STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING ______ B. WING ______	C 06/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION AND HEALTHCARE	**43 N WHITE HORSE PIKE HAMMONTON, NJ 08037**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ143394, NJ144178, NJ144173 NJ143682, NJ143749, NJ143453, NJ143170, NJ141901, NJ141644, NJ141598 Census: 185 Sample Size: 29 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 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Complaint Intakes NJ143394 and NJ143682 Based on record review, document review, facility policy review, and interviews, it was determined that the facility failed to ensure residents were free from abuse for 3 (Resident #25, Resident #4, and Resident #3) of 5 residents investigated for abuse. Specifically, the facility failed to ensure	F 600	1. Resident #25 was revisited by [redacted] and [redacted] indicating no lasting negative effect. Resident was reassured and reminded of the interventions put in place to ensure that [redacted] is free from any abuse.	6/24/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 06/27/2021

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.

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F 600

Continued From page 1
Resident #25 was free from physical abuse when the resident was grabbed around the by another resident (Resident #29), resulting in Resident #25 feeling fearful. The facility failed to ensure Resident #4 and Resident #3 were free from abuse, when the two residents were touched inappropriately by another resident (Resident #2), resulting in Resident #4 feeling fearful.

Findings include:

1. Resident #29's quarterly Minimum Data Set (MDS), dated , revealed the resident had with a Brief Interview for Mental Status (BIMS) score of . Behaviors included . The resident was independent with ambulation. Diagnoses included .

Resident #25's quarterly MDS, dated , revealed the resident had cognition with a BIMS score of . No behaviors exhibited. Resident #25 was independent with ambulation. Diagnoses included .

A review of the investigation form, dated as occurring , revealed in part, Licensed Practical Nurse (LPN) reported she was standing in the hallway with her medication cart in the hallway of unit . (Resident #29) came out of their room asking for help to turn off the air conditioner. As the nurse locked her medication cart to assist, she witnessed Resident #29 lunge toward Resident #25 who was sitting in the hallway and put his/her hands around the resident's area. An LPN immediately

F 600

Resident #4 was revisited by and indicating no lasting negative effect. Resident was reassured and reminded of the interventions put in place to ensure that is free from any abuse. In addition, resident #4 was reminded that the aggressor (resident #2) was discharged from the facility in the days immediately following the incident.

Resident #3 was revisited by and indicating no lasting negative effect. Resident was reassured and reminded of the interventions put in place to ensure that is free from any abuse. In addition, resident #4 was reminded that the aggressor (resident #2) was discharged from the facility in the days immediately following the incident.

2.
All residents have potential to be affected by this deficient practice however, all resident-to-resident altercations were reviewed for 60 days. Follow up interviews conducted by social work with the victims noted that no other resident was identified to have any residual negative affect from the incident. The residents stated that they were not fearful of any additional incident.

3.
An in-service will be conducted with all staff on Abuse specifically focusing on ensuring that residents are free from physical, sexual, and psychological abuse by implementing interventions targeted at the aggressor□s triggers. The Inservice will focus on prevention of additional

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F 600 Continued From page 2

intervened and separated both residents. Resident #29 was redirected to their room and was unable to give an explanation. Resident #25 was unable to give an account of events. No visible injuries were noted. No pain or discomfort. The physician was called and [redacted], [redacted], and [redacted] follow up were ordered. Findings: There was an identified trigger to Resident #29's aggression toward Resident #25. The LPN intervened with no physical contact occurring; both residents immediately separated. Conclusion: Resident #29 lunged at Resident #25 attempting to put their hands around the resident's [redacted]. The LPN intervened and avoided any physical contact. This incident was unpredictable and unavoidable due to the resident's psychological condition and congregate living. Interventions were put into place to avoid any future. A reasonable person would include that there was no abuse, neglect, mistreatment, and/or misappropriation. An interview with the LPN completed by the facility revealed, "On May 2nd, 2021, at 1530 [3:30 PM]; I was at the nurse station by [redacted] wing, when (Resident #25) came to me saying that a [gender] [redacted] [gender]. I moved (Resident #25) to the dining room and asked [gender] to remain there until I came back. I went to inform nurse in charge, nurse was already aware. She said (Resident #29) was trying to [redacted] (Resident #25) and she separated them."

