STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315275	A. BUILDING _____ B. WING _____	08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORD HEALTHCARE & REHABILITATION CENTER	**963 OCEAN AVE LAKEWOOD, NJ 08701**

(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 Survey Date: 8/6/21 Census: 75 Sample: 19 + 3 + 1 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 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure a resident received treatment and services to promote healing of a chronic stage two (Stage II) pressure ulcer. This deficient practice was identified for 1 of 3 residents, (Resident #19) reviewed for pressure ulcers and	F 686	F686: Plan of Correction The nurse responsible for Resident #19, was educated on proper [redacted] care procedures. A wound care competency was conducted on the nurse by the Staff educator on 8/5/21. An audit was conducted on all nurses by	8/9/21

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

Electronically Signed | 09/09/2021

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F 686	Continued From page 1 was evidenced by the following: On 08/2/21 at 07:11 PM, the surveyor observed Resident #19 sitting upright and asleep in his/her bed on a fully inflated and functioning [redacted]. On 08/5/21 from 10:03 AM to 10:17 AM, the surveyor in the presence of another surveyor and the Registered Nurse/Unit Manager (RN/UM) observed the Licensed Practical Nurse (LPN) perform the [redacted] treatment to Resident #19's [redacted]. The following observations were made: At the treatment cart, the LPN gathered the required supplies which included island dressing (a sterile gauze bandage which is centered in a square adhesive pad), wooden tongue depressor (for medication application), and squeezed [redacted] into a small medication cup. The LPN, while at the treatment cart used her ungloved hand to open and date the outside of the island dressing. At 10:08 AM, the LPN performed hand hygiene using soap and water and laid a dry clean pad on the bedside table and placed the supplies. The LPN proceeded to turn Resident #19 with the assistance of the RN/UM exposing a clean, oval shaped, reddish-pink, healing [redacted] on his/her [redacted]. The LPN then performed hand hygiene using alcohol based hand rub and put on clean gloves. The LPN dampened a clean gauze with [redacted] and [redacted]. The LPN then disposed of the soiled gauze and immediately grabbed new, clean, dry gauze and	F 686	Nursing Supervisors to ensure that proper wound procedures was being followed. It was noted that all residents received the proper wound treatment and proper procedures was being followed. All residents that receive wound care have the potential to be affected by this practice. All nurses received education and had to undergo wound care competency training by the Staff educator or Nursing Supervisors on proper wound treatment procedures. All nurses received education and had to undergo wound care competency training by the Staff educator or Nursing Supervisors on proper wound treatment procedures. As a systemic change, On-going monitoring will be performed by the Nursing supervisors to ensure that proper wound treatment procedures are being followed. The auditing will occur daily for one week, then weekly for three weeks and then monthly thereafter for the next 6 months. All results will be brought to the Quality Assurance Committee for review and recommendations Quarterly. The Director of nursing is responsible for implementing the plan of correction and date of completion was 8/9/21.	

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F 686	Continued From page 2	F 686		

patted the [redacted] dry. There was no observed glove change or hand hygiene performed after the disposal of the soiled gauze and the application of the clean gauze. The LPN using the same gloves, then applied the [redacted] with the tongue depressor to the resident's [redacted]. Then the LPN without any observed glove change or hand hygiene applied the clean pre-dated island gauze dressing to the resident's [redacted] and then removed her gloves and preformed hand hygiene.

The surveyor reviewed Resident #19's medical record.

A review of the Admission Record reflected that the resident was re-admitted to the facility in [redacted] with diagnoses which included [redacted] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted]

A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated that the resident had NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. . A further review of the NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. , reflected that the resident had no active [redacted]

A review of a telephone physician's order dated [redacted] for NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. ; to cleanse [redacted] with NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. , apply [redacted] to [redacted] and cover with clean dry dressing daily for [redacted] days.

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F 686	Continued From page 3	F 686		

A review of the Progress Notes reflected a [redacted] Note dated [redacted], that the resident had a [redacted] that evolved into a [redacted] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] in size. The plan was clean [redacted] and apply [redacted] with clean dry dressing daily and as needed if soiled.

A review of the resident's individualized care plan reflected that the resident had a focus area dated 6/27/21, for the potential for skin breakdown related to compromised skin integrity on [redacted]. Interventions included; to administer treatment per physician orders.

