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			SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE 07/01/2021

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING С 315309 B. WING 06/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 23 SCHOOLHOUSE ROAD **ARISTACARE AT WHITING** WHITING, NJ 08759 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 656 Continued From page 1 F 656 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-(A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: C#: NJ146034 Element 1: Facility implemented a visual on the door for Resident #1 indicating the CP preference of having a female aide. Based on interviews, record review, and review of Element 2: facility will audit all residents pertinent documents on 6/16/2021, it was with aide preference care plan to ensure determined that the facility failed to follow a compliance. resident's care plan interventions for the Element 3: Facility updated Visual Cue resident's preferences for female caregivers for 1 policy to reflect care givers. Facility staff to of 3 residents (Resident) reviewed for care be educated on updated policy. plans. This deficient practice was evidenced by Element 4: Nursing administration will the following: conduct audits to ensure compliance and will be reported to the quality steering Review of the Electronic Medical Records committee meeting monthly for three (EMRs) were as follows: month. Following the three months, the committee will determine the frequency According to the "Admission Record (AR)," and need of the reports/audits. Resident was admitted to the facility on , with diagnoses which included but were not limited to

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 315309 B. WING 06/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 23 SCHOOLHOUSE ROAD **ARISTACARE AT WHITING** WHITING, NJ 08759 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 656 Continued From page 2 F 656 According to the Minimal Data Set (MDS), an assessment tool dated , Resident had a Brief Interview for Mental Status (BIMS) , indicating the resident was score of . The MDS also showed that Resident #2 needed assistance with Activities of Daily Living (ADLs). Review of Resident Care Plan (CP) showed under Focus: Resident at-risk/wander r/t (related to) disorientation to place. Resident wanders aimlessly and cognitive impairments, dated Further review of the CP revealed under Interventions: Resident prefers female caregivers, dated A review of the staffing schedule dated 6/13/2021 for the 3:00 p.m. to 11:00 p.m. shift revealed a male Certified Nurse's Assistant (CNA) was assigned to Resident #2. During an interview on 6/16/2021 at 12:32 p.m., when asked by the Surveyor if he was assigned to Resident , on 6/13/2021, the CNA confirmed he was assigned to the resident. The CNA also stated that he was previously assigned to Resident The CNA explained he did not know if the resident prefers male or female staff members. During an interview on 6/16/2021 at 12:50 p.m., the Unit Manager (UM) stated, "the resident prefers females only. We had five CNAs that night (6/13/2021); the resident usually is assigned a female. The UM further stated. "I educated everybody that she prefers female staff." During an interview on 6/16/2021 at 1:36 p.m., the Assistant Administrator (AA) stated, "the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED A. BUILDING NAME OF PROVIDER OR SUPPLIER 315309 B. WING 06/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 06/16/2021 ARISTACRE AT WHITING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETED C			D HUMAN SERVICES MEDICAID SERVICES					FORM APPROVED B NO. 0938-0391	
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