A review of the [redacted] physician notes, dated [redacted], revealed in part, "Patient last seen [redacted]. No medication adjustments made at that time. Follow-up requested today due to another incident of physical assault towards another resident. [Gender] was witnessed ambulating down the hallway when an elderly [gender] resident approached [gender]. There

F 600

resident to resident altercations with the use of targeted interventions.
Staff will be educated that follow up to altercations with psychiatry, psychology, and social work is necessary

4.

The DON/ Designee will complete weekly audits of all resident-to-resident altercations for targeted interventions and completion of interventions weekly x 4 weeks and then monthly until compliance is met.

The results of these audits will be presented at QAPI.

The Social Work director will conduct follow up interviews with victims of residents to resident altercations to ensure that is no lasting residual effect of fear from incidents.

The results of these audits will be presented at QAPI.

The Administrator is responsible for oversight of this POC.

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were words exchanged and then [gender] attempted to [gender]. Staff immediately separated them. No injury to either resident. Staff report increased episodes of and have been verbalized by [gender]. Patient seen. In bed.
...Plan: Increase milligrams (mg) orally (po) every 8 hours (q8h) for . Dx:
...Unfortunately [gender] behavior is very hard to predict. It is generally triggered and unprovoked. Two episodes in a very short period where [gender] attempted to another resident. Suggest transfer to a more appropriate behavioral setting."

Resident #25 was interviewed on 06/01/2021 at 9:08 AM and 06/02/2021 at 11:55 AM. The resident said there was a concern about another resident abusing him/her. The resident said the incident happened when he/she was living on the floor. Resident #25 said a resident grabbed the resident by the and the resident was still afraid. Resident #25 stated he/she was placing a table in front of the door; but stopped because it was scaring the resident's roommate. The resident said [gender] felt okay on the current floor they resided, away from the person who the resident. The resident remained "shocked" the other resident was still in the building. Resident #25 said he/she was still afraid it might happen again.

Certified Nurse Aide (CNA) #1 was interviewed on 06/02/2021 at 11:37 AM. She said Resident #29 had behaviors and thought the resident was "spaced out." CNA #1 said Resident #29 had been like this over the past month.

The Unit Manager (UM) was interviewed on

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F 600	Continued From page 4 06/02/2021 at 11:41 AM. The UM said Resident #29 had not had any recent behaviors. The UM said this resident tended to [redacted] and was [redacted]. The UM said there was a previous incident where Resident #29 punched their roommate in the [redacted] because of the TV volume. The UM said this occurred because they had completed a gradual dose reduction on one of their medications but there were not any changes before the incident with Resident #25. The UM said this resident may not be appropriate for this facility due to a long [redacted] history. The UM said she was not aware of Resident #25 being fearful. The UM said the resident was frightened when it happened, but then was fine. She said Resident #29 mostly stayed in their room unless they needed to go to the shower room or ask for more food. The Director of Nursing (DON) was interviewed on 06/02/2021 at 1:26 PM. She said she was told Resident #25 was standing in the hallway and talking to the nurse. The DON said the nurse was getting medication pass ready and Resident #29 came out of his/her room for assistance. She said the nurse locked her cart and turned around and Resident #29 just went across to Resident #25 and headed for the resident's [redacted]. She said they moved Resident #25 to another hall and had the resident on supervised monitoring. The DON said she was not aware this resident was still fearful. The social worker (SW) was interviewed on 06/02/2021 at 2:38 PM. She said she remembered this incident and completed some of the interviews with the resident. The SW said it was difficult trying to interview Resident #29. She said she did not remember if she interviewed any other residents on the hall. The SW said she was unaware Resident #25 was still fearful.	F 600		

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2. Resident #2 was admitted on [redacted] and discharged on [redacted] The annual Minimum Data Set (MDS), dated [redacted], revealed the resident had intact cognition with a Brief Interview for Mental Status score of [redacted] Behaviors were not exhibited. Diagnoses included [redacted], [redacted]. The resident received [redacted] over the 7-day period. Resident #2 was independent with ambulation.

Resident #4 was admitted on [redacted]. The quarterly MDS, dated [redacted], revealed the resident had [redacted] with a BIMS score of [redacted]. Behaviors were not exhibited. Diagnoses included [redacted] The resident was not ambulatory but able to use wheelchair with supervision.

