STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315092	A. BUILDING ______ B. WING ______	12/07/2021

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CARE ONE AT HOLMDEL	188 HIGHWAY 34 HOLMDEL, NJ 07733

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F 000	INITIAL COMMENTS Survey Date:12/07/21 Census:99 Sample:20 + 21 = 41 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent documents obtained from the facility, it was determined that the facility failed to thoroughly investigate an allegation of	F 610	1. Investigative summary for Resident [redacted] was appropriately documented and summarized on [redacted].	1/21/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 12/24/2021

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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abuse for 1 of 20 sampled residents (Resident [redacted]

This deficient practice was evidenced by the following:

On 11/23/21 at 10:23 AM, Surveyor #1 observed Resident [redacted] lying in a, low to the ground bed, with his/her eyes closed. There was a floor mat located to the right side of the bed.

A review of Resident [redacted]'s Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to, [redacted]

On 12/01/21 at 8:47 AM, Surveyor #2 reviewed two facility provided fall incident reports for Resident [redacted]. One of Resident [redacted]'s fall incident reports, dated [redacted] 07:10, included the following note: as per CNA (Certified Nursing Assistant), the resident was very [redacted] during final rounds and very [redacted]. [Resident [redacted]] kept stating there was a man trying to hurt [Resident [redacted]] (an allegation of abuse). Further review of the incident report included additional notes on [redacted] and [redacted] regarding the [redacted] There was no documented evidence on the incident report that Resident [redacted]'s allegation of abuse was investigated.

A review of the electronic Progress Note (ePN) dated [redacted] 07:30, indicated that Resident [redacted] fell near the TV room and that the resident was [redacted] but [redacted]. Further review of the ePNs for [redacted] did not include documentation regarding Resident [redacted]'s allegation of a man trying to hurt the resident.

Provider's Plan of Correction (F 610):

2. No other residents were affected by this practice. Any resident with an alleged violation was at risk to be affected by this practice.

3. ADON/Designee will educate staff to report all alleged violations to the supervisor. The supervisor will initiate investigation and document according to the policy. The supervisor will ensure timely notification of the alleged violation to the Administrator and Director of Nursing for completion of the investigation.

4. DON/Designee will review all incident within 24 hours to ensure appropriate investigations has been initiated and documented. Any instances not in compliance will be immediately addressed. Tracking will be presented at the QAPI meeting monthly X3 for compliance in the first quarter.

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At 9:10 AM, Surveyor #2, in the presence of the survey team, received confirmation from the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) that the incident reports that were provided to Surveyor #2 were the only incidents or investigations for Resident [redacted] for for the prior six months. The facility did not provide an incident report or an investigation for an allegation of abuse.

At 11:36 AM, Surveyor #2 via telephone call interviewed the CNA that had stated Resident [redacted] kept stating there was a man trying to hurt the resident. The CNA stated that she did not think the fall happened on her shift and that she didn't remember Resident [redacted] stating that someone was hurting the resident. She could not recall making the statement.

At 11:59 AM, Surveyor #2 attempted to interview Resident [redacted] and the resident did not respond to Surveyor #2.

At 12:00 PM Surveyor #2 interviewed the Unit Manager (UM) regarding Resident [redacted]'s cognition. The UM stated the resident was [redacted] intact when admitted but that Resident [redacted] did not verbalize now. The UM stated that Resident [redacted] would not be able to be interviewed.

At 3:26 PM, Surveyor #2 interviewed the Registered Nurse/Supervisor (RN/S), via telephone. The RN/S had documented the note regarding Resident [redacted] stating that a man was trying to hurt the resident. The RN/S stated that she vaguely remembered the incident report. She then stated that she did not remember that the CNA stated that Resident [redacted] had stated someone was trying to hurt the resident. She

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F 610	Continued From page 3 further stated that if a resident or a staff member would state someone was hurting a resident, she would report it to the DON. On 12/02/21 at 9:36 AM, in the presence of the survey team, Surveyor #2 interviewed the DON regarding the incident report. The DON stated that she spoke with the CNA and that the CNA stated that she [CNA] was frequently in Resident ███'s room, and that there was no man around. The DON then stated that if someone is alleging abuse that they would do an internal investigation to substantiate (proved it occurred) or unsubstantiated (unable to prove it occurred) the allegation. She then added that any statement that someone made regarding that someone was hurting them would prompt her to complete an investigation. Surveyor #2 then asked the DON if the statement made by Resident ███ regarding a man trying to hurt [Resident ███] was an allegation of abuse. The DON stated that if she had to do an investigation than it would be an allegation of potential abuse. She then stated that she did not think there would need to be a separate incident report but that there should have been follow-up. She further stated that the nurse checked on Resident ███ and checked the area for any residents that were wandering but that the nurse did not complete an incident report and that "nothing" was documented. At 9:58 AM, in the presence of the survey team, Surveyor #2 interviewed the Director of Social Services/Abuse Officer (DSS/AO) regarding the incident report. The DSS/AO stated that she was not aware that Resident ███ voiced an allegation of abuse and that she should have been informed. She then stated that if there was an allegation of abuse that a full investigation should have be done. She further stated that she did not	F 610		

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have documentation that an investigation was completed regarding Resident [redacted]'s allegation of abuse and that she did not know why it was not completed.

At 12:02 PM, in the presence of the survey team, Surveyor #2 discussed the concern that an allegation of abuse was not investigated with the LNHA and the DON. The LNHA stated that the RN/S looked into the allegation as a clinical change in Resident [redacted]s status and not abuse.

On 12/03/21 at 9:49 AM, in the presence of the survey team, the DON stated that at the time of the incident the staff did a mini investigation that was not documented. At that time, the DON provided Surveyor #2 with a copy of a document titled, "Investigation Report" which contained an investigative summary, completed after surveyor inquiry, and dated [redacted].

At 10:13 AM, in the presence of the survey team, Surveyor #2 asked the DON to clarify the "Investigation Report". The DON stated that the "Investigation Report" is an addendum that was added to the incident report on [redacted] which was the written documentation of the abuse investigation. She further stated that the actions were done at the time of the incident but were not documented until [redacted].

