of e urinary catheter output ministrator and the Director is no additional information		658	3			2/22/18
	§ 483.25(i) Respirator tracheostomy care an							

Facility ID: 61205

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TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315279		. ,	(X3) DATE SURVEY COMPLETED		
		B. WING	02/08/2018		
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WYCK AT EDISON EST	ATES				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIO	
needs respiratory care, including trache care and tracheal suctioning, is provide		F 695	5		
practice, the compreh care plan, the resider and 483.65 of this sul This REQUIREMENT by:	nensive person-centered hts' goals and preferences, bpart. is not met as evidenced				
review, it was determ maintain the necessa services for 3 of 35 re #152 and #79) review	ined that the facility failed to ry respiratory care and esidents (Resident #115, /ed.		<ul> <li>695E 1. Residents #115, 152</li> <li>their respiratory equipment change dated (oxygen tubing and masks</li> <li>2. All residents with oxygen tubing masks and tubing, and nebulizer had this equipment changed and</li> <li>3. Facility nurses will be inservice</li> </ul>	ged and ). ng, trach masks I dated.	
Resident #115 seated The resident was reconsal cannula at 2 lite A nebulizer machine wight stand. The residution of the residution of the residution of the residue of the	d on the side of the bed. eiving Oxygen (O2) via ers per minute (LPM). was on top of the resident's dent's nebulizer mask and n top of the machine and not		facility policy regarding storage, of and dating of oxygen tubing and 4. The nursing supervisor will per (twelve) monthly random audits to all oxygen tubing and masks are properly and dated. Results of the audits will be submitted monthly Director of Nursing at Nursing Professional Practice by the super	masks. erform 12 o assure stored nese to the	
portable O2 tank attac wheelchair. The port attached to it. The O2 were hanging over the not covered in a plast	ched to the back of the table O2 tank had O2 tubing 2 tubing and nasal cannula e resident's wheelchair and tic bag.		Preparation and/or execution of t of Correction does not constitute admission/agreement of the prov the truth of the facts alleged or conclusions set forth in any state deficiencies. This Plan of Correction is prepare executed solely because it is req	rider of ment of ed and/or	
	CORRECTION ROVIDER OR SUPPLIER WYCK AT EDISON EST/ SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page The facility must ensu- needs respiratory car care and tracheal suc- care, consistent with practice, the compreh- care plan, the resider and 483.65 of this sul This REQUIREMENT by: Based on observatio review, it was determ maintain the necessa services for 3 of 35 re #152 and #79) review This deficient practice following: 1. On 1/29/18 at 9:45 Resident #115 seated The resident was reconsal and a plastic b The resident's wheele portable O2 tank attar wheelchair. The por attached to it. The O were hanging over the not covered in a plastic	CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         315279         ROVIDER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 14         The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.         This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to maintain the necessary respiratory care and services for 3 of 35 residents (Resident #115, #152 and #79) reviewed.         This deficient practice was evidenced by the	CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING.         315279       B. WING         ROVIDER OR SUPPLIER       JD         WYCK AT EDISON ESTATES       JD         REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX         The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.         This REQUIREMENT is not met as evidenced by:       Based on observation, interview and record review, it was determined that the facility failed to maintain the necessary respiratory care and services for 3 of 35 residents (Resident #115, #152 and #79) reviewed.         This deficient practice was evidenced by the following:       1. On 1/29/18 at 9:45 a.m., the surveyor observed Resident #115 seated on the side of the bed.         The resident was receiving Oxygen (O2) via nasal cannula at 2 liters per minute (LPM).       A nebulizer machine was on top of the resident's night stand. The resident's nebulizer mask and tubing were resting on top of the back of the wheelchair. The portable O2 tank attached to the back of the wheelchair. The portable O2 tank had O2 tubing attached to it. The O2 tubing and nasal cannula were hanging over the resident's wheelchair and not covered in a plastic bag.         On 1/29/18 at 11:00 a.m., the surveyor observed       Wheel Chair. The portable O2 tank had O2 tubing attached to it. The O2 tubing and nasal cannula	CORRECTION       DENTIFICATION NUMBER:       A BUILDING         315279       B. WING         SOVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         WYCK AT EDISON ESTATES       D BROVIDER'S PLAN OF CORRECTIVE ALTION SM         SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTIVE ACTION SM         Continued From page 14       F 695       F 695         Continued From page 14       F 695         The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care plan, the resident's goals and preferences, and 483.65 of this subpart.       F 695         This REQUIREMENT is not met as evidenced by:       Based on observation, interview and record review, it was determined that the facility failed to maintain the necessary respiratory care and services for 3 of 35 residents (Resident #115, #152 and #79) reviewed.       G95E 1. Residents #115, 152 their respiratory equipment changed and ot facility policy regarding storage, and dating of oxygen tubing and masks are tubing were resting on top of the machine and not covered in a plastic bag.       G95E 1. Resident #115 all oxygen tubing and masks are tubing at antaka and tub in service         The resident's wheelchair. The portable 02 tank had 02 tubing attached to it. The 02 tubing and nasal cannula were hanging over the resident's wheelchair and not covered in a plastic bag.       Preparation and/or execution of 1 of Correction does not constitute admission/agreem	