A review of the investigation form, dated as occurring [redacted], revealed in part, "On [redacted] at 12:00 PM (Resident #4) reported to the activity director that around 11:00 AM [gender] was in the [redacted] floor [redacted] dining room when another resident (Resident #2) walked up to [gender] and [redacted] [gender] jacket near [gender] [redacted] area and immediately walked away. (Resident #4) reported that (Resident #2) did not say anything to [gender]. (Resident #4) reported to the activity director that [gender] does have any issues with (Resident #2) and [gender] is not afraid of [gender] ... (Resident #4) reported that the incident occurred in the [redacted] dining room while the residents were waiting to go outside to smoke. The resident reported that the [redacted] monitor was present in the room ... (Resident #2) denied any interaction with (Resident #4). [Gender] stated [gender] did not grab or touch [gender] jacket. The smoke monitor

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reported that he was in the dining room with the resident at 11:00 AM and he did not witness (Resident #2) approach (Resident #4), touch [gender] or speak to [gender] ... (Resident #4) requested to have a room change and the resident was moved from (room #) to (room #) ...Conclusion: The ...team met to discuss and review the incident. A reasonable person would conclude that this allegation could not be substantiated as the [redacted] monitor was present and with the residents. At no time did he witness (Resident #2) speak to or touch (Resident #4)."

Resident #4 was interviewed on 06/02/2021 at 5:18 PM. He/she said Resident #2 had pulled Resident #4's sweater and coat out to look at his/her [redacted]. The resident said he/she was still fearful something would happen again. The resident said this incident occurred in the [redacted] area. Resident #4 said Resident #2 walked up to him/her and pulled his/her top back to look at their [redacted]. The resident said the [redacted] monitor was there, but Resident #2 did it when the [redacted] monitor was not looking.

The SW was interviewed on 06/02/2021 at 3:48 PM. She said Resident #4 accused Resident #2 of touching [gender] [redacted], but Resident #2 denied it. She said the [redacted] monitor denied seeing anything.

The DON was interviewed on 06/02/2021 at 1:26 PM. She said they were unable to find the psych reports completed for Resident #2. She said the reports were not in the resident's record. She said she was not in the building at the time of these incidents. She said the care plan revealed the residents were to remain separated but was not sure what that entailed. She acknowledged there were multiple occurrences regarding Resident #2

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F 600	Continued From page 7 and [redacted] 3. Resident #2 was admitted on [redacted] and discharged on [redacted]. The annual Minimum Data Set (MDS), dated [redacted], revealed the resident had [redacted] with a Brief Interview for Mental Status of [redacted] Behaviors were not exhibited. Diagnoses included [redacted]. The resident received [redacted] over the 7-day period. Resident #2 was independent with ambulation. Resident #3 was admitted on [redacted]. The quarterly MDS, dated [redacted], revealed the resident had [redacted] with a BIMS of [redacted] Behavior included [redacted] and [redacted]. Diagnoses included [redacted] Resident #3 was independent with ambulation. A review of the investigation form, dated as occurring [redacted], in part, "On [redacted] at approximately 10:00 PM, (Resident #3) came out of [gender] room to the nurses' station and was visibly upset. The resident reported to staff that (Resident #2) came into [gender] room uninvited, sat on [gender] bed and [redacted] [gender] [redacted] and [redacted] [gender]. (Resident #2) room was located on the same hallway. (Resident #2) was immediately moved to another hallway and kept on close observation ...As per (Resident #3), (Resident #2) entered [gender] room uninvited following a [redacted] break they were both on. (Resident #2) sat on [gender] bed, placed [gender] [redacted] in [gender] [redacted] and then between [gender] [redacted]. The resident resisted and kicked [gender] out of [gender] room. [Gender] roommate returned to the room following [gender] [redacted] break. (Resident #3)	F 600		