A review of the facility provided policy titled, "Abuse, Neglect Exploitation or Misappropriation-Reporting and Investigating" with a revised date of April 2021, included the following:
Under Policy Statement
All reports of resident abuse ...are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated

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by facility management. Findings of all investigations are documented and reported.
Under Policy Interpretation and Implementation Reporting Allegations to the Administrator and Authorities
1. If resident abuse ...is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.
Investigating Allegations
1. All allegations are thoroughly investigated. The administrator initiates investigations ...
7. The individual conducting the investigation as a minimum:
a. reviews the documentation and evidence;
b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident;
c. observes the alleged victim, including his or her interactions with staff and other residents;
d. interviews the person(s) reporting the incident;
e. interviews any witnesses to the incident;
f. interviews the resident (as medically appropriate) or the resident's representative;
g. interviews the resident's attending physician as needed to determine the resident's condition;
h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident;
i. interviews the resident's roommate, family members, and visitors;..
k. reviews all events leading up to the alleged incident; and
l. documents the investigation completely and thoroughly ...
11. Upon conclusion of the investigation, the investigator records the findings of the investigation on approved documentation

A review of the facility provided policy titled,

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F 610	Continued From page 6 "Accidents and Incidents-Investigating and Reporting", with an edited date of 4/24/19, included the following: Under Policy Statement All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. Under Policy Interpretation and Implementation 1. The Nurse Supervisor/Charge Nurse and/or department director or supervisor shall promptly initiate and document investigation of the accident or incident. A review of the facility provide policy titled, "Abuse, Neglect, Misappropriation Prevention Program", with a revised date of April 2021, included the following: Under Policy Interpretation and Implementation 8. Identify and investigate all possible incidents of abuse ... N.J.A.C. 8:39-4(a)5	F 610		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 686		1/21/22

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F 686	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure that preventive measures to prevent/ promote healing of [redacted] were in place and staff were consistently following the order. This deficient practice was identified for (Resident [redacted]), 1 of 4 residents reviewed for [redacted] and was evidenced by the following: During the initial tour on 11/23/21 the surveyor observed Resident [redacted] lying in bed. Resident [redacted] told the surveyor that he/she needed staff assistance to get out of bed. The surveyor reviewed Resident [redacted]'s clinical record on 11/23/21 at 12:55 PM. The Admission Face Sheet revealed that Resident [redacted] was admitted to the facility with diagnoses which include [redacted]. The Admission Minimum Data Set (MDS), an assessment tool, dated [redacted] revealed that Resident [redacted] scored [redacted] on the Brief Interview for Mental Status (BIMS) Normal score [redacted]. Further review of the clinical record revealed that Resident [redacted] was at risk for [redacted]. Resident [redacted] received a [redacted] score on the [redacted] (tool used to determine [redacted] risk). Also noted was a Physician Order Sheet (POS) with a physician order dated [redacted] to cleanse the [redacted] with [redacted], cover with [redacted] pad and wrap with kling. Diagnosis: [redacted].	F 686	1. Resident [redacted] on [redacted] during the survey period. Plan of care was updated at that time. 2. Residents with heel wounds are at risk of being affected. No other residents were identified as being affected. 3. The ADON/Designee provided the aides and nurses with education on the responsibility of reviewing the Kardex and obtaining report on their assigned patients at the start of their shift. ADON/designee provided education to the nurses on implementing orders as written by the physician and obtaining a discontinuation of the order if the treatment/intervention is no longer warranted. 4. Unit Manager/Designee will perform weekly audits of heel off loading and treatment completion and present to DON weekly. DON will present results to the QAPI committee monthly X3 with full compliance within the first quarter, and then quarterly X3.	

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A review of the clinical record also revealed a care plan initiated on [redacted] and revised on [redacted] with a focus area of Actual [redacted] related to [redacted] The goal was for Resident [redacted] to show continued signs of healing.
The interventions were to:
Administer treatments as per physician orders.
Education provided not to use [redacted] for positioning.
Encourage and assist as needed to turn and reposition; use assistive devices as needed.
[redacted] as able.

On 11/24/21 at 8:59 AM the surveyor observed Resident [redacted] in bed and the [redacted] resting directly on the mattress.

On 11/24/21 at 10:42 AM, the surveyor inquired about the POS for the dressing to the [redacted]l. The Licensed Practical Nurse (LPN) assigned to the unit revealed that Resident [redacted] had an order for [redacted] (a protective barrier) to be placed on the [redacted]

On 11/24/21 at 10:46 AM, the surveyor entered the room with the nurse and observed Resident [redacted] in bed. The LPN informed the resident that she needed to check the resident's [redacted] The resident agreed to the request. The nurse removed the sheet and observed in the presence of the surveyor, that there was no dressing on the resident's [redacted] Resident [redacted] had a [redacted] area to the [redacted] surrounded by dry skin. The [redacted] was resting directly on the mattress. The nurse returned covered Resident [redacted]'s and left the room.

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F 686	Continued From page 9 On 11/29/21 at 8:44 AM, the surveyor returned to the room and noted Resident [redacted] lying in bed and the [redacted] was resting directly on the mattress. On 11/29/21 at 10:20 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who had cared for Resident [redacted]. The CNA told the surveyor that Resident [redacted] could assist with care and would get out of bed with the Physical therapy staff. The surveyor asked to see Resident [redacted]'s [redacted]. The CNA removed the cover and it was observed that Resident [redacted] did not have a dressing to the [redacted]. The [redacted] was not [redacted] (was not suspended so there would be no pressure on the [redacted]) but was noted to be resting directly on the mattress. The surveyor interviewed the CNA regarding Resident [redacted]'s care. The CNA told the surveyor that Resident [redacted] did not have an order for a [redacted] [redacted] (device used to [redacted]). The CNA further stated that she never observed Resident [redacted] with a [redacted] on. On 11/29/21 at 11:43 AM, the surveyor returned to the room with the CNA. The CNA checked the dresser and the resident's drawer but could not locate a [redacted]. On 11/30/21 at 8:30 AM, the surveyor observed Resident [redacted] lying in bed and the [redacted] was resting directly on the mattress. On 11/30/21 at 8:45 AM, an interview with the CNA revealed that Resident [redacted] did not have a dressing in place, or a [redacted]/or a pillow to [redacted]. That same day at 8:52 AM, the surveyor accompanied the nurse to the room where both	F 686		