On 08/5/21 at 11:53 AM, the surveyor interviewed the LPN who stated that the process to perform wound care would be to remove the dressing off the wound, assess the wound for any sign of infection, clean the wound as ordered, remove gloves, sanitize hands, put on new clean gloves and then apply medication and new dressing as ordered. When the surveyor asked the LPN if she missed any of these steps during the wound care, the LPN replied that she could not remember.

On 08/5/21 at 12:07 PM, the surveyor interviewed the RN/UM who stated to that the procedure for wound care after gathering supplies and checking physician orders was to remove the dirty dressing and assess for signs of infection, remove gloves and wash hands, put new gloves on, apply ointment or medication and dressing. When the

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F 686	Continued From page 4 surveyor asked the RN/UM if the LPN had missed any of these steps, the RN/UM replied that she could not remember. On 8/5/21 at 12:54 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the procedure for wound care would be to wash hands, put on clean gloves, remove dressing already in place, dispose of dirty dressing and dirty gloves, perform hand hygiene, put on new gloves, clean wound site as ordered, dispose of gloves and perform hand hygiene, and apply treatment medication and clean dressing. On 08/6/21 at 09:23 AM, the Vice President (VP) in the presence of the DON, Licensed Nursing Home Administrator, and the survey team stated that, "The nurse who forgot to change her gloves, she should have. She knew what to do, but she got scared." A review of the facility's "Wound Care Procedure for Major Wounds" policy dated revised 2009, included the procedure for wound care is to remove soiled dressing, remove gloves and discard, wash hands, clean the wound according to the order, place soiled gauze used for cleaning in (trash) bag, remove gloves, put on new gloves, apply clean dressing as ordered, remove gloves, and initial, date and time dressing. NJAC 8:39-27.1(e)	F 686		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides-	F 805		8/9/21

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F 805	Continued From page 5 §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, it was determined that the facility failed to provide the correct consistency of diet according to physician's orders. This deficient practice was identified for 1 of 4 residents (Resident #58) reviewed for nutrition and evidenced by the following: On 8/4/21 at 11:45 AM, the surveyor observed the Certified Nursing Aide (CNA) place a lunch meal tray in front of an unsampled resident. The meal ticket on the tray identified the meal was for sampled Resident #45 and contained a peanut butter and jelly sandwich, jello, creamed celery, health shake (nutritional supplement) and thin liquids (consistency) of water and gingerale. The CNA set-up the meal by placing a spoon in the soup, opened all three beverage containers, and cleaned the resident's hands. The surveyor observed no identification on the resident so they asked the resident what his/her name was. The resident had not responded and the CNA told the resident to tell the surveyor his/her name. The resident identified him/herself as Resident #58 and the CNA confirmed this. At this time, the CNA left the resident alone with the meal tray to eat and drink. On 8/4/21 at 11:50 AM, the surveyor asked the Licensed Practical Nurse/Unit Manager (LPN/UM) to identify Resident #58, which the LPN/UM confirmed that the resident was Resident #58. At this time, the surveyor asked the LPN/UM to	F 805	F805: Plan of correction Resident #58 tray was immediately removed, and the resident was provided with the proper tray. A root cause analysis was conducted, and it was determined that the Nursing assistant gave the resident the wrong tray. All staff in the building were in-serviced on tray accuracy by Dietitian and staff educator. All residents have the potential to be affected by this practice. Resident meal trays were audited by the Dietician and Nursing supervisors for accuracy during the following mealtime. It was noted that all residents received their meals according to their physician orders during that audit. Director of Nursing will ensure that during mealtimes the nurses and Nursing Assistance check trays to make sure all residents are receiving their meals according to their physician orders. All Nursing assistance and Nurses were in-serviced on Meal Tray Accuracy by the Dietician and the staff educator. As a systemic change, On-going monitoring will be performed by the Dietician or Nursing supervisors utilizing the Meal Tray Accuracy Audit tool to ensure continued compliance. The auditing will occur daily for all meals for one week, then daily for one meal for three weeks and then monthly thereafter for the next 6 months. All results will be brought to the Quality Assurance	