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F 600	Continued From page 8 was visibly upset and told [gender] roommate what occurred. (Resident #2) was interviewed by the nurse that evening and the next day through an . (Resident #2) stated that following the break, [gender] was passing (Resident #3's) room and [gender] invited [gender] in. [Gender] requested that [gender] sit on [gender] bed. (Resident #2) denied anything else occurred. (Resident #2) was put through the offender database with (Resident #2) not identified in the ...A review of (Resident #2's) medical record and past incidents brought forth two other incidents for review. The first incident was when (Resident #2) put [gender] through the of a [gender] resident's and poked [gender] in the process ...The second incident occurred following a break and was not witnessed ...Conclusion: as per both resident's statements (Resident #2) went into (Resident #3's) room on the night of . As per (Resident #3), (Resident #2) was not invited and [gender] proceeded to [gender] and [body part] in addition to trying to [gender]. (Resident #2) denied the incident and staff did not witness, nor did they witness (Resident #2) in (Resident #3's) room. (Resident #2) had two other allegations of [gender] however, those two allegations were concluded as abuse in contrast to this allegation of abuse. The outcome of this investigation is inconclusive." A review of the physician's progress note, dated , revealed "Resident seen and examined for discharge to another facility ...Resident is medically stable at this time. This resident discharge is necessary and appropriate for being an endangerment to other residents."	F 600		

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F 600	Continued From page 9 Resident #3 was interviewed on 06/01/2021 at 3:07 PM. The resident said there was an incident that occurred with another resident. Resident #3 said Resident #2 got [redacted]" and put [gender] [redacted] down [gender] [redacted]. Resident #3 said [gender] pushed Resident #2 off. Resident #3 said Resident #2 left the facility shortly after the incident. The social worker was interviewed on 06/02/2021 at 3:48 PM. She said she completed some of the interviews, but the Director of Nursing and the Nursing Home Administrator completed the actual reports of the investigation. She said Resident #3 accused Resident #2 of trying to [redacted] [gender] and Resident #2 denied it happened. She said the roommate did see Resident #2 in the resident's room, but [gender] was leaving the room. A review of the abuse policy, revised 02/2019, provided by the DON on 06/02/2021 at 4:28 PM revealed in part, "The facility prohibits the mistreatment, neglect, and abuse of resident's/patients and misappropriation of resident/patient property by anyone including staff, family, friends, etc." New Jersey Administrative Code § 4.1 (a)(5)	F 600		
F 677 SS=D	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 NJ143749	F 677	1. Resident #9 was in the process of	6/28/21

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Based on record review, document review, and interviews, it was determined that the facility failed to provide timely incontinent care for 1 (Resident #9) of 3 residents who were reviewed for the provision of incontinent care.

Findings include:

1. The quarterly Minimum Data Set (MDS) for Resident #9, dated [redacted], indicated the resident was [redacted]. The resident required extensive assistance for bed mobility, transfers, and toilet use. The resident was occasionally incontinent of [redacted]

The resident had diagnoses which included [redacted].

A review of Resident #9's care plans, initiated [redacted], indicated the resident was at risk for [redacted] related to [redacted], and the resident had [redacted] incontinence. The resident had a history of [redacted]. The interventions included to minimize extended exposure of the skin to moisture by providing frequent incontinence care and prompt removal of wet/damp clothing or sheets, and to check the resident every two hours and assist with toileting as needed.

On 06/01/2021 at 9:55 AM, the resident stated the staff had not changed [gender] between the hours of 10:00 PM on [redacted] and 5:00 AM on [redacted]. Resident #9 stated [gender] had activated the call light because [gender] needed incontinent care due to a [redacted] brief. The resident stated the call light had been on for 7 hours and staff had not responded. The resident added the brief was [redacted] and

F 677

receiving incontinence care when the police arrived.

Skin evaluation of the resident indicated no skin breakdown from incident.

2.
All residents have potential to be affected by this deficient practice.

There was no other identified resident that did not receive incontinence care on the 11-7 shift. Review of skin evaluations, there were no identified new skin alterations.

3.
An in-service will be conducted with all nursing staff on ADL care provided for dependent residents specifically focusing on providing timely incontinence care.

4.
The DON/ Designee will complete weekly audits of the PPC POC to ensure that incontinence care is rendered to residents. The audits will be completed weekly x 4 weeks and then monthly until compliance is met.

The results of these audits will be presented at QAPI.

The administrator/ designee will complete random call bell audits to evaluate for timely response weekly x 4 weeks and monthly until compliance is met.