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F 686	Continued From page 10 observed Resident [redacted] in bed. There was no dressing on the resident's [redacted] and, the [redacted] [redacted] was resting directly on the mattress. On 11/30/21 at 9:52 AM, the surveyor interviewed the Registered Nurse ADON, covering for the Unit Manager, regarding how Resident [redacted]'s Plan of Care was communicated to the CNA. The ADON stated to the surveyor that in the morning the facility did huddles (staff gathered to discuss residents) and all information regarding a residents care was entered and accessible to staff under Task on the Electronic Plan of Care (E-POC). An interview with Resident [redacted] on 11/30/21 at 9:58 AM, revealed that he/she had not been provided with a [redacted] or pillow to [redacted] the [redacted]. The surveyor asked the ADON to provide information or documentation regarding Resident [redacted]'s refusal to wear a [redacted] and the facility was unable to provide any such documentation. On 11/30/21 at 10:15 AM, the surveyor again interviewed the ADON who was covering for the Unit Manager, regarding the order on the care plan to off-load the resident's [redacted] The ADON stated that staff should use a [redacted] [redacted] or pillow if a resident refused to offload the [redacted] The surveyor asked the ADON to view Resident [redacted] while in the bed and asked the ADON if the right heel was off-loaded at that time. The ADON confirmed that the [redacted] was not off-loaded and there was no dressing applied to the [redacted]. There was no documentation in the clinical record regarding Resident [redacted]'s refusal to off-load the [redacted] at the time of the observation.	F 686		

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On 12/01/21 at 9:35 AM, the surveyor accompanied the ADON to the room and both observed Resident [redacted] lying in bed without a dressing on the [redacted]. It was also observed that the staff had signed the Treatment Administration record (TAR) on 11/23/21,11/24/21, 11/29/21, 11/30/21 and 12/01/21 which indicated the [redacted] dressing and off-loading of the [redacted] was in place. This documentation occurred on the days when the surveyor had observed Resident [redacted] in bed without a dressing on the [redacted] and without a pillow or [redacted] in place to off-load the [redacted]

The facility was informed of the above concerns for Resident [redacted] on [redacted] at 12:30 PM.

A review of the facility's policy for Charting and Documentation, dated 02/27/18, indicated the following under policy statement:

All services provided to the resident, progress toward the care plans goals, or any change in the resident's medical, physical functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.

A review of the facility's policy titled, Prevention of Pressure Injuries last revised 04/2020 revealed the following:

Purpose
The purpose of this procedure is to provide information regarding identification of [redacted] injury risk factors and interventions for specific risk factors.

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(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 686	Continued From page 12 Preparation Review the resident's care plan and identify risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. The policy was not being followed. Staff failed to review the care plan and implement interventions identified to reduce/prevent [REDACTED]. The policy was not being followed. NJAC 8:39-27.1 (e)	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records and other pertinent facility documentation, it was determined that the facility failed to apply a positioning device as ordered by the physician for 1 of 1 residents (resident [REDACTED] reviewed for positioning. This deficient practice	F 688	1. The [REDACTED] was reapplied to resident [REDACTED] immediately on 11/24/2021. The [REDACTED] remained in place until the discontinuation of the order on [REDACTED]1.	1/21/22

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F 688	Continued From page 13 was evidence of the following: On 11/23/21 at 9:15 am during tour, the surveyor observed Resident lying in bed wearing an (A is a device used to prevent your from moving out of the surgery. The pillow is placed between your and attached to your with straps). The resident was observed with and was unable to be interviewed. The surveyor reviewed Resident electronic medical record (EMR) revealed the following: The Admission Record (AR) dated , indicated that Resident was admitted with the diagnosis of subsequent encounter for with routine healing, resulting from damage or injury to the specific According to the admission Minimum Data Set (MDS) an assessment tool dated , Resident # scored on the Brief Interview for Mental Status (BIMS) which indicated . The MDS also reflected extensive to total of two person assistance with bed mobility, transfers, and activities of daily living (ADL). The Order Summary Report (OSR) dated , indicated that the staff was to ensure that an was in place while the resident was in bed every shift for a .	F 688	2. No other residents were observed to be affected by this practice. Residents with positioning devices have the potential to be affected. 3. ADON/Designee to provide education on positioning devices and review of report prior to start of the assignment. 4. Director of Rehab to maintain the master list of all positioning devices. The updated list provided to the Unit Manager and DON weekly. Unit Manager to conduct audit weekly and present results to the DON. DON will present the results to the QAPI committee monthly X3, to be in compliance within first quarter, and then quarterly x3.	

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F 688	Continued From page 14	F 688		

The Treatment Administration Record (TAR) dated on [redacted], indicated that the staff was to ensure [redacted] was in place while the resident was in bed every shift for a [redacted] [redacted]

The resident's Care Plan (CP) dated [redacted] indicated that the resident was at risk for complications due to [redacted] problems related to [redacted]. The interventions in place on the CP specified the following:
-[redacted] approach): Use [redacted] between [redacted] when lying in bed to prevent [redacted]
-Provide support device to site as needed immobilizer when in bed.
[redacted] while in wheelchair.

On 11/24/21 at 9:34 AM, the surveyor observed the Resident #[redacted] lying in bed not wearing an [redacted] that was ordered by the physician.

On 11/24/21 at 9:55 AM, the surveyor interviewed a Certified Nursing Assistant (CNA) who completed morning care for Resident #[redacted]. The CNA indicated that morning care consisted of complete bathing and dressing of the resident, while resident was in bed. The CNA revealed that she did not know why the resident was here and that she did not get report from the nurse that morning before she provided care to Resident #[redacted]. She further added that the resident was [redacted] and did not know how to [redacted].