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	0: 03/15/2018 1 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		315279	B. WING				02/	08/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	=		
JFK HARTWYCK AT EDISON ESTATES				0 BRUNSWICK AVENUE EDISON, NJ 08817				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 695	resting against the para nasal cannula was attached in the president tank was empty and the new one. The nurse of removed the O2 tubin and attached it to the pulled the attached to the state of the unclean O2 resident. The survey applying the O2 equip stated she realized she the unclean nasal can replaced it with a new That same day at 1:30 observed that Reside and tubing remained the morning observat a plastic bag.	The resident's back was int of the tubing where the tached. The resident's nd regular. a.m., the surveyor #115 who stated that the O2 he nurse had gone to get a came into the room and ng from the empty O2 tank new one. The nurse then ubing and nasal cannula ent back. The nasal ere not covered in a plastic go toward Resident #115 to tubing and cannula on the or stopped the nurse from oment. The nurse then he should have discarded mula and tubing and y one.	F	695				

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	-	D HUMAN SERVICES					FORM	): 03/15/2018 MAPPROVED
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		315279	B. WING				02/	08/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZI	P CODE		
JFK HARTWYCK AT EDISON ESTATES					BRUNSWICK AVENUE DISON, NJ 08817			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BI		(X5) COMPLETION DATE
F 695	<ul> <li>way of portable O2 ta surveyor observed on outlet was located O2 bundled up against th bag. The surveyor in present in the residen CNA stated that the n and store it on the way</li> <li>3. On 1/29/18 at 11:44 Resident #152 out of The surveyor observe nebulizer treatments I over bed table and no protection.</li> <li>02/1/18 12:20 p.m., th Resident #152 in bed nasal cannula and tut to the wheelchair and</li> <li>02/01/18 12:39 p.m., nurse assigned to Re regarding the O2 mas was the proper storag The nurse stated that mask should be in a p aware of who remove not place it in a plastic</li> <li>On 02/1/18 at 2:15 p. the concern observed tubing storage with th of Nursing. A policy re masks and tubing way</li> </ul>	nk and nasal cannula. The the wall where the wall O2 tubing that was not in use, e wall and not in a plastic terviewed the CNA who was it's room at that time. The urses remove the tubing II. 4 AM, the surveyor observed bed seated in a wheelchair. ed an O2 mask used for hanging at the end of the ot in a plastic bag for the surveyor observed watching television. The O2 bing were on the floor next portable O2 tank. the surveyor interviewed the sident #79 and #152 sk and O2 tubing and what ge when they are not in use. the tubing and nebulizer blastic bag. She was not d the oxygen tubing and did	F 6	95				

Facility ID: 61205

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/15/2018 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		315279	B. WING			02/08/2018	
NAME OF PROVIDER OR SUPPLIER		•	s	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
JFK HARTWYCK AT EDISON ESTATES							
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID		EDISON, NJ 08817 PROVIDER'S PLAN OF CORRECTI		(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF	IX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETION DATE
E 005							
F 695	10		F	695	5		
		0 indicated "All respiratory will be changed on a weekly					
		stored in plastic bags when					
	NJAC-15.1(a)						

Event ID: QTFW11

Facility ID: 61205

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