The results of these audits will be presented at QAPI.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING ______ B. WING ______	C 06/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION AND HEALTHCARE	**43 N WHITE HORSE PIKE HAMMONTON, NJ 08037**

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F 677	Continued From page 11 had also had a [redacted] in the brief. The resident stated [gender] placed multiple calls to the local police department informing them [gender] needed help. A police report, dated [redacted] (no time provided), indicated the resident had made multiple calls to the police department stating [gender] needed assistance. The report indicated at 5:06 AM, the police dispatched an ambulance and a patrol unit to the facility. Upon their arrival, the facility had just started to assist the resident. The resident's activities of daily living (ADLs) form indicated the resident had not been provided with incontinent care on [redacted] during the 11 PM to 7 AM shift. The form also contained no indication the resident had been provided incontinent care since 2:28 AM on [redacted] On 06/02/2021 at 12:15 PM, the Director of Nurses (DON) was asked if she was aware of the episode. She stated she was unaware the police and an ambulance crew had entered the facility. She was asked to provide the resident's ADL sheet for [redacted] On 06/02/2021 at 12:30 PM, the Assistant Director of Nurses (ADON) provided the resident's ADL sheet for [redacted]. She was asked if the sheet indicated the resident had been provided with incontinent care between the hours of 10:00 PM on [redacted] and 5:00 AM on [redacted]. She replied that the sheet did not indicate the resident had been provided with incontinent care during the time frame. The facility staff from the 11 PM to 7 AM shift were no longer employed at the facility and unavailable for interview.	F 677		

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F 677	Continued From page 12 New Jersey Administrative Code § 8:39-27.2 (h)	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Complaint Intakes: NJ143170, NJ141598, and NJ141901 Based on record reviews, facility policy reviews, and interviews, it was determined that the facility failed to ensure quality of care and services were provided to 4 (Residents #1, #10, #6 and #11) of 10 residents reviewed for quality of care and services. Specifically, the facility failed to ensure resident weights were obtained per physician's order for 2 (Residents #1 and #10) of 5 residents investigated for weight loss and failed to ensure medications were provided as ordered by the physician for 2 (Residents #6 and #11) of 5 residents reviewed for medication administration. Findings include: 1. Resident #1 was admitted on [redacted] and discharged on [redacted]. The admission Minimum Data Set (MDS), dated [redacted] revealed a Brief Interview for Mental Status (BIMS) was not completed. The staff assessment for mental status revealed the resident had	F 684	1. Resident #1□s weight was reviewed and the resident has had weights obtained. The resident□s nutritional status was evaluated by the physician and the dietician with no negative outcome identified. Resident #10□s weight was reviewed and the resident has had a weight obtained prior to discharge. This Resident no longer resides in the facility. Resident #6□s medical record was reviewed director and there was no indication of a negative outcome for the medication omission. A medication error was completed and an inservice on the seven rights of medication administration was given to the nurses assigned. This Resident no longer resides in the facility. Resident #11□s medication record was reviewed and there was no identified	6/28/21

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F 684	Continued From page 13 [redacted]. The resident required limited to extensive assistance for all activities of daily living (ADLs). The diagnoses included [redacted] The resident's family was interviewed on 06/01/2021 at 6:47 PM. The family stated the resident had lost a significant amount of weight. They said the resident was unrecognizable when they observed the resident during a visit. A review of the care plan, created on [redacted], revealed, [redacted] past medical history of [redacted], is on [redacted] Interventions included: monitor weights as available weekly, monthly." A review of the nursing admission evaluation, dated [redacted], revealed the most recent weight section was blank. A review of the comprehensive nutrition assessment, dated [redacted], revealed the most recent weight was [redacted]. "Admit weight pending, per face sheet was [redacted] [pounds]...Intake documented as [redacted] A review of the resident's weights revealed the resident had a weight on [redacted] of [redacted] pounds. No other weights were obtained during the resident's stay at the facility. The registered dietitian (RD) was interviewed on 06/02/2021 at 10:19 AM. She said they had a problem identified with obtaining resident weights. The RD said it was difficult getting the weekly	F 684	negative effect for the omitted medications. Medication errors were completed and the assigned nurses was educated on the 7 rights of medication administration. 2. All residents have potential to be affected by this deficient practice. All residents weight orders were reviewed and necessary weights were obtained. The missed medication report was reviewed and residents with medication omissions were evaluated with no negative outcome was noted for any resident. Medication errors were completed for each resident and counseling/ education was issued to the corresponding nurses. 3. Nursing staff and the dietician will be educated by the staff educator on quality of care with emphasis on following obtaining weights. The education will include newly implemented facility procedure in which weekly weights are obtained on Mondays and the dietician will review and request reweights for Tuesdays. Licensed nurses will be educated on quality of care with emphasis on administration of medications as ordered by the physician. Course content will include timely administration of	