On 11/24/21 at 9:57 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated Resident #[redacted] was in the facility for [redacted] from [redacted]. She also added that Resident #[redacted] received Physical Therapy (PT) and

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F 688	Continued From page 15 according to the physician orders, Resident # should be wearing an while in bed. The LPN indicated that she gave report to the CNA this morning and that she told the CNA to wash and dress the resident. She did confirm that she did not relay to the CNA that Resident was on precautions. The LPN explained to the surveyor that precautions required that an be worn while in bed to prevent the residents from being The LPN did not give the surveyor an explanation as to why she did not explain these precautions to the CNA who provided morning care. The surveyor then asked the LPN why the resident was not wearing the at this time. The LPN accompanied two surveyors to the room and admitted that the resident was not wearing an that was ordered by the physician. The LPN then proceeded to look for the and found it in a hamper underneath clothing. The LPN then explained that the resident had a room change and was transferred from room to room the evening on . The LPN then took the out of the hamper and placed it on the resident. The LPN could not explain as to how long the resident # was without the . On 11/24/21 at 10:13 AM, the surveyor interviewed the CNA who has been who employed in the facility for years. The CNA indicated that she was assigned to provide care to Resident # She revealed that she usually got report from the nurse in the morning about her assignment and what care she was to provide to her residents, but did not receive report today. She stated that Resident # was and unable to his/her needs or wants. The CNA stated that the resident's speech was and that he/she was	F 688		

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F 688	Continued From page 16	F 688		

difficult to understand. The CNA also added that when she provided morning care to Resident # that the resident was not wearing an in-between his/her . She stated that Resident required complete care with all aspects of activities of daily living and that when she provided care to the resident she washed and dressed him/her and turning the resident side to side without wearing the . She explained that she was not told that the resident required one.

On 11/24/21 at 11:01 AM, the surveyor interviewed the Physical Therapist, who stated that she has worked in the facility for years. She stated that Resident was admitted to the facility for . She added that the resident was ordered to have an in place while in bed. She revealed that the was to prevent of the and to prevent . She further stated that if the did become it could cause to the resident which would require tests and possible She explained that if the resident was in bed then the should be used and if the resident was in a wheelchair, a could be used if ordered by a physician.

On 11/29/21 at 9:51 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that it was the nurse's responsibility to report if a resident required precautions and to the CNAs. She explained that it was also added to the Care Plan and MDS. The ADON further added that she was not sure why the CNA was not given report on but that she would investigate it. She explained that an was used to prevent the from

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F 688	Continued From page 17 and that the nurse should have noticed that the was not in place during morning rounds first thing in the morning. The facility form titled, "Occupational Therapy Plan of Care (OTPOC)" dated , indicated that Resident # was admitted for . Precautions that were listed on the OTPOC included the following: risk, precautions, when in bed, The facility form titled, "Physical Therapy Plan of Care (PTPOC)" dated , indicated that Resident #453 was admitted for Precautions that were listed on PTPOC included the following: risk, precautions, when in bed, to . The facility policy titled, "Resident Mobility and Range of Motion (ROM)" with a revised date of July 2017 indicated that residents with limited ROM would receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility was unavoidable. The policy also indicated that interventions may include therapies, the provision of necessary equipment, and/or exercises and will be based on professional standards of practice and be consistent with state laws and practice acts. NJAC 8:39-27.1(a)	F 688		
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	F 690		1/17/22

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F 690	Continued From page 18 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 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: Based on observations, interviews, record review, and review of pertinent facility documents, the facility failed to ensure that the [redacted] [redacted] bag was stored in a manner to prevent [redacted] Infection [redacted] for 1 of 3 residents reviewed for [redacted] care (Resident [redacted]). The deficient practice was	F 690	1. Resident [redacted] was discarded on 11/24/21. Immediate competencies were completed on all aides for changing [redacted] and [redacted] 2. Residents with [redacted] are at risk to be affected by this practice. No	

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F 690	Continued From page 19 evidenced by the following: Resident [redacted] was readmitted to the facility with diagnoses which included [redacted] A care area assessment (CAA) associated with an admission Minimum Data Set (MDS), an assessment tool, dated [redacted] specified Resident [redacted] had a diagnosis of [redacted] and Resident [redacted] used a [redacted] inserted into the [redacted] drainage). A care plan dated [redacted] identified Resident [redacted] at risk for [redacted] due to a history of [redacted] and the need for a [redacted] due to [redacted] related to [redacted]. The care plan goal specified the resident would have no acute complications of [redacted] use. Interventions included: Administer medications per physician order. Change catheter per physician order. Change [redacted] bag as needed. Evaluate as needed for possible removal of [redacted] or [redacted] plan. Maintain [redacted] bag below [redacted] level. Provide [redacted] care per protocol and change [redacted] per physician's orders. A review of Resident [redacted]'s medical record revealed that Resident [redacted] was last treated for a [redacted] on [redacted] and the organism involved was [redacted]). An Admission MDS dated [redacted] indicated Resident [redacted]'s was awake, [redacted] and [redacted] at	F 690	other residents were found to be affected. 3. ADON/Designee performed competencies for all aides related to changing drainage and leg catheter bags. Competencies will be completed for all new staff to review the center policy. 4. UM/Designee will perform audits of the catheter bags weekly and present to DON. DON to present results of audits at QAPI monthly with full compliance within the first quarter.	

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F 690	Continued From page 20 times. The MDS coded the resident required some assistance with bed mobility and transfers. The MDS specified the resident had an [REDACTED] and used a wheelchair for locomotion. An observation on 11/23/21 at 12:30 PM revealed Resident [REDACTED] laying in bed. The surveyor observed the [REDACTED] bag stored in a plastic bag, hung on the rails in the bathroom. The [REDACTED] was not [REDACTED]. A [REDACTED] dated 1[REDACTED] was also noted next to the bag. An additional observation on 11/24/21 at 1:15 PM, revealed Resident [REDACTED] lying in bed and a leg bag on. The [REDACTED] bag was not in the bathroom. An interview was conducted on 11/24/21 with the Certified Nursing Assistant (CNA) who cared for Resident [REDACTED]. The CNA revealed that Resident [REDACTED] was dependent on staff for care, had a [REDACTED], and wore a [REDACTED] during the day to facilitate ease with therapy. The CNA further stated that the [REDACTED] was changed to a [REDACTED] bag at night. The surveyor then inquired about the storage of the [REDACTED] bag. The CNA went to the room and pulled a plastic bag out from the resident's drawer. The CNA opened the plastic bag and showed to the surveyor the [REDACTED]e bag stored with [REDACTED] and the [REDACTED] was not [REDACTED] The surveyor left the room and observed another surveyor in the hallway. The surveyor shared the observed practice with the other surveyor. The two surveyors went to the room and the CNA again showed how the [REDACTED] bag was stored with [REDACTED] and the	F 690		