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F 805	Continued From page 6 accompany them to the resident's tray and identify whose lunch tray this was. The LPN/UM confirmed that the tray was Resident #45's and not Resident #58's. The LPN/Um immediately removed the lunch tray and put it at the nurse's station. The LPN/UM stated that it had not appeared that the resident had eaten or drank from the lunch tray. At this time, the surveyor observed a list on the cabinet entitled "Residents with Thickened Liquids/Fluid Restrictions Ordered" dated revision 8/4/2, which indicated that Resident #58 was on nectar thick liquids (consistency slightly thicker than thin liquids) and not the thin liquids he/she was served on Resident #45's lunch tray. On 8/4/21 at 11:53 AM, the surveyor observed Resident #58's lunch tray which contained chopped carrots and cheese blintz, pudding, cream of celery, health shake, and nectar thick cranberry juice and nectar thick lemon beverage. On 8/4/21 at 11:54 AM, the surveyor interviewed the CNA who stated that he was given Resident #45's lunch tray and was told to give it to Resident #58. When asked who the person was, the CNA responded that he could not remember, but confirmed that he was suppose check the tray as well to ensure that correct resident received the correct tray. The CNA confirmed that Resident #58 drank nectar thick liquids, but he was unsure the liquid consistency that he/she received on the other resident's tray. The surveyor reviewed the medical record for Resident #58. A review of the Admission record reflected that	F 805	Committee for review and recommendations Quarterly. The Dietician is responsible for implementing the plan of correction and date of completion is 8/9/21.	

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F 805	Continued From page 7	F 805		

the resident was admitted to the facility in [redacted] of [redacted], with diagnoses which included [redacted] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted]

A review of the admission Minimum Data Set, an assessment tool dated [redacted], reflected a Brief Interview of Mental Status (BIMS) score of [redacted] out [redacted] which indicated [redacted] A further review of the MDS in [redacted] - [redacted] indicated that the resident required extensive assistance of one person physical assistance for eating.

A review of the active Order Summary Report dated 8/4/21, reflected a physician's order dated 7/15/21, for nectar thick liquids.

A review of the Progress Notes reflected a Nursing Progress Note dated 7/15/21, that the [redacted] stated that the resident was coughing during session ([redacted]) so diet was downgraded to mechanical soft (food texture) with nectar thick liquids.

A review of the resident's individualized care plan reflected a focused area dated 7/6/21, that the resident has a [redacted] problem or potential [redacted] problem with regards to [redacted] and [redacted]. Interventions included to feed self after tray set up; staff will monitor for sign and symptoms of [redacted] ([redacted]) and staff will provide and serve diet as ordered.

On 8/4/21 at 12:29 PM, the surveyor re-interviewed the CNA who stated that the

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F 805	Continued From page 8	F 805		

resident was able to feed him/herself, but required assistance with the set-up. The CNA stated that staff observed the resident eating to ensure that the resident took small bites and drank plenty of liquids to prevent pocketing of food or aspiration (when something such as food or liquids enters your airway or lungs by accident).

On 8/4/21 at 12:36 PM, the surveyor re-interviewed the LPN/UM who confirmed that the resident fed him/herself, but it had not appeared that the resident had touched anything on Resident #45's lunch tray.

On 8/4/21 at 1:09 PM, the surveyor interviewed the ST via telephone who stated that Resident #58 was currently receiving [redacted]. The resident arrived to the facility with a diet order of regular texture food and thin liquids. The ST stated that she had observed the resident two weeks later eating poorly and he/she seemed congested so she put the resident in [redacted] and changed the diet order to mechanical soft food texture with nectar thick liquids with a goal to return back to regular texture food and thin liquids. The ST stated that thin liquids were not "dangerous" to the resident, and if the resident were to receive, they would not be at risk for "choking" or "death."

On 8/5/21 at 1:11 PM, the surveyor in the presence of the Licensed Nursing Home Administrator, Director of Nursing, Regional Nurse, and survey team addressed this concern.

A review of the facility's undated "Meal Tray Policy and Procedure" which included that staff passing trays will check the meal ticket to identify the

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F 805	Continued From page 9 correct resident before passing each tray and special or altered diets listed on the meal ticket will be verified before the resident begins eating. NJAC 8:39-17.4(a)(1,2); 27.1	F 805		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315275	A. Building B. Wing	9/9/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORD HEALTHCARE & REHABILITATION CENTER	963 OCEAN AVE LAKEWOOD, NJ 08701

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0686 Reg. # 483.25(b)(1)(i)(ii) LSC	Correction Completed 08/09/2021	ID Prefix F0805 Reg. # 483.60(d)(3) LSC	Correction Completed 08/09/2021	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/6/2021

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**