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F 684	Continued From page 14 weights and during quarantine, some of the admission weights. She said they had put a plan in place, and it was getting better. The Director of Nursing (DON) was interviewed on 06/02/2021 at 1:26 PM. She said there was a problem with obtaining weights. She said it was a challenge. She said they had a process in place currently where they double checked to make sure everything got done. She said they verified everything the next morning. The DON acknowledged weights were missing for this resident. 2. Resident #10 was no longer in the facility. The resident was admitted [redacted] and discharged on [redacted]. The MDS revealed the resident was [redacted] with diagnoses including a below the [redacted] and [redacted]. A review of the medical record revealed a physician's order, dated [redacted], for an admission weight then weekly for four weeks, then monthly. The resident's clinical weight record contained no information that an admission weight had been obtained. The only weight recorded was on [redacted]. There should have been four recorded weights. The DON confirmed that the weights had not been obtained per the physician's order. A review of the Weight Assessment Policy, revised 05/2019, provided by the DON on 06/02/2021 at 4:28 PM revealed in part, "The nursing staff will measure resident weights within 2 hours of admission, weekly for 4 weeks; then monthly thereafter."	F 684	medication and documenting the administration of medication or appropriately coding the medical record for not administering a medication I.E refusal, out on pass, etc. 4. The dietician will audit weights weekly for 4 weeks then monthly until compliance is met. Results of these audits will be submitted at QAPI meeting. The ADON/ designee will audit medication administration for timely administration and omissions daily times 4 weeks and then weekly until compliance is met. The results of these audits will be submitted at QAPI. The DON is responsible for execution and monitoring of this POC.	

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F 684	Continued From page 15 3. Resident #6 was admitted on [redacted] and discharged [redacted]. The admission Minimum Data Set, dated [redacted], revealed the resident had [redacted] with a Brief Interview for Mental Status (BIMS) of [redacted]. The resident was independent for activities of daily living and ambulation. Diagnoses included [redacted]. The resident's family was interviewed on 06/01/2021 at 4:04 PM. They stated medication was administered to the resident late. A review of the [redacted] medication administration record (MAR) revealed the resident did not receive one 6:00 AM dose medication on [redacted] for [redacted] Capsule [redacted] milligram (mg). 4. Resident #11 was admitted on [redacted]. The 5-day Minimum Data Set, dated [redacted], revealed the resident had intact cognition with a Brief Interview for Mental Status (BIMS) score of [redacted]. The resident was independent with ambulation and required none to extensive assistance for activities of daily living. The diagnoses include [redacted], and [redacted]. The resident was interviewed on 06/01/2021 at 9:49 AM. Resident #11 said medications were late at times, depending on the nurse. The [redacted] medication administration record (MAR) revealed the following: -[redacted] (an [redacted]) tablet [redacted] mg (milligrams), ordered on [redacted], was held	F 684		

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F 684	Continued From page 16 from , and discontinued on . Administration was blank on 04/11/2021 and 04/16/2021. - tablet (mg, ordered on and discontinued on . Administration was blank on 04/11/2021 at 9:00 AM, 04/15/2021 at 5:00 PM, 04/16/2021 at 9:00 AM, and 04/20/2021 for both 9:00 AM and 5:00 PM doses. -) tablet mg, ordered on , held from 1 and discontinued on . Administration was blank on 04/10/2021 at 10:00 PM, 04/11/2021 at 2:00 PM, 04/15/2021 at 10:00 PM, and 04/16/2021 at 2:00 PM. -): inject at bedtime; ordered on held from and discontinued on . Administration was blank on 04/15/2021. -) tablet mg, ordered and discontinued . Administration was blank on 04/11/2021 and 04/16/2021. The MAR revealed the following: - /ml: inject at bedtime, ordered Administration was blank on 05/15/2021. Licensed Practical Nurse (LPN) #1 was interviewed on 06/02/2021 at 9:08 AM. She said she was not aware of who completed audits for	F 684		