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F 690	Continued From page 21 [redacted] was not [redacted]. The CNA then tied the plastic bag and returned the bag in the resident's drawer. The surveyor returned to the unit on 11/29/21 at 9:15 AM and observed Resident [redacted] in bed. A second interview with the CNA on 11/29/21 at 9:22 AM who cared for Resident [redacted] revealed that in the morning he assisted Resident [redacted] to the bathroom for care and switched the [redacted] bag to the [redacted] and stored the bag in a secure plastic bag. The surveyor inquired twice about the process, the CNA did not mentioned any cleaning or disinfecting of the [redacted] prior to applying the [redacted]. The CNA then informed the surveyor that he shared the conversation with the Unit Manager on 11/24/21 (UM) and he was told to discard the [redacted] An interview with the Registered Nurse (RN) assigned to the unit on 11/29/21 at 9:40 AM, revealed that the [redacted] was changed monthly. The surveyor reviewed with the nurse the order for [redacted] care. The RN indicated that she had to make sure that the [redacted] was not kinked and the [redacted] was not clogged. The RN indicated that CNA's were responsible to switch the [redacted] bag to the [redacted] in the morning and at bedtime. On 11/30/21 at 9:05 AM, an interview with the CNA who had cared for Resident [redacted], revealed that he had been in-serviced on storage of the [redacted] bag but could not recall the date. Regarding the process, he indicated that he assisted the resident to the bathroom and switched the [redacted] to the [redacted] and that the [redacted] was changed daily. The CNA did not mentioned the use of a disinfectant to wipe the	F 690		

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F 690	Continued From page 22	F 690		

prior to applying the

On 11/30/21 at 9:50 AM, an interview with the Infection Control Preventionist (IP) revealed that the facility initiated some in services about storage of the on 11/24/21. The IP provided the in-service education with the attached policy. The IP commented on the process. She indicated that the be rinsed of , and stored in a plastic bag. When inquired about the rationale for the above statement, the IP indicated that was to prevent infection.

On 11/30/21 at 9:42 AM, a review of the lab result dated revealed a for a The involved was with a greater than

On 12/01/21 at 9:46 AM, the surveyor observed another CNA switching the bag to the The CNA went to the pantry, obtained a and took it to the resident's room. The CNA entered the room, donned (applied) gloves and went to the bedside to switch the bag to the . The CNA returned to the bathroom to obtain the . The CNA did not wash her hands or change gloves. The CNA returned to the bedside to start the process. The CNA removed the from the and threw the in the receptacle bin next to the bed. The CNA was about to disconnect the bag when the surveyor questioned the process. The surveyor referred the CNA to the Unit Manager for clarification with the process. Upon further inquiry, the CNA told the surveyor that she had been working at the facility for the last months and did not receive any in-service on

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[redacted] care. The CNA further stated, "This is the way I always do it".

A second interview with the CNA on 12/01/21 at 12:20 PM, revealed that she informed the Assistant Director of Nursing (ADON) of the process. The CNA stated that she recognized the problem. She went on to state she did not perform hand hygiene and did not have a wipe to cleanse the [redacted].

Review of the facility's policy's for, "[redacted] [redacted] Bags" undated and revised 10/2010 indicated the following:

Purpose:

The purpose of this provide guidelines to decrease the likelihood of nosocomial [redacted] [redacted] associated with the intermittent use of [redacted] bags with [redacted].

General guidelines:
Every attempt should be made to maintain a closed [redacted] system.
[redacted] should be used only after careful consideration and after a decision has been made that the benefits of use of the [redacted] outweigh the potential increased of [redacted] [redacted]. The resident should be informed that there is increased risk of infection when the integrity of the closed [redacted] system is compromised.
A new sterile [redacted] bag should be used every time the regular [redacted] is disconnected and the [redacted] is used.
The regular [redacted] bag may be reconnected only if it appears that the integrity of the system has been maintained.
Aseptic technique must be used when handling

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[redacted] systems.
Do not wash or disinfect [redacted] in an attempt to reuse them.

Steps in the procedure.
Place the clean equipment on the bedside stand or overbed table. Arrange the supplies so they can be easily reached.
Wash and dry your hands thoroughly.
Put on gloves.
Wipe the [redacted] junction with alcohol wipe before disconnecting.
Disconnect the [redacted] from the [redacted]. If the drainage system has a tamper-proof seal, the seal will have to be broken. (Note: If the system has been previously opened, remove the tape.)
Carefully remove sterile cover over connection tip of the [redacted] bag.
Place the cover over the connection tip of the [redacted] bag.
Connect the [redacted] with the [redacted] bag. Anchor as needed.
Empty [redacted] bag and measure [redacted] as indicated. Keep the [redacted] bag in a safe place where it will not be mishandled. Continue to keep [redacted] bag beneath the [redacted] to prevent contamination. When the [redacted] bag is no longer needed, wipe the [redacted] alcohol wipe.
Wipe connection tip of [redacted] with alcohol wipe. If there is reason to believe the integrity of the system has not been maintained, obtain a new [redacted] bag.
Reconnect system. Secure the junction with tape.
Measure [redacted] bag into designated container.
Discard all disposable items into designated containers.
Remove gloves and discard in designated

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT HOLMDEL	188 HIGHWAY 34 HOLMDEL, NJ 07733

(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 690	Continued From page 25 containers. An interview with the Director of Nursing (DON) on 12/03/2021 at 9:24 AM, revealed her expectation was to ensure that the care was being delivered properly. The DON indicated that going forward the facility will do audits to ensure that staff were in compliance. NJAC 8:39-27.1 (a)	F 690		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication observation on 11/24/21, the surveyor observed three (3) nurses administer medications to five (5) residents. There were 32 opportunities, and three (3) errors were observed which calculated to a medication administration error rate of 9.38 %. This deficient practice was identified for two (2) of five (5) residents, (Resident [redacted] and [redacted], that were administered medications by two (2) of three (3) nurses. The deficient practice was evidenced as follows: 1. On 11/24/21 at 8:57 AM, the surveyor observed the Licensed Practical Nurse (LPN) preparing to administer medications to Resident [redacted]. The LPN stated that she was going to administer the	F 759	1. Medication error forms were completed for Resident [redacted] and Resident #[redacted] with notification of physicians. No new orders provided. Clinical practice referrals with immediate medication pass observations by the pharmacy consultant were initiated. 2. Residents receiving [redacted] [redacted] and over the counter medications(OTC) were at risk to be affected. No other residents were found to be affected. 3. ADON/Designee provided education to all nurses on proper administration technique of [redacted] and OTC medications. All new hire medication pass observations to include [redacted] administration observation.	1/21/22

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CARE ONE AT HOLMDEL	188 HIGHWAY 34 HOLMDEL, NJ 07733

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F 759	Continued From page 26 resident's first and then return to the medication cart and prepare the resident's oral medications. The LPN removed the resident's (ML) solution (a disposable single-patient-use prefilled pen) from the medication cart and explained that the resident had a physician's order (PO) on the electronic medication administration record (eMAR) for . The LPN showed the surveyor the resident's and indicated on the in the dose window that had been selected. On 11/24/21 at 9:02 AM, the surveyor observed the LPN inject the resident's with the . The surveyor reviewed the medical records for Resident . A review of the resident's Admission Record reflected that the resident was admitted on with diagnoses which included) and . According to the quarterly Minimum Data Set (MDS) (an assessment tool), dated reflected that the resident had a Brief Interview of Mental Status (BIMS) score of out of which indicated that the resident had a . A review of the resident's Order Summary Report reflected a PO dated for solution , inject one time a day for ." On 11/24/21 at 12:34 PM, the surveyor	F 759	4. ADON/ Pharmacy consultant/ Designee will perform two medication pass observation of a and OTC medications per week X4 and then one per week for three months. Results to be presented at QAPI meeting monthly X3 with compliance in first quarter.	

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CARE ONE AT HOLMDEL	**188 HIGHWAY 34 HOLMDEL, NJ 07733**

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F 759	Continued From page 27	F 759		

interviewed the LPN regarding the technique for administering with the The LPN stated that she had put a new needle on the and selected the right dose of and when she had injected the had held the button in for more than five (5) seconds. The LPN stated that she thought that was the correct procedure. The surveyor asked the LPN if there was any procedure for priming the before administering a dose. The LPN stated that the did not need to be primed. (ERROR#1)

On 11/24/21 at 11:44 AM, the Director of Nursing (DON) provided the surveyor with the administration instructions titled "Using and " that the facility used to instruct the nurses on the proper technique. The instructions revealed "Always prime your before each injection." The instructions also included to "Dial on your and then press the button to shoot some into the air to make sure it works." Further review included that "If you do not see at least after repeated priming, do not use the

At that time, the DON also provided the surveyor with a form that the facility educator completed when observing the nurses for medication observations titled "Medication Administration Observation Quality Improvement Program." The form included that when a medication observation was being completed the nurse was reviewed for the proper technique when administering injections.

On 11/30/21 at 9:30 AM, the surveyor interviewed the DON who stated that all

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CARE ONE AT HOLMDEL	**188 HIGHWAY 34 HOLMDEL, NJ 07733**

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F 759	Continued From page 28	F 759		

including [redacted] were required to be primed before each injection. The DON also stated that she was unsure the reason the [redacted] required priming but had received a handout of information from the Consultant Pharmacist (CP) regarding the proper technique and thought the reason would be included.

A review of the [redacted] Injections" handout of information provided by the CP reflected that the steps required to properly administer an [redacted] included "Always prime your [redacted] before each injection." The information also revealed to "Dial [redacted] on your [redacted] and then press the button to shoot some [redacted] into the air to make sure it works." In addition, "Priming means removing air bubbles from the needle, and ensures that the needle is open and working. The [redacted] must be primed before each injection"

On 11/30/21 at 12:26 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON who stated that she had already started in-services regarding the proper technique for [redacted] with the nurses. The DON also stated that the nurses were observed for medication administration after orientation and usually on a yearly basis. The DON stated that she would have to check for a completed medication observation and in-servicing for the LPN.

On 11/30/21 at 12:37 PM, the survey team met with the CP and the Consultant Pharmacist Director of Operations (DCP). The DCP acknowledged that information was provided to the facility regarding proper insulin pen technique. The DCP and CP also acknowledged that [redacted] must be primed before each dose and by not priming the [redacted] could cause an

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 759	Continued From page 29	F 759		

inaccurate dose to be administered. The DCP stated that she had provided the facility with the "Medication Administration Observation Quality Improvement Program" form that was used during a medication administration observation. The CP stated that medication observations were performed by her upon request by the facility and there was no specific frequency. The CP stated that the DON or nurse educator would let her know which nurse required a medication pass. The DCP added that the facility educator also performed medication observations with the nurses.

The DON provided the survey team with a "Preventing Medication Errors Inservice Record" for the LPN dated 2/2/20 indicating that the LPN had completed the in-service.

The DON had not provided a "Medication Administration Observation Quality Improvement Program" form for the LPN.

A review of the manufacturer's specifications for "How to use your [redacted] pen in 6 steps" revealed that a safety test was to be performed before each injection. The safety test entailed dialing a test dose of [redacted] pointing the needle up and injecting the dose to see that the [redacted] came out of the needle and that would help ensure the most accurate dose.