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F 684	Continued From page 17 medication administration. LPN #1 was unsure what the blank areas for medication administration meant. She was unsure if the medications were missed or an accidental oversight. The DON was interviewed on 06/02/2021 at 1:26 PM. She said sometimes the medication may have been given but not signed off as given. The DON said they may have forgotten to sign the medication off. She said if it was not documented, then it was not done. She said they had an audit going on right now as documentation was not getting completed. A review of the Medication Administration Policy, revised 12/2019, provided by the DON on 06/02/2021 at 4:28 PM, revealed in part, "Medications must be administered in accordance with the orders, including any required time frame." New Jersey Administrative Code § 8:39-27.1(a)	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the	F 690		6/28/21

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F 690	Continued From page 18 resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Complaint Intake NJ143749 Based on record review, document review, and interview, it was determined the facility failed to provide timely incontinent care for one (Resident #9) of three residents who were reviewed for the provision of incontinent care. Findings include: 1. The quarterly Minimum Data Set (MDS) for Resident #9, dated [REDACTED], indicated the resident was cognitively intact. The resident required extensive assistance for bed mobility, transfers, and toilet use. The resident was occasionally incontinent of [REDACTED] The resident had diagnoses which included	F 690	1. Resident # 9 received incontinence care on [REDACTED] at approximately 5 am. The resident was evaluated with no subsequent skin breakdown noted. 2. All resident's dependent on staff for ADL care have potential to be affected by this deficient practice. There was no other identified resident that did not receive incontinence care on the 11-7 shift. Review of skin evaluations, there were no identified new skin alterations. 3. An in-service will be conducted with all nursing staff on Bowel/ Bladder	

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F 690	Continued From page 19 following . A review of Resident #9 ' s care plans, initiated , indicated the resident was at risk for , and the resident had incontinence. The resident had a history of . The interventions included to minimize extended exposure of the skin to moisture by providing frequent incontinence care and prompt removal of wet/damp clothing or sheets, and to check the resident every two hours and assist with toileting as needed. On 06/01/2021 at 9:55 AM, the resident stated the staff had not changed [gender] between the hours of 10:00 PM on and 5:00 AM on . Resident #9 stated [gender] had activated the call light because [gender] needed incontinent care due to a wet and soiled brief. The resident stated the call light had been on for 7 hours and staff had not responded. The resident added the brief was and had also had a movement in the brief. The resident stated [gender] placed multiple calls to the local police department informing them [gender] needed help. A police report dated (no time provided), indicated the resident had made multiple calls to the police department stating [gender] needed assistance. The report indicated at 5:06 AM, the police dispatched an ambulance and a patrol unit to the facility. Upon their arrival, the facility had just started to assist the resident. The resident ' s activities of daily living (ADLs) form indicated the resident had not been provided with incontinent care on during the 11	F 690	Incontinence specifically focusing on providing timely incontinence care for dependent residents. 4. The DON/ Designee will complete weekly audits of the PPC POC to ensure that incontinence care is rendered to residents. The audits will be completed weekly x 4 weeks and then monthly until compliance is met. The DON is responsible for execution and monitoring of this POC.	

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F 690	Continued From page 20 PM to 7 AM shift. The form also contained no indication the resident had been provided incontinent care since 2:28 AM on [redacted]. On 06/02/2021 at 12:15 PM, the Director of Nurses (DON) was asked if she was aware of the episode. She stated she was unaware the police and an ambulance crew had entered the facility. She was asked to provide the resident ' s ADL sheet for [redacted]. On 06/02/2021 at 12:30 PM, the Assistant Director of Nurses (ADON) provided the resident ' s ADL sheet for [redacted]. She was asked if the sheet indicated the resident had been provided with incontinent care between the hours of 10:00 PM on [redacted] and 5:00 AM on [redacted]. She replied that the sheet did not indicate the resident had been provided with incontinent care during the time frame. The facility staff from the 11PM to 7 AM shift were no longer employed at the facility and unavailable for interview.	F 690		