2. On 11/24/21 at 9:15 AM, the surveyor observed the LPN preparing to [redacted] [redacted] 87 which included one tablet of [redacted] milligram (MG)) (a [redacted] medication used to relieve [redacted]). The LPN stated that [redacted] was an over the counter (OTC) medication and was obtained by the facility as a house stock product

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and was stored in the original container in the medication cart. The LPN also stated that according to the eMAR for Resident [redacted], [redacted] was the OTC medication ordered by the physician. The LPN poured one (1) brown colored tablet into a medication cup from the bottle labeled [redacted]

On 11/24/21 at 9:31 AM, the surveyor observed the LPN administer the eight (8) oral medications which included the one (1) tablet of [redacted] to Resident [redacted].

Upon returning to the medication cart, the surveyor reviewed the eMAR with the LPN. The eMAR revealed a PO dated [redacted] for " [redacted]) (a combination [redacted] medication used to relieve [redacted] ." The LPN stated that she thought that [redacted] was the correct medication. The surveyor, with the LPN, reviewed the OTC medications in the medication cart which revealed a bottle labeled [redacted] with the ingredients listed as [redacted] MG and [redacted] MG. The LPN stated that she thought the [redacted] was a more concentrated product and did not think that [redacted] should have been administered for the PO. The LPN was unable to speak to the ingredients of [redacted] matching the PO. (ERROR#2)

On 11/24/21 at 10:23 AM, the surveyor with the Unit Manager/LPN (UM/LPN) reviewed the facility OTC house stock medications which included [redacted] MG) tablets and [redacted] MG- [redacted] MG) tablets. The UM/LPN stated that the two (2) medications were not the same and the [redacted] was a combination product that contained

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both and . The UM/LPN added that the PO would specify MG or MG for .

On 11/24/21 at 10:27 AM, the surveyor, with the UM/LPN, reviewed the PO for Resident . The UM/LPN stated that should have been administered for the PO for " MG, ( )."

The surveyor reviewed the medical record for Resident .

A review of the resident's Admission Record reflected that the resident was admitted on 1 with diagnoses which included) and).

According to the quarterly Minimum Data Set (MDS) (an assessment tool) dated reflected that the resident had a Brief Interview of Mental Status (BIMS) score of out of which indicated that the resident had a .

A review of the resident's Order Summary Report reflected a PO dated for " MG, ( ), give tablet by mouth two times a day for "

On 11/30/21 at 12:26 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON who stated that the nurses were observed for medication administration after orientation and usually on a yearly basis. The DON stated that she would have to check for a completed medication observation and

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in-servicing for the LPN.

On 11/30/21 at 12:37 PM, the survey team met with the CP and the Consultant Pharmacist Director of Operations (DCP). The DCP stated that the facility decided which OTC products the facility purchased, and that the CP was not involved in the decision. The CP and DCP acknowledged that the nurses were to administer the correct OTC medication which correlated with the PO. The DCP stated that she had provided the facility with the "Medication Administration Observation Quality Improvement Program" form that was completed during a medication observation. The CP stated that medication observations were performed by her upon request by the facility and there was no specific frequency. The CP stated that the DON or nurse educator would let her know which nurse required a medication pass. The DCP added that the facility educator also performed medication observations with the nurses.

The DON provided the survey team with a "Preventing Medication Errors Inservice Record" for the LPN dated [redacted] indicating that the LPN had completed the in-service.

The DON had not provided a "Medication Administration Observation Quality Improvement Program" form for the LPN.

A review of the facility policy, provided by the DON, dated as edited 5/21/19, reflected that medications were administered in accordance with prescriber orders. In addition, the policy reflected that the nurse administering the medications was to check the label three times to verify the right medication.

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F 759	Continued From page 33 3. On 11/24/21 at 9:49 AM, the surveyor observed the Registered Nurse (RN) preparing to administer six (6) medications to Resident # On 11/24/21 at 10:03 AM, the surveyor observed the RN return to the medication cart after administering the six (6) medications and reviewed the resident's eMAR and explained that she had to administer two (2) additional medications which included ((a supplement). The RN stated that (was an OTC medication and was obtained by the facility as a house stock product and was stored in the original container in the medication cart. The RN prepared one (1) MG tablet of (At that time, the surveyor, with the RN, reviewed the eMAR for the PO for (. The RN stated that she had the correct OTC medication. On 11/24/21 at 10:07 AM, the surveyor observed the RN administer one (1) MG tablet of (to Resident Upon returning to the medication cart, the surveyor asked the RN to further review the eMAR which revealed that the PO dated was for " MG, give one tablet by mouth times a day for supplement." The RN stated that she thought she had administered the correct dose but had administered MG one tablet. (ERROR #3) The RN added that she should have administered tablets of the MG to make the dose of MG. The RN was unsure if the facility had the MG tablets of and was unable to find a bottle of the	F 759		

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F 759	Continued From page 34 MG tablets on her medication cart. On 11/24/21 at 10:12 AM, the RN#2 stated that she was the nurse in charge at the desk of the Unit for the day and thought the facility had (MG tablets as an OTC house stock medication. The UM/RN further stated that the PO should be followed as ordered. The RN#2 explained that if the PO indicated to administer MG then a MG tablet should be administered. The RN#2 added that if the facility had MG then the PO would indicate to administer MG tablets to make the dose of MG. On 11/24/21 at 10/16/21, the surveyor interviewed LPN#2, who stated that she had ( ) MG tablets on her medication cart. The LPN#2 also stated that she followed the PO as to whether she administered the MG tablets or the MG tablets. The surveyor reviewed the medical record for Resident . A review of the resident's Admission Record reflected that the resident was admitted on with diagnoses which included) and According to the admission Minimum Data Set (MDS) (an assessment tool), dated reflected that the resident had a Brief Interview of Mental Status (BIMS) score of out of which indicated an . A review of the resident's Order Summary Report reflected a PO dated for " (MG, give tablet by mouth two times a day for supplement."	F 759		

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F 759	Continued From page 35	F 759		

A review of the list of house stock medications provided by the DON reflected that [redacted] ([redacted] [redacted] MG and [redacted] MG tablets were ordered by the facility.

On 11/30/21 at 12:26 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON who stated that the nurses were observed for medication administration after orientation and usually on a yearly basis.

On 11/30/21 at 12:37 PM, the survey team met with the CP and the Consultant Pharmacist Director of Operations (DCP). The DCP stated that the facility decided which OTC products the facility purchased, and that the CP was not involved in the decision. The CP and DCP acknowledged that the nurses were to administer the correct dosage of the OTC medication which correlated with the PO. The DCP stated that she had provided the facility with the "Medication Administration Observation Quality Improvement Program" form that was completed during a medication observation. The CP stated that medication observations were performed by her upon request by the facility and there was no specific frequency. The CP stated that the DON or nurse educator would let her know which nurse required a medication pass. The DCP added that the facility educator also performed medication observations with the nurses.

The DON provided a completed "Medication Administration Observation Quality Improvement Program" form dated [redacted] by the nurse educator indicating the RN had no errors.

A review of the facility policy dated as edited 5/21/19 reflected that medications were

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F 759	Continued From page 36 administered in accordance with prescriber orders. In addition, the policy reflected that the nurse administering the medications was to check the label three times to verify the right dosage. NJAC 8:39-11.2(b), 29.2(d)	F 759		

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	061312	A. BUILDING: ______ B. WING ______	12/07/2021

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes	S 560	1. The facility leadership team has met on a ongoing basis and continue to identify staffing challenges and areas of improvement for licensed and certified needs. Recruitment efforts include: online advertisements, local community advertisements at areas such as apartment complexes and shopping and entertainment centers, availability of CNA training course at sister facility, sign on bonus, refer a friend bonus for current employees, weekend and offsite interview availability, offering of temporary license, and continued use of agency staff to supplement. The center also utilizes the	2/18/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/24/21

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S 560	Continued From page 1	S 560		

effective 2/1/21.

1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios:

(1) one certified nurse aide to every eight residents for the day shift;
(2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and
(3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties

b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census.

c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place.
(2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place,

assistance of nurse management, physical therapist and occupational therapists to assist with direct care as directed by the Director of Nursing.

2. All residents have the potential to be affected.

3. The facility has implemented significant above market rate for nurses and certified nursing aides including sign on bonus when appropriate. The facility continues to utilize online recruitment and job fairs with immediate interviews and contingency offers. The facility implemented an expediated but robust onboarding process. The facility will use agency staff as needed to meet staffing needs.

4. The Director of Nursing or Designee will meet with the staffing coordinator daily to review call outs if any, facility census vs. staffing needs. The Director of Nursing or Designee will monitor call outs and staffing ratios weekly until the requirement is met. The results of the audit will be forwarded to the Administrator. The results will be sent to QAPI committee monthly for further review and recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061312	A. BUILDING: ____ B. WING ____	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT HOLMDEL	188 HIGHWAY 34 HOLMDEL, NJ 07733

(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) COMPLETE DATE
S 560	Continued From page 2	S 560		

is fifty-one hundredths or higher.
(3) All computations shall be based on the midnight census for the day in which the shift begins.

d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ...

On 11/23/21, 11/24/21, 11/29/21, 11/30/21, 12/1/21, 12/2/21, and 12/3/21 the surveyors observed nine to eleven Certified Nursing Assistants (CNA)s working on the units and providing direct resident care.

Review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 11/7/21 and 11/14/21 revealed the facility was deficient in CNA staffing for residents on 14 of 14-day shifts and was evidenced by following:

- 11/07/21 had 8 CNAs for 108 residents on the day shift, required 14 CNAs.
- 11/08/21 had 10 CNAs for 105 residents on the day shift, required 14 CNAs.
- 11/09/21 had 11 CNAs for 105 residents on the day shift, required 14 CNAs.
- 11/10/21 had 11 CNAs for 105 residents on the day shift, required 14 CNAs.
- 11/11/21 had 11 CNAs for 105 residents on the day shift, required 14 CNAs.
- 11/12/21 had 10 CNAs for 103 residents on the day shift, required 13 CNAs.
- 11/13/21 had 10 CNAs for 102 residents on the day shift, required 13 CNAs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061312	A. BUILDING: ______ B. WING ______	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT HOLMDEL	188 HIGHWAY 34 HOLMDEL, NJ 07733

(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) COMPLETE DATE
S 560	Continued From page 3	S 560		

- 11/14/21 had 10 CNAs for 102 residents on the day shift, required 13 CNAs.
- 11/15/21 had 11 CNAs for 101 residents on the day shift, required 13 CNAs.
- 11/16/21 had 11 CNAs for 100 residents on the day shift, required 13 CNAs.
- 11/17/21 had 9 CNAs for 99 residents on the day shift, required 13 CNAs.
- 11/18/21 had 10 CNAs for 96 residents on the day shift, required 12 CNAs.
- 11/19/21 had 10 CNAs for 96 residents on the day shift, required 12 CNAs.
- 11/20/21 had 8 CNAs for 96 residents on the day shift, required 12 CNAs.

On 11/29/21 at 12:48 PM, the surveyor interviewed CNA#1 who stated they worked at the facility for over 10 years on the 7:00 AM - 3:00 PM shift. CNA#1 stated when he/she worked, they usually had 12 plus residents to care for and when he/she worked overtime on the 3:00 PM - 11:00 PM shift, he/she could have up to 17 residents on their assignment. CNA#1 stated it was very difficult to perform his/her job functions. For example, on their assignment CNA#1 could have 4 residents that need to be fed, while feeding the residents, other residents needed help and it's was impossible to provide the necessary care for all the residents on his/her assignment. CNA#1 stated they wished to remain anonymous because he/she, "did not want to get into trouble."

On 11/29/21 at 1:01 PM, CNA#2 stated they worked at the facility for 7 months and usually worked the 7:00 AM -3:00 PM shift. CNA#2 stated he/she also worked overtime on the 3:00 PM -11:00 PM shift. CNA#2 stated it would depend on how many staff members worked to how many residents he/she cared for.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061312	A. BUILDING: ______ B. WING ______	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT HOLMDEL	**188 HIGHWAY 34 HOLMDEL, NJ 07733**

(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) COMPLETE DATE
S 560	Continued From page 4 On 11/29/21 at 1:03 PM, CNA#3 stated they worked at the facility for, "a long time" and worked full time on the 7:00 AM - 3:00 PM shift. CNA#3 stated he/she usually cared for 10-11 residents on her care assignment.	S 560		